Reiki: Practitioners' Perceptions of the Effectiveness of a Complementary Therapy in the Treatment Regime of People with Dementia

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Graham R. Webber

Diploma of Teaching, Graduate Diploma of Education, Master of Disability Studies,
Reiki Master/Teacher, Seichim,
Therapeutic Touch (Beginners Level),
Certificate II in Massage (Aromatherapy).

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Abstract

International and national research has shown that the use of complementary therapies (often referred to in the scientific literature as either alternative therapies or unconventional therapies) is widespread. However, there is little in the scientific literature about the use of complementary therapies in the treatment regime of people with dementia. Specifically, there have been no published results of investigations into the use of Reiki, a holistic complementary therapy, in the treatment regime of people with dementia.

Before proceeding with an in-depth examination into the use of Reiki in the care of people with dementia, a questionnaire containing both closed and open-ended questions was distributed to 162 South Australian High Care Residential Facilities (formerly called Nursing Homes) in 2002. The return rate was 58.0% (n=94) of which 50.0% of the mail out (n=81) was available for analysis. Findings from the questionnaires suggested that a wide range of complementary therapies including aromatherapy, massage, music, behaviour therapy, healing touch, Reiki and Therapeutic Touch (Krieger/Kunz method) were used regularly within South Australian High Care Residential Facilities. Complementary therapies were reportedly used to calm residents, improve behaviour management, enhance the quality of life of residents, promote 1:1 interaction, stimulate the senses, and reduce the need for medication.

Due to 15 facilities reporting the use of Reiki, a series of semi-structured interviews with Reiki practitioners caring for people with dementia was conducted in 2004/2005. Interview participants (n=10) included a representative range of people providing care for people with dementia in eight Nursing Homes in Adelaide, South Australia. Data reduction methods included 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.

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.

The receipt of the first Jack Loader Scholarship from the Rosemary Foundation for Memory Support Inc. in early 2005 enabled the researcher to transfer to full-time studies from April 2005.

Key Words: aged care; alternative therapies; complementary therapies; dementia; early onset dementia; one to one interaction; quality of life; Reiki; therapeutic touch; unconventional therapies.

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
26 September 2006

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1. 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.*

The genesis of this thesis lies in the researcher's personal experience in assisting his elderly and dying aunty to weave her way through the complexities of the emergency department of a large metropolitan public hospital, the demands of a prolonged stay in the recovery ward of the hospital, finding a suitable nursing home placement, and her eventual death. She had advanced breast cancer which had spread to her lungs. A fiercely independent woman who had lived alone for over 25 years following the death of her husband, she found it extremely difficult to commit the responsibility for her care to the hands of strangers.

During this period, the researcher was highly impressed by both the dedication and professionalism of the various staff members responsible for providing care for his aunty and their efforts to maximise the quality of life for a person near the end of her days. Personal observations and discussions with various staff members when visiting his aunty in the hospital and a wide range of Residential High Care Facilities (formerly called Nursing Homes) in metropolitan Adelaide, showed that, generally, the staff members of these institutions looked well beyond the immediate medical needs of their clients to provide a level of personal care that was truly remarkable.

Interactions with staff members in the nursing homes during this period indicated that the increasing number of people with dementia being admitted to residential care facilities caused severe strain on both resources and staff morale. This fact was affirmed subsequently by the literature surveys conducted by the researcher.

In addition to the 'traditional' allopathic skills necessary for providing medical care, many staff members at all levels utilised a wide array of 'Complementary Therapies' (often referred to in the scientific literature as either alternative or unconventional therapies) to assist their clients. While it was obvious that these complementary therapies were being used extensively in a large number of facilities, a search of the academic databases indicated that there is a dearth of research into the use of complementary therapies in the care of the elderly.

This lack of published research into the use of complementarity therapies had been confirmed by the researcher's investigation into aspects of Attention Deficit Hyperactivity during his work for the master of Disability Studies.

The researcher is a Reiki Master/Teacher with training in aromatherapy massage and Therapeutic Touch (Krieger/Kunz method). In addition to practicing in these areas, he has conducted training at Reiki I, Reiki II and Reiki Master/Teacher levels. He was able to draw upon experiences gained through these activities to inform various stages of this research, to assist in the framing of questions in both the survey of nursing homes and the interviews with Reiki practitioners, and to recruit volunteers for the interviews.

Having perceived a major limitation in current research into the use of complementary therapies in the care of people with dementia it could be argued that **there was a moral obligation to conduct research into the phenomenon**. Therefore, the researcher chose to investigate the use of complementary therapies (with a focus on Reiki) in the care of people with dementia. The following research is based on three questions:

1. Is Reiki used as a therapy for the treatment of dementia in South Australian nursing homes?
2. Is there any evidence for the efficacy of Reiki in the treatment of dementia?
3. How do residents, family and staff members in nursing homes perceive the effectiveness of Reiki?

The ordering of the major chapters is as follows:

- ☆ Literature Survey: The Management of Dementia
- ☆ Management of Dementia in South Australian High Care Residential Facilities
- ☆ Literature Survey: Complementary Therapies
- ☆ Literature Survey: How Can Energy Heal?
- ☆ Literature Survey: Usui Reiki
- ☆ Interviews with Reiki Practitioners Caring for People with Dementia

This reflects the researcher's scientific journey in attempting to come to grips with issues relating to dementia, the care of people with dementia, the nature of complementary therapies and the theories underlying their purported efficacy.

2. Literature Survey: The Management of Dementia

… every day a little bit … has gone forever *(Freeth, 1994, p. 26).*

2.1. Dementia and its prevalence

Dementia is a degenerative condition which impairs the physical and mental functioning of the brain, resulting in "multiple cognitive deficits" (American Psychiatric Association (APA), *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, *DSM-IV-TR*, 2000, p. 147). The term dementia is an umbrella term covering a range of conditions variously described as Alzheimer's disease, Huntington's disease, vascular dementia, alcohol related dementia, the AIDS Dementia Complex (Freeth, 1994), fronto temporal dementia [frontal lobe dementia], drug related dementia, Lewy body disease (Geriaction, 2001a), Parkinson's disease, dementia due to head trauma, Pick's disease, Creutzfeldt-Jakob disease and dementia due to multiple aetiologies (APA, 2000). A 1994 study of 123 dementia cases in Australia reported that Alzheimer's disease accounted for 49.5%, Huntington's disease 22.3%, vascular dementia 6.8%, Pick's disease 4.9%, alcohol abuse 4.9%, Creutzfeldt-Jakob disease 1.0%, Parkinson's disease 1.0% and other causes 4.9% of the cases surveyed. In 4.9% of the cases the cause of the dementia was not known (Freeth, 1994).

In 1998 it was estimated that dementia affected 1 in 4 Australians aged 85 years and over, 1 in 9 from 80 to 84 years and 1 in 15 from 65 to 80 years, while there may have been as many as 2,000 people under the age of 65 years with dementia. Dementia was the fourth largest killer in Australia after heart, cancer and respiratory diseases. The incidences of dementia in the Australian population are expected to increase by 254% from 1995 to 2041 due to the general ageing of the population. (Alzheimer's Disease and Related Disorders Association of NSW, 2001b). Although normally associated with old age, there is an increasing incidence of Early Onset Dementia (also called Younger Onset Dementia) in people under the age of 65 years. Dementia has been diagnosed in people in their 30's (Alzheimer's Association Victoria 01, no date) and the DSM-IV-TR (2000) suggested that a diagnosis of dementia is possible in children as young as 4 to 6 years of age, when it is usually associated with head trauma or brain tumour, but that it is uncommon in children and adolescents.

2.2. The symptoms of dementia

Early symptoms of dementia may be simply a slight memory loss and aphasia while, in the latter stage of the disease, there may be a complete mental and physical incapacity leading to an early death. Physical and psychological features associated with dementia include spatial disorientation, poor judgement and insight, unrealistic assessments of abilities, understatement of risks associated with an action, violence, suicidal behaviour, motor disturbances of gait, falls, disinhibited behaviours, slurred speech, anxiety, mood and sleep disturbances, and vulnerability to physical and psychosocial stressors (APA, 2000; Freeth, 1994; The Alzheimer's Association Victoria 01, no date).

For a formal diagnosis of dementia to be made, there must be an impairment of memory coexisting with at least one of the following conditions; aphasia (a deterioration of language functioning), apraxia (an impairment of motor functioning), agnosia (a failure to recognise or identify objects), or a disturbance in executive functioning (an impairment of abstract thinking and planning) (DSM-IV-TR, 2000). The Alzheimer's Association Victoria 01 (no date) stressed the importance of including a detailed medical history, a thorough physical and neurological examination, an array of laboratory tests specifically designed to screen for dementia, a mental status evaluation, a psychiatric assessment, and neuro-psychological testing in the evaluation process.

While there are published standardised diagnostic tools available, the DSM-IV-TR (2000) emphasised that the degree of impairment may vary according to the social setting. Some of the assessments may be culturally sensitive and the individual's educational background must be considered when making a diagnosis. With early onset dementia, the first symptoms may be work related and, because the individual can 'perform' normally when seen by a doctor, failure to accurately diagnose the condition may place considerable strain on the individual's family and work colleagues. An Australian study involving 123 carers of people with dementia reported that 20% experienced problems with misdiagnosis of the condition (Freeth, 1994).

2.2.1. Conditions to be eliminated before a diagnosis of dementia

The DSM-IV-TR (2000) advised that dementia must be differentiated from delirium, amnestic disorder, mental retardation, schizophrenia, major depressive disorder, malingering, factitious disorder and the normal decline due to ageing.

2.3. How is dementia acquired?

The degeneration of brain function, which will eventually be described as dementia, may be caused by physical trauma, substance abuse (both alcohol and drugs), disease (such as HIV/AIDS), pre-existing medical conditions such as Down Syndrome, vascular disorders, degeneration, and/or genetic mutation (Freeth, 1994). In addition, research has indicated that there may be hereditary (particularly among first degree relatives), environmental, racial and regional factors (Freeth, 1994) involved in the development of dementia which "… [may be] the result of highly complex, and only partially understood, interaction between inheritance and the environment" (Freeth, 1994, p. 11).

2.4. Can dementia be cured?

While certain of the dementias such as those caused by substance abuse and cerebrovascular disease may be preventable (Alzheimer's Disease and Related Disorders Association of NSW, 2001b), there is no known cure for degenerative dementias such as Alzheimer's disease (Collins, 2001; Jorm, 2002; Rowe & Alfred, 1999).

2.5. The effects of dementia

2.5.1. Problematic behaviours

Problematic behaviours associated with dementia can be extensive. The Cohen-Mansfield Agitation Inventory rates 29 problematic behaviours including pacing and aimless wandering, inappropriate dressing or disrobing, spitting (including while feeding), cursing or verbal aggression, constant, unwarranted requests for attention or help, repetitive sentences or questions, hitting (including self), kicking, grabbing onto other people or things inappropriately, pushing, throwing things, making strange noises, screaming, biting, scratching, attempting to get to a different place, intentionally falling, complaining, negativism, eating or drinking inappropriate substances, hurting self or others, handling things inappropriately, hiding things, hoarding things, tearing things or destroying property, performing repetitious mannerisms, making verbal sexual advances, making physical sexual advances or exposing genitals, and general restlessness. Even though the person may be physically restrained, unable to walk, or unable to manoeuvre their wheelchair, people with dementia may demonstrate problematic behaviours as frequently as several times an hour (Cohen-Mansfield, 1999, pp. 47-48). To this list of behaviours can be added depression, anxiety, delusions, hallucinations and insomnia (Alzheimer's Disease and Related

Disorders Association of NSW, 2001a). However, for simplicity, problematic behaviours can be grouped into seven broad categories of vocalisation, pacing and walking, manual manipulation, searching and wandering, resisting, tapping and banging, and escaping restraints (Rowe & Alfred, 1999).

In the early stages of dementia the individual may recognise the increasing problems and this can, in turn, cause "great distress and clinical depression" (Collins, 2001, p. 18) and loss of self-esteem (Hyde, 1996). Being forced into early retirement, the loss of independence and the inability to drive and cope with other normal daily routines may add to the frustrations experienced by the individual (Collins, 2001). As the ability of the individual with dementia to cope "normally" and the range of problematic behaviours displayed by the individual increases, the health, stress and financial burdens on family members and caregivers increases (Freeth, 1994).

2.5.2. The effect on caregivers and family members

Individual caregivers have described anger, depression, despair, frayed temper, frustration, grief, guilt, heartache, loss of contact with friends and relatives, loss of mutual sharing, loss of physical intimacy, remorse, sadness, self-reproach, and sorrow (Collins, 2001). The term "living death" has even been used to describe the effects of dementia (Collins, 2001, p. 18). In a study involving 30 husbands and 30 wives (with equal numbers at home and in institutions) who were spousal caregivers (Rudd, 1994) the carers expressed feelings of anger, anxiety, being trapped, denial, depression, guilt, having been robbed of their hopes and dreams, helplessness, hopelessness, inadequacy, loneliness, loss of control (of the caregiving situation), being offended (by their spouse's offensive behaviour), and sadness. Rudd found that the "home caregiving wives" expressed the most anger (Rudd, 1994, p. 116). Some partners of individuals with dementia may even feel "cheated" by the early "loss" of their loved one (Freeth, 1994, p. 26).

Problems associated with dementia not only affect the individual and their partner. The children of the person with dementia, particularly in cases of early onset dementia, may react so adversely to the increasing debility of their parent that they become a problem both at home and school with a resulting severe and long-lasting detriment to their education (Freeth, 1994).

The provision of protective care, toileting problems, managing behaviour resulting from memory loss and confusion, and aggressive behaviour were found to be the major issues affecting the families of 20 Chinese-Australian people with dementia (Tan, Fleming & Ledwidge, 2001). The effects of having to cope with these situations caused "psychological stress, social isolation and loss of recreational opportunities, [and] cessation of employment" among the caregivers (Tan et al., 2001, p. 13). In addition, there was "a lack of support from male members of the family and family conflict" (Tan et al., 2001, p. 13).

In his biography, *Betty & Me: A Love Story, Living with Alzheimer's*, Hyde (1996) who was the husband/carer of a person with dementia, talked about the bereavement he felt as he realised that the brain damage caused by dementia was robbing his wife of "the spirit and personality that were an essential part of her very being" (Hyde, 1996, p. 61). Another husband/carer felt that dementia "seems to rob the human body of everything except the soul" (Tuohy, 1994). Hyde (1996) emphasised that, despite the loss of short-term memory and the inability to manage "normal" daily tasks, the long-term memory of the individual with dementia may remain intact. Thus the individual is able to recognise, and take pleasure in discussing; events, people and places from their early life.

While many of the comments made by carers about their relationships with the person with dementia, appear to be negative, some carers have commented on the role reversal that has been caused and how they are able to gain fulfilment in giving pleasure to the person with dementia (Downie, 1994; Hyde, 1996).

2.5.3. The need for early intervention and education

The need for early intervention, support for socially isolated caregivers, and overnight respite for home based carers has been highlighted in a Western Australian study involving staff members of a Program for Seniors (n=12), providers of community based services to home carers (n=5), and home carers referred to the Program for Seniors (n=8) (Dicker, 2001). The needs analysis conducted by Dicker identified seven areas of information and instruction required by home-based carers. These were general knowledge about dementia, general knowledge about behavioural and psychological symptoms of dementia, non-pharmacological management strategies, pharmacological management strategies, carer self-help and self-awareness, financial and legal issues, and community resources.

2.5.4. The need for respite services

The need for respite services for home-based carers is emphasised by Hayes (1999) while, in Australia, home-based caregivers might receive "adequate support for their physical needs" but "there are very few services available to cater for their emotional needs" (Rudd, 1994). The provision of adequate support for home-based caregivers could be an important element in the management of dementia as there appears to be a correlation between the number and severity of disturbed behaviours, carer burden and a likely increase in admissions to institutions (Opie, Rosewarne & O'Connor, 1999).

2.6. The management of dementia

In the United States of America, "unconventional", "alternative" or "complementary therapies" are increasingly being used in the management of a wide range of conditions (Eisenberg, Davis, Ettner, Appel, Wilkey, Van Rompay & Kessler, 1998; Eisenberg, Kessler, Foster, Norlock, Calkins & Delbanco, 1993). There is an indication that this may also be the case in Australia (Blacklock, 1992; Cosford, 1999; Davies, 2000 & 2001; Easthope, Gill, Beilby & Tranter, 1999; Godfrey, 1994; Henry, 2001; Sherwood, 2000; Tysoe, 2000; Van der Riet, 1999a & 1999b; Yeldham, 2000).

Therefore it could be assumed that complementary therapies are being used in the management of dementia.

However, in March 2002, a search conducted by the researcher of the *CINHAL (R) 1999-2001/7*, *HIV-AIDS, RURAL*, *Ausport_Med*, *APAIS_Health*, *AUSTRALIAN_MEDICAL_INDEX_AMI*, *CINCH_Health*, *Health _&_Society*, *DRUG*, and *ASTIhealth* electronic databases found that there was little in the scientific literature about the use of complementary therapies in the management of dementia.

The terms "dementia", "complementary", "Reiki", "massage" and "touch" were used for this search. Dementia resulted in 3,386 'hits', complementary - 2,212, Reiki – 57, massage – 1,024, and touch – 1,477. When the terms were combined, dementia +complementary returned 59 occurrences, dementia +Reiki 2, dementia +massage 34, and dementia +touch 57. From these figures, of 3,386 papers discussing dementia only 152 (4.48%) contained the term dementia in combination with complementary, Reiki, massage or touch.

Opie et al. (1999) conducted a manual search of selected journals and references listed in previous reviews combined with a search of Medline, CINAHL, PsycInfo

and Cochrane databases. They found that "non-pharmacological strategies" used to reduce disturbed behaviours in persons with dementia included changes to the physical environment, a variety of activity programmes, music, behaviour therapy, massage, light therapy, intervention by a multidisciplinary team, and carer education. They concluded, "there is evidence to support the efficacy of activity programs, music, behaviour therapy, light therapy, carer education and changes to the physical environment" (Opie et al., 1999, p. 789). However, they suggested that there is insufficient evidence to support the efficacy of "multi-disciplinary teams, massage and aromatherapy" (p. 789).

Since early 1997 the staff at the *Bundaleer Gardens Retirement Village* in Wauchope, New South Wales, have had to be qualified in massage, reflexology and aromatherapy as a condition of their employment. The home was active in introducing hydrotherapy, massage, clay packs, reflexology and ear candling. These therapies were designed to aid in the management of joint mobility, pain control, and Alzheimer's disease, multi-infarct dementia, Parkinson's disease and maniac depression. Since the introduction of these therapies, residents have experienced an increase in mobility and muscle relaxation, decreased joint stiffness, less anxiety, stimulation of the digestion and lymphatic systems, and a general improved feeling of well-being. Each resident involved in the regime had a complementary care plan and was rated on a scale of 0 (no significant degree) to 10 (extreme or chronic degree) if they displayed the symptoms under review (Henry, 2001).

Tobin (1995) claimed that aromatherapy massage using lavender, orange, geranium, and clary sage essential oils can delay, reduce and prevent agitation. However, Robins (1999) draws attention to the controversy which surrounds the use and study of essential oils, particularly the difficulty in separating the effect of the oils from the placebo effect associated with touch. In *The Fragrant Pharmacy: A Complete Guide to Aromatherapy and Essential Oils* Worwood (1996) claimed that various essential oils (when used in baths, compresses, lotions, massage and/or vaporising according to the individual's unique needs) can be effective in the management of Alzheimer's disease, depression, despair, hypertension, infections, insomnia, muscle tension, pain, stress, and a wide range of other conditions. Placing lavender essential oil on subjects' pillows at night has been found to improve sleep quality in 84% of subjects and increase daytime alertness in 70% of subjects (Hudson, 1996).

According to Butts (2001, p. 180), Comfort Touch, which is "skin-to-skin touch for the sole purpose of comfort", is "one of the most frequently used nursing inter-

ventions" that "generally produces positive feelings in elderly patients." In a four - week study of 45 randomly selected female subjects from two nursing homes in the rural south of the United States, participants received twice weekly, five-minute comfort touch sessions involving handshaking and patting of hand, forearm and shoulder during social and verbal interaction. Self-esteem over time, well-being and social process, life satisfaction/self-actualisation, and faith/belief and self-responsibility were tested and recorded as a baseline, after two weeks and after four weeks of treatment. Butts concluded that:

> *Comfort touch made a clinically and statistically significant difference in how elderly female residents felt about themselves in all aspects of Neuman's system variables. [The] study appears to indicate that nurses may enhance elders' sense of well-being and self-regard through comfort touch with nursing home residents. (Butts, 2001, p. 183).*

Rowe and Alfred (1999, p. 30) devised a program of slow stroke massage to be applied to shoulders, base of skull, upper neck, and back and then trained family caregivers to administer the massage "at predicted episodes of agitation or occurrences of unanticipated agitation." The procedure required only a quiet space and the massage was provided while the recipient was seated. As no other equipment was required, it could be administered at a moments notice. It was found that the massages decreased behaviours such as pacing, wandering, and resisting. However verbal aggression was not diffused. Provision of massage was contraindicated when the recipient was "agitated to the point of aggression" (p. 33) or the massage was perceived by the recipient to invade personal space. The massage routine developed by Rowe and Alfred did not require any special tools, education, certification or physician's orders. In addition to the direct benefit provided to recipients, it was found that the carers benefited through a reduction in the frequency of stressful events.

In a study conducted by Snyder, Egan and Burns (1995), twenty-six subjects from three large metropolitan Alzheimer care units were provided with a simple hand massage (2.5 minutes per hand) before morning and afternoon care activities. It was found that there was a small lessening of behaviours including grabbing, screaming, yelling, hitting, pinching and trying to get to another place after the morning massage. However, there was little improvement in physical resistance or repeating behaviours. The researchers suggested that inconsistencies found in the results might have arisen because the nurses were not comfortable providing the massage, afternoon staff were less enthusiastic than morning staff, the length of the massage may have not been sufficient, or the subjects may have had higher stress

levels in the afternoon and therefore the hand massage was not sufficient to promote relaxation. They found different results for male and female residents with the hand massage increasing the frequency of agitated behaviours in men and they questioned whether hand massage was a suitable therapy for men with dementia. Snyder et al. did not collect data on the gender of the carers providing the massages.

As with the slow stroke massage routine developed by Rowe and Alfred (1999), the simplicity of the hand massage developed by Snyder et al. (1995), means that it can be taught readily to both nursing staff and family members.

Following a daily 20-minutes session on a glider swing over a two-week period, 30 subjects from three Alzheimer Special Care Units in two large metropolitan nursing homes in the United States of America exhibited significantly improved emotions and relaxation. However there was no significant reduction in aggressive behaviours (Snyder, Tseng, Brandt, Croghan, Hanson, Constantine & Kirby, 2001). The glider swings had been adapted for wheelchair access and sessions were conducted in the afternoon when agitated behaviours tend to be highest. It was found that subjects with less cognitive impairment exhibited greater enjoyment from the swinging sessions which are safe for persons with dementia and can be easily used by staff, family and volunteers.

The effect of carer attitude, alluded to by Snyder et al. (1995) in their research into the effectiveness of hand massage was supported by Kovach and Meyer-Arnold (1997). In a study of bath time behaviours exhibited by 33 people with Alzheimer's disease they found that "Rushed, task-orientated behaviour by the caregiver was associated with agitated behaviour by the person being bathed." (Kovach & Meyer-Arnold 1997, p. 114). They advised avoiding situations which trigger aggressive behaviour and that, if the person with dementia refuses to be bathed; then there is always tomorrow. In addition, Kovach and Meyer-Arnold (1997) recommended "rescuing" where a second caregiver can take over the task which then causes the resident to feel rescued from the original caregiver. Because of the loss of short-term memory, the resident will quickly forget the incident. Giuliano (1996), a nurse who specialised in the night-time care of nursing home residents with dementia, and the developer of *ThreePhase Therapy*, strongly suggested that carer attitude is pivotal in avoiding situations which trigger aggressive behaviour and in deflecting the resident's attention.

Reminiscence therapy (Hyde, 1996) and validation therapy (Campbell 1994) are two very similar processes in that they both involve direct, close, social involvement

with the person with dementia. Hyde (1996) recounted his life caring for his wife who had dementia. Unsatisfied with Betty's "zombie" like behaviour following the prescription of Serenace (Hyde, 1996, p. 23), Hyde provided "opportunities for [Betty] to involve herself in past interests" through reminiscence therapy (Hyde, 1996, p. 77). This involved talking with Betty about past experiences in her life, taking her to visit familiar places from her past, and having photograph albums of pictures from her early life. The efficacy of this form of therapy is dependent on the individual's long-term memory function remaining despite a complete breakdown in short-term memory function, thus enabling the individual to "re-live, re-experience and savour" past experiences (Hyde, 1996, p. 39). In addition to reminiscing with his wife, Hyde took every opportunity available to him to "communicate [his] love to her, whether it be in words or touch or feeling or intimacy or more public gestures – perhaps even red roses on Valentine's Day" (Hyde, 1996, p. 76). These actions assisted to 'validate' Betty's life as a human being.

According to Campbell (1994), validation therapy requires carers to reorientate their attitudes, judgements and expectations and become an empathetic listener. Validation therapy acknowledges the "reality of feelings" and how these feelings affect the individual regardless of the realities of those feelings. This form of therapy involves carers centering and releasing their own emotions, using non-threatening, factual words, rephrasing what has been said using key words, asking the person to imagine the opposite, reminiscing, maintaining genuine, close eye contact, using ambiguity, using clear, low tones of voice, mirroring (observing and matching the person's motions and emotions), linking the behaviour with the unmet need, identifying and using the person's preferred sense whether it be visual, auditory or kinaesthetic, touching the person to relax and encourage conversation, and the use of music particularly for people in 'time confusion' (Campbell 1994, p. 146).

Krieger (1993, p. 17) described 'centering' as:

> *an act of self-searching, a going within to explore the deeper levels of yourself...[an]...act of journeying inward ...to trace or follow the energy flows of your own consciousness in a quest to understand your own being and your relationship to the universe.*

A positive carer attitude of not making demands on patients, regarding them as valuable human beings, and accepting the patient's behaviour as a meaningful expression was found to be important in generating "spontaneous" episodes of lucidity in a study undertaken in three nursing homes in Norway (Normann, Asplund & Norberg 1998). The advantages achieved through positive carer attitude is empha-

sised by the biographical works of Downie (1994), Giuliano (1996), Hyde (1996), Tuohy (1994), and two anonymous carers (Geriaction, 2001b & 2001c)

As cited above, Campbell (1994) and Opie et al. (1999) referred to the use of music as an effective tool in the management of dementia. Kramer (2001, p. 192) proposed that the "specialized use of music" has been found to provide three key beneficial effects of "relaxation, mood / consciousness alteration, and distraction". Kramer (2001, p. 192) further suggested that the use of music "should be individualized to produce the best results". Among twelve positive recommendations about the use of music in dementia management, Kramer (2001) advocated the inclusion of a music therapist in the management team and summarised that "music therapy fits well into nursing [as a] noninvasive, holistic means to contribute to health and healing" (p. 194).

Chen, Snyder and Krichbaum (2001) claimed that Tai Chi, a form of gentle exercise, can have major benefits for the frail elderly including: improvement in balance and posture, prevention of falls, enhanced cardiovascular and ventilatory functioning, rheumatoid arthritis rehabilitation, and reduced pain, stress and nightmares. While advocating the use of Tai Chi, they recommended making a detailed assessment of the individual before commencing exercise as, in some acute conditions such as angina and ventricular arrhythmia, Tai Chi may be contraindicated.

In a comprehensive overview of the integration of complementary and conventional procedures used with dementia, Rauckhorst (2001) detailed the use of dietary supplements (antioxidants, B vitamins, Acetyl-L-Carnitine, and Phosphatidylserine), herbal therapy (ginkgo biloba, Asian ginseng, Huperzine A, and other herbs), homeopathy, mind-body approaches (meditation, aromatherapy, massage, Therapeutic Touch, healing sounds/music therapy, and light therapy), and holistic ancient healing systems (Traditional Chinese Medicine, and Ayurveda). Rauckhorst concluded that "those who manage nursing home caseloads, need to be aware of the range of [complementary therapies] available that may help to prevent cognitive decline … and improve the quality of … life" (2001, p. 53) and that "Recommending appropriate [complementary therapies] to [Alzheimer's disease] patients and their caregivers can be very empowering in a situation so often characterized by helplessness and frustration." (2001, p. 53).

Touch, in many forms, is necessary for the management of people with dementia. While it has been suggested above that some forms of touch such as massage, Therapeutic Touch and reflexology may have therapeutic benefits for people with

dementia, Routasalo (1999) reminded that not all touch is necessarily therapeutic. Following a literature review, Routasalo (1999) was able to describe 27 forms of touch routinely used within patient care including the following:

1. *Necessary: deliberate physical contact to perform a task.*
2. *Non-necessary: spontaneous, affective.*
3. *Instrumental: seems necessary.*
4. *Expressive: seems non-necessary.*
5. *Affectional: the 'caring' form of touch.*
6. *Procedural: the kinds of behaviour in which nursing personnel routinely engage.*
7. *Empathic: an expression of the caregiver's participation in the patient's experience.*
8. *Philanthropic: touch as a gift from one who is whole to one who is not.*
9. *Spontaneous: caressing in one's own special way.*
10. *Pragmatic: massage, applying cream.*
11. *Silent: holding hands.*
12. *Non-procedural: not incidental to a procedure.*
13. *Investigator: deliberate stroking without talking.*
14. *Therapeutic: the laying on of hands.*
15. *Systematic: massage.*
16. *Comforting: helping the patient cope with the illness and its related stressors.*
17. *Protective: to protect the patient from physical harm and the nurse physically and emotionally.*
18. *Caring: largely emotional contact.*
19. *Task: performing nursing procedures.*
20. *Functional: interconnected with many aspects of patient's care.*
21. *Purposeful: an intentional physical contact by the nurse with the patient with the intent of helping.*
22. *Connecting: reinforcing the nurse's focus on the patient.*
23. *Working: physical contact to complete activities.*
24. *Orientating: the purpose of clarifying.*
25. *Social: in joking and teasing.*
26. *Work/task: task, physical supportive, controlling, glove/barrier.*
27. *Caring/social: comforting, reassuring, encouraging, fun/happy.*

In addition, Routasalo (1999) found that in nursing studies, touch is regarded as a "non-verbal, non-vocal form of communication" (p. 844) and that the experience of touch is always "individual" (p. 847). The experience and use of touch is gender based with expressive touch from a female nurse being more readily accepted than expressive touch from a male nurse; female nurses use touch more often than male nurses; and female patients are touched more often than male patients. Issues relating to touch will be explored in greater depth in later chapters.

The range of medications available for the management of dementia is comprehensive. A *HelpNote* produced by the Alzheimer's Disease and Related Disorders Association of NSW (2001a) indicated that medications commonly used included antipsychotics, atypical antipsychotics, antidepressants and sedatives. The *HelpNote*

provided a list of 32 individual drugs together with a statement that both the list of medications and the list of possible side effects were incomplete.

It is possible that individuals may be prescribed more than one medication. A study conducted by Rowe and Alfred (1999) found that the mean number of psychotropic drugs taken by participants was 1.15 with a range from 0 to 3. Only one of the nine participants was not on psychotropic medication. Participants were found to be taking alprazolam, amitriptyline, diazepam, lorazepam, paroxetine hydrochloride, sertraline hydrochloride and/or trazodone. Of these medications, amitriptyline, diazepam, lorazepam, paroxetine hydrochloride, and sertraline hydrochloride are listed in the *HelpNote* cited above.

If these medications are recommended for the management of dementia, then it could be assumed that they are generally safe. Or are they? The 2001 edition of *MIMS Annual* (MediMedia, 2001) listed 23 possible adverse events while taking alprazolam (Table 2.1) and 65 possible adverse events while taking sertraline hydrochloride (Table 2.2). What is worrying is not the list of possible adverse events associated with the medication but the total percentage of adverse events – 285.7% for people taking alprazolam and 299.6% for people taking sertraline hydrochloride. This would indicate that each individual participant reported between two and three adverse events while taking the medication. If some individuals reported none or one adverse event then some individuals would have reported four (or even more) adverse events.

Table 2.1: Percentage of patients reporting adverse events from alprazolam

Insomnia	29.5	Decreased salivation	10.6
Light-headedness	19.3	Irritability	10.5
Anxiety	19.2	Cognitive disorder	10.3
Fatigue and tiredness	18.4	Blurred vision	10.0
Abnormal involuntary movement	17.3	Muscular twitching	6.9
Headache	17.0	Impaired coordination	6.6
Nausea/vomiting	16.5	Muscle tone disorders	5.9
Sweating	14.4	Weakness	5.8
Diarrhoea	13.6	Memory impairment	5.5
Weight loss	13.3	Depression	5.1
Decreased appetite	12.8	Confusional state	5.0
Tachycardia	12.2	**Total**	**285.7**

Adapted from MIMS Annual 2001

Table 2.2: Percentage of patients reporting adverse events from sertraline hydrochloride			
Nausea	26.1	Rhinitis	2.0
Headache	20.3	Micturition frequency	2.0
Diarrhoea/loose stools	17.7	Weight loss	1.9
Insomnia	16.4	Amnesia	1.9
Dry mouth	16.3	Yawning	1.9
Sexual dysfunction (male) - psychiatric	15.5	Polyuria	1.8
Libido decreased	15.5	Hypoaesthesia	1.7
Somnolence	13.4	Myalgia	1.7
Dizziness	11.7	Sexual dysfunction (female) - psychiatric	1.7
Tremor	10.7	Fever	1.6
Fatigue	10.6	Back pain	1.5
Increased sweating	8.4	Urinary retention	1.5
Constipation	8.4	Twitching	1.4
Dyspepsia	6.0	Thirst	1.4
Agitation	5.6	Tinnitus	1.4
Respiratory disorder	4.3	Micturition disorder	1.4
Abnormal vision	4.2	Hypertonia	1.3
Vomiting	3.8	Increased appetite	1.3
Palpitations	3.5	Impaired concentration	1.3
Weight increase	3.5	Pharyngitis	1.2
Nervousness	3.4	Taste perversion	1.2
Flatulence	3.3	Convulsions (inc myoclonus)	1.1
Anorexia	2.8	Urticaria	1.1
Pain	2.7	Malaise	1.1
Depersonalisation	2.7	Abnormal thinking	1.1
Anxiety	2.6	Teeth grinding	1.1
Abdominal pain	2.4	Apathy	1.1
Hot flushes	2.2	Coughing	1.1
Arthralgia	2.2	Dyspnoea	1.1
Paroniria	2.2	Earache	1.1
Rash	2.1	Chest pain	1.0
Vaginal haemorrhage	2.1	Menstrual disorder	1.0
Paraesthesia	2.0	**Total**	**299.6**
Adapted from MIMS Annual 2001			

Ryden, Bossenmaier and McLachlan (1991) cited in Rowe and Alfred (1999) found increased verbal aggression scores for "patients using psychotropic drugs than patients who were not using such drugs" (Rowe & Alfred, 1999, p. 24)

If, as Rowe and Alfred (1999) found, individuals may be prescribed multiple psychotropic drugs, it can be assumed that some individuals may be taking multiple medications both for dementia and for other conditions. One elderly person was

found to have 80 different medications in 270 medication containers (Lim & Mason, 2000). Unfortunately adverse reactions to polypharmacy can include cognitive impairment, increased risk of falls and an increase in aggressive behaviour (Lim & Mason, 2000).

Following an extensive review of research findings published between 1989 and 1998 Opie et al. (1999), found that evidence in support of psychotropic medication for dementia is "limited" yet "side effects are frequent and often hazardous" (Opie et al., 1999, p. 790). In addition, anecdotal evidence suggested that medication might be counter-productive in largely unexpected ways. An elderly nursing home resident known to the researcher, with advanced breast and lung cancer, expressed a desire to cope without morphine. She was eventually given Kapanol for pain relief. Kapanol is a respiratory suppressant (MediMedia, 2001) and poor breathing leads to a build-up of toxins (Harrison, 1998). Therefore, it must be asked whether her increasingly laboured and distressed breathing was a result of the progress of the cancer or the effects of the medication.

