# Reducing Stress in Professional Carers of People with Dementia: An Exploratory Study Using Reiki in Aged Care


## Graham R Webber

***Master of Science (Medicine) by research, Master of Disability Studies,***

***Diploma of Teaching, Graduate Diploma of Education,***

***Reiki Master/Teacher, Seichim,***

***Therapeutic Touch (Beginners Level),***

***Certificate II in Massage (Aromatherapy).***

***Graham.webber@flinders.edu.au***


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At the Flinders University of South Australia

Disability and Community Inclusion, School of Health Sciences,

Faculty of Medicine, Nursing and Health Sciences,

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# Abstract

This Doctor of Philosophy project investigates the potential for Reiki to reduce the stress facing professional carers of people with dementia who are resident in High Care Aged Facilities. My previous research for a MSc (Webber, 2008) demonstrated that, although Reiki was being used in the care of people with dementia, there was very little in the scientific literature about the use of Reiki and no evidence as to its efficacy. From this masters-level work, my original contribution to knowledge in this PhD demonstrates that the use of Reiki in the care of people can provide benefits to both the carer who uses Reiki and the persons for whom they care.

Based on a single subject/single case research design, this mixed method, exploratory project examined the potential for using Reiki to reduce stress in professional carers of people with dementia and who are resident in Aged Care Facilities. It was structured to enmesh with conventional working conditions as closely as possible and allowed the participants autonomy in their practice of Reiki. Staggered base lines were obtained by training three groups separately: one in September 2011, another in mid-March 2012 and the third in late-March 2012.

A Reiki Master/Teacher (in the lineage of *Mikao Usui, Chujiro Hayashi, Mrs Takata, and Phyllis Lei Furumoto*) trained 19 volunteer carers in *Usui Shiki Ryoho* Reiki I. For the period of the study, the carers conducted their normal duties and applied Reiki on a needs basis to themselves, their family members and their clients.

The major focus was an analysis of qualitative data gained through in-depth, semi-structured interviews which I conducted with the carers, pre-Reiki training, six to seven weeks after the training, and 12 months after the second interviews and through group meetings held with the newly trained Reiki practitioners at three weeks and six weeks following the Reiki training. The project also collected quantitative data about participant demographics and self-assessed stress levels at each interview as well as participant use of Reiki via Reiki Recording Sheets maintained by the participants.

Although the overall results regarding the use of Reiki are inconclusive, this research has demonstrated that, by learning and using Reiki in their daily work, some carers experience reduced stress levels. This could then have a flow-on effect of relaxing the people for whom they provide care. The examples of successful outcomes provided by participants in this study, together with their ability to adapt the use of Reiki according to the different situations which they encountered in their work, suggest that Reiki is an appropriate touch therapy for use as a PRN (‘*pro re nata’* – according to need, or as the

circumstances require) therapy in aged care facilities. In fact, it may provide aged care workers with a reason to offer residents comforting touch that is so often missing in aged care.

This research has demonstrated that a mixed method project based on a single subject design can be a valuable tool for investigating the use of Reiki in aged care. Challenges emerged during this doctoral research and these are acknowledged and discussed throughout my doctoral research to ensure that future research projects can mitigate these variables.

**Key Words**

Alternative therapies, CAM, carer stress, complementary therapies, dementia, disability; Nurses; one-to-one interaction, Patient Care Attendants, Personal Care Workers, quality of life; Reiki, therapeutic touch, unconventional therapies, well-being, wellness.

# Declaration

*I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.*

Graham R Webber

Date: Thursday, 15 September 2016

# Acknowledgements

I would like to acknowledge the following people for their valuable contributions to this doctoral project.

First and foremost my thanks go to the South Australian residential aged care workers who participated in this research. Of particular value was the contribution made by one participant who believed that 'the power to have energy flow through you, is not something that a human can do' but was prepared to 'give it a go'. Also, without the considerable contributions made by Ian Dick, the Reiki Master/Teacher who conducted the Reiki training this doctoral project would not have progressed. As a boilermaker by training and an aged care worker at the time of his involvement in this project, he must be congratulated for the professionalism of the training: particularly so, because he was not a trained educator.

My thanks also go to Judy Gent, a Reiki I practitioner who willingly volunteered to act as an assistant to the Reiki Master/Teacher and generously welcomed Group 1 participants into her home for Reiki training. Her foresightful comments regarding this thesis were also greatly appreciated. I also appreciated the involvement of the university senior lecturer who attended the first Reiki training as an independent observer. Although he was, and still is, sceptical about Reiki, his willingness to act as a 'crash test dummy' during the Group 1 training day was certainly appreciated by all participants present on the day. The willingness of Dr Peter Cookson, a fellow PhD student, to offer brutally honest criticism was also greatly appreciated. Without his personal support during many difficult times, this thesis would never have been completed. The professional transcriptions of the digitally recorded interviews provided by Wyn Gough made my task so much easier. I also appreciated the speed in which she returned the transcripts to me. I would also like to thank Dr. Brian Matthews, my original principal PhD supervisor.

My thanks also go to Professor Emeritus Trevor Wilson who commented on an early draft of this thesis. His positive comments about my topic convinced me to work through a difficult period and continue with my research.

I am deeply indebted to Professor Tara Brabazon, Dean of Graduate Research at Flinders University, who willingly stepped into the role of my principal supervisor when I had given up hope of completing a successful PhD thesis. Her support and encouragement enabled me to 'soldier on' against what I thought were insurmountable

odds. Because of her support, the contributions of the participants in this project will receive the recognition that they so richly deserve.

Finally, but not least, Reiki Master/Teacher, Beryl Barker, deserves my special thanks for her support and understanding during my training in Reiki. She provided so much comfort to so many people during her lifetime. Although she has passed over, I believe her legacy lives on in her students. Also, thanks go to Professor Roy Brown, former Dean of the School of Special Education and Disability Studies at Flinders University, who accepted my application to study the efficacy of complementary therapies as part of the Master of Disability Studies. Work carried out during that course laid the foundations for my MSc study and this doctoral project.

## Dedication

I would like to dedicate this Thesis to Ian Dick, the Reiki Master/Teacher who willingly donated his time and energies to conduct the Reiki Training for this Doctoral Study. At about the time of the training he was diagnosed with cancer and, unfortunately, he passed over before I received notification that this study had been accepted as worthy of a PhD. I would not be surprised if Beryl Barker (our mutual Reiki Master/Teacher) and Ian are now discussing Reiki while sharing a heavenly cup of tea!

The world of Reiki has lost a truly gentle and loving soul who devoted many years to the care of people living in an Adelaide aged care facility.

Graham R. Webber: 23rd February 2017

# 1 Launching a New Approach to Dementia Care: Thesis Introduction

> All things are connected, whatever befalls the earth, befalls the sons of the earth. Man didn't weave the web of life; he is merely a strand in it. Whatever he does to the web, he does to himself.
>
> Attributed to Chief Seattle and presented to the American Congress in the late 1800s.

## 1.1 Background

A PhD thesis should be 'an explorative, experimental and experiential journey in order to create something original' (Brabazon & Dagli, 2010, p. 39). This doctorate, which investigates the potential for Reiki to reduce the stress of professional carers of people with dementia who are resident in High Care Aged Facilities, was conceived as a rigorous and original journey, following on from my MSc by Research study (Webber, 2008). That study was developed when assisting my elderly and dying aunty move from an Adelaide hospital into a nursing home. At that time, personal discussions with a variety of staff members from several Residential High Care Facilities in Adelaide, South Australia, suggested that the increasing numbers of residents with dementia was an issue for the staff members working in the facilities. Recognizing that a doctorate requires an original contribution to knowledge, my goal is to provide a strategy to study Reiki in a way that was rigorous, scholarly and made an original contribution to knowledge, yet also in keeping with the already existing literature from practitioners.

Although dementia is generally considered to be a disease of old age, the facilities that completed my 2002 survey indicated that residents with dementia were aged between 39 and 105 years. Disruptive behaviours including physical and verbal aggression placed additional burdens on carers, visitors, family members and friends, threatened the safety of other residents and staff members, caused stress, required additional time to manage the behaviours, impacted on resident and staff privacy, caused property damage, raised legal issues and required education for staff and volunteers. Staff members then begin to feel 'anxious, disempowered, [and] frustrated' and it becomes 'difficult to communicate and alleviate anxiety' (Webber, 2008, p. 26). For the facilities in that study, staff and resident stress was a major factor because the individual with dementia can sense the stress thus causing problematic behaviours to continue or escalate. Therefore, I proposed that if a way could be found to alleviate carer stress then this would enable them to provide a better service to the people with dementia. This task became the focus of my doctoral research.

Responses to a questionnaire sent to all High Care Residential Facilities in South Australia discovered that a wide range of complementary therapies were being used to assist the residents maintain a high quality of life. Through that research, I found that Reiki was being openly used in 18.5% of the facilities. I say 'openly' because personal conversations with people working in aged care facilities revealed that individual carers would use Reiki even if their facility precluded it in their policy statements. This was particularly so where the facility was owned by a religious organization that only allowed 'the laying on of hands, in the name of Jesus' (Martinez, 1996).

Subsequent interviews with 10 Reiki practitioners either working or volunteering in the facilities demonstrated that they were using Reiki in dementia care because they believed it had value. Also, it has been claimed that the calming effect of Reiki can lower stress in people suffering from cancer or undergoing operations (Alandydy & Alandydy, 1999; Chandwani, Ryan, Peppone et al., 2012).

The 2006/2007 literature surveys conducted for this thesis confirmed that there was little in the academic literature regarding the use of Reiki in the treatment of people with dementia. At that time, the only projects analysing the use of Reiki in dementia care retrieved were Webber (2006) and Salach (2006). Since then, only three other projects have been retrieved and assessed: Crawford, Leaver and Mahoney (2006), Morris and Warner (2009) and Meland (2009) which has not been cited in this thesis because it was a series of case reports. Although my MSc study had demonstrated that Reiki was being used in the care of people with dementia, there was no evidence to support the claims made by the people I had interviewed. This, together with a continuing lack of published research in the academic literature, revealed a major gap in knowledge. Therefore my doctoral research would enable me to offer an original contribution to knowledge.

## 1.2 My proposal

From this research base and acknowledging my personal experiences with Reiki, I developed a proposal for a Doctor of Philosophy in which I hypothesised that encouraging carers to learn and use Reiki is a method for reducing stress and thus enabling them to provide better services to their clients. In fact, it is possible that additional benefits could accrue for the carer if, as claimed by writers such as Vitale (2006), Reiki is synchronic nature and the practitioner receives the Reiki energy as he or she is providing it to a recipient. A review of a massage programme for people with multiple neurological conditions (Webber & Yeoman, 2000) found that the timing of the therapy to suit individual needs may be important to the success of the therapy. Therefore, I proposed that using a little Reiki often, as recommended by Ellyard (2002),

as a PRN therapy would deliver the therapy when and where it was needed and save time if the client's behaviour was modified and the carer's stress reduced.

A major difficulty encountered when trying to devise a viable research project into a complementary therapy such as Reiki is the fact that, because complementary therapies are rarely used in isolation and are often tailored according to individual needs, the behaviour being exhibited and/or the context of that behaviour, there can be significant problems in isolating the effect of the therapy under investigation (Douglas, James, & Ballard, 2004; Westcombe, Gambles, Wilkinson et al., 2003). Also, a number of researchers have found that a sham or mimic Reiki treatment (where individuals not attuned to Reiki mimic the process of a Reiki treatment) may not be inert (Mackay, Hansen, & McFarlane, 2004; Vitale & O'Connor, 2006). Therefore, I proposed that it was necessary to devise a research project that could identify the type and severity of an adverse behaviour demonstrated by a person either receiving or providing Reiki, both immediately before and after the use of Reiki, thus showing whether the therapy had been effective or not. After an extensive literature survey, I investigated the possibility of conducting a pragmatic randomised control trial with a pre-test, post-test format, with testing at three weeks, six weeks, and 12 months. There would be three groups of professional carers of people with dementia. One group would be attuned to Reiki and providing Reiki treatments, one not attuned to Reiki and providing a sham-Reiki treatment, and one providing conventional care only. As the researcher, I would be unaware of the Reiki users. Also, the Reiki and sham-Reiki participants would be blind to their condition until the post-testing at six weeks. However, after consulting an epidemiologist, it was found that the number of participants required in order to produce statistical meaningful results would necessitate conducting the trial in multiple Residential High Care Facilities. Given the lack of financial, personnel and physical resources available to me, implementing a project on this scale was not feasible. Therefore, it was necessary to determine if there was an alternative approach available.

Because other researchers had reported that sham or mimic Reiki treatments might not be inert, an attempt was made to find a research method where a control group was not necessary. At this stage it was suggested to me that a single subject or single case design where the participants are tested prior to the introduction of an intervention, several times during the progress of the intervention and finally, after the intervention has been removed, may be an alternative method worthy of investigation. An intensive literature survey revealed that 'single subject' does not refer to the number of subjects but to the way in which data are gathered and analysed. It also revealed that, normally,

several sets of quantitative data are gathered on each individual over time and that a group can be treated as an individual. Thus, the individuals (or groups) become their own control.

For more than 40 years, this form of research has been used extensively to systematically document the outcomes of any intervention and enable easy incorporation of the study into normal clinical procedures. Also, it has been used to investigate subjects as diverse as adaptive behaviour, autism, cardiology, challenging behaviours, communication deficits, disability and rehabilitation, drug therapy, educational systems, family medicine, feeding, gastroenterology, independent living skills, internal medicine, literacy, nutrition, paediatrics, psychology and psychiatry, social skills, special education, therapeutic recreation, toileting and work refusal. Because I had planned to use a mixed method approach with a focus on gathering and analysing qualitative data, I initially felt that this form of research may not have been appropriate for my project but believed that I could adapt the process to suit my aims by gathering both qualitative and quantitative data during the course of the project. I then proposed to gather quantitative data through a researcher-administered questionnaire at the commencement of each interview with participants. This would include demographic data about the participants, their use of complementary therapies (if any) and a self-reported stress level. The questionnaire would be informed by information from my MSc research and enable triangulation with that project. I would then administer the *Spielberger State-Trait Anxiety Inventory (STAI)* (Spielberger, Gorsuch, Lushene, Vaag, & Jacobs, 1983) (which provides a measure of current anxiety as well as underlying anxiety) at the conclusion of each interview. Results from the STAI would permit triangulation with at least four other studies into Reiki described below (Magnuson, 2003; Miles, 2003; Salach, 2006; Vitale & O'Connor, 2006). The results from the STAI would also permit triangulation with the results gathered from participant's self-reported stress levels. Other studies into the use of Reiki discussed below provide a wide array of assessment tools that could be used with, or replace, the *STAI* depending on the aim of the researcher and their target population. Also, each participant would be issued with a Reiki Recording Sheet to be maintained by during the course of the project. This would obtain data about the date, time and duration of any Reiki treatments provided to their client, themselves and/or other persons. It would also enable the participant to make a brief comment about each Reiki session. At an early presentation of my proposal, it was suggested that a salivary test could be used to measure participant stress but, unfortunately, I did not have either the expertise or finances that would have enabled me to conduct such a test.

The major goal of my project would be to gather qualitative data via digitally recorded, in-depth, semi-structured interviews with volunteer participants prior to the Reiki training, and again at least six weeks after the Reiki training as well as from digitally recorded group meetings held three weeks after the Reiki training and before the final individual interviews. During Reiki training, participants are advised that it may take three weeks for the effects of the attunements to manifest. Therefore a six-week trial period would be long enough to capture any possible changes, but short enough to prevent significant attrition. However, it eventually became possible to conduct a third interview with participants 12 months after their second interview. In fact, participants had suggested that this would be advantageous. This is one advantage of conducting PhD research on a part-time basis.

Thus the final shape of my proposed project was:

- ☆ recruiting volunteer participants who had no previous training in any form of Reiki;
- ☆ conducting individual interviews with each participant;
- ☆ training and attuning participants into Reiki;
- ☆ meeting with participants three weeks after the Reiki training;
- ☆ meeting with participants six weeks after the Reiki training; and
- ☆ interviewing participants for a second time.

In addition to providing an opportunity to gather data, the group meetings were considered to be part of the volunteers' training in Reiki. By proceeding with this doctoral research, I am offering an original contribution to knowledge by developing a unique and successful method of studying the use of Reiki in the care of people with dementia who are living in Residential High Care Facilities.

## 1.3 Initial problems encountered

Upon commencing this part-time study in 2006, I quickly encountered many unexpected hurdles, which – at times – seemed insurmountable. Initially, I found it very difficult to gain the approval of some senior university staff members to pursue this topic. It was seen as too far outside the current medical discourse. In fact, a number of individuals made comments such as, 'There is no point in studying Reiki because we all know that it does not work' although I had previously demonstrated that Reiki was being used in Residential High Care Facilities and that further study was needed. During the early stages of my research project, I gained university ethics approval for my proposal before I was granted consent to proceed from my external advisor. Whether the readers, researchers – or indeed examiners – agree or disagree with the use of Reiki, the imperative of this project is to assess value for carers.

The delays involved in gaining formal approval to conduct my research ultimately led to the loss of my pre-arranged contacts in three Australian states (South Australia, Western Australia and the Australian Capital Territory). These contacts included: Residential High Care Facilities willing to participate in the project in Adelaide, Canberra and Kalgoorlie; an Adelaide based Reiki/Master Teacher who was a volunteer Reiki practitioner in a local Residential High Care Facility; a Canberra based Reiki Master/Teacher who had been an officer in the navy, and was then a part-time lecturer in the Australian Defence Force Academy in addition to being self-employed as a masseuse and Reiki therapist; and a Kalgoorlie based Reiki Master/Teacher who owned and operated an esoteric business in addition to providing Reiki treatments.

This then required me to undertake a lengthy and time consuming process of establishing new contacts restricted to Adelaide, South Australia alone. Fortunately, I was able to obtain the services of a Reiki Master/Teacher who had been a boilermaker in a large defence establishment but who was then employed as a carer in an Adelaide aged care facility. In addition, I was able to obtain the co-operation of the Directors of Nursing in four Residential High Care Facilities in suburban Adelaide. I also obtained the services of a trained Reiki I practitioner who volunteered to assist the Reiki Master/Teacher during the training sessions and group meetings.

It was suggested that my, 'zeal for Reiki made the development of a rigorous study on this topic difficult'. However, I would argue that anyone wishing to make an original contribution to knowledge by engaging in PhD research would only do so if they have an enthusiasm and commitment to their topic. It is clear that my commitment to the practice poses both advantages and challenges for this study. I have, through the pages that follow, mitigated and managed these interpretations, potentials and weaknesses through a robust commentary on the findings, including over discussion of methodological and theoretical dissonances and irregularities.

I was also criticised for describing Reiki as 'non-invasive'. However in my MSc thesis I defined non-invasive as meaning that 'there is no need for the recipient to undress, as in some forms of massage … there is no manipulation of body parts as with Chiropractic, massage, foot reflexology or physiotherapy … [and there is] … no invasion of the body as with acupuncture, orally ingested preparations, injections, or surgery' (Webber, 2008, pp. 59-60). I also use this definition in this doctoral thesis.

## 1.4 Data collection

Recruiting potential volunteers eventually commenced in early September 2011 and continued until late February 2012. First interviews were conducted with volunteers between mid September 2011 and early March 2012. Volunteers were divided into three groups and Group 1 training was conducted in a private home in a beachside suburb of Adelaide, South Australia. Group 2 training was conducted in a cramped boardroom in an inner-west suburban facility. Group 3 training was conducted in a cramped training/office/store room in a western beachside suburban facility. People collecting supplies interrupted Group 3 training several times during the first day. Group meetings were held with participants three and six weeks after the Reiki training. Individual interviews were conducted with participants after the second Group meeting and then 12 months later.

## 1.5 Problems encountered during the data collection period

Once I had commenced the project, multiple, unforseen issues created problems for me as a researcher. These variables are important to log and reveal challenges for future scholars to manage and mitigate. These included:

- ✯ needing to use two venues which proved to be inappropriate for Reiki training;
- ✯ the need for me to assume a role as an assistant in some of the Reiki training and Group sessions because the Reiki I practitioner had been called interstate on urgent family business. This then led to a possible conflict of interest which I was keen to avoid;
- ✯ the brevity of many of my interviews and the additional difficulties encountered because of some participants' minimal English language skills. The language skills of some of the people trained in Reiki were so poor that this eventually caused me to discontinue using the STAI and was possibly the cause of an extremely poor rate of return of the Reiki Recording Sheets;
- ✯ the composition of two groups being beyond my control and the eventual discovery that that at least eight participants from these groups may not have been true volunteers and had only participated because of senior management pressures;
- ✯ the possible lack of commitment by some participants as evidenced by a high rate of attrition and low return of Reiki Recording Sheets provided to the participants; and
- ✯ my attempt to make a meaningful analysis of minimal data.

These issues will need to be addressed if future research into the use of Reiki in dementia care is to be satisfactory.

## 1.6 'Therapies' or 'Medicine', 'Complementary' or 'Alternative'?

Throughout the academic literature these terms are often freely interchanged when describing 'Complementary and Alternative Medicine' (CAM). However, I believe that the term 'medicine' applies to something ingested and 'alternative' means 'in place of' while 'complementary' refers to a treatment that is used in conjunction with allopathic medicine. Therefore, throughout this thesis, I will use the terms 'complementary' and 'therapy' when referring to Reiki and other such therapies.

## 1.7 'Attunement' or 'Initiation'

Through personal experience while I was learning and teaching Reiki I, found that some individuals react very negatively to the term 'initiation' so I prefer to use the term 'attunement' as I have done in this doctoral thesis. The only occasion where 'initiation' is used is when I comment on the Nationally Accredited *Certificate IV in Reiki Treatment Practice* because the term 'initiation' is used in the description of the Certificate (AIHBN, 2014; Reiki Australia, 2014).

## 1.8 Chapter conclusion

This exploratory, single subject, mixed method doctoral research project is based on two questions:

1. Can learning and using Reiki in their daily work reduce stress in professional carers of people with dementia who are resident in Aged Care Facilities?
2. Is there an appropriate method for researching therapies such as Reiki?

This inter-disciplinary doctorate does not focus on dementia. Instead, attention is focused on the carers – a group of people who are often difficult to study being low waged, from non-English speaking backgrounds and/or with little formal education beyond secondary level. It examines factors that may reduce their stress levels, thus enabling them to provide a better service to the people for whom they care. Likewise, it does not examine 'normal' treatments but focuses on 'complementary' therapies, nor does it attempt to be a quantitative analysis but quantitative data were collected to frame the qualitative data that are the primary focus of this work. It also reflects what actually occurred during the course of my research, identifies the problems revealed by my research and makes suggestions for future research which needs to be designed to avoid the problems encountered by other researchers into the use of complementary therapies generally and those that I encountered.

Interim approval to conduct this doctoral research was granted by the Flinders University Social and Behavioural Research Ethics Committee on the 7th March 2008

(Appendix R). Responses to several items such as a request to explain what 'normal practice' was could only be actioned after initial contact had been made with facilities and. Also I decided that I would not be working directly with people who had dementia as was originally planned so this item was removed from my application for ethics approval. Final approval to conduct this research was granted by the Flinders University Social and Behavioural Research Ethics Committee on the 21 December 2010. The Directors of Nursing in the participating facilities provided approval for participants in this study to begin using Reiki as part of their daily work.

By using a research method based on a 'single subject' (Barlow & Hayes, 1997) or 'single case' (Matson, Turygin, Beighley, & Matson, 2012), which do not refer to the number of subjects, but to the way in which the data are collected and analysed (Barger-Anderson, Domaracki, Kearney-Vakulick, & Kubina, 2004), this doctoral research attempts to devise a new way of examining the use of Reiki in dementia care. The following chapters will investigate issues relating to dementia and carer stress, difficulties encountered when researching complementary therapies such as Reiki, Reiki and research into the use of Reiki, the professionalism of Reiki training, developing a viable research project, the method used in this project, the analysis of the data gathered, recommendations for future research projects and implications for practice.

# 2 Literature Survey

## 2.1 Chapter introduction

> Exploratory research is research which simply aims to find out more about a particular problem or phenomenon rather than to test a specific prediction
>
> (Dyer, 1999, p. 43).

When I was developing my proposal for this PhD research project, I scanned a wide range of academic databases including *Informit*, *Ovid*, *ProQuest Dissertation Theses* and *Scirus* during the period 2005 to late 2010. This was in addition to the extensive electronic database searches conducted for my MSc research (Webber, 2008). I also continued to search the literature through to August 2016 using the search engines Google Scholar and FindIt@Flinders. Because the search terms, which were used, differed according to my focus at the time they will be defined and specified where appropriate throughout this thesis.

These searches continued to highlight the lack of published research into the use of Reiki generally and in the care of people with dementia. It was found that, where research has been conducted, it has tended to be 'short-term', an issue which has been supported by the work of Dougherty and Katz (2005) and Vitale (2006). However, between 2002 and 2007 inclusive, there were a small number of research projects using a variety of research methods and Reiki practitioners variously trained to each of the three levels of Reiki that warrant analysis. These are discussed below.

A key challenge emerges when investigating the research literature on Reiki. There is a sizeable gulf between the popular literature on the practice and its role and place in the refereed scholarly literature. The literature surveys conducted for the previous research project (Webber, 2008) and this doctoral project demonstrated that there was little in the academic literature about the use of Reiki in dementia care. Another problem I encountered was the narrow focus of analysis of research into the management of dementia, especially the concentration on randomised controlled trials with large numbers of participants. Also, there is an apparent exclusion of 'complementary' or 'alternative' therapies in search parameters (Hogan, Bailey, Carswell et al., 2007; M. S. Lee, Pittler, & Ernst, 2008). In fact, it has been suggested that data relating to complementary therapies may be actively suppressed by a 'culture which does not value it' (MacMahon & Kermode, 1998, p. 48). Therefore, publication of this doctoral thesis will assist to fill the void in the academic literature and advise future researches as to how they can design their research to either avoid or mitigate the problems reported by

other researchers cited in this thesis and the problems encountered during this course of this project.

Researchers have identified unique problems, including accounting for the placebo effect, encountered when studying complementary therapies generally. Also, each of the 14 studies of Reiki detailed below had potential limitations, which were identified by either the original researcher or by myself and have been summarised in Table 2.2. Any viable research into the use of Reiki in dementia care will need to address those issues.

## 2.2 Problems encountered when researching complementary therapies

One major difficulty encountered when studying complementary therapies is trying to determine exactly what is considered to be a complementary or alternative treatment. As Ross confirms, 'What is deemed alternative at a particular time and place is often a main-stream practice in another time and place' (Ross, 2012, p. 5). Also, it is difficult to determine the efficacy of a particular therapy if that therapy is rarely used as a stand-alone treatment and is often tailored according to individual needs, the behaviour being exhibited and/or the context of that behaviour (Douglas et al., 2004).

Cushman and Hoffman (2004) have suggested that there is room for both conventional medicine and complementary therapies to work together, but that research into complementary therapies has been hampered by: a lack of funding; limitations imposed by an outdated framework for scientific research; adherence to the dominant biological, disease orientated paradigm; the dominance of surgical and drug orientated health care; and the separation of mind/spirit and body. At the time of writing, current research in the United States of America (Porock, Bakk, Sullivan et al., 2015) called for national priorities to be directed to addressing the long term needs of people with dementia and their carers rather than 'merely' focusing on finding cures and treatments for dementia.

After conducting a randomised controlled trial into the use of aromatherapy with patients with advanced cancer, Westcombe, Gambles and Wilkinson et al. (2003) suggested that it is necessary to establish treatment protocols based on 'best practice' while allowing therapists 'a fair degree of autonomy in practice' but imposing 'some parameters to maintain broad consistency between the [practitioners]' (p. 302). They also acknowledged that the 'experience of the therapist is related to the outcome of the treatment' (p. 302). The authors warned against being too ambitious and tabularised the major lessons they learnt from their trial. Their suggestions have been summarised in Table 2.1.

| **Table 2.1: Lessons learnt from implementing a Random Controlled Trial into aromatherapy (From Westcombe et al., 2003, p. 305)** | |
|---|---|
| **Initial Design**<br>● Maintain realistic expectations. Take a 'pragmatic' approach which may necessitate certain compromises to strict methodological rigour in order to assure the validity of such a trial. | ● Be as flexible as possible in terms of setting exclusion/inclusion criteria to avoid restricting the [participant] base unnecessarily.<br>● Keep follow-up periods as short as possible whilst maintaining clinical relevance to minimise attrition.<br>● Keep as simple as possible whilst maintaining clinical relevance. Avoid overly complicated designs that may necessitate unrealistic levels of recruitment.<br>● Be open and flexible regarding data collection (e.g. telephone, home visits) so that [participants] who have difficulty travelling etc can still be accommodated. |
| ● Invest time and money in carrying out a full exploratory phase prior to 'rolling out' the full Random Controlled Trial. | ● To establish the acceptability/validity of proposed methodology, outcome measures, planned recruitment/attrition levels, standardisation of treatment protocols etc. Some preliminary qualitative and/or observational work would be likely to highlight potential obstacles to success.<br>● To allow health professionals/potential patients to become familiar with both the requirements of the trial and the personnel to engender trust. |
| **During the data collection period**<br>● Establish and maintain a high profile for the trial prior to and throughout the data collection period. | ● Use data collectors at each of the sites who are familiar to potential referees (either drawn from personnel already working in each centre or through a period of familiarisation during the exploratory phase – see above) and who remain visible, proactive and accessible.<br>● Have a senior member of staff from each centre present on the steering group to further promote the relevance of the trial in individual centres.<br>● Encourage 'clinical champions' across the trial sites to take responsibility in their areas for encouraging referral. |
| ● Provide adequate local supervision and support for data collectors and the opportunity to meet together regularly to discuss trial issues. | ● To avoid potential isolation of researchers and to enable the appropriate management of [participants] who give cause for concern. |
| ● Provide opportunities for therapists in each centre to meet and share practice. | ● To avoid potential isolation of therapists and to ensure that the treatment protocols are adhered to. |

Miles and True (2003) reported a 'delay' in observable effects which could mean that possible effects may not be noticed in short-term research. Engebretson and Wardell (2002) commented on the paradoxical nature of participants' reactions which may be attributed to the 'balancing' nature of this type of healing and therefore could mean that observed results may be contradictory to those found in other researches or research hypotheses. The American Medical Association (American Medical Association, 1997)

has suggested that a reductionist approach may not be appropriate for the study of complementary therapies. Also, there is a possibility that the practitioner may be an integral part of the therapy (Richardson, 2000).

Because 'spiritual healing [such as Reiki] does not have a specifically known curative aspect … randomized and placebo testing is difficult' (D. A. Barnett, 2005, pp. 11-12). In recognising these problems, Richardson (2000) suggested that data found by quantitative measures can be supported by qualitative analysis which may supply a 'rich source of data that allows the *experience* of the subject to be reported' (p. 404 - italics in the original). Further, she suggested that the often individualistic nature of complementary therapies makes standardisation difficult (p. 401). She called for a pragmatic approach which would 'allow treatment to be carried out in line with everyday clinical practice' (p. 404). In supporting the adoption of both qualitative and quantitative methods, Lewith and Holgate (2000) suggested that random controlled trials follow observational studies and depend on 'the kind of question being asked, who wants to know the answer and why, and in some cases, the nature of the therapy' (p. 20).

Olson, Hanson and Michaud (2003) argued that, if a sham-Reiki were to be provided, 'the results may be confounded by the intention of the provider' (p. 993). In addition, Potter (2003) stated:

> if we try to compare Reiki with a mock treatment in a control group, we still do not know if the mock treatment is truly inert – benign touch may still have some treatment effect beyond placebo (p. 91).

During the past 20 years, research in neurophysiology, which clearly demonstrated connections between the brain and bodily immune responses, has 'not only [been] ignored but ... outrightly rejected by western medicine' (Sternberg, 2001, p. xi). In fact, 'alternative medicine … is commonly represented as the elusive and challenging *other* of modern capitalist biomedical systems' (Ross, 2012, p. 1 - italics in the original). Also, in some quarters, there is a determined effort to purge the study of 'Alternative Medicine' from university courses (Moynihan, 2012).

Following a 2007 survey, Grace (2012) listed 21 Complementary and Alternative Medicine (CAM) Professional Associations that were in existence at the time of the survey. However, Grace did not list any Professional Reiki Associations but must have been aware of Reiki because she cited Easthope, Tranter and Gill (2000) who included Reiki in the list of complementary therapies used in a self-completion survey posted to all 467 Tasmanian general practitioners and Pirotta, Cohen, Kotsirilos and Farish (2000) who reported on a 1997 survey of 800 Victorian General Practitioners' (GPs') attitudes towards various CAM modalities including Reiki.

Through personal experience, and a Google search conducted in mid November 2012 using the search parameter *Reiki +Association +Australia*, I found the names of five Reiki Associations that were in existence before a 2006 national Reiki conference held in Redcliffe, Queensland. These were: *Reiki Australia*; *Australian Reiki Connection*; *Reiki Association (WA) Inc*; *Australian Usui Reiki Association (AURA) Inc*; and *The Reiki Association of Australia*. Therefore, it is puzzling that Grace (2012) did not cite the professional associations for Reiki practitioners.

## 2.3 Dementia and Carer Stress

The American Psychiatric Association (2000) suggested that the broad symptoms of dementia may include anxiety, delirium, delusions, disinhibition, falls, hallucinations, mood and sleep disturbances, motor disturbances, persecution complex, poor judgement and insight, slurred speech, spatial disorientation, suicidal behaviour, unrealistic assessment of own abilities, violence, vulnerability to physical and psychosocial stressors (American Psychiatric Association, 2000). Hardesty (2006) added agitation, depression, irrational thinking, loss of memory, personality changes, psychosis, Sundowning, suspicion, and withdrawn/passive behaviour. Also, it is generally recognised that there is 'no cure' for dementia (Access Economics, 2006, p. 22; Australian Institute of Health and Welfare, 2006, p. 219). In addition, the prevalence of dementia in the Australian and Pacific region has been repeatedly described as an *epidemic* (Access Economics, 2003, 2004, 2005, 2006, 2009). It has been estimated that in Australia there were approximately 230,000 people with dementia in 2008 (Access Economics, 2009). It was also estimated that the number will rise to 465,000 by 2030 (Access Economics, 2009) and in excess of 730,000 by 2050 (Access Economics, 2009). In 2006 in South Australia alone, the prevalence was estimated to be 19,440 or 1.26% of the population and was expected to rise to 50,740 (3.42%) by 2050 (Access Economics, 2005, p. 13). In 2008 it was estimated that for people with dementia: 37% lived in the community with no formal support; 23% lived in the community with some formal support; and 40% lived in Residential Aged Care Facilities (Access Economics, 2009).

Caring for a person with dementia may have a negative impact on the physical and mental wellbeing and lifestyle of the carer (Access Economics, 2009) and cause heightened levels of carer stress, fatigue, depression, physical morbidity and mortality (Bruce, Paley, Underwood, Roberts, & Steed, 2002; Donaldson, Tarrier, & Burns, 1998; Herrmann, Gauthier, & Lysy, 2007; Morgan, Stewart, D'Arcy, Forbes, & Lawson, 2005; Rodney, 2000). This is because the daily barrage of fatigue, stress and poor nutrition among carers of people with dementia can cause a breakdown in the body's cellular

communication systems (Cushman & Hoffman, 2004). In fact, stressed carers may have 50% more visits to doctors and consume 86% more prescribed medications than other carers (Donaldson et al., 1998).

Thirty-three High Care Residential Facilities (40.7%, n=81) in my previous study (Webber, 2008) indicated that high level of stress experienced by staff members caring for people with dementia was a problem for individuals and the institution. It was reported that this stress could be caused by both fear of being abused by residents as well as frustration and helplessness because nothing staff members do seems to help in alleviating residents' disruptive behaviours.

Heightened levels of stress may lead to staff burnout and turnover either internally, when staff members are moved to different positions, or externally, when staff members leave the establishment or the profession. This turnover impacts negatively on client welfare and quality of care (Hayes, O'Brien-Pallas, Duffield et al., 2006). In addition, Webber (2008) noted that carer stress can, in turn, cause residents' disruptive behaviours to escalate. This phenomenon was also reported in a study of 102 registered nurses, primary care assistants and direct-care workers from 15 nursing homes in Canberra and Sydney where it was found that 'resident aggression was significantly related to an increase in nurse stress' (Rodney, 2000, p. 172). It has also been recognised that people with dementia who are living with stressed family care givers may display more agitated behaviours (Dunkin & Anderson-Hanley, 1998).

Staff members with low empathy and less positive attitudes experience heightened levels of burnout (Astrom, Nilsson, Norberg, Sandman, & Winblad, 1991). Also workers with between one and two years experience in dementia care have higher stress levels when compared with longer term workers (Zimmerman, Williams, Reed et al., 2005) and worker stress levels are 'higher in facilities with specialized dementia units' (Zimmerman et al., 2005, p. 103).

Factors such as high workloads (Hayes et al., 2006) and an increase of aggressive behaviours can contribute to heightened stress levels in carers particularly if the carers feel inadequately prepared for their role in dementia care (Morgan et al., 2005). Physical aggression and verbal aggression were the most common behaviours causing concern for staff members interviewed in the previous study. In addition, the Residential High Care Facilities surveyed in that study reported that disruptive behaviours placed additional burdens on carers, visitors, family members and friends, threatened the safety of other residents and staff members, caused stress, required additional time to manage the

behaviours, impacted on resident and staff privacy, caused property damage, raised legal issues and required education for staff and volunteers (Webber, 2008).

Because the non-cogitative features of dementia are a strong predictor of carer stress, it is important to either alter the symptoms of dementia, reduce staff exposure to clients with dementia and/or change the care-giver's response to the behaviours (Donaldson et al., 1998). Therefore, adequate training for carers is essential (Mackenzie & Peragine, 2003), stress reduction methods should be taught to people working in dementia care (Williams, Hyer, Kelly, Leger-Krall, & Tappen, 2005) and new models of care need to be trialled and utilised (Access Economics, 2003, p. v). Although they were working with family members providing support for people with dementia, Brodaty and Gresham (1989) demonstrated the effectiveness of providing carers with specialised training in reducing their stress levels.

It has been demonstrated that touch therapies such as Reiki, Therapeutic Touch and Healing Touch can improve the quality of life of terminally ill people (Henneghan & Schnyer, 2015). Also touch therapies such as massage can reduce aggressiveness and stress levels of people with severe dementia (Suzuki, Tatsumi, Otsuka et al., 2010). However, if carers are unaware of comfort touch strategies which can mitigate client anxiety about the necessity of the 'care' being offered, or fail to use them as part of their regular duties, then the rejection of that care can escalate into combative behaviours (Volicer, 2015). Comfort touch therapies are inexpensive and cost effective (Henneghan & Schnyer, 2015; Volicer, 2015) while having no adverse side effects (Viggo Hansen, Jørgensen, & Ørtenblad, 2008; Volicer, 2015).

My MSc study (Webber, 2008) demonstrated that Reiki was being used as a touch therapy by professional carers of people with dementia yet there was no evidence as to its efficacy. Therefore, the current doctoral study was developed in an attempt to answer the challenge: 'Can learning and using Reiki in their daily work reduce stress in professional carers of people with dementia who are resident in Aged Care Facilities?' Before addressing such a question, it is necessary to introduce Reiki.

## 2.4 Reiki (a Complementary Therapy)

Reiki can be simply described as:

> An energy medicine practice that originated in Japan [and in which] the practitioner places his [sic] hands on or near the person receiving treatment, with the intent to transmit ki, believed to be a life-force energy (NCCAM, 2006, p. 1).

The traditional form of Reiki is known as *Usui Reiki Ryoho* (Stein, 1996) or *Usui Shiki Ryoho* (Petter, 1997). It is taught at three levels: Reiki I which involves hands-on healing

for self and others; Reiki II which involves distance healing; and Reiki Master/Teacher which enables the practitioner to train and 'attune' others into the practice of Reiki (L. Barnett, Chambers, & Davidson, 1996; Gallob, 2003).

Vitale (2006) suggested that the use of Reiki around the world has expanded rapidly because of its simplicity of use, adaptability, and self-care benefit. Reiki may be given as a stand-alone, one to one and a half hour therapy using a set of standardised or intuitive hand positions. Conversely it may also be provided in short 'grabs' when and where it is needed (Ellyard, 2002; Webber, 2008) in a similar fashion to PRN medication. There may also be a variation between practitioners in the manner in which Reiki is provided depending on the style of Reiki practiced by individuals and their level of training (Webber, 2008).

It is claimed that Reiki is activated by simply placing the hands on oneself or another person (Ellyard, 2002) and that the practitioner is not required to make an assessment of the recipient's condition. Further examples of Reiki's simplicity include the fact that it is non-invasive and there is no need for the Reiki practitioner to enter an altered state of awareness. In this context, 'non-invasive' means that '… there is no need for the recipient to undress, as in some forms of massage … there is no manipulation of body parts as with Chiropractic, massage, foot reflexology or physiotherapy … [and there is] … no invasion of the body as with acupuncture, orally ingested preparations, injections, or surgery (Webber, 2008, pp. 59-60).

Also, the Reiki practitioners interviewed in the previous study reported that they could:

> do Reiki anywhere, at anytime; effortlessly adapt their practice of Reiki to suit the needs of individual clients and the demands of their working environment; and easily incorporate Reiki with other complementary therapies to enhance the quality of life of the people for whom they care (Webber, 2008, p. 125).

The National Centre for Complementary and Alternative Medicine (NCCAM, 2006, p. 3) has reported that people have sought Reiki treatments for conditions such as: the effects of stress, chronic pain, recovery from surgery and anaesthesia, the side effects of chemotherapy and radiation therapy for cancer, lowering heart rate, improving immunity, mental clarity, promoting a sense of well-being and/or spirituality, and enhancing the sense of peace in people who are dying.

Webber (2008) found that 15 (18.5%, n=81) of the South Australian High Care Residential Aged Care Facilities which responded to a 2002 questionnaire reported using Reiki in the care of people with dementia. Wilkinson and Simpson (2002) found that 6.8% of the 832 nurse respondents to their survey reported the personal use of Reiki,

2.5% used Reiki with patients and 11.3% would refer patients to a Reiki practitioner. It has been claimed that Reiki is an appropriate tool for use within psychotherapy therapeutic sessions to promote calm in both the client and the therapist (LaTorre, 2005) and that the recipient controls the speed of healing (Cushman & Hoffman, 2004).

Talton (1995) suggests that, because Reiki can involve touch, it may be therapeutic simply because there is an intention of achieving a therapeutic goal. Talton (1995) also cites research, which has demonstrated that touch can lower heart rates, blood pressure, pain, stress, and anxiety. This notion is supported by a number of researchers such as Vitale and O'Connor (2006) who concluded that the 'placebo or sham Reiki … [which they provided] … may not be inert' (p. 270).

While it is not connected with any religion, Reiki is considered to be a spiritual, holistic, energy based, touch therapy (Webber, 2008). In fact, 'spirituality is seen to have broken free of … religious boundaries' (Beeler, 2015). While Australian medical literature has been 'silent on the relationship between spirituality and health' (Peach, 2003, p. 87), there has been a call for more research into the relationship between health and patients' spiritual needs (Peach, 2003).

The use of Reiki in mainstream medical practice is growing. As cited in my previous study (Webber, 2008), Dr Mehmet Oz, a leading American cardiovascular surgeon, introduced a wide-range of complementary therapies into his practice at the Columbia Presbyterian Medical Centre in New York City (Oz, Arias, & Oz, 1999). He has since added Reiki to the therapies offered (Rogacion, 2007). Reiki is now offered in at least the Manhattan Eye, Ear and Throat Hospital, the Memorial Slone Kettering Hospital, the Columbia/HCA Portsmouth Regional Hospital, the Tucson Medical Centre, the California Pacific Medical Centre, the University of Michigan Medical School, Hartford Hospital (Rogacion, 2007) and the University of Arizona (Weil, No Date-a, No Date-b) in the United States of America.

Reiki, like many similar complementary therapies, purports to work by transmitting energy variously called *Qi, Ki, prana,* or *vital force* (Webber, 2008, p. 48) yet many authors deny that this energy exists or can be measured (Ernst, 2001; Eskinazi, 1998; Leskowitz, 2003; W. J. Martin, 2005). However, modern medicine uses energy generated by the body as a diagnostic tool in a variety of situations (Leskowitz, 2003; Webber, 2008). In the 1930s Kirlian photography demonstrated the existence of a human energy field extending beyond the body, a process which has been replicated by a scientific team from the Columbia-Presbyterian Medical Centre in New York (Oz et al., 1999). The advent of advanced electromagnetic recording equipment has confirmed the fact that

energy generated within the body can be transmitted beyond the physical limits of the body (Oschman, 2000, 2003). More recently there has been the suggestion that therapies such as Reiki may work through the movement of free or mobile electrons which exist in almost limitless numbers on the earth's surface (Oschman, 2008).

A variety of therapies including acupuncture (Ross, 2012), Reiki (NCCAM, 2006) and Therapeutic Touch (Gregory & Verdouw, 2005) as well as exercises such as tai chi and qigong recognise that it is necessary to restore a balance in the body's energy systems for healing to occur. The invocation of this 'subtle energy … [which] … is found in every culture and worldview except that of the Western European intellectual tradition'(Leskowitz, 2003, p. 81). Therefore, Western allopathic medicine is the world's only healing tradition that does not recognise that the alignment of this energy field is essential to the healing process. Therefore is seems to be highly contradictory that, following an extensive literature survey, I was able to identify 32 separate mechanisms used by western medical practitioners to both diagnose and 'treat' a wide range of conditions, these included Angiography, Cerebral function monitor (CFM), Cold and hot packs, Computed tomography (CT), Computerised axial tomography (CAT), Electro-acoustic measurement, Electro-acupuncture, Electrocardiogram (ECG), Electroconvulsive therapy (ECT), Electroencephalogram (EEG), Electro-motor stimulation (EMS), Electromyogram (EMG), Electro shock aversion therapy, Electrosurgery, Extracorporeal shock wave lithotripsy (ESWL), Laser (light amplification by stimulated emission of radiation), Magnetocardiogram, Magnetic resonance imaging (MRI), Magnetometer, or superconducting quantum interference device (SQUID), Nuclear medicine, Photoradiation therapy (PRT), Positron emission tomography (PET), Pulsed (Pulsating) electromagnetic field (PEMF), Radiography, Ray lamps, Single photon emission computed tomography (SPECT), Static magnetic field therapy, Topographical electro-retinogram, Transcranial magnetic stimulation, Transcutaneous electrical nerve stimulation (TENS), Ultrasound, X-rays (or Roentgen rays) (Webber, 2008).

A specific claim about Reiki is its supposed synchronic nature where the practitioner receives the Reiki energy as he or she is providing it to a recipient (Vitale, 2006; Webber, 2008). This may make Reiki unique among the various therapies used in dementia care. It is claimed that Reiki can be used to enhance practitioner self-care and promote self-healing on physical, emotional and/or spiritual levels (D. A. Barnett, 2005; Brathovde, 2006; Gallob, 2003; Magnuson, 2003; Schiller, 2003; Vitale, 2006; Webber, 2008). And Ellyard (2002) claims that self-healing is the most important feature of Reiki

therefore, learning and using Reiki could potentially assist in maintaining 'The self-care of nurses [which] is a requirement for the care of the patient' (Beneri, Santos, & Lunardi, 2001). It is acknowledged that for carers to work at optimum efficiency, they must ensure that their own health is at optimal levels (Beneri et al., 2001; Vitale, 2006) and, to quote an unknown commentator cited by Ellyard, 'If you don't look after your body where will you live?' (2002, p. 138).

However, the concept of self-healing is not unique to Reiki, or even humans. After an extensive literature and web survey, Robb (2006) identified five forms of self healing:

- ☆ Synthetic self-healing which relates to certain forms of polymers;
- ☆ Cyber self-healing which relates to certain types of computer systems;
- ☆ 'Self-help' self-healing which relates to the use of books, courses, retreats, creams, crystals and links to certain professionals with expertise in self-healing modalities;
- ☆ Biophysical self-healing which relates to the use of certain of the body's cells to promote healing; and
- ☆ Metaphysical self-healing which relates to certain energy based therapies such as Reiki.

Robb (2006) postulated that metaphysical self-healing is an energetic process which can be learned, stimulated or facilitated, that it invokes an innate vital force found in all living organisms and that the power comes from within. To be effective, there must be an energetic catalyst and a re-channelling of the body's energy fields. She also postulated that there must be an initial energy imbalance, a belief in the ability to self-heal, the willingness or desire to rebalance, and an adequate energy supply. Robb also warned of the danger of causing self-harm by relying on self-healing to the exclusion of other therapies emphasising that, 'Self-healing is a supportive process that works in conjunction with conventional medicine to keep the individual in a harmonious state' (p. 71). Therefore, even if Reiki has a self-healing aspect, it must be used only to complement other pharmacological and non-pharmacological therapies that are commonly used in aged care.

It is possible that the use of comfort touch therapies may be important because older adults are often touch deprived (Nicholls, Chang, Johnson, & Edenborough, 2013; Oz et al., 1999), even though the human need for touch continues until the end of life (Nicholls et al., 2013). Also, it is well recognised that a lack of touch results in a failure to thrive while touch has a profound effect on us as humans (Maclaren, 2014). However, caring touch with physical and emotional objectives is central to Namaste aged care as practised in several residential facilities in New South Wales. Namaste means to honour the spirit

(Nicholls et al., 2013). Also, comfort touch is accepted as fundamental to the practice of nursing in the United States of America and is recognized in the Nursing Interventions Classification Code (Wardell & Engebretson, 2001).

However, not all touch is necessarily therapeutic, because much of the touch experienced in patient care is routine and task orientated (Gleeson & Timmins, 2004; Routasalo, 1999). In fact, in dementia care, there 'may be little time during the working day for expressions of affection, caring, comfort, empathy, encouragement, fun, happiness, protection and reassurance through the use of touch' (Webber, 2008, p. 114). There may be added benefits if the form of comfort touch used is non-invasive, which, in the context of this thesis, means that 'there is no need for the recipient to undress, as in some forms of massage … there is no manipulation of body parts as with Chiropractic, massage, foot reflexology or physiotherapy … [and there is] … no invasion of the body as with acupuncture, orally ingested preparations, injections, or surgery (Webber, 2006, pp. 82-83). Routasalo (1999) identified 27 forms of touch routinely used by nurses within patient care and suggested that touch is regarded as a 'non-verbal, non-vocal form of communication' (p. 844). Webber (2008) also suggested that, 'in the latter stages of dementia, touch may be the only viable form of communication with people who no longer have the cognitive ability to respond to other forms of communication' (p. 128). Cardiac surgeon Mehemet Oz (1999) states that 'a simple touch of a hand on the skin can lower blood pressure and heart rate' (p. 106). Further information about Reiki is also presented in L. Barnett et al. (1996), Ellyard (2002), Honervoght (1998), Lubeck (1995, 1997), Petter (Petter, 1997, 1998), Rand (1991), Rowland (1998) and Stein (Stein, 1996). In my MSc thesis (Webber, 2008) I provided a detailed description of Reiki and how it is taught at Reiki I, Reiki II and Reiki Master/Teacher (sometimes called Reiki III) levels. This included information about the symbols used by the Reiki Master/Teacher during the 'attunement' process for each level, the recommended hand positions to be used during a Reiki treatment and the processes involved in providing distant Reiki. I also emphasised that I would use the term 'attunement' rather than the tern 'initiation' which is used by some Reiki Master/Teachers.

Studies of complementary therapies including Reiki have revealed a range of issues and problems, which must be overcome if a viable study of Reiki in dementia care is to be implemented. These issues will be discussed in the pages that follow before detailing a proposed method to be used in this project.

Also, before proceeding, it is necessary to determine how Reiki has been studied. A multi-disciplinary approach will be used with examples taken from fields as diverse as

Counselling, Disability Studies, Gerontology, Medicine, Nursing, Psychology and Transpersonal Psychology. The subjects in these studies include healthy volunteers, HIV/AIDS patients, mothers healing from child sexual abuse, nurses and other health care providers, parents who were experiencing stress, people suffering from chronic illness, people with cancer, people with mild cognitive impairment or Alzheimer's disease. In addition to Reiki practitioners using Reiki in dementia the efficacy of trained Reiki Masters was compared to that of mimic healers. The research projects have been selected to illustrate a wide range of research and data collection methods.

## 2.5 Research into the Use of Reiki

### 2.5.1 A crossover trial of Reiki and rest only

*Tsang, Carlson and Olson (2007)*

In Canada, Tsang, Carlson and Olson conducted a pilot crossover trial of Reiki compared to rest only for treating cancer-related fatigue. Sixteen patients (13 women and five men) were assigned to two groups. The first group received five Reiki treatments over five days followed by a one-week washout period to test the longevity of any possible effect from the Reiki, another two Reiki sessions, five days of rest (approximately one hour per day), and another one-week washout period. For the second group the procedure was five days of rest, one-week washout, five Reiki sessions, one-week washout and then two Reiki sessions. A Reiki Master with experience in treating cancer patients provided Reiki and the length of the sessions varied as determined by the Reiki Master.

Participants were tested for fatigue, pain, anxiety, and overall quality of life before and after all Reiki treatments or rest periods. The researchers found significant decreases in tiredness ($P < 0.001$), pain ($P < 0.005$), and anxiety ($P < 0.01$) following the Reiki sessions as compared to the resting condition. Conversely, rest did not significantly improve fatigue and the results pre and post-rest were similar.

Tsang et al. recognised that the lack of a control group and the small sample size were limitations to the research. Nor were they able to isolate the effect of Reiki from the effect of receiving additional attention. The researchers recommended further research with a larger sample size and a sham Reiki treatment.

When developing my proposal, I had intended to have a minimum of four groups with four volunteers each. In fact, if I had been able to implement my planned trial in Adelaide, Canberra and Kalgoorlie, it would have been possible for me to have three or four groups in each location. Eventually, I had three groups with a total of 19 volunteers who were trained and attuned to Reiki (Table 10.1). However, because a number of researchers have found that a sham or mimic Reiki treatment, where individuals not

attuned to Reiki mimic the process of a Reiki treatment, may not be inert (Mackay et al., 2004; Vitale & O'Connor, 2006) I decided to determine if there was a research method which did not require a control group.

### 2.5.2 A randomised controlled trial

*Deborah Barnett (2005): PhD in Transpersonal Psychology*

Deborah Barnett examined the benefits of teaching Reiki I to a group of 57 American parents who were living in the San Francisco Bay Area of California or New Hampshire and were experiencing stress. To be included, potential participants had: to score 'nine or more' on a stress screening; not have started 'any anti-depressant or anti-anxiety medication' in the previous three months; not be 'on any anti-psychotic medication'; be 'physically able to practice (sic) Reiki'; have 'at least one child between the ages of 3 and 18'; be 'willing and able to attend the three sessions' described below; and abstain from 'additional daily stress reduction practices' other than Reiki; and be willing to practise Reiki (pp. 48-49).