Whatever techniques are used to manage dementia, Pond (1994, p. 149) emphasised that a "balance must be struck between respect and patronage, independence and dependence, and the whole person and the illness." In addition, Clark (2002) drew attention to the dichotomy between hopes of a cure and the acceptance of death, and acknowledged the challenge to carers in balancing technical intervention and a humanistic approach to patients. As it seems that the progression of dementia is "unique" for each individual (Alzheimer's Disease and Related Disorders Association of NSW, 2001b), it would appear that any treatment regime would need to be based on the unique needs of the individual and that a range of management practices need to be implemented. As emphasised by Eliopoulos (1999, p. 142):

> *Using an herb or massage to treat a symptom without considering the full range of interventions that can benefit the client is no better than using a drug at the exclusion of mind/body interventions. Nurses must remember that holism is the essence of professional nursing practice, and CAM (complementary and alternative medicine) is but one tool at their disposal.*

In addition to considering issues relating to management practices for the individual with dementia as noted above, the severity and frequency of disturbed behaviours is likely to result in increased admissions to institutions (Opie et al., 1999). However, mismanagement of the problems associated with dementia can result in major health problems for the carers (Rowe & Alfred, 1999).

2.7. Quality of life and dementia

> *Good dementia care is that which enables a person to feel supported and socially confident (Younger & Martin 2000, p. 1210).*

Each individual is "profoundly different from all others" (Kitwood , 1997) and individual perceptions may vary (Australian Government Department of Health and Ageing, 2004), however the concept of quality of life in dementia can be "multidimensional…disease specific…[and] shaped by the presence of the dementia" (Brod, Stewart, Sands & Watlton, 1999, p. 28). Younger and Martin (2000) emphasised that it is necessary to consider the quality of life from the perspective of the person with dementia and not from the perspective of the carer and Bond (1999) questioned whether a family member (or carer) of a person with dementia has the right to make a judgement about the person's quality of life "because…from my perspective I know [what] I would prefer."

The complexity associated with attempting to measure the quality of life of people with dementia is evidenced, in part, by the fact that Brod et al. (1999) recognised 10 domains of physical functioning, daily activities, discretionary activities, mobility, social interaction, interaction capacity, bodily well-being, sense of well-being, sense of aesthetics, and overall perceptions. Sub-domains included items such as walking, navigating stairs, reaching, bending, hobbies, travel, intimacy, happiness with family, social participation, communication, comprehension, confusion, fatigue, sleep, self-esteem, embarrassment, self-consciousness, sense of control, depression, sadness, feeling loved and wanted, anxiety, loneliness, fear, anger, irritability, frustration, boredom, feelings of belonging, feeling useful, calmness, peacefulness, happiness, cheerfulness, sense of humour, enjoyment and appreciation of nature and beauty, creativity, awareness and appreciation of surroundings, self-related health, and life satisfaction. Merchant and Hope (2004) recognised 13 domains of physical health; energy, mood, living situation, memory, family, marriage, friends, self as a whole, ability to do chores around the house, ability to do things for fun, money, and life as a whole. Younger and Martin (1999) considered issues such as active interaction with others, passive social involvement, being socially uninvolved, eating and drinking, use of cognitive ability, walking (coming and going), reading, watching T.V. etc, and sleeping when assessing the standard of care provided for people with dementia.

The quality of life for a person with dementia may be equated with the maintenance of dignity which can include:

> *…having adequate pain and symptom management, appropriate incontinence management, relieving burdens, achieving a sense of control, strengthening relationships with loved ones, having the capacity to communicate, being able to recognise friends and family members, and avoiding inappropriate prolongation of dying*
> *(Australian Government Department of Health and Ageing, 2004, p. 6).*

A simplified view of the quality of life of people with dementia is supplied by Kitwood (1997, pp. 81-84) who suggested that, rather than having a hierarchy of needs, people with dementia have a cluster of psychological needs including the need for:

- ☆ *comfort*: which encompasses tenderness, closeness, soothing of pain and sorrow, calming of anxiety and promoting the feeling of security;
- ☆ *attachment*: the need for which may be as strong as in early childhood because people with dementia are "continually finding themselves in situations that they experience as 'strange'");
- ☆ *inclusion*: which may cause the, "so called, attention seeking behaviour" and a tendency to cling;
- ☆ *occupation*: which, in a dementia care setting, does not refer to 'work' but to the individual being involved in decisions pertinent to their well-being and daily life. It is the opposite of "boredom, apathy and futility"); and
- ☆ *identity*: which involves knowing who one is, having a connection with the past, and having a 'narrative', or a story, which can be told to others.

This cluster then has one "all-encompassing" need – the need for *love*. Kitwood graphically illustrated this cluster concept as shown in Figure 2.1. He added that the "personhood" of the individual with dementia must be "continually replenished" (p. 99) and that, in addition to providing good quality physical care, carers must cater for the psychological needs of the person with dementia.

Carers often have difficulty in gauging the effectiveness of their care (Merchant & Hope, 2004), however there are tools available for the measurement of quality of life for people with dementia. These include *The Dementia Quality of Life Instrument (DQoL)* (Brod et al., 1999), *The Quality of Life in Alzheimer's Disease Scale (QOL-AD)* (Merchant & Hope, 2004) and the *Dementia Care Mapping* instrument developed by Kitwood and the Bradford Dementia Group (Younger & Martin, 2000). These tools variously use a combination of questionnaires and observations when assessing the person with dementia. However, Brod et al, (1999) suggested that the ability of persons with dementia to self-report their perceptions may be influenced by the stage of their dementia.

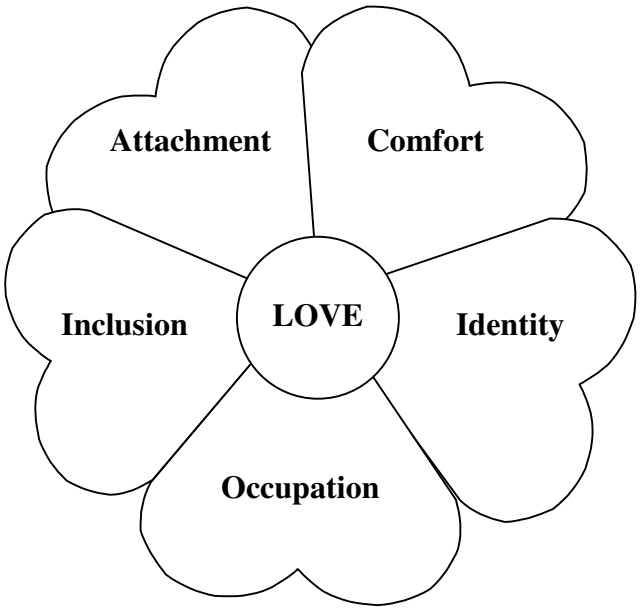


Figure 2.1: The main psychological needs of people with dementia (adapted from Kitwood, 1997, p. 81)

While a person living at home may be considered to have a reasonable quality of life, 'incarceration' in an 'institution' may result in a sudden decline in the quality of life due to adverse changes which may, in turn, result in a sharp reduction in life expectancy (Bond, 1999; Kitwood, 1997). Once the individual has been institutionalised some of the quality of life domains such as *travel*, *ability to do chores around the house*, and *money* which were recognised by Brod et al. (1999) and Merchant and Hope (2004) may no longer apply to the individual. Conversely, issues such as *anxiety*, *loneliness*, *fear*, [loss of] *friends*, *embarrassment*, and *self-consciousness* may assume a greater degree of importance as the individual tries to come to terms with living alongside strangers in a strange environment, and being cared for by strangers. As the individual's dementia progresses, issues such as *having adequate pain and symptom management,* and *appropriate incontinence management* which were recognised by the Australian Government Department of Health and Ageing (2004) may assume a greater degree of importance. In addition, maintaining a sense of *well-being*, *feeling loved and wanted*, *calmness*, *peacefulness*, *happiness*, *cheerfulness*, *sense of humour*, *enjoyment*, and an *active interaction with others* may be important throughout the progression of the individual's condition.

Because "human life is interdependent and interconnected" (Kitwood, 1997, p. 8) and humans are all part of an "inseparable web of relationships" (Davies, 2000, p. 21), it is conceivable that the quality of life of each individual in a residential care setting may be partially dependent upon the quality of life of other individuals. These individuals will probably include the persons with dementia and the professional carers working within the residential facility as well as family members of the people with dementia and other visitors to the facility. Kitwood (1997) maintained that if an organisation is committed to upholding the personhood of its clients then it "must necessarily be committed to the personhood of all staff, and at all levels" (p. 104). He suggested that this could be achieved for the person with dementia through:

- *recognition*: acknowledging the individual with dementia as a person;
- *negotiation*: consulting the individual about their preferences;
- *collaboration*: sharing the tasks and 'working together';
- *play*: for sheer pleasure;
- *timalation*: sensuous or sensual interaction (from the Greek *tiamo*, I honour, + stimulation;
- *celebration*: celebrating the positive interactions;
- *relaxation*: promoted by being near and/or in physical contact with others;
- *validation*: having an empathetic understanding of the person's reality and acknowledging that reality;
- *holding*: psychological and physical – i.e. not being driven away by any expressions of rage;
- *facilitation*: assisting the person undertake the tasks that he or she may no longer be able to do alone;
- *creation*: when the person with dementia initiates an action such as singing or dancing enabling the carer (or others) to join in; and
- *giving*: as initiated by the person with dementia – this may include expressions of "concern, affection or gratitude" (Kitwood, 1997, pp. 90 -92).

Since dementia can be considered to be a "behaviour syndrome" (Bond, 1999), it could be theorised that many of the behaviours detailed in Section 2.5.1 will have the potential to impact negatively on the quality of life of persons with dementia, people around them, their family members, and their carers.

2.8. Conclusion

Having recognized the paucity of published research into the use of complementary therapies in the management of dementia, the researcher decided to conduct an initial survey of South Australian High Care Residential Aged Care Facilities (formerly called nursing homes) to determine if complementary therapies (and Reiki in particular) were used in dementia care in South Australia before proceeding with specific research into the use of Reiki in the care of people with dementia. After gaining Ethic Committee approval (Appendix F), questionnaires were mailed to 162 facilities listed by the Seniors Information Service in October 2001.

The results obtained from this questionnaire are discussed in Chapter 3.

3. Management of Dementia in South Australian High Care Residential Facilities (formerly Nursing Homes)

3.1. Introduction

As noted above, the paucity of published research into the use of complementary therapies in the management of dementia was recognized and the decision made to conduct an initial survey of complementary therapy use in South Australian High Care Residential aged care facilities.

3.2. Questionnaire design

The researcher designed a questionnaire containing both closed and open-ended questions to ascertain the specific use of complementary therapies, staff and facility attitude to the use of complementary therapies, the perceived efficacy of these therapies, funding and staffing considerations, the prevalence of dementia in the facilities, the type of behaviours exhibited by residents with dementia, and pharmacological interventions used in residential high care facilities in South Australia.

Developing content validity, that is, "assess[ing] the content of the questionnaire against its intended purpose or aim" in an instrument ensures that it adequately assesses the "issues or topics which theory has identified" (Dyer, 1999, p. 128). Content validity of the questionnaires was ensured by assessing the draft questionnaires with:

- ☆ a professional educator who had been responsible for the development and delivery of educational programmes in a number of colleges of Technical and Further Education
- ☆ a research colleague working in the disability field
- ☆ the researcher's three supervisors.

Following their suggestions, some questions were re-worded to remove any ambiguity and re-ordered to provide a more logical sequencing of information.

In addition, assessing the draft instrument with people not working in the area of aged care assisted to ensure face validity which is "the extent to which a scale or questionnaire appears to be appropriate for its purpose when viewed by non-[professionals]" (Dyer, 1999, p. 128). Ensuring the face validity of an instrument can increase its effectiveness "simply because respondents perceive it to be appropriate for its task" (Dyer, 1999, p. 128). Once the questionnaire had been re-drafted, and prior to submission to the University Ethics Committee, it was shown to the Ex-

ecutive Director of the Alzheimer's Association of South Australia who offered to include information about the research in one of the Association newsletters together with a request for people to respond promptly.

The Social and Behavioural Research Ethics Committee of the Flinders University of South Australia granted approval on the 17th July 2002 (Appendix F).

3.3. Ethical considerations

To ensure confidentiality of information provided by respondents there was no information which would identify either the facility or the person completing the questionnaire. A self-addressed and stamped envelope was provided for the return of completed questionnaires, and respondents were not asked to identify either themselves or their facilities. As the questionnaires were addressed to "The Director of Nursing" (DON) it was assumed that the recipient was over the age of 18 years and able to give informed consent. The recipients were informed that they did not have to answer any of the questions.

3.4. Questionnaire distribution

During August 2002 the questionnaire was posted to the 162 South Australian metropolitan and country High Care Residential aged care facilities (formerly called nursing homes) as identified by the Seniors Information Service on the 2nd October 2001. Recipients were requested to return the questionnaires by the 30th September 2002.

To encourage a high return rate, a request was included for the return of questionnaires if the recipient chose not to answer any of the questions beyond the first question asked if there were residents with dementia in their facility. If the answer was "No" the respondent had no further questions to answer.

A copy of the questionnaire is included in Appendix A.

3.5. Analysis of responses

The researcher personally designed a computer database in *Microsoft Access* ® for the analysis of responses and entered information as the questionnaires were returned.

Up to and including the 1st October 2002 a total of 91 questionnaires (56.2% of the mail-out, n=162) had been returned. Of these six were blank, one was marked *Return to Sender* by Australia Post (a subsequent attempt to telephone the facility

determined that the telephone number had been disconnected thus suggesting that the facility had closed since the compilation of the Seniors Information Service list of 2nd October 2001), one was returned with a note that the facility had closed, one facility returned a completed questionnaire but indicated that the facility was *Low Care* only, and one facility did not have any residents with dementia and only Question 1 was completed. The remaining 81 questionnaires (50.0% of the mail-out) were considered as "Live" and the data entered into the database for anal ysis.

From the responses analysed it would appear that residents with dementia represent slightly over 50% of all residents in residential high care facilities in South Australia, however, as six of the respondents did not provide resident numbers, it is not possible to project this figure with confidence. The reported ages of residents with dementia range from the youngest at 39 years of age to the oldest at 105 years of age. Twenty-five facilities (30.8%, n=81) reported having residents with early onset dementia (under the age of 65 years). A further six facilities reported having residents aged 65 years with dementia.

A detailed analysis of these figures is provided in Table 3.1.

Table 3.1: Demography of residents in South Australian residential high care aged care facilities (n=81)

Number of residents (n=75) [1]	4,741
Residents with dementia (n=75) [1]	2,443
Percentage of residents	51.5%
Age range of youngest residents with dementia (n=77) [2]	39 to 85 years
Mean	66.4 years
Age range of oldest residents with dementia (n=77) [2]	86 to 105 years
Mean	97.0
Number of facilities reporting early onset dementia [3]	25 years
Percentage of facilities reporting early onset dementia	30.8%

1 Six facilities with 42, 70, 80, 100, 110 and 115 residents respectively did not report the number of residents with dementia so these have not been included in the totals.
2 Four facilities did not report ages.
3 A further six facilities reported youngest residents with dementia aged 65 years.

Late returns

Following the cut-off date for the return of questionnaires a further three surveys were returned giving a total of 94 returns from the original 162 questionnaires distributed. All three respondents reported the use of complementary therapies in their

facilities. Inclusion of these responses would have resulted in a return rate of 58.0% (n=162) and provided an indication that more than 50% of High Care Residential aged care facilities were using complementary therapies in the management of dementia. Unfortunately, due to time constraints it was not possible to use these responses in the analysis reported below because the data analysis had proceeded beyond a point at which the additional material could be included.

3.5.1. Which complementary therapies are being used?

Based on the literature survey and anecdotal evidence gathered through personal conversations with staff and volunteers in High Care Residential facilities, the researcher had compiled a list of 17 complementary therapies which were possibly being used in the management regime for people with dementia. The list included aromatherapy (massage), aromatherapy (vaporising), behaviour therapy, Chiropractic, Healing Touch, light therapy, massage, meditation, music (instrumental), music (recorded), music (voice), prayer, reflexology, Reiki, Tai Chi, Therapeutic Touch (Krieger/Kunz method), and ThreePhase Therapy. Respondents were asked to state which therapies from this list (arranged alphabetically) were used in their facility and to indicate the use of complementary therapies not included in the 17 listed complementary therapies (Question 2).

All responses analysed (n=81) reported the use of at least two of the listed complementary therapies and 26 facilities (32.1%, n=81) reported the use of a range of complementary therapies not included in the list provided.

Seventy-seven facilities (95.1%, n=81) used three or more of the 17 listed complementary therapies while four facilities (4.9%, n=81) used only two of the 17 listed complementary therapies. The four facilities which reported the use of only two of the listed complementary therapies did not use any other (non-listed) complementary therapies.

A detailed analysis of responses is shown in Table 3.2.

Table 3.2: Complementary therapy use in residential high care facilities in South Australia (n=81)			
Therapy	Number	Percentage	95% Confidence Interval
Aromatherapy (vaporising)	72	88.9%	82.1%, 95.7%
Music (recorded)	65	80.2%	71.5%, 88.9%
Aromatherapy (massage)	64	79.0%	70.1%, 87.9%
Massage	57	70.4%	60.4%, 80.3%
Prayer	50	61.7%	51.1%, 72.3%
Music (instrumental)	49	60.5%	49.8%, 71.1%
Music (voice)	38	46.9%	36.0%, 57.8%
Behaviour Therapy	31	38.3%	27.7%, 48.9%
Healing Touch	17	21.0%	12.1%, 29.9%
Reiki	15	18.5%	10.0%, 27.0%
Therapeutic Touch (Krieger/Kunz method)	13	16.0%	8.0%, 24.0%
Tai Chi	12	14.8%	7.1%, 22.5%
Light Therapy	11	13.6%	6.1%, 21.1%
Reminiscence Therapy	9	7.3%	1.6%, 13.0%
Pet Therapy	8	6.5%	1.1%, 11.9%
Snoezelen	8	6.5%	1.1%, 11.9%
Meditation	6	7.4%	1.7%, 13.1%
Reflexology	6	7.4%	1.7%, 13.1%
1:1 activities	3	3.7%	0.0%, 7.8%
Cooking	3	3.7%	0.0%, 7.8%
Validation Therapy	3	3.7%	0.0%, 7.8%
Chiropractic	2	2.5%	0.0%, 5.9%
Doll Therapy	2	2.5%	0.0%, 5.9%
Gardening	2	2.5%	0.0%, 5.9%
Red Cross (hand & nails)	2	2.5%	0.0%, 5.9%
Church Services	1	1.2%	0.0%, 3.6%
Craft	1	1.2%	0.0%, 3.6%
Hair Dresser	1	1.2%	0.0%, 3.6%
Hot Towel	1	1.2%	0.0%, 3.6%
Laughter	1	1.2%	0.0%, 3.6%
Multi-sensory	1	1.2%	0.0%, 3.6%
ThreePhase Therapy	1	1.2%	0.0%, 3.6%
Visits (outings)	1	1.2%	0.0%, 3.6%

When responses are grouped: a total of 79 (97.5%, n=81) facilities use at least one form of **aromatherapy**; 77 (95.1%, n=81) use at least one form of **touch** therapy (aromatherapy massage, Chiropractic, Healing Touch, massage, reflexology or Reiki); 76 (93.8%, n=81) use at least one form of **massage** therapy (aromatherapy

massage, massage or reflexology); 71 (87.6%, n=81) use at least one form of **music** therapy (instrumental, recorded, or voice); and 30 (37.0%, n=81) use at least one form of **energy healing** therapy (Healing Touch, Reiki or Therapeutic Touch). This usage is represented in Figure 3.1.

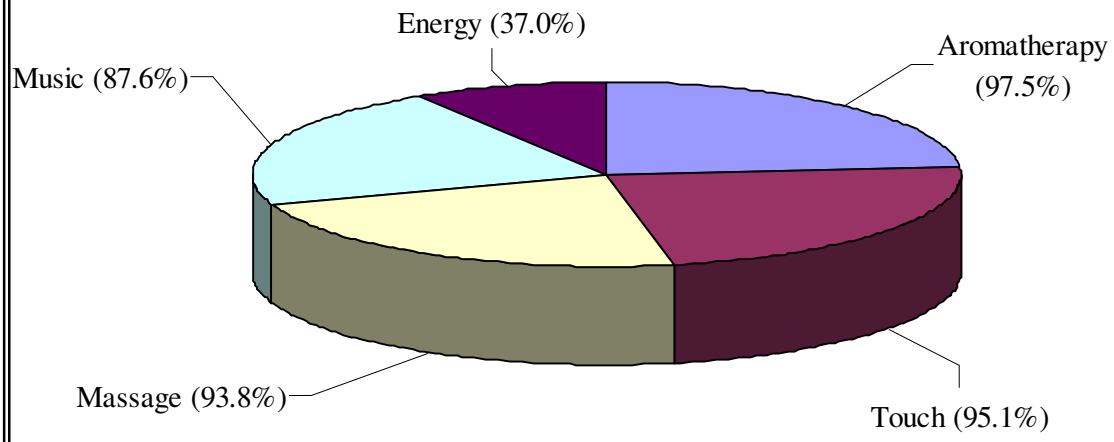


Figure 3.1: Percentage of facilities using specified therapies (n=81)

3.5.2. Why are complementary therapies being used?

In addition to being asked which therapies are being used, respondents were asked, 'Do you consider complementary therapies have a place in the management of dementia? Yes/No", and they were asked to explain why (Question 5). This question therefore provided an opportunity for respondents who considered that complementary therapies are inappropriate for use in managing clients with dementia to explain their reasoning. Eighty-one (100%) of the respondents considered that complementary therapies do have a place in the management of dementia and 68 respondents (84.0%, n=81) provided an explanation.

As the responses were being keyed into the database it was evident that a number of patterns were developing in the information being provided by respondents. The researcher identified six possible themes in the responses including 1:1 interaction, the effect on behaviour management, the calming of residents, a reduction in the need for medication, an improvement in the quality of life for residents, and the stimulation provided by the therapies. To ensure rater reliability when grouping responses under these possible headings, all of the responses were printed then the researcher and a professional colleague independently read the responses to identify words and phrases which could be synonymous with 1:1 interaction, behaviour

management, calming, medication, quality of life, and stimulation. Discussion were then held until there was 100% agreement on a final list of key words which might return a list of comments reflecting these six groupings.

While the researcher was preparing a computerised database search using the agreed key words, it became apparent that appropriate information could be gained more efficiently by using a search based on a selected list of root words with an asterisk being used as a wild card in order to find all references based on the particular root, i.e. using calm* would find calm, calms, calmed, and calming. The search parameters eventually used are detailed in Table 3.3.

Table 3.3 Search parameters used to group comments about the place of complementary therapies in the management of dementia

Grouping	Search Parameters used
1:1 interaction	1:1, one*
Behaviour management	behav*
Calming	calm*, still*, relax*, reduce*, lesses [sic], decrease*, settl*
Medication	medicat*, drug*;
Quality of life	quality, life, enjoy*
Stimulation	stimula*

3.5.2.1. Calming, soothing and settling

Calming, soothing and settling effects were reported by 42 respondents (61.8%, n=68). Reported benefits gained included:

- ☆ *divert* [residents'] *attention and provide relaxation when restless and agitated*
- ☆ *gentle exercises such as Tai Chi maintain balance and mobility*
- ☆ *provide focus, stimulation, relaxation, peaceful environment*
- ☆ *enhance the lives of those with dementia in many ways* [such as] *create sensory stimulation, calm restlessness, create a focus and increase self-esteem*
- ☆ [provide] *restful sleep* [and] *alleviation of pain*
- ☆ *managing adverse behaviours*
- ☆ *help staff relate/cope with dementive clients*
- ☆ *create pleasant, comfortable environment*
- ☆ *improved socialisation*
- ☆ *reduce reliance on medication*
- ☆ *decrease wandering at night*
- ☆ *creating a home-like calm environment.*

3.5.2.2. Improved behaviour management

Fifteen respondents (22.0%, n=68) reported improved behaviour management through the use of complementary therapies. Benefits reported included *1:1 contact between residents and staff*, *calming and soothing effect*, *reduces at risk behaviour*, *relaxation and/or mental stimulation*, *modification of behavioural problems*, *lesses* [sic] *restless behaviour*, *management of behaviours. Increased self-esteem and self-worth*, *group and 1:1 activity reducing inappropriate behaviours and maintains skills*, and *relaxation*.

3.5.2.3. Enhanced quality of life

An enhanced quality of life through the use of complementary therapies was reported by 14 respondents (20.6%, n=68). In addition to direct references to *quality of life*, comments included [most] *Residents enjoy music therapy*, *gives value to life*, *improve self-esteem*, *make life worth living*, *enhance enjoyment now*, *enhances holistic well being*, *…gives resident feeling of being valued…provides outlet for anger, grieving, stress. Provides spiritual comfort,* and *1:1 and group human interaction [is] what life is all about*.

3.5.2.4. 1:1 interaction with residents

Of the 68 respondents who provided an explanation for the benefits to be gained through the use of complementary therapies, nine (13.2%) commented on the value of the 1:1 interaction with residents which is made possible with the use of complementary therapies. Benefits reported included *soothing, settling*, *stimulation of concentration*, *stimulating of senses*, [improved] *behaviour management*, *reduce*[d] *anxiety/restlessness*, *calming effect*, *gives resident feeling of being valued*, and *reducing inappropriate behaviours*.

3.5.2.5. Stimulation

The comments made by nine respondents (13.2%, n=68) indicated that they considered stimulation of the interest, senses, concentration and/ or mental functioning provided by complementary therapies to be important.

3.5.2.6. Reduced need for medication

Five respondents (7.4%, n=68) commented on the reduced need for medication which can be achieved through the use of complementary therapies.

The above findings are illustrated in Figure 3.2.

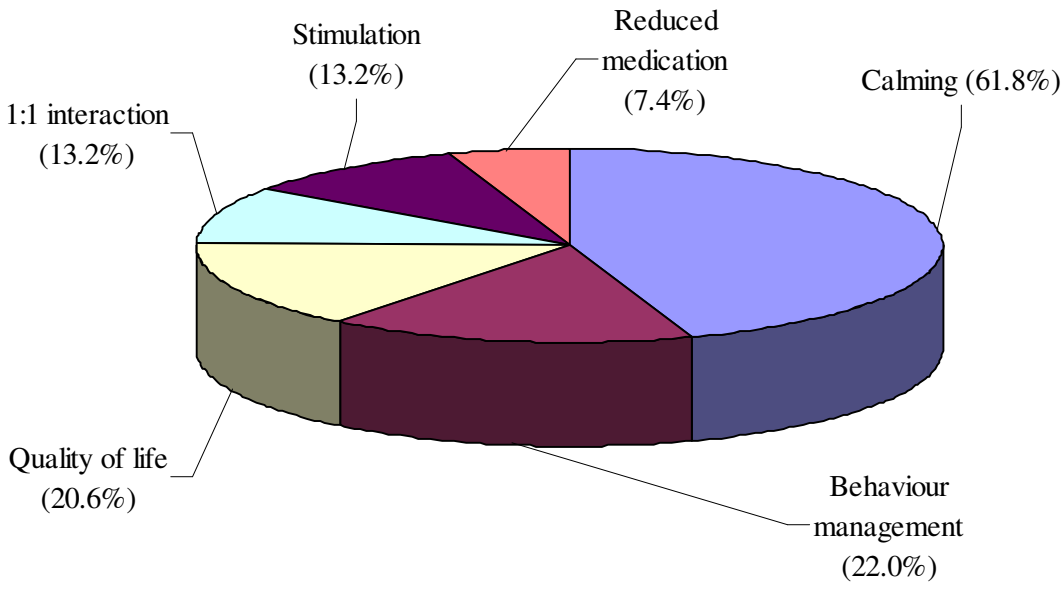


Figure 3.2: Why facilities use complementary therapies (n=68)

3.5.3. Who uses complementary therapies?

Forty-five respondents (55.6%, n=81) reported personally using a wide range of complementary therapies including *aromatherapy, behaviour therapy, church services, concerts, hot towel therapy, light therapy, massage, meditation, music, pet therapy, prayer, Reiki, reminiscence therapy (conversation), Tai Chi, touch, Therapeutic Touch, and validation therapy*.

The responses to Question 6 (If complementary therapies are used in your facility are they provided by: Nursing staff [Registered or Enrolled Nurses]; Patient Care Attendants; Diversional Therapist; Resident's friends and/or relations; Visiting specialists; Volunteers; Other staff – please specify) are illustrated in Figure 3.3.

'Other' staff employed by High Care Residential facilities and who provide complementary therapies for residents included massage therapists, aromatherapists (it was not specified if these therapists were simply aromatherapists or aromatherapy masseurs), a physio-aid, a naturopath, religious nuns, a chaplain, occupational therapists, a minister of religion, a palliative care professional, and a pastoral care professional.

Internally employed staff members (Nursing staff [Registered or Enrolled Nurses], Patient Care Attendants and/or Diversional Therapists) provide complementary therapies in 79 (97.5%, n=81) of the High Care Residential Facilities. How-

ever 57 (70.4%, n=81) of the facilities utilise the voluntary services provided by residents' family or friends and/or volu nteers.

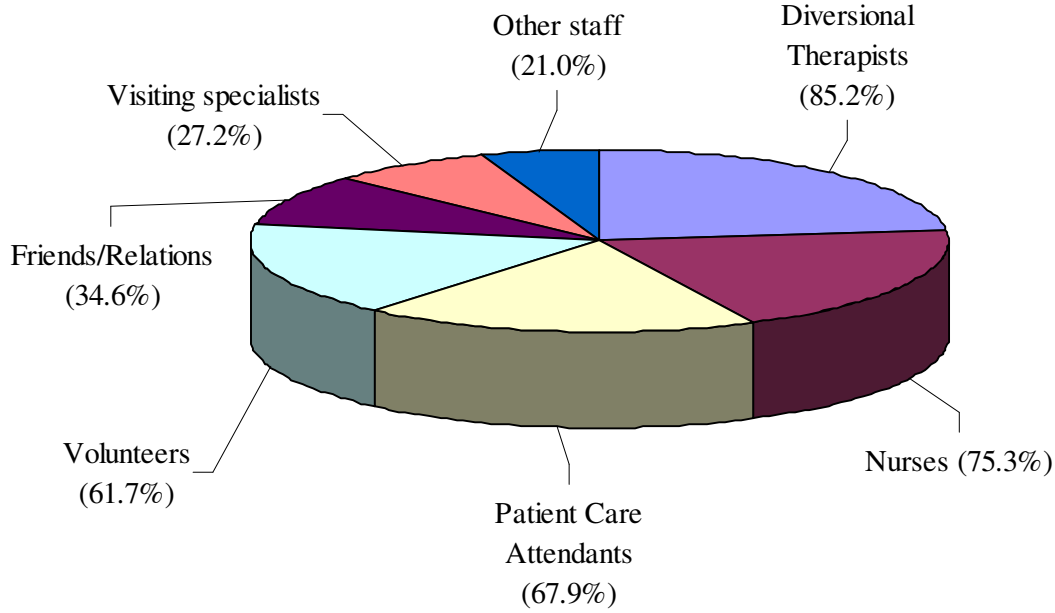


Figure 3.3: Categories of persons providing complementary therapies (n=81)

One facility reported relying solely on the nursing staff for the provision of complementary therapies and two facilities appeared to rely solely upon the services of their Diversional Therapist while the remaining 78 facilities (96.3%, n=81) reported using the services of at least two groups of people (staff, visiting specialists, family and friends of the residents and/or volunteers) for the provision of complementary therapies.

3.5.4. Do facilities have a policy about complementary therapies?

Fifty-four respondents (66.7%, n=81) reported that their facility has a policy on the use of complementary therapies. Of these policies, all were reportedly supportive of complementary therapies in the management regime for residents with dementia.

3.5.5. Why are particular complementary therapies excluded?

Fifteen respondents (18.5%, n=81) indicated that their facility specifically precludes a particular therapy, or therapies, because of doubts about their efficacy (2, 13.3%, n=15), lack of staff training (11, 73.3%, n=15), religious considerations (2, 13.3%, n=15), or time constraints (11, 73.3%, n=15).

Other reasons for precluding particular complementary therapies include family or resident choice/individual needs (5, 33.3%, n=15), difficulty in attracting specialist staff or volunteers (4, 26.7%, n=15), and lack of funding (6, 40.0%, n=15).

3.5.6. Who pays for the complementary therapies?

Eighty respondents (98.8%, n=81) reported that their facility contributed budgeted funds to the provision of complementary therapies for residents. The sole respondent who did not answer in the affirmative to this question added the comment that the facility contributed a *small amount from facility's budget*. A total of 25 respondents (30.9%, n=81) indicated that residents contribute funding towards the provision of complementary therapies. Other sources of funding for complementary therapies include Medicare and private health funds, fundraising, staff personal expenditure, and donations.

3.5.7. What type of accommodation is provided for residents with dementia?

Two respondents (2.5%, n=81) did not directly answer questions 13 (Are the residents of dementia accommodated in a secure dementia area only, in a non-secure area only, a combination of both?) and 14 (Are there provisions for residents to move from a non-secure area to a secure area as the need arises?), but wrote that the whole facility was secure (from the street). Of the remaining 79 respondents 17 (21.5%) indicated that residents with dementia were accommodated in a secure area only, 17 (21.5%) reported they only had a non-secure area, and 45 (57.0%) reported that they had access to both secure and non-secure facilities.

Forty-seven respondents (58.0%, n=81) indicated that residents with dementia have the opportunity to move from a non-secure area to a secure area as the need arises. Of these, one respondent reported having only a secure facility and one reported having only a non-secure facility for residents with dementia.

When these figures are combined, the majority of facilities (62, 76.5%, n=81) have secure facilities for residents with dementia.

3.5.8. What types of agitated behaviours do residents with dementia display?

Respondents were asked if there were any "aggressive or non-aggressive" behaviours which cause problems/concerns for the facility and/or staff. To ensure an open-ended response, types of behaviour were not listed, but respondents who answered, "Yes" to this question were asked to list three behaviours which cause the most concern (Questions 15 and 16).

Seventy-six (93.8%, n=81) indicated that there were aggressive or non-aggressive behaviours which cause problems/concerns for their facility and/or staff. As the responses were being keyed into the database it was evident that a number of patterns were developing in the information being provided by respondents. The researcher identified eleven possible themes including absconding, attention seeking, intrusiveness, moving furniture, physical aggression, repetitive actions, resistance, sexual behaviour, unacceptable behaviour, verbal aggression, and wandering. To ensure rater reliability when grouping responses under these possible headings, all of the responses were printed then the researcher and a professional colleague independently read the responses to identify words and phrases which could be synonymous with the eleven themes. Discussions were then held until there was 100% agreement on a final list of key words which might reflect these groupings. As in the previous search process, an asterisk was used as a wild card and the search parameters eventually used are detailed in Table 3.4.

Table 3.4 Search parameters used to group reported aggressive or non-aggressive behaviours which cause problems/concerns for the facility and/or staff

Grouping	Search Parameters used
Absconding	abscond*, leav*, get-out, get out
Attention seeking	attention
Intrusiveness	intrusi*, invasi*, disrupt*, interfer*
Moving furniture	furniture
Physical aggression	physical, punch, kick, hit, lash, grab, biting, bite, throw, threat, spit*
Repetitive actions	repetit*
Resistance	resist*, non complia*, non-complia*
Sexual behaviour	sex*, inhibit*
Unacceptable behaviour	unaccept*, inappropriate
Verbal aggression	verbal*, call, vocal, noise, yell*, shout, voice, curs*, swear
Wandering	Wander, abscond*, leav*, get-out, get out

Five respondents (6.2%, n=81) indicated that they had no problematic behaviours. However one respondent then stated, *Generally no as behavioural management plans are very specific, however anxiety and agitation are an ongoing problem because of the stress these residents experience*. This respondent then stated, *They don' t cause problems for us, we are here to give a service to these residents, they cause problems for the residents*.