In this random controlled trial, one-half of the participants were trained and attuned to Reiki and the other half were trained with the first group but received mock attunements (p. 43). During the mock, attunements the Reiki Masters 'did not utilize the Reiki symbols … [but] … counted to eight silently' (p. 59). The participants were divided into six classes and taught Reiki I by the researcher and her mother Libby Barnett (L. Barnett et al., 1996). Libby Barnett had previously trained Deborah Barnett to Reiki Master/Teacher status. Once trained, participants were asked to practise self-Reiki for 15 minutes per day and to provide Reiki for one of their children for 15 minutes per day (p. 60).

Participants were pre-tested before training and post-tested at three weeks with a follow-up test after six weeks. They also maintained a log of 'the frequency and length of their Reiki Practice' (p. 43). Participants were tested for stress (by using the *Perceived Stress Scale*), well-being (*Friedman Well-Being Total Score*), sociability (*Friedman Sociability*), self-esteem/self-confidence (*Friedman Self-esteem/Self-confidence*), joviality (*Friedman Joviality*), emotional stability (*Friedman Emotional Stability*), happiness (*Friedman Happiness*), vitality (*Vitality Plus Scale*), positive states (*Positive States Of Mind Scale*), cohesion (*Family Relationships Index: Cohesion*), expressiveness (*Family Relationships Index: Expressiveness*), conflict (*Family Relationships Index: Conflict*), gratitude (*Gratitude questionnaire – six item form*), and spirituality (*Spiritual perspective scale*) (pp. 43, 50-56, 70). The three-week post-test period was chosen to coincide with the 21-day 'integration process after learning' Reiki recommended by Dr

Usui, the founder of Reiki and the follow-up was conducted after six weeks to 'minimize participant attrition' (p. 45). At the training, post-test and follow-up sessions, participants also practised Reiki. Subsequently, following the six-week follow-up session all participants were presented with a small pewter pin and the 'mock Reiki participants were attuned to Reiki' (pp. 44, 61-62). Participants who did not attend this session were followed-up on an individual basis (p. 62).

Deborah Barnett found that '[o]verall, both the [Reiki attuned] and [non Reiki attuned] participants experienced positive, significant, desired changes across time' (p. 89). Also, 'participants experienced significant decreases in stress and conflict, and significant increases in well-being, self-esteem/confidence, positive states, and cohesion' (p. 89). No 'significant differences were found between the treatment and control group at any assessment period' (p. v). She concluded that, '[f]urther research should investigate the mechanisms by which Reiki is hypothesised to work, such as the attunement, simple attention, the elicitation of the relaxation process, and/or the placebo effect' (p. v).

Upon reflection, the major limitation of this study is the fact that the principal researcher provided Reiki training to some of the participants. She was also closely related to the other Reiki Master. Therefore, it is conceivable that there may have been a conflict of interest, or that participants may have acquiesced to her as the 'Master' and researcher. Deborah Barnett acknowledged that, because the name 'Barnett', especially that of her mother, was closely associated with Reiki, this may have biased potential participants towards the study. In addition, potential participants who may have been familiar with Reiki, might have 'expected a benefit simply from participating in Reiki' (p. 95).

The mock training conducted by Barnett differed considerably from the one provided in the research conducted by Shiflett, Nayak, Bid, Miles and Agostinelli (2002) during which the Reiki Master conducted attunements by using a Reiki II distant healing technique. This method broke from the traditional attunement method whilst the method used by Barnett followed the normal attunement procedures.

### 2.5.3 A split-half, double blind trial

*Ostojic (2006): Master of Psychology (Counselling)*

Ostojic examined the psychological factors and the perceived efficacy of Reiki distance healing at Monash University in Victoria, Australia. From 29 respondents 'within a division of a large Australian corporation', 22 volunteer Reiki recipients were recruited.

Of these 17 completed the project (pp. 25-26) and were assigned to two groups ($n_1$=9, $n_2$=8). One hundred and thirty Reiki channels worldwide were recruited and, of these, 17 assigned to two groups ($n_1$=9, $n_2$=8). A split-half, double blind design was adopted for the project.

During two 'continuous (but staggered) 21-day' periods (p. 5), Group 1 Reiki practitioners supplied over 1,697 hours of Reiki to Group 1 recipients during the first 21 days of the project and Group 2 channels supplied approximately 313 hours of Reiki to the Group 2 recipients during the second 21 days (pp. 5, 32). At the recruitment stage:

> potential recipients were informed that the experiment would last six weeks and that sometime over that period they would receive Reiki. Their normal routine would not however be interrupted *[and]* recipients were not told when *[the]* energy would be sent, how much they would receive or the time period over which they would receive it (p. 31).

Ostojic concluded that there had been 'no significant effect of distance Reiki on any of the measures used' (p. 5) and postulated that this may have been because, among other factors, there was 'insufficient 'dose' of Reiki to effect change … [and] … inappropriate time to allow effects to manifest before testing' (pp. 5-6), poor statistical power, difficulties in project management, confusion about the number of channels who participated, and a major restructure of the organisation from which the 'receivers' were recruited (pp. 5-6, 26-27, 54-55).

The issue of requiring an appropriate time for the effects of Reiki to manifest is supported by Miles and True (2003) who suggested that there is a 'delay' in observable effects of Reiki. In addition, there was no commitment required from the recipients, which is contrary to the 'normal' practice for sending and receiving Reiki. At the Reiki Australia 2006 National Conference, Phyllis Lei Furumoto (Reiki Master and acknowledged Spiritual Lineage Bearer of Reiki) indicated that it is normal for practitioner and recipient to agree on a time for the sending of Reiki and set that aside as a quiet time just as a person would do if physically attending a Reiki session (Furumoto, 2006).

Furthermore, there was no control group that did not receive Reiki. Consequently, possible negative effects of the reported organisational change could not be measured. It is therefore possible that the Reiki prevented a major negative effect on the recipients during the time of the research. Participant receivers were not tested for existing medical conditions and Reiki may treat underlying health conditions rather than the condition being tested, a fact that is acknowledged by Ostojic. However, Ostojic does not appear to have pre-tested and post-tested the Reiki Recipients using the same assessment tools.

### 2.5.4 Mixed quantitative and qualitative data collection methods

*1. Brathovde (2006)*

Brathovde examined the self-care potential of Reiki by training 10 health-care providers in Reiki I. Participants were pre-tested by using a demographics sheet and the *Caring Efficacy Scale*. Post-tests were conducted within three months with the *Caring Self-Efficacy Scale* [sic] and a 10-item survey 'regarding their perceptions of any changes in being able to care for themselves and their clients' (p. 97). Semi-structured personal or telephone interviews were conducted after the return of the questionnaires.

Participants reported a wide range of experiences; seven positive, one neutral and two negative. 'Spirituality' and 'Increased self-care and caring behaviours' were two major themes identified by Brathovde. 'Healing presence' and 'Increased personal awareness' were sub-themes of self-care and caring behaviours. Brathovde suggested that:

> healthcare providers who practice (sic) a self-care activity, such as Reiki energy therapy, can learn to attend to their needs and the needs of others within the environmental context (p. 100).

The need for carer self-care in order to operate effectively is supported by Vitale (2006, 2009) and the American Nurses Association (Natale, 2010) while D. Barnett (2005) wrote of a 'spiritual self-development' component to learning Reiki.

*2. Magnuson (2003): Master of Social Work*

Magnuson examined the effects of adding Reiki therapy and Reiki training to group talk therapy for 10 Canadian mothers healing from child sexual abuse. Multiple in-depth interviews and repeated assessments with the *Spielberger State-Trait Anxiety Inventory (STAI)* over time were used to gain qualitative and quantitative data. The interview data were analysed by using a thematic analysis approach (p. ii). Following the initial interview, a three-generational Genogram was developed to expose the context and intergenerational impact of childhood sexual abuse (p. 77).

The first group, the *Mothers' Group* (n=5), was a talk therapy group to which Reiki therapy and Reiki training were added. It operated from September 2000 to May 2001 (p. 68). From September 2000 to December 2001 it functioned as a traditional talk therapy group with Reiki I being added in January 2001 (p. 69). The second group, the *Reiki Exchange Group* (n=5), comprised graduates of a previous Mothers' Group. It operated from September 2000 to June 2001 with Reiki I training being conducted in September and October 2000 and Reiki II training in May 2001 (p. 69). Magnuson was a participant observer in this group (p. 65).

Magnuson concluded that: Reiki training 'reduced symptoms of trauma, improved parent-child relationships, increased confidence and responsibility in self-healing, and increased spirituality' (p. ii); and 'Reiki, when combined with traditional approaches to healing, is cost effective, empowering, and heals survivors from trauma more effectively than talk therapy alone' (p. iii). The reduction in anxiety found through the interviews was triangulated with the *STAI*.

Magnuson recognised that the small sample size (n=10), the staggered timing of the *STAI*, and the fact that not all participants completed the third and fourth *STAI* forms were limitations to this research. In addition, I consider that the inclusion of Magnuson as participant observer in such a small sample size (n=10) had the potential to skew the findings.

### 2.5.5 Qualitative data collection methods only

*1. Mitchell (2006): Master of Community Health and Epidemiology*

Mitchell examined the perceptions of a paired convenience sample of four Canadian Reiki practitioners and four clients suffering from chronic illness over a 12-month period. Hour-long interviews were conducted before and after participation in the study and 10 minute telephone interviews were held no longer than 48 hours after each Reiki session. The semi-structured interviews using an interview guide were audio taped and transcribed. Data analysis was conducted using a phenomenological approach.

Initial selection criteria for patients were:

> [to be] at least 18 years of age; speak, read and write English; suffer from a chronic condition … with little or no experience with Reiki (no more than 2 Reiki session) (p. 24).

The criterion relating to prior experience with Reiki was later relaxed to incorporate people who were interested in participating. In order to recruit sufficient people, financial compensation was provided for patients (1/2 cost of treatments up to $200.00). Difficulty was also found in recruiting practitioners to the project because some practitioners were not interested while others did not have the appropriate patients. The initial criteria for practitioners were:

> [to be] at least 18 years of age; speak, read and write English; have at least second-degree Usui Reiki training; have at least two years of experience practicing Reiki on others; see at least 3 different patients per week; work in either a private or clinical situation; and treat patients with chronic conditions (p. 24).

Practitioners in Mitchell's study were recruited through 'snowball sampling', part-time practitioners were accepted and an attempt was made to 'establish a gender balance' (p. 24). Practitioners and patients variously reported different sensory experiences during the

treatments. They variously reported an improved ability to handle stressful situations, a spiritual awakening and decreased anxiety

While Mitchell indicated that the program for individuals concluded after approximately 10 Reiki sessions, she did not indicate the frequency of these sessions. Therefore, it is not possible to determine how long each participant was involved in the project. Mitchell cites the 'difficulty in recruiting participants' and the 'lack of depth in some of the interviews' as limitations to the study (pp. 87-88).

*2. Webber (2006, 2008): Master of Science (Medicine) by research*

Webber conducted in-depth, semi-structured interviews with 10 Reiki practitioners caring for people with dementia. Of these, one was a Diversional Therapist, three were Patient Care Attendants (Personal Care Workers) (two of these were trained Enrolled Nurses but not employed in that capacity), one was a Reflexologist/Masseuse, one was an Enrolled Nurse, one was a Director of Nursing, two were volunteers, and one was a relative of a person with dementia. Their level of Reiki training included two Reiki Masters, four Reiki II level practitioners and four Reiki I level practitioners. They had been involved in dementia care from one to 12 years (mean, 6.4; median, 7.0 years) and represented eight High Care Residential facilities in the metropolitan and near hills districts of Adelaide. One of the Patient Care Attendants (Personal Care Workers) interviewed was teaching Reiki as part of the staff training program in the establishment where he worked. Self-reported stress levels ranged from 0 (lowest) to 9 (highest) (mean, 5.0; median, 4.0). The most frequently words and/or concepts used by the participants were *feel* (used on 69 occasions by all 10 of the participants); *energy* (66; 7); *calm(ing)* (42; 9); *touch* (42; 9); *heal* (37; 4); *help(ing)* (31; 9); *lower stress* (30; 6); *relax(ing)* (22; 7); *dying/pass over* (20; 7); and *reduced pain* (17; 7).

The interview participants reported a 'domino' or 'flow-on' effect whereby easing a problem or potential problem in one area had the possibility of easing problems in other areas or prevent the problem from escalating, either within the individual or across the facility. I found that:

> The results of the interviews suggested that Reiki is an easy to learn and easy to use holistic complementary therapy which has the potential to enhance the quality of life of the persons with dementia, their family members, and their carers. The interview participants reported improved physical, psychological, mental and emotional well-being as well as enhanced relationships and a reduction in negative behaviours following the use of Reiki (2006, p. ix).

I further suggested that:

> Because of the close relationship between the residents and the carers in High Care Residential Facilities, the individual's quality of life is inextricably interwoven with that of the others in the facility (2008, p. 130).

I did not claim to have 'proven the efficacy, or otherwise, of Reiki when used as a complementary therapy in the care of people with dementia'. However, I did suggest that it might be the apparent adaptability of Reiki which could explain its widespread use in care situations, including in dementia care (2008, p. 119). This Doctor of Philosophy research builds on my MSc study and investigates the potential for Reiki to reduce the stress of professional carers of people with dementia, who are resident in High Care Aged Facilities,

### 2.5.6 Quantitative data collection methods only

*1. Mackay, Hansen and McFarlane (2004)*

In a study involving 45 healthy volunteers divided into three groups (rest only, Reiki treatment, and mimic Reiki), Mackay, Hansen and McFarlane found a significant decrease in the heart rate and diastolic blood pressure of the Reiki group compared to the other groups. They also found a number of similar changes in both the Reiki and placebo groups that were not present in the control group.

While Mackay et al. based their placebo treatment on the work of Mansour, Beuche, Laing, Leis, and Nurse (1999), they did not detail how the Reiki treatment was provided or the level of the Reiki practitioner, other than that the person was 'an experienced Reiki practitioner' (Mackay et al., 2004, p. 1077).

*2. Miles (2003)*

A group of thirty HIV/AIDS patients were provided with Reiki I training and tested using the *Spielberger State-Trait Anxiety Inventory (STAI)* and *Visual Analog Scale* following a 20-minute self-Reiki session or Reiki provided by another student on days three and four of training. Four-hour Reiki training sessions were provided on four consecutive days. Students were tested pre- and post-treatment. Students reported a decrease in pain and anxiety following treatment but there was no significant difference between the 'self-treatment' and 'treatment by another student' groups. There were no 'no treatment' or 'sham' Reiki (Vitale & O'Connor, 2006) control groups.

*3. Olson, Hanson and Michaud (2003)*

Olson, Hanson and Michaud tested the quality of life, pain, and analgesic use in cancer patients. A control group (n=13) received standard opiate treatment and rested for one-

and-a half hours on days one and four while a treatment group (n=11) received standard opiate treatment and a one-and-a half hour Reiki treatment from a Reiki practitioner one hour after their first afternoon medication. Confusingly, in different places Olson et al. stated that the Reiki practitioner was a Level II practitioner (p. 990) and a Reiki Master (p. 992). Before and after each rest period or Reiki treatment patients were tested for pain, blood pressure, heart rate and respiration, and analgesic use for seven days. The researchers originally aimed to have a total group of 100 patients but experienced difficulty in recruiting enough people for the no treatment group because of 'persistent requests for Reiki'. Twenty potential participants refused to participate if they could not receive Reiki (p. 991).

Olson et al. reported that patients in the treatment group experienced improved pain control and quality of life after treatment but no reduction in opiate use when compared to the control group. Patients had been advised to continue their normal opiate use unless advised differently by their physician. It was also observed that the benefits lasted for approximately two to three days following treatment. While Olson et al. could not rule out the possibility of a placebo effect, they argued that, if a sham-Reiki were to be provided, 'the results may be confounded by the intention of the provider' (p. 993).

### 2.5.7 Quasi-experimental trials using quantitative data collection methods

*1. Crawford, Leaver and Mahoney (2006)*

Crawford, Leaver and Mahoney conducted a quasi-experimental empirical study into the effects of Reiki on memory and behaviour patterns in people with mild cognitive impairment or Alzheimer's disease. A trial group (n=12) was provided with four, 30 minute weekly Reiki sessions by two Reiki Masters. A control group (n=12) received no treatment. Participants were pre and post-tested using the *Annotated Mini-Mental State Examination* and the *Revised Memory and Behaviour Problems Checklist*. The researchers found a significant improvement in the treatment group on both tests. It was acknowledged that the results might have been different if newly attuned Reiki practitioners had provided the Reiki.

*2. Salach (2006): Master of Arts in Gerontology*

Salach (2006) from the San Francisco State University used a quasi-experimental research design to study the effect of Reiki on depression and anxiety in people with Alzheimer's disease and other dementias. Eight adults (seven females and 1 male) between 58 and 89 years of age with dementia as well as depression and/or anxiety were allocated to two groups and received either 30 minutes of Reiki once a week for eight

weeks or mock Reiki treatments of the same duration. The treatments were administered in a 'fairly quiet room … [with the participants seated] … in a comfortable armchair' (p. 19).

In addition to anxiety and depression, participants were tested for heart rate and blood pressure. The *Spielberger State-Trait Anxiety Inventory (STAI)* and *Geriatric Depression Scale (GDS)* were used to test for anxiety and depression. Pre- and post-tests were administered with each treatment. Salach reported that Reiki had positive, cumulative effects on the participants while the mock treatment had little effect.

Confusingly, Salach stated that treatments were conducted with the practitioner's hands one to four inches above the recipient's body and in another 12 inches above the body. Salach identified the small sample size, the cognitive ability of some participants, the fact the participants were in the midst of other physical and emotional challenges during the trial period, and the limited duration of the trial as limitations to the study. During the trial two participants had their diagnosis of anxiety and/or depression reversed. I consider that there may have been a conflict of interest because Salach was both the researcher and Reiki practitioner.

### 2.5.8 Traditional nursing care plus Reiki compared to traditional nursing care only

*Vitale and O'Connor (2006)*

Vitale and O'Connor examined the effect of Reiki on a group of women undergoing abdominal hysterectomies. The treatment group (n=10) received traditional nursing care plus Reiki and a control group (n=12) received only traditional nursing care. Reiki was performed by nurse Reiki Masters for 30 minutes pre-operatively and then for 30 minutes each at 24 hours and 48 hours post-operatively. Data were collected using the State component of the *Spielberger State-Trait Anxiety Inventory (STAI), which* was administered immediately before discharge, and the patients' medical records. The Reiki group reported less pain and state anxiety and requested fewer analgesics than the non-Reiki group. Further, the experimental group spent less time in surgery than the control group. Vitale and O'Connor postulated that this might have been due to the relaxing effect of Reiki.

While the medical rigour and random assignment of patients to the two groups controlled for as many extraneous variables as possible, Vitale and O'Connor cite the small number of participants as a limitation to this research. Because the Reiki was administered in the patient's private room possible 'contamination' of the control group was avoided. Vitale and O'Connor also asserted that the introduction of a sham-Reiki

group may have confounded the study because there is doubt among researchers that a sham treatment is inert.

### 2.5.9 Trained Reiki practitioners compared to mimic healers

*Weir (2004): Master of Arts in Psychology*

Weir examined the physiological changes and subjective experiences of Canadian Reiki Master healers. Two groups, Reiki Master healers (n=10) and mimic healers (n=12), matched for age, education and gender, were tested for temperature, respiration rate, heart rate, skin conductance and EEG [electroencephalogram] before, during and after a healing session.

The Reiki sessions lasted for 20 minutes and eight hand positions (head and torso with recipient laying supine) were specified. In order to ensure uniformity of practice, a chart of hand positions was provided for reference during each session, which was non-touch with the hands held three to four inches above the body. Weir observed each session to ensure uniformity of process. Weir did not provide information as to how long a gap there was between treatments. The same recipient was used to 'remove the confounding variable of different recipients of healing energy' (p. 19). Short, unstructured interviews followed the healing session. Apart from asking if there were any comments the Reiki practitioner wanted to make, I asked no further questions.

Weir reported that there were no significant differences between the groups or over time in EEG, respiration rate, heat rate and skin conductance but that there were significant differences in peripheral skin temperature between the groups and over time. The healers exhibited significant changes in this phenomenon over time. However, both the healers and mimic-healers reported a wide range of sensations, which did not necessarily match the recorded physiological changes.

Weir suggested that the research could be expanded to determine if the providers' physiological measures change if they 'treat' multiple recipients. Weir claimed that 'the study had no major limitations' however, the EEG was not bi-polar and multi-site (p. 30) and therefore may have missed considerable brain activity. It is also possible that the use of the one recipient could have resulted in an 'over dose' of Reiki [Refer to Ostojic (2006) above] and therefore adversely affected the degree of healing occurring.

### 2.5.10 Section conclusion

These cited projects cited are varied, utilising both qualitative and quantitative methodologies. Both the effects of Reiki on the recipients and newly trained practitioners have been measured using a wide range of instruments. The time span of Reiki treatment

has varied from one treatment to 10 treatments given over an unspecified time frame, to an unspecified series of multiple treatments over a nine to ten-month period.

A summary of the 14 research projects into Reiki discussed above has been provided in Table 2.2. The potential limitations are an amalgamation of suggestions from the original researchers and myself.

**Table 2.2: Summary of 14 research projects into Reiki**

| Researcher | Topic and Subjects | Method and Time | Potential Limitations |
|---|---|---|---|
| Barnett (2005) | • Parental stress (n=57)<br>• Newly trained Reiki I practitioners and non-attuned practitioners | • RCT<br>• Six weeks | • Direct researcher involvement in teaching Reiki<br>• Possible researcher conflict of interest<br>• No 'no treatment' control group |
| Brathovde (2006) | • Self-care in health workers (n=10)<br>• Newly trained Reiki I practitioners – self treatment | • Quantitative and semi-structured interviews<br>• Three months | • Small sample size<br>• No 'no treatment' control group |
| Crawford et al. (2006) | • Memory and behaviour patterns in people with mild cognitive impairment or Alzheimer's disease (n=24)<br>• Recipients of Reiki | • Quasi experimental with quantitative methods<br>• Four, 30 minute weekly treatments | • Small sample size<br>• Short time frame |
| Mackay et al. (2004) | • Heart rate and diastolic blood pressure in healthy volunteers (n=45)<br>• Recipients of Reiki, mimic-Reiki and 'rest only' control group | • Quantitative<br>• One 'treatment' | • Pilot study<br>• Relatively few subjects |
| Magnuson (2003) | • Mothers healing from childhood sexual abuse (n=10)<br>• Newly trained Reiki I practitioners | • Mixed method<br>• Nine to ten months | • Small sample size (two groups of five)<br>• Direct researcher involvement as participant observer<br>• No 'no treatment' control group |
| Miles (2003) | • HIV/AIDS patients (n=30)<br>• Recipients of self-Reiki or Reiki by another | • Quantitative<br>• Two 20-minute treatments on days 3 and 4 of training | • No 'no treatment' control group |
| Mitchell (2006) | • Chronic illness<br>• Reiki II practitioners (in private healing practice) (n=4) and recipients (n=4) | • Qualitative<br>• 10 Reiki sessions – time span not specified | • Difficulty recruiting participants and pairing practitioner with client<br>• Small sample size<br>• Lack of depth in some interviews<br>• No 'no treatment' control group |

| Table 2.2: Summary of 14 research projects into Reiki | | | |
|---|---|---|---|
| **Researcher** | **Topic and Subjects** | **Method and Time** | **Potential Limitations** |
| Olson et al. (2003) | • Pain, blood pressure, heart rate, respiration and analgesic use in cancer patients (n=24)<br>• Recipients of Reiki and no-treatment control group | • Quantitative<br>• Seven days with two 1.5 hour treatments on days one and four | • Small sample size<br>• Difficulty in obtaining volunteers for the 'no Reiki' group<br>• Limited number of treatments |
| Ostojic (2006) | • Workers 'within a division of a large Australian corporation' (22 recruited – 17 completed the project)<br>• Recipients of distant Reiki | • Split-half, double-blind quantitative<br>• Two continuous (but staggered) 21-day' periods | • No 'no treatment' control group<br>• Major structural changes in the organisation from which the recipients were chosen<br>• Difficulty in determining how much Reiki was sent and how many Reiki practitioners participated<br>• Uneven 'doses' of Reiki between the two groups<br>• No commitment from the recipients<br>• Small sample size (17 recipients) |
| Salach (2006) | • Depression and anxiety in people with dementia | • Quasi experimental with treatment and sham treatment groups. | • Small sample size (n=8)<br>• Additional physical and emotional stress during the trial<br>• Limited duration<br>• Cognitive ability of participants<br>• Possible conflict of interest |
| Tsang et al. (2007) | • Fatigue, pain, anxiety, quality of life in cancer patients | • Crossover Reiki and rest periods<br>• 5-6 weeks | • No control group<br>• Small sample size<br>• Inability to isolate the effect of Reiki from the effect of receiving additional attention |
| Vitale and O'Connor (2006) | • Anxiety, pain, analgesic use and time in surgery for women undergoing abdominal hysterectomies (n=22)<br>• Recipients of Reiki and a 'no-Reiki' control group | • Qualitative<br>• Three sessions of 30 minutes each. Pre-operatively and then at 24 and 48 hours post-operatively. | • Small sample size |
| Webber (2008) | • Reiki in dementia care<br>• Reiki practitioners working in dementia care | • In-depth, semi-structured interviews | • No triangulation of data |

| Table 2.2: Summary of 14 research projects into Reiki | | | |
|---|---|---|---|
| **Researcher** | **Topic and Subjects** | **Method and Time** | **Potential Limitations** |
| Weir (2004) | • Physiological changes and subjective experiences of practitioners<br>• Reiki Master practitioners and mimic-Reiki | • Mixed method<br>• One Reiki treatment each | • EEG not bi-polar and multi-site<br>• Use of one recipient of Reiki<br>• Data based on one Reiki/mimic-Reiki session<br>• No 'no treatment' control group |

In my view, each of the research projects discussed had at least one serious limitation. Any viable research into Reiki must address these limitations.

## 2.6 The placebo effect

For the purposes of this study, 'placebo' is taken to mean more than 'the narrow effect of a dummy intervention … [and encompasses the] … broad array of nonspecific effects in the patient–[practitioner] relationship, including attention; compassionate care; and the modulation of expectations, anxiety, and self-awareness' (Kaptchuk, 2002, p. 817). Given this definition, all carer-resident interactions, should produce a placebo effect and be therapeutic if they are underscored by compassionate care and are conducted in a manner intended to reduce resident anxiety. Consequently it could be claimed that all positive results reported by the participants may be simply a result of a placebo effect.

Richardson (2000) suggested that, in therapies such as Reiki, there is a possibility that the practitioner may be an integral part of the therapy. Also,

> Alternative medicine may be composed of healing rituals that have especially potent performative efficacy. Therapeutic characteristics that may enhance placebo effects seem especially prominent in unconventional healing …[and] … an enhanced placebo effect raises complex questions about what is legitimate therapy, and who decides (Kaptchuk, 2002, p. 822).

However, there are limitations to placebo control (Richardson, 2000), because [practitioners] can transmit their ideals to patients (Brody, 2000) and the placebo effect 'is consistent' (Richardson, 2000, p. 402). I acknowledge the possibility that any improvement in carer stress after Reiki training would be due to a placebo effect.

## 2.7 The 'Hawthorne Effect' and 'Practitioner Certitude'

The Hawthorne Effect, first described by Elton Mayo in 1927, identifies the tendency for people under observation to alter their behaviour and increase their compliance when they are aware of the observation (Kohli, Ptak, Smith et al., 2009). Also, the expectations of myself and other people directly involved in this research project could influence potential outcomes because, 'Even in blinded controlled RCTs (randomised controlled

trials), practitioner certitude seems to influence the magnitude of the placebo effect' (Kaptchuk, 2002, p. 819). The implications of the 'Hawthorne Effect' and 'Practitioner Certitude' for this research will be discussed below in the Research Method chapter.

## 2.8 Possible quantitative data collection methods

The 14 trials of Reiki described above provide examples of a wide array of both quantitative and qualitative tools that could be used to monitor the possible effects that providing Reiki could have on either the people trained in Reiki or their clients with dementia. A selection of possible data collection methods will be examined below before proceeding with an analysis of possible research methods.

### 2.8.1 Spielberger State-Trait Anxiety Inventory (STAI) Form Y

One quantitative data collection tool which can be used to measure carer anxiety/stress is the ***Spielberger State-Trait Anxiety Inventory (STAI) Form Y*** (Spielberger et al., 1983). This inventory is a widely used 40-item self-reporting test of anxiety that could be given to participants at each of their interviews. Two 20-item subscales measure current anxiety (State) and underlying anxiety (Trait). Inquiring about both negative and positive qualities, the *STAI* was developed for use with high school and college students as well as adults. As noted above, this assessment tool had been used by Magnuson (2003), Miles (2003), Salach (2006), and Vitale and O'Connor (2006) and its use in this study would permit triangulation with these previous studies. However, this is a language-based tool, and the English version is possibly open to misinterpretation by people from non-English speaking backgrounds and others whose English language skills may be limited.

### 2.8.2 Caring Efficacy Scale

Another quantitative data collection tool that can be used to measure the effectiveness of an individual's caring effectiveness is the ***Caring Efficacy Scale*** (Brathovde, 2006; Manjlovich, 2005; Watson, 2002). It was designed for nurses and is an 'instrument of self-assurance in the ability of a caregiver to express and demonstrate a caring relationship, and have confidence in providing care without depleting the self' (Brathovde, 2006, p. 97). It is a '30-item … tool, arranged in a 6-point Likert type format [and] items are balanced between positive and negative content' (Manjlovich, 2005, p. 43). However, this is also a language-based tool, and the English version is possibly open to misinterpretation by people from non-English speaking backgrounds and others whose English language skills may be limited.

### 2.8.3 Abbey Pain Scale

Because I had initially intended to work directly with people with dementia as well as their carers, I searched the literature for tools, which may have been appropriate to my aims. One such quantitative, observational tool suitable for evaluating the effect of Reiki on people with dementia is the ***Abbey Pain Scale*** (Abbey, Piller, De Bellis et al., 2004). This tool had been recommended by the Dementia Training Institute of Australia (Webber, 2008). As an observational tool, it would require either the presence of the researcher during the implementation of Reiki or the recruitment of appropriately trained staff members in the facilities where the research project is implemented. Although I did not work directly with people with dementia, I have included it here to inform potential future researchers.

### 2.8.4 Physical testing for stress

It would be possible to conduct either salivary or blood tests for the adrenal hormone cortisol at each interview. It has been suggested that cortisol levels vary with changes in stress (Anisman, Griffiths, Matheson, Ravindran, & Zul, 2001; Lim, 2011; Ross, 2012) and 'reliably [decrease] as a result of touch-based therapies' (Ross, 2012, p. 129). However, there is also the possibility that, when using Reiki, salivary cortisol tests may not be indicative of perceived changes in stress levels (Bowden, Goddard, & Gruzelier, 2010; Kanitz, Reif, Rihs, Krause, & Seifert, 2015). To administer this test would require the researcher to be trained and qualified in implementing the procedure.

## 2.9 Possible qualitative data collection methods

### 2.9.1 Using a phenomenological research method

Qualitative data can be gathered by using a phenomenological method which can be a valuable tool for researching nebulous concepts such as 'caring' (Priest, 2002, p. 50). It is designed to 'shed light on' the nature of the phenomenon under investigation and probe the lived experience of the subjects so that the 'totality of [the individual's] being may be better understood' (Paul, 1999, p. 196). The significance of the context is also important because understanding is exclusive to the individual (Paul, 1999; Priest, 2002). People taking part in an event may have radically different opinions about that event (Willis, 2004). In this form of research, 'the researcher's principal purpose is to know and understand' (Fitzgerald, 1997, p. 53) the individual experiences of the subjects. As a research tool, phenomenology has evolved from philosophy (Krasner, 2001) and provides an experience-based, person-centred description of the subject under review (Henricson, Berglund, Maatta, & Segesten, 2006).

Analysing the data involves describing the phenomenon then searching for the essence of the experience which is retrospective (i.e. it happened in the individual's past rather than in the present) and open to interpretation (Paul, 1999). During this process, the researcher suspends his or her preconceptions and develops 'intensive engagement' with the data. The most valuable information comes from direct transcripts of recorded interviews (Priest, 2002). Maintaining rigour is essential to ensure that the 'study is believable, accurate … and useful to people beyond those who participated in [the research]' (Priest, 2002, p. 57).

Brown, Barnes and Clarke et al. (1999) used a phenomenological approach to analyse the lived experiences of 20 relatives of critically ill patients in the Royal Hobart Hospital. Using a team approach to the analysis of the data, they found that complementary therapies (including aromatherapy, massage, music, Reiki and flower remedies) had the effect of: inspiring calm and relaxation as well as promoting sleep; enhancing connectedness and eliminating feelings of negativity; humanising the technology and distracting attention from the noises of the machinery; and enhancing the essence of being and promoting a sense of meaning.

Cahil (1999) analysed the motivations of 39 Queensland wives, daughters and daughters-in-law providing dementia care for a relative. Cahil used in-depth, semi-structured interviews to gather data which were then analysed using a phenomenological approach. Data were grouped into themes using a within-case and across-case analysis approach which included counting, noting patterns and themes and cross-linking solicited and unsolicited data. Peer review was used to ensure consensus and enable plausible conclusions to be drawn.

Two studies, Mansour, Laing and Leis et al. (1998) and Whelan and Wishnia (2003), used a phenomenological approach to analyse the effects of Reiki. Mansour, Laing and Leis et al. (1998) analysed the experiences that five women had with Reiki. Data were collected through a series of in-depth interviews over a five-month period. The interviews were guided by four key questions with additional information being elicited with verbal probes. Data collection and analysis were undertaken concurrently. The transcripts of the first interview with each participant were read and re-read with any unclear areas being probed at subsequent interviews until a clear understanding had been obtained. Checking with the participants validated the transcripts. Whelan and Wishnia (2003) analysed the experiences of eight female nurses who were Reiki Masters. The interviews in this study were structured with 17 comprehensive questions being used.

Wilkin and Slevin (2004) used a phenomenological approach to analyse the meaning of care as reported by 12 Registered nurses with at least one-year's experience in intensive care unit nursing. Their method involved reading and re-reading transcripts of interviews, extrapolating and organising meanings, integrating the results and formulating a detailed description of the phenomenon before validating the findings with four of the participants. Wilkin and Slevin indicated that a limitation of their research was that patients and relatives were not interviewed.

In addition to this research, phenomenological approaches have been used to study: complementary and alternative medicine modality use and beliefs among African American prostate cancer survivors (Jones, Taylor, Bourguignon et al., 2007); paediatric nurses' attitudes to massage and aromatherapy massage (Hunt, Randle, & Freshwater, 2004); and nurses providing healing touch in an intensive care unit (Henricson et al., 2006).

### 2.9.2 Qualitative interviews

The semi-structured, unstructured or biographical in-depth interviews used to gather data for phenomenological studies can be described as qualitative interviews (Broom, 2005; Bryman, 2004). Qualitative interviews, whether semi-structured or unstructured, offer the opportunity to undertake an in-depth exploration of the subjective and complex experiences of the individuals involved in smaller sample sizes (Broom, 2005). Semi-structured interviews are guided by an interview schedule to ensure the same topics are covered with all participants but provide an opportunity for open dialogue and it is the participants who drive the direction of the study. The use of open rather than closed questions provides an opportunity to develop new questions and produce unexpected results (Broom, 2005). Qualitative interviews differ substantially from quantitative interviews which ask exactly the same questions of all participants and usually offer a fixed range of answers in order to permit statistical analysis of the results (Broom, 2005).

The aim of qualitative interviewing is to develop an understanding of the participants rather than simply knowing (as in quantitative research) (Lempp & Kingsley, 2007). Therefore qualitative research is a useful tool for 'translating scientific results into realistic everyday clinical practice and patients' lives' (Lempp & Kingsley, 2007, p. 861).

While qualitative interviews are a valuable tool in research, they are not necessarily 'quick-fix solution' and the ethical issues relating to this form of research must be carefully considered (McIlfatrick, Sullivan, & McKenna, 2006). It is important to recognise that 'the researcher is the primary data collection tool … and the very nature of

focused in-depth interviews may lead the researcher to be drawn into other unanticipated areas' (McIlfatrick et al., 2006, p. 41).

Myers and Newman (2007) identified a number of potential problems with conducting qualitative interviews. They can be artificial, intrusive and time consuming, however, if the interviews are too short the data may be incomplete. There may be a lack of trust between the parties so the participants may not be willing to provide intimate information. The researcher may have entered at too low a level in the organisation and may not be able to interview senior personnel at a later stage. On the other hand, there may be a tendency to interview elite people with high status within the organisation. The interviewer is part of the process and is continually constructing knowledge. There may also be an ambiguity of language with possible misunderstanding of the questions.

Qualitative research, which studies 'small samples in depth rather than … large samples in less detail' (Webber, 2008, p. 75), is focused on the quality of the output and, 'Readers should find the descriptions reasonable, informative, and sensible' (Heppner, Kivlinghan, & Wampold, 1999, p. 249). Also, the validity of the research may be judged by the degree to which participants 'benefit as a result of their experience in the research' (Heppner et al., 1999, p. 250). Triangulation which uses a variety of methods to view the data from different angles such as obtaining accounts from different people and/or combining qualitative and quantitative methods over time (Banister, Burman, Parker, Taylor, & Tindall, 1999) may also be used to establish validity. Because there are no 'real' truths in qualitative research and it is the 'importance of the findings' which is paramount (Heppner et al., 1999, p. 251), differing viewpoints are acceptable.

> Qualitative studies are applied when methods are needed to specifically understand [individuals'] experiences and perceptions … when phenomena have to be explored, for gaining an understanding of social life, and for answering questions about the why and how of individual experiences. Qualitative studies involve an interpretive approach, with greater openness and flexibility than quantitative studies
>
> (Franzel, Schwiegershausen, Heusser, & Berger, 2013, p. 1).

As will be shown throughout this doctoral research, the comments made by volunteers in this project indicated an extreme range of opinions from an enthusiastic acceptance of Reiki as a suitable tool for use in the care of people with dementia to a total rejection of Reiki as a therapy.

## 2.10 A possible pragmatic randomised control trial

Initially, my intention was to conduct a pragmatic randomised control trial of the efficacy of a complementary therapy used in the care of people with dementia in one South Australian high care residential facility. The proposal was to divide volunteer

professional carers of people with dementia into three groups: one with full Reiki training and providing Reiki treatments; one providing a sham-Reiki treatment; and one providing normal care only.

The first two groups would be trained in the use of Reiki, however, 50% would be attuned to *Usui Shiki Ryoho* Reiki I while 50% would be given a mock attunement as descried by D. A. Barnett (2005). The study would have had a pre-test, post test at three weeks, six weeks, and 12 months. After Reiki training, both the professional carers and the people they cared for would be monitored over a 12-month period. As a researcher I would be blind to who had been attuned to Reiki. Also, the Reiki and sham-Reiki participants would be blind to their condition until the post-testing at six weeks. However, after consulting an epidemiologist, it was found that the number of participants required in order to produce statistical meaningful results would necessitate conducting the trial in multiple high care residential facilities. Given the lack of financial, personnel and physical resources available to me, implementing a project on this scale was not feasible. Therefore, it was necessary to determine if there was an alternative approach available.

## 2.11 Finding an alternative approach

### 2.11.1 Is it necessary to have a control group when studying Reiki?

There is, in fact, one research method in which it is not necessary to have a control group because each participant acts as their own control. This is a single subject or single case design where the participants are tested prior to the introduction of an intervention, several times during the progress of the intervention and finally, after the intervention has been removed.

### 2.11.2 Single subject/single case research designs

The terms ‘single subject’ (Barlow & Hayes, 1997) and ‘single case’ (Matson et al., 2012) do not refer to the number of subjects, but to the way in which the data are collected and analysed (Barger-Anderson et al., 2004). Personalised data are compiled and analysed individually for each participant (Barger-Anderson et al., 2004) in a systematic and detailed fashion (R. H. Horner, Carr, Halle et al., 2005). Two treatments can be compared within each subject (Barlow & Hayes, 1997) and a group of subjects can be treated as an individual (Foster, Watson, Meeks, & Young, 2002). If necessary, a number of common statistical techniques can be applied to the data obtained when using a single subject design (Aeschleman, 1991) while a single case design can also be used for observing and describing naturally occurring phenomena (Matson et al., 2012)

Although randomised parallel group trials are considered to be the 'gold standard' research method (Janosky, 2005, p. 549) (and evidenced by the work of Lee and Lim (S. H. Lee & Lim, 2016)), these trials provide insight into the average result and may not be applicable to the individual (Janosky, 2005). A single subject research method provides considerably more information about the individual than does a large group method (Foster et al., 2002; Harvey, May, & Kennedy, 2004). It also permits a study of both individual-based and time-lagged effects (where an individual's performance is measured under different conditions or at different times) (Hobbs & Yan, 2008) within the one project. In large-scale, homogenous trials, it is difficult to control for environmental variables and finding a large number of individuals with the same condition may be difficult (Dattilo, Gast, Loy, & Malley, 2000).

With a single subject design there is no limitation on the phenomenon that can be investigated, although repeated measurements are essential (Aeschleman, 1991). In addition to providing an opportunity to systematically document the outcomes of any intervention, single subject research design enables easy incorporation of the trial into normal clinical procedures (Backman & Harris, 1999). This design has the potential to demonstrate:

> that the intervention apparently produces the same kind of behavior change … across different subjects, each displaying a different behavior in a different setting, all of which nevertheless respond to the common intervention in a similar manner …
>
> (R. D. Horner & Baer, 1978, p. 189).

Foster et al. (2002) suggest that the simplest form of single subject research design is an A-B-A format (Figure 2.1) where: data are taken to provide a base line; an intervention is implemented during which data are collected; then data are collected after the intervention has been removed.

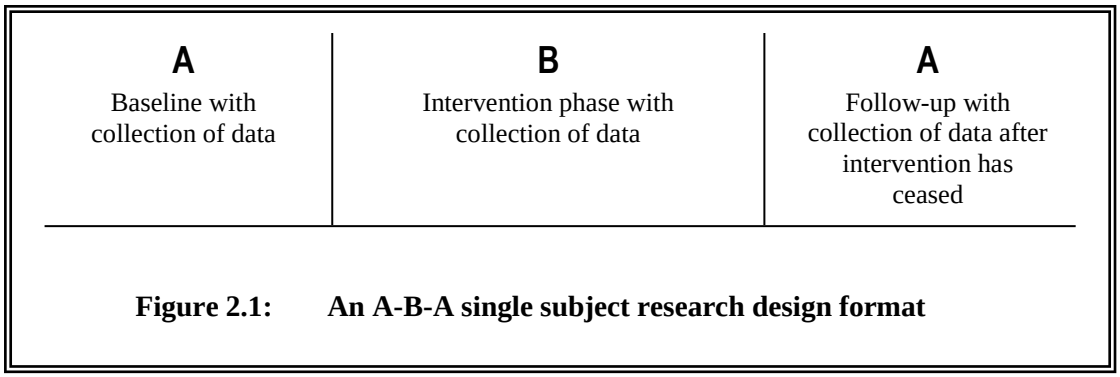


**Figure 2.1: An A-B-A single subject research design format**

Archival material can be used to establish the base line while multiple baselines can be set up by examining the same individual across behaviours, the same individual

across settings, or the same behaviour across individuals (Foster et al., 2002), or by using more than one investigator (Dattilo et al., 2000).

At this point, it must be stressed that single subject/single case research designs are not synonymous with case studies (Aeschleman, 1991). In fact, it has been claimed that case studies are not rigorous enough to be called single subject research (R. H. Horner et al., 2005). A comparison between the features of case studies and single subject research design has been provided in Table 2.3.

**Table 2.3: Comparison of case study and single subject research designs from Sanders (2003)**

| Case study | Single subject research design |
|---|---|
| Subjective description of individual | Objective measurement of individual or single system |
| Anecdotal | Precise methods of measurement |
| No control | Subject acts as own control |
| Cannot document relationship between independent and dependent variable | Can document relationship between independent and dependent variable |
| Can generate hypothesis for future research | Can generate and test |

In single subject research, the independent variable is actively manipulated while the choice of socially significant dependent variables often enhances the importance of the research to the participants, their immediate contacts and society generally (Aeschleman, 1991; Harvey et al., 2004; R. H. Horner et al., 2005). Above all, the research question should guide the research design and the subject(s) must be representative of the general type of person to which the intervention would be applied (Janosky, 2005).

***History and application***

The single subject, experimental research method has been utilised for over 40 years to establish evidence-based practice and there are now at least 45 professional journals reporting this method. Single subject research methods are growing in popularity (Barger-Anderson et al., 2004; Jenson, Clark, Kircher, & Kristjansson, 2007; Zhan & Ottenbacher, 2001) and primary care providers are likely to use a single subject method when designing treatment for individuals (Janosky, 2005). Of 600 articles reporting on research into aphasia over a five-year period, 332 involved single subject research - 252 (40.33%) single subject experimental studies and 80 (13.33%) case studies (Beeson & Robey, 2006).

The adaptability of single subject/single case research designs is demonstrated by its use in investigating subjects as diverse as: disability and rehabilitation (Aeschleman, 1991; Zhan & Ottenbacher, 2001); drug therapy, gastroenterology, internal medicine,

paediatrics, family medicine, cardiology, and nutrition (Janosky, 2005); educational systems (Harvey et al., 2004); literacy research, psychology and psychiatry (Barger-Anderson et al., 2004); special education (R. H. Horner et al., 2005); therapeutic recreation (Dattilo et al., 2000); and autism, challenging behaviours, feeding, social skills, adaptive behaviour, toileting, work refusal, communication deficits, and independent living skills (Matson et al., 2012).

Single case research methods have been used extensively in a number of areas of special education when randomised, controlled experiments are either absent or impossible or impractical to implement (Wolery, 2013).

### *Control*

In a single subject research method with a pre-test/post-test format and staggered baseline assessments (Ulman & Sulzer-Azaroff, 1975, in Barlow & Hayes, 1979), the need for a control group is removed because the individual participants become their own control (R. H. Horner et al., 2005). Control is established through the procedures and is enhanced through multiple replications (Aeschleman, 1991; Barger-Anderson et al., 2004). This permits the study of a small number of people with varying conditions (Dattilo et al., 2000).

### *Multiple baselines and replication*

In a multiple baseline design, the intervention period remains the same but is introduced at different times for different participants (Zhan & Ottenbacher, 2001). Multiple baselines across individuals are particularly useful if it is not possible for participants to return to the original baseline. After a baseline has been determined and an intervention implemented with an individual or group, the other participants remain at the baseline conditions (Barger-Anderson et al., 2004). Using multiple baselines across subjects, settings and/or behaviours extends the normal A-B-A single subject design (Gaskill, 2006).

The use of multiple baselines becomes a form of replication and three to four replications are recommended (Barger-Anderson et al., 2004; Brossart & Meythaler, 2008). Systematic replication across participants, locations, and/or researchers can reduce the margin for error, increase confidence (Tawney & Gast, 1984), improve external validity (Dattilo et al., 2000), and foster generalisability (Holm, 1983). The use of staggered, or multiple, baselines with only one intervention phase: removes the problem of possible flow-on effect of the treatment; negates the need to remove

treatment; and is frequently used when evaluating complex interventions (Zhan & Ottenbacher, 2001).

Harvey et al. (2004) argue that, 'nonconcurrent [baseline] designs have a degree of flexibility that may allow for their use in studying complex social contexts … that might otherwise go unanalyzed' (p. 267) and that a 'multiple baseline design lends itself to use … [when] … instructive practices cannot be readily withdrawn or reversed' (p. 269). Perhaps the most important feature of a multiple baseline format is that it tries to 'negate threats to internal validity without withdrawing treatment' (Sanders, 2003, p. 21). Also:

> By comparing all the baseline measures it should indicate if the condition was staying static in all subjects irrespective of time and to evaluate if treatment was having an effect and not time or other factors (Sanders, 2003, p. 21).

It is claimed that, the use of multiple baselines is better than implementing a format where there is a baseline phase, an intervention phase, a withdrawal of the intervention phase, and a further intervention phase (Tawney & Gast, 1984).

Figure 2.2 provides a stylised example of one form of a multiple baseline research project. Recording for all individuals starts at the same time while the intervention begins at different times and there are three recordings for one subject before the intervention is commenced for that individual, six for the second subject and nine for the third.

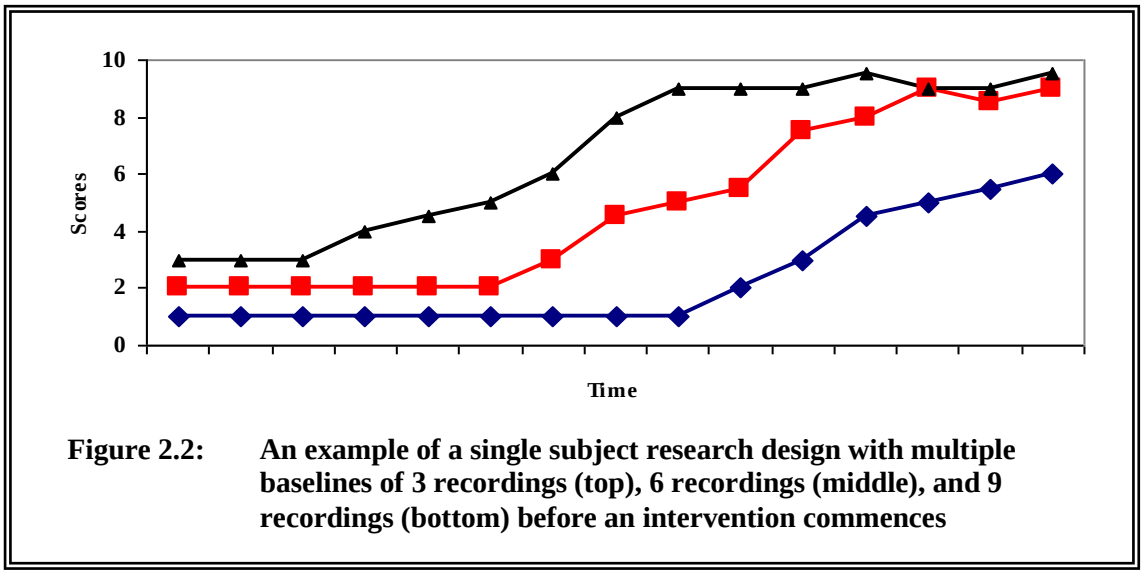


**Figure 2.2: An example of a single subject research design with multiple baselines of 3 recordings (top), 6 recordings (middle), and 9 recordings (bottom) before an intervention commences**

Figure 2.3 provides an example of a single subject research design with staggered, multiple baselines where recording begins at a different time for each individual. In this example, each individual will remain at his or her baseline condition during the non-recording period and there are three baseline recordings for each individual.

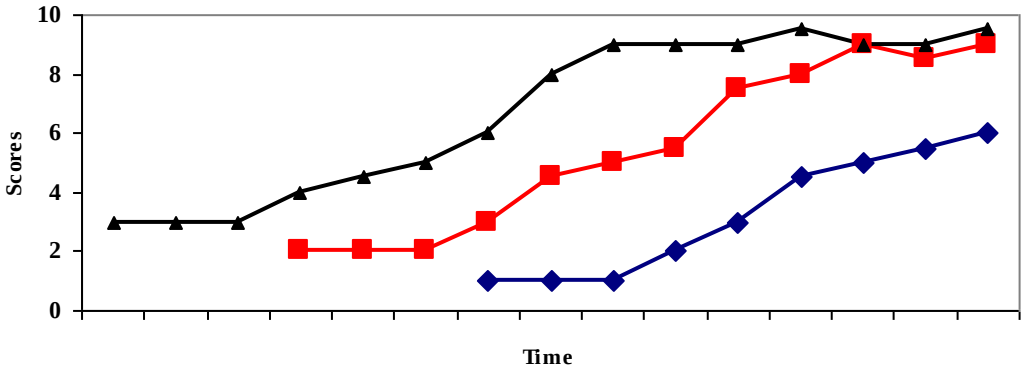


**Figure 2.3:** **An example of a single subject research design with staggered, multiple baselines starting at different times for each subject**

In June 2009, a search in the *Scirus* search engine using the criteria "'single subject' and 'multiple baselines'" returned 27,477 'hits' including 1,240 journal articles. A similar search in the Google Scholar search engine returned 256 'hits'. From these searches, 14 randomly selected research projects published between 2002 and 2008 were selected for examination. The selection contained four PhD theses and articles from 10 academic journals and indicated the wide variety of settings in which a single subject, multiple baseline research method may be applied in a range of important areas of clinical investigation. Two of these projects used both quantitative and qualitative assessments (Centofanti, 2002; Pates, Karageorghis, Fryer, & Maynard, 2003) while the other 12 projects used only quantitative assessments.

***Power and validity***

Because no individual single subject project can prove a causal connection, there is need for replication of the research. However, a single subject research design provides an excellent opportunity for systematic replication across participants, locations, and/or researchers. This can: reduce the margin for error and increase confidence (Tawney & Gast, 1984); increase the internal validity of the design (Brossart & Meythaler, 2008); improve external validity (Dattilo et al., 2000; Rogers & Graham, 2008); and foster generalisability (Holm, 1983). In addition, the use of staggered, or multiple, baselines with only one intervention phase: removes the problem of possible flow-on effect of the treatment; negates the need to remove treatment; and is frequently used when evaluating complex interventions (Zhan & Ottenbacher, 2001).

Also, a multiple baseline format tries to 'negate threats to internal validity without withdrawing treatment' (Sanders, 2003, p. 21) because:

> By comparing all the baseline measures it should indicate if the condition was staying static in all subjects irrespective of time and to evaluate if treatment was having an effect and not time or other factors (Sanders, 2003, p. 21).

Varying the length of the baselines also controls for some threats to internal validity, particularly when factors such as history, maturation, changes in the environment, and the possibility of spontaneous recovery exist (Bailey, Riddoch, & Crome, 2002; Gauvreau & Bouchard, 2008; Holm, 1983). In addition 'threats to internal validity are controlled through within and between-subjects comparisons' (Rogers & Graham, 2008, p. 880). I proposed that this could be achieved by instigating a three-way analysis of data within and across groups as depicted in Figure Q1, Appendix Q.

***Advantages***

Zhan and Ottenbacher (2001, p. 7) suggest that the advantages of single subject research design include the ability to: incorporate the research into normal clinical practice without disrupting the standard therapeutic routine; record changes, analyse the course of the intervention, and modify the design as the study progresses; identify the optimum treatment for individuals; and use replications to establish the generalisation of the results.

Single subject research is 'practice based and practitioner orientated' (Zhan & Ottenbacher, 2001, p. 7) and permits practitioners to contribute to the scientific knowledge base (Dattilo et al., 2000; MacMahon & Kermode, 1998). Also, as noted above, single subject, multiple baseline research methods are especially useful when it is not possible for participants to return to the original baseline (Barger-Anderson et al., 2004).

## 2.12 The timing and duration of the therapy

It has been suggested that nurses may spend as little as 25% of their time in 'direct patient care' (Daley, 1997, p. 1124) and that people with dementia and resident in high care facilities may receive (on average) as little as 4.25 hours per day in care (3.30 hours from 'care staff' and 0.95 hours from 'support staff') (Access Economics, 2009, p. 28). Also, in a 2000 survey of nursing homes in South Australia (Webber, 2008), 11 respondents (8.9%, n=81) reported that their facilities precluded the use of certain (unidentified) complementary therapies because of time constraints (p. 41). Paradoxically, 'others reported the use of complementary therapies because of the time that can be spent with individual residents' (p. 119). In that study, the Reiki practitioners reported that 'spending 'quality' time with residents was important' to them (p. 119) yet:

> having insufficient time to provide 'full' Reiki treatments have meant that [they] had to change how they use[d] Reiki, change the length of time spent on a treatment, or incorporate Reiki into other activities' (p. 119).

In addition, the timing of the therapy may be important to its success. In a 2000 evaluation of a massage programme for people with physical and neurological conditions, both the nature and timing of the massage were found to be of importance. For instance, a massage provided during the daytime might enable a person to sleep well at night because he or she was able to walk and do small jobs during the day. Conversely, if the massage was provided at night the person's body might become too stimulated to enable him or her to sleep (Webber & Yeoman, 2000). Therefore, using a little Reiki often as recommended by Ellyard (2002) as a PRN therapy would deliver the therapy when and where it is needed and, in the long run, possibly save time if the client's behaviour is modified and the carer's stress reduced.

## 2.13 Supplementary Literature Survey

When I was analysing the findings from this study, a number of factors prompted the undertaking of a further literature survey before proceeding with the discussion. Because of this additional literature survey:

1. Information about a Nationally Accredited *Certificate IV in Reiki Treatment Practice* (AIHBN, 2014; Reiki Australia, 2014) became available to me in March 2014.
2. Information about a study into the effects of Reiki instruction on stress management for family caregivers of people with dementia (Morris & Warner, 2009) became available to me in May 2014.
3. A paper on Reiki as a nursing procedure (de Sousa et al., 2012) became available to me in January 2015.

Rather than amending my original literature surveys, the results of the additional literature surveys have been appended within this Chapter as a Supplementary Literature Survey. In my view, this honestly reflects the historical development of my doctoral thesis.

In addition, I conducted a series of literature surveys investigating the use of Reiki and touch in dementia care through to May 2016. For these searches I used both Google Scholar and FindIt@Flinders. These surveys continued to highlight the paucity of research into the use of Reiki in dementia care and indicated that a saturation point had been reached. However two papers found in May 2016 and which refer to Reiki as a touch therapy, Jain and Mills (Jain & Mills, 2010) and Lu and Herr (Lu & Herr, 2012), are also discussed in this Section. Also, in July 2016 Professor Brabazon raised the issue

of ‘well-being’ as a theme for consideration. However, because my original intent was to investigate carer stress in this doctoral thesis, I had made only passing references to ‘well-being’ and ‘quality of life’ if the various researchers whom I had cited mentioned these concepts. Therefore, in July and August 2016, I used FindIt@Flinders to conduct an intensive literature survey into these concepts as discussed below.

### 2.13.1 Professionalism of Reiki training

It has been claimed that ‘Practitioners of non-Western medical traditions seek legitimacy by imitating Western methods and formulae, and pursuing licensure and professionalization’ of their practice (Ross, 2012, p. 157). However, some non-Western medical therapies such as Therapeutic Touch were developed within Western mainstream academia and have become recognised medical practices. Conversely, Reiki has been a ‘folk art’ (Webber, 2008) and, because there have been no formal guidelines regarding training and practice, it is possible that it could be seen as a ‘Mickey Mouse’ exercise. In my MSc study I commented that:

> If Reiki is to be considered as a complementary therapy which has a valid place in the care of people with dementia, it will need to …[be]… incorporated into the Australian National Training Framework (Webber, 2008, p. 136).

Subsequently, in March 2014, I received an email from *Reiki Australia* informing people that the inclusion of Reiki in the National Training Framework had occurred towards the end of 2013. I immediately checked the details regarding this new qualification.

A person who has ‘completed in-person training and initiation in Reiki 1 and Reiki 2 by a Reiki Master whose lineage of initiation is traceable to the founder of the practice, Mikao Usui’ (AIHBN, 2014; Reiki Australia, 2014) can then study the Nationally Accredited *Certificate IV in Reiki Treatment Practice* (AIHBN, 2014; Reiki Australia, 2014) at the Australian Institute of Health and Business Management (AIHBN). The course includes:

- ✯ Seven core units that are common to other Certificate IV courses (*Apply First Aid, Communicate and work effectively in health, Contribute to WHS (sic) processes, Administer a practice, Make referrals to other health care professionals when appropriate, Communicate effectively with clients, and Use specific health terminology to communicate effectively*).
- ✯ Four Units specific to Reiki (*Work within a Reiki treatment framework, Apply Reiki client assessment framework, Plan and provide Reiki treatment and care, and Provide extended Reiki treatment*).

- ✭ Four of eight elective units, which are common to other Certificate IV courses (*Confirm physical health status, Work effectively with others, Comply with infection control policies and procedures, Plan, organise and facilitate learning in the workplace, Work effectively with culturally diverse clients and co-workers, Undertake home visits, Manage a practice, and Work effectively with older people*) (AIHBN, 2014).

This course does not teach Reiki or ensure that Reiki Master/Teachers conduct professional standard training. It simply prepares previously trained Reiki practitioners to conduct a business designed to provide professional services to clients.

### 2.13.2 Effects of Reiki instruction on family caregivers' stress management

When the search parameter '"Reiki" and "dementia"' was entered into the search engine, FindIt@Flinders, the first item returned was a link to the abstract of a paper presented to the Gerontological Society of America's 62nd Annual Scientific Meeting, November 18–22, 2009, Atlanta, GA (Morris & Warner, 2009, p. 372). This reference had not been found in any of the previous database searches I had conducted.

Morris and Warner's study was designed to 'explore the effects of teaching Reiki to family caregivers to manage stress related care of a loved one with dementia'. Classes were held once a week for four weeks. A total of 81 people were trained in Reiki relaxation techniques. There were 73 women and 8 men all aged from 28 to 90 (mean=61). Of these 34 were daughters, 31 were spouses, 4 daughters-in-law, 1 son 1 sibling and 1 cared for a friend. Among the carers, the average time as a caregiver was 5 years with a median of 4 years. In Morris and Warner's study, the care recipients':

> mean age was 80.7 years with a range of 58 to 96 years; with 41 females and 39 males. Eighteen lived in a nursing home; 37 lived with the caregiver; 16 another family member; 5 in assisted living; and, 3 lived alone.

Participants were asked to complete three self-administered questionnaires. One on the first day of class, another on the last day of class, and a mailed questionnaire completed four weeks after the last class. Morris and Warner found that:

> There were no significant changes in caregiver sleep; there was a significant decline in caregiver stress and burden scores; the depressive symptoms scores increased at Time 2 but were not different at the end of the study; there was a decrease in caregiver perceived stress and burden; the caregivers' quality of life scores increased; and [Recipients'] behaviours decreased for behaviours related to depression and memory problems (2009, p. 372).

Because I was not present at the conference and the study has not appeared in any other form in the refereed scholarship, there were a number of questions that could not be answered. Was there more than one group? Were there staggered base lines? If there

was more than one group, how many students were there in each group? What was the version of Reiki taught? How many Reiki Master/Teachers were there? If there was more than one, did they share the teaching or did they teach separate groups? Did any Reiki trained people help the Reiki Master(s) during training? Did any of the participants have previous experience with complementary therapies?

Were there staggered base lines? If there was more than one group, how many students were there in each group? What was the version of Reiki taught? How many Reiki Master/Teachers were there? If there was more than one, did they share the teaching or did they teach separate groups? Did any Reiki trained people help the Reiki Master(s) during training? Did any of the participants have previous experience with complementary therapies? The questions regarding staggered base lines and group structure arise because of my doctoral research design. Also the form and level of Reiki could affect possible outcomes because some Masters teach distant healing in Level One while in my lineage this is not introduced until Level Two. The question regarding prior use of complementary therapies arises because of Beeler's (2015) finding that the majority of her participants had considerable experience in complementary therapies before undertaking Reiki training. In May 2016 a Google Scholar search using the terms '"morris" and "warner" and "Reiki"', '"morris" and "Reiki"' and '"warner" and "Reiki"' still did not return and references other than the original citation found in May 2014.

### 2.13.3 Reiki as a nursing procedure

When the words 'Reiki dementia Webber' were entered into the Google Scholar search engine, one of the references returned was a systematic literature review of the use of Reiki in Nursing (de Sousa et al., 2012). Because the paper was published in Portuguese, I used Google Translate to translate the paper into English.

A further search subsequently found that the work had been presented to the: 5th National Reiki Congress, Lisbon, 25th October 2014; Integrative Therapy in Nursing Practice conferences at the Atlantic University (Universidade Atlântica), 2012 and 2013; 12th International Conference on Research in Nursing, Lisbon, 2012; 1st Nursing Conference, Lisbon, 2012; International Congress of Rehabilitation Nursing, Lisbon, 2011; and Process of Rehabilitation Workshops in Rehabilitation Nursing International Congress, Lisbon, 2011 (de Sousa, Severino, & Marques-Vieira, 2014).

The authors analysed 27 papers originating in 10 countries between 2001 and 2011 inclusive. Figure 2.4 illustrates the years of publication and Figure 2.5 illustrates the country of origin for each of the papers.

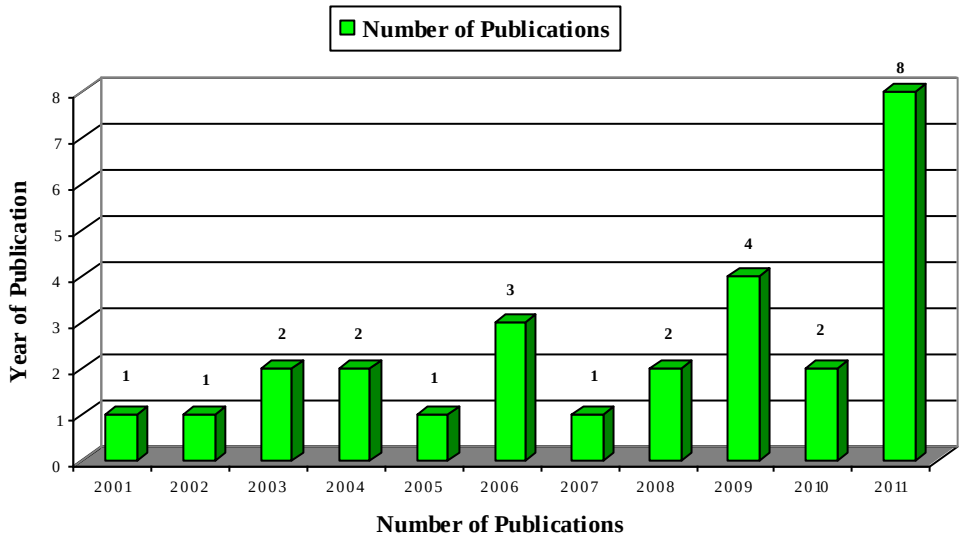


**Figure 2.4 The number of publications studied in each year adapted from de Sousa et al. (2012)**

Of the 27 papers analysed by de Sousa, Severino and Marques-Vieira, seven had been cited in this thesis: Mackay, Hansen, and McFarlane (2004); Mitchell (2006); Salach (2006); Shiflett et al. (2002); Vitale and O'Connor (2006); Webber (2006); and Whelan and Wishnia (2003). De Sousa et al. also referred to a further five papers that had been cited in this thesis: Crawford et al. (2006); Mansour et al. (1999); Miles and True (2003); Olson et al. (2003); and Tsang et al. (2007). Only four of the papers cited by de Sousa, Severino and Marques-Vieira, investigated the use of Reiki in dementia care. Of these, Salach (2006), Webber (2006) and Crawford et al. (2006) have been cited in this thesis. However, Crawford et al. (2006) only worked with people experiencing mild cognitive impairment or Alzheimer's disease. Meland (2009) was less relavent because it was a series of case reports.

The authors found that, although the evidence was low, the studies did not refute the notion that Reiki had a potential for use as a complementary therapy in nursing. They suggested that the effect of Reiki on a group of people over an extended period of time should be examined. They also suggested that, in future research, there should be a variety in the practitioner's level in Reiki, their method of implementing Reiki and the frequency and duration of the treatments provided. De Sousa's work confirmed the depth of my literature surveys for this doctoral project and the lack of published research into the use of Reiki in dementia care.

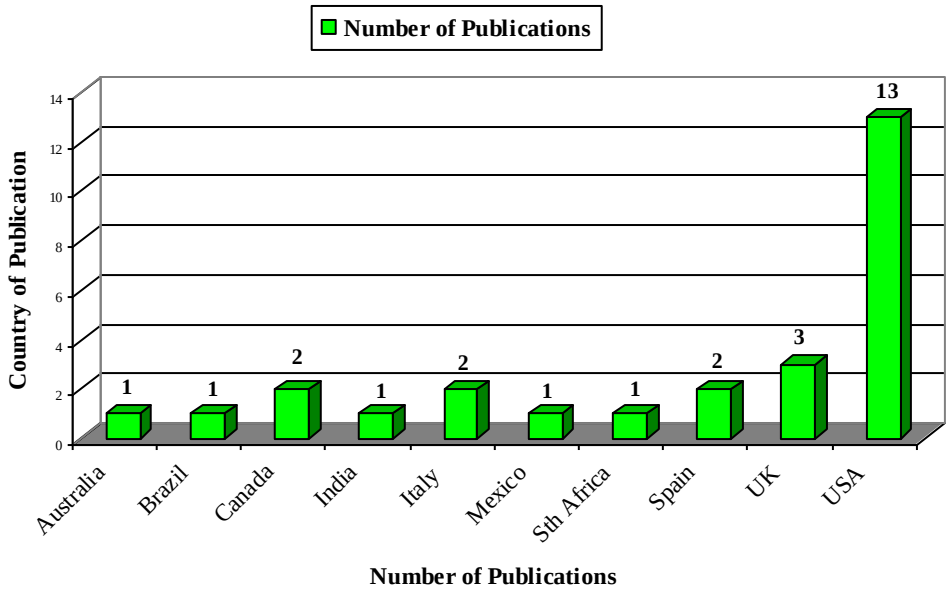


**Figure 2.5** **The number of publications studied from each country adapted from de Sousa et al. (2012)**

### 2.13.4 Evidence for Biofield Therapies

In a review of 65 biofield research studies published in English language, peer-reviewed journals between 1976 and 2007, Jain and Mills (2010) included studies on humans where interventions such as Reiki treatments could be isolated from other interventions such as meditation or distant healing. Following their comprehensive review, they concluded that biofield therapies showed varying degrees of positive evidence for reducing pain in people with cancer, decreasing negative behaviours in people with dementia and decreasing anxiety for people in hospital while improving the quality of life for people with cancer. They also called for further studies of biofield therapies.

Ten of the projects reviewed by Jain and Mills, were Reiki trials. Of these I had previously cited nine in this doctoral thesis. They are Crawford et al. (2006), Mackay et al. (2004), Meland (2009), Miles and True (2003), Olson et al. (2003), Shiflett et al. (2002), Tsang et al. (2007), Vitale and O'Connor (2006) and Wardell and Engbretson (2001). The tenth reference was to a paper by Olson and Hanson (1997). In Mid May 2016, a search using FindIt@Flinders failed to locate any reference to the article while a Google Scholar search only returned the abstract of the paper and the *Cancer Prevention & Control* website went back only to 1998. They reported that 20 volunteers experiencing pain due to cancer exhibited a 'highly significant ($p < 0.0001$) reduction in pain following the Reiki treatment', which had been provided by a Reiki II practitioner. The volunteers' level of pain was measured using a visual analogue scale and a Likert

scale both before and after the therapy (p. 108). Because no further information is available, I am unable to provide a detailed discussion of this trial.

As with the work of de Sousa et al. (2012), this paper demonstrates the depth of my original literature surveys for this PhD project and confirms the lack of published research into the use of Reiki in dementia care.

### 2.13.5 Pain management in dementia

Because people with dementia are often unable to verbally communicate their discomfort due to pain, Lu and Herr (2012) call for a 'Vigilant monitoring of their comfort and effective use of multidimensional pain management strategies'(p. 12). In their paper they discuss both pharmacological and non-pharmacological strategies for pain treatment in people with dementia and recognise that biofield therapies such as Reiki can induce a 'relaxation response' (p. 11). Therefore, it is possible that using Reiki when caring for people with dementia could have a 'double-barrelled' effect of reducing resident pain and carer stress to the benefit of both parties, particularly if the effect of Reiki is synchronic in nature as has been claimed (Vitale, 2006; Webber, 2008). Because people with dementia are often unable to verbally communicate their discomfort due to pain, Lu and Herr (2012) call for a 'Vigilant monitoring of their comfort and effective use of multidimensional pain management strategies'(p. 12).

### 2.13.6 Well-being/Quality of life

In this doctoral thesis I have given only passing reference to the terms 'well-being' and 'quality of life'. I have cited Deborah Barnett (2005) who used the *Friedman Well-Being Total Score* to test the well being of parents who learnt and practiced Reiki and my MSc project in which the interviewees believed that using Reiki could improving quality of life of people with dementia by improving physical well-being, improving psychological / mental / emotional well-being, improving relationships, and reducing negative behaviour (Webber, 2008). I have also previously cited Tsang, Carlson and Olson (2007), Olson, Hanson and Michaud (2003), Morris and Warner (2009) and Jain and Mills (2010) who have suggested that Reiki can improve the quality of life of people with a range of adverse conditions. In late July and early August 2016, I used FindIt@Flinders to conduct an intensive literature survey using multiple combinations of the terms *well-being*, *wellness*, *quality of life*, *Reiki*, *complementary therapies*, *alternative therapies* and *CAM* in addition to returning to my original Disability Studies text books. Findings from this literature survey are discussed below.

After a three-year study, Birocco, Guillame and Storto et al. (2012) claimed that receiving Reiki improved the 'well-being, relaxation, pain relief [and] sleep quality [and reduced] anxiety' for oncology patients attending a day unit (p. 290). Birocco, Guillame and Storto et al. (2012) then suggested that hospitals should offer Reiki as a way of responding to the physical and emotional needs of their patients. Catlin and Taylor-Ford (2011) also demonstrated that Reiki and Sham-Reiki can improve the well-being off people receiving chemotherapy as compared to patients who received only normal care. Biofield therapies such as Reiki may be effective in improving the quality of life for people receiving end of life care (Henneghan & Schnyer, 2015) and presence as compared to the physical effects of complementary therapies may be important for the well-being of hospice residents while a caring culture may result in increased staff job satisfaction (Nelson, 2006). This literature survey also located four dissertations in which the authors investigated various aspects of well-being including cancer survivors who choose complementary and alternative therapies (Jesic, 2006), the use of Reiki as a complement to traditional mental health services (Kelley Jr., 2009), the biopsychospiritual influence of Reiki on university students and Reiki practitioners' clients (Lenzen, 2002) and rural clinicians' perceived ethical dilemmas, well-being and burnout (Love, 2015).

What then is 'quality of life'? What is 'well-being'? Are these terms interchangeable or mutually exclusive? Because it has been claimed that Reiki can enhance/improve both the 'well-being' and 'quality of life' for individuals with dementia and/or other conditions, a detailed analysis of these terms is necessary. Quality of life refers to:

> the discrepancy between what an individual has attained and what the individual would like to attain [and] is also reflected in the extent to which the individual within the environment can gain increasing control over that environment (R. I. Brown & Hughson, 1993, p. 114)

and is 'concerned with the whole individual in the context of his or her social environment' (p. 12). Also, the 'personal perceptions of the [individual] may be either important or paramount' (p. 6). At this point it could be argued that the person with dementia is losing control of their environment as their dementia increases while the carer may also feel that they are losing control over their environment as their clients become increasingly dependent on their care so, for both individuals, their perceived quality of life may be declining so that anything that can be done to improve their sense of well-being will have positive effects on their perceived quality of life.

Both physical factors such as pain, shortness of breath and nausea as well as emotional and psychosocial factors such as restlessness, delirium and anxiety can

negatively impact on an individual's quality of life and sense of well-being (Henneghan & Schnyer, 2015). Also, progressive, degenerative diseases such as Parkinson's Disease (Johns, Blake, & Sinclair, 2010) can adversely affect a person's well being. However, there appears to be no consistent relation between experienced well-being measures and income, health and labour market status (Kapteyn, Lee, Tassot, & Vonkova, 2015) nor do cultural differences affect perceived well-being between people from different ethnic backgrounds living within the same national environment (Kim, Schimmack, & Oishi, 2012). Yet different life events such as marriage, divorce, bereavement and childbirth, unemployment, reemployment, retirement and relocation / migration can have significant impacts on well-being (Luhmann, Hofmann, Eid, & Lucas, 2012). While 'conventional' medicine is seen as central to well-being older people appear to use complementary therapies and medicine to address the limitations of conventional medicine (Lorenc, Clow, Forte, & Robinson, 2012).

Although there has been 'a marked tendency … to strive for middle-class standards of living (R. I. Brown & Hughson, 1993, p. 61) and concepts of personal well-being can be related purely to materialism (Dittmar, Bond, Hurst, & Kasser, 2014), there is a growing recognition that there is more to well-being than just economic factors (Diener, Oishi, & Lucas, 2015). In fact, the assessment of subjective well-being is becoming more important when assessing world development (D'Acci, 2011) and it has been suggested that 'National Accounts of Well-being' should be created to 'help decision makers evaluate policies that improve societies beyond economic development' (Diener et al., 2015, p. 234). Diener, Oishi, and Lucas cite 43 nations where measures of subjective well-being have been collected (p. 235). However, Ng & Diener (2014) found that 'satisfaction with material aspects of life is essential for well-being [and] has a stronger impact on [subjective well-being] in wealthier than in poorer countries'. They then postulated that 'societies that are economically developed and stable should not simply neglect economic growth and refocus all attention to [self-expression] values' (p. 336). Although 'financial satisfaction was the strongest predictor of life evaluation … respect was the strongest predictor of positive feelings' (p. 326). Also, parental attitudes may have a significant impact on adolescent identity formation and therefore their psychological well-being (Sandhu, Singh, Tung, & Kundra, 2012).

Another form of well-being is spiritual well-being, which can include elements of faith, peace and meaning (Crammer, Kaw, Gansler, & Stein, 2011), and may be an important factor in perceived quality of life (Olver & Dutney, 2012) but could be experienced in a different ways by individuals (Lenzen, 2002). Following a July 2011 to

January 2013, randomised, controlled trial in which 120 adults with depression received either only 'routine treatment [of] antidepressants and structured psycho-education' or were involved in 'body-mind-spirit group sessions [which included] self love techniques, acceptance of negative emotions teaching strategies to improve general health and emotional management in addition to the routine treatment' Rentala, Fong, Nattala, Chan, & Konduru (2015) concluded that there was 'evidence for the effectiveness of integrating a complementary therapy such as the body-mind-spirit intervention with conventional treatment in improving prospective outcomes among the depressive patients' (pp. 2153-2154). Also Yoga (Satyapriya, Nagarathna, Padmalatha, & Nagendra, 2013), massage therapy and guided relaxation (Sharpe, Williams, Granner, & Hussey, 2007) may assist in improving spiritual well-being.

As a former teacher and as a university student I am personally aware of the fact that the exchanges between teacher and student can be unequal. However, as a person who has not worked in dementia care, I can only surmise that the exchanges between the 'carer' and the 'cared for' may also be unequal. If this is in fact true, then it could be an important factor affecting the well-being of people with dementia because unequal exchanges can predict worse emotional well-being profiles among older adults and emotional well-being helps to protect against disease, disability, and mortality (Keyes, 2002).

In addition to the *Friedman Well-Being Total Score* (D. A. Barnett, 2005; Sandhu et al., 2012) and the *Functional Assessment of Chronic Illness Therapy–Spiritual Well-being* questionnaire (Olver & Dutney, 2012) there is an array of tools available for assessing well-being and/or quality of life. One tool is the *Arizona Integrative Outcomes Scale (AIOS)* which is a 'one-item visual analogue [scale] which 'assesses self-rated global sense of spiritual, social, mental, emotional, and physical well-being over the past 24 hours and the past month' (Bell, Cunningham, Caspi, Meek, & Ferro, 2004, p. 1).

## 2.14 Chapter conclusion

The second research question that structured this doctoral research project was:

Is there an appropriate method for researching therapies such as Reiki?

I believed that it was possible to develop a mixed method, pre-test/post-test research project that has been based on a Single Subject/Single Case Research design where the participants become their own control to test the efficacy of Reiki in reducing anxiety in professional carers of people with dementia. While replicating working conditions as closely as possible, this design has the potential to provide rich and detailed data about

the individual participants, the setting and the intervention. It should also reduce any potential limitations that may be inherent in conducting trials of complementary therapies. Although randomisation can be built into single subject research (Edgington, 1996), it will probably be better to use a purposive sampling technique when selecting participants to ensure that the research is as close to normal working arrangements as possible (D. A. Barnett, 2005; Richardson, 2000).

The design includes training small groups of carers at different times to establish staggered base lines and the gathering of both qualitative and quantitative data pre-intervention, during intervention, and post-intervention. The power of the project will be enhanced because training several individuals or groups at different times will become a form of replication. Conducting trials in different locations could further strengthen the power of the project. Although it will not be possible to use different investigators in this project as Dattilo et al. (2000) suggested, external validity could be increased by using different Reiki Master/Teachers to train carers. While meeting the criteria of being tightly controlled and replicable, this possible research protocol is compatible with the holistic nature of Reiki therapy and does not jeopardise the individualistic nature of a holistic treatment (Korn & Ryser, 2007). This design would also provide an opportunity to develop evidence-based practice regarding a complementary therapy that is being used in dementia care but about which there is little in the research literature. The method implemented for this research project is detailed in the next section.

# 3 Research Method

## 3.1 Chapter introduction

This chapter details the design and implementation of the project. The objective of the mixed method research project described below was to test the use of Reiki in reducing anxiety/stress in professional carers of people with dementia. The study was designed on the premise that giving a little Reiki often is better than giving a lot of Reiki infrequently (Ellyard, 2002) and was adapted from a single subject research method.

The major focus was to be an analysis of qualitative data gained through: in-depth, semi-structured interviews conducted with the carers, pre-Reiki training and six weeks after the training; and group meetings held with the newly trained Reiki practitioners at three weeks and six weeks following the Reiki training. However, once the project had commenced, it was decided to conduct additional interviews with the Reiki Master/Teacher, a Reiki I practitioner who assisted at the training, the university senior lecturer who attended the first Reiki training as an independent observer, and a Director of Nursing. It was also decided to conduct interviews with the participants trained in Reiki 12 months after the second interviews. Because it has been recognised that the ambience of the setting may effect the outcomes of a therapy such as Reiki (Webber, 2008), the processes used for conducting individual interviews and the Reiki training have been detailed in Appendix S. This will enable future researchers to replicate the research.

## 3.2 Research design

This project was designed to replicate the participants' normal working conditions as closely as possible (D. A. Barnett, 2005; Richardson, 2000). It also allowed the participants autonomy in their use of Reiki (Westcombe et al., 2003). The intervention phase lasted for six weeks and assessed the same behaviour (use of Reiki) across individual participants (Foster et al., 2002).

Figure 3.1 illustrates how recordings were made during the baseline, six-week intervention period and post-intervention phases (Zhan & Ottenbacher, 2001) through in-depth, semi-structured interviews (Appendix B) conducted pre- and post-intervention; discussions held with the participants during the initial Reiki training and at follow-up Reiki meetings held three and six weeks after the initial training; and the Reiki Recording Sheets (Appendix A) maintained by the participants during the six-week intervention phase.

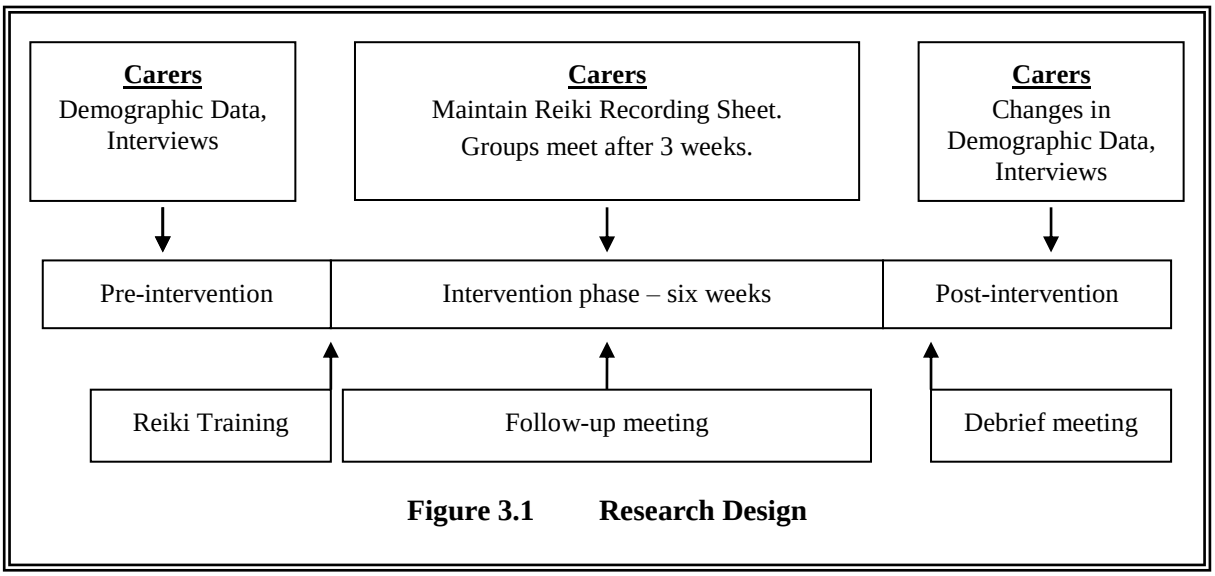


**Figure 3.1 Research Design**

By basing the research on a 'single subject' design, the individual participants became their own control. Also, this design removed problems associated with controlling for variability between subjects and groups; provided for the possibility of a no-intervention/intervention comparison over time; avoided ethical issues that may have been inherent in actively withholding an intervention that may have been seen to provide benefits; and permitted the examination of behaviour across the individual participant carers (Foster et al., 2002). Once the participants were trained in Reiki it was not possible to undo this training therefore, it was impossible to withdraw the intervention.

### 3.2.1 Intervention

***Reiki I training***

The volunteer carers received training in Level One *Usui Shiki Ryoho* Reiki (*in the lineage of Mikao Usui, Chujiro Hayashi, Mrs Takata,* and *Phyllis Lei Furumoto*) from an independent (from me) Reiki Master/Teacher. The Reiki training will be described in detail below.

***Using Reiki***

For the period of the trial, the carers conducted their normal duties and applied Reiki on a needs basis to themselves, their family and friends, work colleagues, and/or their clients wherever they may have been at the time. Maintaining 'normal practice' enabled Reiki to be provided in a care situation in line with everyday clinical practice (Richardson, 2000).

***Mid- and end-of-project group meetings as part of the Reiki training***

By mutual agreement, the Training Master and I decided that these meetings would be considered as part of the participants' training in Reiki I. When appropriate, the training

Master, the Reiki I trained assistant and/or I responded to issues voiced by the participants at these meetings.

***Reiki I certificate***

Through personal experience, I was aware that it is normal for people attending Reiki training to either receive a certificate at the conclusion of their training or by post at a later date. Participants were presented with their Reiki I certificate by me at the conclusion of their second interview. The Reiki Master/Teacher who had conducted the training generated the certificates in his normal format following the end-of-project meetings.

### 3.2.2 Training manual

To ensure that this research can be replicated, it was essential that participants were trained in Reiki that followed the *Usui Shiki Ryoho* lineage and presented with a uniform content across all training groups. Thus a comprehensive ***Training Manual***[1] was developed in conjunction with two independent (from myself) Reiki Master/Teachers in the lineage of *Mikao Usui, Chujiro Hayashi, Mrs Takata,* and *Phyllis Lei Furumoto*. This manual contained information specifying: the training programme; the research project; Reiki practice and procedures; the Reiki Master's lineage; the Reiki attunements; how Reiki can be used in general practice; and a comprehensive reference list. It is important to specify the lineage of the Master/Teacher because, over time, a number of 'branches' of Reiki have developed (Webber, 2008) and the practice of Reiki can vary considerably depending upon the individual's training.

### 3.2.3 Replication

Internal replication and multiple, staggered baselines were achieved by training three groups of participants as recommended by Barger-Anderson et al. (2004) and illustrated in Figure 3.2. When the intervention had been implemented with one group, the other participants remained at the baseline condition. The baseline condition was when the participants were working under normal conditions and not yet trained in Reiki. For each individual, the baseline condition was established through the initial interview.

[1] Because the Training Manual is a compilation of work done by three Reiki Master/Teachers and is not exclusively copyrighted © to the researcher, it is not included in an Appendix. However, if any researcher wishes to replicate this study then the manual and appropriate approval can be obtained from the researcher (Graham.Webber@bigpond.com).

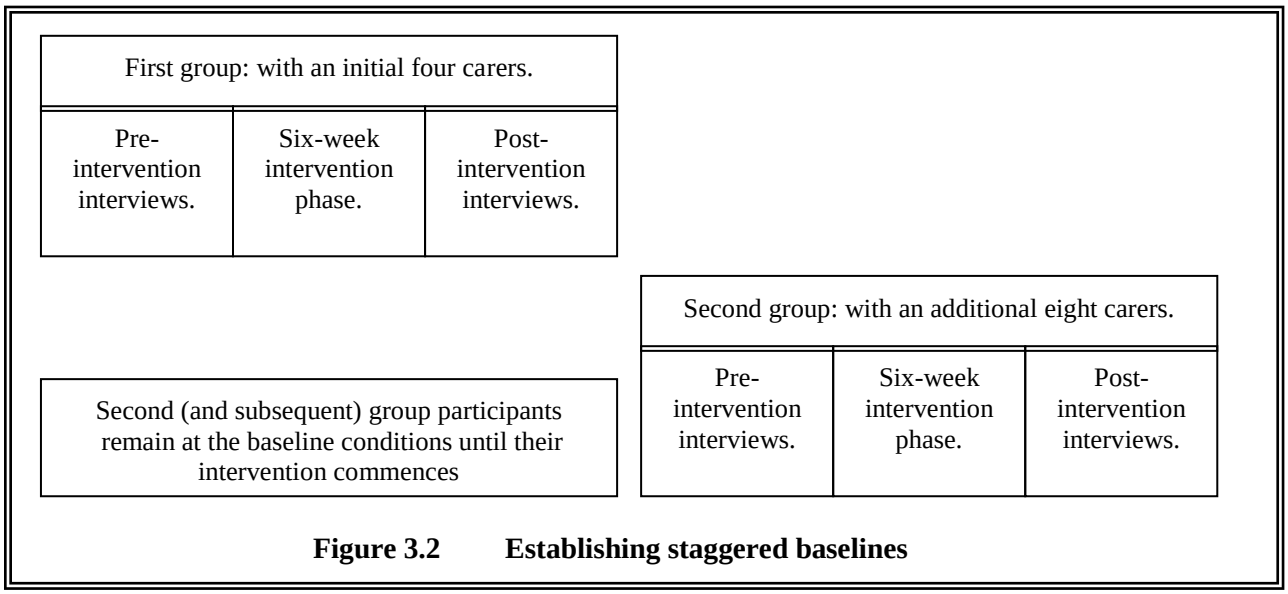


**Figure 3.2 Establishing staggered baselines**

### 3.2.4 Special considerations for research into Reiki

This project was designed to account for special considerations for research into Complementary Therapies, particularly Reiki. These include the: reported 'delay' in observable effects of Reiki (Miles & True, 2003); paradoxical nature of the participants' reactions which may be attributed to the 'balancing' nature of this type of therapy (Engebretson & Wardell, 2002); effect of the ambience of the setting and other therapies applied by the practitioners; realisation that a reductionist approach may not be appropriate for the study of complementary therapies (American Medical Association, 1997); and possibility that the practitioner may be an integral part of the therapy (Richardson, 2000).

## 3.3 Ethical issues

### 3.3.1 Providing Reiki

At the time of treatment, if the person receiving Reiki indicated either verbally or non-verbally (through their body language) that they did not want Reiki, the participant immediately ceased providing Reiki. Webber (2008) found that people who do not have the necessary verbal communication skills, "will quite often wriggle and squirm and will pull away. So it is their physical way of saying no I don't like [Reiki]" (p. 104). Observing and responding to the client's body language was in accordance with normal practice in aged care.

### 3.3.2 Confidentiality

To ensure the confidentiality of all information given during the interviews, a code was used rather than the participants' names on the Interview Sheets, the Reiki Recording Sheets, and the digitally recorded sessions. All personal information was filed separately from data gathered during interviews or via the Reiki Recording Sheet. All information

was stored in a locked filing cabinet, in a locked room in the Disability and Community Inclusion Unit, School of Health Sciences, Faculty of Medicine, Nursing and Health Sciences, Flinders University for the required period before being destroyed. Only my supervisors and I had access to the data. The Reiki Master/Teacher, support person and transcriber were required to sign two copies of a confidentiality agreement – one of which they retained with the other being filed as above (Appendix I).

Although it was intended to analyse the findings of this project both within groups and across groups, it was not possible to report some of the within group data in detail. The small size of the groups meant that to do so would allow the identification of individuals. Therefore some data were only reported and analysed across all participants; qualifications were only discussed according to the level of the qualification; and raw scores for the self-reported stress levels were not discussed within the groups.

Also, pronouns such as 'they' and 'their' were used to replace personal pronouns such as 'he' or 'she' to avoid identifying individuals by concealing their 'sex' (Swan, 2009). While these pronouns are strictly plural, there is an evolving use of them as singular pronouns (Commonwealth of Australia, 2007, pp. 58-59, 76).

### 3.3.3 Potential risks to individual participants

Appropriate support for research participants is paramount for their wellbeing (D. A. Barnett, 2005; Webber, 2008; Westcombe et al., 2003). Participants were able to contact me (I am a Reiki Master/Teacher in the *Mikao Usui, Chujiro Hayashi, Mrs Takata, and Phyllis Lei Furumoto* lineage of Reiki) by email and/or telephone at any stage during the project. The training Master and I conducted follow-up meeting/training sessions with the participants three weeks and again six weeks after the initial Reiki training.

Also, because, Reiki touch is non-invasive (Bush, 2001) which, in this context means that 'there is no need for the recipient to undress, as in some forms of massage, … there is no manipulation of body parts as with Chiropractic, massage, foot reflexology or physiotherapy … [and there is] … no invasion of the body as with acupuncture, orally ingested preparations, injections, or surgery' (Webber, 2008, pp. 59-60), there were no apparent identified risks for the people receiving Reiki.

### 3.3.4 Safety implications for the researcher

There were no apparent identified safety implications for me beyond normal practice.

### 3.3.5 Benefit from participation in the research

No participants benefited financially from participation in this research. However, the Reiki I training, which was integral to this research, became a 'reward' for the

participants because they would normally have to pay for their Reiki training. The carers who participated in the Reiki training received a training manual and a certificate of training consistent with the Reiki Master/Teacher's normal practice. Participants also benefited from any therapeutic gains that may have accrued from their training in Reiki.

## 3.4 Participant recruitment, selection and exclusion

### 3.4.1 Section introduction

During 2007 and 2008 I approached contacts made during my previous research (Webber, 2008). As a result of those discussions, Reiki Masters and Directors of Nursing of Residential High Care Facilities in Adelaide, Canberra and Kalgoorlie expressed interest in being involved.

However, due to the passage of time, these contacts were lost so, in 2011, I was forced to begin the process of establishing personal contacts again. This process included:

1. Gaining the support of an appropriate Adelaide based Reiki Master/Teacher who worked in aged care. This Master's lineage was Dr Usui , Chujiro Hayashi, Hawayo Takata, Phyllis Lei Furumoto, Claudia Hoffman, Mackenzie Clay, Mary Shaw, Christine Henderson, and Beryl Barker (who trained the Master/Teacher).
2. Telephoning, in July 2011, the owner of a chain of privately owned residential nursing homes in South Australia. I was referred to a Regional Operations Manager who later met with me. Information provided by me at this meeting was relayed to the Site Manager in one of their high care residential facilities in early August 2011. I then met with the Site Manager in early September 2011 to discuss the research.
3. Meeting, in July 2011, with the Chief Executive Officer of the Aged Care Association of South Australia who subsequently emailed member organisations. Following this email, the Executive Director of Nursing (DON) of a residential chain in Adelaide contacted me and I then met with her in mid August 2011.
4. Meeting, in mid October 2011, with the Executive Director of Nursing of three privately owned nursing homes in suburban Adelaide. She expressed a desire for all three facilities to be involved and offered to provide in-house training facilities.

At these meetings I provided a letter of introduction (Appendix E), a copy of the *Information sheet for carers* (Appendix C), and a copy of the Research Proposal.

The recruitment of volunteers for each Group will be detailed in the appropriate section below. Any persons previously trained in Reiki, irrespective of the branch of Reiki were excluded from this research.

### 3.4.2 Group 1

The Site Manager from the first nursing home (Item 2 above) placed a notice regarding the project (Appendix F) in the facility's staff room. Subsequently, six staff members – including two Registered Nurses and four Personal Care Workers (also known as Patient Care Attendants (Webber, 2008)) – volunteered to participate. While I had intended to train several groups of four, after discussions with my principal PhD supervisor and the Site Manager, I decided to accept all six volunteers for the first phase of the project and, in early September 2011, met with them as a group in a room provided by the facility.

At this meeting I:

- ☆ thanked the volunteers for attending;
- ☆ provided each volunteer with a letter of introduction (Appendix E) and a copy of the information sheet (Appendix C);
- ☆ explained the project;
- ☆ answered any questions the volunteers asked;
- ☆ advised the volunteers that they could withdraw at any time without the necessity to provide a reason and assured absolute confidentiality of any information they may provide;
- ☆ provided details regarding the time, date, venue and the name of the Reiki Master/Teacher for their Reiki training. The volunteers were asked to bring a 'light lunch' for themselves and wear comfortable clothing;
- ☆ explained that, for the purpose of this project, they would be using Reiki in a similar fashion to PRN medication;
- ☆ instructed the volunteers that, once trained in Reiki and using it, if the person receiving Reiki indicated either verbally or through their body language that he or she did not want it then they were to immediately cease providing Reiki to that person;
- ☆ obtained contact details and a signed copy of a Consent to Participate form (Appendix D) from each participant;
- ☆ made individual appointments to interview each of the volunteers; and
- ☆ thanked the volunteers once again for their attendance and interest in the project.

### 3.4.3 Groups 2 and 3

During December 2011 and January 2012, the Executive Director of Nursing from the chain of three nursing homes in Metropolitan Adelaide discussed in Item 4 above, recruited potential volunteers from the three facilities in the chain. Potential volunteers were told by letter that they had been *selected to participate* because it was believed that

they had *the attributes which will ensure that the results will be positive and productive* (Appendix L) and that they would be paid to attend the initial meeting and the Reiki training (this was a decision made by the manager, not myself as the researcher).

In a telephone conversation early in February 2012, she advised me that there were approximately 15 potential volunteers from the three homes. Mindful of the withdrawal rate in Group 1, I decided to accept all potential volunteers. However, because of the numbers involved, it was agreed to divide the participants into two groups: one from two of the homes (one of which was located in an Adelaide inner-west suburb and the other in an inner-north suburb) (detailed below as Group 2); and the other from the third home located in a western beachside suburb (detailed below as Group 3).

In late February 2012, ten potential volunteers, five from each of the facilities in Group 2, attended a meeting held in a room provided by the management in the inner-west suburb facility. In addition to questions about the research project and Reiki, I was closely questioned about the involvement of management in this research. I assured them that, apart from assisting to recruit potential volunteers and offering the use of the establishment's facilities, management had no involvement in the research, that everything said or done during the project would remain totally confidential and that they could withdraw from the project at any stage without the need to provide a reason. Because of the intensive questioning, the meeting ran longer than expected (slightly over an hour).

Eight (four from each facility) of the attendees (80.0%, n=10) signed consent forms before leaving the meeting. However, due to the length of the meeting, it was not possible to make appointments for the first interviews so I telephoned the volunteers to arrange appointments.

In late February 2012, six potential volunteers attended a meeting held in a room provided by management in the western Adelaide beachside facility. The same letter as for Group 2 had been sent to selected staff members in the (Appendix L). Because of the questions put during the meeting with Group 2, I assured the attendees that, apart from assisting to recruit prospective volunteers and offering the use of the establishment's facilities, management had no involvement in the research and that everything said or done during the project would remain totally confidential. All of the attendees completed consent forms and made first interview appointments before leaving the meeting. However, one volunteer withdrew the day before their scheduled first interview due to another commitment.

## 3.5 The Facilities

### 3.5.1 Group 1

According to advertising brochures obtained from the facility, which was in eastern metropolitan Adelaide, it was one of a chain of 14 privately owned residential care facilities in South Australia and Queensland. It was an 'Extra Service Home' approved by the Australian Federal Government to offer 'additional' facilities and charge an additional daily fee and an Accommodation Bond. 'Alternative Therapies' advertised by the facility included: aromatherapy, beauty pampering, a beauty therapist, counselling, massage, music, pet therapy, sensory gardens, and Snoezelen Therapy (a multi-sensory therapy (Webber, 2008)). This facility also listed in excess of 32 other activities available to residents, which, while advertised as part of the 'normal routine', could possibly be considered as 'therapies' (Webber, 2008). Also, the chain advertised that it had a Registered Training Organisation (RTO), which delivered Government Accredited Training to the chain's Personal Care Workers (also known as Patient Care Attendants (Webber, 2008)).

From information obtained from the DPS Guide to Aged Care (accessed 30/9/2011), the facility had 52 beds, with 13 being secure dementia beds, and a secure garden.

### 3.5.2 Groups 2 and 3

Information published by the Seniors Information Service Inc. on the 15th February 2012 (Seniors Information Service Inc., 2012) indicated that the inner-west facility was a 51-bed, high and low care facility with ageing in place (a resident can move from low to high-care status) and included a secure garden. The inner-north facility was a 50-bed, secure, high care facility with a secure garden. The western beachside suburb was a 46-bed, secure high care facility with a secure dementia unit, a secure garden and its own pets.

## 3.6 First individual interviews with participants

### 3.6.1 Group 1

Before the interviews commenced, a volunteer withdrew from the project without offering an explanation. Subsequently, five first interviews were scheduled within one week commencing two days after the meeting described above. However, one volunteer withdrew from the project the day before their interview citing work pressures as the reason for their withdrawal. Therefore, four first interviews were held over a seven-day period in early to mid-September 2011 and all four participants attended Reiki training. The setting for the interviews has been detailed in Appendix S.

### 3.6.2 Group 2

Eight first interviews were scheduled during late February/early March 2012 between two days and slightly over two weeks after the introductory meeting. When I was conducting the last of the booked interviews I was approached by two additional volunteers. Thus a total of 10 first-interviews were conducted at this time.

### 3.6.3 Group 3

In early March 2012, five first interviews were conducted between one and two weeks after the introductory meeting.

### 3.6.4 Changes in Group 2 and 3 structure beyond the researcher's control

Subsequent to the initial interviews, the Executive Director of Nursing:

- ✯ notified me by personal email that she had 'moved' two of the Group 2 participants to Group 3 in order to make 'the classes more even and manageable for' the Reiki Master conducting the training. Therefore, all initial data obtained from these two volunteers have been included as part of Group 3;
- ✯ refused permission for one of the additional volunteers to attend Reiki training; and
- ✯ ensured that one of the potential volunteers present at the initial meeting but who had not left a signed consent form with me, attended the Reiki training. (I obtained a signed consent form before the training began and subsequently made an appointment to interview the participant at a convenient time.)

The numbers of participants who attended Group 2 and 3 Reiki training has been summarised in Table 3.1.

**Table 3.1: The number of volunteers who attended Reiki training in Groups 2 and 3**

| Facility | Group 2 | Group 3 |
|---|---|---|
| The inner-west suburban facility | 3 | 2 |
| The inner-north suburban facility | 5 | |
| The western beachside suburban facility | | 5 |
| Total | 8 | 7 |

## 3.7 Reiki Training

All Reiki training was conducted by a Reiki Master/Teacher whose lineage was *Dr Usui , Chujiro Hayashi, Hawayo Takata, Phyllis Lei Furumoto, Claudia Hoffman, Mackenzie Clay, Mary Shaw, Christine Henderson,* and *Beryl Barker*. He was also working in aged/dementia care at the time of the training and had previously conducted Reiki training for other people working in dementia care.

Group 1 Training was conducted in a private home in a beachside suburb in Adelaide, South Australia, Group 2 training was conducted in a cramped boardroom in

the inner-west suburban facility and Group 3 training was conducted in a cramped training/office/store room in the western beachside suburban facility. People collecting supplies interrupted Group 3 training several times during the first day.

Following the one-day Reiki training conducted for Group 1, in consultation with the training Master, I decided to conduct a two-day training session for Groups 2 and 3. While the content remained the same as for Group 1, the format provided more time for participants to practise their newly gained skills during the training session. Details relating to the conduct of training sessions and the individual venues are provided in Appendix S.

## 3.8 Mid-project group meetings with participants

### 3.8.1 Introduction

It was planned for these meetings to be unstructured, and this was the case for the Group 1 meeting. However, during the Group 2 and 3 meetings I had to ask a number of direct questions to keep the meetings flowing. These questions were based on the findings from the Group 1 mid-project meeting. It was possible that the lack of 'flow' in the Group 2 and 3 meetings was because the participants were from three facilities and therefore not used to working with each other, there were a number of participants from non-English speaking backgrounds, many of them had worked in aged care for a relatively short period of time, they were not used to working in group situations or had had unsatisfactory experiences in previous group related activities, some of them may not have been true volunteers, or a combination of these factors.

### 3.8.2 Group 1

At the end of the Reiki training day I arranged to meet the participants in a room supplied by the facility three weeks after the training. However, on the night before the meeting, a participant notified me by email that they were withdrawing without providing a reason. Another participant did not attend the meeting or contact me. Thus, in attendance at the meeting were the two remaining participants, the Reiki I practitioner who had assisted during the Reiki training, the training Master and myself.

### 3.8.3 Group 2

At the end of the second Reiki training day, I arranged to meet the participants in the dining room of the northern suburban facility three weeks after the training. In attendance at the meeting were six of the eight participants (75.0%), the training Master and myself. The people present informed me that the two absent participants were working at the time.

### 3.8.4 Group 3

At the end of the second Reiki training day, I arranged to meet the participants in a room in the western beachside suburban facility three weeks after the training. In attendance at the meeting were five of the participants (71.4%, n=7), the Reiki I practitioner who had attended the Group I training and myself. The training Master had a prior commitment. Apologies were not received from the two absent participants.

## 3.9 End-of-project group meetings with participants

### 3.9.1 Introduction

As with the mid-project meetings, it was planned for these meetings to be unstructured. The Group 1 meeting was unstructured, however, during the Group 2 and 3 meetings I had to ask a number of direct questions to keep the meetings flowing. These questions were based on the findings from the Group 1 mid-project meeting.

### 3.9.2 Group 1

Six weeks after the Reiki training day the training Master and I met the two remaining participants in the room supplied by the facility.

### 3.9.3 Group 2

Six weeks after the second Reiki training day the training Master, the Reiki I practitioner who had attended the Group I training, and I met with five of the participants (62.5%, n=8) in the dining room of the northern suburban facility. The people present informed me that one of the absent participants was working at the time and one was ill). No apology was received from the other absent participant.

### 3.9.4 Group 3

Six weeks after the second Reiki training day, the training Master and I met two of the participants (28.6%, n=7) in the dining room of the western beachside suburban facility. The Reiki I practitioner had a prior commitment. The people present informed me that two of the absent participants were ill, one had family commitments and one was on leave. No apology was received from the other absent participant.

## 3.10 Second individual interviews with participants

The setting and format of each interview followed that for the first interviews. The focusing questions are detailed in the Second Interview Sheet in Appendix B.

The second interviews for: Group 1 were held on the 4th November 2012, two days after the end-of-project meeting; Group 2 were held within a week and a half after the end-of-project meeting with the final interview being held on the 7th May 2012; and

Group 3 were held on, or before, the 28th May 2012 – three and a half weeks after the end-of-project meeting.

A total of 16 of the 19 participants (84.2%) who attended Reiki training also attended the second interview. These included: two from Group 1 (50.0%, n=4); eight from Group 2 (100.0%, n=8); and six from Group 3 (85.7%, n=7). Of the three participants who withdrew before their second interview, two were female and one was male.

## 3.11 Unsolicited correspondence from a Group 1 participant

Two weeks after the final Group 1 second interviews I received an unsolicited letter from one of the participants.

## 3.12 Third individual interviews with participants

During their second interviews, all participants acknowledged that a third interview 12 months later would be appropriate. All participants indicated their willingness to attend. My principal PhD supervisor and the Directors of Nursing of the four facilities involved in the research also agreed that this would be an appropriate action.

Consequently: both Group 1 participants gave their third interviews on the 13th November 2012; and I made repeated attempts to contact the 14 participants from Groups 2 and 3 by telephone, email or through the Director of Nursing. One of the participants was on extended leave and informed me that they were not using Reiki and only a further four participants could be contacted. Times for interviews with these four participants were arranged. However, two of these participants did not attend their scheduled interviews and made no attempt to contact me. Thus one Group 2 participant's third interview was conducted on the 2nd May 2013 and one Group 3 participant's third interview was conducted on the 4th May 2013. The setting and format of each interview followed that for the first interviews. The focusing questions are detailed in the Third Interview Sheet in Appendix B.

## 3.13 Data collection and analysis

### 3.13.1 Participant background data and self-reported stress levels

To enable comparison with my previous study (Webber, 2008), the demographic data collected in that study formed the basis for the collection of demographic data in this study (Appendix B). This included age, gender, role in institution, length of time in dementia care, qualifications, other complementary therapies used, and self-rating of current level of stress. Data relating to possible changes in the participants' work environment or personal circumstances, complementary therapy use and self-reported stress levels were collected at the second and third interviews.

Following the interviews with the first two participants in Group 1, I developed a *Microsoft Excel 2000* ® spreadsheet designed to assist with the analysis of the participants' responses to the demographic questions and the self-reported stress levels. As soon as possible after each subsequent interview all relevant data were entered into the spreadsheet.

### 3.13.2 Reiki Recording Sheets

Participants were asked to maintain a Reiki Recording Sheet that asked for: the date, time, and duration of Reiki; the type of subject (client, self or other); and a participant comment (Appendix A). Blank forms were handed to the participant at the conclusion of the Reiki training and the completed forms returned at the second interview.