3.5.8.1. Physical aggression

Having been reported by 52 respondents (68.4%, n=76), incidents of physical aggression were the most frequently reported problems for the facility and staff. Problem behaviours included; *biting, grabbing, hitting, kicking, pinching, punching, spitting*, and *throwing food*. These actions may have been aimed at other residents, staff members, and/or the physical environment. One respondent indicated that aggressive residents may be a *danger to self or others*.

3.5.8.2. Verbal aggression

Forty-seven respondents (61.8%, n=76) reported verbal aggression. Examples of verbal aggression included calling out, *calling out with word salad*, *haranguing of staff*, *shouting*, *unintentional outburst of offensive language*, *verbal abuse*, vocalising in a *sing/song/crying noise*, and *yelling*.

3.5.8.3. Wandering

Wandering as a problematic behaviour was reported by 27 respondents (35.5%, n=76). Included in these figures are six (7.9%, n=76) respondents who commented about residents attempting to leave the secure area and/or the facility.

3.5.8.4. Intrusiveness

Intrusiveness was considered to be a problem by 25 respondents (32.9%, n=76). This included interfering with other residents, intrusion onto personal space, wandering into other residents' (and staff) rooms, intrusive gathering of other residents' belongings, vocal intrusion, and inappropriate behaviour including sexual behaviour.

3.5.8.5. Resistance to care

Resistance to care during showering, bathing, dressing, toileting, and other personal care activities was reported as a problem by 16 respondents (12.2%, n=76).

3.5.8.6. Other agitated behaviours

Seven (9.2%, n=76) respondents commented on *repetitive speech***,** *calling out***,** and *questioning* while six respondents (7.9%, n=76) considered *sexual innuendo and behaviours* to be a problem. Four respondents (5.3%, n=76) commented on *unacceptable behaviour* such as faecal smearing, inappropriate undressing and inappropriate sexual behaviour and three (3.9%, n=76) made comments about residents *moving or*

destroying furniture. Two respondents (2.6%, n=76) listed *attention seeking* as a problem without expanding on their comment.

The above responses are illustrated in Figure 3.4.

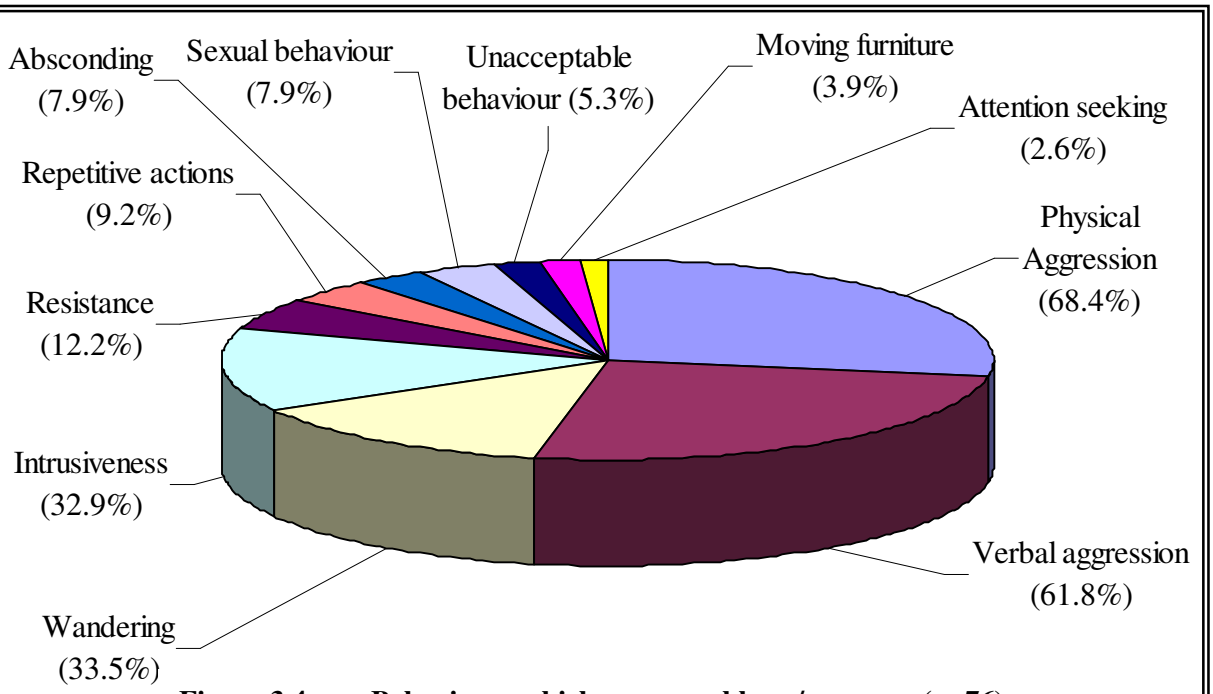


Figure 3.4: Behaviours which cause problems/concerns (n=76)

3.5.9. How do these behaviours impact on staff?

In addition to listing problematic behaviours, respondents were asked to, 'briefly describe how these behaviours cause problems/concerns for your facility and staff' (Question 16). A total of 72 respondents (88.9%, n=81) provided information.

As with previous information, it was evident that a number of patterns could be identified in the information provided by respondents. To ensure inter-rater reliability when grouping responses, all of the replies were printed then the researcher and a professional colleague independently read the responses to identify words and phrases which could be used to identify possible themes. Discussions were then held until there was 100% agreement on a final list of key words which might return a list of comments reflecting the agreed groupings. As in the previous search process an asterisk was used as a wild card. With 'stress' both a leading and following asterisk was used in order to identify words such as 'stress', 'di stress' and 'stressful'. The search parameters eventually used are detailed in Table 3.5. For ease of later analysis, all occurrences of occupational health, safety and/or welfare had been entered into the database as 'OH&S'.

It should be noted at this stage that, in some of the categories, other possible search words and roots were identified but not used as they did not add to the results – some respondents having used synonyms in their descriptions. Care had to be taken with root words such as "friend*" as this returned comments about a "friendly environment" rather than a "resident's friends". Another difficulty occurred when searching on "resident" as this could have returned a comment about the effect on individual residents displaying the behaviour or on the other residents in the facility.

Table 3.5 Search parameters used to group comments on how problem behaviours affected the facility and/or staff

Grouping	Search Parameters used
Agitation/disruption	agitat*, disharmony, disrupt*
Damage to property and belongings	damag*, broke*, replac*
Disruption to routine and time commitments	time*, extra, routine, addit*
Education	educat*
Effect on other residents	other resident*, other people, others, fellow
Effect on staff	staff, carer*
Family, friends and visitors	family*, friends, relative*, relations, families, visitor*
Invasion of privacy and/or personal space	privacy, intrusi*, inva*, proxim*, interfer*, harass*, space
Legal and industrial issues	oh&s, workcover, legal, ethic*, document*
Resistance to care	resist*
Safety of staff and residents	oh&s, safe*, injur*, harm*, risk*, fear*, viol*, abus*, physical, hurt*, pain*, resist*
Stress for staff and residents	*stress*, fear, agitat*, emotio*, anxi*, frustrat*

In the following analysis, care has been taken to ensure that respondent comments have not been repeated under different headings and therefore exaggerating the importance of that comment compared to others.

3.5.9.1. Additional carer burden

Fifty-six respondents (77.8%, n=72) reported that problematic behaviours caused additional burdens for staff in the form of injury, the additional time needed to manage the residents, the challenge to staff in maintaining resident interest in activities, the added difficulty in maintaining basic needs such as cleanliness, hygiene and dignity, the *wearing* nature of continual noise, and the possibility of reduced staff morale. In addition, staff can be upset and offended by the unacceptable behaviour and/or language from some residents. One respondent indicated that a shortage of staff (and volunteers) made it difficult to provide 1:1 care for residents.

3.5.9.2. Staff and resident safety

Safety of staff and/or other residents was a concern for 54 respondents (75.0%, n=72). Physical aggression in the form of biting, grabbing, hitting, punching, and/or pushing can result in staff (and other residents) suffering bruises, cuts, scratches, and/or sprains. This can cause staff to feel anxious, disempowered, frustrated and/or stressed as well as making it difficult to communicate and alleviate anxiety [in the individual and others]. The physically aggressive resident diverts staff time from other residents and may disturb, disrupt and/or agitate others thus setting off other behaviours. In addition to being unpleasant, behaviours such as faecal smearing can compromise the dignity and health of staff and other residents. Physical aggression may increase the difficulty of risk management through the necessity of providing physical and/or chemical restraints. Physical aggression may be unexpected and can occur during personal care activities such as washing, showering, drying, dressing, and/or toileting and can cause problems in hygiene management. One respondent commented that *violence aimed at other residents is of most concern* [as] *other residents must feel safe*. Another stated that they have *no way of providing a secure safe area within* [the] *facility*.

3.5.9.3. Effect on other residents

Forty-two respondents (58.3%, n=72) mentioned the effect of problem behaviours on other residents. There can be a risk of harm to other residents, staff time is diverted to the individual causing the problem, personal possessions have to be locked away, other residents are disrupted, and the behaviour can exacerbate other people's behaviour, stress and/or agitation level.

3.5.9.4. Stress

Staff and/or resident stress caused by problematic behaviours was reported by 33 respondents (45.8%, n=72). The aggressive individual can sense this stress and the aggression can continue or escalate. As reported above, problem behaviour(s) exhibited by one resident can agitate other residents and set-off other behaviours. One respondent commented, *Staff sometimes feel that nothing they do changes difficult behaviour and frustration*.

3.5.9.5. Time

Eighteen respondents (25.0%, n=72) commented on the additional time needed to manage problem behaviours. Not only is the *extra* and *constant* 1:1 supervision *time*

consuming but it *turns attention from others* and leaves *staff feeling guilty at* [the] *lack of attention for the not-so-demanding resident*.

3.5.9.6. Privacy

Invasion of privacy in the form of physical invasion and/or noise can be *wearing* on staff (as outlined above) and/or other residents. Wandering residents can cause safety problems for other residents and staff, interfere with other residents' belongings, and cause agitation in other residents. Impingement on individual privacy may be more marked when residents are in *close proximity*. Seventeen respondents (23.6%, n=72) made direct comments about invasion of privacy.

3.5.9.7. Visitors, family and friends

As 16 respondents (22.2%, n=72) reported, problematic behaviours impact on visitors (relatives, volunteers and others) to the facilities as well as other residents and staff. Visitors can be disrupted, distressed, offended and/or upset by these behaviour and their physical safety can be threatened. In addition, they can make negative comments about the staff and/of facility and some visitors may not accept that *staff* [members] *do not cause the behaviours*.

3.5.9.8. Legal issues

Given the levels of stress and threats to physical safety reported above, it could be assumed that legal consequences could be a major issue for the facilities. However, only ten (13.9%, n-72) respondents commented directly on legal issues. Six referred directly to Occupational Health and Safety, two to the need for [increased] *Work-Cover* [insurance], one to the *excess documentation* required, and one simply referred to *ethical and legal issues* regarding restraint issues and risk taking.

3.5.9.9. Property damage

Four respondents (5.6%, n=72) commented on the damage to the facility (broken doors, stains on carpets and walls "etc", and/or broken furniture), damage to residents' personal belongings, and/or the cost of replacing damaged equipment.

3.5.9.10. Staff education

Four respondents (5.6%, n=72) drew attention to the need for appropriate *education* of staff and volunteers with one respondent particularly concerned about *behaviour assessment and management*, which was described as a *key area in our sector*.

3.5.9.11. Resident resistance

Four respondents (5.6%, n=72) commented directly about the *resistance* displayed by some residents to *ADLs* (Activities of Daily Living), washing, drying, and/or dressing. One respondent indicated that the *fear of resistance* could cause staff stress and anxiety about the duty of care.

The impact of negative behaviours reported above in Section 3.5.9 is illustrated in Figure 3.5.

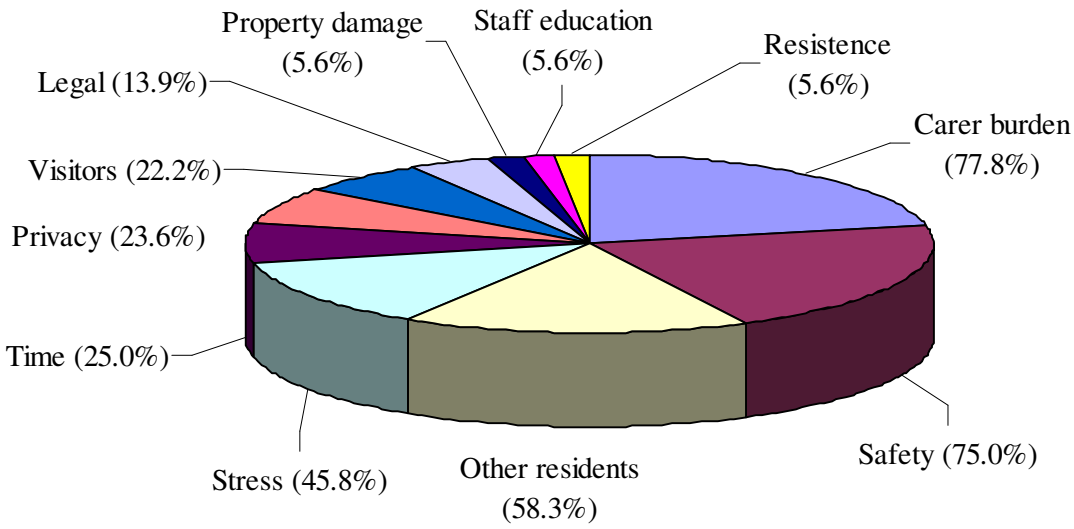


Figure 3.5: Impact of problem behaviours (n=72)

3.5.10. Do residents with early onset dementia cause special difficulties?

In response to question 18, "Research in Australia has shown that the incidence of Early Onset Dementia (in people under the age of 65 years) is increasing. If you have any residents under 65 who have dementia has this caused any specific problems/challenges in your facility?" 17 respondents (21.0%, n=81) answered in the affirmative. Issues raised in the 17 responses were:

- *Strength, volatility, sexual concept, increases staff intimidation/wariness (youngest resident age reported - 54 years);*
- *Music etc tastes will vary from the majority ... "She actually enjoys ' Beatle's music!" Reminiscence will also have to be directed forward a decade or so (59);*
- *In the past yes particularly with younger residents with Lewy Body disease because of very high anxiety and emotional* [unable to read comment] *ability (62);*
- *Better mobility ... abscond more readily ... ability to be more intrusive ... other residents less tolerant because of their younger appearance and perception that they therefore should understand and be accountable for their behaviour (66);*

- *The younger residents with dementia is physically fitter and stronger and tends to have more erratic outbursts which staff find challenging and unsettling (58);*
- *Resident has intellectual disability as well. Non compliant (39);*
- *Most activities are tailored for an older age group (62);*
- *63 year old male for respite ... very active mentally alert and aware ... activities* [unsuitable] *... encouraged him to continue with his external community activities (68);*
- *Result of head injury therefore [unsure] whether dementia or purely head injury (53);*
- *...mobility ... running ... jumping along like "Skippy the Kangaroo" (and singing the song) ... frightened other residents ... not aggressive ... younger or similar in age* [to some staff] *... didn't remember wife and 3 young kids ... (42);*
- *Physical aggression - residents have more strength. Inappropriate behaviours of these residents place more stress on family which unfortunately is then taken out on staff (65);*
- *The younger residents ... are generally "fitter" than the frail elderly and require more Diversional Therapy time to "entertain" them as well as being a different generation with different values etc (61);*
- *Problems with boredom, music selection - i.e. rock-n-roll preferences where majority of residents enjoy WWII music at this stage, sexual disinhibition (53);*
- *We had a resident aged 58 years who has since been placed in a secure facility as he posed an extreme risk to staff, other residents and relatives by his unpredictable aggression (*after this person was moved the youngest resident with dementia was reported to be *75);*
- *Resident involved has been a challenge to manage. Very repetitive behaviours varying from compulsive actions when first admitted then progressed to repetitive movements which are uncontrollable. Is now mostly bed or chair-fast, is walked regularly (58);*
- *Main problem is usually for families - spouse, children especially when a person is so young with dementia, difficult to come to terms with. This often impacts on the initial relationships with family - expectations, understanding - and staff (60); and*
- *Being able to provide suitable distractions, management & therapies. Physical strength & being ambivalent. Threatening behaviour - to staff and other residents. Socialising with other residents of older age group (60).*

3.5.11. Are any agitated behaviours gender specific?

In response to Question 19, "Do you find any agitated behaviours to be gender specific?" 15 respondents (18.5%, n=81) answered, "Yes". Comments from the 15 responses were:

- *Most women become anxious about 'mother' or 'the children' and keep trying to find them. ... can't find their hand bags ... no money in purse. Men tend to display sexual disinhibition more often and make advances toward female staff and ... residents;*
- *Women ... repetitive things ... (dusting. polishing) ... more likely to be soothed by holding and stroking toy doll or fluffy animal. Men ... more impatient ... more violent when upset;*
- *More aggressive behaviours predominantly displayed by males towards female/young staff i.e. hitting/punching/pinching/scratching;*

- *However relatives and staff are more concerned if male residents are mobile and have dementia because of physical presence;*
- *Female residents ... become agitated looking for their children and concerns about meal preparation. Male residents tend to wander looking for their spouse ... or significant female companion ... both tend to resist hygiene in equal amounts;*
- *The severe aggression in generally male residents but agitated behaviours are "across the board" both male and female;*
- *Calling for wife - women more likely to look for partner. Ownership of the facility – men;*
- *Punching and kicking ... male behaviour. Pinching/clutching ... female behaviour. Swearing/yelling/cursing staff - both male and female;*
- *Physical aggression associated with paranoia* [unable to read comment] *more prevalent in War Vet' s and N.E.S.B. Inappropriate sexual behaviour more likely male;*
- *Physical aggression - male dominated;*
- *Physical aggression more prevalent in males as is destruction of furniture;*
- *Higher proportion of female residents;*
- *Physical aggression toward staff occurs more often with male clients than female clients;*
- *Male and aggression (physical) i.e. throwing furniture through windows: sexual disinhibition. Females tend to be more wandering etc; and*
- *More verbal aggression in men. More inclined to respond to others' behaviours and less tolerance in men.*

3.5.12. What medications are used?

The response to question 21; "Information provided by the Alzheimer's Associ ation of New South Wales lists the following medications as being possible options for people with dementia. Please indicate which, if any, of these medications are used in your facility (proprietary names have been deliberately avoided)" is detailed in Table 3.6.

Seventy-seven respondents (95.1%, n=81) provided information about the medications used in their facilities and from Table 3.6 it can be seen that, of the 32 medications listed in the questionnaire, all but phenelzine are used in the various facilities. In addition to the listed medications, four respondents indicated that they had recently commenced using pericyazine.

However it cannot be assumed that all of the medications listed are used all of the time as one respondent stated, *The…icked list are not all in use but have been used from time to time over the last twelve months*. Although there was no question about the use of medications other than those listed, it is possible that residents receive other medications as a second respondent stated, *most residents have other conditions*.

Table 3.6: Frequency of reported medication use (n=77)			
Medication	Number	Percentage	Confidence Interval
Temazepam	62	80.5%	71.6%, 89.4%
Oxazepam	61	79.2%	70.1%, 88.3%
Haloperidol	60	77.9%	68.6%, 87.2%
Diazepam	59	76.6%	67.1%, 86.0%
Olanzapine	59	76.6%	67.1%, 86.0%
Risperidone	53	68.8%	58.4%, 79.1%
Sodium valproate	45	58.4%	47.4%, 69.4%
Carbamazepine	43	55.8%	44.7%, 66.9%
Sertraline	42	54.5%	43.4%, 65.6%
Doxepin	40	51.9%	40.7%, 63.1%
Nitrazepam	34	44.6%	33.5%, 55.7%
Amitriptyline	33	42.8%	31.7%, 53.8%
Dothiepin	30	39.0%	28.1%, 49.9%
Thioridazine	27	35.1%	24.4%, 45.8%
Moclobemide	25	32.5%	22.0%, 43.0%
Paroxetine	24	31.2%	20.8%, 41.5%
Mianserin	21	27.3%	17.3%, 37.2%
Citalopram	20	26.0%	16.2%, 35.8%
Lorazepam	19	24.7%	15.1%, 34.3%
Chlorpromazine	18	23.4%	13.9%, 32.8%
Fluoxetine	17	22.1%	12.8%, 31.4%
Imipramine	16	20.8%	11.7%, 29.9%
Venlafaxine	13	16.9%	8.5%, 25.3%
Fluvoxamine	6	7.8%	1.8%, 13.8%
Flunitrazepam	4	5.2%	0.2%, 10.2%
Nortriptyline	4	5.2%	0.2%, 10.2%
Chlordiazepoxide	3	3.9%	0.0%, 8.2%
Nefazodone	2	2.6%	0.0%, 6.2%
Tranylcypromine	2	2.6%	0.0%, 6.2%
Desipramine	1	1.3%	0.0%, 3.8%
Quetiapine	1	1.3%	0.0%, 3.8%
Phenelzine	0	0.0%	0.0%, 0.0%

Paradoxically, it is possible that residents with dementia may, in fact, receive less medication than other residents as a third respondent commented, *We recently moved to a new facility... it was noted by myself and the pharmacist that the residents with dementia had far less tablets/medication than the other frail, but alert residents.*

Due to the complexity of the information about the use of medication, a query table from *Microsoft Access* ® was pasted into *Microsoft Excel* ® and the functions of the spreadsheet used to calculate the figures below.

As noted above, seventy-seven respondents (95.1%, n=81) provided information about the medications used in their facilities. The maximum reported number of medications used by an individual facility was 25, and the minimum 2 (mean, 10.96; median, 11; mode, 9).

Of the four completed questionnaires which did not include information about the use of medication one was compiled by a Care Manager; one jointly by the Director of Nursing and a Diversional Therapist; one by a Diversional Therapist; and one by a Registered Nurse.

3.5.13. Comments about the use and efficacy of medications

Thirty-four respondents (42.0%, n=81) commented about the use of medication in their facilities. These comments included:

- *Medication as prescribed for residents effective. Dose changes infrequent.*
- *Most residents have other conditions.*
- *Medications are not always the answer and last resort usually prescribed by a consulting geriatrician.* [This facility reported only two medications being used].
- *The medications used very dependent on our resident mix and individual GP preference.*
- *Used very minimally and then only for therapeutic intervention not for behavioural management except extreme anxiety and agitation.* [This facility indicated that medication is used] *to treat other conditions.*
- *Find us one that works!*
- *Frequently (not in this facility) psychotropic medication is used first rather than analgesic. Much agitated behaviour relates to pain. Residents can become very restless and agitated - this can become very stressful for them and often the above types of medication can reduce this stress.*
- *Sadly, with many residents, medications are used to control difficult behaviours because all other interventions have not been beneficial.*
- *We believe that least is best. Sometimes mixing medications is not always effective.*
- *Often used without trying other complementary therapies - easier, quicker. Our time constraints are huge.*
- *We try to minimise the use of medications by employing distractions and avoidance of triggers.*
- *The effectiveness of medication is very individual and what works on one may not on another. The time the medication is given affects effectiveness.*
- *Regularly review resident' s medication.*
- *If used appropriately can reduce episodes and length of behaviours.*
- *I prefer an alternative eg food, drink, pain AX, repositioning, music. Doctors still seem too keen to prescribe.*
- *Use sparingly in conjunction with therapies. At this facility we try to avoid the use of haloperidol as at times* [agitated] *behaviours can be increased and it masks Parkinson's S&S.*
- *Limited use for frontal lobe – often causes falls – best to avoid these* [indicated medications] *for dementia. Important for* <u>*doctors*</u> [emphasis supplied] *to treat*

any depression and diagnose accurately and promptly infections and other issues for best care of dementia persons. [This facility indicated that medication is often given for medical reasons other than dementia.]

- *This is a serious issue, i.e. most medication has to be crushed & mixed with a media eg jam to enable resident to swallow it. We have explored (to no avail) for the medication to be in an alternative form eg liquid, suppositories etc. Not on the market.*
- *Extremely difficult to administer when resident – non-compliant, when families are against the use of these types of drugs. We find G.P's (majority) do not sufficiently explain pros and cons of medications to family – nursing staff are constantly explaining and doing most of family consults. Many G.P's are still very inexperienced i.e. poly-pharmacy of the above [medications] and effect. It is extremely difficult to titrate psychotropic medication regimes in our environments with minimal medical support as opposed to going to Glenside/Hillcrest for assessment and review with 24 hr psychiatric backup med/nursing.*
- *Encourage treatment of depression - can mimic dementia and high incidence in institutionalised aged* [care] *needs addressing. Try to minimise medication but need to weigh up quality of life of residents (sufferer) and ' housemates'* [This facility drew attention to the fact that multiple medical conditions are often associated with dementia.]
- *Reduces agitation and restlessness*
- *Has limited use as do not wish to affect resident so that they are unable to function.*
- *Overused. Not regularly reviewed by GP' s. First alternative instead of the last.*
- *In long-term care of residents with dementia (some residents have lived here for 5-9 years) very little* [of listed] *medication required for the management of aggression – effects swing from too much to too little.*
- *Minimal medication used - other strategies eg complementary therapies in place.*
- *We recently moved to a new facility which has a secure area for residents suffering dementia. Whilst transferring the medications it was noted by myself and the pharmacist that the residents with dementia had far less tablets/medication than the other frail, but alert residents.*
- [In response to the number of medications used.] *Usually related to other conditions (eg cardio-vascular) rather than dementia.*
- *Medications are generally used as a last resort. Other strategies are used predominantly.*
- *Medications are a necessary adjunct to the overall care of residents. Complementary therapies are only a part of the care needs of the individual.*
- *Too many! Would like to be better funded to allow more staff intervention for behaviours, physical environment impacts as well. The above ticked list are not all in use but have been used from time to time over the last twelve months.*
- *M.O,' s flexible generally, review regularly with views to reduction where possible, also happy to liaise with Southern Mental Health Services.*
- *Regularly review with doctors and try to find alternatives but this is usually unsuccessful.*
- *Generally as a rule many medications are trailed – some in early stages of dementia at home. Ultimately with some noisy behaviours – no medications are successful and often residents become over medicated and only improve when all medications cease and other therapies are looked at.*

3.5.14. How many different medications do residents receive?

A total of 76 respondents (93.8%, n=81) answered Question 22, "What is the approximate average number of medications (including ones not listed above) used by people with dementia in your facility?" of these:

- ☆ 31 (40.8%, n=76) reported an average use of more than three medications
- ☆ 20 (26.3%, n=76) reported an average use of three medications
- ☆ 16 (21.0%, n=76) reported an average use of two medications
- ☆ 9 (11.8%, n=76) reported an average use of one medication per resident.

None of these facilities actively reported the non-use of medication. These figures are illustrated in Figure 3.6.

Of the five (6.2%, n=81) respondents who did not provide information about the average number of medications being used by residents, four did not provide any information about medications being used.

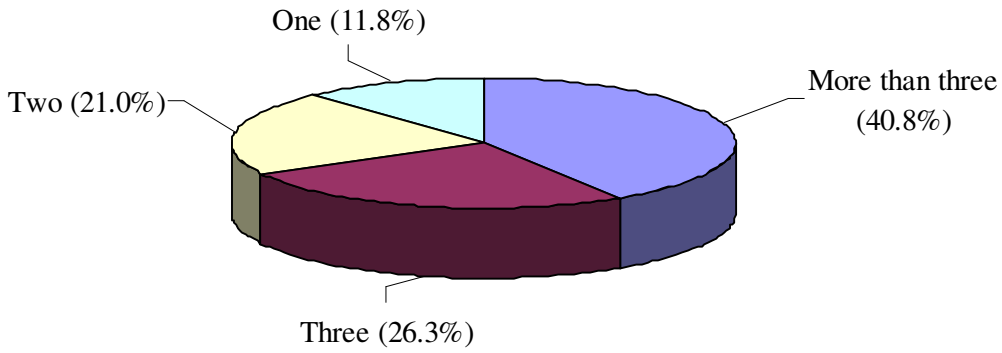


Figure 3.6: Average number of medications used per person (n=76)

3.5.15. The 'domino' effect

Forty-two respondents (51.8%, n=81) expressed concern about disruptive behaviours causing anger, frustration, stress and distress, fear, disruption, agitation, loss of privacy, disharmony, offence, and agitated behaviours in other residents, as the disruptive individuals are intrusive to other residents and there is a potential of safety problems for the other residents. One respondent commented on noise disturbing other residents and keeping them awake and grumpy.

The agitated behaviour displayed by one resident may have the potential to agitate other residents and set off other behaviours. This may be particularly so when people are living and working in close proximity to each other. The 'domino' effect

may also include visitors who can be disrupted, distressed, offended and/or upset by these behaviour and their physical safety can be threatened.

3.5.16. Other issues

One respondent reported a *feeling* [of] *disempowerment* [because it is] *very difficult to communicate and alleviate anxiety* while one respondent commented on the potential of residents to sense the wariness of staff to the fact that they may be hit or punched by aggressive residents. Another commented on the fact that "Sundowning" [which is an escalation of agitated behaviours in the late afternoon] can cause problems for staff and residents, particularly those with *poor ambulation*.

One respondent commented that agitated/aggressive behaviours have the potential to *present* [a] *negative image* while another commented that problems for staff occur when *families* [do] *not accept that we do not cause the behaviours*. The potential for behaviours such as *smearing* [of faecal material] to compromise the health of the individual, the staff members, and other residents was emphasised by one respondent while another commented on *feelings of helplessness* which can exacerbate staff stress.

Four respondents commented that disruptive behaviours can make it difficult for staff to attend to *ADLs* (Activities of Daily Living) and provide adequately for residents' *basic needs* however one respondent commented that, *it is hard but happening with education that it is not a sin if someone doesn' t have a shower occasionally*

As noted above, one respondent stated that they do not have enough staff or volunteers to provide 1:1 intervention while another stressed that there is a *need to have assistance of volunteers*. A third respondent stated that there is a *need to observe residents 15/60* [sic] *to know whereabouts* while another commented on the need to *redirect* [people] *to* [an] *appropriate place*.

3.5.17. Who were the respondents?

One respondent (1.2%, n=81) did not provide information about who had completed the questionnaire, 27 questionnaires (33.3%, n=81) were a joint effort with a number of staff having participated in completing the questionnaire, and 53 questionnaires (65.4% n=81) were completed by an individual staff member. The Director of Nursing alone completed thirty-five questionnaires (43.2%, n=81) and twenty questionnaires (24.7%, n=81) in consultation with other staff members. The status of the respondents is detailed in Table 3.7.

Table 3.7: Respondents to questionnaires by category (n=81)		
Director of Nursing only	35	43.2%
Joint responses	27	33.3%
Clinical Nurse only	8	9.9%
Registered Nurses only	7	8.6%
Care Manager only [1]	2	2.5%
Diversional Therapist only [1]	1	1.2%
No response	1	1.2%
Enrolled Nurses only	0	0.0%
Patient Care Attendant(s) only	0	0.0%
Note: 1. It was not possible to determine if these people had a nursing background.		

A total of 117 individuals assisted in the compilation of information returned via the questionnaires. This included 55 Directors of Nursing, 31 Registered Nurses, 15 Diversional Therapists, nine Clinical Nurses (including CNCs), three Care Managers, two Enrolled Nurses, one Patient Care Attendant, and one Manager: Residential Aged Care. The number of persons who assisted complete the questionnaires is illustrated in Figure 3.7.

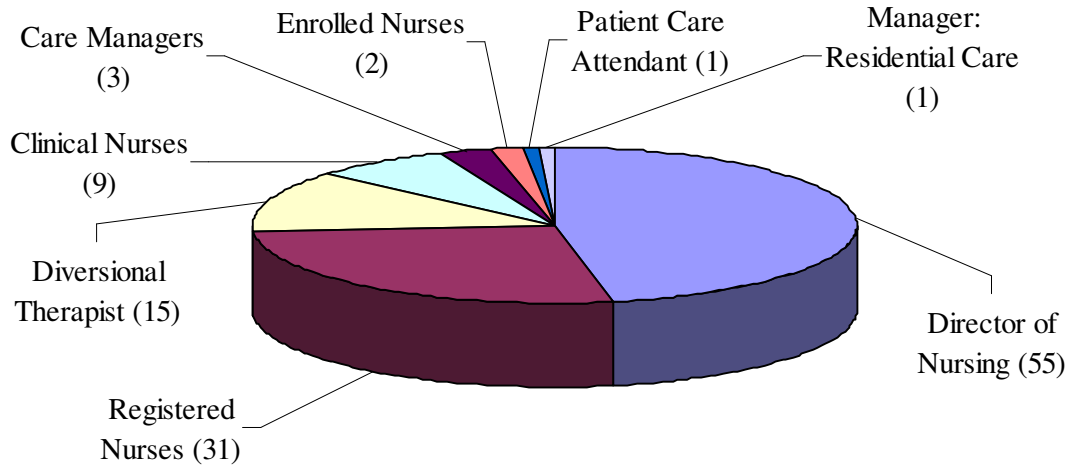


Figure 3.7: The number of persons who assisted complete the questionnaires (n=117)

3.6. Conclusion

Given the widespread use of complementary therapies in dementia care in South Australian Nursing Homes and the belief in their efficacy, it is necessary to examine in greater detail the notion of 'complementary' therapies and how they purport to work.

4. Literature Survey: Complementary Therapies

> *Let us step outside our outdated sectarian views and look to the essence of what we are practicing in place of the outward forms which our minds are so attached which we place so much misguided importance* [sic].
> *(Dr. Mikao Usui in Ellyard, 2002, p. 113).*

4.1. Complementary therapies defined

"Complementary" as a term to describe certain forms of therapy is used by Ezzo, Berman, Vickers and Linde (1998); Petry (2000); Wirth, Richardson and Williams (1996); and 20 other authors cited elsewhere in this thesis. In addition, the term "complementary" appears in the title of at least four journals: *Complementary Therapies in Medicine*; *The Journal of Alternative and Complementary Medicine*; *Complementary Medical Research*; and *Complementary Therapies in Nursing and Midwifery*.

As discussed in Chapter 2, various terms including "unconventional" (Eisenberg et al., 1993), "alternative" (Eisenberg et al., 1998) and "complementary" are often used synonymously to describe therapies that are neither taught widely in medical schools nor generally available in US hospitals (Eisenberg et al., 1998). In addition, the terms alternative and complementary may be mutually exclusive by definition; a practitioner and/or recipient can define individual therapies as either alternative or complementary depending on their use (Achilles, 2000).

Complementary therapies can be described as therapies that "work in conjunction with conventional medicine rather than in place of" (Yen, 1999, p. 52) 'conventional' therapies. This description is supported by the findings of Astin (1998) that the "vast majority of individuals" who participated in a United States of America telephone survey used "alternative therapies" to complement conventional therapies (p. 1551).

Therefore, in order to avoid confusion, the term '*complementary*' will be used in this thesis to label and describe non-allopathic therapies.

4.2. 'Therapies' or 'Medicine'?