To ensure confidentiality of their comments, participants were asked to complete one copy of the Reiki Recording Sheet at home and another at work (which they could take home with them if necessary to prevent other people from reading their comments).

### 3.13.3 Digitally recorded interviews and meetings

In-depth, semi-structured interviews designed to provide an experience-based, person-centred description of the phenomenon of being trained in, and using, Reiki (Henricson et al., 2006) were conducted pre- and post-Reiki training. In addition to the focusing questions (Appendix B), verbal probes were used to gather additional information and/or seek clarification. I also made brief notes for future reference and to assist with the analysis of the data. A set of questions for each of the first and second interviews had been formulated as part of the research proposal, however, the responses of the Group 1 volunteers to the first interview questions and the Group 1 Reiki training, enabled the editing of the planned second interview questions and the addition of new focusing questions. To ensure uniformity across groups no further changes were made to the focusing questions. All interviews were digitally recorded for later transcription.

With the consent of all people present, mid-project and end-of-project meetings were digitally recorded for later transcription. If participants asked, I turned off the recorder. A professional typist was employed to transcribe the digital recordings into *Word 2000* ® format and then I listened to each recording while reading the transcript to ensure that it was accurate. Unfortunately, due to the acoustics in some rooms and some participants' accents, both the typist and I were unable to correctly transcribe some comments. All interview transcripts were sent to the participants, either by email or regular post according to the individual's instructions, with an invitation for the person to make any changes they deemed necessary.

Analysis of the responses began immediately following the receipt of the transcript of the first participant's interview. The accents and minimal English language skills of some participants from non-English speaking backgrounds caused extreme difficulty for me when trying to analyse their comments. It was planned for the group meetings to be unstructured, and this was the case for the Group 1 mid-project meeting. However, during the Group 2 and 3 meetings I had to ask a number of direct questions to keep the meetings flowing. These questions were based on the findings from the Group 1 mid-project.

In my previous study, I conducted a 'quasi-statistical counting of key words and repeated re-readings of the transcripts to discover the essences, abstract the meanings and arrange them into themes and sub-themes' (Webber, 2006, p. ix). Two independent raters and myself separately, and then in discussion, compiled a list of possible themes and sub-themes from the list of key words. These were:

- ☆ Improving quality of life including: Improving physical well-being; Improving psychological / mental / emotional well-being; Improving relationships; and Reducing negative behaviour.
- ☆ The spiritual nature of Reiki.
- ☆ End-phase dementia including: Easing passing (death); and Effect on carers.
- ☆ Reiki treatments including: The nature of Reiki; Reasons for using Reiki; Reasons for rejecting Reiki; and Informed consent.

Initially, I had planned to analyse the findings of this doctoral research project under the above themes to enable triangulation with the previous project. However it soon became apparent that this would not be possible because of the participants' lack of experience with Reiki, the tendency of participants to respond only to direct questions, and the brevity of many recordings. This was subsequently confirmed through repeated re-readings of the transcripts.

In this study, the questions asked at the first interviews were designed to establish individual base lines regarding the participants': personal circumstances; work circumstances; reasons for volunteering to participate; use of complementary therapies; and knowledge of Reiki. The questions asked at the second and third interviews were designed to ascertain if there had been any changes in the above issues over time because of the participant's training in, and subsequent use of Reiki.

Therefore, the responses from the participants in this study are grouped under the following headings which reflect the interview questions:

- ☆ Why participants volunteered to participate in the project.

- ☆ Expectations of the research project.
- ☆ Personal circumstances including: Existing health issues and changes in health issues; The most significant problems in their daily work and their coping strategies before the Reiki training; The most rewarding aspects of their daily work; Major changes since the 1st interview; and Major changes since the 2nd interview.
- ☆ Knowledge of, and experiences with Reiki including: What did participants initially know about Reiki; On which groups of people did they use Reiki; Experiences with Reiki – second and third interviews; How they felt when providing Reiki; Difficulties experienced when providing Reiki; What makes Reiki different from other therapies; Were their expectations about Reiki fulfilled; and The attitude of other staff members towards Reiki.
- ☆ Any other issues.

Repeated re-readings of the transcripts indicated that a number of major themes based on the interview questions could be divided into sub-themes.

- ☆ There were five main reasons why individuals volunteered to participate and these were: Management asked them to participate; To see if something different could work; To help residents; To learn something new; and Personal reasons.
- ☆ The most significant problems in their daily work reported by participants could be divided into five sub themes of: Commitment and attitude towards quality aged care; Residents' health and behaviour; Time management; Completing Activities of Daily Living (ADLs); and Other issues.
- ☆ Also, participant coping strategies before the Reiki training could be divided into seven sub themes of: Calling for assistance; Re-directing agitated residents; Knowing resident's individual needs; Not hurrying residents; Talking with residents; Just getting on with the job; and Other coping strategies.
- ☆ And the difficulties experienced when providing Reiki could be divided into four sub themes of: Needing to find a quiet or comfortable location for providing Reiki; Finding an appropriate location for providing Reiki; Needing more time; and Medication.

To ensure validity in coding, all examples used were double checked with a fellow PhD student to make sure that they were appropriately placed. The PhD student then checked them against the transcripts to ensure that they were a representative example of the comments made by participants.

## 3.14 The 'Hawthorne Effect' and 'Practitioner Certitude'

I acknowledge that, in this research project, it was not possible to control for the 'Hawthorne Effect' or 'Practitioner Certitude' because I had direct contact with each individual, the participants were aware that I am a trained Reiki Master/Teacher, the participants received specialised training, the Reiki Master/Teacher who conducted the Reiki training believed that being trained in Reiki would bring positive effects and in all instances, the management of the facilities supported the involvement of the volunteer participants in this project. Acknowledging this context is important. In one facility this involvement was then used to support the facility's Quality Improvement programme. Also, when contacting staff members, the management of three facilities told potential volunteers that they were *selected to participate* because it was believed that they had *the attributes which will ensure that the results will be positive and productive* (Appendix L).

However, I was not present (observing the participants using Reiki) during the intervention phase. This reduced any possible contamination, which could have been caused by providing additional attention at this point. Because the management of three facilities controlled the structure of Groups 2 and 3, a series of specific questions were developed (Appendix M) in order to determine if there had been any undue influence on the participants' decision to participate in the project or the way they practised Reiki. These were asked of each participant as additional questions during their second interview (Appendix B).

## 3.15 Individual recorded interviews with 'support' personnel

In the original research proposal, it was not expected to be able to interview Reiki training support personnel, a university senior lecturer, or Directors of Nursing in the High Care Residential Facilities. However:

- ☆ The Reiki Master/Teacher who conducted the Reiki training was pivotal to the success, or otherwise, of the project.
- ☆ In my personal experience, it is 'normal' for a training Master to have at least one Reiki practitioner (or Master in training) present to assist during the training so the Reiki I practitioner present during Group 1 training also became essential to the success, or otherwise, of that part of the project.
- ☆ I had invited the university senior lecturer to observe the Group 1 training and to ensure that the training followed the process detailed in the Training Manual. During the day he accepted the training Master's invitation to receive Reiki from the participants on at least three occasions and experienced a Reiki attunement.

- ✭ Because of their position, the Directors of Nursing had insights into aspects of work within the facilities that may not have been available to the carers trained in Reiki.

As discussed in this doctorate, in qualitative research, 'the researcher's principal purpose is to know and understand' (Fitzgerald, 1997, p. 53). Therefore, it can be argued that failure to interview these individuals could have meant that potential valuable information would be lost.

Notes made during the Group 1 Reiki training day helped formulate focusing questions for the three individuals who were at the training (Appendix H). The interview with the Reiki I practitioner was held the day after the training; the university senior lecturer two days after; and the Reiki Master/Teacher a week after.

Information gathered during the course of the project helped formulate the questions for the Directors of Nursing (Appendix O). The interview with the Director of Nursing for Group 1 was held on the 13th November 2012 immediately following the interviews with the two participants.

In addition to the focusing questions verbal probes were used to gather additional information and/or seek clarification. The interviews were digitally recorded for later transcription by a professional typist.

## 3.16 Testing for stress/anxiety

I had intended to administer the *Spielberger State-Trait Anxiety Inventory (STAI) Form Y* (Spielberger et al., 1983) to each participant at each of their interviews. However, because I was not aware of participants' backgrounds until the first interview when the tool was to be administered, it was not possible to obtain versions of the assessment tool in individual participant's first language. During the first few interviews, I was asked what many of the questions meant. Providing answers for these questions would have inflected the results. Therefore, after consultation with my principal PhD supervisor, I decided to cease using the test and to disregard the early results.

## 3.17 Chapter conclusion

This chapter and Appendix S (which was originally part of this chapter) are highly detailed. Further, I have chosen to present the material in this form and positioning in the thesis, rather than in a 'Findings' chapter. This decision confirms the interdisciplinarity of the thesis, but also acknowledges the key challenge specified in the introduction of this thesis. The management of the scholarly literature and practitioner commentaries requires a discussion of this detail. I believe that the scale of scholarship I have provided is essential to enable replication without the necessity for the reader to jump between a

method chapter and a findings chapter in order to glean the details regarding the method I planned to use and the reality of what actually happened.

Also, it could be claimed that the venue for the interviews, the music played, the books on display and any aromatherapy used could all affect the outcome of the research. In fact, I believe that the venues used for Group 2 and Group 3 Reiki training did adversely affect the outcomes for the participants. From personal experience I have found that the Reiki Master/Teacher's selection of music played and the aromatherapy used during Reiki training is highly personal therefore the details I have provided will enable future researchers to faithfully replicate my research.

# 4 Participants' Demographic Data

## 4.1 Chapter introduction

In this chapter, I present and evaluate the demographic data that were obtained through a researcher administered questionnaire at the commencement of each individual interview with participants (Appendix B). Where it will not identify individuals within the three groups, the raw demographic data of the 19 participants who completed their first interview and were trained in Reiki have been detailed in Table J.1 (Appendix J). Also, because of the small number of participants in this research and the corresponding small group sizes, to specify some of the information discussed below (such as the name of the degree held by individual participants) will identify the participant. Therefore, that information will be presented in general terms only.

## 4.2 Age ranges and gender

The age ranges used in this doctoral study were selected to allow comparison with my MSc study (Webber, 2008). Of the 19 participants who attended Reiki training five (36.3%) were aged between 16 and 35 years; ten (52.6%) between 36 and 55 years; and four (21.1%) over 56 years of age. Participants were not asked to provide their actual age. Figure 4.1 illustrates the age range of the participants who were trained in Reiki. Of the four participants who attended the third interview three were in the 56-75 year age bracket and one was in the 36-55 year age bracket.

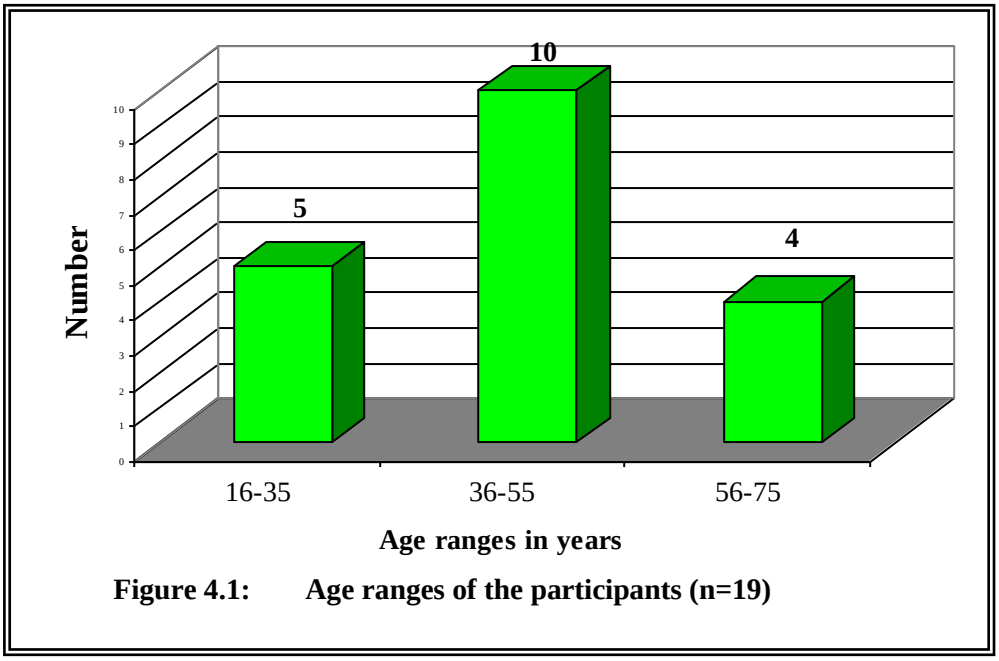


**Figure 4.1: Age ranges of the participants (n=19)**

Of the 19 participants who attended Reiki training four were male and 15 were female. All of the four participants who completed the third interview were female.

The majority of participants in this study were female and in the older age brackets. This is consistent with the findings of the previous study (Webber, 2008) and the Disability Support Workers in Cookson's 2008 random survey of 188 Disability Support Workers providing accommodation services for people with intellectual disabilities in Adelaide, South Australia (Cookson, 2014). The age distribution of participants in the three studies (2014) has been illustrated in Figure 4.2 and the gender of the participants in Figure 4.3. Although Cookson's study involved carers of people with intellectual disabilities it is worthy of comparison because it is contemporaneous to my doctoral study and was also conducted in Adelaide, South Australia.

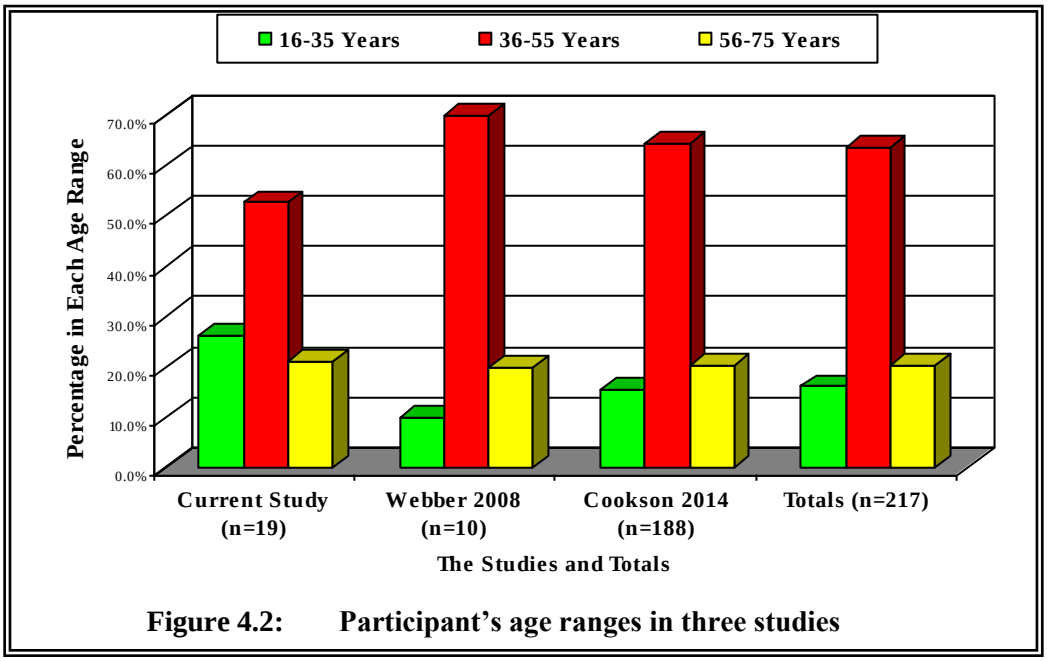


**Figure 4.2: Participant's age ranges in three studies**

This pattern of age and gender distribution in care workers in the three studies is similar to that of Aged Care Nurses in Queensland where the 'predominately female aged care nursing workforce is ageing' (Eley, Hegney, Buikstra et al., 2007, p. 860). It is also reflected in an analysis of the 2003 Australian Bureau of Statistics survey data (Hugo, 2007) which found that the aged care workforce across Australia is predominantly female and aging. Hugo concluded that 'there is a major challenge [because] the aged care workforce has grown only slowly in Australia and is concentrated in the older working ages presaging a loss of workers through retirement' (p. 169). Meagher (2007) also commented that the aged care workforce in Australia is 'relatively old and ageing' (p. 154). By 2007 over 90% of the Australian aged care workforce was female (King, Wei, & Howe, 2013).

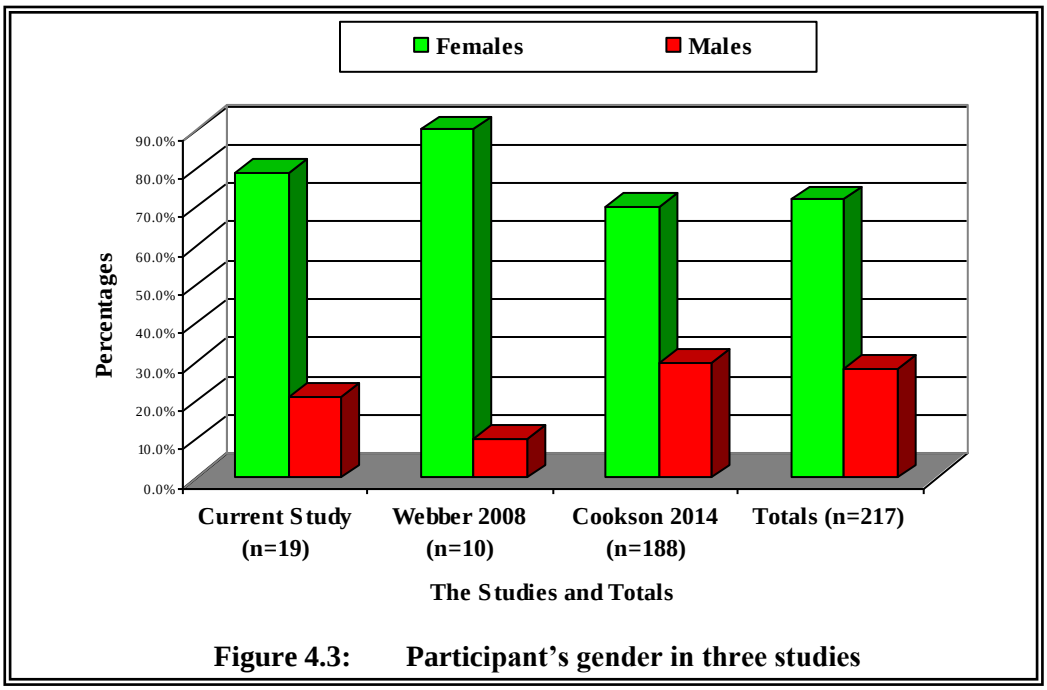


**Figure 4.3: Participant's gender in three studies**

## 4.3 Roles in aged care

Of the 19 participants who attended Reiki training fifteen (78.9%) were Personal Care Workers (Patient Care Attendants). Of these, only three (20.0%) attended the third interview. Three participants were Enrolled or Registered nurses – two of whom were in Group 1, none in Group 2, and one in Group 3. Of these, only two proceeded beyond the Reiki training and only one attended the third interview. One participant was a Diversional Therapist. There were no senior staff members (Directors of Nursing or Site Managers). Figure 4.4 illustrates the roles of the participants.

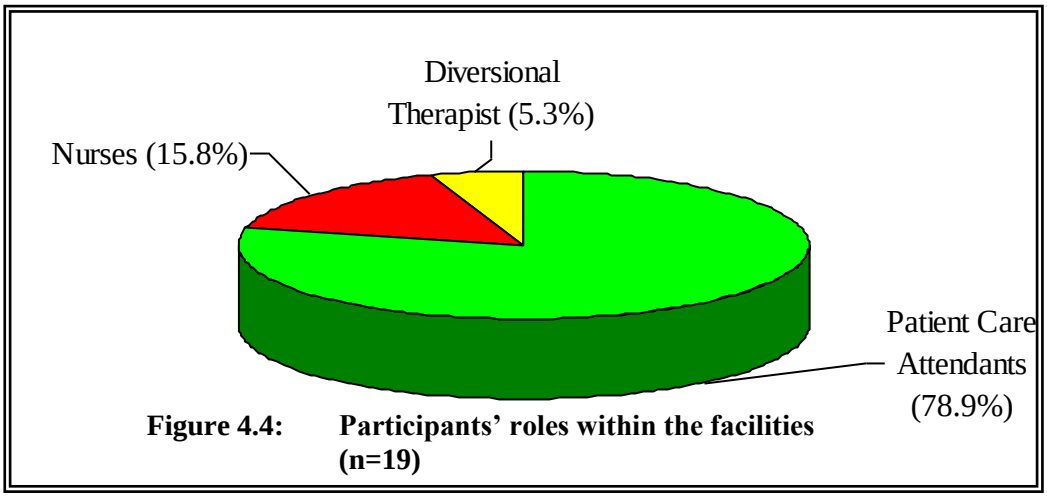


**Figure 4.4: Participants' roles within the facilities (n=19)**

## 4.4 Length of service in dementia care

The length of service in dementia care of the 19 participants who attended Reiki training ranged from one to 21 years (mean, 8.0 years; median, 7.0 years). Over a quarter (26.3%, n=5) had been working in dementia care for two or less years. Figure 4.5 illustrates the participants' length of service in dementia care.

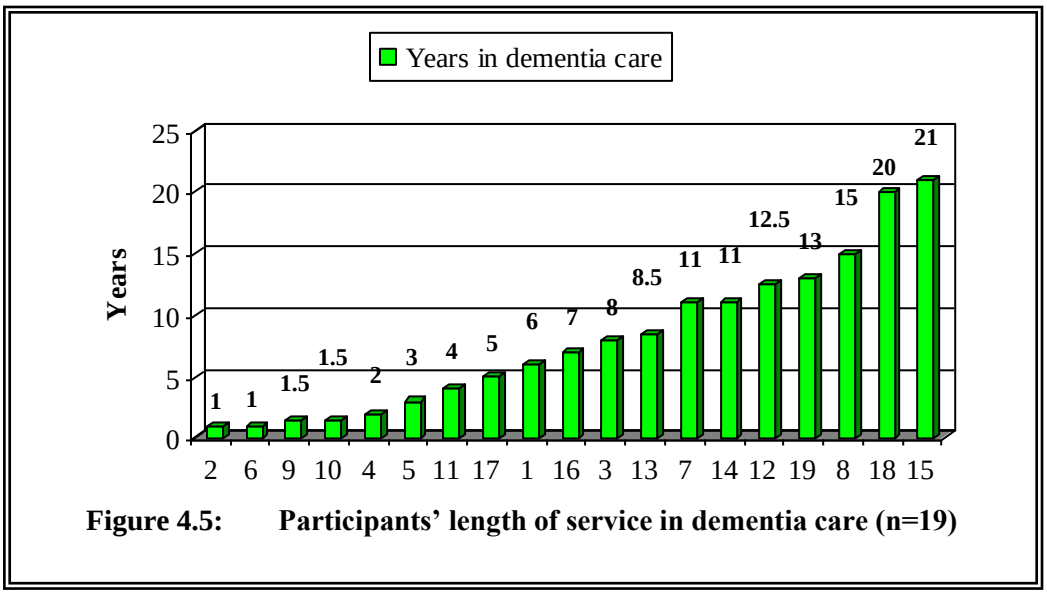


**Figure 4.5: Participants' length of service in dementia care (n=19)**

The four participants who completed the third interview had worked in dementia care for 6, 7, 8 and 15 years respectively.

Neither this nor my previous study (Webber, 2008) asked participants how long they had been working in aged care. Participants were only asked how long they had been involved in dementia care. However, the length of service in dementia care of the 19 participants who attended Reiki training compares with the previous study where the ten participants had been involved in dementia care from 1 to 12 years (mean 6.4 years; median 7.0 years) (Webber, 2008).

## 4.5 Qualifications and training

### 4.5.1 Training in aged care and dementia

Nearly one third of the 19 participants who attended Reiki training (6; 31.6%) had no formal qualifications in aged care. Of the 13 (68.4%) who held the Certificate III in Aged Care, a number used the terms 'Alzheimer's' and 'dementia' as if they were separate conditions. This suggested that some of the participants either, had completed their qualification before the Unit in Dementia became a compulsory part of the qualification, or did not have a clear understanding of dementia.

Of the four people who completed the third interview, one was a nurse, only two held the Certificate III in Aged Care and one had no qualifications. In addition to the Certificate III in Aged Care one of these held a Certificate IV in a related field. The participants' general lack of qualifications in aged care is consistent with other findings that the Personal Care Assistants (Attendants) in aged care may be unqualified (Wells & Ellis, 2010).

In this doctoral study comments were made about some staff members not having had adequate training, including nurses who appear not to have had any personal care

training so they are more rigid and make residents more annoyed than they already are. In my study a comment was made about new staff members in senior positions not knowing routines and therefore putting more pressure on the Personal Care Workers (Patient Care Attendants). Also, it was suggested by a participant in my study that some people were only working in aged care because it was easy to obtain employment in the sector. It was also suggested by a participant in my study that there was a lack of respect towards and empathy with residents shown by some younger staff members and people from some unspecified non-English speaking backgrounds. During their interview, one participant spoke at length about how the thoughtless actions of a staff member can cause major problems. In one facility a resident regularly conducted small ceremonies on special occasions. One morning a worker thought that it would be funny to change the music that the resident was expecting to use. When the wrong music was played:

> The resident went absolutely crazy. He was so distressed and angry that he nearly tore the place apart. But it wasn't funny because that was a special time for him. We had to deal with his subsequent aggression towards us and the other residents as well. It had a catastrophic effect that went throughout the building. So one little thing led to chaos, which then made breakfast late because we were dealing with the problem. Something like this affects the whole day.

During an interview, the Reiki Master/Teacher commented that, while people can enter aged care work with no qualifications, this was done on the condition that they obtain appropriate qualifications with a Certificate III as the basic qualification. However, the carers 'are trained and retrained all the time in dementia because there's always things that change and different techniques that are implemented'. At this point I asked: 'Would it be difficult working with people with dementia without knowing anything about dementia?' To which the Master responded:

> Yes, yes, because it's a whole different world, an absolutely whole different world because peoples' personalities change so dramatically with the onset of dementia and most people don't know anything about dementia until someone in their family comes down with it.

These comments indicate that adequate training for and monitoring of people working in aged care is essential for maintaining a high quality of life for both the residents and their carers.

### 4.5.2 Post-secondary qualifications

Participants variously held post-secondary qualifications ranging from Certificate III level to Post Graduate level, with some holding multiple qualifications. However, to specify the actual qualifications will identify individuals. At the time of their first interview two participants held no post-secondary qualifications; fourteen (73.7%) held a

Certificate III (one of which was not related to Aged Care); two held a Certificate IV; one held an Advanced Diploma; five held a Degree; and two had a Post-graduate qualification. Figure 4.6 illustrates the participants' post-secondary qualifications.

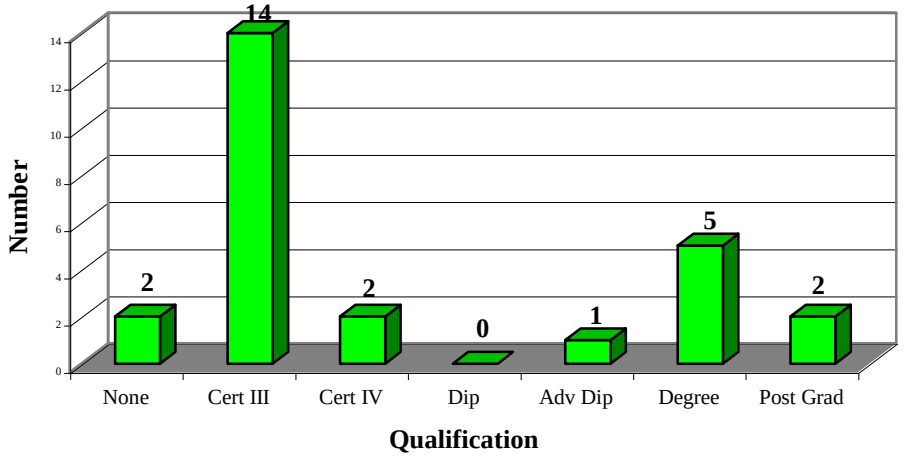


**Figure 4.6: Participants' post-secondary qualifications (n=19)**

### 4.5.3 Qualifications and experience not related to aged care or nursing

Individuals in this doctoral study variously reported having qualifications and/or prior experience in Beauty therapy, Dressmaking and pattern making, Education, Geology, Hairdressing, History, Hospital emergency room work, Hospitality, Mental health support work, Midwifery, Social Work, Taxi driving, Territory area management (the participant did not specify the industry), Type compositor and Working in a University library. Of the four people who completed the third interview, one had worked in three different roles outside of Aged Care including 20 years in one position.

The wide variety of prior experience and qualifications not related to age care reported by participants in this study reflected a similar variety reported by the participants in the previous study. Individuals in that study had variously been trained in boiler making, massage, Reflexology, teaching, Women's Education, and youth work (Webber, 2008). It is also reflected by the variety of qualifications and experiences reported by the participants in the 2008 survey of 188 Disability Support Workers providing accommodation services for people with intellectual disabilities in Adelaide, South Australia. In that survey 31 participants held various TAFE qualifications not related to disability; 27 had Graduate qualifications not related to disability; and seven held Post-graduate qualifications not related to disability. Participants in Cookson's study also reported prior work experiences in community services such as aged care, child care, youth work and welfare; factory work and labouring; management,

professional and artistic employment; nursing; office and clerical work; hospitality; cleaning; retail sales; and self-employment (Cookson, 2014).

## 4.6 Relatives with dementia

Six (31.6%) of the participants reported that they had a relative with dementia. The relatives included a mother (two of the respondents), a partner's father, a father-in-law, an aunty and a parental grandmother. They had worked in demetia care from one to 15 years (mean, 8; median, 7). The participants were not asked if this relationship affected the way in which they approached their work with people with dementia or if this relationship was a factor in their decision to work in aged care. However, in his South Australian study of people caring for individuals with intellectual disabilities, Cookson found that 36.1% of his participants who had a relative or acquaintance with and intellectual disability acknowledged that this was a factor in their decision to work in the area (2010). Because it is a possibility that having a personal relationship with someone with dementia may evoke empathy and understanding in the care worker, or be a factor in their decision to work in dementia care, then this is an area for further study.

## 4.7 The ethnicity of the participants

Statistics regarding the ethnicity of participants in this study were not compiled. However, a number of participants were from non-English speaking backgrounds and this did cause some problems when transcribing and analysing data obtained through the interviews. As early as 2007, female aged care workers were more likely to have been born outside of Australia than females in the general workforce and concern was expressed about the growing number of staff with poor English language skills. Of care workers born outside of Australia, the fastest growing groups were from Asia and the Pacific islands (Wells & Ellis, 2010). Also, 28% of aged care workers reported being fluent in a language other than English. Fifty percent of these workers used that language at work (Wells & Ellis, 2010).

## 4.8 Prior experience with complementary therapies

The participants in this study were selected because they had not previously been trained in any form of Reiki. In addition, the majority had little or no prior knowledge of Reiki. In fact, of the 19 people who attended Reiki training, less than a quarter (4, 21.1%, n=19) had previously experienced a Reiki therapy. Also the 19 participants who attended Reiki training reported having had little prior experience in the use of complementary therapies. Two had not used any complementary therapies and over a quarter had used

only one complementary therapy, other than Reiki, each. The four people who completed the third interview reported having used between one and three complementary therapies before attending the Reiki training. The therapies variously used were aromatherapy, humour, massage, music, prayer, and touch.

This contrasts with the participants who participated in a study of Reiki Practice in Britain where two thirds of the 29 Reiki practitioners interviewed had been involved in some form of energy work, CAM or spirituality as a vocation or lifestyle before becoming Reiki practitioners (Beeler, 2015). It also contrasts with the interview participants in my MSc study who reported using between zero and ten complementary therapies in addition to Reiki. It is possible that, if participants have been using complementary therapies in their daily work and/or home life before training in Reiki, this could influence how they would react to Reiki training and how they might use Reiki in their care of people with dementia.

## 4.9 Chapter conclusion

Although this was a small group, and did not include any representatives from senior management, it was a relatively representative group of care workers. The predominance of Personal Care Workers in this study is consistent with a 2007 national census of the Australian aged care workforce where, 'Personal Care Assistants' (Personal Care Workers / Patient Care Attendants) accounted for 63% of the total Australian residential aged care workforce (King et al., 2013).

I eventually encountered a number of problems because of the English language skills of some of the participants. I had to cease administering the *Spielberger State-Trait Anxiety Inventory (STAI),* which was developed for use with high school and college students as well as adults (Spielberger et al., 1983) and it is possible that minimal English language skills may have been responsible for both the brevity of some of the interviews and the failure of participants to return their Reiki Recording Sheets. However, to limit participants to people who 'speak, read and write English' as Mitchell (2006, p. 24) did, would possibly seriously skew any results obtained. In addition, it is possible that an individual's level of training in aged and dementia care and/or their prior use of complementary therapies other than Reiki could affect the way in which that individuals react to Reiki training and the subsequent use of Reiki in their daily work.

My original contribution to knowledge, as enabled through this chapter, has been twofold. Firstly, through my own findings and my literature survey, I have demonstrated that the age and gender characteristics of aged care workers, disability care workers and nurses in some jurisdictions in Australia may be very similar. Secondly, through this

doctoral research which has built on my MSc research, I have demonstrated that aged care workers will have widely different experiences with complementary therapies that they can use in their work with high care dementia residents.

# 5 Participants' Self-reported Stress Levels

## 5.1 Chapter introduction

In this chapter, I present and evaluate the participants' self-reported stress level data that were gathered at the beginning of each interview and make recommendations for future research. Participants were asked to self-rate their current stress level on a 10-point Likert scale with 0 as the lowest and 9 the highest (Appendix B). Table J.2 (Appendix J) summarises the participants' self-reported stress levels at the first and second interviews. Two of the participants from Group 1 and one from Group 3 withdrew after the Reiki training. Therefore, only the data gained from the 16 participants who attended the second interview will be analysed.

## 5.2 Individual self-reported stress levels

Individual self-reported stress levels are depicted in Figure 5.1. The first column shows the self-reported stress level at the first interview and the second column shows the self-reported stress level at the second interview. It needs to be emphasised here that, at the first interview, Participant 16 reported a stress level of 10 even though the scale was 0 as the lowest and 9 the highest stress level. Of the 16 participants who attended the second interview seven (43.8%) reported higher stress levels, six (37.5%) reported lower stress levels and three (18.8%) the same stress level.

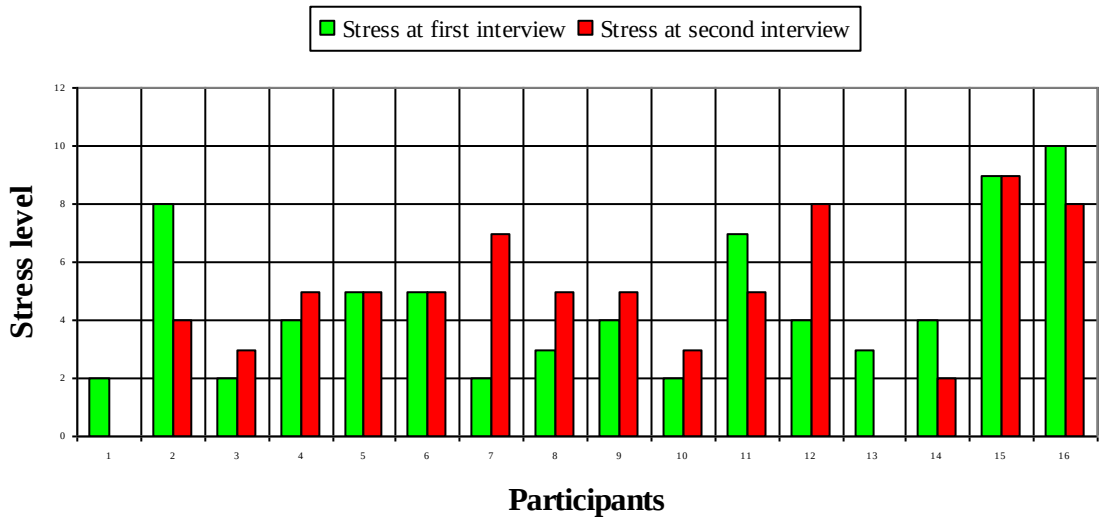


**Figure 5.1:** **Self-reported stress levels for the participants who completed the second interview (n=16)**

**Note:** Participants 1 and 13 reported a stress level of 0 at the second interview.

At the first interview, all of the four initial participants in Group 1 indicated that their stress levels could vary significantly depending on the task at hand. They also suggested that day work could be more stressful than the late and/or the night shift. During the day

there were a number of activities being conducted and numerous ‘outside’ people (such as family members and doctors) visiting residents, each requiring additional carer time.

Of the 16 participants who completed the second interview only two participants indicated that there had been no major changes in their personal or working lives at the time of their second interview. One of these said that they were ‘a bit more aware [and] probably more relaxed at work [and] in myself’. Another participant reported that their adult son was now living at home and having considerable problems with the Immigration Department. Three participants commented about personal health issues. One who had sustained knee damage was due to ‘see an orthopaedic surgeon very shortly’ and another had developed a problem with their hip. The third was suffering an illness at the time of the interview but did not specify what the illness was. One participant said that the major change in their life was the fact that they now knew Reiki while another participant reported that they had been ‘doing a lot more creative work at work [and, at home], I started two big paintings, [which was] something I hadn’t done for years’. Another participant was ‘sleeping better’.

Paradoxically, a participant who self-reported an increase in stress level from two to three (with 0 being the lowest and 9 the highest) said, ‘I seem calmer more relaxed, less stressed. Things don’t worry me as much … and that’s with work and home’ and added ‘I just go with the flow and do the best I can’. Three were cancer survivors with on-going issues related to their illness and one of these was due for further major surgery soon after the second interview. One participant had a major family problem, which cannot be detailed without identifying the individual and another had recently commenced further study. Others also reported personal life issues, which may have impacted significantly on their stress levels.

Therefore, it is possible that over half may have been subject to at least two significant stressors, from within both their work and private environments at the time of the second interview. Reasons cited for higher stress levels included the accreditation process, the need to backtrack and tie up loose ends in paperwork because of the accreditation audit, family problems, and having commenced further study. Paradoxically, two of the participants who self-reported an increase and one who reported no change in their stress levels, commented during the second interview that they personally felt ‘calmer’ since learning Reiki. Three of the participants with major health issues reported lower stress rates while a fourth reported no change in their stress level. One participant who reported a lower stress level had been both ill and involved in an accreditation process in their facility.

Following the decision to cease administering the *Spielberger State-Trait Anxiety Inventory (STAI)* (Spielberger et al., 1983), there was no procedure for validating the participants' assessment of their stress levels. Nor was it possible to triangulate the results with Magnuson (2003), Miles (2003), Salach (2006), and Vitale and O'Connor (2006) as had been planned. Because some participants my have difficulty completing language based questionnaires, future researchers should ensure that their research includes at least one non-language based assessment of participant stress levels.

## 5.3 Self-reported stress levels by facility

To analyse self-reported stress levels by group would be unproductive because Group 2 and Group 3 each contained participants from two different facilities and their working conditions could have been substantially different. However, both participants from Facility 1 reported lower stress levels. In facilities 2, 3 and 4 where accreditation audits were underway at the time of the second interview the majority of participants from Facility 4 reported lower stress levels while the majority of participants from Facilities 2 and 3 reported higher stress. Figure 5.2 shows changes in self-reported stress levels between the first and second interviews grouped by facility.

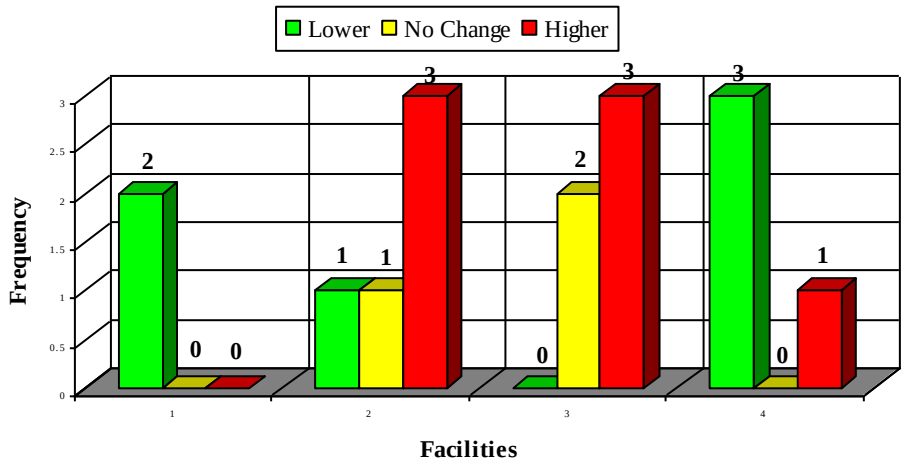


**Figure 5.2: Changes in self-reported stress levels between the first and second interviews grouped by facility (n=16)**

### 5.3.1 Facilities where the majority of participants reported higher stress levels

In addition to the accreditation audit, increasing workloads and a rise in the number of high care residents were reported as adding to carer stress levels. One participant said that they seemed more stressed in the past few years at work because:

> We now have to do laundry as well when we never used to do that. Also, we now have to do dishes. In the afternoon we have to pick up dishes and put them through the kitchen dishwasher ... I don't know, it just seems to be accumulating.

This carer also spoke about the increase in the number of high care residents and the additional pressure that had been caused because of the increase in 'their behaviours' and the 'need for carers to be there to do a lot more for them'. This was supported by another carer who said, 'it is a rising problem because [people with dementia] are more difficult to manage than someone with physical symptoms' and 'we have some residents who are surprisingly young, frighteningly young'. Although this participant did not specify the ages of the youngest residents in their facility, the South Australian Hight Care Facilities which responded to a questionnaire sent as part of my MSc study reported that the youngest resident with dementia was 39 years of age (Webber, 2008) and it has been recognised that young people with dementia are especially disadvantaged because they need services tailored to their needs because of their stage in life (Access Economics, 2009).

### 5.3.2 Accreditation process

Fourteen of the sixteen participants who completed the second interview had been working in one of the three facilities where an accreditation process was underway. While some of the participants were directly involved in the accreditation process, several indicated that they were not affected. One of these said that, because the accreditation people visited 'mainly in the mornings and sometimes in the afternoons' but not during the night shift All of the seven participants who reported an increase in stress between the first and second interviews had been working in one of these facilities. However, four of the participants working in these facilities reported lower stress levels and three reported no change in their stress levels. Although one participant suggested that the audit was stressful because of the additional work needed to complete paperwork, another suggested that the audit was beneficial because, 'we are a lot more organised so we know better how we have to do our paperwork'. When talking about the accreditation, one participant commented that the audit had not affected them but:

> Others get so flustered by it and I know that [some staff members] have taken today and tomorrow off because they were led to believe [the auditors] were coming in today and tomorrow. I think people do get scared of the accreditation auditors.

The variability in individual reactions to the audit demonstrates that individuals will react differently to the same work-related issues.

### 5.3.3 Death of a resident

Five of the participants who were working in one of the facilities where the accreditation process was underway were also working in a facility where a long-term resident had been sick and was dying at the time of the second interview. One participant spoke at

length about this and another participant, who did not personally provide Reiki for the resident, reported that, 'other people went in there and did some Reiki on her' and added that the resident 'was more relaxed and calm' following the Reiki. Of these five participants, three reported an increase in their stress level and two reported no change in their stress level between the first and second interviews. One reported no change over all three interviews (5 on a scale of 0 to 9, see Figure 5.7). The participant who reported the greatest rise in their stress level (from 2 to 7 on a scale of 0 to 9) was working in this facility and in contact with the dying resident. One participant came to their interview direct from the resident's room. As with the accreditation process, this also clearly demonstrates that individuals will react differently to the same work related issues.

## 5.4 Self-reported stress levels by role within aged care

This cannot be reported because, to do so, would identify individuals.

## 5.5 Self-reported stress levels by gender

Figure 5.3 shows changes in self-reported stress levels between the first and second interviews grouped by gender.

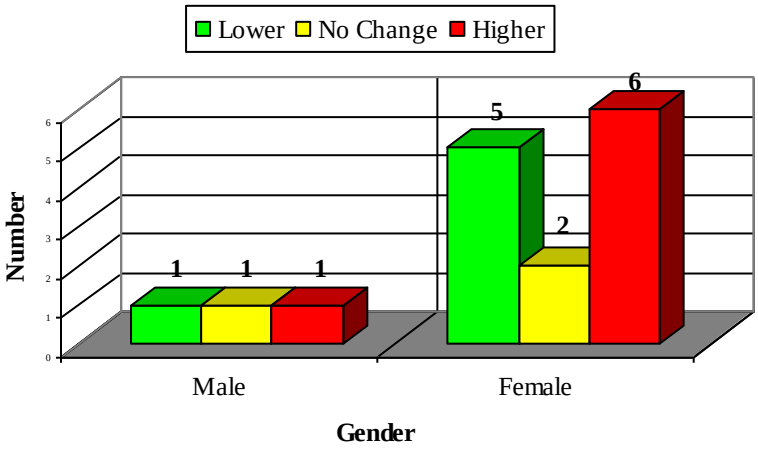


**Figure 5.3: Changes in self-reported stress levels between the first and second interviews grouped by gender (n=16)**

Of the 16 participants who completed the second interview, 13 were female and three were male. One male reported a reduction in his stress level, one no change in his stress level and the third an increase in his stress level. And, of the 13 females, five reported lower stress levels, two reported no change in their stress levels, and six reported higher stress levels. Because the eventual selection of volunteers was beyond my control there was not a gender balance, I am unable to draw any meaningful conclusions based on this data.

## 5.6 Self-reported stress levels by age

The age brackets used in this doctoral project were chosen to permit comparison with my MSc study (Webber, 2008) in which I interviewed 10 people providing Reiki for people with dementia. At the time, I made an assumption that no one under the age of 16 years would be employed in an aged care facility and the twenty-year range for each group fairly evenly divided the participants by age. Given the relatively small number of participants in this study no major advantage would be gained by subdividing these age brackets. Figure 5.4 depicts changes in participant self-reported stress levels between the first and second interviews grouped by age.

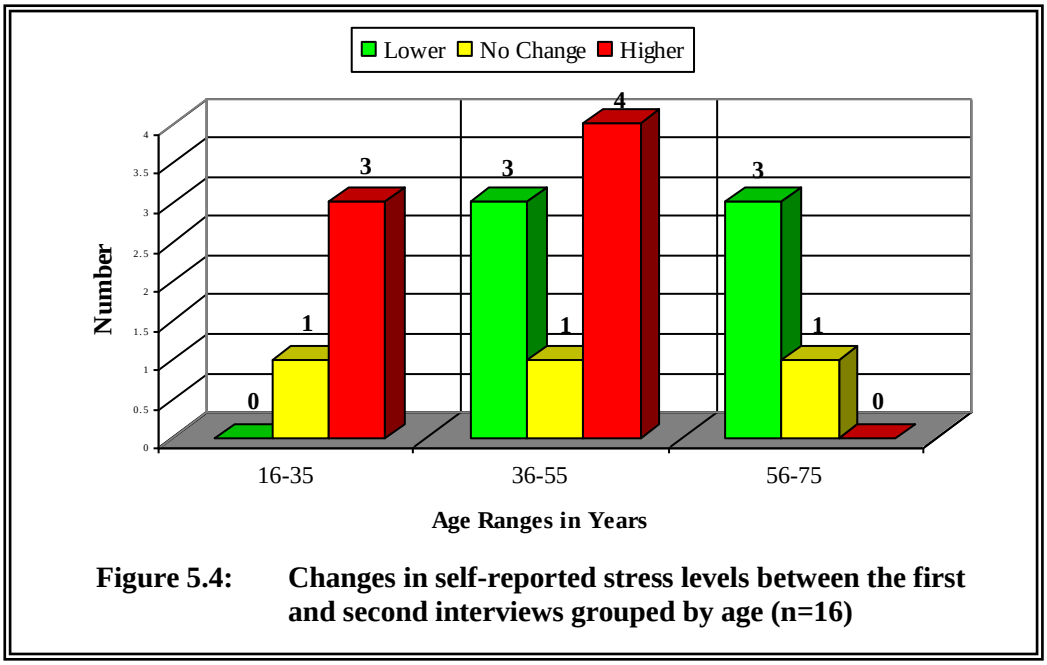


**Figure 5.4: Changes in self-reported stress levels between the first and second interviews grouped by age (n=16)**

In this doctoral study, four of the 16 participants who completed the second interview were in the 16-35 year bracket, eight were in the 36-55 year bracket, and the other four in the 56-75 year bracket. Of the four people in the 16-35 year-old bracket one reported no change in their stress level and the other three reported an increase in their stress at the second interview. Three of the eight participants within the 36-55 year bracket reported lower stress levels; one reported no change in their stress level, and four self-reported higher stress levels. And, three of the four participants in the 56-75 year bracket reported lower stress levels and one reported the same stress level.

These results would seem to indicate that it might be younger workers who would be more likely to suffer increases in stress when exposed to potentially stress causing factors. This is consistent with research which has indicated that younger nurses working in dementia care may report higher stress levels than older nurses (Edvardsson, Sandman, Nay, & Karlsson, 2009). However, further research will be needed to confirm or reject this assumption.

## 5.7 Self-reported stress levels by length of service in dementia care

Figure 5.5 illustrates the participants' self-reported stress levels at the first interview arranged by length of service in dementia care. Stress levels ranged from 2 to 10 (mean, 4.4; median, 4.0).

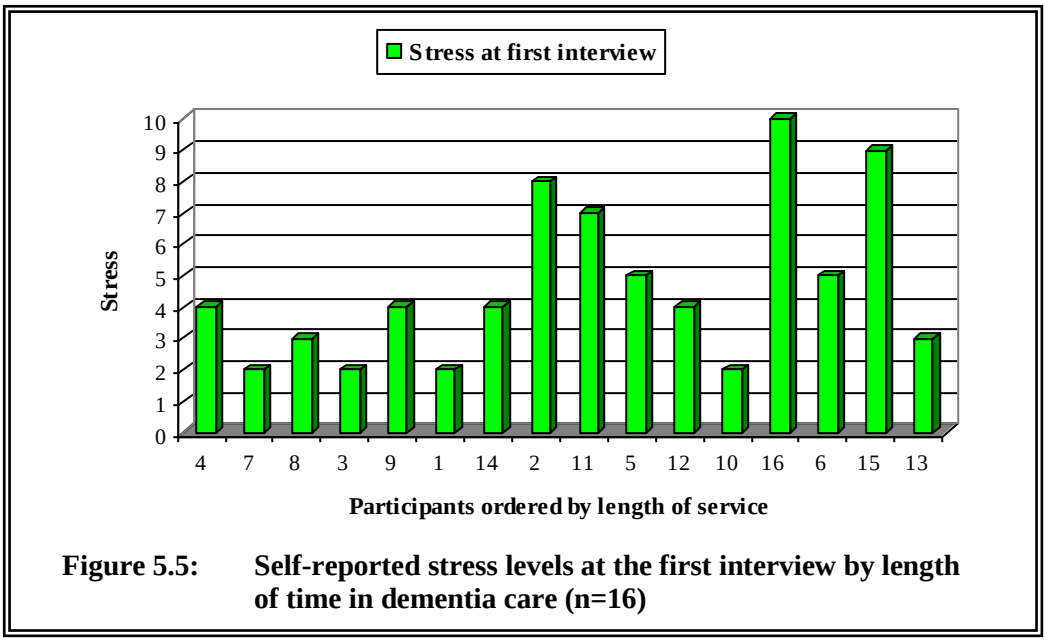


**Figure 5.5: Self-reported stress levels at the first interview by length of time in dementia care (n=16)**

Because my primary focus is an analysis of the qualitative data gathered from participants, I did not conduct a statistical analysis of this data. However from the chart it does not appear that the length of service in dementia care is a factor in the participants' expressed levels of stress.

## 5.8 Changes in stress levels by length of service in dementia care

Figure 5.6 illustrates the participants' changes in stress level arranged by length of service in dementia care.

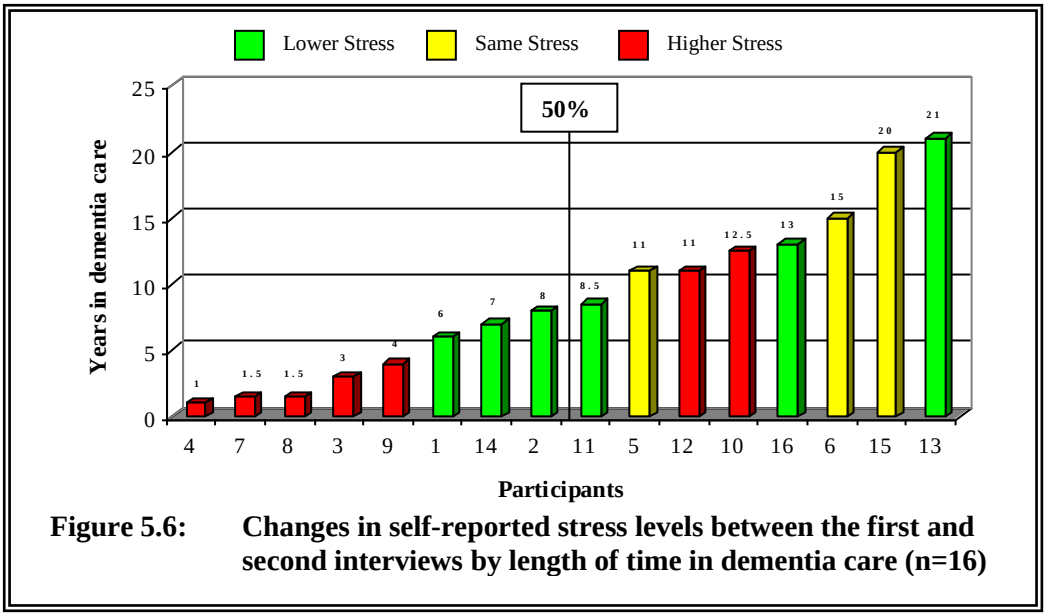


**Figure 5.6: Changes in self-reported stress levels between the first and second interviews by length of time in dementia care (n=16)**

The 16 participants who completed the second interview had been working in dementia care from 1 to 21 years (mean, 9.00 years; median, 8.25 years). Half had been working in dementia care for eight years or less (mean, 4.0 years; median 3.50 years). The other 50% had worked in dementia care from 8.5 to 21 years (mean, 14.00 years; median 12.75 years. The majority of the seven participants who reported increased stress levels (71.4%) had been working in dementia care for less than five years. The six participants who reported a reduction in stress (37.5%, n=16) and the three participants who reported no change in their stress levels (18.8%, n=16) had all been working in dementia care for more than five years. Also, all of the seven participants who reported increased stress levels worked in a facility where a major accreditation audit had commenced following the first interview and was still ongoing at the time of the second interview.