As discussed above, individual authors often use terms such as 'alternative', 'unconventional', and 'complementary', synonymously although their meanings may be quite different. Similarly, authors may interchange the terms 'therapy' and 'medicine'. Eliopoulos (1999) entitles her article *Using Complementary and Alternative Therapies Wisely*, yet, in the first paragraph, writes, 'The skyrocketing popularity of

complementary and alternative *medicine* (CAM) therapies and systems" [underlining added]. However, the researcher understands the noun '*medicine*' to refer to something which is ingested through the mouth. Therefore, in this thesis, the term '*therapy*' will be used to describe non-oral or non-injected treatments or processes such as 1:1 activities, aromatherapy massage, aromatherapy vaporising, behaviour therapy, Chiropractic, church services, cooking, craft, doll therapy, gardening, hair dressing and hand and nail treatments, Healing Touch, hot towel, laughter, light therapy, massage, meditation, multi-sensory therapy, music (instrumental), music (recorded), music (voice), pet therapy, prayer, reflexology, Reiki, reminiscence therapy, Snoezelen, Tai Chi, Therapeutic Touch (Krieger/Kunz method), ThreePhase Therapy, validation therapy, and visits (outings).

Since the researcher developed the above definition early in 2002, the Australian Medical Association (AMA), (2002) has issued a position statement defining:

- *complementary medicines* as "a wide range of non-prescription products with health claims such as herbal medicines, homeopathic medicines, nutritional and other supplements" (AMA, 2002, p.1)
- *complementary therapies* as "acupuncture, Chiropractic, osteopathy, naturopathy, and meditation …aromatherapy, the Alexander Technique, reflexology …crystal therapy, irido logy and kinesiology" (AMA, 2002, p. 1)
- *Complementary Medicine* [note the capitalisation] as both "complementary medicines and therapies" (AMA, 2002, p. 1).

Therefore the term '*therapy*' as used in this thesis specifically excludes medicines, which are beyond the scope of this research.

4.3. The use of complementary therapies

As discussed in Chapter 2, a 1997 nation-wide telephone survey conducted by Eisenberg et al. (1998) found that 42% of the American population used at least one "alternative" therapy for chronic conditions such as allergies, anxiety, arthritis, back problems, depression, digestive problems, fatigue, headaches, high blood pressure, insomnia, liver and kidney abnormalities, lung problems, neck problems, skin problems, and sprains or strains. The authors estimated that the number of visits to alternative therapists exceeded the total number of visits to all primary care physicians. In addition, they found that the use of "alternative" therapies was not confined to any narrow segment of society but was more common in women than men and less common among African Americans. In this survey "alternative" therapies included

acupuncture, biofeedback, Chiropractic, energy healing (including magnets, Therapeutic Touch, Reiki and spiritual healing), folk remedies, herbal remedies, homeopathy, hypnosis, massage, megavitamins, relaxation techniques (including massage), and self-help groups.

The 1997 study was a follow-up survey to one conducted in 1990 (Eisenberg et al., 1993) that found one third of the U.S. population used "unconventional" therapies. Both of Eisenberg's surveys found that the majority of users of "alternative" or "unconventional" therapies did not discuss this fact with their medical doctors. It was suggested that medical schools include information about alternative therapies in their curriculum and that there should be scholarly research and education about them so that doctors could develop a better understanding of what their patients may be doing. doctors would then be in a better position to advise their patients.

In Australia the growing use of complementary therapies has been acknowledged in the scientific literature and research conducted into the efficacy of a range of complementary therapies (Blacklock, 1992; Bensoussan, 1999; Bunn, 1997; Cosford, 1999; Davies, 2000 & 2001; Easthope, Gill, Beilby & Tranter, 1999; Godfrey, 1994; Henry, 2001; Sherwood, 2000; Tysoe, 2000; Van der Riet, 1999a & 1999b; Yeldham, 2000).

4.4. Holistic therapies

In addition to the use of terms such as 'unconventional', 'alternative' and 'complementary' which are applied to certain practices, those which purport to work on the whole person rather than individual parts in isolation can be referred to as '*holistic*' therapies (American Medical Association, 1997; Chang, 2001b; Hepworth, Gaskill & Bassett, 1996; Mornhinweg & Voignier, 1995; Robins, 1999; Young, 1998). A holistic approach to therapy is the main theme for at least four journals including *Holistic Nursing Practice, Journal of Holistic Nursing*, *British Journal of Holistic Medicine,* and *The Australian Journal of Holistic Nursing.* Often these 'holistic' therapies claim to have a "mind-body-spirit connection" (Starn, 1998, p. 576).

Despite being labelled "new-age" by the popular press, a concern for the 'whole person' is far from a new concept. Two thousand years ago, Jesus was concerned for the 'whole' person (Harpur, 1994).

It may be that this holistic approach, which is being referred to as '*integrated health care*', is causing people to seek the services of complementary therapists (Snyder, 2001).

4.5. Several problems acknowledged

4.5.1. The acceptance of complementary therapies

> *Why should we impose our medical model on patients? Their use of CAM* [Complementary and Alternative Medicine] *may be their process of empowerment, which in turn allows them to contain and manage their chronic illness. It is perhaps difficult for those … educated within the conventional medical system to allow … patients the freedom to make such journeys in a truly egalitarian manner.* *(Lewith, 2000, p. 102)*

Discussion about the efficacy and appropriateness of 'complementary' therapies is not new. Famous nurses such as Florence Nightingale (Yeldham, 2000) and Elizabeth Kenny, an Australian Nurse who attempted to reform the treatment for poliomyelitis in the 1930s (Martyr, 1997), recognised the need for a holistic approach to the treatment of patients and the use of complementary therapies. Although the Australian Medical Association derided Kenny's methods and she was "ostracised by the orthodox medical community" (Martyr, 1997, p. 65), history records that her methods were eventually vindicated.

Scepticism about the efficacy of complementary therapies such as aromatherapy continues to flourish (King, 1994) even though Hippocrates advocated the use of aromatic massage and baths as a way of ensuring good health (Robins, 1999). Furthermore, despite the fact that the (over) three thousand year old practice of acupuncture greatly predates the development of Newtonian science (American Medical Association, 1997), it is still considered to be "unconventional" (Eisenberg et al., 1993) and/or "alternative" (Eisenberg et al., 1998).

Notwithstanding the 41 references to Christ's ability to heal in the Bible (Starn, 1998) and Christ instructing his disciples to preach, teach and heal (Harpur, 1994), the lack of acceptance of complementary therapies may have stemmed from the edict of Pope Alexander II, that the healing mission of the clergy be stopped. Nevertheless, the official response of mainstream churches and medical practitioners towards the use of complementary therapies may be changing.

Internationally, the World Health Organisation has released a set of standards for the production of herbal medicines (American Medical Association, 1997) and there is evidence that the use of complementary therapies is increasing in Australia, Canada, the Netherlands, New Zealand, the United Kingdom, and the United States of America (Easthope et al., 1999). In the United Kingdom, William Temple, Archbishop of Canterbury from 1942 to 1944, officially recognised the work of the blind 'healer' Godfrey Mowatt 'Spiritual' healing is now available on the British National Health scheme (Harpur, 1994), and the British Medical Association has

developed recommendations for the implementation of complementary and alternative medicine (American Medical Association, 1997).

In the United States of America, medical schools have introduced elective courses in topics such as Chiropractic, acupuncture, homeopathy, and mind-body techniques (Wetzel, Eisenberg and Kaptchuk, 1998) and the Practice and Policy Guidelines Panel of the American Medical Association has recommended the establishment of guidelines for the development of "Complementary and Alternative Medicine" and for improvements in the way information is made available for doctors (American Medical Association, 1997).

An example of changes in South Australia is the offering of a six-unit undergraduate elective entitled *Exploring Complementary Therapies and Holistic Nursing* by the Flinders University, Faculty of Health Sciences, School of Nursing and Midwifery. In 2002 this unit included the study of the theoretical and historic background to complementary therapies as well as their practical application in nursing and midwifery (Cuthbertson, 2002).

Despite the Australian Medical Association's attempt to have complementary therapies excluded from government funding through Medicare (Easthope, 1993), there was a call for Australian doctors to understand what patients are experiencing (Fallick, 1998) and some medical practitioners began, themselves, using complementary therapies in their practice (Easthope et al., 1999). Lewith (2000), writing in the *Medical Journal of Australia* suggested that, if those involved in practicing and teaching within the "conventional medical system" do not become proactively informed about the place of complementary therapies (and medicine) in health management, then it is possible that economic, social and free market forces will eventually force them to do so.

It would appear that Lewith's words were prophetic, as the Australian Medical Association appears to have reversed its attitude towards complementary therapies with the release of its Position Statement on Complementary Medicines (Australian Medical Association, 2002, p. 4) in which it recognised that:

> *Increasingly, medical practitioners will require a basic understanding of Complementary Medicine and should receive sufficient training in their undergraduate, vocational and further education to enable them to discuss such issues with their patients on an informed basis.*

However, it may be possible that orthodox medicine will continue to fight the introduction of unconventional, alternative or complementary therapies despite having

historically used, eventually controversial practices, such as blood-letting, purging and toxic metals (Jonas, 1998).

4.5.2. The study and efficacy of complementary therapies

> *Certainly much controversy exists regarding the appropriate way to conduct research on holistic therapies. Can their effects be broken down and studied without contradicting the central premise on which holism is based?*
> *(Robins, 1999, abstract)*

Some difficulties in the study of complementary therapies arise because of the purported 'holistic' nature of complementary therapies which "acknowledge that symptoms are the body's way of communicating that the mind and the spirit are in need of change" (Starn, 1998, p. 567) as well as the physical body. Thus it is suggested that the disease, the person, and/or the therapy cannot be segmented into its component parts for study without compromising the process. Problems with a Western reductionist approach to the study of complementary therapies, and the need for a focus on expert opinion and/or consensus have now been recognised by at least one mainstream medical organisation, that is, the American Medical Association (American Medical Association, 1997).

Another complexity arises when the underlying assumption that each patient is an individual, will have individual preferences for the type of therapy, will experience the therapy individually (American Medical Association, 1997, Daley, 1996, Richardson, 2000, Routasalo, 1999), and therefore must be treated as an individual is debunked because it lacks "logic" (American Medical Association, 1997).

Complications in evaluating complementary therapies and developing policy for their implementation may arise because of the differing terminology between disciplines and their underlying philosophies on the nature of disease and the therapeutic process. It is difficult to scientifically document innate assumptions (American Medical Association, 1997; Chang, 2001b).

While some forms of complementary therapies have been practiced for thousands of years it has, until recent times, been impossible to measure scientifically the energy which is claimed to be associated with some therapies and practitioners. However, the development of superconducting quantum interference devices, electrocardiograms and electroencephalograms (Oschman, 2000), and Kirlian photography (Yeldham, 2000) has now enabled scientific measurement of this energy.

In addition, a number of authors are concerned with the need for rigorous testing for the placebo effect (Mansour, Beuche, Laing, Leis & Nurse, 1999; Nield-

Anderson & Ameling, 2000; Olson & Hanson, 1997). However, there is evidence that using a placebo in drug trials can be ineffective (Arpaia, 2000; Brody, 2000). There are limitations to placebo control (Richardson, 2000), because doctors can transmit their ideals to patients (Brody, 2000) and the placebo effect "is consistent at 35.2% (+/- 2.2%)" (Richardson, 2000, p. 402). Research has found that, in Therapeutic Touch, the placebo effect can count for ≈40% of Therapeutic Touch's efficacy (Daley, 1996, p. 1130) although this figure "does not even begin to reflect the significant emotional, psychological, and spiritual benefits" of Therapeutic Touch (Daley, 1996, p. 1130).

Further denigration of complementary therapies, and therefore possible rejection of positive research findings, arises because many practitioners are not trained in main-stream health sciences, or are nurses whose role in health care has been traditionally viewed as subservient to that of doctors (Daley, 1996), and the implementation of complementary therapies into nursing practice is often political (Parish & Willis, 1996). Hopefully, there has been an on-going attitudinal change as nursing studies have moved into universities, research into complementary therapies is undertaken at post-graduate level, and nurse practitioners, teachers and authors such as Chang (2001a &2001b), Chen (Chen et al., 2001), Eliopoulos (Eliopoulos, 1999), Gale (Gale & Hegarty, 2000), Krieger(Krieger, 1993 & 1997), Morse (anthropology and nursing) (Estabrooks & Morse, 1992)., Sansone (Sansone & Schmitt, 2000)., Schmitt Sansone, P. & Schmitt, L. (2000), Sherwood (2000), and Wardell (Engebretson & Wardell, 2002) can speak with the authority of their PhDs.

As a Reiki, Therapeutic Touch, and Massage practitioner, the researcher has experienced difficulty in separating the effect(s) of the therapy from the possible effect(s) of the ambience of the setting. This may include: the relationship with the practitioner; the temperature; the colour of the walls and other objects such as the furniture and the towels; the size of the massage table; any music being played; any incense or candles burnt prior to, or during, therapy; and/or the client's personal preferences regarding any essential oils being used. In addition, it has been recognised (and acknowledged) that:

- ☆ there is difficulty in determining the effect of aromatherapy as compared to touch when essential oils are used in massage (Robins, 1999);
- ☆ multi-sensory therapy (sometimes referred to as *Snoezelen*) has proven efficacy (Holloway, 1997; Schofield & Davis, 2000; Chitsey, Haight & Jones, 2002);
- ☆ the practitioner is an integral part of the therapy (Richardson, 2000); and

- ☆ the reliance on a reductionist approach may not be possible (American Medical Association, 1997).

However, some writers call for the distinct separation of the elements of a therapy when conducting research (King, 1994).

An additional problem is the lack of reported scientific research into therapies such as Reiki as detailed above. Unlike Therapeutic Touch (Krieger, 1993 & 1997), which was developed as a nursing procedure and has been well researched and documented in the scientific literature, Reiki has been largely developed in the general community. Prior to 2000, Reiki in a medical/nursing setting, had been the subject of at least three studies at postgraduate level (Bacon, 1997; Markides, 1996; Thornton, 1991). This contrasted with at least 66 studies of Therapeutic Touch at a similar level. In February 2000, a local bookstore in Adelaide had 66 Reiki titles in its catalogue indicating Reiki's popularity in the general community, yet the Flinders University libraries had only one title (a video) relating to Reiki. The paucity of research into the healing potential of touch therapies had also been recognised by authors such as Richardson (2000) and Chang (2001a & 2001b). Yet we were reminded that:

> *Thanks to a direct hands-on approach to patient care and a focus on personal contact and interaction with patients, the field of nursing has amassed a vast reservoir of empirical medical knowledge gained through time-proven direct observation and clinical assessment.*
>
> *(Daley, 1996, p. 1124).*

Perhaps this growing reservoir of knowledge, amassed through both professional and folk application of complementary therapies, has led to the acknowledgement of the need for formal scientific research into the purported efficacy of complementary therapies (and medicine) and the formation of:

- ☆ the Office of Alternative Medicine (OAM) and the National Centre for Complementary and Alternative Medicine (NCCAM) in the United States of America (http://nccam.hih.gov)
- ☆ the Foundation for Integrated Medicine (FIM) in the United Kingdom (Lewith, 2000)
- ☆ the Office of Complementary Medicine (OCM), the Complementary Healthcare Consultative Forum (CHCF), and the Complementary Medicines Evaluation Committee (CMEC) under the banner of the Therapeutic Goods Administration in Australia (http://www.health.gov.au/tga).

4.5.3. The 'quick fix' syndrome

The use of medication as a "quick fix" alternative to other therapies was acknowledged by some respondents to the questionnaire distributed to South Australian Nursing Homes as part of this thesis. A belief that results must be almost instantaneous is reflected by the comments of Accardo and Blondis (2001, p. 339) that "It must be painfully obvious that more effective therapies will always be quicker than less effective ones."

4.5.4. Carer attitude and time constraints

Both time constraints and the attitude of carers towards the use of complementary therapies in the management of problematic behaviours have been found to be factors in the use and efficacy of those therapies.

Brody (2000) asserted that, if they believe a particular medication will be effective, doctors can transmit their ideals to patients. In advocating against the use of Reiki, Martinez (1996) writes, "We only allow the laying on of hands, in the name of Jesus." Daley (1996) reported that nurses may spend as little as 25% of their time in "direct patient care" (p. 1124) and further stated, "Most experienced nurse practitioners know that they personally can affect a positive therapeutic change for their patients through compassion, intention, and even sometimes with only a loving thought" (p. 1127). In a review of literature relating to Snoezelen multi-sensory therapy, Chitsey et al. (2002) found that there can be "an improvement in staff morale and patient and staff relationships" (p. 47) following the use of Snoezelen therapy.

In a trial of hand massage provided to 26 subjects in three metropolitan Alzheimer's units in the United States of America, Snyder et al. (1995) found that the efficacy of hand massage may be reduced if staff are not "comfortable administering hand massage" (p. 63). In a more negative vein, Kovach and Meyer-Arnold (1997), reported that stress in staff members can invoke agitated behaviours in patients.

Conversely, when carers believe in the benefits of complementary therapies and use them as part of their normal routine the results can be very positive. This is emphasised in the forward to Giuliano (1996) where Keith Flemming, Consultant Geriatrician, stated, "I became aware that when [Giuliano] was on duty the residents weren't given their take when necessary (PRN) sleeping tablets, whereas all were given them on the other …nights."

In the survey of nursing homes in South Australia conducted by the researcher as part of this thesis, 11 respondents (8.9%, n=81) reported that their facilities precluded the use of certain (unidentified) complementary therapies because of time constraints.

Whatever the belief of the practitioner regarding the use of complementary therapies may be, Meehan (2001) reminds us that the needs and wishes of patients must be respected.

4.6. Conclusion

The efficacy of a particular therapy may be the result of one or more processes including chemical reaction, mechanical manipulation, and/or energy stimulation/balancing.

Chemical reactions can occur when substances are ingested, applied to the skin or inhaled and may possibly be present in therapies such as Bach flower remedies, dietary regimes and supplements, essential oils, herbal preparations, homeopathic preparations, and/or medication.

Mechanical manipulation of body parts is an element of therapies such as Chiropractic, exercise, massage, reflexology, and/or surgery.

Energy stimulation/balancing may be considered an element in therapies such as acupuncture, Bach flower remedies, colour therapy, essential oils (which are considered to have low, middle and high note qualities depending on their volatility), Healing Touch, homeopathic preparations, hot towel therapy, laughter, light therapy, massage, meditation, magnets, music, polarity therapy, prayer, reflexology, Reiki, Snoezelen, Tai Chi, and/or Therapeutic Touch (Krieger/Kunz method).

Eisenberg et al. (1998), in their 1997 survey, recognised that some therapies are considered to be 'energy' therapies and reported that the most frequently cited forms of energy healing were magnets, Therapeutic Touch, Reiki and energy healing by religious groups (p. 1157).

The energy associated with music can be used to stir people into frenzy ready for battle (martial music and/or tribal drumming), induce trance states (Shamanic drumming), and/or induce sleep in babies (lullabies). Music:

> *"…hath charms to soothe a savage breast,*
> *To soften rocks, or bend a knotted oak."*
> *(William Congreve, 1670-1729,* The Mourning Bride*, I.i).*

Given that some complementary therapies claim to heal through the use of energy, how then can energy be used to heal?

5. Literature Survey: How Can Energy Heal?

> *In the current era of rapid scientific progress, many of the concepts we were absolutely certain about 20 years ago are no longer true at all.*
> *(James L. Oschman, PhD, 2000, p. 27).*

5.1. Energy

There are many forms of energy including chemical, elastic, electrical, gravitational, heat, kinetic, magnetic, nuclear, potential, radiant, and solar. Energy can be stored. The potential energy contained in water can be stored behind a dam built at a high altitude. Electrical energy can be stored in a battery and potential kinetic energy can be stored in a coiled spring. Energy can be converted. The potential energy in water dammed at a high altitude is converted into kinetic energy when the water is permitted to fall. This kinetic energy can then be converted into electrical energy when the falling water is used to turn turbines. The differential heating of land and sea by solar energy is converted into kinetic energy when air begins to flow from an area of high pressure to one of low pressure. Energy and matter are interconvertible. This concept is expressed in Einstein's formula $E = mc^2$ while Hiroshima and Nagasaki proved, beyond all shadow of a doubt, that a small quantity of matter could be converted into an incredibly large explosion of energy.

If an object has low kinetic energy it is considered to be solid, raise the energy level a little and the object becomes a liquid, a little further and it becomes gaseous. Depending on the energy level of light, it is considered to be infrared, visible or ultra violet. Likewise the energy level of sound can render it either audible or inaudible to the human ear. Energy can be soothing (the gentle rocking of a cradle or quiet music) or harmful (an earth quake or sonic boom) depending upon its frequency level and/or volume (Commonwealth of Australia Bureau of Meteorology, 1966; Coollocott, 1971; Finch, Trewartha, Robinson & Hammond, 1957; Petterssen, 1958; Uvarov & Chapman, 1960).

We cannot see, hear or touch this energy. We can only perceive its effects on our environment and ourselves. While the energy of the wind cannot be seen, touched, or tasted, its effects can be seen, felt and used to advantage. The wind can be used to cool our bodies on a hot day, propel ships, turn windmills, and generate electricity. Conversely, the energy of the wind, in the form of tornadoes and cyclones, can wreak havoc. Humans cannot see, hear or touch the energy used in microwave ovens or X-ray machines since its wavelengths are outside the normal range of human vision, hearing and/or touch. However, these appliances can be used to cook food or

"see" inside the hum an body. Electricity can be used to heat our homes, cook our food, light our cities, and power our communication devices, electric toothbrushes and other 'power' tools. Although some might say that it is poss ible to see electricity in the form of lightning, it is only the evidence of the passage of the electricity through the air that can be seen. Initially, the air is ionised by the powerful electrical fields in the discharge and it is the rapid re-combination of the electrons and ions that produces the light and heat which is called lightning (personal conversation with Professor Robin Storer). Temperatures in excess of 30,000 K are produced within milliseconds (Uman, no date).

The use of energy in medicine is not a new phenomenon. Electricity generated by eels was used to provide shock treatments as early as 2,750 BC (Oschman, 2000) and the Romans used electricity from torpedo fish to treat headaches (Freckelton & Wilson, 2001). How then is energy used in modern mainstream medicine?

5.2. Energy in mainstream medicine

The invention of the Leydon jar condenser in 1745 and the battery by Volta in 1799 enabled the widespread use of electricity in the treatment of mental illness (Freckelton & Wilson, 2001). By 1884 it was estimated that up to 10,000 doctors were using electricity for therapeutic purposes in the United States of America. However, following the passing of the United States of American Pure Food and Drug Act in 1906, the use of electrotherapy was condemned as 'quackery' and physicians threa t-ened with imprisonment if they continued using their equipment (Oschman, 2000). Magnetism was used as an aide to healing by Franz Anton Mesmer in 1773 (Oschman, 2000).

Wilhelm Roentgen laid the foundations of modern radiology with his December 1895 report on the discovery of X-Rays (Gunderman, 1998) and the first reported use of X-Rays in Australia was in late 1896 (McQuellin, 1998). However, as with many revolutionary discoveries, this was not without controversy. As X-rays were invisible to the human eye, Lord Kelvin considered that they were a hoax (Gunderman, 1998). The electromagnetic spectrum and the frequencies utilised in medical imaging is represented in Figure 5-1.

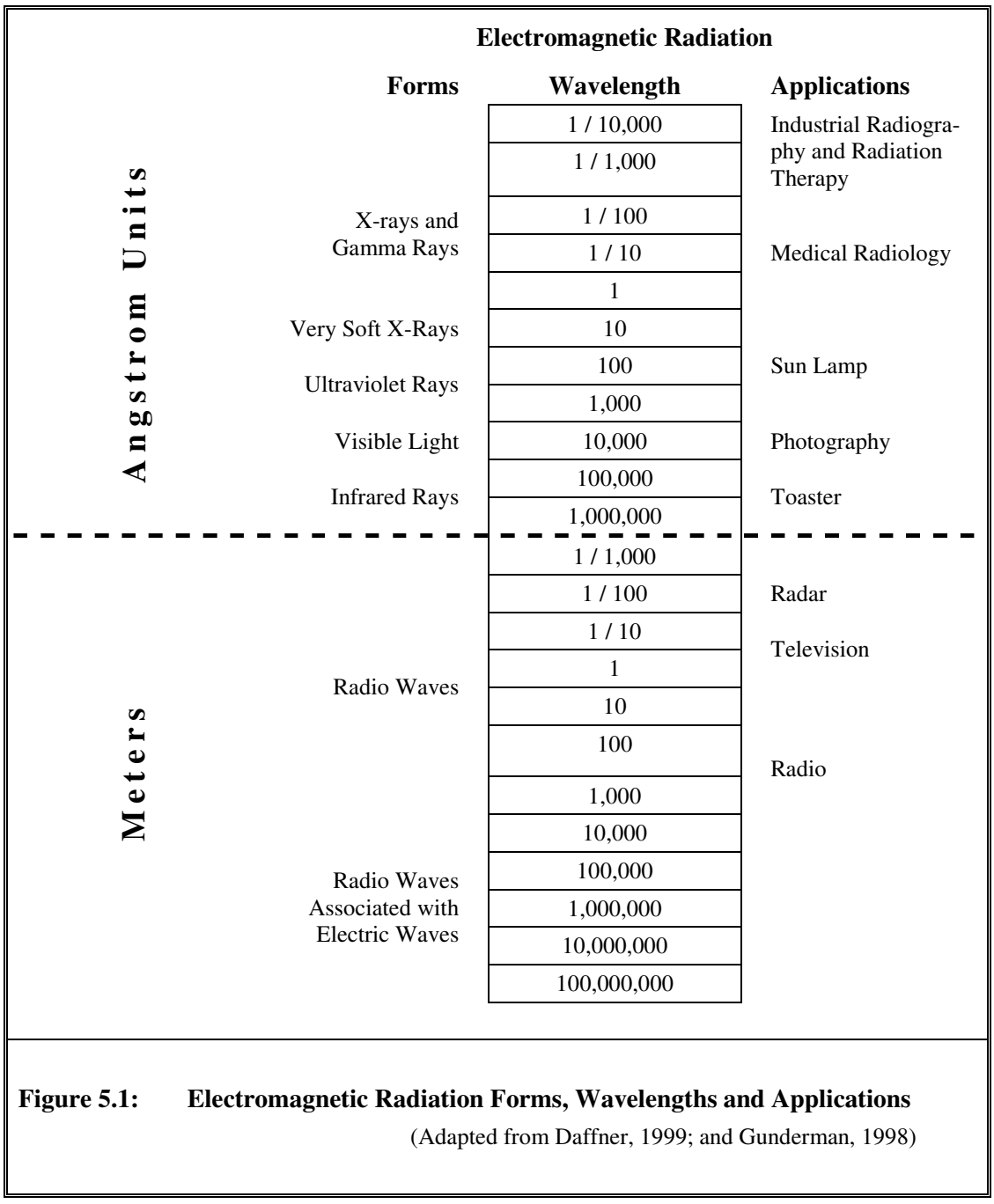


Figure 5.1: Electromagnetic Radiation Forms, Wavelengths and Applications

(Adapted from Daffner, 1999; and Gunderman, 1998)

In addition to the electromagnetic energy utilised for medical imaging, light and sound are used as diagnostic and/or healing tools. Energy generated by the body and recorded with external monitoring devices, as well as energy created by external devices and then directed at the body, is used as either an aide in diagnosis or to perform physical operations in various forms.

Examples of energy use in medical diagnosis and treatment are provided in Table 5.1.

Table 5.1: Examples of energy use in medical practice	
Energy	Application
Angiography	Used to detect vascular disorders, involves the injection of a contrast agent into the vascular system so that a radiograph can be obtained (Gunderman, 1998). Similar processes can be used to detect abnormalities in the urinary tract (*Urography*), body sinuses (*Sinography*), the salivary glands (*Sialography*), and the vertebral canal (*Myelography*) (Daffner, 1999).
Cerebral function monitor (CFM)	'[A] simplified single channel electroencephalogram (EEG)" (Thornberg, Thringer, Hagberg & Kjellmer, 1995, p. 39F) used to monitor the electrical activity of the brain (Thornberg et al., 1995) although it may be only appropriate for long-term monitoring of a condition previously diagnosed with the aid of an EEG (Rennie, Chorley, Boylan, Pressler, Nguyen & Hooper, 2004).
Cold and hot packs	Commonly used to ease muscle strain.
Computed tomography (CT)	Uses a computer to enhance the resolution of images as compared to those of conventional X-ray images (Gunderman, 1998).
Computerised axial tomography (CAT)	A computerised representation of an X-ray scan used to produce a cross-section display of a segment of the body. A CAT-scan can illustrate conditions such as brain damage (Cala, Burns, Davis & Jones, 1984) and osteoporosis (Saha, Singh, Albright, Giyanani & Thompson, 1985).
Electro-acoustic measurement	Used to test hearing aids (Moser, 2000).
Electro-acupuncture	Used to relieve muscle spasm and musculo-skeletal pain (Milne, 1985).
Electrocardiogram (ECG)	Used to record electrical impulses generated by the heart to determine if arrhythmias or other heart disorders are present (McRae, 1983). In addition to the ECG, physicians can use *Phonocardiography* and *Echocardiography* to aid in the diagnosis of heart disorders (Manolas, 1983).
Electroconvulsive therapy (ECT)	Used in the treatment of depressed and schizophrenic patients (Warren 1988). Introduced in 1934 (Katz, 1992) this treatment fell out of favour during the 1960s and 1970s (Warren, 1988) but may be making a comeback (Ragg, 1995). While it is considered by some to be a safe and effective treatment for severe depressive illness (Mendelson, 1983), others claim that it induces permanent cognitive and memory loss as well as acute organic brain syndrome and adds to patients' pre-existing psychological difficulties (Boyle 1988). It is claimed to be an intrusive therapy that can erase memories (Warren, 1988). ECT was introduced into the Parkside Mental Hospital in Adelaide in August 1941 (Freckelton & Wilson, 2001).
Electroencephalogram (EEG)	Used to record total brain activity as an aide in the diagnosis of Epilepsy or other brain dysfunctions (Costa & Bauer, 1997; Nicholson, Patel, & Sleigh, 2001; Yoshikawa & Takamori, 2001).
Electro-motor stimulation (EMS)	Used in muscle strengthening (Hon, De-Domenico & Strauss, 1988). The stimulation of nerves and muscles with electricity is referred to as *Electrotherapy*, *Faradism*, and *Galvanism*. Pulses can last for 30 to 100 milliseconds (Oxford University Press (OUP), 2002).
Electromyogram (EMG)	Used to measure muscle strength, fatigue and weakness (Hamlin & Quigley, 2001).

Table 5.1: Examples of energy use in medical practice	
Energy	Application
Electro shock aversion therapy	Involves the administration of an electric shock (1500 microamperes) sufficiently powerful to induce nausea but not physically harmful. It has been used to 'treat' such 'conditions' as alcoholism, autism, exhibitionism, fetishes, homosexuality, paedophilia, sadistic imaging, smoking, and transvestism. In one incident it was used to stop a nine-month old child from vomiting (Davison & Neale, 1994).
Electrosurgery	Utilises an electrical current in a thin wire to act as a knife (OUP, 2002).
Extracorporeal shock wave lithotripsy (ESWL)	Used in renal stone therapy (Australian Health Technology Advisory Committee (AHTAC), 1991). In 1991-1992 there were 12 of these units in Australia (Australian Institute of Health and Welfare (AIHW), 1993) despite concerns that their use may cause hypertension (AHTAC, 1991).
Laser (light amplification by stimulated emission of radiation)	Used as a surgical tool and for the treatment of ureteral stones (AHTAC, 1991). Laser surgery brings an array of hazards in the form of: flammability and reflection (Smalley, 1999); surgical smoke containing toxic gasses, cells, viruses and vapour (Coles & Williams, 1999); and the potential of injury to both the operator and the patient (Dankiw, Hailey & Angel, 1993).
Magnetocardiogram,	Used to record the biomagnetic energy produced by the heart (Oschman, 2000).
Magnetic resonance imaging (MRI)	Does not use ionising radiation but produces an image by using pulsed radio waves and a magnetic field (Daffner, 1999; Gunderman, 1998). MRI is used in breast cancer screening (D' Astous, Foster, Johns, Yaffe, Brown, & Bronskill, 1985). In 1991-1992 there were 32 magnetic resonance imaging scanners in Australia (AIHW, 1993).
Magnetometer, or superconducting quantum interference device (SQUID)	Used to record the biomagnetic energy produced by the body (Oschman, 2000).
Nuclear medicine	Uses radioactive materials to produce an image of the functioning of various tissues and organs within the body (Gunderman, 1998).
Photoradiation therapy (PRT)	Used in the treatment of malignant gliomas. After surgery, the bed of the tumour is exposed to light generated by a laser (McLeod & Mallon, 1990).
Positron emission tomography (PET)	Used in screening for various forms of cancer (Miles, 2001).
Pulsed (Pulsating) electromagnetic field (PEMF)	Used to "kick start" healing in broken bones (Oschman, 2000), injured muscles (Cohen, Heath, Lithgow, Cosic & Bailey, 2000), and osteoarthritis (Ciombor, Aaaron, Wang & Simon, 2003).
Radiography	Is the use of short wave X-rays (or roentgen rays) to produce an image of the internal organs of the body without the need for surgery. Images can be recorded by a variety of methods including film, fluoroscopic screen, and computer-linked detectors (Daffner, 1999; Gunderman, 1998).
Ray lamps	Used to ease muscle strain.
Single photon emission computed tomography (SPECT)	Has been used as a guide during neck surgery for hyperparathyroidism (Nordin, Larcos & Ung, 2001).

Table 5.1: Examples of energy use in medical practice	
Energy	Application
Static magnetic field therapy	Has been used for hundreds of years and uses either unidirectional (unipolar) or bipolar magnets in the form of specifically placed individual magnets, foot pads, necklaces, and mattress pads to reduce fibro myalgic, lower back, muscle, neck, neuropathic, pelvic, post poliomyelitis, and shoulder pain although the process by which pain reduction occurs is unclear (Brown, Ling, Wan, & Pilla, 2002; Collacott, Zimmerman, White, & Rindone, 2000).
Topographical electro-retinogram	Used to evaluate renal function (Brown & Yap, 1993).
Transcranial magnetic stimulation	Permits non-invasive direct stimulation of cortical neurons (McConnell, Bohnig, Nahas, Shasstri, Teneback, Lorberbaum, Lomarev, Vincent & George, 2003). Research has been conducted into the use of this therapy with Parkinson's disease (Okabe, Ugawa & Kan a-zawa, 2003).
Transcutaneous electrical nerve stimulation (TENS)	Can be used for the control of localised pain in the elderly. Contra-indications include areas such as the eyes, cardiac disease, pacemakers and allergies to the adhesive (Briggs, 2003). On 17/9/2004 a web search using the *Update* search engine found that the Cochrane Review has listed the use of TENS for chronic pain, dementia, chronic low-back pain, knee osteoarthritis, primary dysmenorrhoea, rheumatoid arthritis, recurrent headache, low-back pain and post-stroke shoulder pain. When applied to the head this process is known as cranial electrical stimulation (CES) (Cameron, Lonergan & Lee, 2004).
Ultrasound	Used to monitor heart activity or determine foetal abnormalities, has the advantage of being able to provide real-time imaging (Daffner, 1999; Hides, Richardson, Jull & Davies, 1995). In addition to being used as a diagnostic tool, ultrasound is used in the treatment of muscular pain (Nia, 1994). Ultrasound in nature is used by bats for navigation, in engineering to detect indiscernible cracks in metal, and in the navy to locate submarines (SONAR) (Gunderman, 1998). Ultrasound operates in a frequency range from 1 to 10 MHZ (Daffner, 1999).
X-rays, (or Roentgen rays)	Are smaller and finer than visible light and are used to photograph internal organs and kill cancerous cells. Unfortunately X-rays kill healthy cells by accumulation and/or high dosage and create a heightened risk of leukaemia (McEwan, Le-Heron & Poletti, 1994). The first recorded use of X-ray therapy for cancer patients in Australia was in late 1896 (McQuellin, 1998).

Unfortunately the medical uses of energy detailed above frequently require expensive capital input and costly maintenance. In 1991 there were in excess of 2,000 low and high powered medical lasers in Australia ranging in cost from $1,000 to over $10,000 each (Dankiwet al., 1993), in 1991-1992, there were 60 nuclear medicine centres in Australia, and in the 1991-1992 financial year technology services accounted for 32% of Medicare services and 44% of benefits paid (AIHW, 1993). Both the frequency of use and the cost of medical imaging equipment have risen dramatically in recent decades (Daffner, 1999).

Although it cannot be denied that modern scientific developments have greatly eased the suffering of millions of people and added considerably to their quality of life, it has been demonstrated that some of the energetic diagnostic and treatment techniques described above are not only expensive but may actually be harmful to humans. The dangers associated with X-rays were recognised soon after their discovery by Roentgen. In 1904 Thomas Edison's assistant, Clarence Dally, may have been the first person to die from radiation-induced cancer (Gunderman, 1998).

Despite the advances of medical imaging, the accuracy of diagnosis still relies on human expertise. Between 30% and 35% of significant problems may go undetected by experienced radiologists and between 1% and 2% false-positive readings may be made (Gunderman, 1998).

5.3. The human energy field

The human body uses, converts and produces energy. Chemical reactions convert our food into heat and other forms of energy. Potential chemical energy stored in the muscles is converted into kinetic energy when we move. Electrical energy 'flows' along neural pathways to send 'messages' to and from the central nervous system. However, until recently, it could be stated emphatically that the human body does not produce its own electro-magnetic energy nor possesses an energy field because proof of its existence relied solely on the word of psychics who claimed to be able to see and/or feel the energy while it remained invisible and/or unfathomable to people with 'normal' vision and sensitivity. Brennan (1988) provided colour drawings of how the human energy field (aura) appears to her.

Writers such as Ernst (2001) and Eskinazi (1998) stated that nothing is known of the existence or nature of this energy which is known variously as *Qi, Ki, prana,* and *vital force*. However, according to other researchers in the field, this is not correct. Modern, highly sensitive recording instruments such as the superconducting quantum interference device (SQUID) magnetometer, electrocardiogram, electromyogram and electroencephalogram (Oschman, 2000) and Kirlian photography (Starn, 1998; Yeldham, 2000) enable the demonstration and measurement of human energy fields. In 1924 Willem Einthoven was awarded a Nobel Prize for his work in recording heart electricity with a galvanometer and electrocardiograms are now standard tools in medical diagnosis. With the improvement in metering equipment, it has been found that the energy produced by the heart can be detected up to "15 feet" from the body. During the 1930's Harold Saxon Burr was able to detect electronic

fields in all living things. Burr was able to show that voltage changes occurred in women during the ovulation cycle and that, in mice, voltage changes occurred from 10 days to two weeks before the appearance of a tumour. In addition, it has been demonstrated that the electromagnetic field in humans can change according to phenomenon such as weather patterns, intentions, or specialised fingering exercises undertaken by string musicians (Oschman, 2000). Nevertheless practitioners and patients who maintain that energy therapies can assist in healing are either ignored or dismissed as being fooled by "deception, illusion, trickery, fakery, hallucination, or the placebo effect" (Oschman, 2000, p. 17).

Before discussing how electromagnetic energy generated by the human body can be used to 'heal', it is necessary to consider the concept of healing as compared to 'curing'.

5.4. Healing or curing?

> *… it is possible for a patient to feel healed even when a cure is no longer possible and to be cured but not healed (Achilles, 2000).*

The Macquarie Dictionary (1981) and the Macquarie Thesaurus (1984) considered the terms 'heal' and 'cure' as synonymous and to mean "to make whole or sound; restore to health; free from ailment" and to "doctor, heal, nurse, rehabilitate, remedy, restore". However it could be argued that providing a person with an analgesic for a headache may simply mask the pain and relieve the symptom without treating the underlying cause of the headache. The cause of the headache may be a blow to the head; an allergy; sinusitis; stress; exposure to loud noises; back injury; or a developing bout of influenza. Consequently the recipient may feel that the headache has been 'cured' when the problem has not, in fact, been 'healed'. The analgesic will simply 'deaden' (deadening is a synonym for analgesic) the pain leaving the underlying cause untreated unless there is a thorough investigation into the root cause of the pain.

Focusing on a 'cure' may even produce undesirable and toxic, side effects. For example, "Chemotherapy … is toxic to healthy cells as well as cancerous ones" (Yeldham, 2000, p. 23). Achilles (2000) contends that 'curing' is the removal of all symptoms of a disease while 'healing' involves a spiritual, mental and emotional dimension in addition to the physical component of the disease. Accordingly, it could be reasoned that allopathic medicine concentrates solely on 'curing' the isolated physical and/or biological aspects of illness through the use of drugs or surgery

(Starn, 1998). Conversely, the concept of 'healing' derives from the Anglo-Saxon 'Haelen' which means "to be or to become whole" (Smyth, 1995. p 18). It incorporates cultural, energetic, physiological, psychological, social, and spiritual dimensions (Davies, 2000; Yeldham, 2000) and there is a "mind-body-spirit connection" (Starn, 1998, p. 576).

Consequently there would appear to be a disconnection between the concepts of 'healing' and 'curing'. As noted above, Clark (2002) draws attention to the dichotomy between hopes of a cure and the acceptance of death and acknowledges the challenge to carers in balancing technical intervention and a humanistic approach to patients. Patients may seek alternatives when they realise their disease cannot be cured (Achilles, 2000). The notion of complementary therapies, as discussed above, recognises that both 'curing' and 'healing' and the concept of 'wellness' as opposed to 'dis-ease' have a valuable role to play in modern health practice. This is emphasised by the attitude of a cardiovascular surgeon who believes that:

> *At the completion of the operation, no matter how successful…I also had to show the patient the path to recovery – a task made easier with complementary medicine treatments, particularly those that engage the mind to relax and lower fear, anxiety, and tension. These therapies can enable patients to pursue healing on their own…* *(Oz, Arias & Oz, 1999, p. 8).*

5.5. The body's inbuilt healing mechanism

While modern medication has virtually eliminated bacterial diseases such as cholera, poliomyelitis, and smallpox, it can be argued that no therapy, drug or surgical procedure can 'heal' – only the body's inbuilt healing machine, which is called the immune system, can 'heal'. Therefore all healing is self-healing (Hodgkinson, 1990).

The brain acts through the hypothalamus (which is part of the nervous system) and pituitary glands to influence the immune system (Marieb, 1990; Starn, 1998) which provides a highly specific defence against disease by "destroying 'foreign' cells, and by inactivating toxins and other foreign chemicals with its antibodies" (Marieb, 1990). However, after puberty, the immune system begins to degenerate as the pineal gland calcifies (Marieb, 1990) and the thymus, which produces and 'seeds' the body with T lymphocytes, begins to reduce in size and activity. Eventually, in old age, the thymus is reduced to mainly fibrous connective tissue and fat (Kapit & Elson, 1993; Marieb, 1990).

The immune system is thought to be antigen specific and systemic, with a 'memory' which enables it to recognise previously encountered antigens and mount a stronger counter-attack (Marieb, 1990). However, recent research by Jay Levy from the University of California has indicated that a primitive, innate and non-specific part of the immune system may have been responsible for saving the lives of HIV-infected people who have refused anti-HIV drugs (Wilson, 2002).

The mind-body concert which activates an "inner pharmacy" to enhance healing is often referred to as the placebo effect, or spontaneous healing (Brody, 2000). In contrast to those people who draw upon an inner ability to activate their immune system, there are recorded examples of patients convincing themselves that they are dying, and actually are dying, despite not having a terminal condition (Brody, 2000).

5.6. Conclusion

While it is not necessary to know how electricity works in order to use an electrical appliance, knowledge of what electricity is and how it works will assist in the effective and safe use of electrical appliances. Likewise an understanding of energetic healing will assist recipients and practitioners to use it effectively.

The concept of energetic healing rests on the assumption that humans are all part of an "inseparable web of relationships" (Davies, 2000, p. 21), that we are constantly interacting with all other aspects of the environmental energy, and that certain types of energy can 'kick start' healing (Oschman, 2000). Theories about energetic healing vary greatly and include the use of instrumental music or voice (Dewhurst-Maddock, 1993; Goldman, 1992), drumming (Drake, 1991), Tibetan singing bowls (Jansen, 1994), colour (Gardner, 1988; Maclvor & LaForest, 1990), interaction with the human energy field (Brennan, 1988; Krieger, 1993 & 1997), and touch (Talton, 1995). The use of touch for healing can take many forms including massage (Field, Quintino, Hernandez-Reif & Koslovsky, 1998; Mitzel-Wilkinson, 2000; Webber & Yeoman, 2000), foot reflexology (Byers, 1991), Kinesiology (La Tourelle with Courtenay, 1997) and Reiki (Barnett & Chambers, 1996; Gollagher, 1998; Honervogt, 1998; Lubeck, 1995 & 1997; Petter, 1997 & 1998; Rand, 1998; Rowland, 1998; Stein, 1996).

That energetic healing modalities are gradually being accepted by mainstream science is demonstrated by the use of music therapy, hypnotherapy, massage, reflexology, yoga, aromatherapy, and Therapeutic Touch in the treatment regime of pa-

tients undergoing cardiac surgery (Liu, Turner, Lin, Klaus, Choi, Whitworth, Ting & Oz, 2000; Oz, 1998; Oz & Whitworth, 1998; Whitworth, Burkhardt & Oz, 1998).

Dr Mehmet Oz (Oz et al., 1999), a cardiovascular surgeon in the Columbia-Presbyterian Medical Centre in New York, helped develop the left ventricular assist device (LVAD), which is an artificial heart used to keep patients alive while waiting for a heart transplant. Oz and perfusionist Jery Whitworth established a Complementary Care Centre within the hospital and conducted research into the use of "music therapy, nutrition, massage, yoga, aromatherapy, acupressure, and therapeutic touch (or energy healing)" (Oz et al., 1999, p. 31) for people undergoing heart surgery and began to explore the fact that there is a phenomenon which "science can't yet mea sure or prove exists – a phenomenon somehow affected by consciousness, concern, empathy, or love" (Oz et al., 1999, p. 39).

Oz cited research which indicated that massage can reduce asthma, anxiety, migraines and diabetes, promote more efficient food absorption, elevate natural killer cells in the immune systems of people with AIDS, and promote the movement of the lymphatics (a function which can also be promoted by exercise). In addition, he stated that "a simple touch of a hand on the skin can lower blood pressure and heart rate" (Oz et al., 1999, p. 106) and reminds the reader that patients in hospital are touch deprived (Oz et al., 1999, p. 120).

Oz and colleagues acknowledged that people are individuals and react differently to given situations. When preparing people for the trauma of heart surgery, specialist staff members and volunteers from the Complementary Care Centre, tailored therapeutic sessions "to each pe rson's preferred method of learning – that is, visual, auditory, or by body movement" (Oz et al., 1999, p. 73).

Oz questioned why, emotions such as love, rage or anxiety which promote "flu ctuations in specific neurotransmitters, hormones, and various chemicals in the brain and blood" can't "res onate beyond the body, reaching out across us or across great distances" in the form of prayer or thoughts (Oz et al., 1999, pp. 39-41). He emphasised that studies "strongly suggest that depression and heart disease are somehow connected" (Oz et al., 1999, p. 53), many people reject complementary therapy tec hniques because they want "a magic bullet" (Oz et al., 1999, p. 73) and that many do not recover following successful surgery. In addition, Oz wondered why the electrical pulses transmitted by the nerves cannot be "transferred outside of the body" (Oz et al., 1999, p. 121) because "Everyone of our cells has energy" and that "our bodies

work only because our cells have energy gradients, or changing rates of ion flow across the surfaces" (Oz et al., 1999, p. 126).

With Kirlian photography in mind, Oz and colleagues used engineer Mark Russo, a developer of stealth weapons, and Asim Choudhri, a biochemist and computer hacker, to develop special technology for measuring human coronas. They found that everyone tested emitted a characteristic halo when his or her middle finger touched the recording plate. However, only some people in the "energy healer group" could change the colour of their halos at will (Oz et al., 1999, p. 128).

Oz proposed that:

> *Modern medicine…would someday have to cross the chasm separating hard science and the realm of spirituality (Oz et al., 1999, p. 40).*

and:

> *We shouldn't eliminate using whatever works, no matter how strange, ancient, or unexplainable – in Western terms – the treatment is (Oz et al., 1999, p. 135).*

Reiki is one of the energetic healing modalities now being researched and reported in the scientific literature. What then is Reiki?

6. Literature Survey: Usui Reiki

> *if something hurts, then reach for your hands before you reach for an aspirin* *(Ellyard, 2002, p. 139).*

6.1. Reiki described

6.1.1. Overview

Figure 6.1

"Rei-ki" (pronounced Ray-key) is a Japanese word (Figure 6.1) meaning "Universal Life Energy" (Webber, 1998, p. 3) and its roots lie in ancient Buddhist, Tibetan and Sanskrit writings (Comtois, 2000; Engebretson & Wardell, 2002; Ray, 1999). The Japanese "Ki", or life energy which "animates all living things", equates to the Chinese "Chi", Sanskrit "Prana" and Hawaiian "Ti" or "Ki" (Rand, 1998, pp. 1 -2). Reiki purports to be a non-invasive, hands-on channelling of this vital life energy, which has been found to promote profound relaxation as well as lowering blood pressure, heart rate and pulse. It is claimed that this calming effect can lower stress and decrease the amount of pain medication required after operations (Alandydy & Alandydy, 1999). While many other 'healing' modalities concentrate on only one aspect (either physical, mental or spiritual), Reiki claims to promote healing on the physical, mental, emotional and spiritual levels. However, it is not connected with any religion, sect or creed. In addition, it claims to promote self-healing and "fuels the body's homeostatic mechanisms and therefore assists the restoration of balance" (Barnett & Chambers, 1996, p. 2). It is claimed that Reiki provides the opportunity for the body's natural healing mechanism to operate effectively and efficiently:

> *Reiki supports the recipient in taking charge of his process, acknowledging that the one receiving the treatment holds the power to heal. By its very nature Reiki gives the power and control for healing to the receiver, where it rightly belongs* *(Barnett & Chambers, 1996, p. 5).*

Reiki's claimed efficacy is based, in part, on its purported 'synchronic' nature where both the provider and the recipient are healed by the flow of energy (Nield-Anderson & Ameling, 2000) and its simplicity of use (Honervogt, 1998; Young, 1998). The aim of Reiki, along with other complementary therapies, is to:

> *preserve and maintain a health that is not only the absence of disease, but rather, ideally, a "high-level wellness." ... and ... to provide meaning and purpose in life, including the search for meaning and purpose in illness and disease, death, and dying; to empower clients and assist them with choices, hope, and relief of suffering* *(Markides, 1996, p, 1509).*

Reiki has been described as a form of "Eastern massage technique" (NSW Health Department, 2002), a form of Oriental touch healing (Engebretson & Wardell, 2002), a form of "spiritual healing" (Pirotta, Cohen, Kotsirilos & Farish, 2000), or a form of "energy healing" (Eisenberg et al., 1998). However, by using the definitions developed in Chapters 4 and 5, Reiki can be described as a complementary, energetic, holistic therapy with a mind-body-spirit connection.

A detailed description of Reiki follows and, unless specified, is of the *Usui Shiki Ryoho* lineage.

6.1.2. A brief history of Reiki

It is purported that Dr. Mika Usui (1865-1926) discovered Reiki in Japan during the late 1800's. While Usui was a practicing Buddhist, it is claimed that he was trained in Western Medicine, either in the United States of America or by an American doctor working in Japan. A discussion of the 'legends' surrounding Usui and the founding of Reiki is beyond the scope of this thesis. Ellyard (2002), Petter (1997 & 1998), Rand (1998), Ray (1999), and Stein (1996), among other authors, have detailed the 'story' of the discovery of Reiki and its introduction to the Western world by Mrs Hawayo Takata, a Japanese American who lived in Hawaii. She initially travelled to Japan for Reiki treatments and eventually learnt Reiki from Dr. Chujiro Hayashi, a pupil of Dr Usui. After her return to Hawaii she practiced Reiki and taught twenty-two Reiki Masters between 1970 and 1980 (Ellyard, 2002; Rand, 1998). From this beginning Reiki has spread around the world. Smillie (1998) implies that it was the Reverend Beth Gray, a Master attuned by Mrs Takata, who introduced Reiki into Australia.

6.1.3. The oral tradition of Reiki

In the early stages of its development Reiki was taught orally and passed from master practitioner to student, as is the case with indigenous healing traditions (Miles & True, 2003). From personal discussions with other Reiki practitioners, the researcher has found that while the students of some Reiki Master/Teachers may have been permitted to make notes when learning the Reiki symbols, they were required to ritually burn the notes before leaving the training venue. Hence the student had to rely on their memory of their training when practicing Reiki. In certain circumstances a reliance on oral training may be appropriate if there is continuing support for the learner. However, from personal discussions with Reiki practitioners trained

by other Masters, the researcher has found that a number of new Reiki practitioners may have not continued with their practice of Reiki because they could not remember the hand positions or the Reiki symbols.

Because of this oral tradition and the supposed 'lineage of authority' in Reiki which is described as "the passing of Reiki teachings from master to student" and purportedly "preserves the original form" of the teaching (Nield-Anderson & Ameling, 2001, p 44), it is possible to trace the influence of particular individuals in the teachings offered to students. After experiences gained from attending Reiki sessions conducted by a number of masters, and talking with Reiki practitioners, the researcher has found that some Masters teach a very intuitive method of practising Reiki while others teach a rigid structure for implementing Reiki.

However, it has been through the publication of books by Reiki Masters A. J. Mackenzie Clay (Clay, 1992), William Lee Rand (Rand, 1998), and Diane Stein (Stein, 1996) that many of the so-called 'secret' aspects of Reiki have been made public. Since the discovery of some of Dr Usui's manuscripts by Dr Richard Blackwell (Ellyard, 2002) and the research conducted by a western trained Reiki practitioner now working in Japan (Petter, 1997 & 1998) there has been a concerted effort to try to resurrect Dr Usui's original teaching to inform current Reiki practitioners.

6.1.4. The Reiki energy

> *In the eyes of Reiki, everything is alive and therefore worthy of respect: from the rocks in your garden to the hand of your beloved in yours…*
> *(Petter, 1997, p. 14).*

The texts on Reiki variously refer to Reiki energy as 'Universal Energy' or energy from 'God'. It is for the individual practitioner to decide for themselves, according to their personal beliefs, the source of Reiki energy. Certain 'energetic' therapies such as Therapeutic Touch (Krieger, 1993) and Polarity Therapy (Siegel & Young, 1992) require the practitioner to make an assessment or diagnosis of the client's energy patterns and then implement certain procedures to rectify any 'problems' which may have been detected. However, in Reiki, the practitioner is believed to be simply a "vehicle through which the Universal Energy will heal" (Webber, 1998, p. 6). It is believed that, once opened, the Reiki channel never closes even if the individual does not use it – it will remain with them ready to be used if the individual wishes to resume the practice of Reiki at some time in the future (Webber, 1998).

6.1.5. The Reiki attunements

While some authors use the term *initiation* (Engebretson & Wardell, 2002), the expression *attunement* will be used in this thesis.

During training the Reiki student receives a series of "attunements that activate" (Whelan & Wishnia, 2003, p. 210) the Reiki in the student and "empowers the Reiki practitioner to channel energy from the universe" (Anderson, 2001, p. 41). It is purported that the attunements are "what separates reiki [sic] from other energy-healing models" and that these attunements are "given to students by reiki [sic] teachers/masters through the use of ancient symbols" (Lorenzi, 1999, p. 128). Rivera (1999, p. 32) stated that the attunements are:

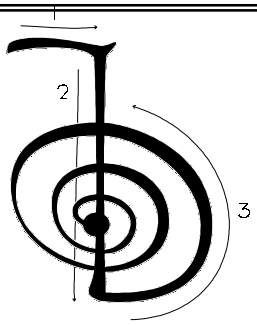
> *based on ancient Buddhist practice passed down through the ages* [and are the] *transfer* [of energy] *from the teacher to the student, during which time the student's 'chakras,' or energy centres, are opened and cleared.*

As a Reiki Master/Teacher, the researcher would describe the attunements as being a process much like tuning an engine to ensure that it runs at peak efficiency or a musical instrument to ensure that it produces a harmonious sound. Wetzel (1989) likens the process to tuning a radio.

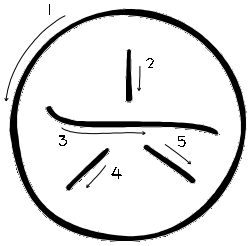
6.1.6. The Reiki symbols

A reported feature that distinguishes Reiki from other forms of energy healing is the symbols that are used in the attunement process (Engebretson & Wardell, 2002), in Reiki II 'treatments', and in various distant healing techniques (Webber, 1998). "Symbols have been used as a means of communication since earliest man first picked up a stick and made a mark on the earth" (Smillie, 1998, p. 87). The Reiki symbols which were reportedly "discovered" by Dr Usui and convey certain meanings to the Reiki practitioner trained in their interpretation and use. In addition, it is claimed that the Reiki symbols help substantially increase the power of Reiki, bring in the Reiki power, ground the participants, activate the "God" within, and enable distant healing (Stein, 1996).

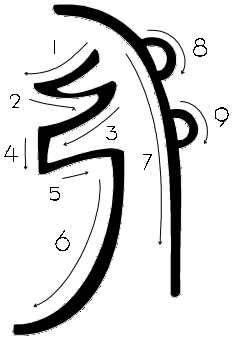
The Reiki II symbols taught to, and by, the researcher are illustrated in Figure 6.2 and the Reiki Master symbols taught to, and by the researcher, are illustrated in Figure 6.3.



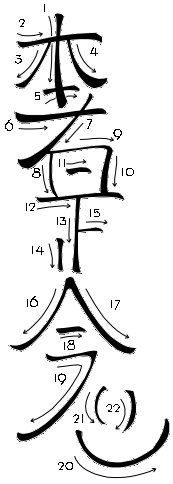
Cho-ku-rei



Tam-a-ra-sha



Sei-he-ki



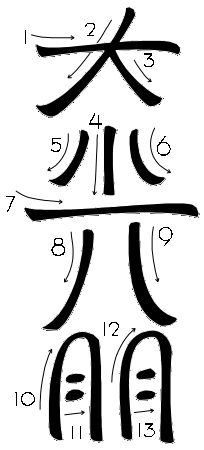
Hon-sha-ze-sho-nen

Figure 6.2: **The symbols taught by the researcher during Reiki II training**
Note: The numbers refer to the order in which the lines are drawn.

From personal experience the researcher is aware that the Tam-a-ra-sha (Figure 6.2) is not taught by all Reiki Masters but is apparently a Kofutu symbol which may have been introduced by New South Wales Reiki Master A. J. Mackenzie Clay (Clay, 1992). The Tam-a-ra-sha is not included in the symbols reportedly taught by Mrs Takata (Ellyard, 2002, p. 321) or those illustrated by Stein (1996, pp. 57-58). One of the Master symbols, Raku, is not present in those reputedly taught by Mrs Takata (Ellyard, 2002, p. 312; Stein, 1996, p. 97).

It is possible that some differences in the way the symbols are drawn can be ascribed to differences in handwriting styles rather than a major difference in meaning and/or application. However, just as the number and style, of symbols taught may vary from Master to Master, it is possible that the interpretation of these symbols may vary from individual to individual depending upon their educational background, knowledge and level of understanding of Reiki. In addition, it is possible that the difference in the symbols taught by different Reiki Masters may be due to

the oral tradition of Reiki in which there were apparently no published representations of the symbols prior to the works of Stein (1996) and Ellyard (2002).



Dai-ko-mio

Raku

Figure 6.3: The symbols taught by the researcher during Reiki Master/Teacher training

6.1.7. Reiki I (first level Reiki)

In *Usui Shiki Ryoho* Reiki I is a purely hands-on therapy. Students are taught the meaning and history of Reiki, the Reiki principles, what to expect during attunements, how Reiki can be used in the student's daily personal and professional life, contraindications to the use of Reiki, and to never provide Reiki unless the potential recipient agrees. Some Reiki Masters may provide students with a manual which includes a listing of recommended texts for further reading as well as a signed and dated Certificate of Attunement. In addition, some Masters invite graduating students to participate in practice, or sharing, sessions. Examples of the hand positions used by the researcher during a Reiki session are provided in Figures 6.4 and 6.5.

Additional hand positions, for treating the legs and for use in self-treatment, are taught but have not been illustrated. Depending on the individual Master's attitude towards Reiki, the practitioner may be encouraged to adapt the hand positions appropriate for their own needs and the situation in which Reiki is being used. What is appropriate for use during one full Reiki session may not be appropriate for use in another setting. In addition, variations in the hand positions may be required according to the practitioner's hand si ze compared to the recipient's body size. Gender and

cultural differences may necessitate variations in hand positions used during a treatment. Because of these reasons, the use of some of the hand positions illustrated in Figure 6.5 may not be appropriate in certain circumstances, however the recipient controls the process throughout and the positions would only be used if specific permission was given. Participants are also taught how to conduct a Reiki session for self-healing, in a social setting for family and friends, formally on a massage table, and with a person who may be sitting in a chair or a wheelchair.

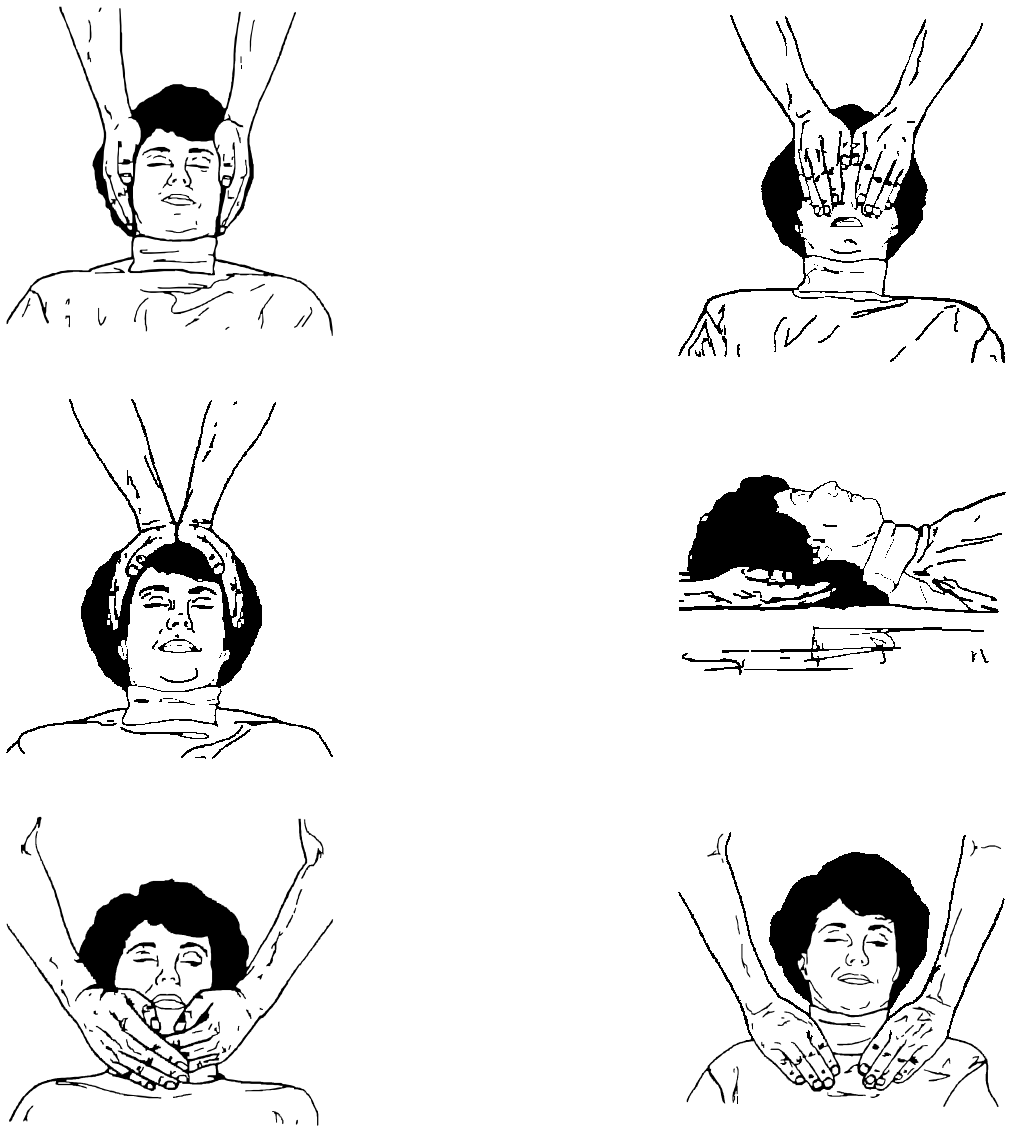


Figure 6.4: Sample of hand positions for use during a Reiki session. Adapted from Rand (1998)

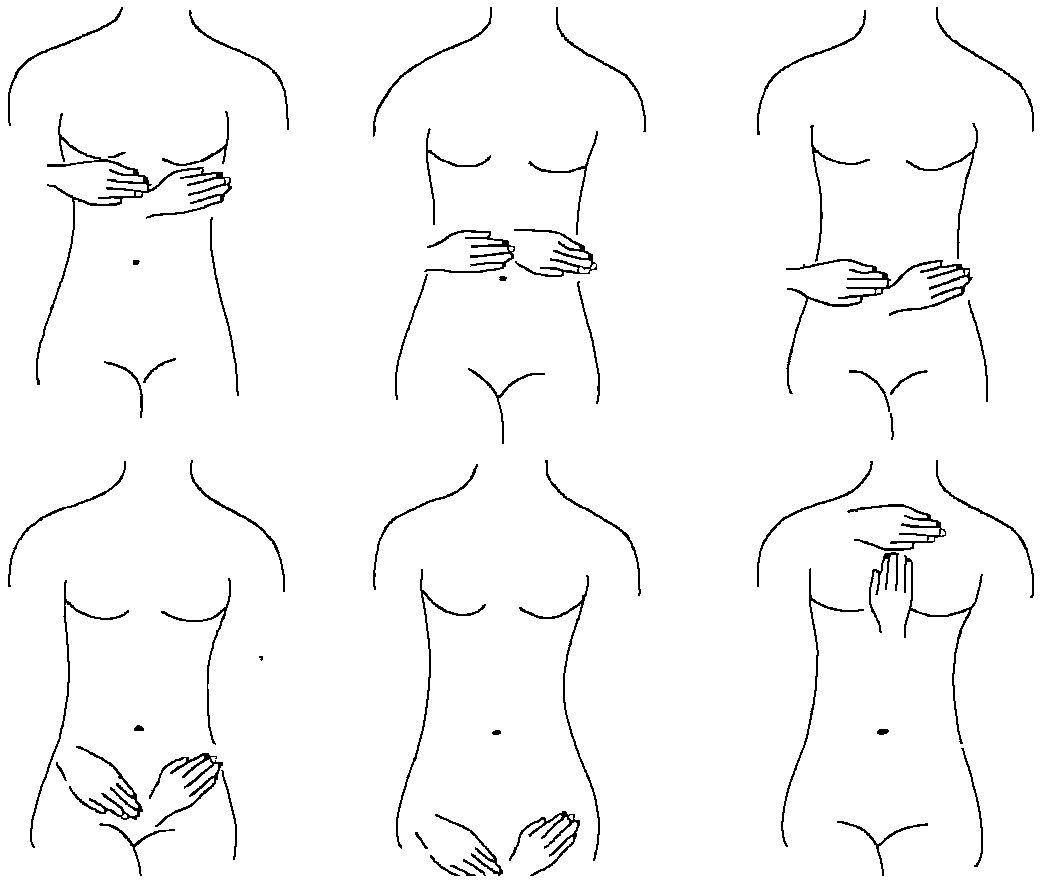


Figure 6.5: Sample of hand positions for use during a Reiki session. Adapted from Webber (1998)

As discussed above, Reiki can be provided equally as well in short, frequent sessions or in a full 1½ hour session. Providing Reiki in frequent, short sessions may be more appropriate for people in an agitated state. Both the personal experience of receiving Reiki, and experience gained from working with clients and students, has taught the researcher to expect apparently paradoxical experiences when receiving and / or giving Reiki. This is supported by the findings of Engebretson and Wardell (2002) and is discussed in Section 6.3.

Reiki I training is self-contained and there is no need to progress past this stage to be able to use Reiki effectively (Nield-Anderson & Ameling, 2001).

6.1.8. Reiki II (second level Reiki)

Reiki II uses a set of symbols which can be invoked during hands-on work or distance healing. During Reiki II training students are given four additional attunements and taught:

- ☆ the meanings of the Reiki symbols and how to draw and use them without them being obvious to observers;

- ☆ how to incorporate the symbols into their hands-on healing practice;
- ☆ how to use a surrogate such as a doll or photograph to send distance Reiki to an absent client, friend or family member;
- ☆ how to send distance Reiki without the need to use a surrogate;
- ☆ how to provide Reiki for groups of people without the need for the laying-on of hands; and
- ☆ to provide Reiki for the 'best possible outcome'.

As with Reiki I, students may be provided with a manual which includes a listing of recommended texts for further reading as well as a signed and dated Certificate of Attunement, and be invited to participate in monthly practice / sharing sessions.

6.1.8.1. Using a surrogate

In a Reiki II distant healing session, a surrogate such as a doll or photograph can be used to focus the practitioner's attention. The surrogate can be either 'treated' as a representation of the person and the Reiki I hand positions used accordingly or simply held by the practitioner and used to focus his or her attention on the client.

6.1.8.2. Distant Healing

Distance healing is defined as "a conscious, dedicated act of mentation attempting to benefit another person's physical or emotional well-being at a distance" (Sicher et al., 1998, p. 356). In addition to being a Reiki II practice, distance healing has proponents in the Christian, Jewish, and Buddhist religions as well as various shamanic traditions (Sicher et al., 1998). While the issue of distance healing is extremely controversial, a number of researchers are investigating this practice (Astin, Harkness & Ernst, 2000; National Centre for Complementary and Alternative Medicine (NCCAM), 2003a; Sicher, Targ, Moore & Smith, 1998).

6.1.9. The Reiki Master/Teacher

During Reiki master/Teacher training students may be taught two additional symbols (Figure 6.3), the attunement processes for Reiki I, Reiki II and Reiki Master/Teacher training, how to provide the attunements, and how to incorporate the Reiki Master symbols into their healing practices. Reiki Master/Teacher training is usually conducted as an apprenticeship process (Whelan, & Wishnia, 2003) whereby the student observes the teacher, assists in classes, and provides attunements while observed by the teacher. When the student has reached the required level of expertise, he or she is attuned as a Master/Teacher and provided with a signed certificate.

6.1.10. The purported effects of Reiki

There are numerous 'popular' Reiki books to be found in the 'self-help' or 'new-age' sections of most bookstores (in February 2000, a bookstore in Adelaide had 66 Reiki titles in its catalogue). Many of these contain anecdotal reports which may not be able to be verified scientifically. However, as discussed below, Reiki is being researched scientifically.

Reiki has been found to lower stress, decrease the amount of pain medication required after operations (Alandydy & Alandydy, 1999), decrease perceived anxiety, increase signs of relaxation, and increase humoral immunological functioning (Wardell & Engebretson, 2001a). In addition, Reiki has been found to produce paradoxical responses in clients (Engebretson & Wardell, 2002). A detailed analysis of the uses and effects of Reiki in a medical/nursing setting will be provided in Section 6.2 and a detailed analysis of scientific research into Reiki will be provided in Section 6.3.