From this chart, it would appear that increased stressors due to the audit and the death of a resident had greater impact on the participants with less service in dementia care. However, because I conducted this analysis after I had completed the second interviews, it was not possible to question participants about the reasons for their increased stress levels because of time constrains and the poor attendance at the third interviews. Future researchers should re-interview participants who report or physically demonstrate an increase in stress levels during the course if the intervention in order to determine why this increase in stress levels has occurred.

## 5.9 The pressures of day shift

Some participants reported that the additional workload during day shift added to their stress while others said that they actually enjoyed the activity because they ‘like to be busy’. Paradoxically, the participant who said of day shift, ‘I always like [the] hustle, bustle and constant go, go, go, so I like to be busy’, reported a small increase in their stress level at the second interview. However, this person was working in the facility where a long-term resident was dying at the time of the second interview and this may have increased their stress level. Participants in this study were not asked which shifts they worked, so information was only available if the participant mentioned it. Therefore future researchers should ascertain the shift(s) participants are rostered for and whether there had been any changes in their rosters during the course of the trial.

## 5.10 Stress levels of participants who completed the third interview

Of the four participants who completed the third interview, two reported no change in their stress level since the second interview, and two reported a slight increase in stress but this was still lower than at the first interview. Three of these participants reported

that there had not been any changes in their work environment since the second interview. However, the fourth had been able to increase their workload because of improved health. One participant reported that, for them personally, the year had been rather miserable because their mother had died, the family dog had been put to sleep, a friend had died and the new house that they had been building for 18 months was not yet ready for them to move in. Another participant who had, reported at the second interview that their adult son was living at home and having considerable problems with the Immigration Department reported that the issues had been resolved enabling the son's wife and child to join him in Australia. A third participant had sold their existing house and bought a new one and now had their adult daughter living at home again. The participants' self-reported stress levels at each of the three interviews are illustrated in Figure 5.7.

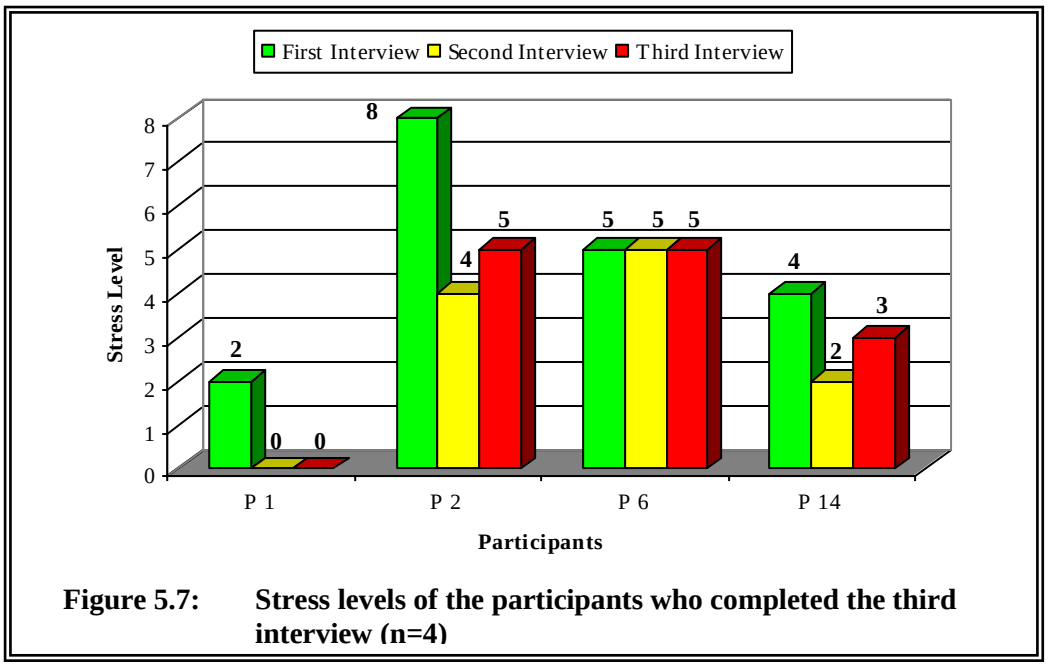


**Figure 5.7: Stress levels of the participants who completed the third interview (n=4)**

For three of these four participants it is possible that learning and using Reiki may have been a contributing factor in their reduced stress level.

## 5.11 Stress levels of participants who returned the Reiki Recording Sheets

The self-reported stress levels of participants who returned the Reiki Recording Sheets are illustrated in Figure 5.8. Of the seven participants who returned their Reiki Recording Sheets: four reported a lower stress level at the second interview (participants P 1, P 2, P 11 and P 16); two reported the same stress level (participants P 5 and P 6); and one reported a higher stress level (participant P 10). I will discuss these results when evaluating issues relating to the Reiki Recording Sheets.

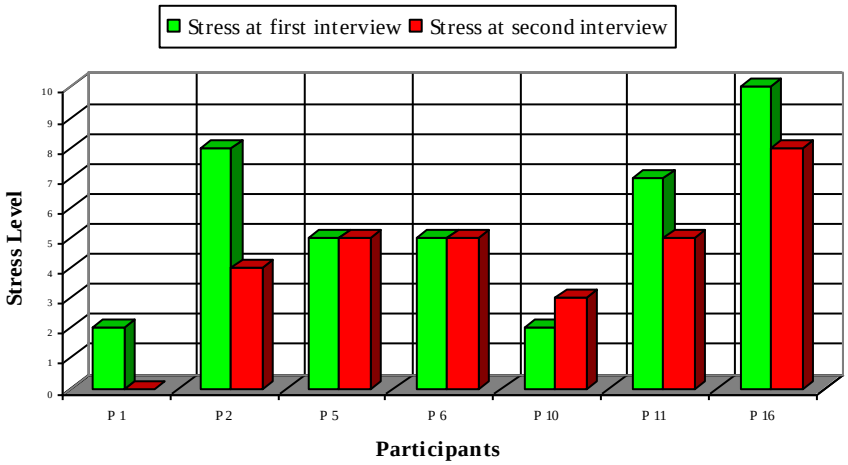


**Figure: 5.8 Stress levels of participant who returned the Reiki Recording Sheets**

## 5.12 Chapter conclusion

It has been suggested that high workloads contribute to heightened stress levels in carers (Hayes et al., 2006) and that caring for people with dementia causes heightened levels of carer stress, fatigue, depression, physical morbidity and mortality (Bruce et al., 2002; Donaldson et al., 1998; Herrmann et al., 2007; Morgan et al., 2005; Rodney, 2000). The Reiki Master/Teacher who conducted the Reiki training for this study confirmed that caring for people with dementia is a stressful occupation and that the residents can feel carer stress. He commented, 'I have found that it works on the residents' side as well as the staff side'. Even though staff members may 'try to be extremely professional about what they're doing' if they come to work after a bad day, 'even though the residents have dementia, they'll hone in on that energy'. As soon as 'they feel that negative energy then that just flips for them'. However:

> Quite often, if you can give them some positive energy they feel more comfortable, more relaxed and even if they just go to sleep for five minutes it can be amazing. I call these Reiki naps and they can make a huge difference right through from top to bottom so yes I think there is a snowball effect.

All of the participants in this doctoral study were caring for people with high care needs because of dementia. Also, for some participants in this project, there were potentially stress causing changes and increases in workloads including having to cover for 'slack' carers who they felt 'don't do their work properly', being required to do laundry, being required to collect dishes then put them through the dishwasher and needing to care for an increasing number of high care residents, who often require two people working together to help them. Also, as reported by one participant, there may also be a

difference in the staff to resident ratio in different areas of a facility thus causing time management problems when there are more residents to care for. In addition, it was also suggested that, stressors were greater during day shifts compared with afternoon and night shifts. During day shift there are 'outsiders' such as doctors or relatives who needed attention at the same time as carers are preparing residents for their daily activities. However, in this study, participant self-reported stress levels have indicated that individuals caring for people with dementia in High Care Residential Facilities will react differently to these apparently stress causing factors, a factor which future researchers will need to consider.

Ostojic, when concluding that distance Reiki had no perceptible effect on people working 'within a division of a large Australian corporation' (2006, p. 4), failed to account for any possible negative effects of the organisational change which had occurred during the time of that study. For the participants in this doctoral study, there were a range of organisational issues that could potentially have caused an increase in individual stress levels during the course of the project, but individuals appear to have reacted differently to those changes. Therefore, this study has demonstrated that it is not possible to ignore organisational changes when assessing the stress levels of individuals working in dementia care. Therefore, future researchers will need to ensure that they consider organisational factors that could affect participants' stress levels before drawing any conclusions from their data.

My original contribution to knowledge, as scaffolded through this chapter, has demonstrated that people working in high level dementia care cannot be treated as a homogeneous group because they will each react differently to the same potentially stress causing factors which they encounter in their daily work. In the following chapters, I introduce and evaluate issues raised by an appraisal of the participant maintained Reiki Recording Sheets, the interviews, the group meetings and unsolicited correspondence.

# 6 Reiki Recording Sheets

## 6.1 Chapter introduction

In this chapter, I present and evaluate the data gained from the Reiki Recording Sheets (Appendix A) cross-referenced with data from the participants' self-reported stress levels and the digitally recorded sessions. Of the 16 participants who completed the second interview only seven (36.8%) returned their Reiki Recording Sheets. Of the four participants who returned their Reiki Recording Sheets, two were from Group 1 (100.0%, n=2), three were from Group 2 (37.5%, n=8) and two were from Group 3 (33.3%, n=6). The number of entries on the sheets recording each participant's use of Reiki ranged from a minimum of eight to a maximum of 59 (mean, 25.9; median 16.0). Figure 6.1 illustrates the number of Reiki treatments reported by participants who returned the Reiki Recording Sheets. All participants verbally reported having used Reiki more frequently than reported on the Reiki Recording Sheets.

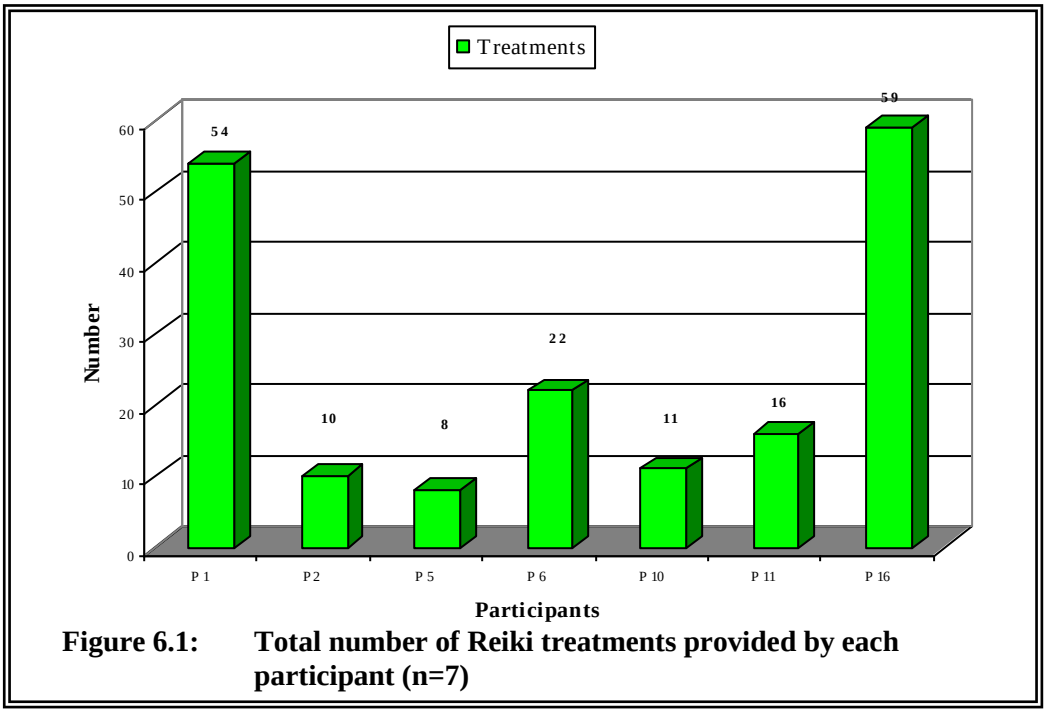


**Figure 6.1: Total number of Reiki treatments provided by each participant (n=7)**

The participants in this doctoral study were not asked why they did not return their Reiki Recording Sheets. However, it is possible that there were a number of reasons why they failed to do so. They might not have been sufficiently committed to the project, they might not have had sufficient English language skills needed to complete the form, they might not have understood the requirements, there might not have been sufficient time during a busy working day in which to make the necessary entries or they may have simply forgotten to bring the forms to the second interview.

## 6.2 On which groups of people did participants use Reiki

Of the 180 Reiki treatments reportedly provided by the participants, 117 (65.0%) were provided for residents, 41 (22.8%) were self-Reiki treatments, and 22 (12.2%) were provided for other people such as friends, family members and work colleagues. Figure 6.2 illustrates the categories of people who received Reiki.

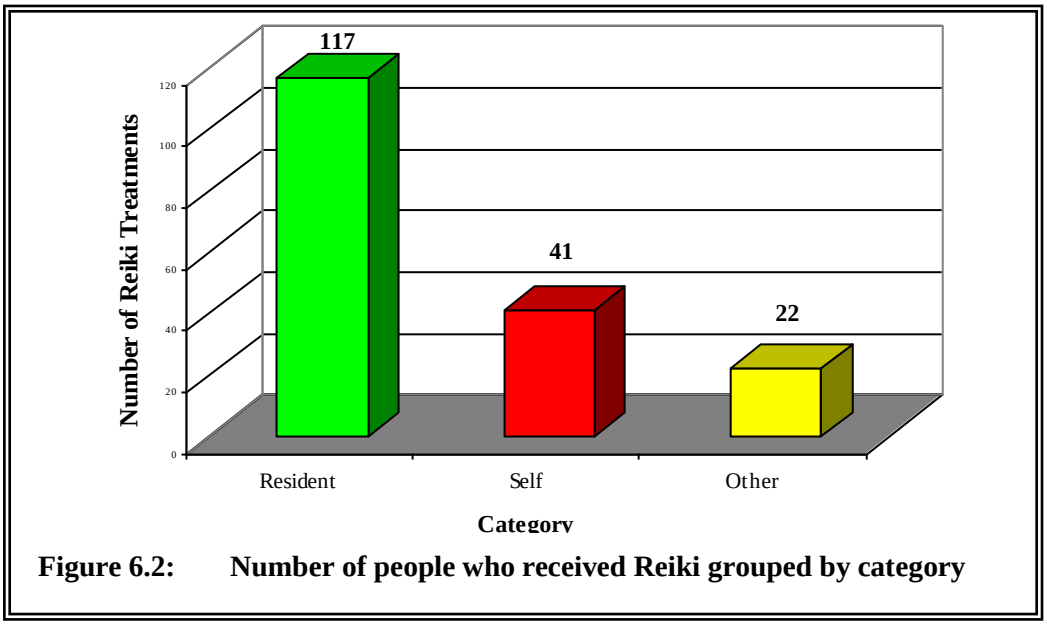


**Figure 6.2: Number of people who received Reiki grouped by category**

During the interviews one participant indicated that they had not provided Reiki for any residents, only 'myself' but then described how they had relaxed a resident by giving him or her Reiki. Other participants variously reported providing Reiki for Residents, self, family members (including parents, spouses and/or children), other staff members, and or the family pet including providing Reiki for people. They reported providing Reiki for residents who 'were being difficult or uncooperative when [she was] changing a pad' and/or while turning them or 'are just needy and want you to be there … in the hope that they would sleep and not keep ringing the bell at night'. They also reported providing Reiki for residents who had shoulder, neck, and/or back pain, had difficulty eating (or refused to eat), were distressed, were having a blood test, had Parkinson's disease, were becoming confused, wanted relief before their weekly visit to the hairdresser, or were resistive and calling out. They also reported providing Reiki for residents who were either ambulatory or confined to a chair or bed.

Because all of the participants were employed in aged care, the concentration on providing Reiki for residents is understandable. However, when the categories of people who received Reiki are grouped by participant, there are considerable differences in the categories of people for whom individual participants provided Reiki (see Figure 6.3).

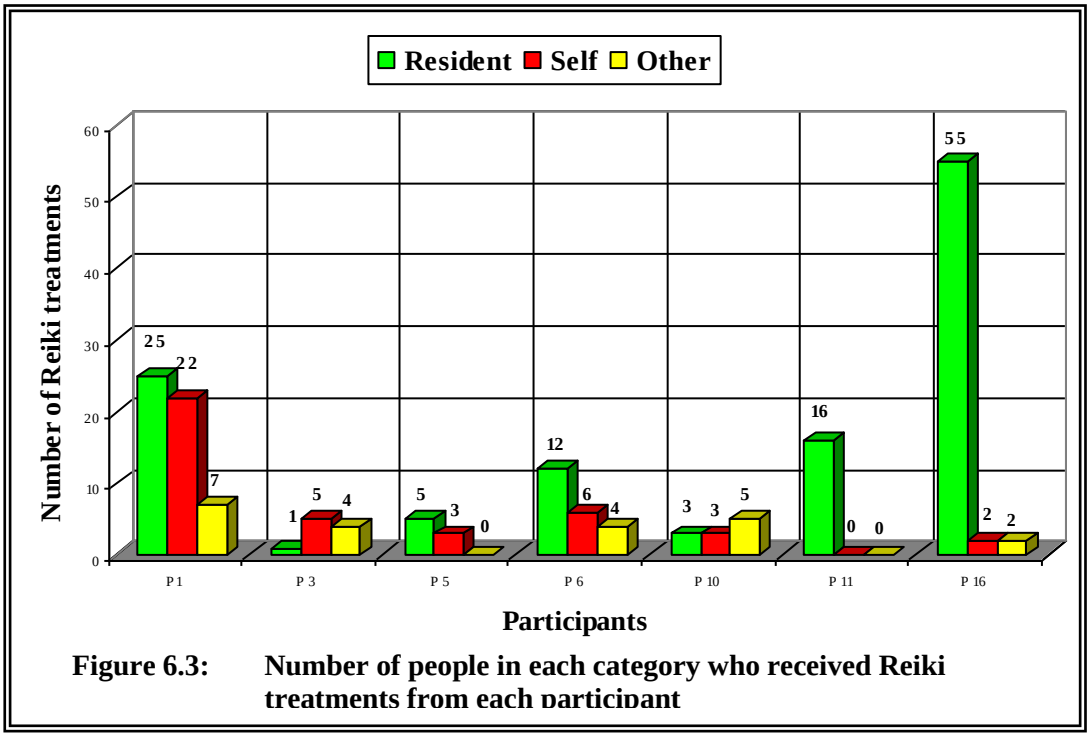


**Figure 6.3: Number of people in each category who received Reiki treatments from each participant**

Three participants (Participants 1, 3 and 10) each provided less Reiki treatments in total for residents than for self or others combined. Of these, Participant 1, who provided a total of 54 Reiki treatments, gave 43.6% (n=25) to residents and 53.7% (n=29) to non-residents. The other four participants (Participants 5, 6, 11 and 16) each provided more Reiki treatments to residents than for self or others combined. Two of these predominantly concentrated on providing Reiki for residents. Participant 16, who provided 59 Reiki treatments gave 93.2% (n=55) of them to residents and only 3.4% (n=2) each to self and others while Participant 11 provided all 16 treatments for residents and none for self or others.

In response to a direct question, five Group 2 participants reported using self-Reiki with positive, calming and relaxing results (including having a good sleep). Of these, one said, 'I don't know if it's working. I feel relaxed but I don't know if it's working'. Also, in response to a direct question, one Group 3 participant said:

> I seem to sleep a lot better. Instead of waking up all through the night, I'm feeling more relaxed when I got to bed and sleeping better and I'm not getting stressed at work.

Conversely, in response to a direct question, one Group 2 participant said, 'I have no idea how to do it. I can't Reiki myself'. And a Group 3 participant asked, 'so I can put my hands anywhere on my body to make me feel better?' Another added:

> I don't do as much on myself. I can't relax. I am a very stressed person. I can't relax myself enough to do Reiki on myself. I don't know what my problem is.

At their interview, one participant reported that, with self-Reiki, 'I get about halfway … and then I become really restless. It doesn't feel right'. While another said that they did not know how to provide self-Reiki.

## 6.3 Why did participants provide Reiki

Figure 6.4 illustrates the reasons for providing Reiki as reported by the participants who returned their Reiki Recording Sheets. Participants did not always specify the reason for providing Reiki however, all seven cited emotional issues such as agitation, anxiety, stress and feeling drained on a total of 55 occasions. Five participants cited physical problems such as feeling cold, headache, pain, stroke and upset stomach on 48 occasions. Three reported using Reiki while providing activities of daily living on 18 occasions. Two mentioned dementia and/or Parkinson's disease on 15 occasions and four provided Reiki for sleeplessness on 11 occasions. Another participant reported providing Reiki as a demonstration for residents or colleagues on six occasions, at a request from a resident twice, and twice for practice. One participant also reported giving self-Reiki on 19 occasions while sitting in bed, watching television, during a meeting and/or while a passenger in a car or bus, but did not specify the reasons for these treatments.

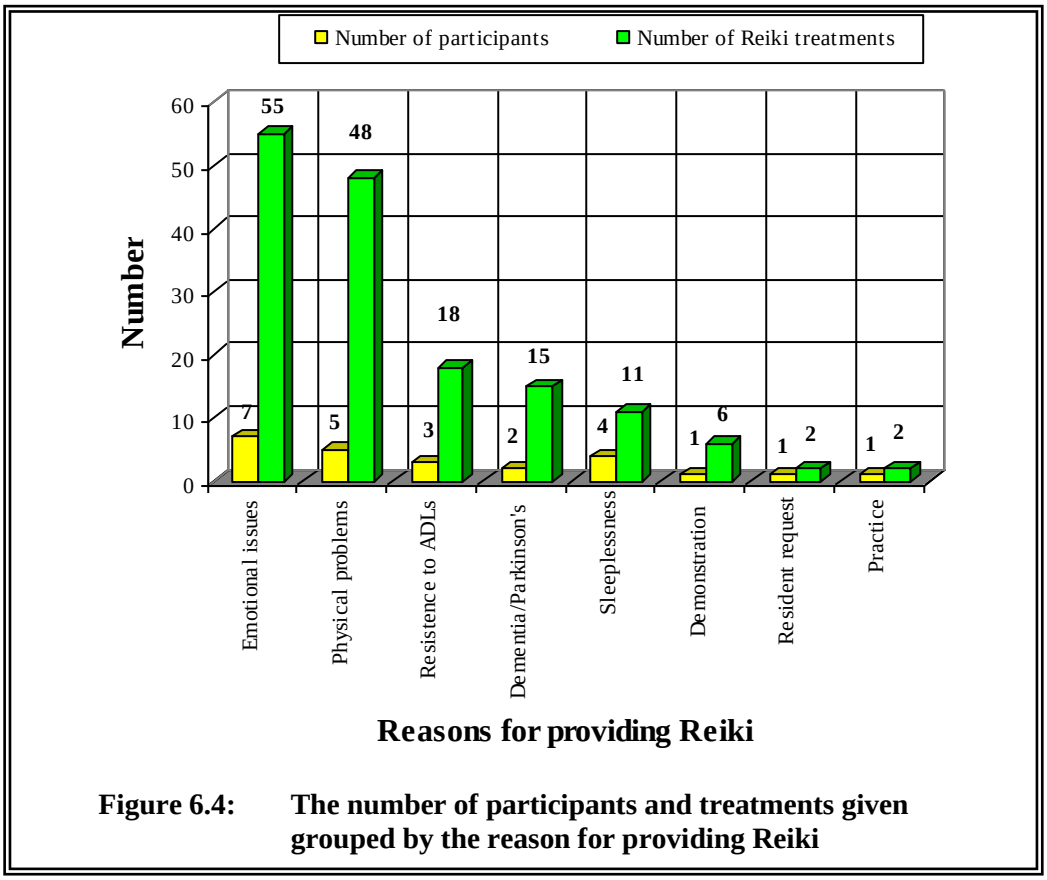


**Figure 6.4: The number of participants and treatments given grouped by the reason for providing Reiki**

## 6.4 Duration of Reiki treatments

Figure 6.5 illustrates the length of Reiki treatments.

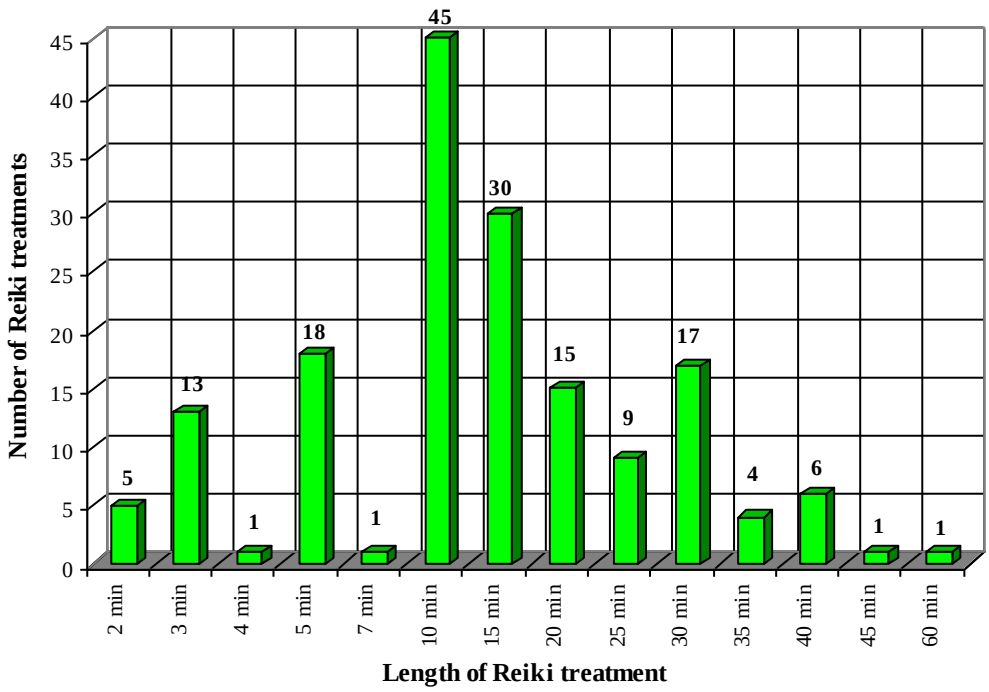


**Figure 6.5: Number of Reiki treatments grouped by duration in minutes (n=166 treatments)**

## 6.5 Length of service for participants who returned their Reiki Recording Sheets

The length of service in dementia care for the participants who returned their Reiki Recording Sheets is illustrated in Figure 6.6.

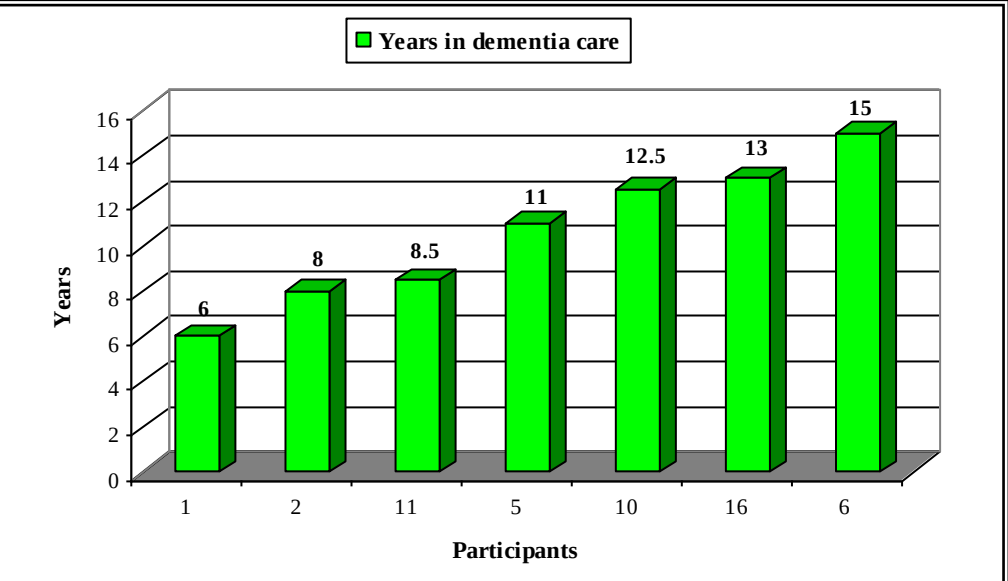


**Figure 6.6: Length of service for participants who returned the Reiki Recording Sheets (n=7)**

The length of service in dementia care for the participants who returned their Reiki Recording Sheets ranged from 6 to 15 years (mean, 10.6 years; median, 11.0 years). This contrasts with the length of service in dementia care for the 16 participants who attended the second interview. Their length of service ranged from 1 to 21 years (mean, 9.0 years; median, 8.25 years).

## 6.6 Synchronic nature of Reiki

It has been claimed that the Reiki practitioner receives the Reiki energy as he or she is providing it to a recipient (Vitale, 2006; Webber, 2008). Therefore, it could be argued that, the more an individual practises Reiki then the more they will benefit and the more their stress level will reduce. Figure 6.7 illustrates the changing stress level of participants who returned the Reiki Recording Sheets in descending order of the number of Reiki treatments provided by the individuals. Although the numbers returning their Reiki Recording Sheets were small, these results indicate that learning Reiki and providing Reiki treatments could possibly result in a decrease in the stress levels of professional carers of people with Dementia. This assumption is consistent with Morris and Warner's (2009) finding that there was a significant decline in stress scores among 81 family care givers trained in Reiki.

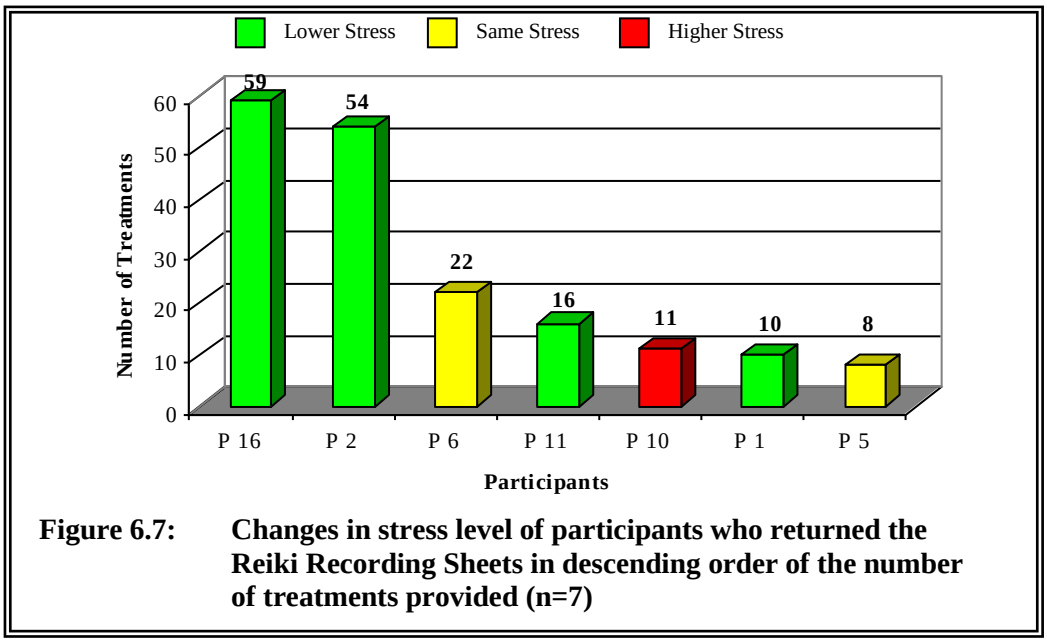


**Figure 6.7: Changes in stress level of participants who returned the Reiki Recording Sheets in descending order of the number of treatments provided (n=7)**

## 6.7 Chapter conclusion

It is possible that there were a number of reasons why participants failed to return their Reiki Recording Sheets. They might not have been sufficiently committed to the project, they might not have had sufficient English language skills needed to complete the form, they might not have understood the requirements, there might not have been sufficient

time during a busy working day in which to make the necessary entries, or they may have simply forgotten to bring the forms to the second interview.

Given that one participant commented that ‘paperwork, paperwork’ was a significant problem, asking participants to complete Reiki Recording Sheets may have been an additional burden on already overworked carers. Alternatively, it could be an example of people from non-English speaking backgrounds not completing paperwork as one participant complained during their interview.

Because the Reiki Recording Sheets have the potential to return much rich quantitative and qualitative data, future researchers should develop strategies designed to maximise the return rate of Reiki Recording Sheets. These could include stressing the importance of returning the forms when they are given to participants at the first interview, asking participants how they are coping with the forms during the mid- and end-of-project meetings; contacting the participants before the second interviews to remind them to bring the forms to the interview, offering an incentive to complete the forms, and/or making it part of their training and a requirement for receiving their Reiki Certificate.

The small number of self-Reiki treatments, and a comment made by one participant that that they did not know how to provide self-Reiki, seem to indicate that more emphasis should have been placed on issues relating to self-Reiki and self-care during the Reiki training.

# 7 Interviews, Group Meetings and Unsolicited Correspondence

## 7.1 Chapter introduction

In this chapter, I introduce and examine the qualitative data obtained during the digitally recorded individual interviews and group meetings together with data gained from unsolicited correspondence. Forty individual interviews were conducted with the professional carers who volunteered to participate in this doctoral study and the digitally recorded section of the interviews ranged from 3:50 minutes to 32:37 minutes (mean, 11:32 minutes; median, 10:29 minutes). Group meetings were held with the carers in the three facilities three weeks after Reiki training and again six weeks after the Reiki training.

Of the 40 interviews with carers 20 were first interviews with the professional carer volunteers and ranged from 4:10 minutes to 28:14 minutes (mean, 10:26 minutes; median, 10:01 minutes). One of the potential participants withdrew after their interview so only 19 of these volunteers then participated in Reiki training. Sixteen were second interviews held with participants who had participated in the Reiki training and ranged from 3:50 minutes to 32:37 minutes (mean, 12:06 minutes; median, 10:08 minutes). Finally, four were third interviews with participants. These ranged from 4:38 minutes to 25:58 minutes (mean, 14:46 minutes; median, 15:15 minutes).

At the mid-project meetings, the Group 1 recorded section was 43:36 minutes, the Group 2 recorded section was 15:39 minutes and the Group 3 recorded section was 25:41 minutes. At the end-of-project meetings the Group 1 recorded section was 41:07 minutes, the Group 2 recorded section was 19:58 minutes and the Group 3 recorded section was 13:49 minutes. However, approximately half of the Group 2 recording was advice given by the training Master and Reiki I practitioner and approximately a quarter of the Group 3 recording pertained to issues such as restraint and lifting rather than Reiki.

In qualitative research, ‘the researcher’s principal purpose is to know and understand’ (Fitzgerald, 1997, p. 53) therefore, failure to interview persons who had a close association with the research (other than the participants who were trained in Reiki) could have meant that potentially valuable information would be lost. Consequently, four interviews were held with the Reiki I practitioner who assisted at the training, the university senior lecturer who attended the first Reiki training session as an observer, the Reiki Master/Teacher who conducted the training, and the Director of Nursing of one of

the High Care Residential Facilities. These interviews ranged from 7:25 minutes to 1:05:49 hours (mean, 34:19 minutes; median, 32:02 minutes).

## 7.2 Prior knowledge of Reiki

As a condition of acceptance of entry into the research project, participants had not been trained in any form of Reiki. The majority of carer participants either knew nothing or very little about Reiki. However, four participants had previously received Reiki. Of these, one had received Reiki 'from one of my old neighbours who was a Reiki Master' while another had received Reiki from a client's mother. The third participant had received Reiki from their spouse and the fourth from the Reiki Master/Teacher (who conducted the training) in their place of work. Of these, one said, 'because I like it, I've had it done a few times and I've had it done on my daughter as well'. Another participant reported that 'nothing happened as far as I knew' while another reported feeling 'heat' coming from the practitioner's 'hands'. The participant who had previously received Reiki from the Reiki Master/Teacher commented that it does help then added:

> I used to get terrible pains in the shoulders and he'd just work his magic, put his hands on me and I could feel the warmth coming through. After a few minutes the pain goes, no tablets, nothing.

Two participants who had read about Reiki thought that it was 'a flow of energy'. One of these thought that:

> People put their hands about two inches above the body [then] they'd slowly go over the person's body and be able to feel any areas that needed healing or there were blockages of the flow energy and they would actually be able to fix that, heal it with their own gentle energy force**.**

One participant who knew nothing about Reiki except the name, and 'was going to look on the internet', emphasised that they were 'better off not knowing because then [they] might have a preconceived idea of what [to] expect'. Another thought that Reiki involved the use of 'healing hands'. One thought it had something to do with 'the pressure points'. Another thought it was a special kind of massage. Another thought that people 'had to do years and years of preparation like a guru in India'. One participant, who also knew 'nothing', had heard the name Reiki and reported that it had been used in an establishment where they used to work and other staff members had said that people felt 'calmer' after being given Reiki.

The Reiki Master/Teacher who conducted the training for this PhD project reported that he had practised Reiki for nearly 16 years. During this time he had taught Reiki for 13 years and incorporated it with caring work in aged care for 10 years. Approximately 15 years before becoming involved in this research project, he decided that it was time

for a change after having spent 30 years as a boilermaker during which time he worked on many large projects. He said:

> I'd had enough and headed off in a different direction, firstly being involved with people who were in rehabilitation situations with Work Cover in a company I worked for and then slowly edging into aged care. That's how I got into aged care and left [my] trade altogether.

During his employment in a large defence establishment, he had 'begun doing Reiki on the side' for the blue-collar workers. This 'came to the attention of the second in charge of [the job]' who wanted to know if the Reiki was doing any good. He reported that, after discussions with his work supervisor, he 'had a rite of passage to do Reiki on anyone who wanted it' so, for the last four years in that job 'I didn't do my trade but helped with [worker] rehabilitation and did Reiki'. He also said that he had 'had the privilege of being able to [provide Reiki training for] different people in health fields from mainstream medicine through to allied health'. He listed Bowen therapists, carers, chiropractors, General Practitioners, nurses, physiotherapists, police officers, and specialists as the types of people he had trained as well as people in palliative care situations and who were helping people who were dying. He had also trained people 'who [were in the process of] dying, to use the Reiki to help themselves and quite often to help their families'.

The Reiki I practitioner who assisted at the training had been attuned privately as a Reiki I practitioner and, therefore, had not previously attended a group training day. Neither the university senior lecturer nor the Director of Nursing had any training in Reiki. From 2002 the researcher had had numerous discussions about Reiki with the university senior lecturer. While supporting the need for research into Reiki, he had always been sceptical about it and, when questioned about the reason for this scepticism, he indicated that he 'didn't have a good knowledge base about Reiki and [was] fairly sceptical about most untested procedures'. Part of this scepticism was due to the fact that, unlike the explanations about Reiki provided by the researcher and other people he had 'met during the recent process,' he had met 'people who are into Reiki who haven't impressed me in terms of what they have said about Reiki'. Generally his knowledge of Reiki had come from people he had:

> met at parties [and] who have been so general and so enthusiastic but seemed to be very uncritical about their approach [towards Reiki]. So I suppose in many ways I've bought into dominant stories in the community about complementary therapies [and,] at times, equating them to fish slapping.

In this instance, 'fish slapping' was in reference to a health fund, which had advertised that it, didn't 'fund fish slapping, but [did] fund chiropractic'. Another part of his

scepticism was due to an acknowledged ‘lack of understanding of the processes involved [and] the rationale behind [Reiki]’ as well as his ‘tendency to give limited credibility to procedures that have backgrounds that appear to be superstitiously based’. He also expressed that, while being ‘very respectful of other people’s spiritual beliefs’, he also had ‘concerns about issues related to miracles’, especially the fact that Dr Usui supposedly had ‘visions after fasting for 21 days’ by which time a person would probably be experiencing ‘hallucinations and have lost touch with a lot of the normal sensory experiences [which] we know happens from extreme deprivation over time’.

## 7.3 Experiences with Reiki

### 7.3.1 The Reiki energy

Reiki has been described as energy medicine practice (NCCAM, 2006, p. 1) and it has been claimed that both the practitioner and the recipient can feel the energy (L. Barnett et al., 1996; Stein, 1996). Also, the advent of advanced electromagnetic recording equipment has confirmed the fact that energy generated within the body can be transmitted beyond the physical limits of the body (Oschman, 2000, 2003). However, participants in this doctoral study reported diametrically opposite views about the existence of Reiki energy.

One participant said, ‘I can feel it buzzing around or in me all the time’ and reported that they could feel the energy in their hands but could not feel that they had received Reiki. Conversely another participant said that they couldn’t feel the energy and therefore felt that they were not as good as the other participant. Several participants spoke about the sensation of heat being associates with providing Reiki. One reported that their son had said ‘Oh … your hands feel really warm I can feel them through my clothes’ while another reported that, ‘one of the residents said that my hands were really hot but that’s about it’, and a third added, ‘my whole torso heats up and then I have to stop’. A fourth participant reported that ‘some of the residents say I have got really hot hands and that sometimes they do feel like they are boiling’. One participant said, ‘I provided Reiki for one staff member who had a headache and she said that she was getting hot feet’ and another commented:

> Today, my hands were freezing like ice, but as soon as I put them on [a resident] she said that my hands were hot but to me they were cold, freezing.

One Group 3 participant said, ‘I seem to tire very easily’ and then, in response to a direct question, added, ‘I’m not sure [but] I feel that maybe I might be giving too much energy to them when I need it’. Another participant added, ‘with one older lady here I feel as if I am taking on all of her ill feeling or concerns. I am not sure’.

Non-participant staff members in the Group 1 facility suggested that, because the Reiki practitioners were relaxing people and 'sending them to sleep', they were taking away the recipient's energy. Also, in Group 3 one participant said, 'sometimes I feel like I'm taking all their energy and it's leaving them and coming to me' and another reported feeling discomfort in certain parts of their body and subsequently found that this corresponded to problems that the Reiki recipient was having. The issue of possibly drawing energy out of people was supported by one of the participants who commented that:

> One of the things that people say is, "Are you drawing the energy out of me?" They think that I am taking their energy away because they get so relaxed. I say, "No, I'm not doing that."

A Group 3 participant was concerned that, 'if I am feeling stressed, will that interfere with whomever I am doing Reiki on or not?' And a Group 2 participant said, 'as soon as I touch someone I heat up' and, when asked if this was a problem, responded:

> For me it's a problem. It just makes me too hot and feels like I'm getting hot flushes. I don't like that because I am too young for that. But I'm just constantly hot every time I touch someone.

After having received Reiki from the student participants during the Group 1 training, one non-participant interviewee commented that the energy 'wasn't [the students'] but they were able to transfer it and that the energy was different from each person' with some hands feeling 'cool' while others were 'very warm' but both provoked 'a wonderful feeling, elation almost'. They concluded by saying that the training day had 'reinforced what [they] already felt and [had] given [them] more confidence [in their own] ability to be a conduit for the power that is there'. Another non-participant attendee at the training also accepted the training master's invitation to receive Reiki from the trainees. They felt that 'it was really useful to spend so much time [receiving Reiki] because it did give me the opportunity to get a sense of what Reiki might feel like'. They were also 'incredibly surprised that people who were absolute novices were actually having an effect on me so quickly' and added that, although he 'felt really privileged, the experience seemed to go beyond the privilege of just having a lot of people attending to [them] and there was something more about it'. In fact, they said that they 'could feel things that [they] wouldn't have expected from just having hands laid on'.

Conversely, one participant believed that, 'the power to have energy flow through you, is not something that a human can do' and indicated that they had not considered having a Reiki session or asking one of the participants for Reiki. They also spoke at length about not believing in spiritualism, life after death, reincarnation and Armageddon

concluding, ‘I don’t believe in it. That’s why it has been very hard for me to try and get over these hurdles with Reiki’.

### 7.3.2 The effects of providing/receiving Reiki

Group 1 participants variously reported about a resident who was having nightmares said that their feet got warm and then fell asleep while being held and given Reiki, putting an alert, talkative resident to sleep after five minutes of Reiki, making a colleague feel relaxed, being less ‘agro’ after providing self-Reiki and the soreness in a participant’s legs and an upset stomach disappearing after providing self-Reiki. Also, a Group 2 participant said:

> I have been trying it on my youngest. He was upset so I cuddled into him. He fell asleep for two hours then woke up like nothing had happened. I also did it another time and within five or ten minutes he was happy go lucky like as if nothing had happened.

While another reported having used Reiki:

> On a number of residents and some have shown changes while others haven’t. There is one lady here who I tried it on and she ate her breakfast, which is something I could never get her to do. When I applied Reiki she became quite relaxed.

All Group 3 participants reported feeling personally more relaxed. Additional comments included ‘people [receiving Reiki] look more relaxed … [but] … it is better when somebody can tell you what’s happening’, ‘if (name removed) is quite agitated and continually calling out, I seem to be able to just put my hand on his forehead and he relaxes’ and ‘there’s a lady here [who is constantly] moving around and fidgety. When I put my hand on her shoulder or her forehead she just relaxes’.

Contrary to these experiences, one participant reported that, after an early session of Reiki given by a colleague, they could not concentrate on their bookwork. Therefore, they were now choosing when to have Reiki because ‘it could be a problem when you need to be alert’. In addition, one participant spoke at length about the need to be comfortable when providing Reiki. They said:

> I can’t say I get the same reaction when I do it myself as when [my colleague] did it [to me]. Perhaps, when providing Reiki to residents, you are not fully comfortable. … I can’t do it for as long as I would be able to do it with someone on the table and I was sitting or standing comfortably [with the massage table at] a good height. … In the nursing home you have to sort of lean over somebody [and] can’t actually get as up close and personal as you would like. You can’t rearrange the resident, as you might want.

A Group 2 participant said:

> The last time I did it on a resident I had one hand on him all the time and the other one soothing him, which I had never done before. I found that relaxing and he relaxed within five minutes [when] he is [usually] very good at yelling. That felt good, and I realised it was working.

And, after a discussion between two participants, one concluded, ‘we are having the same result for the same person. She is highly receptive’. In a similar vein, a Group 3 participant said, ‘I use it mainly to relax [residents], … to stop anxiety, … to settle them down and … to try to calm them down’ and another commented, ‘If I do resident’s nails I try to keep their hands in mine a bit longer [while] thinking about Reiki.’

One Group 1 participant said that they felt drained and flat for several days after the Reiki training while another commented that they had a headache for a couple of days when they didn’t normally get headaches. However, in response to a direct question during a Group 2 meeting, there were only positive responses, including, ‘not to my end, I was very relaxed and tired. I felt good. I felt really relaxed. Really, really relaxed like nothing would worry me. Really tired and relaxed’. Also in response to a direct question, one Group 3 participant said:

> Not straight after but I did feel sick for a week. I felt like I want to vomit in the morning and had little headaches. I don’t know whether it is related or not.

In my experience as a Reiki practitioner, these apparently negative experiences are perhaps indicative of a possible ‘cleansing’ period that can last for three weeks after Reiki training. This is an issue that is explained to people at Reiki training.

### 7.3.3 Calming/relaxing nature of Reiki

Participants variously made a total of 15 comments about the calming/relaxing nature of Reiki for themselves and others. Examples of these comments included ‘[I am a lot less] cross and crabby’, ‘Reiki is calming for myself, and the person getting it – particularly my daughter’ and [I put my hand on the head of a resident who normally] doesn’t want to eat [and] after about five minutes [he] opened his mouth and … ate breakfast’.

One participant said that, after self-Reiki, they felt more relaxed and slept better. Also, their spouse had become less nervous after receiving Reiki and passed an examination, which they had failed on three previous occasions. Another participant recounted providing Reiki to a resident who was ‘terrible for getting her blood taken [because] she likes to take the tourniquet off’. When this resident was given Reiki, ‘she sat through it the whole time, didn’t flinch, didn’t tap her feet like she does and didn’t take the tourniquet off’. A third participant spoke at length about using Reiki on a resident with both Parkinson’s disease and dementia and an incident when:

> One afternoon he was really unsettled and there were three carers and myself trying to get him to just stay in the bed, so I started to do Reiki on him and, although it wasn’t magic, it helped him [calm down].

This participant added that, following this incident, ‘every afternoon I’m on, he asks for me to come and put him into bed because I give him Reiki’. In relation to people with dementia, one participant said, ‘even though they can’t tell you, you can see them relaxing by their movement of their hands or their head’. Another participant commented that they had not, ‘done much at all really except to sit … holding their hands and they felt calmer when I was doing that’. A Director of Nursing, who had not been trained in Reiki, supported the concept that Reiki could induce sleep. She reported that, following a three-month trial, sleep charts indicated that the ‘people [receiving Reiki] actually settled and went to sleep better … and we were using less sedation due to the Reiki’.

Group 1 participants registered surprise at being able to relax a recipient, being so relaxed after receiving 15 to 20 minutes of ‘beautiful Reiki’ from a participant colleague that ‘it was difficult to concentrate on my bookwork’, the ability to feel the energy, the ability to put an alert, talkative resident to sleep by providing five minutes of Reiki and novices having an effect. Comments made by other people associated with the research have indicated that novices in Reiki practice can indeed have a positive effect. After receiving Reiki as part of the Group 1 training session, the university senior lecturer expressed surprise that ‘absolute novices’ could have an effect ‘so quickly’.

### 7.3.4 Potential for Reiki to ease pain

During the second interviews, an example of Reiki’s potential to ease pain provided included the participant who had described the effect of Reiki on a resident with Parkinson’s disease adding that the major effect on them personally was that ‘it’s nice to know that I can help somebody even for a little bit, to take their pain away, to help them to settle and be comfortable’. This participant also described a time they were ‘suffering with a really bad migraine at work’ and was contemplating going home because ‘I wasn’t being functional to anybody’. One of the other participants provided a head massage and Reiki thus enabling the participant with the migraine to remain at work because it was like ‘being in another world and was just bliss[ful]’.

Another participant commented that, when they were ‘feeling sick in the stomach’, they provided self-Reiki after which they had been able to enjoy a full meal. This participant also used self-Reiki when they had a headache and a neck pain and reported that, since starting Reiki they had had no problems with their ‘restless legs’ or pain from their ‘plantar fasciitis’ (an inflammation of the fascia of the long ligament under the foot). A third participant spoke of providing Reiki on his or her own throat to assist with breathing when it became difficult.

During the third interviews one participant, who had reported at the second interview that they had done very little Reiki, was now working in conjunction with another participant to provide Reiki to a resident with dementia, Parkinson's disease and pneumonia when they were agitated after returning from hospital. Another participant, who was using Reiki intensively at the time of the second interview said, 'sometimes I forget … [and a] … situation might come up [where] I think afterwards, oh I could have done some Reiki'. However, they were still maintaining the recording book commenced following the Reiki training. A third participant said that other staff members 'keep coming back for more [Reiki]' while another commented:

> [When I'm giving a massage] … I might just stay a bit longer, take a bit extra time without thinking I'm doing Reiki … I'm just not aware of it … I'm not sure how good I am but anyway I still think it's good.

Examples of positive outcomes when providing Reiki for residents included easing an individual's pain, calming residents so that they would eat their breakfast, calming a resident who was normally uncooperative when having a blood test, inducing sleep in residents who normally had difficulty sleeping and calming a person who had both Parkinson's disease and dementia who then repeatedly asked for the participant who had provided him with Reiki.

### 7.3.5 A recipient refusing Reiki

During the mid- and end-of-project meetings participants spoke about times when a recipient had refused the Reiki energy. In one meeting a Group 1 participant reported giving Reiki to their granddaughter who had sinusitis and a high temperature. They were asked to stop providing Reiki and the participant thought that the Reiki might have been adding to the temperature. In response to a direct question in one meeting, three Group 2 participants indicated that people had refused Reiki. Then, when asked how they knew that people were refusing it, one participant said, 'because I didn't feel any heat I didn't heat up myself it only works when I heat up'. Another participant commented that, 'there are a few residents I just have to let go. I just can't do it'. At the other meeting a Group 2 participant said:

> I started on my eldest son just mucking around to see if I could do it. I got about half way and he started getting fidgety, talking and mucking around so I just stopped. It didn't feel right I suppose so I stopped. By the time I got down to his lower back he had [had enough].

Also in response to a direct question in one meeting, a Group 3 participant said, 'Yes. And it has been on the same person. One time it worked on him and he calmed down and the second time he wouldn't'. At the other meeting, one respondent reported that a

resident had verbally refused Reiki and another indicated through their body language that they did not want it.

During the second interviews, three participants reported that some residents indicate that they did not want Reiki either verbally or non-verbally by 'pushing or slapping' the Reiki practitioner's hands away. This confirms the need for practitioners using Reiki for people with dementia to constantly monitor the recipient's body language because people who do not have the necessary verbal communication skills 'will quite often wriggle and squirm and will pull away. So it is their physical way of saying no I don't like [Reiki]' (Webber, p. 104). Observing and responding to the client's body language was in accordance with normal practice in aged care.

### 7.3.6 Being unsure if they had done any good

During the first Group 1 meeting, participants spoke about a resident who was taken to hospital after being given Reiki. He was having seizures at the time and, after Reiki, he seemed to be reasonably calm but, as the ambulance people took him away, he had another seizure. The participants wondered if Reiki had caused the seizures. At the other meeting, a participant reported that, when providing Reiki for a colleague, 'she said she could feel the warmth and things like that but I don't know that it actually did anything for her'. At this point the other participant commented, 'Yes but she might need a few sessions … she's been agitated for forty, fifty, sixty years it's not going to just disappear in two minutes is it?' This comment supports the proposal that using a little Reiki often, as recommended by Ellyard (2002) should be better than using a lot of Reiki seldom.

During the first Group 2 meeting, one participant reported:

> There was a gentleman who is no longer here that I tried Reiki on. He was quite relaxed at the time but after I left he attempted to break out [of the home]. I believe he had a fall outside and he had to go to hospital. Because he is no longer here I don't know if the Reiki had a positive or negative effect on him.

At the second meeting, a participant said:

> [If I am] talking to them and engaging them then, if they do calm, if they are responding to the Reiki, I would very easily laugh it off as just interaction which most of the residents are craving.

While another said, 'I can't call myself a sceptic, but I can't identify [a] result with Reiki or if it was because of interaction and personal time. I can't'.

At the first Group 3 meeting, participant comments included 'because some residents can't speak you don't know [if you are doing any good]' and 'it's actually better when somebody can tell you what's happening'. At the second meeting, a participant said, 'when I've got my hand behind their back as I am [walking with] them I [sometimes]

feel like I'm doing something. But then I don't because [it's too short]' and another reported, 'when I think about it, maybe I do [Reiki] without really thinking about it [when] I hold their hands longer or put my hand on their shoulder longer'.