6.1.11. A Reiki session

As Reiki can be performed anywhere at anytime (Ellyard, 2002) and practitioners may individualise the session according to the needs of the client (Engebretson & Wardell, 2002), it is not possible to describe a 'typical' Reiki session. Having said that however, as a Reiki practitioner providing a professional service to a client the researcher would:

- ensure that a quiet, comfortably heated (or cooled) room was set aside for the session
- use a massage table for the comfort of both the client and the practitioner
- adjust the ambience in the room by providing drawn curtains or blinds, relaxing music, dimmed lighting, candles and incense (if the client is not allergic to it)
- take a full, appropriate medical history at the first appointment and record this information on a purpose designed record sheet (Appendix D)
- determine if the client has any special needs and/or preferences
- fully explain the process to the client prior to commencing the session
- arrange the client either prone or supine on the massage table according to the client's preference
- cover the client with a drape if appropriate. The client may fall asleep during the session and body temperature can fall (causing the client to feel uncomfortable)

- ☆ start from the client's head and spend up to 1½ hours (as agreed) working through the hand positions and finishing at the client's feet. Hand positions are changed either intuitively or every three to five minutes. Both sides of the body (laterally) are 'treated' during the session
- ☆ permit the client to remain quietly on the table for five to ten minutes after the completion of the therapy then assist the client off the massage table
- ☆ provide the client with a glass of water at the end of the session
- ☆ discuss the session with the client and make notes in the client's record.

Changes to the routine described above would be made if the client had any special needs or requests, is confined to bed or is sitting in a chair or wheelchair. The researcher is not trained in manual handling procedures so would be reliant on the client's carer if a transfer from a bed or wheelchair is required. In a busy institutional setting, the routine described above may be totally inappropriate if the client cannot be relocated to a quiet, private space for the treatment. In this situation the researcher would vary the time allotted for the treatment and provide Reiki while either: sitting beside the client's bed, administering a hand massage, holding the client's hand during a conversation, holding the client's hand and watching television together, performing necessary daily care routines, and/or giving the person a hug.

6.1.12. The simplicity of Reiki

> *Reiki can be done anywhere and at anytime, regardless of disturbing influences in the environment, the healing taking place is still the same.*
> *(Ellyard, 2002, p. 267).*

Part of Reiki's efficacy could be ascribed to its simplicity which is illustrated by the claim that "Reiki is activated by touch, so Reiki is as simple as placing the hands on oneself or another" (Ellyard, 2002, pp. 119-120). The Reiki practitioner is not required to make a diagnosis or assessment of the client's condition. Therefore, there is no need for lengthy training or in-depth knowledge of anatomy and physiology as with allopathic medical practice or some of the other modalities discussed above.

This simplicity can be further illustrated by comparisons with a range of other complementary modalities:

- ☆ Unlike meditation and Therapeutic Touch, there is no need for the Reiki practitioner to enter an altered state of awareness.
- ☆ With Reiki there is no need for the recipient to undress, as in some forms of massage.

- ☆ During a Reiki "treatment" there is no manipulation of body parts as with Chiropractic, massage, foot reflexology or physiotherapy.
- ☆ There is no need for a complicated set of movements as in massage, reflexology, polarity therapy or Therapeutic Touch.
- ☆ With Reiki there is no invasion of the body as with acupuncture, orally ingested preparations, injections, or surgery.

In addition to "full" treatments, Reiki can be used in short, unobtrusive sessions, particularly when used for self-healing. Ellyard (2002) suggested that a little Reiki often is better than a lot of Reiki infrequently. For example, Reiki can be used as a self-treatment when travelling by bus or train; when reading; when watching television; on retiring for the night; or upon awakening in the morning.

Barnett and Chambers (1996) provided examples of how nurses and medical practitioners can use Reiki in brief, informal encounters; complementary to conventional medicine; when conducting a medical diagnosis; in emergency situations; when engaged in clerical tasks; to aid concentration when studying; when engaged in daily routine tasks; with babies; when conducting routine nursing tasks; to reduce patient anxiety; during labour and delivery; and to maximise everything the nurse does.

Being non-invasive, Reiki is safe for use with people of all ages and can be taught to anyone old enough to understand its application. The researcher taught a seven-year old boy at the same time as he was training the boy's mother (Webber, 2001b). The boy concerned has subsequently used his Reiki to assist his parents, his brother and himself (this information is based on personal discussions with the boy's parents over a period of time since the training). Some variations in procedure may be necessitated by the child's age, cognitive development and ability to sit still during attunements (Ellyard, 2002).

6.1.13. The complementary nature of Reiki

Medical and other health practitioners may use Reiki while providing routine therapeutic treatments. Barnett and Chambers (1996) provided an illustration of how a Reiki Practitioner can comfort a patient while they are receiving emergency treatment from a medical practitioner or nurse in a hospital situation (1996, p. 32).

It is emphasised by some authors that Reiki should be used as a complement to normal medical assessment and treatment (Barnett & Chambers, 1996; Ellyard, 2002; Rowland, 1998; Webber, 1998). However, while Reiki is complementary and

may be used safely in conjunction with all other forms of therapy, it may also be used as a stand-alone treatment if circumstances are appropriate and necessary expert medical advice has been sought.

6.1.14. Reiki and self-healing

> *A basic premise of the practice of Reiki is that it brings healing to oneself and others* *(Nield-Anderson & Ameling, 2000, p. 27).*

As outlined above, Reiki's reported efficacy is based, in part, on its synchronic nature where both the provider and the recipient are healed by the flow of energy (Nield-Anderson & Ameling, 2000). In addition, Reiki is a modality which is readily self-administered. Reiki Masters Barnett and Chambers (1996), Ellyard (2002), Rand (1998), and Stein (1996) all provided examples of how Reiki practitioners can treat themselves. The self-healing nature of Reiki, and the need to take care of self to advance the ability to assist others, has been recognised in the scientific literature (Lorenzi, 1999; Nield-Anderson & Ameling, 2000 & 2001; Rivera, 1999).

6.1.15. What sets Reiki apart from other complementary healing modalities?

> *The ability to do Reiki is part of the human genetic code, wired into our DNA.* *(Stein, 1996, p. 106).*

Complementary practitioners such as Stein (1996) believe that all humans have enormous potential to heal both themselves and others. However, in practices such as nursing, massage, Chiropractic, and physiotherapy, the practitioner is expending considerable physical energy during a treatment. It could be reasonably argued that other health practitioners, such as doctors, while not necessarily expending physical energy, do expend considerable emotional energy during the course of a working day. Therefore, the individual is at greater risk of depleting their own energies and becoming un-well himself or herself. The main feature of Reiki, which sets it apart from these 'hands-on' modalities, is its claim to be synchronic in nature whereby the practitioner receives the healing energy whilst providing it for others (Barnett & Chambers, 1996; Nield-Anderson & Ameling, 2000).

Modalities such as aromatherapy, Chiropractic, mainstream medicine, massage, physiotherapy, and Therapeutic Touch require the practitioner to make an assessment of the client's condition, decide upon a course of action, and then implement the therapy based on the original assessment. With Reiki, it is claimed that it is the attunements, which the practitioner receives during training, that enable him or her

to automatically tap into the universal energy described above (Ellyard, 2002; Lorenzi, 1999; Rivera, 1999) and provide the opportunity for client self-healing to occur without the need for a diagnosis and the implementation of a treatment based on that diagnosis. This universal energy has been described as akin to using another "battery" to "jump-start" a car when its own battery is flat (Comtois, 2000).

Many of the other unique features of Reiki have already been discussed at various points above. Reiki can be performed anytime and anywhere, it does not require the relocation of the recipient to a quiet place, it is non-invasive, it does not require the recipient to undress, it can be administered while other activities are being performed, the practitioner does not have to be consciously aware of providing it, it is activated by the simple act of touching, it works simultaneously on the physical, mental, emotional and spiritual levels, the practitioner is a facilitator, it does not require expensive equipment or facilities, and it can be easily self-administered.

However, it needs to be noted and emphasised at this point that:

> *Reiki is not a panacea. It works to enhance and accelerate the normal healing process of the body and the mind*
>
> *(Barnett & Chambers, 1996, p. 25).*

6.1.16. Contraindications to the use of Reiki

There are a small number of contraindications to the application of Reiki. The practitioner must not make contact with broken skin or exposed burns and must ensure that clients receive the appropriate medical treatment for such conditions as soon as possible. Reiki should not be provided over fractures until a qualified medical practitioner has properly set the bone although it may be provided to calm the patient and reduce the effect of shock. It is not advisable to provide Reiki if the potential recipient's regular medical practitioner has said otherwise (Webber, 1998). Furthermore, the doctrine of informed consent requires that the client must have the right to refuse treatment (Wardell & Engebretson, 2001b). This refusal can be stated either verbally or by changes in body language if the intended recipient does not have sufficient skills to provide their response verbally.

6.1.17. A criticism of Reiki

It has been claimed that Reiki can take on a "cult-like atmosphere", be a way to "control the minds of vulnerable or sick people to make money" and be "secretive" (Tattam, 1994, pp. 2 & 52). Tattam claimed that certain individuals can assume

"guru" like status and "hijack" Reiki in order to control vulnerable people (p. 3). Ellyard reminds Reiki practitioners that:

> *It is surprising how many people develop a concept of being spiritual. This can be a trap of sorts, a way of replacing one set of neuroses with another (Ellyard, 2002, p. 323).*

6.1.18. Legislative requirements

In Australia there are currently no legislative requirements regulating the practice of Reiki within the general population. However, some authorities are moving towards the regulation of complementary therapy practitioners including Reiki practitioners (NSW Health Department, 2002; Parker, 2003). While the Nurses Boards of Victoria (1999), Western Australia (2003), and Tasmania (no date) may not specifically cite Reiki, they have established guidelines for the use of complementary therapies in nursing. It is the understanding of the researcher that these guidelines apply to all nurses working either as salaried nurses or private providers within those states.

In South Australia, Mandatory Reporting of Child Abuse legislation applies to any person providing an educational, health, welfare, residential, or child care service "wholly or partly for children" (Department of Human Services: Family and Youth Services, no date, p. 164). Therefore, Reiki practitioners in South Australia should ensure that they undertake the necessary training to enable them to comply with the legislation. Reiki practitioners working in an institutional setting such as a school, hospital or aged care facility must adhere to all policies and administrative instructions issued by the institution in which they work. Professional indemnity insurance for professional Reiki practitioners can be obtained through insurance companies which specialise in providing insurance for massage therapists. In addition, practitioners who intend to work professionally must be mindful of any legislation which controls the practice of "laying on of hands" in their country or state.

6.1.19. Learning Reiki

Currently Reiki may be taught by anyone who has been attuned as a Master/Teacher and the standard of teaching varies greatly in content, duration and cost. However, as Reiki is gradually becoming accepted within the healing professions, it is also becoming accepted within tertiary teaching institutions. Reiki training is accepted as part of a nurse's continuing education in the USA (Mitzel-Wilkinson, 2000; Whitsitt, 1998). A search of the Australian National Training Information Service (2002) database indicated that Government Accredited Reiki courses were available

through two Registered Private Service Providers in Queensland. In addition, a South Australian group of Reiki Master/Teachers submitted an application for the accreditation of a *Certificate IV in Natural Health Management (Reiki)* in 2003 (personal communication with the authors). The Reiki Masters responsible for the development of this application aim to improve the professional standing of Reiki practice and have Reiki accepted for health fund rebates. As well as providing training, many Reiki Masters provide on-going support through established Reiki Clinics and practice/sharing nights.

While the three major levels of Reiki are progressive, it is not necessary for the individual to receive training in all three levels in order to effectively practice Reiki. In addition, there is no need for an individual to study Reiki I, Reiki II and Reiki Master/Teacher with the one Reiki Master/Teacher. Masters such as Rand (2002), Rowland (1998) and Stein (1996) received their training from a number of teachers. In addition, Reiki practitioners may be encouraged to visit and learn from other Masters and their pupils.

It has been claimed that Reiki can be learned by simply reading about it (Samways, 1994, p. 47). However, it could be contended that, reading about any procedure and learning how to apply it correctly are two vastly different things. Nor would the reader receive the attunements that are considered an integral feature of Reiki.

6.1.20. Branches of Reiki and variations in Reiki practice

While it is claimed that it does not matter which method individual practitioners use because it is the same Universal Energy that is being channelled by the practitioner, there are some variations in Reiki practice which must be considered before proceeding with a discussion of how Reiki is used in medical and nursing practice.

According to Ellyard (2002) the Masters taught by Mrs Takata were Barbara Weber Ray, Phyllis Lei Furumoto, Beth Gray, George Araki, Barbara McCullough, Ursula Barlow, Fran Brown, Paul Mitchell, Iris Ishikuro, Ethyl Lombardi, Wanja Twan, Virginia Samdahl, Dorothy Baba, Mary McFayden, John Gray, Rick Bockner, Bethal Phaigh, Harry Kuboi, Patricia Ewing, Shinobu Saito, Kay Yasmashita, and Barbara Brown (Ellyard, 2002, p.36). From these individual Masters a number of 'branches' of Reiki have deve loped.

While Barbara Weber Ray claimed to be the only person entrusted with the complete Reiki knowledge taught by Mrs Takata and has registered her 'brand' of

Reiki as *The Radiance Technique* ® (Ray 2002), it is claimed that Phyllis Lei Furumoto, Mrs Takata's granddaughter, is the 'lineage bearer" (Barnett & Chambers, 1996; Stein, 1996). Other Reiki Masters freely admit that they teach a non-traditional form of Reiki (Stein, 1996) or have introduced new concepts into their teaching (Clay, 1992). Further, it has been claimed that Mrs Takata deliberately taught variations in method that were only discovered when the Reiki Masters began to talk among themselves following her death (Rowland, 1998). Some adaptations of Reiki are called variously *Seichim Reiki* (anecdotal evidence from personal discussions), *Reiki Touch* (Engebretson & Wardell, 2002), and *Karuna Reiki* ® (Rand, 1998). The 'traditional' form of Reiki is known as *Usui Reiki Ryoho* (Stein, 1996, p. 14) or *Usui Shiki Ryoho* (Petter, 1997, p. 18).

Because there is no regulatory body which controls the standard of Reiki practice and teaching, the length of Reiki I and II training will vary from one day to several each depending on the individual Master/Teacher's style. In addition, Reiki Master/Teacher training may span two or more years. Attempts have been made by some individuals to establish regulatory bodies but these attempts have not been successful (Adelaide Usui Reiki Centre no date; Ellyard, 2002; Rand, 1998; Ray, 1999; Webber, 1998). The 'levels' of Reiki taught by different Reiki Masters can vary from:

- ☆ three levels - Reiki I, Reiki II and Reiki Master/Teacher (Honervogt, 1998; Stein, 1996) to
- ☆ five levels - Reiki I, Reiki II, Reiki 3A, Reiki Master and Reiki Master/Teacher (Gollagher, 1998) to
- ☆ seven levels - (Ray, 1999) [Ray did not name the levels in her book].

One of the major variations in Reiki concerns the number of hand positions used during a Reiki treatment. This is highlighted by the fact that, while the majority of Reiki practitioners will use touch during a Reiki session (Ellyard, 2002; Rand, 1998; Webber, 1998), one group of researchers into the use of complementary therapies has claimed that Reiki is a form of energy therapy which does not involve touch (Cherkin, Eisenberg, Sherman, Barlow, Kaptchuk, Street, & Deyo, 2001). Without explaining why, papers written by substantially the same group of researchers, specify that Reiki has either 13 hand positions (*Mansour*, Beuche, *Laing*, *Leis* & *Nurse,* 1999) or 18 hand positions (*Mansour*, *Laing*, *Leis*, *Nurse* & Denilkewich, 1998). Bullock (1997) and Smillie (1998) state that there are 12 hand positions used during a Reiki session while Olson and Hanson (1997) posit that there are 18 hand positions

in a Reiki treatment – 10 covering the head and torso, and a further eight on the back. Anderson (2001) claimed that there are between 10 and 20 hand positions that "cover the chakras, major organs, and glands" (p. 41) while Rivera (1999) says that there are between 12 and 15 basic hand positions "beginning on the head, moving to the trunk, and finishing on the back" (p. 31). It is possible that these variations may influence the results of Reiki treatments reported by recipients or measured using standard medical procedures.

When providing a 'full' Reiki treatment, some practitioners will commence at the client's head and work down to the client's feet (Rand, 1998) while others will terminate the session at the groin (Adelaide Usui Reiki Centre, no date). Alternatively, a Reiki session can start at the client's feet and conclude at the head (Smillie, 1998). As mentioned above, some practitioners will commence with the client lying supine and then, halfway through the session, ask them turn them face down (Olson & Hanson, 1997) while others will leave the client face-up throughout the session so as not to disturb him or her (Smillie, 1998). The researcher teaches hand positions for both the front and back of the body but provides the individual client with a choice of laying supine or prone during the Reiki session. In addition some people either dislike, or have difficulty because of body shape, lying in a prone position (Smillie, 1998).

While Reiki may be used as a 'stand alone' therapy, some practitioners may combine Reiki with prayer, meditation, the burning of incense and/or candles, relaxing music, canting of mantras either silently or vocally, Chakra balancing, herbal preparations, the invocation of angels, positive affirmations, visualization, hypnosis, Bach flower remedies, and/or Aura Soma colour therapy (Ellyard, 2002; Honervogt, 1998; Petter, 1997; Smillie, 1998). Unfortunately this often makes it difficult to determine if the purported effects are due to the Reiki treatment itself, one or other of the 'alternative' therapies used, and/or a combined result.

Although there is an underlying uniformity in the Reiki symbols taught to the researcher, those published by Stein (1996), and those published by Ellyard (2002), there are variations in both the number of symbols taught and the way they are drawn. When discussing symbols, most of the authors cited in this thesis refer to three symbols taught in Reiki II while the researcher was taught four symbols (Figure 6.2). In addition to the Reiki II symbols, the researcher was taught two "Master" symbols which are used in the attunement of Reiki practitioners (Figure 6.3).

Rowland (1998) provided a practical example of how Reiki Master Beth Gray (who had been taught by Mrs Takata) varied her practice over time. This variation might have occurred because she may have become more proficient in the art/science of Reiki practice, was adaptable, and was open to new ideas (Rowland, 1998, p. xviii). Rowland suggested that this attitude can improve the practice of Reiki. Petter (1997 & 1998), a Western trained Reiki Master teaching in Japan, has conducted extensive research into the teachings of Dr Usui and current Japanese Reiki practices. He says of Reiki:

> *Some Reiki schools claim to teach the "original teaching" and put down all the others. The truth is that there is no original teaching! Reiki is alive and therefore always changing, always flowing and expanding. Reiki and dogmatism don't mix.* *(Petter, 1997, p. 38)*

If a detailed scientific study of Reiki is to be conducted it may be necessary to test for the style of Reiki being used by the Reiki practitioners participating in the study.

6.2. Reiki in medical and nursing practice

6.2.1. Overview

Despite evidence that the practice of Reiki, as a complementary therapy, is growing among members of the medical and nursing profession, there is little widely accepted and documented scientific research into the efficacy of Reiki. This is emphasised by the fact that a thorough search of the Flinders University Libraries in 2000, 2001, 2002, 2004 and 2005 failed to locate any Reiki textbooks or manuals. As may be expected with any new procedure, where there has been formal research into the effects of Reiki, the results have been varied.

Following a phenomenological doctoral study by Markides (1996) of twenty-four woman healers in Maine she suggested that techniques and approaches found in the energetic model [including Reiki] should be included in counsellor education programs as there have been shifts toward preventative health, early intervention, wellness, prevention, and empowerment. These approaches to health, she argues, coincide with the central foci of counsellor education.

In a Master of Science thesis assessment of Reiki, where an experimental group (n=22) received Reiki and a control group (n=20) received a mimic treatment, results were analysed using the *Spielberger State-Trait Anxiety Inventory* and the *Barret Power as Knowing Participation in Change Tool*. It was found that "anxiety was

significantly lower" for both people who received a Reiki treatment and those who received a Mimic-Reiki treatment (Thornton, 1991). This reaction would not be unexpected as it could be proposed that the subjects would react positively to any form of personal attention. As Talton (1995) emphasised, touch of all kinds may be therapeutic and that, to be therapeutic, touch must be appropriate to the circumstances and wishes of the patient.

For her Master of Science thesis, Bacon (1997) conducted a mailed, stratified random sample survey of nurse practitioners in New England. She found that the perceived helpfulness of acupuncture was higher than that of Reiki. Unfortunately, the current researcher only had access to a copy of Bacon's abstract and was unable to obtain further details about this research

The examples provided by Markides (1996), Thornton (1991) and Bacon (1997) have been emphasised because they are dissertations at Masters level or higher, thus indicating a precedent supporting the possible need for further academic research into the use and efficacy of Reiki.

Examples of the use of Reiki in medical and nursing practice gained from an extensive search of the scientific literature follow.

6.2.2. Reiki in the Operating Room

At Columbia/HCA's Portsmouth Regional Hospital [sic] in 1998, "more than 872 patients chose a 15-minute Reiki treatment to settle and centre themselves both before and after surgery" (Alandydy & Alandydy, 1999, p. 90). The hospital's chief executive officer provided initial support for the programme and the assistant director of surgical services conducted in excess of 1,500 training sessions in the local community prior to the introduction of Reiki into the hospital. Only one physician requested that his patients be excluded. As a consequence of this initiative and the perceived success of the programme, Reiki was offered as part of a preoperative regime at the hospital and studies were established to "document the changes in pain medication and the length of stay for patients who take advantage of these complementary treatments" (p. 90). Alandydy and Alandydy do not specify the level of training of the Reiki practitioners who participated in this programme.

As clinical coordinator of plastics/gynaecology and oral surgery at Dartmouth-Hitchcock Medical Centre, Sawyer (1998) recounted her concerns when asked by a surgeon if his patient's Reiki practitioner could be present during surgery. After checking the legal consequences and ensuring the proposal had the support of the

various staff who would be involved in the operation, she decided to "give it a try". Sawyer reported that, after the operation, the patient "woke as if she had just taken a nap" (p. 2) and that months after the operation comments were still being made about "the serenity and the positive experience in the OR [Operating Room] that day" (p. 2). Because of the success of the experiment, the use of complementary therapies is now recognised in the centre's Operating Room policy manual. Sawyer did not provide information about the level of the Reiki practitioner.

Using a randomised, double-blind, within subject, crossover experiment with 21 volunteers Wirth, Brenlan, Levine and Rodriguez (1993) assessed the effects of Reiki and LeShan healing on patients undergoing extraction of impacted third molars. Treatments alternated with LeShan being provided on the even numbered hours and Reiki on the odd numbered hours. They found a "statistically significant difference" between the treatment and control groups (p. 133) in the levels of postoperative pain experienced and the researchers concluded that there was a potential for both modalities to be "a safe and effective analgesic for postoperative pain following surgical removal of impacted third molar teeth" (p. 137). The authors suggested that further research into the effect of complementary healing on the presence of infection, the duration and extent of swelling, and the reparation of bone could be conducted. In addition, they suggested that research could be conducted into the administration of complementary therapies while the patient is under general anaesthetic. The level of training of the Reiki practitioners who participated in this programme is not specified; however, as the research involved distance healing, it is most probable that the Reiki practitioners were trained to Level II Reiki.

6.2.3. Reiki as a nursing practice

There is a growing body of evidence that Reiki is becoming an accepted Nursing practice. In addition to the uses of Reiki discussed above, Barnett and Chambers (1996) provided a list of 11 medical institutions where they had personally taught Reiki (p. 3). Reiki training as part of a nurse's continuing education is discussed by Mitzel-Wilkinson (2000), an instructor in Nursing at the College of Nursing in the University of Arkona, and Whitsitt (1998) who stated that "Reiki therapy is taught to RNs and LPNs [sic] across the country [USA] as part of their continuing nursing education" (p. 12).

How then is Reiki used in nursing?

During the early stages of this research, the researcher became aware that a trial of Reiki may have been conducted in the Renal Unit of the Flinders Medical Centre, South Australia, during the early to mid 1990's (Tattam, 1994). However, no further information about this research could be found in the scientific literature. In an attempt to ascertain information about this trial, the researcher made a personal visit to the Renal Unit (Ward 6G) of the Flinders Medical Centre in early June 2003. By chance he met with the Nurse Manager of the unit, Ann Kruger, who had been personally involved in the trial of Reiki during 1994 and 1995. She agreed to contact Sally Warburton, one of the other nurses involved in the trial but who had retired from nursing in 1995. The following information about the trial is taken from personal conversations with Kruger and Warburton and provided with their consent.

Encouraged by Professor Bill Crammond, Renal Unit Psychologist from 1990 to 1995, several nurses were trained in Reiki by a dermatologist who used Reiki in his own practice. Although not discussed in the conversations with Kruger and Warburton, it is assumed that the nurses involved in this programme were trained in Level I Reiki. Following their training, the nurses worked with a number of haemodialysis patients and a transplant patient. Participants were purposefully selected from among those who were perceived to have the worst quality of life. Two nurses administered Reiki while the participant was seated in a recliner chair. While the participants were comfortable, the nurses found it extremely physically difficult, especially the strain placed on their backs. In addition, Warburton reported working with a number of elderly and confused patients as well as providing home visits to terminal patients. The experiment ran for approximately 18 months. To ascertain patient response, four common Lifestyle Assessment Tools were administered three to four times during this period. Although a number of difficulties occurred because of Reiki trained nurses being transferred to other wards, Warburton saw the experiment as a success. She reported that it provided a peaceful, caring, sharing environment and an improved quality of life for the participants. Warburton presented a paper to the 1995 conference of the Renal Society of Australia but, unfortunately, did not have a copy of her paper at the time of our conversation and the researcher has been unable to locate a copy.

As an Emergency Nurse and Certified Holistic Nurse, Young (1998) proposed that Reiki and Healing Touch can be used:

> *Following a bone or joint realignment, after suturing, over burns, during anxiety attacks, with psychiatric patients, with patients in shock, and during preoperative and postoperative periods (Young, 1998, p. 483).*

She indicated that Reiki and Healing Touch are often used "in the ambulance while en route to the emergency department, while awaiting assessments and procedures, and prior to medication administration and effect" (p. 483). Young did not specify the level of training of the Reiki practitioners who provided the treatments she described.

Bullock (1997) reported on a case study she conducted with a 70 year old person with cancer. Following the use of Reiki, the patient's tumour marker index fell from 50,000 in May to 12,000 in October after which the physician recommended an increased frequency of Reiki treatments. Bullock reported, "With the Reiki as his intent, he [the patient] was able to achieve his goal of long-term stability with freedom from immobilizing pain and swelling." (p. 33). This then resulted in an improved quality of life for the patient. Bullock concludes that:

> *Some general trends seen with Reiki include: periods of stabilization in which there is time to enjoy the last days of one's life; a peaceful and calm passing if death is imminent; and a relief from pain, anxiety, dyspepsia, and edema. (Bullock, 1997, p. 33).*

Bullock did not specify the level of her training in Reiki but it is most likely that she was a Reiki Master.

McLaren (1999) described a personal experience of having Reiki treatments as an anti-stress therapy following a car accident. She reported that it "was the most relaxing experience in my life" (p. 28) and returned to Reiki treatments after trying reflexology. Subsequently she decided to learn Reiki in order to provide treatments for herself and others. McLaren did not specify the level of training of the Reiki practitioners who provided the Reiki treatments.

Van Sell (1996), a member of the *RN* editorial board and Associate Professor of Nursing in the College of Health Sciences at the University of Nevada in Las Vegas, provided anecdotal information about the use of Reiki in treating AIDS, systematic lupus erythematosus and chronic pain. The Reiki practitioners involved in this project were trained to Reiki II level.

Following a formal study of Reiki involving 20 (18 female and 2 male) volunteers who were experiencing pain in 55 sites, Olson and Hanson (1997) from the Cross Cancer Institute, Edmonton, Alta reported a "highly significant ($p < 0.0001$) reduction in pain following the Reiki treatment" (p. 108). During the trial they

worked in conjunction with pain specialists, the hospital ethics committee and a Reiki II therapist. Individual experience of pain was rated immediately before and after treatment using a visual analogue scale (VAS) and a six-point Likert scale. Six volunteers had been experiencing pain for one year or less; seven from one year to seven years; and the remainder for longer than seven years. One participant had been experiencing pain for 48 years. The authors recognised that the results were difficult to interpret because there was a lack of a placebo group, the duration of the analgesic effect was not measured, and music was played during the treatment. They recognised that "Current understanding of the therapeutic effect of touch is limited" (Olson & Hanson, 1997, p. 110). They conclude that:

> *The use of nonpharmacologic interventions, such as Reiki, may make it possible to provide cancer patients with good pain control at lower doses of traditional opioid preparations, thus reducing these symptoms*
> *(Olson & Hanson, 1997, p. 112).*

Olson and Hanson (1997) do not specify the level of training of the Reiki practitioners who participated in this programme.

Dr Ahlam Mansour, from the University of Saskatchewan, has investigated the possibility that Reiki can assist in combating the side effects of drugs used to fight cancer and therefore improve patients' quality of life (Martin 1998). However, the results of this research were not available to the current researcher. A search of the scientific literature and a personal email sent to Mansour proved fruitless.

Kennedy (2001), a nurse/therapist working with the Healing Hands Network in Sarajevo, provided evidence that Reiki was able to assist survivors of torture by inducing relaxed sleep and lessened the need for sleeping tablets, providing a renewed feeling of self-worth, reducing pain and the need for pain killers, reducing nightmares, and reducing headaches. Following the demonstrated effect of Reiki on her patients, the medical staff went to Kennedy for Reiki therapy to relieve stress and openly sent their patients to her for treatment. A report on the success of her treatments was sent to the United Nations in Geneva. Kennedy found that she needed to adapt her Reiki procedures to cater for the individual needs of her patients. Kennedy did not specify the level of her training in Reiki.

Through personal contact, the researcher was aware that Reiki was being used in the management regime of residents suffering dementia in at least one Adelaide nursing home. In addition, he had trained two volunteers working in a Resthaven Nursing Home to Reiki I level, following suggestions from staff at the home.

6.2.4. Reactions to the introduction of Reiki into medical and nursing practice

As might be expected, reaction to the introduction of Reiki into medical or nursing procedures has varied from extremely supportive (Sawyer, 1998), to "[the] results have ranged from pleasant to truly amazing." (Vega, 1996, p. 9), to "... there is no place in the profession of nursing for a new-age religion masquerading as science" (Lewis, 1996, p. 10), to "We only allow the laying on of hands, in the name of Jesus" (Martinez, 1996, p. 10).

This range of attitudes towards Reiki is reflected in the results of a 1997 survey of 488 medical General Practitioners (GPs) in Victoria (Pirotta et al., 2000). Pirotta et al. found that two percent of GPs thought that Reiki was frequently harmful, 12% occasionally harmful and 41% seldom harmful. Conversely three percent felt Reiki was highly effective, 19% moderately effective and 28% seldom effective. Eighteen percent considered that it was appropriate for trained GPs to practice Reiki and 27% thought that Reiki should be eligible for Medicare rebates. Eighteen percent would encourage a patient's suggestion to have Reiki, 12% were interested in training in Reiki and 5% were trained Reiki practitioners. Pirotta et al. (2000) concluded that these results were likely to represent the situation across Australia, as their sample was sufficiently large and reflective of General Practitioners' characteristics.

With Reiki and other forms of hands-on-healing, it is possible to enter the realms of religious dogma. Although Reiki is not associated with any religion, sect or creed, authors such as Whitsitt (1998) equate Reiki with "occult practices" (p. 13) which are apparently condemned by the Bible and therefore not to be practiced by Christians.

It could be possible that researchers who support the use of Reiki and find positive results may be more likely to report and publish than researchers who support the use of Reiki but obtain negative results. Equally, researchers with a vested interest in refuting the purported efficacy of Reiki may be inclined to report negative rather than positive results.

6.3. Scientific research into Reiki

In addition to research described above, the National Institute of Health (NIH) in the USA through the Office of Alternative Medicine (OAM) (Eskinazi, 1998) has funded at least one randomised, blind and placebo-controlled study into the effect of Reiki (Nield-Anderson & Ameling, 2000). Since then the National Centre for Complementary and Alternative Medicine (NCCAM) has funded research into the effect

of Reiki in the treatment of Advanced AIDS (NCCAM, 2003b), Fibromyalgia (NCCAM, 2003c), and Painful Neuropathy and Cardiovascular Risk Factors (NCCAM, 2003d). The results of these research projects were not available to the researcher at the time of writing and the research proposals do not specify the level of training of the Reiki practitioners who will be involved in providing Reiki.

While participants in much of the research into Reiki have had pre-existing medical conditions, a study conducted by Engebretson and Wardell (2002) used 23 "Generally healthy volunteers who were naïve to Reiki" recruited from a major health science centre (p. 48). A Reiki Master with 20 years of experience provided 15 minutes of Reiki to the face and 15 minutes to the abdomen for each participant in a soundproof, softly lit, windowless room while at least one of the researchers was present. Following the Reiki sessions there was found to be a significant drop in participant anxiety and systolic blood pressure. There was an increase in skin temperature and a fall in electromyographic readings during treatment while salivary IgA levels rose significantly. However, there were a number of paradoxes in the way in which participants described their experience of the Reiki session. Participants, and sometimes the same person, reported feelings of "heaviness", "weightlessness", "heat", "coldness", "fear", "safety", being "detached" or in a "dream-like trance". Time was experienced as both "slow" and "very fast". Some participants reported being acutely aware of the environment while others were hardly aware of the environment. A number of participants reported feeling certain instances of touch from either the Reiki practitioner or one of the researchers when there had been no such touch. There were reported experiences of "vulnerability", "safety", "giving", "receiving", being "addlebrained", improved "clarity", of feeling "secure" or being slightly "panicky".

Engebretson and Wardell (2002) hypothesise that the paradoxical nature of the participants' reactions may be attributed to the "balancing" nature of this type of healing and therefore many models used to study touch therapy (including part of their own process) may not be sufficiently complex. They further suggested that:

> *Concluding that nothing happened to participants based on the analysis of aggregate data could misinterpret those balancing actions that are described by healers (Engebretson & Wardell, 2002, p. 52).*

In a randomised, placebo-controlled, 4-round, crossover experiment, Dr Ahlam Mansour from the University of Saskatchewan and colleagues tested to determine if participants could distinguish between placebo and Reiki practitioners (Mansour et

al., 1999). The researchers used 12 students, four breast cancer survivors, four independent observers, two Usui Reiki II practitioners and two placebo practitioners who had been trained in Reiki techniques but not attuned to Reiki. Training was provided by the study Reiki Master and the principal researcher. The placebo practitioners were chosen to closely resemble the Reiki practitioners. They were professionals, and resembled the Reiki practitioners in "physique, warmth, and friendliness" (p. 158). In addition, they had to agree to abide by the study rules and instructions. The placebo practitioners were given instruction in the hand positions to be used but were not attuned to Reiki.

In an orientation session participants were informed that they may feel heat, tingling, or nothing. Twenty subjects blind to the procedures were provided with two interventions which were either Reiki plus Reiki, placebo plus placebo, Reiki plus placebo, or placebo plus Reiki. Participants evaluated the procedures with a self-administered questionnaire. Sessions were of 15-minute duration and utilised a set of three hand positions chosen by the study Reiki Master. In round four of the experiment, the four observers blind to the procedures, were used to evaluate the performance of the four practitioners. The researchers were able to conclude that they had been successful in "standardizing a placebo Reiki intervention that looked exactly like the Reiki Treatment" (p. 162). While it would appear from this study by Mansour and colleagues that it is possible to test for the placebo effect when studying the efficacy of Reiki, it needs to be remembered that there exists considerable controversy regarding the placebo effect as discussed in Section 4.5.2.

A modified double-blind, placebo-controlled clinical trial with fifty ischemic stroke inpatients in a major rehabilitation hospital conducted by Shiflett, Nayak, Bid, Miles and Agostinelli (2002) had three aims:

> *(1) to evaluate the effectiveness of Reiki as an adjunctive treatment for patients with subacute stroke who were receiving standard rehabilitation as inpatients, (2) to evaluate a double-blinded procedure for training Reiki practitioners, and (3) to determine whether or not a double-blinded Reiki and sham practitioners could determine which category they were in (p. 755).*

In this trial, a Reiki Master from the *Reiki Alliance* trained 14 (2 males and 12 females) potential Reiki practitioners in Reiki I techniques. At the end of the training session the Reiki Master used a "second degree [Reiki] 'distant healing' technique" (Shiflett et al., 2002, p. 757) to silently attune half of the students while they sat in a meditative state. Therefore, the trainees were blinded to their status in Reiki. They

did not know whether they had been attuned or not although they were aware that half of them had been attuned. Shiflett et al. admit that this procedure breaks from the traditional attunement process wherein the Reiki Master "touches [the trainees] in a ritual manner" (p. 757). During a 2 ½-week period following this training, the Reiki Master, the seven newly attuned Reiki I practitioners and the seven trained-but-not-attuned trainees provided up to 10 thirty-minute treatments to the 50 inpatients. The treatments consisted of 12 hand positions on the subject's head and torso. As some of the patients were discharged during the course of the trial, only those who received six or more 'treatments' were included for analysis. Shiflett et al. concluded that the students could not determine whether they had been attuned, and that:

> *Reiki did not have any clinically useful effect on stroke recovery in subacute hospitalised patients receiving standard-of-care rehabilitation therapy. Selective positive effects on mood and energy were not the result of Attentional or placebo effects (Shiflett et al., 2002, p. 755).*

The one positive effect reported by Shiflett et al. was that the therapy provided by the Reiki Master and the newly trained Reiki practitioners had a significantly substantial effect on the subjects' ability to "get going" (p. 760).

6.4. Summary

Reiki currently has applications as a "folk art" (from personal discussions with the committee members of the Usui Reiki Practitioner Alliance, 2003) and as a formal nursing procedure where a nurse can claim Reiki training as an element of his or her continuing education (Mitzel-Wilkinson, 2000; Whitsitt, 1998). Given this, the early oral nature of Reiki training, and the fact that there are currently no regulatory controls over either the practice or teaching of Reiki, it could be expected, as discussed above, that there will be considerable variation in the understanding of what Reiki is and how it works. From personal experience the researcher has found this to be the case. When the individual is open to new ideas, it is possible that the practice of Reiki can expand and develop in response to new and challenging situations. Masters such as the Reverend Beth Gray have demonstrated this in their own teaching (Rowland, 1998). Nor, arguably, should Reiki remain static.

Although it is claimed that Reiki can be practiced anywhere and at anytime (Ellyard, 2002) without affecting the healing, it is possible that the ambiance of the setting for the Reiki treatment may cause considerable differences in client perception of the efficacy of Reiki.

As can be seen from Table 6.1, the level of training the Reiki practitioners participating in the studies cited above varies from newly trained Reiki I practitioners to a Master with 20 years experience in Reiki. In the majority of papers cited (11/19 = 57.9%) the level of Reiki practitioners involved is not specified and, in one case (Shiflett et al., 2002), the newly attuned Reiki practitioners were blind to their status as Reiki practitioners. Just as a Formula I racing car will travel a given distance in far less time than a family sedan, it is possible that a Reiki Master may be able to achieve the same level of healing in a much shorter time than a Reiki I practitioner. Therefore, given the diversity in the level of Reiki practitioners in the various studies, and that Reiki I, Reiki II, and Reiki Master practitioners may invoke different energy levels because of their training, it could be reasoned that it is not possible to draw accurate comparisons between the diverse results reported.

Table 6.1: Summary of Reiki level of research participants

Authors	Treatment Situation	Reiki Practitioners
Alandydy and Alandydy (1999)	Hospital surgery patients	Reiki practitioner level not specified
Bullock (1997)	Individual with cancer	Reiki practitioner level not specified but it can be inferred that she is a Master
Engebretson and Wardell (2002)	Generally healthy volunteers who were naïve to Reiki	Reiki Master with 20 years of experience
Kennedy (2001)	Survivors of torture	Reiki practitioner level not specified
Kruger and Warburton (personal correspondence)	Haemodialysis patients and a transplant patient	Reiki I assumed from personal discussions
Mansour et al. (1998)	Combating the side effects of drugs used to fight cancer	Reiki Master
Mansour et al. (1999)	Reiki and placebo	Reiki II – supervised by a Master
McLaren (1999)	Personal experience of having Reiki treatments as an anti-stress therapy following a car accident	Reiki practitioner level not specified
NCCAM (three proposed studies cited above)	☆ Advanced AIDS ☆ Fibromyalgia ☆ Painful Neuropathy and Cardiovascular Risk Factors	Only the research proposals were available to the researcher. Reiki practitioner level not specified
Nield-Anderson and Ameling (2000)	Literature review and general article	Reiki practitioner level not specified
Nield-Anderson and Ameling (2001)	Use of Reiki as a nursing practice	Reiki practitioner level not specified – but it may be possible that Nield-Anderson is a Reiki Master

Table 6.1: Summary of Reiki level of research participants		
Authors	Treatment Situation	Reiki Practitioners
Olson & Hanson (1997)	Pain management	Reiki practitioner level not specified
Sawyer (1998)	Hospital operating room	Reiki practitioner level not specified
Shiflett et al. (2002)	Ischemic stroke inpatients and Reiki practitioners	A Reiki Master, 7 newly attuned Reiki I trainees who were not told that they had been attuned, and 7 students who had undergone the same training but not attuned and who were not told that they had not been attuned
Van Sell (1996)	AIDS, systematic lupus erythematosus and chronic pain	Reiki II
Wardell & Engebretson (2001a)	Generally healthy volunteers who were naïve to Reiki	Reiki Master with 20 years of experience
Whelan & Wishnia (2003)	Literature review	Lived experiences of eight female Nurse/Reiki Masters
Wirth et al. (1993)	Pain levels following removal of impacted third molars	Reiki practitioner level not specified but, as distant healing is involved, Reiki II can be assumed
Young (1998)	Hospital emergency department and ambulances in transit	Reiki practitioner level not specified

Furthermore, for a number of reasons, the study by Shiflett et al. (2002) outlined above may have been seriously flawed by the way the researchers chose their 'Reiki' practitioners and then conducted their experiment. (1) Shiflett et al. state that their procedure for 'training' the Reiki and Sham Reiki practitioners broke from the traditional method of training Reiki practitioners in that the procedure they used "did not involve the ***usual*** practice of the master touching them in a ritualistic manner" [emphasis added] (p. 757). Therefore, it could be expected that individuals may have been unsure of their status as a Reiki practitioner as was the case. (2) It is generally acknowledged in the major Reiki texts that the newly attuned Reiki practitioner may experience physical, mental, emotional and/or spiritual 'cleansing' (self-healing) during a 21-day period following attunement. As the trial Reiki treatments lasted for only 2 ½ weeks, it is possible that the 'practitioners' in this study may have been experiencing their own initial healing while providing the Reiki sessions. (3) It is usual for the Reiki Master to discuss with the Reiki student any experiences they may have had during the attunement procedure. From the paper by Shiflett et al., this did not appear to have happened during the trial. Therefore, it would be natural for the newly attuned students to experience some degree of confusion following

their 'attunement'. (4) The newly attuned Reiki practitioners were asked to perform Reiki on recovering stroke inpatients without being provided with the opportunity to integrate their newly acquired knowledge prior to providing Reiki. (5) If, as Stein (1998) suggested, all individuals have an innate capacity for healing, then it may not be possible to eliminate "the possibility of unconscious intentionality" as proposed by Shiflett et al. (2002, p. 756).

It is possible that the subjects in the study conducted by Shiflett et al. (2002) needed the reported "get up and go" feeling to assist recovery and preparation for discharge from hospital and therefore the Reiki was indeed successful in meeting their needs. If the Reiki assisted them to leave hospital earlier than would have been expected, then it could be hypothesised that there was "a clinically useful effect on stroke recovery patients" (Shiflett et al., 2002, p. 755). It is possible that those who most benefited from the Reiki may have left hospital early with less Reiki treatments and therefore were not included in the final analysis.

In the studies where the information has been provided, there is considerable variation in the duration and frequency of treatments as well as the number of hand positions used. The frequency varies from one to 10 and the duration from 15 minutes to the length of an operation while the number of hand positions varies from three to 12. Therefore, it could be hypothesised that considerable variation in outcome is to be expected.

Given that:

- ☆ Reiki can be adapted to suit the needs of the individual client (Kennedy, 2001)
- ☆ paradoxical results have been found by researchers (Engebretson & Wardell, 2002)
- ☆ the practitioners' level and experience may vary from newly attuned Reiki I practitioners to Reiki Masters with 20 years of experience (Table 6.1)
- ☆ the frequency and duration of treatments may vary (Alandydy & Alandydy, 1999; Engebretson & Wardell, 2002; Mansour et al., 1999; Shiflett et al. 2002; Wirth et al., 1993)
- ☆ the number of hand positions used during treatment may vary (Mansour et al., 1999; Shiflett et al., 2002)
- ☆ results may be influenced by practitioner intent (Shiflett et al., 2002)

future research should test for these factors.

It is possible to rely on quantitative tools to test for factors such as client anxiety, systolic blood pressure, skin temperature, electromyographic readings, salivary IgA levels (Engebretson and Wardell, 2002), pain medication usage (Kennedy, 2001; Olson & Hanson, 1997; Talton, 1995; Van Sell, 1996; Wirth et al., 1993), tumour index markers (Bullock, 1997), and the placebo effect (Mansour et al., 1999). However, it may be necessary to use qualitative assessment techniques to test for factors such as the ambiance of the treatment area, subject and practitioner perceptions of the efficacy of Reiki, subject perceived experiences during the Reiki treatment, and the practitioners' reasons for providing Reiki.

6.5. Conclusion

To this stage, this research has demonstrated both the paucity of published research into the use of Reiki as a complementary therapy and the fact that the published research into Reiki has varied considerably in both methodology and reported outcomes. In addition, it has demonstrated that Reiki is used in at least 15 South Australian High Care Residential aged care facilities (Table 3.2).

Therefore, it was considered possible for the researcher to conduct a series of interviews with Reiki practitioners using Reiki in the care of people with dementia in an effort to:

- ☆ determine how Reiki is being used in South Australian nursing homes;
- ☆ determine why Reiki is being used in those facilities; and
- ☆ investigate if there is any evidence for the efficacy of Reiki in the treatment regime of people with dementia.

These interviews are discussed below.

7. Methodology

7.1. Introduction

The paucity of research into the use of Reiki generally, and specifically in the care of people with dementia, was supported by a further search of the electronic databases in May 2004. A search of all *Informit* databases returned 29 titles for Reiki and 2,054 for dementia but zero titles when the terms were combined. Another search of the *Journals@Ovid Full Text, Cinahl, ERIC, Psych Info,* and *Your Journals@Ovid* databases returned 327 titles for Reiki, 61,849 for dementia, and 12 titles for Reiki and dementia. When these titles were examined, three were found to be duplicate references leaving a total of nine articles that mentioned both Reiki and dementia. The titles of three articles (*National Centre for Complementary and Alternative Medicine Perspectives for Research in Cardiovascular Disease, Management of Pain in Labor Delivery, and CAM in Cardiovascular, Lung and Blood Research*) would appear to indicate that they did not directly address the issue of dementia and were not pursued.

Of the remaining six articles, one was a general examination of a range of complementary therapies used in treating stroke, falls, arthritis, dementia and Parkinson's disease in which Reiki was summarised in 13 words with no direct correlation to dementia being drawn (Gaylord & Crotty, 2002). Another was a report of research into which complementary therapies were being used by a group of patients with Parkinson's disease. Patients with dementia were specifically excluded from the survey and Reiki was simply mentioned as one of a number of therapies being used by one patient (Rajendran, Thompson & Reich, 2001). The third paper was a general description of a range of complementary therapies that can be used in the care of the elderly where Reiki was described in two paragraphs with no direct association being made to dementia (Lorenzi, 1999). A paper by Chez and Jonas (1997) discussed the general challenge of complementary therapies to conventional medicine and the need for doctors to become patient advocates. In this article Reiki rated a one-word mention as a manual healing method while dementia was only referred to in the context of herbal medicines.

Free and Chambers (2001) described the perceived success of providing in-home aromatherapy, reflexology and Reiki by a Mobile Therapy Unit from the Allied Dunbar's Dementia Care Programme in England without discussing the specific use of any of the therapies in detail. The final article was a report on a survey designed

to determine which complementary therapies were being used in the treatment regime of people with dementia in the United Kingdom and Ireland. From a distribution of approximately 130 questionnaires the researchers obtained a total of 85 responses; 53 from individual therapists, five from family carers and 27 from a variety of agencies including nursing homes, other clinical units and volunteer agencies. The use of massage was reported by 51 respondents, aromatherapy by 49, reflexology by 31, healing by 14, Reiki by eight, and herbal medicine by seven respondents. Reiki was simply described in one paragraph and there was no detailed analysis of its use in dementia care (Wiles & Brooker, 2003).

Two of the papers, Free and Chambers (2001) and Lorenzi (1999) had been located in the March 2002 database search described in Section 2.6. None of the nine articles provided a comprehensive study into the use of Reiki in dementia care.

A subsequent additional search of the *Medliner, Sociofile* and *Sociological Abstracts* databases returned 50 titles for Reiki and 36,457 for dementia but none for Reiki and dementia, further emphasising the paucity of scientific research into the use of Reiki in dementia care reported in the scientific literature.

7.2. Method

The literature reviews conducted by the author since 2002 have shown that it is possible to undertake a rigorous quantitative analysis in an attempt to demonstrate the efficacy or otherwise of Reiki. However, because there was no existing research into the use of Reiki in dementia care, it was considered to be too early to conduct a narrowly focused quantitative research project. This position was supported by Dr Caroline Smith, Associate Professor of Complementary Therapies, Division of Health Sciences, University of South Australia in a personal conversation. Professor Sarah Mott, an expert in residential aged care and rehabilitation from the Royal Rehabilitation Centre, University of Western Sydney, who, in support of the author's application for a National Health and Medical Research Council scholarship, wrote:

> *Case study research (i.e. focussed research in one site) is intended to explore areas in which little is known. It is the ordinariness of everyday life that can be best captured through interview and observation.*

In addition, it is considered that '[t]he 'quality of life' is harder to measur e scientifically than the 'quantity of life'" (Moynihan, 1998, p. 101) and qualitative research methods are best for exploring nebulous concepts such as "care" (Priest, 2002).

Because the researcher was unable to find any published scientific research into the use of Reiki in the care of people with dementia in institutional situations, it was impossible to predict what the research might or might not uncover.

Therefore, it was decided to use a ***Mixed Method*** research format (Krasner, 2001b; Miles & True, 2003) consisting of a researcher administered questionnaire containing predominantly closed questions followed by a taped interview based on a series of open ended questions. This method will enable the "capture of information which…might otherwise be difficult, or impossible, to express by quantitative means" (Dyer, 1999, pp. 260-261).

7.2.1. Qualitative research

Qualitative studies aim to "describe human behaviour or subjective experience that cannot be readily quantified" (Krasner, 2001a, p. 70) and "cannot be understood outside of its context" (Heppner, Kivlinghan, & Wampold, 1999, p. 246). Insights provided by qualitative research "should result in greater understanding of a phenomenon, but they are not generalizable in the quantitative sense" (Krasner, 2001a, p. 71). It is the "applicability" of the findings that is important in qualitative research and for policy makers who "are often concerned with local solution and are less interested in results from random samples" (Heppner, 1999, p. 248).

Qualitative research tends to study small samples in depth rather than studying large samples in less detail, as is the case with quantitative research (de Laine, 1997). As discussed above, the results obtained from qualitative research methods are not usually generalisable.

Validity, as recognised in quantitative research, is not often allied to qualitative research, which is more focused on the quality of the output. Heppner et al. (1999, p. 249) suggested that, "Readers should find the descriptions reasonable, informative, and sensible." However, the validity of the research may be judged by the degree in which participants "benefit as a result of their experience in the research" (Heppner et al., 1999, p. 250), and/or by triangulation. Triangulation involves using a variety of methods to view the data from different angles. This may be through data triangulation (obtaining accounts from different people), investigator triangulation (using different investigators from different disciplines), and/or method triangulation (combining qualitative and quantitative methods over time) (Banister, Burman, Parker, Taylor & Tindall, 1999). In qualitative research differing viewpoints based on the emerging data are acceptable as there are no "real" truths in qualitative re-

search. It is the "importance of the findings" which is paramount (Heppner et al., 1999, p. 251).

7.2.2. Questionnaire and interview design

Paul (1999a & 1999b) and Younger and Martin (2000) proposed that there is a need to obtain both qualitative and quantitative data when studying aspects of care for the elderly and dying. Cahil (1999) recommended that information obtained from interviews should be crosschecked with information obtained from closed questions. However, Priest (2002) considered that qualitative research methods are best for exploring nebulous concepts such as "care" while Moynihan (1998) suggested "[t]he 'quality of life' is harder to measure scientifically than the 'quantity of life'" (p. 101).

Whelan and Wishnia (2003) used a phenomenological approach incorporating the "collection of narrative interviewing data" (p. 212) to examine the lived experiences of eight female Nurse/Reiki Masters. They developed an interview instrument containing a total of 17 closed and open-ended questions. A pilot study was undertaken and a few questions revised before interviews were conducted. Most of the interviews lasted for 45 minutes. Whelan and Wishnia then carried out a 'Georgian' data analysis method of:

- ☆ reading the entire transcripts to gain an understanding of the whole
- ☆ re-reading to discover the essences, abstracting the meanings into themes
- ☆ examining the meaning units for clarification
- ☆ relating the meaning units to each other and the whole
- ☆ reflecting on the meanings and essences, transforming each meaning unit into the language of science
- ☆ formulating a consistent description of the meaning units for each participant.

In a study involving 13 males and 19 females with mild to moderate dementia and the carer of each subject, Howorth and Saper (2003) used a semi-structured interview format with open-ended questions to test the insight of people with dementia. During the interviews, participants were given prompts, when necessary, and asked supplementary questions for clarification. Detailed notes were made during the interviews and transcribed at a later time. Results were coded into categories by each researcher, then refined into themes following discussion between the researchers. The results obtained from the interviews were cross-referenced with statistical information obtained through an Activities of Daily Living scale and prediction of performance on a memory task.

Cahil (1999) conducted in-depth interviews with female carers of people diagnosed with dementia. The interviews were taped and the data grouped into themes. Data reduction strategies used included counting, noting patterns and linking solicited (asked for) and unsolicited (not requested) data. Information emerging from the interviews was triangulated with information obtained from fixed choice questions.

An interview, whether structured, semi-structured, or unstructured is much more than a simple conversation between two people who may share common knowledge about the topic. It assumes a lack of knowledge in one participant and a willingness to share knowledge by the other participant. It assumes that the interviewee is motivated to share that knowledge (Dyer, 1999). While the semi-structured interview format has a set of pre-determined questions, it allows the researcher to pursue additional information raised by the interviewee (Dyer, 1999).

Because the researcher wanted to be able to cross-reference information obtained from the questionnaires with information from the proposed interviews, yet was unsure of the depth of information which might be obtained through the interviews, a semi-structured interview protocol with closed and open-ended questions (Appendix C) was designed to obtain information about:

- ☆ the Reiki practitioner's role within the establishment
- ☆ other complementary therapies used by the Reiki practitioners
- ☆ the Reiki practitioner's stress level
- ☆ the number and age profile of residents with dementia
- ☆ residents' aggressive or non-aggressive behaviours which cause concerns for the Reiki practitioner
- ☆ benefits which accrue from the use of Reiki
- ☆ the individual Reiki practitioner's training in Reiki and experience in the use of Reiki in a dementia care setting
- ☆ information about the perceived benefit of Reiki to the quality of life of both the recipient and the Reiki practitioner.

As with the questionnaires distributed to South Australian Residential High Care Facilities (Section 3.2), testing the content validity of the draft interview protocol was carried out with a professional educator, a research colleague working in the disability field, and the researcher's three supervisors. Following their suggestions, some questions were re-worded to remove any ambiguity and re-ordered to provide a more logical sequencing of information.

7.2.3. Recruitment of volunteers

During August 2003, a letter of thanks and a summary report of the findings from the questionnaire distributed to South Australian High Care Residential aged care facilities in 2002, was posted to 162 South Australian metropolitan and country High Care Residential Aged Care Facilities (formerly called nursing homes) as identified by the Seniors Information Service on the 18th March 2003. A small number of changes in facilities listed had occurred since the 2nd October 2001 list used to conduct the original research. Where facilities had separate respite care facilities at the same address (a total of seven facilities) only one copy was sent.

In addition to the mail-out to aged care facilities, copies of the summary report were provided to the:

- ☆ Executive Director of the Alzheimer's Association of South Australia
- ☆ Manager of the Dementia Training Institute of Australia
- ☆ President of the Integrative Healing Practitioners Network (South Australia) for possible inclusion in their newsletter
- ☆ Individuals who contacted the researcher requesting a copy of the report.

The summary report was accompanied by an invitation to participate in the series of interviews planned by the researcher.

As mentioned in Section 6.2.3, when the researcher commenced this research, there was only anecdotal evidence that Reiki was being used in a small number of South Australian nursing homes. The survey indicated that there were at least 15 residential facilities utilising Reiki in dementia care (Table 3.2). Because the response to the invitation to participate in an interview was promising, it became possible to interview sufficient numbers of practitioners in order to provide meaningful information about the use of Reiki in dementia care.

Participants were selected from among the staff of facilities that had contacted the researcher, individuals who made direct contact with the researcher after reading the Summary Report discussed above, and individuals known to the author prior to the commencement of this research. A 'snowball' effect provided additional potential participants. All individuals who agreed to be interviewed were included.

7.2.4. Ethical considerations

The Social and Behavioural Research Ethics Committee of the Flinders University of South Australia granted approval on the 24th October 2003 (Appendix F).

No person under the age of 18 years was interviewed and a signed consent form was obtained from each participant before the interview. To ensure confidentiality of

information provided to the researcher, any personal details provided on the cover sheets were removed from the interview sheets and stored separately in a secure filing cabinet. The participants were not identified by name during the tape recording of their responses to questions 4.1 to 4.16.

A copy of the interview transcript was forwarded to each participant who was able to make or suggest amendments or withdraw their transcript from the research without the need to provide reasons. After receiving the transcript of their interviews, two participants made minor grammatical and spelling changes and another participant returned her transcript to the researcher with a request that it be withdrawn from the study due to changes in her personal circumstances.

7.2.5. Interview procedure

Participants were interviewed separately either in the researcher's office, in their home, or at their place of work depending on the individual's preference. In one instance a staff member was interviewed (alone) in the office of the Director of Nursing and, although nothing was stated, appeared a little uncomfortable with the location and this may have affected the quality of the interview.

The initial telephone contact to make an appointment for the interview enabled the researcher to inform the potential participant about the aims of the research and the process of the interview. Prior to each interview commencing, the researcher was able to develop a rapport with the Reiki practitioner by reiterating the aims of the research, briefly discussing the findings from the questionnaire posted to nursing homes (Chapter 3), and providing the participant with a personal copy of the Summary Report (Appendix B). The participant was informed that the first three questions had been designed to obtain information which would be compared with the information provided by the nursing homes, and that the interviewer would record the answers on the interview sheets. This process provided a further opportunity to discuss these aspects of the original findings and introduce the taped section of the interview. Responses to questions 4.1 to 4.16 were tape recorded for transcription by a professional typist. At the conclusion of the interview, participants were thanked and informed that a copy of the transcript of the interview would be provided for them to amend if they wished to do so.

As noted above, to ensure participant confidentiality, no names that could identify the participants, their colleagues, their clients or their workplace were used during the taped session.

In mid December 2003 a pilot interview was conducted with a Reiki practitioner who was caring for her father who had been diagnosed with dementia. Due to the success of this interview, it was determined that there was no need to make any changes to the Interview Protocol and that the pilot interview could be included as part of the research. Further interviews commenced in late February 2004. A total of 11 interviews were conducted between December 2003 and April 2005. During the pilot interview, subsidiary questions were posed for clarification of a response and to elicit additional information at the end of the subject's response to each question. However, to ensure that all subsequent interviews had a similar 'flow' of information, the researcher decided to make brief notes during the interview and then ask clarifying questions following the response to the final question.

Individual interviews lasted from approximately 30 minutes to over an hour. In total they produced in excess of 31,000 words of transcript in addition to the information obtained from the closed questions. The removal of one transcript following a request from the participant left the results of 10 interviews and a total of approximately 27,400 words of transcript available for analysis.

The interviews are analysed below in two sections, first the questionnaire session of the interview, and then the taped session.

8. Interviews with Reiki Practitioners (Questionnaire Session)

8.1. Analysis of Responses

The researcher designed a *Microsoft Access 2000* ® database to assist in the analysis of the responses to questions 1, 2, 3, 4.1, 4.2, 4.3, and 4.4 (Appendix C). The reactions to these questions are detailed below. The responses to the taped session of the interviews will be analysed in Chapter 9.

8.1.1. The participants

Of the 10 Reiki practitioners whose interviews were analysed:

- ☆ one participant provided services in a nursing home, a private hospital and a hospice,
- ☆ one worked 0.5 time in each of two nursing homes,
- ☆ three worked in the same nursing home,
- ☆ two worked in another nursing home, and
- ☆ three worked in one nursing home each.

Thus the 10 participants represented eight High Care Residential Facilities providing care for people with dementia and two other health facilities.

One participant was in the 18 to 35-age range, seven in the 36 to 55-age bracket, and two in the 56 to 75-age range. Nine were females and one male.

Two participants were trained to Reiki Master level, four to Reiki II level, and the remaining four to Reiki I level. Three had participated in one-day Reiki training sessions and seven had taken part in two to three-day training. Where individual participants had been involved in one-day Reiki I training, their Reiki II training was one-day. For those who had participated in two to three-day training at Reiki I level, their Reiki II training was two to three-days. Individual participants had been practicing Reiki from one to eleven years with a mean of 5.1 years and a median of 4.0 years. Of the two Reiki Masters, one had been involved in Reiki for three years, the other for eleven years; one was female and the other male.

The ten participants had been involved in dementia care from one to 12 years with a mean of 6.4 years and a median of 7.0 years. One participant who had been caring for her father was unsure of the timing of his dementia due to uncertainties about its diagnosis and, therefore, was uncertain as to the time she had spent in dementia care. Two of the participants had been involved in both Reiki and dementia care for approximately the same time (five years and one year respectively). Two participants with the longest history as Reiki practitioners (11 years each) had begun

dementia care after their Reiki training. The remaining six participants had taken Reiki training after becoming involved in dementia care.

One participant was employed as a Diversional Therapist, three as Patient Care Attendants, one as a Reflexologist/Masseuse, one as an Enrolled Nurse, and one as a Director of Nursing. Two participants were volunteers in their facility, one of whom had been assisting in providing care for her father in his own home before his admission to a residential care facility where she continued to provide Reiki until his passing. The other had previously used Reiki with her mother who had dementia. Two of the participants employed as Patient Care Attendants were trained as Enrolled Nurses, but were not working in that role.

In addition to being Reiki practitioners:

- ☆ two had no qualifications past secondary school
- ☆ one was qualified in early childhood teaching
- ☆ one was a qualified Reflexologist
- ☆ one had a Certificate III in Leisure and Health
- ☆ one was an Indentured Boilermaker as well as holding a Certificate II in Therapeutic Massage and the Certificate IV in Assessor Training
- ☆ one was a Registered Nurse with a Bachelor of Nursing and a Graduate Diploma in Aged Care
- ☆ one was qualified as an Enrolled Nurse
- ☆ one had a Certificate III in Community Service (Aged Care)
- ☆ one was a qualified Enrolled Nurse Youth Worker and Infant School Teacher with a Certificate IV in Women's Education
- ☆ each participant practised between zero and ten other complementary therapies with a mean of 5.6 and a median of 6.5.

The demographic information about participants is summarised in Table 8.1.

8.1.2. Which other complementary therapies do the participants use?

As noted above, individual participants reported using between zero and ten (mean, 5.6, median, 6.5) complementary therapies in addition to Reiki. The participants indicated that they used massage, music (recorded), aromatherapy (vaporising), reflexology, aromatherapy (massage), prayer, meditation, music (voice), music (instrumental), Therapeutic Touch (Krieger/Kunz method), behaviour therapy, healing touch, and Tai Chi when working with people with dementia.

Table 8.1: Summary of information about the practitioners providing Reiki in dementia care

Gender	Age	Role	Time in dementia care	Reiki training	Time practicing Reiki	Other qualifications	Stress	Other Complementary Therapies
F	36-55	Relative	5 Years	Reiki II	5 Years	Teacher	4-9	10
F	36-55	Volunteer	7 Years	Master	3 Years	None	4	5
F	16-35	Reflexologist / Masseur	7 Years	Reiki II	11 Years	Reflexology	0-7	1
F	36-55	Diversional Therapist	7 Years	Reiki II	3 Years	Cert III in Leisure and Health	7-8	10
F	56-75	Volunteer	10 Years	Reiki II	7 Years	None	0	0
M	36-55	Patient Care Attendant	4 Years	Master / Teacher	11 Years	Boilermaker, Cert II in Massage, Cert IV in Assessor Training	7-9	8
F	36-55	D.O.N.	8 Years	Reiki II	1 Year	R.N., BNurs, GradDipAgedCare	9	0
F	56-75	Patient Care Attendant	12 Years	Reiki II	8 Years	E.N.	3-4	7
F	36-55	Patient Care Attendant	3 Years	Reiki I	1 Year	Cert III Community Health (Aged Care)	4	6
F	36-55	Enrolled Nurse	1 Year	Reiki I	1 Year	E.N., Youth Work, Cert IV Women's Ed, Infant Teacher	4	10

In addition to the therapies discussed above, individual participants listed *awareness of the environment*, *relaxation*, and *spiritual healing* as complementary therapies which they used regularly. The information about other complementary used by the Reiki practitioners is detailed in Table 8.2.

Table 8.2: Other Complementary Therapies used by the Reiki practitioners (n=10)

Therapy	Number	Percentage
Massage	7	70%
Music (recorded)	7	70%
Aromatherapy (vaporising)	6	60%
Aromatherapy (massage)	5	50%
Prayer	5	50%
Reflexology	5	50%
Meditation	4	40%
Music (voice)	4	40%
Music (instrumental)	3	30%
Therapeutic Touch (Krieger/Kunz method)	2	20%
Behaviour Therapy	2	20%
Healing Touch	2	20%
Awareness of the environment	1	10%
Relaxation	1	10%
Spiritual Healing	1	10%
Tai Chi	1	10%
Chiropractic	0	0%
Light Therapy	0	0%
ThreePhase Therapy	0	0%

Seven of the participants (70%) used some form of aromatherapy, either vaporising or massage, or a combination of both. The same participants reported using some form of music, either instrumental, recorded, voice or a combination of these modalities.

During the interviews, individual participants reported using *flower arranging, oil burners* and *foot spas* as well as *opening…windows to let fresh air in*. Another participant reported using her *Reiki intention for a pleasant event when* [spending] *some time with the residents arranging flowers*. The comments from all participants appear to support the participant who said the use of complementary therapies *depends on the time and the place. I adapt to the circumstances and the person I am working with*.

8.1.3. Carer stress levels

Because 40.7% of the respondents to the questionnaire (33, n=81) commented about the level of staff and resident stress caused by disruptive behaviours a 10 point Likert scale with zero being the lowest and nine the highest was used to rate participant self-perceived stress levels (Appendix C). The Reiki practitioners self-reported stress levels ranged from zero to nine. Five participants provided a spot value for their stress level while the others reported a range from a low to a high value. One participant reported a spot value of zero while another participant reported a spot stress level of nine. The mean stress level for each participant was calculated and then the group mean stress level was calculated to be 5.0 (median, 4.0).

A volunteer who reported a stress level of zero commented that she, *loves doing the work* while the other volunteer, who reported a stress level of four, commented that she tries to *make the time as productive as possible* and that *stress is self-imposed*. One participant commented that her stress level ranged from *zero when positive effects of work can be seen to seven when working in palliative care*. For one participant, whose stress levels ranged from seven to eight indicated that *too few staff, constant change,* [and] *residents now acute* were the major issues. Another participant reported that his stress levels ranged from seven to nine with *time pressures to do things, high care work,* [and the] *increasing number of young people - brain damaged (youngest 18 years, extensive brain tumour, frontal lobe removed, 25% brain left, virtually no functions)* contributing to his stress. The family carer reported that her stress levels ranged from four to nine and that *up to the time of father' s death- nine* because of *unpredictability of behaviour, deterioration of loved-one, never knowing what he knew…*[and]*…every-day needing to cross another line not previously imagined*. A participant, who reported a stress level of nine, cited *management issues* as the cause of that stress. Another participant reported a stress level of between three and four when *things are not going well* at work. One participant who reported a stress level of four commented on *resident behaviour…staffing levels…*[and] *lack of time*, while another attributed her low stress level, in part, to *remaining focused on the needs of the individual so caring is enjoyable*.

8.1.4. Which agitated behaviours cause problems / concerns for the participants?

From a list of behaviours (Question 3.3, Appendix C), the participants identified attention seeking, intrusiveness, physical aggression, verbal aggression, resistance,

sexual behaviour, wandering, absconding, and moving furniture as behaviours which caused them concern.

Individual participants added *anxiety and agitation and the domino effect with staff and other residents*; *continence and removing clothing*; *overall confusion*; and *repetitive vocalisations and the domino effect* to the list. One participant was particularly concerned about *many intrusions by residents into other people's rooms*.

The responses are detailed in Table 8.3.

Table 8.3: Aggressive or non-aggressive behaviours which cause problems/concerns for the Reiki practitioner (n=10)

Behaviour	Number	Percentage
Attention seeking	8	80%
Intrusiveness	8	80%
Physical aggression	7	70%
Verbal aggression	6	60%
Resistance	5	50%
Sexual behaviour	3	30%
Wandering	3	30%
Absconding	1	10%
Moving furniture	1	10%
Anxiety and agitation and the domino effect with staff and other residents	1	10%
Continence and removing clothing	1	10%
Overall confusion	1	10%
Repetitive vocalisations and the domino effect	1	10%

8.1.5. What benefits do the participants believe accrue from the use of Reiki

From a list of reasons as to why complementary therapies are used in residential high care facilities (Question 3.3, Appendix C), the Reiki practitioners identified 1:1 interaction, calming, quality of life, behaviour management, stimulation, and reduced medication as the benefits obtained through the use of Reiki. Individual practitioners added *clarity and understanding; giving a feeling of being special as an individual;* and *reduction in worry and increased self-awareness even if only momentarily* to this list. One respondent (a Patient Care Attendant) commented that *medication is the province of other staff* [and therefore] *could not comment*.

The responses are detailed in Table 8.4.

Table 8.4: Benefits which Reiki Practitioners believe accrue from the use of Reiki (n=10)		
Benefits from the use of Reiki	**Number**	**Percentage**
1:1 interaction	10	100%
Calming	10	100%
Quality of life	9	90%
Behaviour management	8	80%
Stimulation	5	50%
Reduced medication	3	30%
Clarity and understanding	1	10%
Giving a feeling of being special as an individual	1	10%
Reduction in worry and increased self-awareness even if only momentarily	1	10%

9. Interviews with Reiki Practitioners (Taped Session)

9.1. Analysis of Responses

A professional typist was employed to transcribe the interview tapes in Microsoft Word 2000 ® format then a quasi-statistical method of counting words was used to obtain an estimate of the importance of various concepts and repeated re-readings of the transcripts were undertaken to discover the essences, abstract the meanings and arrange them into themes then re-examine the information for clarification.

Following a careful reading of the first two transcripts, the researcher developed a list of 'key words' and concepts which had been highlighted during the initial reading. By using the search facility in *Microsoft Word* ®, the frequency of these words in the first three transcripts was determined. After this initial analysis; the list of 'key words' and concepts was amended and expanded. To test rater reliability, the two people who tested the initial interview protocol (Section 7.2.2) were provided with a copy of the first transcript and asked to highlight what they thought were the 'key words' and concepts in the text. During this process, both 'testers' were blind to each other's reply and the researcher's initial list. A comp osite list of key words and concepts was compiled following discussions between the researcher and the 'testers'.