During the interviews, a participant said, 'I have a sensation that what I am doing is not correct' and concluded, 'because I think I am still learning, I'm so scared that I am going to do it wrong'. Another participant reported that a resident 'told me to take off my hand [because] it's too hot' and a participant who reported using Reiki on residents with Parkinson's disease said, 'I've had to let them go because it got a bit too much [and] they started shaking a little bit more than normal so I stopped'. This participant also stopped providing Reiki if 'I'm not getting hot [because it is] obvious [that] they are not accepting'.

### 7.3.7 Difficulties experienced when providing Reiki

It is possible that individual participants may have experienced a wide range of doubts, difficulties and successes in implementing Reiki because:

1. By the time of the second interview, with only between six and eight weeks' experience in implementing their new skills, participants were all still extremely inexperienced as Reiki practitioners and novices in any discipline may have doubts about their ability to implement their new skills.
2. The effect of Reiki is paradoxical in nature (Engebretson & Wardell, 2002).

Although, during the second interviews four participants reported that they had not encountered any problems other participants did experience an array of doubts and difficulties. During both the group meetings and the second interviews participants variously reported difficulties such as needing to find a quiet or comfortable place in which to do Reiki, the adverse physical conditions such as beds being at the wrong height and rooms being cluttered; needing more time to provide Reiki, a person with dementia not being able to report what is happening when being given Reiki and medication use with Reiki.

#### *Needing to find a quiet, comfortable or appropriate location for providing Reiki*

One participant variously said 'I find that, when I do it, I like a quiet room. I can concentrate better than in a noisy background for some reason'. Another said, '[I need] quieter surroundings [because] there are too many distractions'. And a third:

> I do need to concentrate. I don't need to go into a trance or anything, but I need to concentrate on what I am doing because I want the resident to get the best outcome that can be achieved for them.

A Group 1 participant said 'I have to be really comfortable to do it'. They also commented, that when working on their daughter's foot, they should have sat on the couch and put the daughter's foot on their knee 'but I was stood on the floor leaning over'. Another participant talked about the fact that, when the clients were in bed, the carer needed to bend over so 'it's hard on the back and added, I thought … I should have got into a better position first'. It was concluded that, 'it's not always possible to do exactly the right position you want'.

However, a participant who spoke about beds being at the wrong height said, 'I haven't really been following any of the usual positions that were in the training manual'. Instead they adapted their practice because:

> Without thinking about it, I just was doing it how it was easiest to touch somebody. So I have been either using one hand or just putting one hand on the head and one hand on maybe a leg or somewhere else.

In contrast, a Group 3 participant thought, 'one hand is not really good'.

A Group 1 participant wondered if it had been appropriate to hold their brother's thumb and provide Reiki in public at a wedding. In response to a direct question, one Group 2 participant indicated that providing Reiki in a resident's room was difficult because 'I'm in a different state of mind in work mode. It's hard to get into being relaxed and giving Reiki'. However, One Group 3 participant reported that, 'mealtime is the easiest time for me to do Reiki. Generally I put my hand on their shoulder' while another thought that 'I find it easy [to give Reiki when] I give them a bit of a hand massage. Then we really connect a bit more and they really relax' and a third, '[working in a nursing home] is not ideal [compared to having] a portable table which you put it in the best position'.

These comments suggests that Reiki training for carers of people with dementia must concentrate on how Reiki can be used rather than concentrating on the 'traditional' hand positions.

***Needing more time***

During the mid-project meeting, a Group 1 participant said, 'it's hard to get the time to provide Reiki' while another did not know for how long to provide Reiki. Also, although one participant's mother-in-law who had dementia seemed to calm down, the participant thought that it needed more than the five minutes available. The five participants present at the beginning of the Group 2 meeting agreed that finding time was difficult with one saying, 'I haven't had very much time to work on the residents … because we are always in a hurry. Quick, quick, quick'.

At the end-of-project meeting, Group 2 participants' comments included it is 'difficult to find the time, it is difficult to find time to concentrate and do it' and

> For me, as a person who is trying Reiki, I don't think five to ten minutes does very much at all. In my opinion, it's got to be something like half an hour to get a definable result.

During the second interviews, participants also raised the issue of needing more time with one saying 'it is very difficult especially if you are having a busy morning' and the other that it is 'my personal finding, belief, that it takes more than five to ten minutes to have a … positive effect' and that, in a nursing home situation, 'it is quite pressurised for time'.

As with the comments about needing to find a quiet, comfortable or appropriate location for providing Reiki suggesting that Reiki training for carers of people with dementia must concentrate on how Reiki can be used rather than concentrating on the 'traditional' hand positions these comments suggest that, during training, more time should have been committed to discussing the use of Reiki as a PRN therapy.

### *A person with dementia not being able to report what is happening when being given Reiki*

A Group 1 participant said:

> Most of the people that we [work with] have got dementia … so they don't know they are getting Reiki and … don't actually tell us what they are feeling or how it affects them. So really we are only going on … our observation …

This comment from a participant has confirmed that carers are able to observe their clients' body language and react accordingly. It is consistent with a finding from my MSc research that, when asked about providing Reiki to people who do not have the necessary verbal communication skills, a Director of Nursing indicated that it was necessary to closely observe the resident's body language because they, 'will quite often wriggle and squirm and will pull away. So it is their physical way of saying 'no I don't like [Reiki]).' I was criticised by examiners for making this statement in my MSc thesis (Webber, 2006, pp. 82-83). However, this is why participants in this doctoral research project were instructed to observe the recipient's body language and immediately cease providing Reiki if the recipient is demonstrating that they do not want Reiki.

### *Medication*

During either the group meetings or in an interview, three participants spoke about medication and Reiki. One commented that 'one of the residents has quite a large dose of medication that will sedate him so it seems that it far outweighs what I can do to him'.

Another said, Reiki 'doesn't do anything for anyone on a high dose of morphine and it doesn't help boredom' and the third:

> It wasn't worth giving Reiki [to one resident] because the level of medication was affecting the outcome. You might say it's a catch 22. If you are doing more and more Reiki, they might have less and less medication, but with him I think it's gone beyond that point and I think it's too difficult.

One participant thought that 'nearly everybody in [their] facility would have medication to keep pain under control' but 'sometimes they might have breakthrough pain so then they get extra medication'.

### 7.3.8 Other experiences when using Reiki

During the second interview, one participant supported the idea of being able to help residents by saying, 'I like the way it gives me something to really help the residents'. Another participant reported that they were:

> Being a bit more proactive in other things because I have actually done something I should have done six or seven years ago and didn't get around to doing. But I was unsure if this was because my mind has got more clarity'.

However, this participant did not elaborate on what the issue was. Another participant said, 'the residents do tell me if my hands get hot [when I am providing Reiki]'. A third participant said:

> I can see a positive result but I am not sure how much I can attribute to Reiki and how much I can attribute just to personal touch and time because I've found that … most residents absolutely crave emotional touch and caring [in order to] believe they are still important people and most of them don't get that.

This participant was also unsure if it was Reiki or the 'trust factor', which enabled a resident to:

> Calm down very quickly … there are some people who realise, or seem to realise, what you are doing with the Reiki. Whether they identify it as Reiki or not, they know they feel better.

One participant said, '[when] I was feeding a resident breakfast, I put the rails down and sat next to her on the bed. I just started heating up which [had] never … happened [before]' while another participant reported giving people Reiki when providing a massage or nail manicure. A third participant reported the 'need to close my eyes' as well as seeing 'colours'. In addition, they said, 'once or twice … one hand felt warmer than the other'. Following contact from me to arrange a third interview, one participant said that they had 'been thinking about' whether they had in fact been using Reiki and commented:

> My logical response would be I don't think so but when I stop and think about it probably more on an unconscious level. I never got it quite clear in my head whether it had to be a conscious decision, 'I am going to calm this person I am going to make this person feel better through Reiki' or whether it would happen spontaneously without thought that [with me] just … being with them [and] touching them there is some transfer of whatever. On that level then I suppose I am [using Reiki].

This participant added:

> I don't consciously separate the difference between Reiki, yoga, meditation, … yoga, [and] even pilates in that I don't find them terrible different so it's one of those things. I find [it] difficult to evaluate what part is working.

### 7.3.9 How participants felt when providing Reiki

During the second interviews participants reported a range of feelings, which they had experienced. Five participants variously reported feeling good, peaceful, very calm, relaxed or tired. When asked about the tiredness they had experienced, one participant said that it was:

> A good tired, a calm tired. Not stressed or anything. I walk away feeling good [and] relaxed. If somebody came up and screamed at me it wouldn't worry me as before [I learnt Reiki]. It might get my back up a bit but I'm calmer [now].

Another participant said that, when providing Reiki, they felt 'definitely more peaceful [because] you can't really be giving this presence to someone … and not feel it yourself'. A third commented that it was 'good to have a tool [which could help residents]'. Five participants reported being able to feel the '[Reiki] energy' or 'heat' in their hands, face or chest and another participant felt that it was 'miraculous' and 'totally amazing' but wondered if they 'might be obsessing'. Another said 'it's beneficial for me that I take five, ten minutes to be quiet with somebody'.

To the contrary, one participant said, 'I don't know if it's working or not, because my hands don't get hot. I don't heat up or feel tingling. I don't really get any signs of it'. Another participant commented, 'originally I thought it was draining me a bit'. Despite their colleague and daughter reporting that they could feel warmth coming from one participant's hands when they were providing Reiki, the participant said, 'I don't actually feel the energy and I can't sense the heat'. They added, 'but I do feel like an empty channel'. Another participant commented that:

> Sometimes it makes me feel a bit tired [but, because] I know that it makes me feel tired I always leave it to the last when I've done everything that needs to be done.

This statement indicates that even newly trained Reiki practitioners are able to adapt their procedures to accommodate individual differences rather than simply adhering to a lock-step method of providing Reiki.

### 7.3.10 What makes Reiki different from other therapies

The participants had very little experience with other complementary therapies and two of the participants said that they did not know what makes Reiki different from other therapies, with one adding, 'because I have never tried any others'. However, one participant said, Reiki 'makes the residents a bit calmer than [just] cuddling them. I think they just enjoy it'. Another participant thought that Reiki was 'more gentle and soothing' than massage with their physiotherapist (which they liked). A participant felt that they did not have to put any pressure on themself as they had to with meditation because 'there is no stress, no premeditation, you just do, you just ... are'.

One participant thought that, compared to aromatherapy or music, Reiki 'was more personalised, because anybody can put some music on and walk out of the room. Anyone can light … smelly oils and walk out of the room'. But 'Reiki is more personal because you're doing something to somebody else'. Another participant commented that, compared to 'aromatherapy', which is 'mental', Reiki is a 'hands on' therapy. It was also suggested that Reiki might be 'perfect for the older people' rather than too physical a massage.

### 7.3.11 Were their expectations about Reiki fulfilled

Although, as will be seen in the discussion that follows, some qualified their comments, 10 of the 16 participants (62.5%) who completed the second interview thought that their expectations had been fulfilled. Of these two participants thought that they would either like to learn more or to practise more while another participant said, 'it's a good start I suppose' and a fourth said, 'I didn't really have any thoughts about what to expect, [however,] I [now] know that Reiki can do things; maybe I am expecting it to do more'. One participant said, 'I guess some …[I'm not] an expert [but still] only [a] new [Reiki practitioner]' while another said that 'a thunderbolt would be handy' but then, contrarily, proceeded to describe how self-Reiki on a cramped leg muscle was:

> Close to a thunderbolt. I had done all the normal wiggling, moving, stretching it, all of those things but it just kept coming back so I just clamped my hands on the affected muscle and it was like flicking a switch. That was pretty close to a thunderbolt.

A participant who initially 'knew nothing about' Reiki felt that they had learnt something which could benefit residents, 'especially … my resident who has Parkinson's disease [and that] this resident, and Reiki, and I, are a team'. Another participant who 'wasn't sure what I was expecting in the first place' and was 'sceptical' said, 'I just feel like I am relaxed with it'. Of the participants who thought that their expectations had not been fulfilled, three indicated that they would like to learn more about Reiki with one saying

'having a bit more follow up would be nice'. Of these one participant felt that their expectations had not been fulfilled:

> totally yet because I would like to practise a bit more. I would like to do a lot more and to find a 'victim', probably one of my daughters and Reiki her on a regular basis … [I would like to] … see a gradual, or an immediate improvement, and … to relieve someone of something that has bothered them.

Another said bluntly, 'not yet' while a third said:

> I never had any expectations from the first and there has been no great difference from when I was first introduced to it. I am not sceptical about it I'm sure there is something to it but I just haven't found it.

It is understandable that the newly trained Reiki practitioners reported a wide range of experience with Reiki and understandable that they would vary considerably in their perceptions regarding the fulfilment or otherwise of their expectations for becoming involved with the project. I would be highly sceptical of the results if this were not so.

### 7.3.12 The attitude of other staff members towards Reiki

Participants variously reported that the attitude of other staff members towards Reiki ranged from 'scepticism', to 'acceptance' (and even 'asking for' Reiki), to being 'humoured by it', to thinking that 'it's a load of rubbish' and to being 'a bit funny about it'. One participant reported that their Site Manager had 'really embraced' Reiki and provided them with a book in which to record the use of Reiki. The aim was to see if Reiki provided positive benefits 'over a period of time'. The participant reported that, in addition to having provided Reiki for another participant, they had given Reiki to one of the other night staff members. They also indicated that another staff member 'was most amazed when I gave Reiki to one of the ladies, who fell asleep within about three minutes, [and this] had never happened before'.

Another participant thought that the other staff members 'don't seem to mind', but there was one non-participant staff member who used to work in an establishment outside of Australia 'where everyone did Reiki and … relied solely on and completely on it' so they were 'sick of it up to here' and 'didn't really want to hear too much' about it. They added, 'you get sick of people talking [continually] about … whatever trolley they are pushing'.

A participant said that, one staff member who expressed 'mild scepticism' about Reiki also expressed the same feeling about aromatherapy. In one of the facilities, other staff members used to 'poke fun' at, and 'rib' the participants when they 'first started' but now 'they are quite good about it and ask for Reiki'.

## 7.4 Why individuals volunteered to participate in the project

Repeated re-readings of the first interview transcripts indicated that there were five main reasons why individuals volunteered to participate. These were management asked them to participate, to see if something different could work, to help residents, to learn something new and personal reasons.

Eight people reported that they were participating because management had asked them with one saying 'management thought it might be beneficial for me to attend the course'. Six participants felt that Reiki was 'something new' or 'different' for them. One of these 'wanted to see what Reiki was like and see if it works' while another was 'intrigued' and a third was 'willing to try anything to see if it works or not'.

Five participants indicated that they felt that Reiki might help residents. Of these, one thought that it might help them to 'relax and be more cooperative when it was necessary to perform tasks such as [changing] continence aids [because, when] they are being difficult and won't help … it's almost impossible to change an aid'. Another said 'it will help our residents, whether they are dementia residents or our palliative care residents, other than shoving chemicals into them'.

For four participants, participation in the project was an opportunity to 'learn' as much as possible. Of these, one participant said, '[Reiki] sounded pretty interesting so here I am'. Another commented that 'no learning is a waste' while another 'wanted to extend [my] knowledge base [of] the life flow'. This participant added:

> I'm exploring the flow of Chi in [the] body; the life force, because I have been reading [as well as] listening to Deepak Chopra and reading his books and I believe that there is a flow of life through everything so I want to extend my knowledge base.

Three participants had personal reasons for participating. Of these, one participant thought that their involvement would open a 'door of opportunity [that might] benefit [me] personally' while another thought 'I guess it's a way of possibly relaxing my stress levels'. The third:

> Wanted to do the course because I like Reiki [and other] alternative therapies. I don't like to take medication myself so I like to find something else. I like to do a lot of aromatherapy on myself as well.

## 7.5 Expectations of the research project

Individual expectations included learning something new, learning Reiki and being able to do something that might help people become calmer, mitigate their pain and therefore, assist things to run more smoothly. One participant wanted to learn something that could help a 'very young [person with] advanced dementia and extreme anxiety. [So], if I

could make that person's life less anxious, it would be worthwhile'. Another participant said:

> I just want to see where it leads. I just want to know what effect this would have on a resident with dementia. Residents with dementia are not rational thinkers, they think irrationally, and it would be interesting to see how this works on a resident who is irrational.

A participant repeated the desire to be able to use something 'other than the chemicals and drugs that we give to our residents to help them relax'. Another participant wanted to be able to 'get rid of the pills, Panadol and all that stuff'. One participant wondered if Reiki could help their children while another though that if Reiki could 'benefit my co-workers, or myself as well, then that's an extra bonus'.

Four participants said that they did not know what to expect. One was 'not quite sure because I don't know what Reiki is so I'm not too sure what to expect' while another didn't know because 'I just got selected to do this' and a third thought that 'it depends what we are going to learn'. The fourth said, 'I don't really understand what it is at this stage I don't really know'.

## 7.6 Personal circumstances

### 7.6.1 Health issues

***Health issues reported at the first interview***

Four of the participants reported that they had no current health issues while four participants reported having high blood pressure. Three of these indicated that they were taking medication and one of these participants thought that their high blood pressure might be a result of their 'excitable nature' while another reported having 'high blood pressure, high cholesterol, and high sugar'. Four participants were cancer survivors and three of these had undergone radical surgery. Another two participants reported that sore shoulders were a problem and one of these also reported 'occasional headaches'. In addition, one participant had seen a physiotherapist for minor foot problems. One person reported having had mild asthma for some time (possibly because of an allergy to dust mites) while another indicated that weight and heart palpitations were a problem. Another commented that 'personal backache' was a problem 'because I have a lot of old injuries and work just aggravates them a little, but I don't let it worry or stop me' and one participant did not want to comment.

***Were there any changes in health issues?***

At the second interview, one of the participants with high blood pressure said that their medication had not been changed. Another said, '[my] doctor has put my blood pressure

tablets up a bit for which I am a bit disappointed but it is still negligible' and reported that they had resumed bike riding but this had not affected their asthma. The participant who had indicated at the first interview that 'weight and heart palpitations were a problem' said that they had lost weight (but 'temptation gets in the way') and that:

> The palpitations, come and go, but it's not as severe as it was before we did the [Reiki] training. I had a bout before the training started and I haven't had a serious bout since. I'm not saying that's relative to Reiki. I think that's more because I've dropped a few kilos.

Another participant, who had back and neck pain with resulting migraines and was regularly receiving distant Reiki from a Reiki practitioner not associated with the project, said:

> My back hasn't hurt for a few days. My neck hasn't hurt as much. I haven't had a migraine and I haven't had a headache this week, so I'm feeling good at the moment.

One participant who was due to have radical surgery said, 'I do Reiki myself sometimes now [and] it's been very nice'. Another participant reported feeling much more relaxed and said that their anxiety problem was much better but was still a problem in large groups. At the third interview, a participant reported that, because of improved health, they had been able to increase their workload.

### 7.6.2 The most significant problems in their daily work

The most significant problems reported by participants can be grouped into five sub-themes of Commitment and attitude of other staff members towards quality aged care, Residents' health and behaviour, Time management difficulties, Assisting residents with Activities of Daily Living (ADLs); and Other issues.

***Commitment and attitude towards quality aged care***

Participants across groups spoke about a number of staffing issues that caused them concern. A number of individuals had raised these issues with management, so to avoid possible identification of individuals, the following points are summaries of comments made by participants.

- ☆ A lack of communication skills among some staff members.
- ☆ A lack of respect from some younger staff members towards residents.
- ☆ New staff in senior positions not knowing routines and therefore, putting more pressure on the Personal Care Workers (Patient Care Attendants).
- ☆ Nurses who appear not to have had any personal care training so they are more rigid and make residents more annoyed than they already are.
- ☆ People from non-English speaking backgrounds not completing paperwork.

- ☆ People who were only working in aged care because it was easy to obtain employment in the sector.
- ☆ People working only for the money.
- ☆ Staff having additional workloads when 'slack' carers don't do their work properly.
- ☆ Staff in senior positions who are stuck in a rut and stuck in a routine where everything has to be done by the book.
- ☆ Staff members who don't want to help others.
- ☆ Staff not having had adequate training.
- ☆ The lack of empathy to residents shown by some staff members including people from some non-English speaking backgrounds.

### *Residents' health and behaviour*

#### Resident behaviour

The majority of participants indicated resident behaviour was a problem. However, two of the participants thought that resident behavioural problems were only minor with one saying that carers have 'to live with' the problems. One participant said, 'a lot of residents just don't like to be told when to do something or when they need to get ready or whatever' while another participant had problems:

> Dealing with some frustrating residents because, at times, some can be very difficult [particularly] when they don't want to have their ADLs [Activities of Daily Living] done, and they are yelling, hitting out, in pain.

Another participant felt helpless and sorry because 'people with dementia cannot express what they want or they do not know what they are doing' and wished to 'help [residents] to overcome such situations'. Although this participant tried to redirect the residents, they still felt 'utterly helpless' some days. Other participants reported having difficulty with: residents continually repeating themselves because they are 'forgetful'; residents who 'just want to lash out at [or] grab the carers all the time'; residents with 'dementia [who] can be aggressive if they don't want to get up or do what they are told'; and 'some … residents [who] can be impossible to handle' or become 'a little bit aggravated when you are trying to do their ADLs such as showering, undressing or changing their pads'.

One participant spoke about the 'confusion' that comes with dementia and gets worse as the dementia progresses and another the 'unacceptable toileting habits', which might possibly cause people to be admitted to a nursing home because home carers can't 'put up with' their poor toileting habits.

#### Sleep patterns

One participant who worked the night shift, talked about 'keep[ing] people comfortable so that they can sleep' as being a problem because, 'if they are not sleeping [they] are able to walk around [and] walk into other people's rooms and wake them up'. The issue of people wandering at night was supported by another participant who spoke about wandering residents going into people's rooms and the potential for self-harm or harm to others being of major concern. They felt that residents had a right 'to their gentle sleep [and] to be protected'.

It was also suggested that, if residents with dementia are put to bed around 7:00 to 8:00 pm ('as they often are') then they have had a full night's sleep when they wake between midnight and 1:00 am. When this occurs, some staff members feel terrible that they have to make the resident go back to sleep.

***Time management***

For five participants, 'time management' was a problem. One participant commented that 'there is an expectation of what tasks will be completed by what time and that sometimes does not allow as much interaction with the residents as I would like'. While another said:

> On a number of shifts, which I work, we have more residents to attend to than in the other areas so we try to attend to their ADLs as quickly as we can. However, at times it gets very hard because there are a number of residents who need attention at the same time and it's very hard to attend to one resident and then tend to another resident at the same time because there are a number of doubles (which means it requires two carers to attend to that person's ADLs). If you have three people who require assistance at the same time it's very, very difficult. In the area I work in there are an extraordinary number of residents who require two people to help them so it's very hard to work out the times.

A third participant commented, 'not having enough one on one time which is not fair but that's reality'. And another participant thought that: 'paperwork, paperwork' was a significant problem.

***Assisting residents with Activities of Daily Living (ADLs)***

In addition to the examples cited in the section above, examples of difficulty coping with ADLs included: attempting to get 'people participating'; the 'little things, which can happen throughout the day that can change a resident's behaviour' for the worse; and 'trying to get people up and mobile in the morning'.

***Other issues***

One participant spoke at length about difficulties encountered when changing continence aids. For another participant 'the real basic problem with work, is the lack of visible management' with the 'two top management' people and the 'clinical nurse' rarely on

site so staff members 'never get to discuss any issues'. However, 'when management is here everyone jumps to attention and things are done a little bit differently'. For a third person, coping with residents who were in pain was a major problem. When asked how it is possible to tell if residents with dementia are in pain, the participant said 'I know the residents pretty well and it is visible' and added:

> When moving them they will start groaning and making noises. Some of them just don't get out of bed because they are in pain. I always know when they are in pain.

In addition, one participant commented that 'morning [shift] was actually the most stressful, however, sometimes day shift can run smoothly' while 'on night shift everybody can be up ringing bells. So it just depends on the particular day'.

### 7.6.3 Coping strategies before the Reiki training

Individual participants reported a wide range of strategies they used for coping with the daily problems of their duties. These included: Calling for assistance; Re-directing agitated residents; Not hurrying residents; Knowing resident's individual needs; Talking with residents; Just getting on with the job; and Other coping strategies.

#### *Calling for assistance*

One participant spoke about asking family members to intervene to help residents because 'sometimes they are the only ones that [residents] will listen to'. Another participant reported telephoning for outside help when:

> A resident wouldn't let go of my wrist while I was trying to wash him, I reached over to this person's phone and rang his daughter who put herself on loudspeaker, spoke to him and told him to behave himself and to let go of me, which he did.

Several participants reported that they had called on another worker because:

> A different person with a different approach might be able to better connect with them than what I can which is fine as long as that resident is getting what they need, that's the main thing.
>
> *or*
>
> 'The resident' may not like me for some reason.
>
> *or*
>
> The RN [may be able to provide some] pain management [so I can] continue on with the ADLs, [however,] if they are in pain that much and don't want anything done, then I can't do anything.

One participant commented that, working well with a partner and 'having good rapport with your partner is very, very important'.

#### *Re-directing agitated residents*

Participants variously reported that they re-directed agitated residents by: 'changing the game resident's are playing; moving [another] resident's seat away'; trying to 'make

them laugh; or by removing [a] person' who might be causing the problem. A participant said that it was possible to leaving residents 'be' because:

> They are not hurting anyone. As long as their television is not too loud, leave them in their room and check on them to see if they need anything. Just be there for them and let them do whatever they want to do.

***Knowing resident's individual needs***

For several participants, knowing residents' 'idiosyncrasies' and respecting the individual's needs and/or wants was important because, 'even if a resident is completely demented they have idiosyncrasies. They have certain traits and it is those traits that you have to work on'. An example provided by one participant was of a resident 'whose time zones were completely switched around', and would become agitated if forced to sleep at night so:

> We had to make sure we kept her in the dark during the day so she could sleep and at night time we would set up a TV, a video and a lamp in one of the little lounges so it would be bright with reading books and things [for her to do]. We just thought that's her life and that's how she lives so we can't change her.

Another participant said:

> If [a] resident wants to sleep all day and have a shower at four o'clock in the afternoon or six o'clock in the afternoon, why does it have to be that carers have to get them up at six o'clock in the morning to have a shower and get dressed?

One participant tried to help residents go to sleep by keeping them dry, giving them something to eat, putting them back into bed, talking with them, and/or giving them a cup of tea, but not coffee (the interviewee did not say why they don't give coffee).

***Not hurrying residents***

Two participants commented that it was not possible to hurry residents because:

> With a dementia patient you cannot hurry them and sometimes it's difficult to explain why you want them to have a shower so you've got to go about it a little bit slower and differently than what you would with an average person.
>
> or
>
> You can't push anyone to do anything they don't want to.

Another participant would walk away, giving residents time to calm down and then coming back later 'to see if they have changed their mood' or avoid confrontation with a resident because 'the residents have their rights and if they don't want a shower or a wash really there is nothing we can do about it'.

***Talking with residents***

Two participants suggested that talking with residents was important because:

> You have to talk them through what you are doing step by step. We'll say "You're going to have a shower," but then they will forget what we are doing and then we have to repeat it again.
>
> or
>
> If a resident is getting aggressive towards me, I will try and speak to them in a calm voice, if I am not already doing so, and try and get them to relax. However, if none of this is helping, a cup of coffee will sometimes help.

Another said that when a particular resident was being violent towards the carer, simply saying, 'stop hitting me please' would often be effective because 'he never knew what he was doing'.

***Just getting on with the job***

One participant said that 'just do[ing] your job' was important. Another participant said 'you just do your job'. This participant liked 'to just get there and do my job and help the residents the best that I can because they are the most important ones'. Also, a carer who commented about a lack of one on one time said:

> You just deal with the problems … you just see something that needs doing and you do it but if, at the end of the day when I walk out to my car I can say to myself my residents were fed, they were happy, they were clean, they were dry, and they were safe I don't care about anything else.

***Other coping strategies***

One participant reported relinquishing personal time including tea breaks while another commented about not taking offence with 'a little bit of violence … because they don't know what they are doing'.

### 7.6.4 The most rewarding aspects of their daily work

Thirteen (81.3%) of the participants made comments that indicate that the most rewarding aspect of their daily work was simply 'being' with the residents, 'helping' them, and seeing them 'happy':

> Just knowing I am there for them. If they need a hug, that's fine. If I can help them, that's what I am there for. To treat them the way I would want my parent to be treated. Just to be there for them.

and that the residents deserve to be 'treated with dignity':

> It's nice to come in and let the residents know you treat them with dignity and respect, and that you listen to their stories so, at the end of the day, you know you've done the job and the residents are happy when they go to bed at the end of the day.

Of these, one participant thought that, during the night, when residents 'wake and ring the bell [because] they want to talk', it sometimes provides a little:

> Window of opportunity when you can talk or have a bit of a laugh with them whereas in the daytime … there are just too many people around trying to get everybody up and get them to their activities.

And another:

> The residents. They are the most rewarding part. Just to see that they are happy or that they smile. If they smile when you walk in their room that's what makes it all worthwhile.

One participant felt that the most rewarding aspects of their work was talking with other staff members and learning as much about them as possible. Another spoke about how residents remembering their 'name [and] something that [I've] said to them at some stage and being pleased to see … [me] … is good'. And one participant thought that the work was so 'rewarding' that they 'couldn't think of doing hospitality or anything else'.

## 7.7 Summary of personal changes, common work-related issues and changes in stress levels

A summary of reported personal changes together with common work related issues and changes in stress levels between the first and second interviews, has been presented in Table 7.1 and a summary of reported personal changes together with common work related issues and changes in stress levels between the second and third interviews, has been presented in Table 7.2.

From these examples it can be seen that individuals will react differently to the same stressors such as the commencement of the audit process and a resident passing away.

**Table 7.1 Summary of participants' changed personal circumstances, common work related issues, and change in stress levels between the first and second interviews**

| Participant[1] | Personal circumstances | Work issues[2] | Stress[3] |
|---|---|---|---|
| Between the first and second interview | | | |
| P 2 | • Blood pressure tablets increased slightly<br>• Resumed bike riding<br>• More relaxed at work | • None | 8 to 4 |
| P 5 | • Feeling much more relaxed<br>• Anxiety problem much better but was still a problem in large groups | • Accreditation<br>• Resident dying | 5 to 5 |
| P 6 | • Adult son living at home again.<br>• Having problems with the Immigration Department | • Accreditation<br>• Resident dying | 5 to 5 |
| P 8 | • Palpitations not as severe as it was before the Reiki<br>• No serious bout after Reiki training<br>• Lost weight | • Accreditation<br>• Resident dying | 2 to 5 |
| P 9 | • Receiving distance Reiki from a Reiki practitioner not associated with this project<br>• Back and neck pain reduced<br>• Sustained knee damage and due to see an orthopaedic surgeon | • Accreditation<br>• Resident dying | 4 to 5 |

| **Table 7.1** | **Summary of participants' changed personal circumstances, common work related issues, and change in stress levels between the first and second interviews** | | |
|---|---|---|---|
| **Participant[1]** | **Personal circumstances** | **Work issues[2]** | **Stress[3]** |
| P 10 | • Calmer more relaxed, and less stressed at work and home | • Accreditation | 2 to 3 |
| P 13 | • Sleeping better | • Accreditation | 3 to 2 |
| P 14 | • Health improved so able to increase workload<br>• Doing more creative work (painting) at home<br>• Due to have radical surgery | • Accreditation | 4 to 2 |

**Notes:** 1. Refer to Figure 5.1 for Participants' numbers.
2: Common work related issues.
3. Refer to Figure 5.1 for Participants' numbers and changes in stress.

| **Table 7.2** | **Summary of participants' changed personal circumstances, common work related issues, and change in stress levels between the second and third interviews** | | |
|---|---|---|---|
| **Participant[1]** | **Personal circumstances** | **Work issues[2]** | **Stress[3]** |
| | Between the second and third interview | | |
| P 1 | • Mother died<br>• Family dog put to sleep<br>• A friend died<br>• New house not yet ready for them to move in | • None | 0 to 0 |
| P 2 | • No changes | • None | 4 to 5 |
| P 6 | • Problems with the Immigration Department resolved | • Accreditation<br>• Resident dying | 5 to 5 |
| P 14 | • Sold their existing house and bought a new one<br>• An adult daughter was once again living at home<br>• Still maintaining an increased workload | • Accreditation | 2 to 3 |

**Notes:** 1. Refer to Figure 5.1 for Participants' numbers.
2. Common work related issues.
3. Refer to Figure 5.7 for changes in stress between the second and third interviews.

## 7.8 Diametrically opposite views

Ten examples of diametrically opposite views expressed by individual participants during the six group meetings have been summarised in Table 7.3. Generally, the examples are from different participants. However, where they are from the same individual, this has been specified. Also, because each view expressed is valid for the individual, they have not been categorised as either positive or negative.

| Table 7.3: Examples of opposing views expressed by the participants | |
|---|---|
| **Expressed view** | **Opposing expressed view** |
| 'I can feel [the Reiki energy] buzzing around or in me all the time'. | I can't feel the energy. |
| A participant said, 'my hands were freezing like ice'. | The same participant said, 'but as soon as I put them on [a resident] she said that my hands were hot'. |
| 'I have no idea how to do it. I can't Reiki myself'. | Other individuals reported positive effects from using self-Reiki. |
| A family member falling asleep while being provided with Reiki. | An un-well family member asking a participant to stop providing Reiki causing the participant to think the Reiki might have been adding to person's temperature. |
| 'One time [Reiki] worked on [a resident] and he calmed down …' | This participant continued, '… [but] the second time he wouldn't'. |
| Needing to be in a different state of mind, or in a quiet room, to provide Reiki. | Giving residents Reiki at meal times. |
| Reiki reducing the need for nighttime medication. | '[Medication] seems [to] far outweigh what I can do to him'. |
| Giving too much personal energy away when providing Reiki. | Reiki taking away the recipient's energy (and thus calming them). |
| Not feeling any heat when providing Reiki. | Feeling too hot ('like I'm getting hot flushes') when providing Reiki. |
| One participant said, 'I don't know if [self-Reiki is] working'. | In the same sentence this same participant said 'I feel relaxed'. |

The fact that individuals, when presented with the same evidence or share the same experiences, can express diametrically opposed views is not unique to Reiki research, or this study. It is recognised that people taking part in an event may have radically different opinions about that event (Willis, 2004). And, the fact that, when faced with the same evidence, individuals can hold diametrically opposed views has been explained by the concept of 'exquisitely informed speculation' which was used in the documentary *Enigma Man: A Stone Age Mystery* (Ortega, 2014) that aired on ABC Television in Australia at 8:30pm on Tuesday 24th June 2014. It was used to describe the phenomenon in which, when presented with the same fossils, two scientists can reach 'radically different interpretations … depending on which school of thought they belong to'.

If this dichotomy can occur in a scientific discipline such as paleoanthropology, then the notion of 'exquisitely informed speculation' could equally explain how different people can report diametrically opposite feelings and outcomes when experiencing and/or practising an energy therapy such as Reiki – particularly if an individual can say, 'it was a really interesting experience that I couldn't quite explain [by] using my normal rational processes'.

In my previous study (Webber, 2008), I found that there was a discrepancy between what Directors of Nursing and the Reiki practitioner interviewed considered to be the behaviours which caused problems and the benefits of using complementary therapies in dementia care. However, there are two totally disparate ways in which it is possible to interpret comments made by participants:

1. Only those in more senior positions (such as the Directors of Nursing or Nurses) are in a position to speak with authority because they are the ones with an overall view of the conditions in the aged care facility.

or

2. Only the people closest to the residents, the Personal Care Workers (Patient Care Attendants) are in a position to speak with authority because they are the people with the most intimate knowledge of the needs of the people with dementia.

The ***perceived value*** of comments made by individuals can be dependent upon the role of that person within an establishment or profession. Some commentators such as Hugo may appear to devalue much of care work as 'unskilled' or 'semi skilled' as compared to 'managerial, professional and associate professional [workers]' (Hugo, 2007, p. 178). Also, some people in senior managerial positions express doubts about the ability of care workers to make any meaningful contribution to research into their working conditions (Cookson, 2010). However, because there are no 'real' truths in qualitative research and it is the 'importance of the findings' which is paramount (Heppner et al., 1999, p. 251), differing viewpoints are acceptable.

## 7.9 The use of Reiki in one facility following the implementation of this project

Twelve months after the initial six-week duration of this doctoral project, the Director of Nursing in one facility reported that one of the participants trained in Reiki was maintaining a personal record of their use of Reiki. The use of Reiki was being used as 'a continuous improvement in our processes for … aged care [and] we're using that as evidence that Reiki is beneficial to the residents'. She added that, 'although it's a pretty crude [form of] documentation, it certainly is being used'. She confirmed that, because 'is very difficult for aged people to obtain a good balance in their sleeping patterns … [and] … sleep incorporates anxieties or has [associated disruptive] behaviours', the trial of Reiki in the establishment targeted 'key performance indicators' under Standard Two of the Accreditation Standards for Aged Care (Appendix P). The Director of Nursing conducted 'an audit of people [who] were having sedation at night or needed to have

sedation throughout the night [and] the medications [they were receiving]'. Following a three-month trial sleep charts indicated that the 'people [receiving Reiki] actually settled and went to sleep better … and we were using less sedation due to the Reiki'.

## 7.10 Other issues

***Comparison with other care work***

Before commencing work in aged care, one participant had supported people with mental health issues. They reported that that work had been more stressful than aged care because it had involved working with people who had alcohol problems, been abused during their marriage, been in and out of jail or on the road when younger and/or were on drugs. Therefore:

> These people were more aggressive. They would throw things. They would thump. They would try and get their way full stop so you had to back off and go back later if you could. That was more stressful. That was more trying to calm them down so they wouldn't hurt themselves and wouldn't hurt us.

***Differences between day afternoon and night shifts***

Although the Reiki Master/Teacher did not work the night shift at the time, he had previously worked across all three shifts. He commented that day shift was the most stressful because 'during the daytime we have to do all their ablutions'. Also, staff members had to ensure that the residents who could not feed themselves were fed and make sure that people got to their daytime activities. He also spoke about the difficulties associated with the process of toileting people who were incontinent and encouraging those who weren't incontinent to keep their continence, because it was a lot better for the individual and the carers. He said:

> It's a lot easier to help someone to go to the toilet than to have to actually physically change them (sic) and clean them up. So that process happens from the start of the shift right through until we finish.

During the afternoon shift, residents had to be showered and then prepared for bed, however:

> When they are in bed it's just a maintenance thing. It's easier to monitor residents, because once they are in bed, they usually like to turn the TV on and watch their favourite show and, if they need anything, they can ring the bell.

He also commented that, during the night shift, staff could be more socially interactive with residents, which did not happen as often during the day.

In response to a direct question one participant said:

> Day shift is just constant. There is no stopping whereas, in the afternoon shift, you may get a little bit of quiet time. As for the night shift, well I don't know what they do

> because I don't do afternoons or night so I can't say. I always like [the] hustle, bustle and constant go, go, go, so I like to be busy. That's good.

Another participant spoke at length saying:

> I do mornings mainly. The afternoon shift is a lot different because the residents' ADLs (such as showering and toileting) have already been attended to. What I virtually do in the afternoons is, if they require feeding for tea, I do that and then get them ready for bed. It's a lot different from actually showering them and getting them out of bed in the morning or washing them dressing them and then getting them out into the day room or wherever they want to go. Yes, I'd much rather work mornings because I'd much rather be active and you can be more active in the mornings than you are in the afternoons.

This person did not believe that morning shift is more stressful than afternoon shift.

***Difficulty explaining Reiki***

A Group 1 participant asked for advice about how to explain Reiki to a deaf resident and other comments included sometimes it's like talking to 'a blank wall', people think that Reiki is 'weird' and 'I find it really difficult to explain what it is. Do you find it difficult to explain what it is?' Therefore, a suitable, one page handout should be prepared by the researcher (in conjunction with the Reiki Master/Teacher who would be conducting the training) and given to participants at the end of Reiki training. If necessary, participants could have them duplicated for handing to non-participants and/or displaying in their facilities. This would then assist the newly trained Reiki practitioners to describe Reiki and the research to non-participants.

***Externally imposed rules***

One participant spoke about how externally imposed rules can adversely affect a resident saying:

> There is a resident who is no longer permitted to smoke and that has affected his personality. I'm very disappointed by that because, I think at a certain age you should be allowed to do within reason whatever you want to do. If a resident wants to smoke that's fine, because they've earned that right and I don't think it's anybody's right to say, "No you cannot do that." If a person has been smoking for fifty, sixty years and that person gets pleasure out of it, why take that pleasure away just because there is a rule that comes in and says you can't smoke within twenty feet of the building? Take them outside. Take them twenty feet away from the building and let them smoke out there. It's crazy, it really is, and it's just awful.

***Giving the DON a Christmas present***

In response to a direct question about involving the facility's DON in the project, one participant thought that, 'it's a good thing and the boss should have Reiki done as a Christmas present'.

***Involvement in the project as a team event***

One participant thought that, being involved in the project was a 'team event'. Having opportunities to discuss work related difficulties has been shown to reduce staff stress (Edvardsson et al., 2009). Therefore, establishing the learning and use of Reiki as a group activity may provide carers with an opportunity to discuss their difficulties in a non-threatening environment. This could then lead to an even greater reduction of carer stress. In fact, approximately half of the Group 2 recording was advice given by the training Master and Reiki I practitioner and approximately a quarter of the Group 3 recording pertained to issues such as restraint and lifting rather than Reiki.

***More people providing Reiki***

One participant thought that it would be a good idea if there were more people doing Reiki, particularly during the day shift. Also, someone like the Diversional Therapist could establish a room 'with nice music and candles' and provide Reiki as' a nice experience for residents'.

***Needing to 'resolve' incidents versus 'caring'***

One participant spoke about the difference between resolving 'critical' situations, which required staff members to implement particular procedures during 'life-threatening', or potentially life-threatening situations, compared to 'caring' for the residents and 'just being with' them. This participant also suggested that the majority of a Registered Nurse's time was occupied by required administrative tasks rather than being with residents.

***People who withdrew from the project***

A Group 1 participant said, 'it's a shame there wasn't one of the day staff as well because we … work nights'.

***Reiki as a tool when everything else has failed***

One participant mentioned that it was 'nice to have something. A tool to use as a backup when all else fails' but added that they 'probably should use it as first run up'. I then asked, 'How has the Reiki helped if something else has failed?' The carer responded:

> Even if it doesn't help the resident, it relaxes me enough so that [I] can cope better with the resident and [my] skills are better because [I am] more relaxed and not so pent up. Also, if [I am] more relaxed, the resident becomes more relaxed.

It is therefore possible that learning and using Reiki has given this participant a 'sense of purpose' which has been found to provide a buffer against adversity and enhance life chances (Keyes, 2011) and therefore enhance their sense of well-being.

***Residents dying***

In reference to the resident who was dying at the time of the second interview, one participant said:

> You know everything about them and they know everything about you. It's just hard to see them go. You know you want [family members] to stay but to see the family in tears all the time is horrible. The worst part of the job is watching residents pass away.

***The 'too personal' nature of Reiki touch***

It was reported that 'one person [apparently] felt as though the actual touch was a bit too personal for them and [that was] one of the reasons why they withdrew' from the project after Reiki training.

***The essential elements for using Reiki with clients who have dementia***

The training Master said that, when working with people with dementia in a nursing home environment the Reiki practitioner needs to:

> Be very, very patient; … have a good understanding of dementia and how it works; and … [be aware of the] structure and environment that is an aged care facility and of how that functions, because people with dementia do respond differently on an individual basis to Reiki.

***The number of Residents with dementia in one facility***

Although, one facility had only 13 secure dementia beds, one of the participants reported that, of the 52 residents, approximately two-thirds had varying degrees of dementia.

***Their DON/Site Manager possibly attending Reiki training at the same time***

There were no senior staff members (Directors of Nursing or Site Managers) participating in this study. However, from previous personal conversations, I was aware that one of the Directors of Nursing (DON) had previously trained as a Reiki practitioner. Two participants would have been happy for their Site Manager to attend Reiki training with them thinking that the Site Manager might have benefited from the experience. Another participant thought that, 'it would have been interesting and it probably wouldn't have hurt one of them to learn [Reiki] but I think they are all too busy'. A third participant thought that they 'would have enjoyed it more [if the DON had attended]' and would have been especially interested ''to see their feelings and attitudes towards [Reiki]'.

Only one participant expressed reservations about the DON attending Reiki training at the same time, however, one of the accepting participants said, 'I don't think people would have talked as freely with management present as they would if management was not present'.

***Wanting to know more about Reiki***

A participant said, 'I still don't know … half as much as what there is to learn about Reiki but what I learnt was really fascinating'. It was also reported by another of the participants that two of the participants wanted to know where to learn more about Reiki. This was reflected by the comments of another participant who said, 'I thoroughly enjoyed doing it' and indicated that they would also like to learn more. Therefore the researcher should be equipped to advise them as to who could provide a practise session and/or Reiki II training.

### 7.10.1 The accumulative effect of sleep medication

When discussing the nighttime trial of Reiki implemented in one facility, the Director of Nursing commented that it is easy to give a resident a tablet but sleep medications have a cumulative effect and the residents may then 'wake up feeling lethargic'. She also commented that the medication given to residents has 'only has a four hour life' but that is calculated for someone who has 'good kidney function [and] liver functions'. However, for people who have 'compromised kidney [or] liver functions plus the ageing process' then it is possible that the medication may 'stay in [their system] for an … extra two to three hours'. Therefore, if Reiki can induce sleep in people with dementia that could reduce the need for sleep medication, improve the resident's health and deliver a cost benefit. It would then be possible to direct the savings into other services for the residents.

### 7.10.2 'Caring' for residents

When talking about working with people in a nursing home environment and providing therapies other than allopathic medicine, the Director of Nursing said:

> It's caring for the person's whole being regardless of their preferences, their race, their cultural needs, anything. It's caring for what they want, it's how they've been all their life.

An example she provided was:

> Dementia does cause disturbance to the sleep pattern so there is frequently a lot of [people awake at night] especially on nights of full moon, [which] sounds bizarre… They wander and you deal with it. You make them a cup of tea. You talk to them. You might put the television or some music on and get them involved in something. They might not want to go bed but they might sit in a chair … that's all right [because] they're happy.

This supports comments made by participants that they need to know and cater for resident's individual needs and re-direct agitated residents when necessary. This is essential because 'people with dementia cannot express what they want or they do not know what they are doing'. It is also recognising that, in their working lives many people

such as milkmen, hospitality workers and permanent night shift workers are active during the night and asleep during the day.

## 7.11 Reiki as a PRN touch therapy

### 7.11.1 Using Reiki as a PRN therapy

As proposed by Webber and Yeoman (2000), the timing of the therapy may be important to its success. During training, participants in this doctoral study had been informed that giving a little Reiki often is better than giving a lot of Reiki infrequently (Ellyard, 2002) and that they were to use Reiki as a PRN therapy wherever it might be needed at home, at work, or in other situations. Participant responses suggested that they did in fact use Reiki as a PRN therapy. Examples included providing Reiki when cuddling a child, helping residents at meal time, holding a brother's hand at a wedding, holding a resident's hand after a manicure; putting a normally alert and talkative resident to sleep, relaxing a dying resident and/or walking with residents. In addition to these examples, a participant reported having received Reiki from another participant and then being able to stay at work when a bad migraine would normally have forced the participant to go home. Paradoxically, one participant said that they needed time to be able to concentrate when providing Reiki while another suggested that they had been providing Reiki without thinking about it.

These examples indicate that using Reiki as a PRN therapy will deliver the therapy in a timely manner when it is needed. It was suggested that someone like the Diversional Therapist could establish a room 'with nice music and candles' and provide Reiki as 'a nice experience for residents'. However, if this were to occur, then Reiki would no longer be a PRN therapy.

### 7.11.2 Difficulties experienced when using Reiki as a PRN therapy

Participants expressed a number of issues which indicated that they had difficulties and/or doubts about using Reiki as a PRN therapy including being in 'work mode … [made it] … hard to get into being relaxed and giving Reiki' and that it was hard to find sufficient time to use Reiki when they were busy. One participant suggested that they needed at least half an hour to be successful and another said that it was necessary to find a quiet room where there were less distractions in which to provide Reiki because 'I can concentrate better than in a noisy background for some reason'. Another participant said that if a resident has 'been agitated for forty, fifty, sixty years [then the agitation is] not going to just disappear in two minutes'. Therefore, the resident may need several

sessions. These issues suggest that more research into the use of Reiki as a PRN therapy is needed.

### 7.11.3 Other difficulties experienced when using Reiki in an aged care setting

Other difficulties reported by participants included: needing to be 'really comfortable' but beds can be at the wrong height; using Reiki in a nursing home was not ideal when compared to using a massage table 'which [can be] put … in the best position'; rooms are often cluttered; and the lack of practise in Reiki procedures.

A number of participants reported that some residents indicated, either verbally, or non-verbally by 'pushing or slapping' the Reiki practitioner's hands away, that they didn't want Reiki. However, participants had been advised that, if recipients indicated either verbally or by their body language that they did not want Reiki then they were to cease immediately. Therefore, these issues could also be considered as normal to Reiki practice and not actually difficulties.

Also, one participant expressed doubts about having 'a sensation that what I am doing is not correct … I'm so scared that I am going to do it wrong'. They also said that there was a lack of practise in Reiki procedures. However, from personal experiences, I have found that these feelings are common to most novice Reiki practitioners.

While a number of participants spoke about the physical difficulties of providing Reiki in an aged care facility, one participant said:

> Without thinking about it, I just was doing it how it was easiest to touch somebody. So I have been either using one hand or just putting one hand on the head and one hand on maybe a leg or somewhere else.

This demonstrated that it is possible for novice Reiki practitioners to adapt their procedures according to the unique conditions of working in an aged care facility.

### 7.11.4 Reiki and touch

The participants in this study were taught a form of Reiki that requires the practitioner to touch the recipient. It has been demonstrated that touch is routinely used as a form of therapy in aged care (Bush, 2001; Moore & Gilbert, 1995; Webber, 2008) and is also a form of communication (Routasalo, 1999). It has also been demonstrated that touch can lower heart rates, blood pressure, pain, stress, and anxiety (Oz et al., 1999; Talton, 1995).

However, most touch used in patient care is routine rather than therapeutic (Routasalo, 1999) and people in hospitals and older adults are touch deprived (Bush, 2001; Oz et al., 1999). The notion that people in aged care are touch deprived was supported by one participant in this study who said that, 'most residents absolutely crave emotional touch and caring [in order to] believe they are still important people and most

of them don't get that'. Another participant said, 'I [could] very easily laugh [Reiki] off as just interaction which most of the residents are craving'. Therefore, it is inconsistent that it was reported that one participant 'felt as though [when using Reiki] the actual touch was a bit too personal for them and that's one of the reasons why they withdrew'.

Another participant, who had provided Reiki for their brother at a wedding, wondered if it had been an appropriate thing to do because they were holding hands in public. Other participants variously took the opportunity to touch residents and provide Reiki when assisting with Activities of Daily Living (ADLs) such as: helping residents at meal times; providing a hand massage; manicuring residents' nails; and walking with residents. One participant added, 'maybe I do [Reiki] without really thinking about it [when] I hold their hands longer or put my hand on their shoulder longer'. It is therefore possible that learning and practising Reiki may have given participants permission to provide residents with touch in a comforting manner.

## 7.12 The Reiki training

The Group 1 Reiki training day which followed the 'philosophy that … a little [Reiki] often is better than a lot irregularly' was described as 'very intense [but] very interesting [and] very rewarding' as well as:

> very professionally done in the sense of: attending to details about where people would sit, how they would be comfortable; the music; and just the general environment.

Despite the day being 'very intense', the atmosphere was described as 'very tranquil, quiet and peaceful' and that it was 'uplifting to feel the energy coming from people [who] did not know that they had [it]'. The organisation and conduct of the training day was also described as:

> similar to what [would be expected] in any type of adult training exercise. Issues around developing: rapport, a nice ambience to the atmosphere, and attending to all of those basic human needs around comfort and so on [were catered for].

During the day, the students were individually taken out of the training room for attunements on four occasions and this could have been disruptive to the flow of the training, but one interviewee felt that this:

> wasn't a disruption [but] was just a very natural part of the process and very quickly people were taking their turns remembering where they were in terms of who was [to have the] next attunement.

### 7.12.1 The Reiki Master and his conduct of the training

The Reiki Master was described as 'really excellent' and 'very engaging and natural in the way that he presented information to people'. He explained 'issues … carefully and moved the group quickly … into practis[ing] Reiki. In fact, he did a really good job'.

One interviewee commented that they:

> really liked … [how] … people were encouraged to ask a whole range of questions [which they] did [and] very quickly they became very comfortable with the environment [therefore,] they were engaged, interested [and] wanted to learn.

Although the Reiki Master/Teacher who conducted the Group 1 Reiki Training had contributed to the development of the Training Manual, he expressed some difficulty with the one-day training because he would normally have taught Reiki I over two days. One interviewee supported this notion by saying:

> I think that the main difficulty with the day was that [the Reiki Master] was doing it in a slightly revised format. He would normally provide a two-day session, so any time you make a change like that it has to have an impact on the delivery. I think that [the Master] was overly self-critical and what he was saying was not what was being picked up by the people who were there. If he had said nothing about the difficulties he was having nobody would have known.

When asked if anything could have been done differently to improve the training, the Reiki Master/Teacher did not make any suggestions for change but said:

> Because I normally train over two days I had to really look at being more focused and couldn't digress as I do in a 'normal' training session which sort of broadens itself out.

However, he indicated that the day made him look at Reiki training in a different way because, when he had previously trained people in an aged care situation, he had known them for a while 'so they have had an understanding of me'. But, 'this [training] was coming in cold, cold canvassing for me I suppose if you want to call it that'. Therefore, he needed to 'focus and to present the training in a different way'. This experience had shown him how he 'can now teach it a different way, for different environments and needs'.

Also, he said that any Master/Teacher wishing to replicate the training would need to have 'a solid understanding of dementia, incontinence and how the environment affects people who live in aged care facilities'. People who enter a nursing home have 'lost everything, so they are going through a whole grieving process and it takes months for them to get used to their new environment'. And, 'they have gone from having a reasonable amount of control over their life to what they see as no control over their life'. He added that, if the training Master does not have that knowledge, then the researcher would need to 'sit down and have many discussions with them before' the training. Similarly, if a Reiki Master/Teacher 'focused in on training only physiotherapists or doctors they would have to have a solid knowledge of what they do and the type of people that they treat'.

### 7.12.2 The Reiki I assistant and the researcher

An interviewee thought that the way that the Reiki I assistant and I 'backed [the Reiki Master/Teacher] up was really, really useful' and could see why it 'would be a useful part of the overall training [to] have a number of people there because it is really easy to get stuck on a particular question or a particular aspect of explaining [issues]'.

### 7.12.3 The participants

An interviewee commented that they thought 'all of the people there benefited [from the day which] worked very well' and the participants 'all had a lot in common, were all there to learn' and, despite not knowing anything 'about Reiki, were all very open to learning'. Although, in a training situation, there are usually:

> Some people who are a bit resistant at first and need a little bit more work to open up … nobody seemed to be standing back [since] the overall engagement techniques were really positive.

One interviewee also commented on the fact that individuals 'were not critical of others in the way that they were [practising Reiki] and [thought that this] flowed on from the general scene setting'. This person also commented that, once given:

> An explanation of the hand positions [the students] were moved into practising and nobody seemed to be reserved [but] they all seemed to really put their all into [practising Reiki].

At this point, everyone who attended the Reiki training (the participants, the Reiki Master/Teacher who was a boilermaker by and not a trained educator, the Reiki I practitioner and the university senior lecturer) must be congratulated for making the training a non-threatening experience. This enabled participants to openly share their feelings during the day.

### 7.12.4 Direct researcher involvement in the Reiki training

It was suggested that my, 'zeal for Reiki made the development of a rigorous study on this topic difficult'. However, I am a Reiki Master/Teacher, which in the previous study (Webber, 2008), assisted to generate trust between and the participants and myself and enabled a common understanding of the language being used (Myers & Newman, 2007). I found this to be the case in this doctoral study.

In this doctoral thesis I initially identified possible conflicts of interest in two other research projects into aspects of Reiki. In one project the researcher conducted the Reiki training (D. A. Barnett, 2005). In another project the researcher was the Reiki practitioner (Salach, 2006). Therefore, I did not want to play any part (other than that of an observer) in the Reiki training for this project. Unfortunately, due to the absence of

either the training Master or the Reiki I assistant, I had to actively participate in a number of the group meetings and act as an assistant during training. This then created a possible conflict of interest for me. Conversely, being recognised as a Reiki practitioner granted Beeler entry into groups from which she would otherwise been excluded (Beeler, 2015). In fact, during her research, Beeler introduced herself as a Reiki practitioner first and then as a researcher. Therefore, being a Reiki practitioner was an asset to her as a researcher. Although there has been 'a general move away from the rich tradition of ethnography in sociology, physical cultural studies and criminology in recent years' (Redhead, 2014, p. 329), in some forms of research such as ethnography, focusing on the self of the researcher is acknowledged and the researcher is able to professionally switch between the roles of subject and researcher (Beeler, 2015; Chesney, 2000)

However, in future research projects, there should be several Reiki practitioners who are able to assist the Master/Teacher at all training and group sessions. This would ensure that any individual absences could be easily covered so that the researcher does not need to actively participate. In fact, it would be advantageous if the assistants were also Reiki Master/Teachers.

Also, the person(s) conducting preliminary information sessions must be familiar with the training to be conducted so that any questions from potential participants can be answered with authority – even if that is only to reassure them that the issues raised will be addressed in the training.

### 7.12.5 Providing Reiki training specifically for people working in dementia care

This study has demonstrated that, if Reiki training is to be offered specifically for people working in dementia care:

- ☆ The Reiki Master/Teacher conducting the training must have a solid understanding of the needs of both people with dementia and their carers. Therefore, it would be preferable if they themselves were working, or had worked, in aged care.
- ☆ Training should be conducted over two consecutive days to enable aspects of the material to be treated in greater detail than could be achieved in a single day.
- ☆ Post training support must be provided for the newly trained Reiki practitioners. This could be in the form of meetings conducted by the Reiki Master/Teacher and/or self-support groups and could include other staff members trained in Reiki. To further support the participants, the mid- and end-of-project meetings could be expanded to include both a digitally recorded discussion session and a Reiki practise session.

### 7.12.6 The Reiki Master/Teacher's lineage

It is important to specify the lineage of the Master/Teacher who conduct the training because of the number of 'branches' of Reiki which have developed (Webber, 2008) and the fact that the practice of Reiki can vary considerably depending upon the individual's training. Also, as was initially planned for this project, it is possible that using Reiki Master/Teachers with different lineages could have improved the internal validity of this project. Therefore, wherever possible, future researchers should use Reiki Master/Teachers with different branch lineages to conduct the training for different groups of participants.

### 7.12.7 Reiki certificate

As was done in this study, Reiki certificates should be presented to participants who have completed training and attend the interview at the end of the initial trial period (six weeks).

### 7.12.8 Professionalism of the Reiki training provided to participants

If Reiki training is to be offered to staff members working in aged care facilities and used as an example of continuous improvement, then it can be assumed that the facilities would need to be assured of the professionalism of the person conducting the training.

However, at the time of writing, only the practice of Reiki in a professional setting was Nationally Accredited as part of the Australian National Training Framework (AIHBN, 2014; Reiki Australia, 2014). Because the teaching of Reiki (including the training offered as part of this research project) was not Nationally Accredited, the Reiki training could possibly be seen as 'Mickey Mouse'. However, both the Reiki I practitioner and the university senior lecturer, neither of whom had previously attended a group Reiki training session, commented favourably about the professionalism of the training Master and the positive atmosphere developed during the day. Therefore, the Reiki Master/Teacher who conducted the training for this project should to be congratulated for the quality of the training: particularly so, because he was not a trained educator.

### 7.12.9 The concept of 'do no harm'

Because of the nature of this research and the possible sensitivity of the participants and the residents they support, I was particularly mindful of the maxim: 'above all, do no harm' (McIlfatrick et al., 2006, p. 42). During Reiki training, participants were clearly instructed that, if the person receiving Reiki indicated either verbally or non-verbally (through their body language) that they did not want Reiki, the participant must

immediately cease providing Reiki. Following the Group 1 Reiki training, the university senior lecturer commented that:

> What I like[d] about the Reiki training was that the whole underpinning philosophy [was] of doing no harm, which is the underpinning of the medical oath. Therefore, if a process is being used and nobody can demonstrate that it does harm, and at least some people think it has valuable outcomes, I don't see how people can criticise.

### 7.12.10 Special training for Directors of Nursing or Site Managers

Westcombe et al. (2003) suggested that a senior member of staff from each centre should be present on the steering group to further promote the relevance of a trial in individual centres. Senior managers in the four facilities in this project fully supported this research. Indeed, the executive manager of three of the facilities was able to arrange rosters so that Group 2 and 3 participants were ensured of two clear days in their roster and were, apparently, paid for their attendance. However, this might have been a 'double edged sword' with some participants only attending in order to have two days off work!

Although none of the DONs attended Reiki training, none of the participants objected to the idea of their DON attending Reiki training with them. In fact some of the participants thought that it would have been a positive thing for their DON to attend training. However, one participant believed that 'people would [not] have talked as freely with management present as they would if management was not present.' As a trained Reiki Master/Teacher and educator, this would have been sufficient for me to exclude DONs from a situation in which participants had to feel relaxed and be confident that absolute confidentiality was guaranteed.

### 7.12.11 Training manual

As noted in this doctoral research, the development of the training manual was a combined effort from three Reiki Masters. It was a reflection of the training manuals that they regularly used in their normal training programmes. During an interview, one participant said, 'I haven't really been following any of the usual positions that were in the training manual'. Therefore, it is apparent that the training manual should be adapted to include illustrations relating to aged care if Reiki training is provided specifically for people working in aged care. This could be achieved by inserting photographs of a trained aged care worker, who is also a Reiki practitioner, working with residents in an aged care facility.

### 7.12.12 The length and location of training

The Reiki Master/Teacher normally conducted two-day training sessions. Following the one-day training for Group 1, he commented, 'I had to really look at being more focused

and couldn't digress as I do in a 'normal' training session which sort of broadens itself out'. Although the university senior lecturer felt that the Reiki Master/Teacher 'did a really good job' and 'was impressed' with the standard of training, he commented:

> I think that the main difficulty with the day was that [the Reiki Master] was doing it in a slightly revised format. He would normally provide a two-day session, so any time you make a change like that it has to have an impact on the delivery'

This comment supported the change to a two-day training format for Groups 2 and 3. Therefore, future researchers should use a two-day format for the Reiki training.

A number of problems, such as interruptions and unsuitable rooms, were encountered because Group 2 and 3 Reiki training was conducted 'in house' (Appendix S). Therefore, if Reiki training is to be provided specifically for people working in aged care, it should be a conducted as a two-day format in a suitable venue removed from a work environment. The inclusion of group meetings as part of the training should also be continued because this provided an opportunity for participants to discuss any problems they may have encountered while providing Reiki for residents.

Also, at their second interview, three participants indicated that they would like to learn more about Reiki with one of these remarking that, *having a bit more follow up would be nice*. Therefore, it could be possible to encourage participants to form self-help groups. These could include other people trained in Reiki and working in their facility. This would provide participants with opportunities to practise Reiki on each other, discuss any problems and/or success they had experienced and discuss issues relating to their facility in a non-threatening, supportive environment.

#### 7.12.13 Group structure

Because of factors beyond the control of myself, the structure of Groups 2 and 3 did not permit a detailed analysis of the data within and across groups as proposed (see Figure Q.1 in Appendix Q). This was because participants were not associated with a single facility so the conditions under which they worked were different.

## 7.13 Participant commitment to the project

There were a number of issues that could call into question some participants' commitment towards their involvement in this study. Some participants may not have been true volunteers because fifteen of the participants who attended Reiki training did so because they had received a letter from senior management that said, in part, 'You have been selected to participate … because we believe that you have the attributes which will ensure that the results will be positive and productive' (see Appendix L). Of these, eight said that they had decided to participate because management asked them.

Therefore, it could be assumed that at least eight participants only 'volunteered' to participate in the project because of management pressures.

Of the 19 participants who attended Reiki training, 13 attended the first group meetings but only 9 attended the second group meeting (Table 8.1). While some apologies for non-attendance at the meetings were relayed through other participants, a total of six participants failed to make apologies for their non-attendance. All participants had both my email and telephone contact details. Only seven of the 16 participants who attended the second interview returned Reiki recording sheets.

All of the 16 participants who attended the second interview agreed that a follow-up interview after 12 months would be of benefit. One year after the completion of the second interviews I had ascertained that all of the participants were still working in their facilities. However, only six responded to contacts from me in an attempt to arrange an interview. All of these six participants made an appointment for a third interview but only four attended their scheduled interview (Table 7.4). The other two did not contact me to apologise or cancel their appointment.

Because of these factors it can be assumed that potentially valuable data were lost to the project.

**Table 7.4: Summary of participants present at each stage of the research**

| Groups | Reiki Training | 1st Group Meeting | 2nd Group Meeting | 2nd Interview | 3rd Interview |
|---|---|---|---|---|---|
| Group 1 | 4 | 2 | 2 | 2 | 2 |
| Group 2 | 8 | 6 | 5 | 8 | 1 |
| Group 3 | 7 | 5 | 2 | 6 | 1 |
| Totals | 19 | 13 | 9 | 16 | 4 |

## 7.14 The interviews

Myers and Newman (2007) identified a number of potential problems with conducting qualitative interviews. One of these was that, if the interviews are too short, the data might be incomplete. In this study, the individual first and second interviews with participants ranged from, 3:50 minutes to 32:37 minutes (mean, 11:32 minutes; median, 10:29 minutes). Therefore, because of the brevity of the interviews it can be assumed that potentially valuable data were lost to the project.

## 7.15 Unsolicited correspondence from a Group 1 participant

I received an unsolicited letter from one of the participants two weeks after their second interview. In their letter they related having toileted and given pain medication to a '102.5' year-old lady who had newly returned from hospital with a broken top to her left

humerus. She did not have dementia. Once the lady had been settled in bed, the correspondent and another carer (both participants in this study) worked together to provide Reiki for the resident who 'smiled, then laughed at us three times, relaxed and fell asleep … too soon for [the] Endone (pain medication) to work'. The participant commented that 'it was special'. To my knowledge, this was the first time that both participants had provided Reiki for an individual at the same time. The participant also stated that, if it had not been for the opportunity to participate in the research, she would not have trained in Reiki.

## 7.16 Unsolicited correspondence from the Reiki Master/Teacher

On the 7th of June 2012, I received an email from the Reiki Master/Teacher who conducted the Reiki training as part of this project (Appendix N). He thanked me for 'allowing me to take part as a Reiki Teacher/Practitioner in your research project' which 'allowed me to pass on … the experience that I have gained while working as a Reiki Practitioner / Carer in the Aged Care sector'. He expressed the belief that learning Reiki would 'have a positive affect not only on them [personally] but will have a positive flow on affect on residents and Age Care workers that they have contact with'.

He also indicated that his 'experience in using Reiki in [his aged care work] has been a positive one; it has had a flow on affect to the residents [in] their every day living, pain management, and palliative care situations'. In addition he emphasised that 'the position of a Personal Carer is a stressful one, [so] … using Reiki to reduce this stress / anxiety … has a positive flow on effect [for] the residents'.

## 7.17 Chapter conclusion

Given Kaptchuk's (2002) definition of the placebo effect, the placebo effect may be present in all positive interactions between the complementary therapist and their clients therefore, care must be taken when interpreting any positive results reported. However, given the positive examples provided by people with little experience of Reiki and complementary therapies, it can be argued that Reiki has the potential to be a suitable tool for any person working in aged care and who wishes to be able to do something 'other than shoving chemicals into [residents]'. Also, using Reiki in an aged care facility can provide carers with a reason for using comforting touch, which is often missing in aged care. However, because 'one person [apparently] felt as though the actual touch was a bit too personal for them' a decision to learn and use Reiki must be made by the individual. Carers should not be forced into attending Reiki training, nor should they be prevented from using Reiki if they believe that it will provide a benefit to either

themselves or the people they care for. Because participants reported a wide array of coping strategies they used before the Reiki training it is consistent that they reported a wide array of difficulties and successes when implementing their new Reiki skills.

Although Reiki has been described as an ‘energy therapy’ (NCCAM, 2006) Reiki I as taught in this project is a ‘touch therapy’ therefore it is understandable that a participant could ‘see a positive result’ but be unsure as to 'how much I can attribute to Reiki and how much I can attribute just to personal touch and time because I’ve found that … most residents absolutely crave emotional touch and caring [in order to] believe they are still important people and most of them don’t get that’. If nothing else, learning and using Reiki may provide aged care workers with a reason to regularly offer residents comforting touch as part of their caring and which is so often missing in aged care (Bush, 2001; Oz et al., 1999).

If carers are using Reiki as part of their daily routine, its use must be documented. This can be achieved by providing individual carers with a diary (as was done in one facility in this project) and/or adapting an existing recording sheet, such as a wound management sheet as was reported by one participant in my previous study (Webber, 2008, pp. 115, 328). Maintaining accurate documentation is essential for ensuring that Reiki is being used appropriately. Also, as was done by one facility in this study, the documentation can be used as proof of continual improvement under *Standard Two* of the Accreditation Standards for Aged Care. One participant in this study commented that, being involved in the project was a ‘team event’ therefore providing Reiki training for groups of staff members from a facility could have a subsidiary benefit of encouraging carers to work as a team instead of working as individuals.

The comment made by one participant during the second interview that they had ‘not [done Reiki] as much as I would have liked to have but I am presuming this is a lifetime thing now’ suggests the need for a longer term study than was possible for this doctoral project.

# 8 Developing a future mixed method research project

## 8.1 Chapter introduction

Although based on a single subject / single case research design, this study did not conform to the standard single subject format, which relies on obtaining quantitative data relating to the individual. Therefore strenuous efforts were made to ensure the appropriateness of the research method developed for this project and the minimisation of potential limitations to the study. However, a number of challenges arose during the course of this investigation. These will be discussed in detail and recommendations made for designing a rigorous mixed method research project based on a single subject design which meets these challenges.

## 8.2 Participant recruitment

### 8.2.1 Catering for participants with English language difficulties

It is necessary to recognise that, in this research, only negligible data was obtained from some participants because of two factors. Firstly the brevity of the interviews, which ranged from 3:50 minutes to 32:37 minutes (mean, 11:32 minutes; median, 10:29 minutes). Secondly, only seven (36.8%) of the 16 participants who completed the second interview returned their Reiki Recording Sheets. Future researchers need to be aware of and cater for participants with limited English language skills so that accepting only volunteers with advanced English skills does not skew results.

### 8.2.2 Involving senior members of staff

As was found in this research, senior managers are in a position to easily monitor changes in factors such as sedation and sleep patterns following the introduction of Reiki. Also, as happened following the implementation of Reiki in one facility supporting this project, managers can use the project to demonstrate the establishment of targeted *key performance indicators* under *Standard Two* of the Accreditation Standards for Aged Care (Appendix P).

Therefore, specific training should be offered to any DONs and/or Site Managers not previously trained in Reiki. This need not be Reiki training as provided to participants, but could be designed to provide them with an understanding of how Reiki works and how it could be implemented in their facility. It could also provide an opportunity for them to experience some Reiki.

### 8.2.3 Participants' roles in aged care

Of the 19 participants who attended Reiki training, only three were Enrolled or Registered nurses. Two were in Group 1, none in Group 2, and one in Group 3. Of these,

only two proceeded beyond the Reiki training and only one attended the third interview. However, because of their role, nurses are likely to have a wider view of conditions in a facility than do Personal Care Workers (Patient Care Attendants). It can therefore be assumed that potentially valuable data were lost to this study.

Therefore, future researchers should ensure, as far as practical, that at least one nurse from each facility attends Reiki training as a participant. If this is not possible then: nurses not previously trained in Reiki should be included in preliminary discussions and in any non-Reiki training provided for senior managers; nurses who are Reiki practitioners could be enlisted to provide support for the participants who are newly trained in Reiki; and/or nurses who have not participated in the trial could be personally interviewed both before and after the trial period to ascertain their personal opinions on resident outcomes.

### 8.2.4 Group structure

Future researchers must ensure that each group of participants trained in Reiki is formed from a single facility to enable a meaningful analysis of any changes that might occur within, and across, groups as was initially planned for this project (Appendix Q). In this doctoral study the majority of participants were female (15 females and 4 males) which is consistent with the aged care workforce generally (Hugo, 2007; King et al., 2013; Meagher, 2007). However, future researchers should endeavour to recruit sufficient male and female participants to enable a meaningful cross-gender analysis of the participants' well-being because a gendered understanding is important (Fullagar & O'Brien, 2014).

### 8.2.5 Minimising the effects of attrition

The number of participants in this study reduced over time from the 19 who were trained in Reiki, to the 16 who completed the second interview, to the four who completed the third interview (Table 7.4). Thus, given the poor attendance at the group meetings and the third interview, it can be assumed that much, potentially valuable information was lost to the research project.

1. Because it is impossible to prevent attrition, any future researchers should ensure that, both the initial size of groups trained in Reiki as well as the total number of participants are large enough to permit meaningful analysis of the data obtained.
2. Even if senior managers support research being conducted in their facility, and are prepared to display researcher prepared material advertising the project, future researchers should ensure that all participants are 'true' volunteers and have not

received possibly coercive, personalised letters from senior staff members (Appendix L).

### 8.2.6 Reiki as a touch therapy

Because it was reported that 'one person felt as though the actual touch was a bit too personal for them and that's one of the reasons why they withdrew', potential participants in any future research project should be advised not to proceed if they have personal or cultural difficulties relating to touching other people.

### 8.2.7 Internal validity

The internal validity of this project may not have been as strong as possible because early, lengthy delays beyond the control of myself caused the cancellation of planned data collection in Adelaide, Canberra and Kalgoorlie, where different Reiki Master/Teachers would have conducted the training. Through personal discussions, I was aware that, the lineage of one of the Reiki Master/Teachers who had verbally agreed to participate in the initial project included William Lee Rand. I was informed that Rand (Rand, 1991, 1998, No date) is an Australian Reiki Master who had reportedly studied Reiki with five Reiki Masters: Hiroshi Doi, Hyakuten Inamoto, Diane McCumber, Marlene Schilke, and Leah Smith. In turn, each of these Masters had different lineages reaching back to Dr Mikao Usui. Also, the lineages of Hiroshi Doi and Hyakuten Inamoto did not include Mrs Takata.

Conducting the research in such disparate locations as Adelaide, Canberra and Kalgoorlie would have necessitated using Reiki Master/Teachers who had undergone different training. This would then have provided an additional opportunity for triangulation of data obtained from the different groups. Therefore future research should be conducted in both urban and rural settings, in different states, and with different Reiki Master/Teachers conducting the training.

## 8.3 Data Collection

### 8.3.1 Additional self-reported stress level data points for statistical analysis

Because the focus of this research was to be an analysis of the qualitative data gained through the interviews and group meetings, I did not intend to conduct a statistical analysis as is usual in single case research (Shadish, 2014). Therefore, if future researchers wish to conduct a statistical analysis it will be necessary to have additional data points. This could be achieved by requiring participants to maintain a diary in which they record their stress level on pre-determined days for at least three weeks after the

first interview and before the Reiki training and then weekly during the six-week use of Reiki.

However, only seven out of the 16 participants who completed the second interview (36.8%) returned their Reiki Recording Sheets and some participants reported that staff from non-English speaking backgrounds not completing paper work was a problem. Therefore it is possible that introducing such a requirement could limit the participation rate and skew the data.

### 8.3.2 Assessing carer stress

Asking participants to self-report their stress levels can produce apparently paradoxical results and it is possible that the interview itself could be an additional stressor. One participant who reported feeling calmer, more relaxed, and less stressed at work and home at the time of the second interview also reported an increase in stress from 2 to 3 between the first and second interviews (Participant 10, Table 7.1). Another participant who reported that they were feeling much more relaxed and that their anxiety problem was much better, reported no change in their stress level between the first and second interviews (Participant 5, Table 7.1). Unfortunately, the decision to cease administering the *Spielberger State-Trait Anxiety Inventory (STAI)* (Spielberger et al., 1983) meant that it was not possible to verify the accuracy of participant self-reported stress levels.

Having participants rate their own stress levels on a Likert type scale provided a subjective 'snap shot' of their perceived stress levels at the time of each interview. Although using a cortisol test (Anisman et al., 2001; Lim, 2011; Ross, 2012) would have provided a mechanism for validating a participant's perceived stress, it would also only have provided a 'snap shot' of the participant's stress at the time of the interview. However, using the *STAI* would also have provided a measure of both current anxiety (State) and underlying anxiety over time (Trait).

Future research should use several accepted self-rating and/or physical examination tools (such as cortisol testing) in order to permit triangulation between the results. If this is done, the researchers will need to be adequately trained and qualified in their use, or different researchers will need to be used to implement each test.

### 8.3.3 Accounting for major stress producing changes during the study

As noted in this chapter, in a study towards a Master of Psychology (Counselling), Ostojic (2006) failed to account for major structural changes in the organisation from which the recipients of Reiki were selected. These changes were beyond the control of

the individual participants and it was possible that they may have caused additional stress during the trial.

In this doctoral study, seven of the 16 participants who completed the second interview reported a rise in their stress levels. All of them worked in one of the three facilities where there had been at least one major stress causing change (the commencement of accreditation audits and a resident dying) between the first and second interviews. However, it was not possible to determine if learning and using Reiki actually modified the effects of any additional work related stressors caused by these events. In addition, some participants had personal issues such as family problems or planned radical surgery that could have increased their stress levels during the period of the trial.Therefore, future researchers will need to be aware of, and account for any additional, major stress causing factors that might occur during the course of the trial.

### 8.3.4 Establishing control groups

In a single subject research project the individual participants become their own control (R. H. Horner et al., 2005). However, to strengthen the validity of future research, a 'no intervention' control group could be established in each facility by interviewing and testing non-Reiki trained carers at the same time as the participants who are trained in Reiki.

### 8.3.5 Monitoring resident use of medication

I did not have either the physical, personnel or financial resources, or the time, which would have enabled the monitoring of issues such as individual resident's behaviour, sleep patterns, and or medication use following the introduction of Reiki. However, as has been demonstrated, this can be easily achieved by examining existing records if senior management grants permission. At the end of the trial period, the researcher could ask who had received Reiki from the newly trained Reiki practitioners and then existing records could then be examined for predetermined periods before the commencement of the trial and after its conclusion. If this method were adopted then work practices need not be changed to accommodate the trial and there would be no need to pre-determine who would receive Reiki. Senior management could make this decision according to normal practice in their facility and the researcher would be blind as to who had received Reiki. As with the participants trained in Reiki, each recipient of Reiki would act as their own control and this procedure would provide additional, quantitative data for analysis. This process would also enable the residents' experiences to be explored (Holland & Kydd, 2015) even if they were unable to express themselves verbally.

### 8.3.6 Participant shifts worked

The demographic data obtained from participants in this study did not include information about the shift(s) worked by individuals. Therefore, it was not possible to compare the data obtained from participants who routinely worked on different shifts (e.g. permanent night shift compared to permanent day shift). All future research should ascertain this information at the first interviews with participants.

### 8.3.7 The placebo effect

Given Kaptchuk's (2002) definition of the placebo effect, the placebo effect may be present in all interactions between the complementary therapist and their clients. Therefore, in any research into Reiki, care must be taken when interpreting any positive results reported.

## 8.4 Funding

This project was extremely limited in scope because I was the sole, and self-supporting, part-time researcher and this project did not have funding other than the normal Research Maintenance Grant provided by the Faculty of Medicine, Nursing and Health Sciences at Flinders University. Therefore, future researchers should endeavour to obtain sufficient funding to permit a more intensive and extensive study of the use of Reiki in High Care Residential facilities. Without adequate funding for research into complementary therapies (such as Reiki) 'evidence will not be forthcoming' (Rees & Weil, 2001, p. 119).

## 8.5 Chapter conclusion

This study does not conform to the standard single subject format and that I have adapted the single subject/single case research methodology in an attempt to develop a new way of researching the use of Reiki for reducing carer stress. In hindsight, it seems to me that I was being instructed to work to a pre-determined format despite the fact that, 'Traditional models, methods and protocols [for PhD research] have been challenged, transformed and shaped by professional and practice-based candidatures' (Brabazon & Dagli, 2010, p. 23). To me, the way in which I was initially instructed to format my doctoral research appeared to be akin to painting by the numbers as in my childhood colouring in books (also see Hil, 2012, p. 203 who uses this analogy) or 'learning-by-numbers' (Hil, 2012, p. 44). My original contribution to knowledge through this PhD study has been to demonstrate that the unique method I have developed has real potential for investigating biofield/energy therapies such as Reiki. I also acknowledge a range of unexpected

difficulties I encountered during this journey and make recommendations to assist future researchers.

# 9 The Climax: Thesis Conclusion

## 9.1 Chapter introduction

Because complementary therapies such as Reiki are rarely used in isolation and are often tailored according to individual needs, the behaviour being exhibited and/or the context of that behaviour, there can be significant problems in isolating the effect of the therapy under investigation (Douglas et al., 2004; Westcombe et al., 2003). Also, a number of researchers have found that, a sham or mimic Reiki treatment where individuals not attuned to Reiki mimic the process of a Reiki treatment, may not be inert (Mackay et al., 2004; Vitale & O'Connor, 2006). Therefore, in researching the potential for Reiki to reduce carer stress, it was necessary to develop a research format other than a randomised controlled trial that negated the need for a control group while still demonstrating that the method has validity. There was also a need to develop a research format that replicated normal work practices as closely as possible (D. A. Barnett, 2005; Richardson, 2000).

Thus, this mixed method PhD research project was based on two questions:

1. Can learning and using Reiki in their daily work reduce stress in professional carers of people with dementia who are resident in Aged Care Facilities?
2. Is there an appropriate method for researching therapies such as Reiki?

In this doctoral thesis I have clearly demonstrated that, for some carers, learning and using Reiki has the potential to reduce their stress levels. I have also demonstrated that further, comprehensive research needs to be conducted into the use of Reiki, which is being used in dementia care, so that people responsible for the implementation of Reiki into their 'normal' practices can do so knowing that there are valid reasons for their actions. When published, this thesis will contribute significant, original knowledge to the academic literature.

## 9.2 Lack of published research into the use of Reiki in aged care

Despite the extensive use of complementary therapies in the general community (Eisenberg, Davis, Ettner et al., 1998; Eisenberg, Kessler, Foster et al., 1993; Savas, Robertson, Beatty et al., 2016; Sherwood, 2000; Yeldham, 2000), there is little in the academic literature regarding some of the complementary therapies being used in dementia care. This was confirmed by both the literature surveys conducted for my previous research project (Webber, 2008) and the 2006/2007 literature surveys conducted for my proposal for this doctoral thesis. At that time, the only projects analysing the use of Reiki in dementia care retrieved were Webber (2006) and Salach

(2006). Since then, only three other projects have been retrieved – Crawford, Leaver and Mahoney (2006), Morris and Warner (2009) and Meland (2009) who has not been cited in this thesis because it was a series of case studies.

It has been claimed that all complementary therapies attract criticism because, 'Whenever a new field comes into being, it comes up against the older dogmas … in traditions going as far back as Galileo, Copernicus and beyond' (Sternberg, 2001, p. xi). As a result of this attitude, 'Alternative medicine … is commonly represented as the elusive and challenging *other* of modern capitalist biomedical systems' (Ross, 2012, p. 1 - italics in the original). One example of this is the controversy surrounding Elizabeth Kenney's methods for treating people suffering from poliomyelitis (Martyr, 1997). A further example of this is the feeling expressed by a number of academics about my PhD proposal that there was no point in studying Reiki because they all knew that it does not work although I had previously demonstrated that Reiki was being used in Residential High Care Facilities and that further study was needed (Webber, 2008). This attitude is akin to Hookham and MacLennan's apparent belief in their right to speak for all people with disabilities and their right to criticise/suppress another researcher's academic freedom while defending their own rights during the 'Laughing at the disabled' controversy (Goggin, 2010). However, it merely exposes the 'futility and contempt inherent in much contemporary academic research and teaching' (Goggin, 2010, p. 469). Also, there appears to be a determined effort to purge the study of 'Alternative Medicine' from university courses (Moynihan, 2012). As the scholar, scientist and author, Isaac Asimov wrote:

> it is the most powerful people in a society – the scholars, the leaders – who have the most to lose in the divestment of their knowledge and expertise, in becoming intellectually naked and taking a new chance on education. They often resist with nothing less than savagery (Asimov, Warrick, & Greenberg, 1984, p. 2).

An example of this 'savagery' can be seen in the writing of surgical oncologist, Associate Professor David H Gorski who attacks complementary therapies and proponents of complementary therapies by repeatedly using unscientific and value laden terms such as cow pie, magic, magic-based, magical thinking, mysticism, nonsense, pernicious, quackademic medicine, quackery, ridiculous, snake oil, unethical, useless wastebasket terms, woo and woo-friendly while labelling research into therapies such as Reiki as unethical, unscientific, pseudoscience (Gorski, 2013, 2014a, 2014b, 2014c; Gorski & Novella, 2014). He also attacks the 'magical grants' awarded by the National Center for Complementary and Alternative Medicine (NCCAM) to Dr Weil's department at the University of Arizona (Gorski, 2014c) and supports a suggestion that

therapies such as Homeopathy rely ‘on a purported mechanism that violates the laws of physics’ (Gorski, 2013) while ignoring that the ‘laws of physics’ constantly change as new discoveries are made.

Despite the efforts of ‘mainstream’ academia and medicine to refute the efficacy of complementary therapies/medicine or to ban their use, people have continued to seek ‘alternative’ healing methods such as Reiki and massage. An example of this is that the ngangkari (the aboriginal healers of Central Australia) used their traditional healing techniques to complement western medical treatments, but, for many years, hid their practices because white doctors did not trust them (Ngaanyatjarra Pitjantjatjara Yankuntjatjara Women's Council Aboriginal Corporation, 2013). Fortunately, these attitudes appear to be changing with doctors and the traditional healers of Central Australia now working together. In 2009 the work done by the traditional healers was recognised by an award from the Royal Australian and New Zealand College of Psychiatrists and the Dr Margaret Tobin Award for Excellence in Mental Health Service Delivery. Then, in 2011, the ngangkari were conjoint recipients of the World Council for Psychotherapy’s Sigmund Freud Award for Contributions to Psychotherapy (Ngaanyatjarra Pitjantjatjara Yankuntjatjara Women's Council Aboriginal Corporation, 2013). Although I am not familiar with the healing techniques used by the ngangkari, many of the techniques described by the 21 traditional healers featured in the book appear to be similar to the techniques used by Reiki practitioners. This includes seeing people as a whole, using healing touch and restoring balance in the individual (Ngaanyatjarra Pitjantjatjara Yankuntjatjara Women's Council Aboriginal Corporation, 2013).

Therefore, the publication of my doctoral research will add significant original knowledge about Reiki and its use in aged care to the academic literature.

## 9.3 Further research into the use of Reiki in Aged Care

I have demonstrated that Reiki is being used in aged care and that some practitioners and Directors of Nursing believe that it can be effective in reducing carer stress and assist people with dementia to achieve improved sleep patterns while reducing the need for sedatives (Webber, 2008). I have also demonstrated that there is little in the academic literature regarding the use of Reiki in dementia care. Therefore, there is a need for more, in-depth studies into the use of Reiki in Aged Care. Whether individuals in academia believe that Reiki has any efficacy or not is immaterial – it is being used and therefore should be studied. Also, because complementary therapies are rarely used in isolation, there must be an acceptance of research formats other than randomised controlled trials

which continue to be studied to the exclusion of other valued trials as evidenced by Lee and Lim's meta analysis of trials into the effectiveness of acupuncture in reducing insomnia post-stroke (S. H. Lee & Lim, 2016).

The names 'single subject' (Barlow & Hayes, 1997) and 'single case' (Matson et al., 2012) do not refer to the number of subjects, but to the way in which the data are collected and analysed (Barger-Anderson et al., 2004). By using a single subject format, the individual participants in this doctoral study became their own control (R. H. Horner et al., 2005) and negated the need for a control group. Also, in this doctoral project, staggered base lines were obtained by training three groups separately during a seven-month period. The use of multiple baselines becomes a form of replication (Barger-Anderson et al., 2004; Brossart & Meythaler, 2008). Systematic replication across participants, locations, and/or researchers can reduce the margin for error, increase confidence (Tawney & Gast, 1984), improve external validity (Dattilo et al., 2000), and foster generalisability (Holm, 1983).

This doctoral project used in-depth, semi-structured, qualitative interviews pre-Reiki training, six weeks after Reiki training and 12 months after the second interviews to explore the lived experiences of the carer participants and enable the capture of possible paradoxical and/or unexpected outcomes on an individual basis as suggested by Engebretson and Wardell (2002). The use of open rather than closed questions (Broom, 2005) and flexibility in the interviewing process (Myers & Newman, 2007) provided opportunities to develop new questions and produce unexpected results. Additional qualitative data were obtained from participants during group meetings held three weeks and six weeks following the Reiki training. Qualitative data were also obtained through interviews with the Reiki Master/Teacher, a Reiki I practitioner who assisted at the training, the university senior lecturer who attended the first Reiki training as an independent observer, and a Director of Nursing. I also collected quantitative data via the demographic data and self assessed stress levels obtained from the participants at every interview and the Reiki Recording Sheets.

This research followed the suggestions made by Westcombe et al. (2003) after their trial of aromatherapy (Table 2.1). It also recognised that the practitioner is an integral part of the therapy as suggested by Richardson (2000), provided support for the newly trained Reiki practitioners, and allowed sufficient time for any delayed phenomena to emerge (Miles & True, 2003). In addition, it allowed for flexibility in care procedures as recommended by Alzheimer's Australia (2003) and replicated, as closely as possible, normal clinical practise as advised by Richardson (2000) by encouraging participants to

apply Reiki on a PRN basis as they conducted their normal duties. It was also mindful of the maxim: *above all, do no harm* (McIlfatrick et al., 2006, p. 42).

This doctoral study has proposed that further research into the use of Reiki in dementia care is necessary and that it is possible to develop a rigorous mixed method research project based on a single subject / single case design. However, the researcher could select to move to either a completely quantitative format, or a completely qualitative format. During the course of my project, an array of issues confronted me as a researcher so I offer them as issues which future researchers should consider when developing their own methodology or attempting to replicate this doctoral study. The following suggestions for further research are not presented in any hierarchical order.

Although dementia is generally considered to be a disease of old age, the facilities that completed my 2002 survey indicated that residents with dementia were aged between 39 and 105 years. A participant in this doctoral study commented, 'we have some residents who are surprisingly young, frighteningly young'. Therefore future research should attempt to determine if caring for young people with dementia is more stressful than caring for older people with dementia.

The focus of this doctoral research was on the professional carers, not the people with dementia. However, I have demonstrated that information about the people receiving Reiki can be easily obtained. At the end of the trial period, a future researcher could ask who had received Reiki from the newly trained Reiki practitioners and then existing records could then be examined for predetermined periods before the commencement of the trial and after its conclusion. As with the participants trained in Reiki, each recipient of Reiki would act as their own control and this procedure would provide additional, quantitative data for analysis.

To improve internal validity and provide an opportunity to generalise, future research should be conducted in both urban and rural settings, in different states, and with different Reiki Master/Teachers who have different branch lineages to conduct the training for different groups of participants. Future research should also use several accepted self-rating and/or physical examination tools (such as cortisol testing) in order to permit triangulation between the results. Research should include at least one non-language based assessment of participant stress levels. If this is done, the researcher(s) will need to be adequately trained and qualified in their use, or different researchers will need to be used to implement each test. In addition, future researchers should develop strategies designed to maximise the return rate of Reiki Recording Sheets, also, it is important that future researchers should ensure that all participants are 'true' volunteers

and have not received possibly coercive, personalised letters from senior staff members and need to be aware of and cater for participants with limited English language skills so that accepting only volunteers with advanced English skills does not skew results. To further strengthen the validity of future research, a 'no intervention' control group could be established in each facility by interviewing and testing non-Reiki trained carers at the same time as the participants who are trained in Reiki. Because they can provide a wider view of work within a facility than Patient Care Attendants can, future researchers should ensure, as far as is practical, that at least one nurse from each facility attends Reiki training as a participant.

In this study, participant self-reported stress levels have indicated that individuals caring for people with dementia in High Care Residential Facilities will react differently to the apparently stress causing factors, an issue which future researchers will need to consider. The small number of self-Reiki treatments reported by participants in this doctoral study, and a comment made by one participant that that they did not know how to provide self-Reiki, indicate that more emphasis should have been placed on issues relating to self-Reiki and self-care during the Reiki training. Also, in future research projects specific training should be offered to any DONs and/or Site Managers not previously trained in Reiki. This need not be Reiki training as provided to participants, but could be designed to provide them with an understanding of how Reiki works and how it could be implemented in their facility. This could also provide an opportunity for them to experience some Reiki.

An acknowledged limitation of this research is that I did not ascertain from participants the details of which shifts they worked. Therefore, future researchers should ascertain the shift(s) participants are rostered for and whether there had been any changes in their rosters during the course of the trial. In addition, to enable detailed within and across group analysis of data, future researchers should ensure that each group of participants trained in Reiki is formed from a single facility to enable a meaningful analysis of any changes that might occur within and across groups, as was initially planned for this project (Appendix Q). Also, future researchers should ensure that, both the initial size of groups trained in Reiki as well as the total number of participants are large enough to permit meaningful analysis of the data obtained from each group.

Future researchers should re-interview participants who report, or physically demonstrate, an increase in stress levels during the course of the intervention in order to determine why this increase in stress levels has occurred. Also, future researchers will need to be aware of, and account, for any additional, major stress causing factors that

might occur during the course of the trial, including organisational factors, that could affect participants' stress levels before drawing any conclusions from their data. If future researchers wish to conduct a statistical analysis it will be necessary to have additional data points prior to the Reiki teaching, during the trial period and after the completion of the trial.

To avoid the need for researcher participation in future research projects, there should be several Reiki practitioners who are able to assist the Master/Teacher at all training and group sessions. However, the researcher must be suitably equipped to advise participants as to who could provide a practise session and/or Reiki II training. Therefore it is essential that the researcher be trained to at least Level II Reiki and be able to ascertain such information. Potential participants in any future research project should be advised not to proceed if they have personal or cultural difficulties relating to touching other people. Also, because it is a possibility that having a personal relationship with someone with dementia may evoke empathy and understanding in the care worker, or be a factor in their decision to work in dementia care, then this is an area for further study.

Finally, future researchers should endeavour to obtain sufficient funding to permit a more intensive and extensive study of the use of Reiki in High Care Residential facilities. Without adequate funding for research into complementary therapies (such as Reiki) 'evidence will not be forthcoming' (Rees & Weil, 2001, p. 119).

## 9.4 The study of Reiki and other complementary therapies in Schools of Health Sciences, Medicine and Nursing

Because it has been clearly demonstrated that Reiki and other complementary therapies are being used in the general population, hospitals and aged care facilities around the world, there is an obligation to study the phenomenon. Likewise, a comprehensive study of these therapies should be introduced into mainstream health sciences, medical and nursing studies. Schools of medicine in the United States of America began teaching complementary and alternative medicine courses over 19 years ago (Horton, 1997; Maizes, Schneider, Bell, & Weil, 2002). At the University of Arizona in the late 1990s one of Dr Andrew Weil's aims was to 'Train physicians to combine the best ideas and practices of conventional and alternative medicine into new, cost-effective treatments' (Horton, 1997, p. 1374). Even if they did not wish to use any of the therapies themselves, there is an obligation for doctors and nurses to have an understanding of which therapies their patients and clients are using. As Savas et al. (2016) found, 'complementary therapy use by patients with cancer is highly prevalent' and 'patients valued personalized information and guidance regarding complementary therapy from health care

professionals involved in their care' (p. e311). Also, nearly one and a half decades ago Snyderman and Weil (2002) wrote:

> [Patients] want competent help in navigating the confusing maze of therapeutic options that are available today, especially in those cases in which conventional approaches are relatively ineffective or harmful. Unfortunately, that option is not generally available: physicians with the desired attitudes, knowledge, and training are few and far between (p. 396).

On the 8th July 2016 I entered the terms 'complementary therapies', 'alternative therapies', 'alternative medicine' and 'cam' into the Flinders University web site search engine. This search returned the names of only six academic staff members (one of whom is on the board of a peer reviewed journal specialising in 'Alternative and Complementary Therapies') and one elective unit of the Bachelor of Nursing'. When I entered the term 'Reiki' into the same search engine, the search returned only the name of one academic staff member and a reference to my current doctoral project. This indicates either, only minimal interest in alternative or complementary medicine and therapies, or that academic staff members in general do not feel comfortable mentioning an interest in these issues. It also appears to indicate that the current trainee doctors and nurses trained at Flinders University will not necessarily have the knowledge necessary to provide their clients with 'competent help in navigating the confusing maze of therapeutic options that are available today' (Snyderman & Weil, 2002, p. 396) because there is not a single course in complementary/alternative therapies or cam in the Faculty of Medicine, Nursing and Health Sciences. Unfortunately, it can be argued that the academics who believe that there is no point in studying Reiki because they know that it does not work will not be convinced because:

> proponents of western medicine … are rational, reductionist and rooted in the material world [and believe that] the body is like a machine [and] thoughts, beliefs and emotions don't feature in treatment for medical conditions (Marchant, 2016, pp. xi-xii).

Whereas 'holistic traditions prioritise the immaterial over the material; people over conditions; subjective experience and beliefs over objective trial results [and] claim to harness intangible energy fields' (Marchant, 2016, p. xii).

Enigmatically, ardent complementary therapy debunker, Steven Salzberg (Marchant, 2016, p. xii) has not included hypnotherapy in his list of shams and frauds because he ***believes*** (emphasis mine) that it works (Freedman, 2012). Also, although Marchant has claimed that holistic therapy practitioners give credence to 'subjective experience and beliefs over objective trial results' (p. xii) there is a growing number of scientific studies into a wide array of holistic therapies – this doctoral thesis being one of them. Therefore there is sufficient information in the academic literature to enable doctors to make

informed decisions when discussing the use of complementary therapies with their patients.

## 9.5 Professionalism of Reiki training

If Reiki training is to be offered to staff members working in aged care facilities, then it can be assumed that the facilities would need to be assured of the professionalism of the person conducting the training. Therefore, now that the practice of Reiki in a professional setting has been included in the Australian National Training Framework, the various Reiki associations should cooperate in an attempt to also have the teaching of Reiki included in the Australian National Training Framework. Before commencing my Master of Disability Studies, I had successfully developed and gained recognition for three Certificate Courses and Registered Training Organisation status under the Australian National Training Framework. Therefore, from my experience, I recommended that appropriate Certificate levels for Reiki training would be: Reiki I – Certificate II; Reiki II – Certificate III; and Reiki III (Master/Teacher) – Certificate IV.

If this were achieved, it would not prevent people from teaching and using Reiki as a 'folk art' (Webber, 2008) but would enhance the credibility of persons wishing to use Reiki and/or teach Reiki in professional settings. It would also assist nurses who wish to use the learning of Reiki as an element of their continuing education, as is possible in some jurisdictions (Mitzel-Wilkinson, 2000; Webber, 2008; Whitsitt, 1998).

## 9.6 Reiki as an appropriate tool for reducing carer stress

In this doctoral study, the overall results regarding the efficacy of using Reiki to reduce stress in professional carers of people with dementia and who are resident in Aged Care Facilities are inconclusive, yet they did not refute the use of Reiki. This is consistent with the findings of a systematic literature review of the use of Reiki as a nursing procedure which analysed 27 papers published world-wide from 2001 to 2011 inclusive (de Sousa et al., 2012).

One major advantage arising from the use of Reiki in aged care situations is that Reiki touch is non-invasive (Bush, 2001) because 'there is no need for the recipient to undress, as in some forms of massage … there is no manipulation of body parts as with Chiropractic, massage, foot reflexology or physiotherapy … [and there is] … no invasion of the body as with acupuncture, orally ingested preparations, injections, or surgery (Webber, 2008, pp. 59-60). Even if all positive results reported by participants in this study can be attributed solely to the result of the placebo effect (Brody, 2000; Kaptchuk, 2001, 2002; Richardson, 2000), the examples of successful outcomes provided by

participants in this study, together with their ability to adapt the use of Reiki according to the different situations which they encountered in their work, suggest that Reiki is an appropriate touch therapy for use as a PRN therapy in aged care facilities. In fact, it may provide aged care workers with a reason to regularly offer residents touch as part of their caring and which is so often missing in aged care (Bush, 2001; Oz et al., 1999). As one participant in this study commented, Reiki has the potential to be a:

> tool to use … when all else fails [because], even if it doesn't help the resident [it might relax the carer so that they] can cope better with the resident because [if the carer is] more relaxed and not so pent up … the resident becomes more relaxed.

As an original contribution to knowledge, this doctoral research has demonstrated that, by learning, and using Reiki in their daily work, it is possible that some carers will experience reduced stress levels even though they might be novice Reiki practitioners. This could then have a flow-on effect of relaxing the people for whom they provide care thus improving the well-being of both the carers and the residents with dementia, because the well-being of both the cared-for and the carer are linked (Gattuso & Bevan, 2000). Indeed, personal well-being can be enhanced if the individual can 'find …[a] … calm, stable, and true self' (Markula, 2014). Also, learning and using Reiki could have an unintended spin-off of enhancing the carer's sense of purpose which has been found to provide a buffer against adversity and enhance life chances (Keyes, 2011) whereas hopelessness can enhance a disease and increase mortality (Reilly, 2001). Because there is currently no cure for dementia (Access Economics, 2006; Australian Institute of Health and Welfare, 2006; Kydd & Sharp, 2016), reducing carer stress could enable them to assist the person with dementia to die 'well' (Kydd & Sharp, 2016, p. 5).

However, Reiki should be only **one** of many tools available to carers of people with dementia because there should be 'no single or standard approach to dementia care' (Alzheimer's Australia, 2003, p. 1) and organisations and carers need to be flexible in their routines and practices. Thus, a decision to learn and use Reiki must be made by the individual and people should not be forced into attending Reiki training, nor should they be prevented from using it if they believe that Reiki will provide a benefit to either themselves, or the people they care for. The only criteria for not using Reiki should be the intended recipient refusing it, either verbally, or non-verbally through their body language because, as one participant said, 'it is better to do something rather than nothing, provided that it does no harm'.

Undertaking this PhD thesis has indeed been 'an explorative, experimental and experiential journey in order to create something original' (Brabazon & Dagli, 2010, p. 39). It has been a journey during which many people have accompanied me: the

participants who were trained in Reiki; the Reiki practitioners who conducted the training; the Directors of Nursing who appreciated the value of conducting this research and supported their staff members' involvement; and the many other individuals who supported my efforts and offered their encouragement. Once this original contribution to knowledge is published they will receive the recognition, which they so justly deserve. Also, publication of this original, doctoral thesis, will provide people working in dementia care, whether they are Directors of Nursing, nurses or Patient Care Attendants, a scientific underpinning for the use of Reiki in their daily work with their clients and each other.

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# 11 Glossary of Terms

In this glossary role related terms and descriptions generally apply to the South Australian context. In individual circumstances, the actual role and job description may vary significantly from those cited below.

**Activities of Daily Living (ADLs):** Those activities such as feeding, grooming, shaving, showering, toileting, which, as their dementia progresses, residents are increasingly reliant on the carers for their provision.

**Aged Care Facility:** Any facility catering specifically for the care of the elderly. In South Australia these may be: High Care Residential Facilities (formerly called nursing homes); Low Care Residential Facilities (formerly called hostels); or Supported Residential Facilities (formerly called rest homes).

**Attunement(s):** In some texts 'attunements' are referred to as a process of **'i**nitiation'. Attunements are the processes used when training Reiki practitioners. It is claimed that the attunements set Reiki apart from other therapies, activate the Reiki energy, and enable the Reiki practitioners to channel this energy.

**CAM:** Complementary and Alternative Medicine.

**Carer:** In this research project the term 'carer' is used to describe anyone working with people with dementia and includes: Complementary Therapist, Director of Nursing, Diversional Therapist, Enrolled Nurse, Lifestyle Activities Coordinator, Patient Care Attendant, Personal Care Worker, Personal Care Assistants, and Registered Nurse **(**also **Professional Carer)**.

**Complementary Therapies:** Therapies used to complement allopathic medical procedures. Variously called alternative and unconventional therapies in the scientific literature.

**Director of Nursing (DON):** A job related role description in which a Registered Nurse is employed in an administration role within an aged care facility or hospital. Individuals may undertake some nursing duties depending upon their individual circumstances. The position may be called the Site Director in some aged care facilities.

**Diversional Therapist:** A job description for a person who undertakes various duties including: assisting clients identify their needs, supporting clients in activities, providing information about available resources, training and supervising volunteers, and administrative duties pertaining to their role.

**Domino Effect:** The phenomenon of the domino effect is based on the philosophy of systems thinking and suggests that tension caused by an adverse event will have an effect through the psychosocial system, particularly in a shared living space. However, an adverse event within an individual may cause an internal domino effect within that individual. For instance, 'A patient immobilised by a fractured hip … can quickly develop problems with circulation, skin breakdown, pulmonary function, voiding, and constipation' (Andresen, 1998, p. 51).

**Dr Mikao Usui:** A Japanese Buddhist monk who is recognised as the founder of modern Reiki.

**Enrolled Nurse:** A nurse with non-University, Technical and Further Education (TAFE) qualifications who normally works under the supervision of a Registered Nurse. This position may be called "Registered Nurse Division 2" in Victoria.

**Multi-sensory:** Using light, sound, smell, taste and tactile sensations accessed by the eyes, ears, nose, mouth and skin to promote motor, cognitive, language and social development in people with disabilities (Webber, 2008). Often associated with Snoezelen ® rooms.

**Non-invasive:** In the context of this thesis, 'non-invasive' means that '… there is no need for the recipient to undress, as in some forms of massage … there is no manipulation of body parts as with Chiropractic, massage, foot reflexology or physiotherapy … [and there is] … no invasion of the body as with acupuncture, orally ingested preparations, injections, or surgery (Webber, 2006, pp. 82-83).

**Nursing Home:** The former name for a South Australian High Care Residential Facility providing services for aged people.

**Palliative Care:** Providing services based on an assumption that 'people with a life-limiting illness or condition can die in an atmosphere of care and support'. This approach can 'help reduce the suffering of many people and encompasses a positive and open attitude towards death and dying' (Australian Government Department of Health and Ageing, 2004, p. xi).

**Paradox, Paradoxical results:** Refers to the, often diametrically opposed, descriptions of: heaviness/weightlessness, heat/coldness, fear/safety, slow/very fast, vulnerability/safety, giving/receiving, addle-brained/clarity, secure/panicky used to describe the effects of a therapy and/or medication.

**Patient Care Attendant / Personal Care Worker / Personal Care Assistants:** Synonymous job titles for people working directly with residents in aged care facilities. In South Australia these people are required to have a minimum qualification at a Certificate III level.

**PRN:** An abbreviation of the Latin term '*pro re nata'* – according to need, or as the circumstances require.

**Reiki (Ray-key):** A system of channelling universal energy to promote healing developed in Japan by Dr. Mika Usui.

**Snoezelen ®:** A multi-sensory environmental approach to working with people with disabilities. Originally developed in Holland and introduced into Australia in the Mudingburra Special School in 1993 (Webber, 2008). See Multi-sensory.

**Sundowning:** A term used to describe the escalation of agitated behaviours in the afternoon when people may have been driving home from work, catching public transport, preparing the evening meal for the family etc.

**Synchronic:** Occurring at the same time. In Reiki it refers to the belief that the practitioner receives healing at the same time as the client.

# 12 Appendices

A: Reiki Recording Sheet

B: Demographic Data and Interview Focusing Questions

C: Information Sheet for Carers

D: Consent Form for Participation in Research: (by interview, standardised testing, training in Reiki and providing Reiki)

E: Letter of Introduction

F: Notice placed by management in the staff-room of the Group 1 facility

G: Programme for Reiki Training in Group 1

H: Interview Focusing Questions for people assisting with Reiki training

I: Confidentiality Agreements

J: Tables of Raw Data from the Participant Groups

K: Programme for Reiki Training in Groups 2 and 3

L: Letter sent by management to selected staff members of the Group 2 and 3 facilities

M: Additional questions asked at the beginning of the second interviews for Groups 2 and 3

N: Ian's email

O: Interview Focusing Questions for the Directors of Nursing

P: Accreditation Standards for Aged Care

Q: The proposed three-way analysis of data within and across groups

R: Ethics Committee Approvals

S: Conduct of Interviews and Reiki Training

# Appendix A

# Reiki Recording Sheet

| Date | Time | Duration of Reiki | Subject (Client, self or other) C, S, O | Comment |
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# Appendix B

## Demographic Data and Interview Focusing Questions

### *First Interview*

### Carers

Carer demographic data to be collected at the commencement of the first interview

This will enable comparison with the demographic data collected in the researcher's previous study (Webber, 2008). Because the researcher will be collecting the data personally, the process will be used to develop rapport with the participant.

**Personal Details**

**In which age range do you fit?**

❒ 16-35 ❒ 36-55 ❒ 56-75 ❒ 76-95 ❒ 95+

**Gender**

❒ Male ❒ Female

**What is your role?**

❒ Diversional Therapist
❒ Patient Care Attendant
❒ Visiting specialist
❒ Nursing staff
❒ Volunteer
❒ Relation of a person with dementia
❒ Friend of a person with dementia
❒ Other:

If 'Other', please detail

_____

**If you are a family member of a person with dementia, what is your relationship with that person?**

_____

**How long have you been involved in dementia care? _____**

**What are your qualifications?**

_____

_____

**Which Complementary therapies do you currently use?**

❒ Aromatherapy (massage)
❒ Aromatherapy (vaporising)
❒ Behaviour Therapy
❒ Chiropractic
❒ Healing Touch
❒ Light Therapy
❒ Massage
❒ Meditation
❒ Music (instrumental)
❒ Music (recorded)
❒ Music (voice)
❒ Prayer
❒ Reflexology
❒ Tai Chi
❒ Therapeutic Touch
❒ ThreePhase Therapy
❒ Other (Please detail)

_____

**As a carer, how would you rate your current level of stress?**

(With 0 being the lowest and 9 the highest)

0 1 2 3 4 5 6 7 8 9

**As a carer, what are the major factors contributing to your stress?**

1. Why did you decide to participate in this research project?
2. What do you know about Reiki?

   Where did you learn this information?
3. Have you had any personal experiences with Reiki? Please explain.
4. What are the most significant problems you encounter in your daily work?

   How do you deal with these problems?

   How do you de-brief?
5. What are the most rewarding aspects of your work?

   How do you celebrate these?
6. What are your expectations for being involved in this research project?
7. Do you have any current health issues? Please detail.
8. Do you have any other comments?

## *Second Interview*

Demographic data re-collection

**In addition to Reiki and the therapies you mentioned in your first interview, have you introduced any other Complementary Therapies into your work?**

- ❒ Aromatherapy (massage)
- ❒ Aromatherapy (vaporising)
- ❒ Behaviour Therapy
- ❒ Chiropractic
- ❒ Healing Touch
- ❒ Light Therapy
- ❒ Massage
- ❒ Meditation
- ❒ Music (instrumental)
- ❒ Music (recorded)
- ❒ Music (voice)
- ❒ Prayer
- ❒ Reflexology
- ❒ Tai Chi
- ❒ Therapeutic Touch
- ❒ ThreePhase Therapy
- ❒ Other (Please detail)

_____

**As a carer, how would you rate your current level of stress?**

(With 0 being the lowest and 9 the highest)

0 1 2 3 4 5 6 7 8 9

**As a carer, what are the major factors contributing to your stress?**

1. Have there been any major changes in either your work environment or personal circumstances since your 1st interview? Please explain.
2. On which groups of people did you use your Reiki?
3. Please tell me about some of your experiences with Reiki.
4. From what you have observed, what effects did Reiki have on you?
5. How do you feel when you are providing Reiki?
6. Have you experienced any difficulties when providing Reiki?
7. What do you think makes Reiki different from other therapies?
8. Have your expectations about Reiki been fulfilled?
   If so, why? If not, why not?
9. What has been the attitude of other staff members towards Reiki?
10. Have any of your previous health issues been resolved? Please explain.
11. How would you have felt if your DON/Site Manager had attended Reiki training with you?
12. Do you have any other comments?

## *Third Interview*

**As a carer, how would you rate your current level of stress?**

(With 0 being the lowest and 9 the highest)

0 1 2 3 4 5 6 7 8 9

**As a carer, what are the major factors contributing to your stress?**

1. Have there been any major changes in your work environment since your 2nd interview?
   If so, please explain.
2. Have there been any major changes in your personal circumstances since your 2nd interview?
   If so, please explain.
3. Are you using Reiki?
   If so, why?
   If not, why not?
4. Please tell me about some of your experiences with Reiki.
5. Have you done any further training in complementary therapies since your 2nd interview?
   If so, why?
   If not, why not?
6. Do you have any other comments?

# Appendix C

## Reducing Anxiety in Carers of People with Dementia: A Trial of Reiki in Aged Care

**Graham R Webber**
***Master of Science (Medicine) by research, Master of Disability Studies, Diploma of Teaching, Graduate Diploma of Education, Reiki Master/Teacher, Seichim, Therapeutic Touch (Beginners Level), Certificate II in Massage (Aromatherapy).***

## Information sheet for carers

Thank you for showing an interest in my research into the efficacy of Reiki in reducing anxiety in carers of people with dementia.

Reiki is a gentle, non-invasive 'energy medicine practice that originated in Japan [and in which] the practitioner places his [sic] hands on or near the person receiving treatment, with the intent to transmit ki, believed to be a life-force energy' (NCCAM, 2006, p. 1). There is no need for recipients to undress or be removed from their normal situation for a treatment. Prior research has shown that it is being used in at least 15 South Australian High Care Residential Facilities.

The project outlined below is a logical extension of the research conducted for my Master of Science. A copy of my thesis, ***Reiki: Practitioners' Perceptions of the Effectiveness of a Complementary Therapy in the Treatment Regime of People with Dementia***, is available on line at http://catalogue.flinders.edu.au/local/adt/uploads/approved/adt-SFU20061009.093745/public/02whole.pdf.

The project is divided into several distinct phases:

- selecting the participant carers;
- conducting one-hour, in-depth interviews with the carers;
- one-day training in Reiki to be provided by an independent Reiki/Master Teacher;
- introducing Reiki into the carer's daily routine (as with PRN ('*pro re nata')* medication) for a period of six weeks and the maintenance of a simply Reiki Recording Sheet;
- conducting a second one-hour, in-depth interview with the participants at the end of six weeks.

If you decide to participate, you will be interviewed, participate in Reiki training, implement Reiki into your practice for a period of six weeks, and maintain the Reiki Recording Sheet.

You will be able to withdraw from the project at any stage without needing to provide an explanation.

Carers who do not participate in the research will continue their normal duties. There will be no change to routine.

I will maintain contact with the participants on a regular basis in order to monitor the project. My supervisors (Dr Brian Matthews and Dr Caroline Ellison) from the

Department of Disability Studies at Flinders University will provide support for me throughout the project.

I am a Reiki Master/Teacher and will be available on a regular basis to discuss any issues you may have regarding any effects you may be experiencing from the application of your new skills in Reiki. I can be contacted by email (graham.webber@flinders.edu.au) during the course of the trial and for six months afterwards. Because I will not be at the university on a full-time basis, participants will also be supplied with my home telephone number. They will be asked to keep this number confidential.

Participant privacy and confidentiality will be protected by:

1. storing participant names and personal information separately from all data collected;
2. ensuring that the participants' names and any other identifying information are not used during the personal interviews or in any written or verbal reports about the project.

A professional typist will transcribe interview transcripts, but there will be nothing in the interview which will identify participants. All data collected will be stored in a locked filing cabinet in a locked room in the Department of Disability Studies, Flinders University.

As noted above, participants will be able to withdraw from the project at any stage without needing to provide an explanation. If this occurs, all their data will be removed from the project and immediately destroyed.

Other than receiving the normal research maintenance support provided by the university I am entirely self-funded.

While participants will not benefit financially from participation in this research, they will receive Reiki training and a training manual free of charge. Participants will not incur any expenses because of their involvement in this project.

It is intended that the findings of this research will be published through conference presentations, journal papers and a PhD thesis.

My prior research has shown that Reiki is being used in the care of people with dementia yet the research into this phenomenon is almost non-existent. This research will clearly demonstrate whether training carers in the use of Reiki can provide positive benefits for the carers and or their clients.

Thank you again for showing an interest in my research into the efficacy of Reiki in the treatment regime for people with dementia.

Graham R. Webber
PhD Candidate

# Appendix D

**CONSENT FORM FOR PARTICIPATION IN RESEARCH**
**(by interview, standardised testing, training in Reiki and providing Reiki)**

I …..... being over the age of 18 years hereby consent to participate in the research project entitled ***Reducing Anxiety in Professional Carers of People with Dementia: A Trial of Reiki in Aged Care.***

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my interviews.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:

- I may not directly benefit from taking part in this research.
- I am free to withdraw from the project at any time and am free to decline to answer particular questions.
- While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
- Whether I participate or not, or withdraw after participating, will have no effect on any treatment or service that is being provided to me.
- I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
- If I do withdraw my consent any information I have already provided will be immediately destroyed.

6. I agree/do not agree to the tapes of my interviews being made available to a secretarial assistant for transcription.
7. I have had the opportunity to discuss taking part in this research with a family member or friend.

**Participant's signature……Date……...**

I, Graham R Webber, certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

**Researcher's signature……..Date…….**
*NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Items 8 and 9, as appropriate.*

8. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

**Participant's signature……Date……...**

9. I, the participant whose signature appears below, have read the researcher's report and agree to the publication of my information as reported.

**Participant's signature……Date……...**

# Appendix E

# Letter of Introduction

Flinders UNIVERSITY

**Disability and Community Inclusion**
**Flinders Clinical Effectiveness**
**School of Medicine**
**Faculty of Health Sciences**
Sturt Buildings, South Wing
GPO Box 2100
Adelaide SA 5001

Tel: 08 8201 5221
Fax: 08 8201 3646

ABN 65 542 596 200

CRICOS Provider No. 00114A

**LETTER OF INTRODUCTION**

Dear Sir/Madam,

This letter is to introduce Graham Webber who is a Research Higher Degree student in the Department of Disability Studies at Flinders University. He will produce his student card, which carries a photograph, as proof of identity.

Graham is undertaking research leading to the production of a PhD Thesis entitled:

***Reducing Anxiety in Professional Carers of People with Dementia: A Trial of Reiki in Aged Care***

He would be most grateful if you would volunteer to assist in this project, by granting an interview and participating in the research project which is detailed in the attachment.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

Since Graham intends to make a tape recording of the interview, he will seek your consent, on the attached form, to record the interview. A recording or a transcription will be used in preparing the thesis, reports or other publications. A professional typist will transcribe the interview tapes, but there will be nothing in them that could identify participants. Your name or identity will not be revealed in any reports or publications. The recording will not be made available to any other person except that it may be necessary to make the recording available to secretarial assistants for transcription. In this case you may be assured that such persons will not know your name or identity and that the confidentiality of the material will be respected and maintained.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on (8201 3745), fax (8201 3646) or e-mail (Brian.Matthews@flinders.edu.au).

Thank you for taking the time to assist Graham in his research.

**Dr Brian Matthews**
Senior Lecturer, Disability and Community Inclusion, Flinders Clinical Effectiveness,
School of Medicine,
Faculty of Health Sciences.

*This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au*

inspiring achievement

# Appendix F

# Notice placed by management in the staff-room of the Group 1 facility

ALL NURSING STAFF

We have been invited to participate in a research project in 'Reducing Anxiety in Carers of people with Dementia: A Trial of Reiki in Aged Care'
The study will involve voluntary participation from at least 4 staff ( either carers, managers, RNs and or ENs). They will have an hour interview with the researcher, and then following one day training in Reiki (by a Reiki master teacher). Staff will then be asked to introduce Reiki into their daily routines for a period of six weeks (maintaining a record sheet). This could be in using Reiki on family and surroundings to help with your own feelings and emotions around you. Post 6 week trial a secondary interview will be undertaken by the researcher to gather data from the experience.
If you feel you would be interested in this research project and can spare a couple of hours learning Reiki and the benefits it may bring to your work place and home life, can you please place your name on the bottom of this memo by 19th August 2011. If you would like any clarification in the project and what Reiki actually involves, I will leave a copy of the research proposal with Ros to discuss further and also place in your staff room education area.

Warm regards

[redacted] Manager
8th August 2011

Staff Names and current positions:

Note: The researcher has deleted all identifying information in this notice.

# Appendix G

# Programme for Reiki Training in Group 1

**10.00 am - Start**

1. Introductions.
2. Meditation - ***Reflections.***
3. History of Reiki.
4. What is Reiki?

Reiki 1

Reiki 2.

5. Lineage.
6. What happens during an Attunement?
7. **First attunement.**

Break for Coffee

1. Demonstration of hands-on positions on front of body.
2. Practice.
3. **Second attunement.**
4. Reflection time.

**12.30 pm - Break for Lunch**

**01.00 pm - Start**

1. Brief re-cap discussion and question time.
2. Demonstration of back positions.
3. Practice.
4. **Third attunement.**

Break for coffee

1. Question time.
2. Demonstration of seated positions.
3. Practice.
4. **Fourth attunement.**

**03.30 pm – Reiki in Dementia Care**

1. Adapting Reiki to work in dementia care for this research project.
2. Using Reiki as with PRN medication.
3. Maintaining the Reiki Recording Sheet
4. Discussion time.
5. Presentation of Manual for future reference.

**04.00 pm - Close**

# Appendix H

# Interview Focusing Questions for people assisting with Reiki training and Directors of Nursing

## *Reiki I Practitioner*

1. … you have been attuned privately as a Reiki I Practitioner and assisted in Group 1 training. What are your impressions of the day?
2. In the words of the training Master you acted as a 'crash test dummy'. What are your impressions of that experience?
3. Do you have any suggestions as to how the day could be improved?

## *The university senior lecturer*

1. While supporting the need for research into Reiki you have always been sceptical about it. Why is this?
2. As a hard-nosed, sceptical observer you attended Group 1 Reiki training. Can you please relate your impressions of the day?
3. In the words of the training Master you acted as a 'crash test dummy'. What are your impressions of that experience?
4. When asked if you would like to experience a Reiki attunement you agreed. What are your impressions of that experience?
5. You have previously acknowledged high stress levels. How would you have rated your stress level immediately following the training

   (With 0 being the lowest and 9 the highest)

   0 1 2 3 4 5 6 7 8 9

6. Do you have any suggestions as to how the day could be improved?

### *The Reiki Training Master*

1. You are the Reiki master/Teacher who conducted the Reiki training for Group 1 of my research project. Can you please tell me something of your background?
2. What bought you to Reiki?
3. What do you believe are the essential elements for using Reiki with clients who have dementia?
4. Before the training session you mentioned some of the types of people you have trained in Reiki. Can you please tell me about them without mentioning names?
5. In relation to the training day, is there anything you would have done differently to improve the training?
6. You mentioned that you have conducted in-house training for a Nursing Home. Without mentioning names can you please tell me about you impressions of that training?
7. I believe that, at that in-house training, you and your students were given permission to practise on residents in the home. How did you find that experience?
8. Have you personally gained anything from conducting the Reiki training?

# Appendix I

## CONFIDENTIALITY AGREEMENT (Reiki Assistant)

I, ..... ,(Name)
have been asked by the Researcher to assist during the Reiki training for participants in the Research Project entitled: ***Reducing Anxiety in Professional Carers of People with Dementia: A Trial of Reiki in Aged Care.***

1. I have read the information provided.

2. I have agreed on the details and methods for the Reiki training.

3. I agree that all information disclosed during the Reiki training and any associated meetings **must and will** remain totally confidential.

   No information will be:

   - Made available to any other person who has not signed a Confidentiality Agreement.
   - Made available or distributed in any way, either verbally or by printed or electronic copies, to any person other than the Researcher.

4. I am aware that I should retain a copy of this signed Confidentiality Agreement for future reference.

**Reiki Assistant's signature ..... Date .....**

I, Graham R Webber (The Researcher), certify that I have explained the details of this agreement to the Reiki Assistant and consider that he/she fully understands their obligations.

**Researcher's signature ..... Date .....**

# CONFIDENTIALITY AGREEMENT (Reiki Master)

I, ..... ,(Name)
have been asked by the Researcher to conduct Reiki training for participants in the Research Project entitled: ***Reducing Anxiety in Professional Carers of People with Dementia: A Trial of Reiki in Aged Care.***

1. I have read the information provided.

2. I have agreed on the details and methods for the Reiki training.

3. I agree that all information disclosed during the Reiki training and any associated meetings **must and will** remain totally confidential.

   No information will be:

   - Made available to any other person who has not signed a Confidentiality Agreement.
   - Made available or distributed in any way, either verbally or by printed or electronic copies, to any person other than the Researcher.

4. I am aware that I should retain a copy of this signed Confidentiality Agreement for future reference.

**Reiki Master's signature ..... Date .....**

I, Graham R Webber (The Researcher), certify that I have explained the details of this agreement to the Reiki Master and consider that he/she fully understands their obligations.

**Researcher's signature ..... Date .....**

# CONFIDENTIALITY AGREEMENT (Transcriber)

I, ..... ,(Name)
have been contracted by the Researcher to transcribe the content of recorded interviews with participants in the Research Project entitled: ***Reducing Anxiety in Professional Carers of People with Dementia: A Trial of Reiki in Aged Care.***

1. I have read the information provided.

2. I have agreed on the details and methods of the transcription processes, formats and styles to be used in the production of the transcripts.

3. I agree that all information contained in the recorded interviews with individual participants and the transcripts of those interviews **must and will** remain totally confidential.

   No information will be:

   - Made available to any other person who has not signed a Confidentiality Agreement.
   - Made available or distributed in any way, either verbally or by printed or electronic copies, to any person other than the Researcher.

4. On completion and handover of successful transcriptions, I agree to remove, delete and/or destroy all copies of both the recorded interviews and the transcriptions from all systems (e.g. recorders, computers, discs, printed files).

5. I am aware that I should retain a copy of this signed Confidentiality Agreement for future reference.

**Transcriber's signature ..... Date .....**

I, Graham R Webber (The Researcher), certify that I have explained the details of this agreement to the Transcriber and consider that he/she fully understands their obligations.

**Researcher's signature ..... Date .....**

# Appendix J

# Tables of Raw Data from the Participant Groups

| **Table J.1:** | **Summary of the personal characteristics of participants at their first interview** | | | | |
|---|---|---|---|---|---|
| | | **Group 1 (n=4)** | **Group 2 (n=8)** | **Group 3 (n=7)** | **All Groups (n=19)** |
| Age Range | 16-35 | 1 | 3 | 1 | 5 |
| | 36-55 | 1 | 4 | 5 | 10 |
| | 56-75 | 2 | 1 | 1 | 4 |
| Gender | Male | 1 | 1 | 2 | 4 |
| | Female | 3 | 7 | 5 | 15 |
| Role | Diversional Therapist | 0 | 0 | 1 | 1 |
| | Nurse | 2 | 0 | 1 | 3 |
| | Personal Care Worker | 2 | 8 | 5 | 15 |
| Complementary Therapies used | Aromatherapy | 0 | 4 | 4 | 8 |
| | Humour | 0 | 2 | 1 | 3 |
| | Massage | 1 | 5 | 5 | 11 |
| | Music | 1 | 3 | 6 | 10 |
| | Prayer | 0 | 1 | 1 | 2 |
| | Touch | 2 | 1 | 0 | 3 |
| Years in Dementia Care | Minimum | 1 | 1 | 5 | 1 |
| | Maximum | 8 | 15 | 21 | 21 |
| | Mean | 4.3 | 6.2 | 12.2 | 8.0 |
| | Median | 4.0 | 3.5 | 11.0 | 7.0 |
| Qualifications | Certificate III | 1 | 7 | 6 | 14 |
| | Certificate IV | 1 | 0 | 1 | 2 |
| | Diploma | 0 | 0 | 0 | 0 |
| | Advanced Diploma | 0 | 0 | 1 | 1 |
| | Bachelors Degree | 3 | 2 | 0 | 5 |
| | Post Graduate | 2 | 0 | 0 | 2 |
| | Reflexology | 0 | 1 | 0 | 1 |
| | Massage | 0 | 1 | 0 | 1 |
| Relative with Dementia | | 3 | 1 | 2 | 6 |

| **Table J.2** | **Summary of self-reported stress levels of participants** | | | | |
|---|---|---|---|---|---|
| **Group** | **Interview** | **Minimum** | **Maximum** | **Mean** | **Median** |
| 1 | 1st (n=4) | 2 | 8 | 4.3 | 3.5 |
| | 2nd (n=2) | 0 | 4 | 2.0 | 2.0 |
| 2 | 1st (n=8) | 2 | 5 | 3.4 | 3.5 |
| | 2nd (n=8) | 3 | 7 | 4.8 | 5.0 |
| 3 | 1st (n=7) | 3 | 10 | 6.1 | 6.0 |
| | 2nd (n=6) | 0 | 9 | 5.3 | 6.5 |
| All Groups | 1st (n=19) | 2 | 10 | 4.6 | 4.0 |
| | 2nd (n=16) | 0 | 9 | 4.6 | 5.0 |

# Appendix K

# Programme for Reiki Training in Groups 2 and 3

**Day 1: - 10.00 am - Start**

1. Introductions. Meditation**.**
2. History of Reiki. What is Reiki? Reiki 1. Reiki 2. Lineage.
3. What happens during an Attunement?
4. **First attunement.**

Break for Coffee

1. Demonstration of hands-on positions on front of body. Practice.
2. **Second attunement.**
3. Reflection time.

**12.30 pm - Break for Lunch**

**01.00 pm - Start**

1. Brief re-cap, discussion and question time. Demonstration of back positions. Practice.
2. **Third attunement.**

Break for coffee

1. Question time. Demonstration of seated positions. Practice.
2. **Fourth attunement.**
3. Presentation of Manual for future reference.

**3:30 pm Close**

**Day 2: - 10:00 am – Start – Reiki in Dementia Care**

1. Meditation.
2. Adapting Reiki to work in dementia care for this research project. Using Reiki as with PRN medication. Maintaining the Reiki Recording Sheet
3. Discussion time.

Break for Coffee

1. Practice of hands-on positions.
2. Discussion on using Reiki on Residents.

**12.00 pm - Break for Lunch**

**12.30 pm - Start**

1. Using Reiki on residents (Practical).
2. Discussion and wash-up.

**03.00 pm - Close**

# Appendix L

# Letter sent by management to selected staff members of the Group 2 and 3 facilities

Note: The researcher has deleted all identifying information in this Letter.

**Memo**

**To:** [redacted]
**From:**
**CC:** OFFICE
**Date:** February 17, 2012
**Re:** RESEARCH PROGRAM

---

Dear [redacted]

[redacted] facilities have been invited to participate in an exciting research project which involves being trained to use Reiki as a complementary therapy in managing our Residents.

You have been selected to participate in this because we believe that you have the attributes which will ensure that the results will be positive and productive.

The research involves you initially attending

- an introductory meeting [redacted]
- an interview
- REIKI training – 2 days (dates to be organized)

You will then be required to integrate these skills in your daily work practices when attending the Residents.

If you are rostered to work during this time please ensure that your shift time is covered [redacted]

The sessions will be paid education time.

Thank you

# Appendix M

# Additional questions asked at the beginning of the second interviews for Groups 2 and 3

Because management was actively involved in selecting people to participate in this project and determining who would attend particular training venues, I would like to ask the following questions before I turn on the recorder. I remind you that you do not have to answer any of the questions.

1. Did you have any concerns about the possible level of management involvement in this research?
   1.1. If so, were you re-assured by the guarantees of confidentiality given by the researcher and the Reiki Master?
2. Was your participation in the Reiki training in any way influenced by the possibility of management involvement in the project?
3. Did anyone from management attempt to influence the way in which you used Reiki in your work environment?
   3.1. If so, did this make you feel uncomfortable?
   3.2. If so, was this of assistance?

Thank you.

# Appendix N

Email from the Training Master received on 7th June 2012

Hi Graham,

I would like to take this opportunity to thankyou for allowing me to take part as a Reiki Teacher/Practitioner in your research project *Reducing Anxiety in Carers of People with Dementia: A Trial of Reiki in Aged Care.*

This opportunity has allowed me to pass on to the students that I taught in the project, the experience that I have gained while working as a Reiki Practitioner / Carer in the Aged Care sector.

The teaching of Reiki to these students I believe will have a positive affect not only on them [personally] but will have a positive flow on affect on residents and Age Care workers that they have contact with.

My experience in using Reiki in this situation has been a positive one, it has had a flow on affect to the residents [in] their every day living, pain management, and palliative care situations.

As you are aware the position of a Personal Carer is a stressful one, by using Reiki to reduce this stress / anxiety again has a positive flow-on effect to the residents.

These factors that I have mentioned I believe have a positive affect on the quality of life of residents that are in an Aged Care situation where Reiki has been introduced.

Regards,

Ian.

# Appendix O

# Interview Focusing Questions for the Directors of Nursing

1. Have you had training in complementary therapies?
   If so, which ones?
2. Why did you decide to encourage your staff to participate in this research project?
3. Are any of the staff members trained in Reiki as part of this project using Reiki at work?
   If so, how is it being used?
4. Have there been any lasting benefits from the use of Reiki
   If so, what have been the benefits?

# Appendix P

# Accreditation Standards for Aged Care

## Accreditation Standards

### Standard 1

**Management systems, staffing and organisational development**

**Principle:** Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of residents, their representatives, staff and stakeholders, and the changing environment in which the service operates.

**Intention of standard:** This standard is intended to enhance the quality of performance under all Accreditation Standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.

**Expected outcome:**

**1.1 Continuous improvement**
The organisation actively pursues continuous improvement.

**1.2 Regulatory compliance**
The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.

**1.3 Education and staff development**
Management and staff have appropriate knowledge and skills to perform their roles effectively.

**1.4 Comments and complaints**
Each resident (or his or her representative) and other interested parties have access to internal and external complaints mechanisms.

**1.5 Planning and leadership**
The organisation has documented the residential care service's vision, values, philosophy, objectives and commitment to quality throughout the service.

**1.6 Human resource management**
There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives.

**1.7 Inventory and equipment**
Stocks of appropriate goods and equipment for quality service delivery are available.

**1.8 Information systems**
Effective information management systems are in place.

**1.9 External services**
All externally sources services are provided in a way that meets the residential care service's needs and service quality goals.

### Standard 2

**Health and personal care**

**Principle:** Residents' physical and mental health will be promoted and achieved at the optimum level, in partnership between each resident (or his or her representative) and the health care team.

**Expected outcome:**

**2.1 Continuous improvement**
The organisation actively pursues continuous improvement.

**2.2 Regulatory compliance**
The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about health and personal care.

**2.3 Education and staff development**
Management and staff have appropriate knowledge and skills to perform their roles effectively.

**2.4 Clinical care**
Residents receive appropriate clinical care.

**2.5 Specialised nursing care needs**
Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff.

**2.6 Other health and related services**
Residents are referred to appropriate health specialists in accordance with the resident's needs and preferences.

**2.7 Medication management**
Residents' medication is managed safely and correctly.

**2.8 Pain management**
All residents are as free as possible from pain.

**2.9 Palliative care**
The comfort and dignity of terminally ill residents is maintained.

**2.10 Nutrition and hydration**
Residents receive adequate nourishment and hydration.

**2.11 Skin care**
Residents' skin integrity in consistent with their general health.

**2.12 Continence management**
Residents' continence is managed effectively.

**2.13 Behavioural management**
The needs of residents with challenging behaviours are managed effectively.

**2.14 Mobility, dexterity and rehabilitation**
Optimum levels of mobility and dexterity are achieved for all residents.

**2.15 Oral and dental care**
Residents' oral and dental health is maintained.

**2.16 Sensory loss**
Residents' sensory losses are identified and managed effectively.

**2.17 Sleep**
Residents are able to achieve natural sleep patterns.

Aged Care
Standards and Accreditation Agency Ltd

# Accreditation Standards

## Standard 3

### Resident lifestyle

**Principle:** Residents retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.

**Expected outcome:**

**3.1 Continuous improvement**
The organisation actively pursues continuous improvement.

**3.2 Regulatory compliance**
The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about resident lifestyle.

**3.3 Education and staff development**
Management and staff have appropriate knowledge and skills to perform their roles effectively.

**3.4 Emotional support**
Each resident receives support in adjusting to life in the new environment and on an ongoing basis.

**3.5 Independence**
Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.

**3.6 Privacy and dignity**
Each resident's right to privacy, dignity and confidentiality is recognised and respected.

**3.7 Leisure interests and activities**
Residents are encouraged and supported to particpate in a wide range of interests and activities of interest to them.

**3.8 Cultural and spiritual life**
Individual interests, customs, beliefs and cultural and ethnical backgrounds are valued and fostered.

**3.9 Choice and decision-making**
Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.

**3.10 Resident security of tenure and responsibilities**
Residents have secure tenure within the residential care service, and understand their rights and responsibilities.

## Standard 4

### Physical environment and safe systems

**Principle:** Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors.

**Expected outcome:**

**4.1 Continuous improvement**
The organisation actively pursues continuous improvement.

**4.2 Regulatory compliance**
The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about physical environment and safe systems.

**4.3 Education and staff development**
Management and staff have appropriate knowledge and skills to perform their roles effectively.

**4.4 Living environment**
Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs.

**4.5 Occupational health and safety**
Management is actively working to provide a safe work environment that meets regulatory requirements.

**4.6 Fire, security and other emergencies**
Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.

**4.7 Infection control**
An effective infection control program.

**4.8 Catering, cleaning and laundry services**
Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment.

Certified System
Quality
ISO 9001
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Aged Care
Standards and Accreditation Agency Ltd

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AS_IS_01297 V1.3

# Appendix Q

# The proposed three-way analysis of data within and across groups

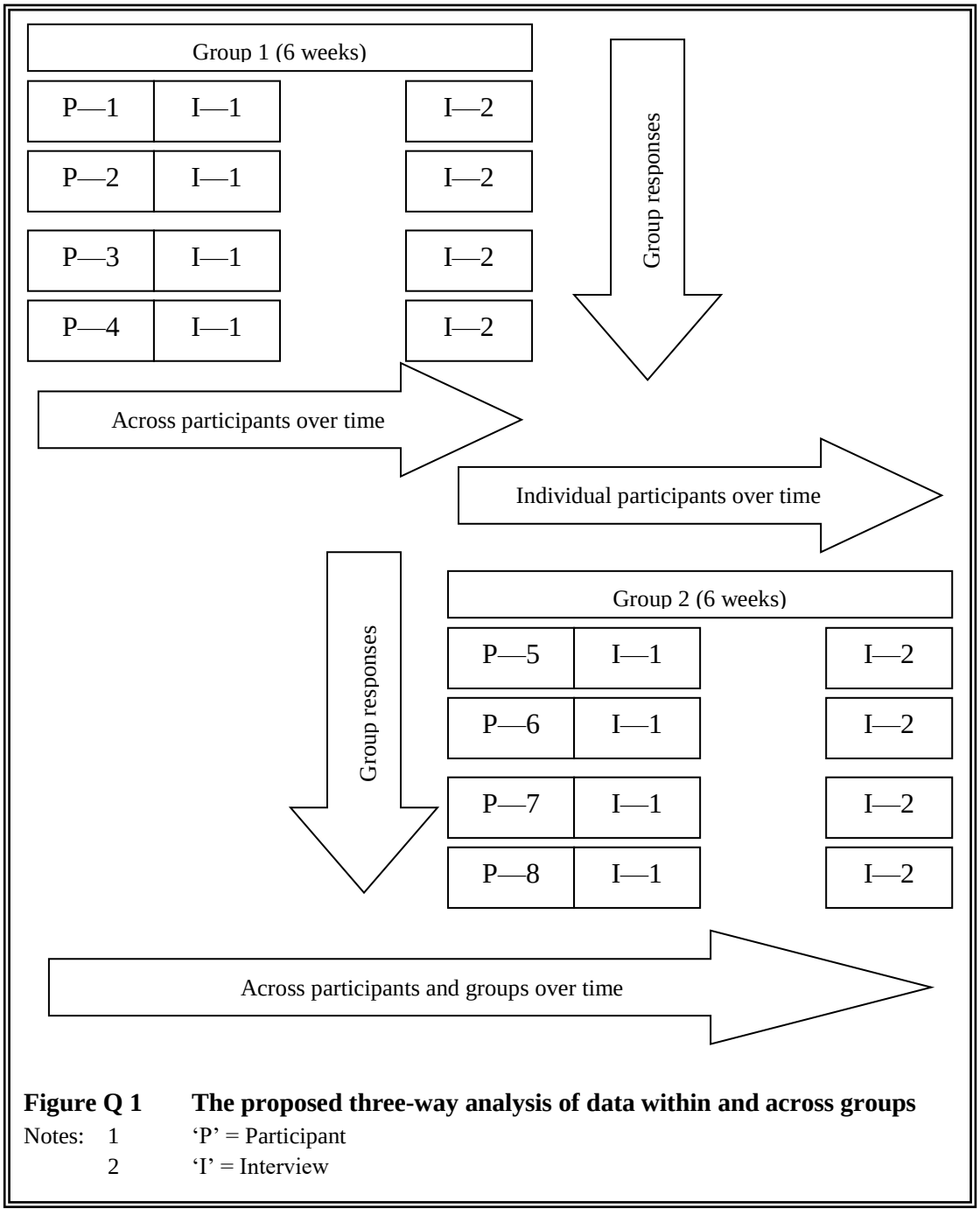


**Figure Q 1** **The proposed three-way analysis of data within and across groups**

Notes: 1 'P' = Participant

2 'I' = Interview

# Appendix R

# Ethics Committee Approvals

Flinders University and Southern Adelaide Health Service

**SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE**

Room 105, Registry Building, Flinders University,
GPO Box 2100, ADELAIDE SA 5001
Phone: (08) 8201 5962
Email: sandy.huxtable@flinders.edu.au

## CONDITIONAL APPROVAL NOTICE

Principal Researcher: Mr Graham Webber

Address: Disability Studies

Project Title: A Trial of the Efficacy of Reiki in Reducing Anxiety in Carers of People with Dementia

Project No.: **4087**

The Social and Behavioural Research Ethics Committee is satisfied that in most respects the above project meets the requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)*. However, some further clarification is needed prior to the commencement of data collection.

The project has been given **conditional approval** subject to:

(i) Confirmation that carers will be required to complete the Cohen-Mansfield Agitation Inventory (item C5).
(ii) Explanation of what is "normal practice" as mentioned in item D1(f).
(iii) Explanation of what "normal information channels" are, as referred to in D4.
(iv) Provision of copies of the letters to the Director of Nursing, the facility management and the facility's ethics committee (item D7) requesting permission to conduct the research in their facility.
(v) Provision of copies of the permission letters from the people referred to in (ii) above when they are received.
(vi) Simplifying the wording of the Information Sheet for clients with dementia and/or their guardians. The Committee believes some people with dementia may have problems understanding the current wording.

Please ensure that the Letters of Introduction appear on the new University letterhead (available from http://www.flinders.edu.au/research/info-for-researchers/ethics/committees/social-behavioural.cfm).

Please respond in writing to the above conditions to enable confirmation of final approval. Do not submit an amended application form. A letter addressed to me in Room 105, Registry Building or an email to sandy.huxtable@flinders.edu.au, along with any amended participant documents, is preferred.

Sandy Huxtable
Secretary
Social and Behavioural Research Ethics Committee
7 March 2008

cc: Dr Brian Matthews, Disability Studies
Dr Caroline Ellison, Disability Studies

Flinders University and Southern Adelaide Health Service

**SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE**

Research Services Office, Union Building, Flinders University
GPO Box 2100, ADELAIDE SA 5001
Phone: (08) 8201 3116
Email: human.researchethics@flinders.edu.au

# FINAL APPROVAL NOTICE

| | |
|---|---|
| Principal Researcher: | Mr Graham Webber |
| Email: | graham.webber@flinders.edu.au |
| Address: | Disability Studies |
| Project Title: | Reducing Anxiety in Professional Carers of People with Dementia: A Trial of the Efficacy of Reiki in Aged Care |

| Project No.: | 4087 | Final Approval Date: | 21 December 2010 | Approval Expiry Date: | **31 December 2013** |
|---|---|---|---|---|---|

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided with the addition of the following comments:

Please ensure that the following information is provided to the Committee as soon as possible following final discussions with the Nursing Home:

(i) Explanation of what 'normal practice' is (item D1(f)).
(ii) Explanation of what 'normal information channels' are (item D4).
(iii) Provision of copies of the letters sent to the Director of Nursing, the facility management and the facility's ethics committee (item D7) requesting permission to conduct the research in their facility and copies of the letters granting permission.

If you have any outstanding permission letters (item D8), that may have been previously requested, please ensure that they are forwarded to the Committee as soon as possible. Additionally, for projects where approval has also been sought from another Human Research Ethics Committee (item G1), please be reminded that a copy of the ethics approval notice will need to be sent to the Committee on receipt.

In accordance with the undertaking you provided in your application for ethics approval for the project, please inform the Social and Behavioural Research Ethics Committee, giving reasons, if the research project is discontinued before the expected date of completion.

You are also required to report anything which might warrant review of ethical approval of the protocol. Such matters include:

- serious or unexpected adverse effects on participants;
- proposed changes in the protocol (modifications);
- any changes to the research team; and
- unforeseen events that might affect continued ethical acceptability of the project.

To modify/amend a previously approved project please either mail or email a completed copy of the Modification Request Form to the Executive Officer, which is available for download from http://www.flinders.edu.au/research/info-for-researchers/ethics/committees/social-and-behavioural-research-ethics-committee/notification-of-committee-decision.cfm. Please ensure that any new or amended participant documents are attached to the modification request.

In order to comply with monitoring requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)* an annual progress and/or final report must be submitted. A copy of the pro forma is available from http://www.flinders.edu.au/research/info-for-researchers/ethics/committees/social-behavioural.cfm.

Your first report is due on **21 December 2011** or on completion of the project, whichever is the earliest. *Please retain this notice for reference when completing annual progress or final reports.* If an extension of time is required, please email a request for an extension of time, to a date you specify, to human.researchethics@flinders.edu.au before the expiry date.

Andrea Mather (formerly Jacobs)
Executive Officer
Social and Behavioural Research Ethics Committee
22 December 2010

c.c Dr Brian Matthews, b.matthews@flinders.edu.au
Dr Caroline Ellison, caroline.ellison@flinders.edu.au

Flinders University and Southern Adelaide Health Service

**SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE**

Research Services Office, Union Building, Flinders University
GPO Box 2100, ADELAIDE SA 5001
Phone: (08) 8201 3116
Email: human.researchethics @flinders.edu.au

# MODIFICATION APPROVAL NOTICE

| | |
|---|---|
| Principal Researcher: | Mr Graham Webber |
| Email: | graham.webber@flinders.edu.au |
| Address: | Disability Studies |
| Project Title: | Reducing Anxiety in Professional Carers of People with Dementia: A Trial of the Efficacy of Reiki in Aged Care |

| Project No.: | 4087 | Modification Approval Date: | 21 December 2010 | Approval Expiry Date: | 30 June 2015 |
|---|---|---|---|---|---|

I refer to your application for a modification of the above project that has been approved previously. I am pleased to inform you that the Acting Chairperson has approved your request to modify the project as outlined below:

| ✓ | Approved Modification(s) | Details of approved modification(s) | | | |
|---|---|---|---|---|---|
| ✓ | Extension of Time: | From: | 30/12/13 | To: | 30/6/15 |
| | Change of personnel: | | | | |
| ✓ | Change of project title | Change of title to 'Reducing Anxiety of Professional Carers of People with Dementia: A Trial of the Efficacy of Reiki in Aged Care' | | | |
| ✓ | Modified research protocol: | Will no longer be working directly with people with dementia. Letter of Introduction, Consent Form for Carers and Information Sheet for Carers were modified accordingly as per the Modification Request Form received on the 10th of December. | | | |

Reminder: The next annual progress or final report to the Social and Behavioural Research Ethics Committee is due on **21 December 2011** or when the project is completed, whichever is the soonest. If you require an extension of time, please send a request for an extension of time, to a date you specify, to human.researchethics@flinders.edu.au before the expiry date listed above.

Andrea Mather (formerly Jacobs)
Executive Officer
Social and Behavioural Research Ethics Committee
22 December 2010

cc: Dr Brian Matthews, b.matthews@flinders.edu.au
Dr Caroline Ellison, caroline.ellison@flinders.edu.au

Flinders University and Southern Area Health Service

**SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE**

Research Services Office, Union Building, Flinders University
GPO Box 2100, ADELAIDE SA 5001
Phone: (08) 8201 3116
Email: human.researchethics @flinders.edu.au

# MODIFICATION APPROVAL NOTICE

| | |
|---|---|
| Principal Researcher: | Mr Graham Webber |
| Email: | graham.webber@flinders.edu.au |
| Address: | Disability Studies |
| Project Title: | Reducing Anxiety in Professional Carers of People with Dementia: A Trial of Reiki in Aged Care |

Project No.: **4087** Modification Approval Date: 29 July 2011 Approval Expiry Date: **30 June 2015**

I refer to your application for a modification of the above project that has been approved previously. I am pleased to inform you that the Chairperson has approved your request to modify the project as outlined below:

| ✓ | Approved Modification(s) | Details of approved modification(s) | | | |
|---|---|---|---|---|---|
| | Extension of Time: | From: | | To: | |
| | Change of personnel: | | | | |
| ✓ | Modified research protocol: | Change of project title<br>To remove the word 'efficacy' from the title as outlined in the Modification Request received on the 27th of July. | | | |

Reminder: The next annual progress or final report to the Social and Behavioural Research Ethics Committee is due on **21 December 2011** or when the project is completed, whichever is the soonest. If you require an extension of time, please send a request for an extension of time, to a date you specify, to human.researchethics@flinders.edu.au before the expiry date listed above.

Andrea Mather
Executive Officer
Social and Behavioural Research Ethics Committee
29 July 2011

cc: Dr Brian Matthews, brian.matthews@flinders.edu.au
Dr Caroline Ellison, caroline.ellison@flinders.edu.au

**Graham Webber**

**From:** Human Research Ethics <human.researchethics@flinders.edu.au>
**Sent:** Wednesday, 19 December 2012 2:43 PM
**To:** graham.webber@flinders.edu.au; Brian Matthews; Caroline Ellison
**Subject:** 4087 SBREC - Modification No. 3 Approved (19 December 2012)

**Importance:** High

Dear Graham,

The Chairperson of the Social and Behavioural Research Ethics Committee (SBREC) at Flinders University has reviewed and approved the modification request that was submitted for project 4087. A modification ethics approval notice can be found below.

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# MODIFICATION (#3) APPROVAL NOTICE

Project No.: **4087**

Project Title: Reducing Anxiety in Professional Carers of People with Dementia: A Trial of Reiki in Aged Care

Principal Researcher: Mr Graham Webber

Email: graham.webber@flinders.edu.au

Address: Disability Studies

Modification Approval Date: 19 December 2012

Ethics Approval Expiry Date: **30 June 2015**

I refer to your modification request for the project above that has been approved previously. I am pleased to inform you that the Chairperson has approved your request to modify the project as outlined below:

| ✓ | Approved Modification(s) | Details of approved modification(s) | |
|---|---|---|---|
| | Change of Project Title | From: | Not applicable. The title change requested had already been approved via a modification previously. |
| | | To: | |
| ✓ | Modified research protocol: | 1. A third round of interviews to be conducted 12-months after the 2nd interviews with participants.<br>2. Directors of Nursing (DONs), outlined in modification request, to be interviewed. Semi-structured interviews will be conducted following the 3rd round of interviews. A standard agreement as per the original application will be provided for each DON. | |

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| | | | |
|---|---|---|---|
| ✓ | Documentation Amendments and/or Additions | Amended Documents | None. |
| | | New Documents | 1. Interview Questions focussed for DONs |

**RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS**

1. **Participant Documentation**
   Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

   - all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Committee does not accept any responsibility for the above mentioned errors.
   - the Flinders University logo is included on all participant documentation (e.g., letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.
   - the SBREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

   *This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 'INSERT PROJECT No. here following approval'). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.*

2. **Annual Progress / Final Reports**
   Please be reminded that in order to comply with the monitoring requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)* an annual progress report must be submitted each year on **21 December** (approval anniversary date) for the duration of the ethics approval.

   If the project is completed *before* ethics approval has expired please ensure a final report is submitted immediately. If ethics approval for your project expires please submit either (1) a final report; or (2) an extension of time request and an annual report.

   A copy of the annual progress / final report pro forma. *Please retain this notice for reference when completing annual progress or final reports.*

   Your next report is due on **21 December 2012** or on completion of the project, whichever is the earliest.

3. **Modifications to Project**
   Modifications to the project must not proceed until approval has been obtained from the Ethics Committee. Such matters include:

   - proposed changes to the research protocol;
   - proposed changes to participant recruitment methods;
   - amendments to participant documentation and/or research tools;
   - extension of ethics approval expiry date; and
   - changes to the research team (addition, removals, supervisor changes).

   To notify the Committee of any proposed modifications to the project please submit a Modification Request Form to the Executive Officer. Please note that extension of time requests should be submitted prior to the Ethics Approval Expiry Date listed on this notice.

   Change of Contact Details

Please ensure that you notify the Executive Officer if either your mailing or email address changes to ensure that correspondence relating to this project can be sent to you. A modification request is not required to change your contact details.

4. **Adverse Events and/or Complaints**
Researchers should advise the Executive Officer of the Ethics Committee on 08 8201-3116 or human.researchethics@flinders.edu.au immediately if:

- any complaints regarding the research are received;
- a serious or unexpected adverse event occurs that effects participants;
- an unforseen event occurs that may affect the ethical acceptability of the project.

Andrea Fiegert
Executive Officer
Social and Behavioural Research Ethics Committee

Cc: Dr Brian Matthews
Dr Caroline Ellison

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Andrea Fiegert
Executive Officer, Social and Behavioural Research Ethics Committee
Research Services Office | Union Building Basement
Flinders University
Sturt Road, Bedford Park | South Australia | 5042
GPO Box 2100 | Adelaide SA 5001
P: +61 8 8201-3116 | F: +61 8 8201-2035 |Web: Social and Behavioural Research Ethics Committee

# Appendix S

# Conduct of Interviews and Reiki Training

## Individual interviews with participants

At the end of the introductory meetings I offered to meet with the participants individually in: their home, their place of work, a coffee lounge, the my home, or my Motor Home which they had seen parked outside of the facility were the meeting was held. They all requested an interview in my Motor Home either outside of the facility or their own home. This then became the venue for all individual interviews.

At the interviews I:

- ☆ had quiet, relaxing music playing when the participant arrived. This varied across interviews and was turned off for the interview;
- ☆ welcomed the participant, thanked them for their interest in the project and offered light refreshments;
- ☆ ensured that my mobile phone was turned off and asked the participant to turn off their phone;
- ☆ reminded the participant that they could withdraw at any time without the need to provide an explanation and re-assured them of the confidentiality of any information provided;
- ☆ began the interview by noting the time and asking the Personal Details questions from the First Interview Sheet (Appendix B), personally writing the participant's answers on the sheet;
- ☆ reminded the participant not to say anything which would identify either themself, other people, or their place of work during the recorded session;
- ☆ digitally recorded the participant's responses to questions 1 to 8 on Page 2 of the First Interview Sheet (Appendix B). While the interviews were guided by the focusing questions, the researcher asked subsidiary questions 'for clarification of a response and to elicit additional information at the end of the subject's response to each question' (Webber, 2008, p. 78). Occasionally I made brief notes to ensure that additional probing questions could be asked at the end of the volunteer's responses to the focusing questions;
- ☆ concluded the recorded interview;
- ☆ recorded the time;
- ☆ thanked the participant for their time and efforts; and

- ✯ offered further light refreshments.

To ensure the confidentiality of all information given during the interview the participant's name was not used on either the Interview Sheet or during the taped sessions. Instead, a code was used to enable future identification and analysis of the information provided.

During each interview I maintained culturally appropriate eye contact with the participant and acknowledged the participant's contribution with a smile, nod of head head, and/or comment as appropriate.

## Reiki Training

### Group 1

Group 1 Training was conducted in a private home in a beachside suburb in Adelaide, South Australia on a Wednesday one week after the final first interview. The programme for the day is detailed in Appendix G. Present at the training were:

- ✯ The four volunteers being trained in Reiki. They were all from the same facility.
- ✯ The Reiki Master/Teacher who conducted the training.
- ✯ A Reiki I practitioner, known to the researcher, and attuned in the *Mikao Usui, Chujiro Hayashi, Mrs Takata, Phyllis Lei Furumoto, William Lee Rand, Christiana Rose, Jason Irving* and *Ruth Rohan-Jones* lineage. She assisted the Reiki Master/Teacher as directed by him. From personal experience, the researcher has found that it is usual for the Training Master to have an assistant (or assistants) present during training. Sometimes this person is a trainee Reiki Master/Teacher.
- ✯ An experienced, university senior lecturer who was present as an independent observer at the invitation of the researcher and the Reiki Master. However, after being asked by the Reiki Master, he willingly received Reiki when the participants practised what they had been taught.
- ✯ Myself. As noted above, I am a Reiki Master/Teacher. I trained in Reiki during 1997 and began teaching Reiki in 1998 (but was not actively conducting Reiki training during this research project). When requested, I was also able to assist the Reiki Master/Teacher conducting the training.

Quiet, relaxing music (Aeoliah, 1995, 1996; Chapman, 1988; O'Connor, 1994a, 1994b) was playing in the background and two, five-hour, non-scented, Australian made, *Natural Impressions*, natural beeswax candles were burning when the volunteers arrived. From personal experience, the I have found that playing relaxing music, burning candles and the elements of the training described below are common to Reiki training although

individual details such as the books on display, the music played and the exact details of the training will vary according to available resources and the people attending the training. As with any training, the content may be prescribed, but the trainer will tailor the delivery to meet the specific needs of the individuals attending the training.

***Confidentiality***

Before the training commenced, I advised the participants that the training would not be recorded and requested that participants maintain confidentiality of anything of a personal nature discussed during training to ensure that all participants could interact freely with each other during the training.

During the training:

- ☆ the weather was such that heating/cooling was not necessary to maintain comfortable conditions for the participants;
- ☆ the candles described above continued to burn throughout the day. It was, in fact, fortunate that non-scented candles were used because one of the participants indicated that they often had asthmatic allergy reactions to scented candles;
- ☆ the quiet, relaxing music described above was played as background music before and after the meditation described below;
- ☆ a selection of Reiki books (L. Barnett et al., 1996; Ellyard, 2002; Honervoght, 1998; Lubeck, 1995, 1997; Petter, 1997, 1998; Rand, 1991; Rowland, 1998; Stein, 1996), references about the scientific basis behind 'energy' therapies (Oschman, 2000, 2003; Oz et al., 1999), a medical dictionary (E. A. Martin, 2002), and a copy of my book relating to my previous research (Webber, 2008) were on display for the participants to browse during breaks in the training;
- ☆ the Reiki Master/Teacher conducting the training provided a hand cleanser (*Enya Clean & Free Instant Sanitiser: Antibacterial, no Water, no Towels, with Aloe Vera*) for the participants to use during the day;
- ☆ I provided a massage table to be used for demonstrations and practising Reiki during the day;
- ☆ participants were able to avail themselves of light refreshments as they wished;
- ☆ fresh water was provided for people who were the recipients of Reiki during the day (and for anyone else who wanted it);
- ☆ the training Reiki Master/Teacher asked the researcher to conduct the introductions and the meditation session;
- ☆ the meditation tape used was Side 1 – *Earth to Sky Balance* – of the *Reflections* audio tape (Adams, Stone, Slater, & Stubbings, 1993). Before the meditation tape was

played the curtains were closed to ensure a subtle lighting for the meditation. The curtains were opened immediately after the tape finished;

- ☆ Reiki attunements were conducted in a quiet location a short distance from the room in which the training was conducted (in this instance in the sunshine under a pergola outside the training venue) while the other participants in the main room practised what they had learnt. The Reiki I practitioner and the researcher were able to assist the participants to practise their new skills while the attunements were being conducted; and
- ☆ in addition to talking about general Reiki issues, the training Master/Teacher also talked about;
  - ❍ the use of Reiki in aged care;
  - ❍ the need to talk with management about the use of Reiki in aged care;
  - ❍ the use of Reiki in palliative care;
  - ❍ how people will refuse the Reiki energy and the need to stop using Reiki when this occurs;
  - ❍ how Reiki does not always work as expected; and
  - ❍ the fact that Reiki is not a cure-all.

At the end of the training session I:

- ☆ thanked the participants for their attendance;
- ☆ provided the participants with the training manual described above;
- ☆ re-emphasised to the participants that, if the person receiving Reiki indicated either verbally or by their body language that he or she did not want Reiki then they were to immediately cease providing Reiki;
- ☆ distributed multiple copies of the Reiki Recording sheet (Appendix A), gave instructions about their use, and asked them to keep one copy at home and another at work (which they could take home each day if they so desired) in order to maintain confidentiality;
- ☆ instructed that maintaining the Reiki Recording sheet was not to impose upon their normal working conditions;
- ☆ informed the volunteer participants that they could contact the Master/Teacher who had conducted the training, the researcher, and/or the researcher's PhD supervisor at any time; and
- ☆ arranged the date and time for a mid-project meeting three weeks from the training day.

**Group 2**

Training was held on a Wednesday and Thursday in mid March 2012 and the programme for the two days is detailed in Appendix K.

The training followed the format detailed above for Group 1 with the exception that:

- ☆ in addition to the eight volunteers, only the Reiki Master/Teacher and I were present (the Reiki I practitioner had accepted an invitation to assist, but was called interstate on urgent family business on the Wednesday of the training);
- ☆ training was conducted in a cramped board room in the inner-west suburban facility;
- ☆ attunements were conducted in a resident's vacant bedroom some distance from the training room;
- ☆ because of sensitive fire equipment, candles could not be burnt during the day;
- ☆ because I did not have access to a portable CD player, music could not be played, and the Reiki Master led a meditation at the start of each day;
- ☆ in order to reduce glare from outside, the net curtains remained drawn during the day;
- ☆ the air-conditioning was adjusted as necessary to maintain comfortable conditions for the participants;
- ☆ in addition to the general precautions about not using Reiki in certain circumstances as discussed in the training manual, the training Master detailed specific precautions relating to the use of Reiki in aged care; and
- ☆ because of the number of people being attuned and the lack of other support, I had to assist the Reiki Master to a much greater extent than he had during Group 1 training.

**Group 3**

Training was held on a Wednesday and Thursday in late March 2012 and the programme for the two days is detailed in Appendix K.

The training followed the format detailed above for Group 1 with the exception that:

- ☆ in addition to the seven volunteers, only the Reiki Master/Teacher and I (the Reiki I practitioner had accepted an invitation to assist, but was still interstate);
- ☆ training was conducted in a cramped training/office/store room in the western beachside suburban facility and was interrupted several times during the first day by people collecting supplies;
- ☆ attunements were conducted in a vacant office adjacent to the training room;
- ☆ because of sensitive fire equipment, candles could not be burnt during the day;
- ☆ because I did not have access to a portable CD player, music could not be played, and the Reiki Master led a meditation at the start of each day;

- ✯ an attempt was made to adjust the lighting by drawing curtains in the room but they would not close properly;
- ✯ it was not necessary to use the air-conditioning available in the room;
- ✯ in addition to the general precautions about not using Reiki in certain circumstances as discussed in the training manual, the training Master detailed specific precautions relating to the use of Reiki in aged care;
- ✯ because of the number of people being attuned and the lack of other support, the I had to assist the Reiki Master to a much greater extent than I during Group 1 training;
- ✯ because Reiki was already being used in the facility, specific details about the use of Reiki were discussed by the training Master who was an employee in the facility;
- ✯ the confidentiality of personal information was discussed at length; and
- ✯ the attendees from the other facility commented on how warmly they had been welcomed by the other participants.