All transcripts were then re-read to refresh the researcher's memory of the inte r-views and to gain further insight into the individual responses. Following this reading, the researcher's list of 'key words' and concepts was expanded further and the first three transcripts re-analysed. The 'copy and paste' function of *Microsoft Word* ® was then used to group all responses to individual questions in a single document. The grouped responses were read to gain a deeper understanding of the answers to each question and possible emerging themes noted for further analysis.

The three raters independently compiled a list of possible themes and sub-themes from the expanded list of key words and concepts. The researcher then added to his list a small number of themes that had become evident from the detailed reading of the combined transcripts, but not evident from the list of key words and concepts. The researcher and the professional educator used the three separate lists to compile a mutually agreed list of themes. This list was then slightly modified following discussion with the third rater. A small number of key words and concepts, which did not readily fit into the themes, was then set aside for further consideration by the researcher.

The mutually agreed themes and sub-themes were:

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

The 'find' functio n of the word processor was then used to count the occurrences of the key words and concepts identified through the process described above and to aid in a further detailed analysis of the comments made by the Reiki practitioners. The 10 most frequently used words and concepts together with the number of inter-view participants using them are illustrated in Figure 9.1.

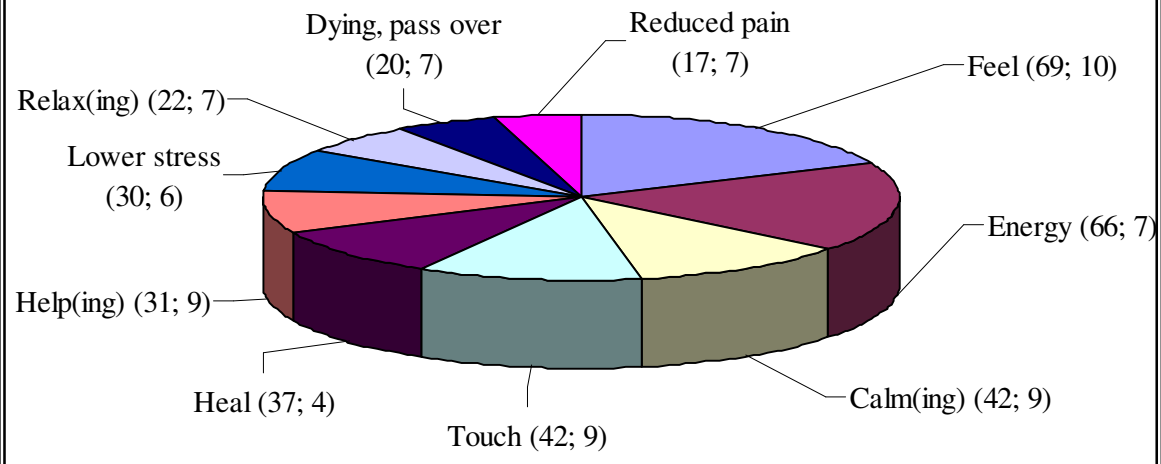


Figure 9.1: The 10 most commonly used words and concepts showing the frequency and the number of participants using each (n=10)

From the repeated re-reading of the transcripts, and from the interview questions, it became apparent that additional themes or sub-themes could be identified. These themes were:

- ☆ Documenting the use of Reiki
- ☆ Problems in using Reiki
- ☆ Issues relating to medication
- ☆ Providing Reiki for the carers
- ☆ Reiki is not a panacea
- ☆ Staff and family attitudes towards Reiki
- ☆ Training and monitoring of the Reiki practitioners
- ☆ Use of Reiki I techniques
- ☆ Use of Reiki II techniques.

These themes were then added and re-ordered to provide a better 'flow' of information. Finally, an 'Other Issues' section was added so that concepts that did not fit into the themes or sub-themes could be analysed.

While there were some difficulties in allocating a number of concepts to an individual sub-theme, as will be detailed below, the raters agreed that the following words or statements could represent the agreed sub-themes for the concept of 'Quality of Life':

- ☆ **Improving physical well-being:** *reduced blood pressure, calming, stress level down, heart/pulse rate slows, BP lower, pain reduction, relaxing, slept, sleep better, home feels different, 'dis-ease',* and *balancing*.
- ☆ **Improving psychological / mental / emotional well-being:** *reduced anxiety, balancing, calming, stress level down, clarity, happier, lower stress, empower, self worth, fear, reduced level of, feels good, calm (individual), peaceful, quality time, quality of life, relaxing, home feels different, 'dis-ease',* and *less agitated.*
- ☆ **Enhancing relationships**: *appropriate response, close interaction, happier, one on one, participate longer, love, focuses,* and *touch*.
- ☆ **Reducing negative behaviour**: *agitated, domino effect,* and *flow-on*.

An example of the difficulties encountered in allocating key words to the agreed themes occurred with the word *balance*. The concept of balance may refer to physical balance (Chen et al., 2001), maintaining a balance between treating the person with respect or patronage (Pond, 1994), balancing client independence and dependence (Pond, 1994), promoting homeostasis within the body (Barnett & Chambers, 1996), and maintaining a balance between emotional events. A further difficulty oc-

curred in determining whether issues such as *reducing stress*, promoting *calming*, inducing *relaxation*, and improving *sleep* would lead to improved physical health, improved emotional health, or both. These issues were resolved following a detailed analysis of the comments made by the interview participants.

As comments from participants were quoted in the analysis, these quotations were colour coded in the collected transcripts to ensure, as far as possible, that duplication of quotations did not occur. A *Microsoft Excel* ® spreadsheet was used to tally the frequency of quotations used from individual participants in an effort to ensure that each participant was given an equal voice. However, this was not always possible due to the uneven length of the interviews and subsequent transcripts which varied in length from approximately 1,400 words to slightly over 6,500 words (mean, 2,740, median, 1,970).

9.1.1. Quality of life

While nine (90%) of the Reiki practitioners had identified an improved quality of life as one of the benefits of using Reiki during the pre-taped questions (Table 8.4), only three participants directly used the term "quality of life" during the taped se c-tion of the interviews. One participant who was a Director of Nursing said:

> *I am a great believer in the nursing home where we provide a lifestyle and a normality for residents … we provide a lif estyle – residents come to us for quality of life, for the rest of their life.*

She emphasised this comment by adding; *I don't focus on the clinical care – the clinical care is a very small component of what we do* and saying, later in the interview, that her *expectations … for residents …* [are to]… *give them an enhanced quality of life*. A fourth Reiki practitioner felt that it was important *to be there with* [end phase dementia clients] *and to have that quality and a special time with them* [and to] *help them to feel really calm and peaceful* [as the clients are often] *really scared*.

However, as discussed above, a major theme relating to quality of life could be identified from the comments made by the participants. A detailed analysis of this theme follows.

9.1.1.1. Improving physical well-being

Some of the benefits of using Reiki reported by the Reiki practitioners included reducing blood pressure, lowering stress, reducing pain, promoting relaxation, calming and improved sleep patterns as well as providing balance and the reduction of '*dis-*

ease'. One person commented that the staff members using Reiki *don't have huge success in total healing of illnesses or injuries.* [Nevertheless, Reiki can] *reduce some of the side affects of* [either] *the natural processes of dementia, …their other illnesses, …*[or their] *drugs*.

Reducing pain

For seven of the participants (70%) the ability of Reiki to reduce pain was important and they commented on this facet a total of 17 times (mean, 2.4; median, 2.0). For one participant pain reduction was important because it is difficult to determine if a problem is due to *behaviours,* [or] *pain*. For this participant the use of Reiki in palliative care can *help* [the dying] *to pass over and to make them peaceful and calm and free from pain*. In a paradoxical way she commented that *you can't see pain relief.* She was unaware that there are standardised pain measurement tools available in the scientific literature. Another participant observed that with self-Reiki, *pain goes, if it doesn't go completely* [Reiki] *lessens the pain a lot*.

Another participant used Reiki to assist other staff members who were experiencing pain and reported that she had used Reiki for a staff member who had *an arthroscopy and cartilage removed from her knee*. The staff member's knee *was burning one night and I put my hands on it and she said my hands were like ice and they relieved the pain*.

Although another participant's father was *a non-believer,* she used Reiki *on his sore back, and he* [was] *impressed with the results* [and said that Reiki had] *taken his pain away*.

Reducing blood pressure and heart rate

Two participants commented directly on a reduction of blood pressure following Reiki and a third commented on a reduction of the client's heart rate. For one Reiki practitioner the experience of lowered blood pressure was a personal experience before major surgery; *when it came to them taking my blood pressure my blood pressure was lower than it normally was.* Another carer drew attention to a flow-on effect of lowering blood pressure in that, for *insulin dependent diabetic* clients:

> *Reiki calms them down, reduces their blood pressure and in turn that changes the level of insulin they need so* [staff] *monitor that and they adjust it accordingly…they can do that* [in the nursing home] *because there are staff who…are trained to facilitate and check their blood levels and the administration of insulin.*

Reducing stress

While six of the participants (60%) commented on a total of 30 occasions (mean, 5.0; median, 3.0) about the ability of Reiki to reduce stress levels, only two commented directly about the improved physical outcomes of using Reiki. When asked what her personal reasons for using Reiki were one participant said:

> *Quite often when people are sick, when they are facing trauma, when they are not in familiar surroundings, everything, their whole body reacts to the stress they are under, and physically they can become more ill when they are stressed.*

Another participant commented that *I always felt that if I was pulled back into alignment … physically, my energy levels* [enabled me] *to cope better with stress and any illnesses.*

Calming

Although nine of the 10 participants (90%) referred directly to the calming nature of Reiki on a total of 42 occasions (mean, 4.67; median, 4.00) none of the comments related to physical issues.

Relaxing

Even though seven participants (70%) used the word relax or relaxing on 22 occasions (mean, 3.1; median, 4.0). none of the comments referred to possible physical effects of relaxation.

Balancing

While the ability of Reiki to promote balance in recipients and practitioners was reported by four participants (40%) on a total of 12 occasions (mean, 3.0; median, 2.0), none of the interviewees referred to physical balance in the context of Reiki.

While not a reference to the effects of Reiki, one respondent mentioned physical balance in the context of medication decreasing the person's balance thus increasing the prospect of falls.

Improving sleep

Five of the participants (50%) believed that Reiki had the potential to promote better sleep patterns and made direct references to this phenomenon on a total of 11 occasions (mean, 2.2; median, 1.0). The importance to one Patient Care Attendant was emphasised by the fact that he mentioned sleep patterns on five occasions and be-

lieved that improved sleep was only one of *a huge range* [of benefits] *from just a calming effect to improving sleep patterns, to reducing pain levels*. Using Reiki to improve personal sleep patterns was important to another participant who commented that *if I am having a really tough time of going to sleep or to relax I will do Reiki on myself and will drift off*. Another participant mentioned that Reiki assisted her in getting to sleep and demonstrated the special hand positions she used at night in order to promote sleep. A further participant maintained that *every time I did the symbols or boosted the Reiki in my own mind …* [my father's] *anxiety reduced and he slept or he became more gentle*. Another participant reported enjoying the fact that, when she was using Reiki on residents, they would fall asleep.

A physical contraindication to the use of Reiki

Reiki as a touch therapy may not always be appropriate. For example, one participant drew attention to the fact that touch may be painful for the recipient because of particular medical conditions.

9.1.1.2. Improving psychological / mental / emotional well-being

As outlined above, the raters were able to identify issues related to psychological, mental, and emotional well-being in participant comments about:

- ☆ reducing anxiety, agitation, 'dis-ease', fear and stress;
- ☆ improving self-worth; promotion of balance, calmness, clarity, peace and relaxation;
- ☆ empowering the individual;
- ☆ providing a happier, quality time; and
- ☆ creating an environment which feels good.

Calming

> *if a person who has got dementia becomes violent or they become extremely distressed, it is very, very hard to calm them down and usually what happens is* [staff or doctors] *administer drugs because it is quick and it is quite often effective*.

As noted above, nine of the 10 participants (90%) referred directly to the calming nature of Reiki on a total of 42 occasions (mean, 4.67; median, 4.00) with the most senior of the participants, in relation to role within the facilities, referring to the calming effects of Reiki on 10 occasions. Comments about the calming nature of

Reiki referred to the clients, the Reiki practitioner, and other staff members and included:

- ☆ Reiki *would calm* [my father] *down and…enable him to access…conversation,* [so] *he could talk or he would listen to what* [people] *were saying.*
- ☆ [By promoting a sense of calmness, Reiki could] *improve* [my clients'] *quality of life, …their enjoyment, …and their attitude to life.*
- ☆ [Calming one person down] *usually has…a fog* [like] *effect,* [which] *goes out and everybody starts to calm down again*.
- ☆ It is the *calmness* following Reiki, which is noted in the progress notes.
- ☆ Reiki has *very positive effects* [because it is] *very settling,* [and] *calming*.
- ☆ Residents are *calmer* …[and] *… easier to approach and to tend to when they have received Reiki*.
- ☆ *It is a wonderful thing to see people immediately calm down with* [Reiki].
- ☆ [Reiki has the ability] *to make* [the residents] *peaceful and calm and free from pain.*
- ☆ *Whenever I would send* [my father] *Reiki … he would definitely become calmer.*
- ☆ *I think it is a calming, it is a soothing, it is deeper probably. I think it is the deepest conscious relaxation that you can get…*[and it is] *refreshing.*
- ☆ *Quite often when* [residents] *are receiving it regularly the effect of the Reiki calms them down*.
- ☆ [Reiki enables me to promote calming] *by reinforcing good intentions of peace and calm, love and goodwill and changing the energy to one that is even more relaxing*.
- ☆ [I use] Reiki to *calm residents who are agitated and upset.*
- ☆ Reiki promotes *calming, peace*, [and] *relaxation and is soothing*.
- ☆ *Being able to console people, …calm them, …ease the situation… or to help them along their way* [is important].

One participant found that the calming nature of Reiki caused residents to *immediately start to breathe through their belly and relax,…feel comforted and…feel like they are being protected*. To promote relaxation this participant would *put one hand on their hand and another one on their shoulder and let the energy flow through them*. Another participant found that, when she was using Reiki residents *would actually go to sleep on me, which is quite nice*. A third participant believed that it is necessary to try to pre-empt a situation and use Reiki in the early stages *before*

[residents get] *wound up*, a belief that apparently was supported by other staff members who believed that *once* [the residents] *are wound up you are battling uphill*.

Five (50%) of the participants had personally experienced the calming effect of Reiki and their comments included:

- ☆ *I am more calm, I am happier, more centred, more balanced and I have got a better perspective on life.*
- ☆ *I was so peaceful, I was so calm…and I just knew everything* (an operation) *was going to be fine.*
- ☆ *It gives you that calming effect, I suppose it grounds you and when you get grounded it certainly changes the way you do things*.
- ☆ *I recall* [receiving] *Reiki from an aunty of mine when I was a child and she had a very calming effect on me…I always felt calm near her.*
- ☆ *I have found it is very calming…I use it to calm myself, to prepare myself, for the day*.

The Director of Nursing specifically used Reiki to assist a *staff member who has a lot of emotional problems, a lot of turmoil in her life.* She found that the Reiki *calm*[ed] *her and help*[ed] *her find her balance* [so that] *she seems to be a lot more balanced now*. In addition to working with individual staff members this participant used *the* [Reiki] *symbols* to *try to keep the staff calm, to solve some of the issues that I have within the management context rather than on the residents.*

Although they had both commented on the ability of Reiki to calm residents, two participants pointed out that Reiki had no effect in certain circumstances. For one it was with a resident who was *quite demented* and wished to *get out of bed in the middle of the night*. For the other, it was that, with *some types of dementia…it doesn't seem to do very much at all* [because] *the brain just doesn't seem to compute somehow, it is as if they have a short in their wiring*.

Relaxing

As mentioned above, seven participants (70%) directly used the word relax or relaxing on 22 occasions (mean, 3.1; median, 4.0). It was this aspect of Reiki which one of the volunteers used when answering questions about what she was doing because she *would like to think it is of value to* [her clients'] *healing process be it physical or emotional* and provides *a relaxing 'one on one'* time with clients. The relaxing nature of Reiki is emphasised by another participant who said that Reiki can provide

total relaxation for her clients. A third participant aims *to provide relaxation, reassurance and comfort through Reiki*.

Another participant used Reiki *specifically to enhance the care of people*, *to help them to relax* …[and] … *gain the wonderful experience of that feeling, the relaxation*. This was important to her personally because she *had a very turbulent childhood and the thing that would make me strong* [enough to] *adapt to my problems was relaxation*. Another participant reported that giving Reiki induced *a relaxing kind of tiredness* in her, on which her husband commented when she returned home from work.

Reducing stress

As cited above, six of the participants (60%) commented directly, on a total of 30 occasions (mean, 5.0; median, 3.0), about the ability of Reiki to reduce stress levels. Four of the participants referred to stress as a personal phenomenon, three referred to stress related issues in their clients, two commented about staff stress and one commented about the stress imposed on the families of people with dementia.

One participant, when asked what her personal reasons for using Reiki were, replied:

> *In the beginning it was because I was in a very stressful situation and had heard it would help to get some clarity and to bring the stress level down and that is a lot* [of] *what I use it for myself, so originally* [I] *used* [Reiki] *because of stress*.

Another participant commented that, *For my voluntary work I believe any lowering of stress is a form of healing*, while another commented that, when faced with major surgery, *I think* [that] *on the stress level end my stress levels should have been absolutely sky high…but they remained really really calm whilst I was in the hospital*. She attributed her low stress level in part to the fact that she was using Reiki on herself.

For another participant stress in:

> *palliative care is a great concern..for everyone, not only for the resident that it is happening to, but for the family and staff because we do make connections with all our residents*.

This participant said that Reiki can relieve the stress of the person with dementia, their family members, and the staff members who use Reiki because, with:

> *the application of Reiki, the person who is giving it always receives a little bit for themselves, so at the end of the day if you are giving Reiki to 15 to 20 people a day, it certainly does help with the stress levels for those staff.*

The ability of Reiki to ease the stress of the practitioner was supported by another participant who reported that:

> *I need a rebalance* [spiritually]*, to regain a sense of equilibrium, to be centred again and grounded once more because I have had quite a busy stressful life, raising* [my] *children on my own, going back to study and working at the same time.*

Reducing anxiety

Five of the participants (50%) commented on a total of nine occasions (mean, 1.8; median, 1.0) that they were aware of reduced anxiety occurring in residents following Reiki treatments. This feature was important to one participant because *anxiety is a big problem within the aged care* [sector]. Another participant believed that Reiki reduced her father's anxiety thus enabling him to sleep better. A third participant felt that the propensity of Reiki to reduce anxiety was of personal benefit to her. This is evidenced by her statement that:

> *I have enormous anxiety attacks when I am in surgery* [and] *I had been lying on the gurney for about four hours and during that four hours I did nothing but pray, meditate and do Reiki…I had no anxiety, no agitation.*

Balancing

The ability of Reiki to promote balance in recipients and practitioners was reported by four participants (40%) on a total of 12 occasions (mean, 3.0; median, 2.0). One participant stated that since being trained in Reiki, she has become *more balanced* within herself, while another participant believed that this state of balance in the body was promoted by the *attunements* received during Reiki training. Another participant who supported the importance of practitioners maintaining a state of balance said; *I need a rebalance, to regain a sense of equilibrium, to be centred again and grounded once more*.

The Director of Nursing mentioned balance on seven occasions and said:

> *I find that after listening to the* [Reiki] *tape and doing the treatment that I am a bit more balanced than I normally would be. And I think that since I have done Reiki I am certainly a much more balanced person than I was before.*

To her, the need for a carer to maintain personal balance was important because *this is an industry that takes a lot out of you; you have to be constantly giving and constantly aware.*

Empowering the individual and enhancing their self-worth

Three participants (30%) commented directly about empowering the individual and enhancing their self-worth through using Reiki. One participant commented that Reiki can improve a carer's *self-worth* [as it] *gives them another tool that they…can use* [to help] *them connect with the resident without having that full on emotional involvement* [but] *still have the empathy and compassion* [that is needed]. This comment was supported by another participant who said that Reiki increases the worker's *self-fulfilment* [because] *you can do something* [productive]. A third participant hoped that learning Reiki would *empower* [her daughter] *in her future life*.

Reducing agitation

Three participants (30%) referred to reduced agitation on a total of five occasions (mean, 1.7; median, 2.0). For one participant heightened agitation was a personal experience when she was facing surgery while for another participant *part of* [her father's experience of] *having dementia was being agitated* [and] *he was agitated a lot.* Therefore, the calming effect of Reiki was an important part of her caring regime.

Another participant commented that Reiki *makes* [residents with dementia] *feel more relaxed and …* [they] *are not as agitated,* but added that Reiki *is not going to stop them from doing something that they want to do*.

Promoting peace

In addition to referring to the calming nature of Reiki, three participants (30%) used the word peace or peaceful to describe the effect of Reiki on a total of seven occasions (mean, 2.3; median, 2.0). One participant stated that *although you know it is really sad because you know that that is goodbye, it is really special to help* [end-phase dementia clients] *be at peace.* Two participants referred to Reiki promoting peace on a personal level for the practitioner.

Reducing fear

Only one participant commented about a reduction of fear when talking about the effects of Reiki. She believed that reducing her father's fear enabled her to make *his passing away very gentle*.

Turning 'dis-ease' into 'ease'

One participant suggested that, if the concept of *disease* can be deconstructed as *'dis-ease'* then Reiki can *create the right mindset and the right mental attitude* and can therefore assist to improve the *quality of your life…which will then improve your health*.

Other effects

One respondent referred to the ability of Reiki to promote *clarity* in the practitioner on four occasions. Another participant spoke about the ability of Reiki to *clear the mind,* while three participants spoke about *clearing the room of negative energy* and *filling it with Reiki* and *good intentions of peace and calm, love and goodwill* thus *changing the energy to one that is even more relaxing*. As will be discussed later, these participants were attuned to Level II Reiki or higher.

One participant reported that using Reiki can make *a more tranquil setting* [so that] *the other residents* [react positively and therefore] *everybody is calmer*.

Another participant said that it is … *very good for people who are anxious* … [as it can] *take* [them] *away to a quiet place and just work on* [them]. Another participant reported that *occasionally we go to their own room for quiet one on one time* while another reported using a special Reiki II technique to quieten a particularly agitated resident *for a little while*.

Four participants (40%) referred to Reiki as *soothing* on a total of six occasions (mean, 1.5; median, 1.5).

9.1.1.3. Enhancing relationships

For one participant, Reiki was able to assist her father to *respond appropriately* and participate in family situations *for longer periods than if* [she] *didn't do it.* For another participant, the *close interaction* promoted by Reiki provided enjoyment within her *voluntary work* and *brought* [her] *relationship* [with her husband] *closer together*.

For one participant improved relationships has been a personal experience. She felt that, since learning Reiki, she has become *more calm, …happier,* [and] *more centred* within herself and has learnt that, *What is important is people and what isn't important is the material things in life*. Through Reiki she has *met new friends*, and now mixes *with a different type of people.* Through her volunteer work she gets *wonderful personal rewards*. Other comments relating to enhancing relationships through touch, love, and 1:1 interaction are detailed below.

Touch

The close relationship reportedly brought about by Reiki may possibly occur because Reiki is a therapy that involves touch. Nine participants (90%) commented directly about touch on a total of 42 occasions (mean, 4.7; median, 2). One participant preferred Reiki to other therapies because it is *hands on* [and provides] *that personal human touch* [which a] *lot of people need…to be able to connect* [and that] *most people enjoy the touch … the contact* and the *warmth from your hands* which she said was *soothing* within itself. However, one participant does not touch some of the people she works if she knows that they have pacemakers.

To adapt the way Reiki is used, another participant:

> *introduced the reflexology points on the feet because* [with] *90% of the residents you can touch their feet, they quite like to have their feet touched or massaged and you cover the different areas of the bodies through applying the energy through the reflexology*.

Another participant commented that touch *is a culmination of a validation psychologically* and later explained that *the lower arm…is a trusting place to touch* [as is] *the middle of the back* while holding *their hands it is a comforting thing to do as well* [as being] *more personal.* She suggested that touching the shoulders will tend to release stress. One participant thought that, even if people do not understand what Reiki is, they will respond to the touch. In addition, she stressed that the Reiki practitioner needs to get *the permission of the person to be able to enter into* [their personal space] *and touch*. (The issue of informed consent will be discussed in Section 9.1.3.7).

One participant emphasised that individual attitudes to touch may vary over time when she reported that, initially, her father *didn't like me to put my hands on him,* [because] *he was never a physical touchy sort of person – he was a very big strong independent bloke* [but] *towards the very end of his life* [he was] *comfortable about me touching him*. In the early stages of his dementia she would send him Reiki and observed that *he would definitely become calmer*. When he eventually permitted her to touch him, she observed that *his heart rate would slow down*.

Another participant stated that the Reiki practitioner can *connect with* [another] *person on a very personal level without even touching them*.

Love

During the interviews, six participants (60%) used the word love on a total of 13 occasions (mean, 2.2; median, 2) in the contexts of their intent when using Reiki. They

said that they enjoy providing Reiki for other people, and that their clients, family members or friends enjoy receiving Reiki. When recounting her personal reasons for using Reiki, one participant said in part, *…now I do it because I love giving people the opportunity to feel good themselves* while another participant, when describing the effect of Reiki on clients said, *I use Reiki at home and my son loves it.* A third participant said of a 57 or 58 year old client with cerebral palsy and poor lungs, *he is great, he loves it…he loves it, makes him feel better*. She added that, *when I do* [Reiki, I] *put all* [my] *love and all* [my] *care into it, it is just so gentle.* Another participant used Reiki *by reinforcing good intentions of peace and calm, love and goodwill*. This intent to send love was reinforced by another participant who, when describing the use of Reiki for herself and her family (including her father who had dementia) said:

> *our intention was to surround…*[with] *love…without harming anyone else…I don't actually think it is any differen t than having an intention about something and sending your love or energy, universal love or whatever it is that you call that*.

Another participant described Reiki as *a love energy*.

1:1 interaction with residents

Three participants (30%) referred directly to the close, one-on-one nature of Reiki on a total of seven occasions (mean, 2.3; mode, 3.0). One participant said, *you have got your hands on them, one on one*; while another participant felt that *with a resident in my volunteer capacity I would like to think that it is a relaxing one on one time we can spend together for personal contact and friendship.* She would *occasionally…go to their own room for quiet one on one time* [but that] *depends on the person* and felt that *sitting with someone and just holding their hand has value that staff can appreciate*. A third participant emphasised that people in institutionalised care *lose the one on one* [contact] *and that is very very important*. This participant spoke at length about the need for one to one contact between staff and clients:

> *One to one is really important for people in residential situations because they usually come from an environment where they have been in control and all of a sudden they have lost their independence, they have lost absolutely everything, they have moved into an environment where they know no-one, so the only contact they quite often have is with people in the facility. Being able to use Reiki allows for that one to one connection, even if it is just sitting with them talking, holding their hand, letting the energy flow…becomes a connection and they do in the majority of times feel co nnected, and they relate not only to you but they relate to a lot of the other staff as well because there is that bond of energy, so it doesn't matter*

whether it is me or whether it is someone I taught, when the energy flows they connect with the energy, they connect with the person who is giving the energy.

9.1.1.4. Reducing negative behaviour

While only three participants (30%) referred directly to the ability of Reiki to reduce agitation, the raters agreed that the claimed incidences of calming, reduction in anxiety, reduction in stress, promotion of balance, promotion of happiness, reduction of pain levels, reduction of fear, promotion of peacefulness, improved quality of life and, increased relaxation discussed above, could either reduce agitation or prevent it from occurring and therefore, in turn, reduce incidents of anxiety.

For one participant the reduced anxiety displayed by her father was an important factor in her use of Reiki as agitation was *part of* [his] *dementia* [and] *he was agitated a lot*. In addition, she used the Reiki symbols to *boost* the power of Reiki whenever her sister became *agitated* when visiting their father. For another participant, a reduction of anxiety was a personally important phenomenon when faced with major surgery. Reduced anxiety was important for a 50-year old client who *had a…mental health illness,* [involving] *massive panic anxiety, agitation,* [and] *depression*. However, this interviewee reported having had *a bad experience with Reiki* where she developed a *massive, massive headache, and…felt really, really unwell* after providing Reiki for this client.

While another participant did not refer directly to reduced agitation, he reported that the calming effect of Reiki on one resident would produce a *rippling* or *flow-on effect …because if* [a resident is] *not stressed then the residents around them aren't getting as stressed nor* [are] *the carers or the nurses or the other staff*. In his experience this then produced *one of those nice circles we like to see, not one of those vicious circles*.

9.1.2. End-phase dementia

Seven participants (70%) referred to caring for people with dementia undergoing end-of-life experiences on a total of 20 occasions (mean, 2.9; median, 2.0) with one participant making seven of those references. Concepts used by the individuals included *dying, pass over, palliative care* and *at the end.*

Three of the participants spoke about the *fear* and *anxiety* that can be experienced by people nearing the end of their life. One participant said, *I have seen a lot of people at that stage who are at the end and are hanging on, and are really*

scared, while another participant referred to the *fear* and *anxiety* experienced by her father. One participant used Reiki with end phase residents to *give them some comfort*. Her *overall expectation is that* [she can] *pass to them a feeling of confidence and well-being, that they belong, that* [someone] *care*[s].

9.1.2.1. Easing passing (death)

In addition to the comments quoted above, one participant stated; *I think when someone is dying Reiki can … be of great value*, while another participant thought that it was important to be able to *sit down and do Reiki on* [terminal residents] *and to be there with them and to have that quality and a special time with them and be able to assist the resident to relax and..feel really calm and peaceful*. She added that Reiki can *help them to* [be] *free from pain*. In addition to using Reiki in palliative care situations, another participant reported that she plays some relaxation type of music in the background. One participant spoke at length about aspects of palliative care since:

> *some of* [the residents] *have been* [in the facility] *for 6 or 7 years and you make friends* [with them] *and friends with their families and you become part of that person's life and when you see them starting to pass away it can get stressful.*

Because of the *dignity of what is happening* and the fact that palliative care is *very stressful for everyone, not only for the resident that it is happening to, but for the family and staff*, both this participant and the other staff in his facility will provide Reiki *in the privacy of* [the resident's] *room*. He indicated that he would provide Reiki II distance healing if he was unable to be present personally due to other professional or personal commitments. To him Reiki is able to assist the dying to, *within themselves*, [feel] *more relaxed*. This belief was supported by another participant who indicated that, when her father was dying, *he was very frightened and* [Reiki] *reduced his level of fear*.

9.1.2.2. Effect on carers

Working in a palliative care situation can be extremely stressful for carers. As noted above, one participant reported that her stress level rose from a low of zero when positive effects of her work could be seen, to seven (out of nine) when working in palliative care.

Another participant reported that her stress level rose to nine (out of nine) towards the end of her father's life. From conversations outside of the interview, the

researcher became aware that this participant was supporting her mother in caring for her father before he eventually found a placement in a nursing home. In addition, this participant had to cope with her sister who would become *agitated* when visiting their father.

A third participant commented that *Palliative care*…[is]… *very stressful for everyone, not only for the resident that it is happening to, but for the family and staff and that Reiki certainly does help with the stress levels for those staff* [working in palliative care]. This participant reported *that we don't only use Reiki on the residents; we do have staff who are trained in Reiki who will come and ask us if we will apply Reiki to them*. He added at a later point in the interview that it is rewarding:

> *to be able to sit there and put your hands on them for 5-10 minutes* [and] *quite often you will look and see their heads have nodded over and they will wake up and feel quite refreshed.*

9.1.3. Reiki treatments

9.1.3.1. The nature of Reiki and Reiki treatments

Reiki as a 'feeling' therapy

The most frequently used word during the interviews was *feel* (or a derivative). It was used at least once by all 10 (100%) of the participants on a total of 69 occasions (mean, 6.9; median, 5; mode, 1). One participant who used it on 33 occasions significantly skewed the results.

References to feelings covered both the emotional (belonging, better, calm, confidence, good, less agitated, love, relaxed, tired, well-being, and worn out) and the physical (cold, heat, relaxed, tired, warmth, and worn out) domains. It was claimed that people could *feel the Reiki***,** but that this feeling may be different for different people according to their circumstances and needs.

One participant described the physical feeling she experienced during a Reiki session as *a strange sensation in my feet, it starts in my feet and I get sort of incredibly hot, incredibly, incredibly hot*. Another participant said that:

> *Sometimes it is … very useful to know where that person's pain is, sometimes you need to feel it. In which case you have let your guard down a little bit and you have got the problem worked out where the area is, then you can sort of go back on it.*

A third participant said that *if I had my hand on* [my father] *I could* [physically] *feel that…he would definitely become calmer,* [and] *his heart rate would slow down*.

For another participant it was [emotionally] a *good feeling* which comes when she *walk[s] out and the residents are sitting there with a smile on their face, or having a chat*. Another participant said that *my overall expectation is that you pass to them a feeling of confidence and well-being, that they belong, that you care, that it opens up their senses as well*. A third participant said that for people *with mental illnesses* [Reiki] *certainly helps, right through to giving them just general well-being, making them just feel better*. It was this participant's belief that Reiki could provide a feeling of *fraternity* [and] *mental stability* and that *people…see Reiki fitting in…because they feel the benefits from it so they associate it with their beliefs*.

When receiving her first Reiki treatment, following a car accident and before being trained in Reiki, one participant was told to *lay down on the bed…not to worry about anything and just go with the feeling*. She added that *having experienced that initial* [pleasant] *feeling…I guess now I do it because I love giving people the opportunity to feel good themselves*.

Another participant, when saying that it is not necessary to have any equipment in order to give Reiki, said that the practitioner only needs a feeling *of wanting to do it and your hands*. Another participant supported this concept when she said:

> *the reason I got into Reiki was because I felt the feeling come through my hands and then, when I met* [my Reiki Master] *and found out he was into Reiki, I found out that that's what* [the Reiki] *energy was*.

She added that, with *one client who has emphysema*, [she] *can feel that the energies go into his lungs as well as his back*. Another participant claimed that *I have always felt that Reiki is a connection that you feel immediately because of your own body energy*.

In relationship to the general 'atmosphere' in a residential facility, one participant commented that:

> *Even if there is only one person in the nursing home such as the one where my father was, if there is only one person in there doing* [Reiki]*, as soon as you walk in the door it feels different than walking into a nursing home that doesn't* [have a Reiki practitioner].

She added:

> *I mean there could be a range of reasons for that – it could be the whole ergonomics of the place, the Feng Shui or whatever, but you can feel the difference, and I think that is very important. If I can feel it walking in the* [door] *people who live there certainly would be able to feel it. I think it is just essential. I think it should be part of every nursing home.*

When talking about the family members of residents, one participant said that *they feel guilty, quite often very guilty about putting their family in places like* [the nursing home].

Energy

The second most frequently used word during the interviews was *energy*. Seven participants (70%) used the word energy on a total of 66 occasions (mean, 9.4; median, 5.0) with one participant personally using the word energy on 24 occasions.

Reiki was described variously as an *energy flow*, *energy therapy, healing energy*, *Universal Energy, vibrational energy*, a *surge of power, tingling,* and *pulsing*. Two participants referred to the Reiki energy as energy from *God* with one participant saying, *I believe it is all from a higher source – universal energy, God, whatever you want to call it* and another saying [my Reiki Master] *calls it an energy but I like to think of it as a God force*. One participant spoke about *manipulate*[ing the] *energy* while another said that Reiki *is an energy that people can accept or reject without causing embarrassment to them*. Two participants referred directly to the application of Reiki as a *channelling* of *energy*.

One participant reported that when he used Reiki he experienced:

> *an energy flowing* [which is] *a feeling of warmth* [that is] *not just a normal rub your hands together* [but] *a different warmth…coming out from my hands* [which is] *quite often…accompanied* [by] *the participant saying, 'oh your hands are cooking', or there is tingling, or pulsing, sometimes coldness, things that you wouldn't normally relate to normal touch.*

This experience of energy flowing during a Reiki session is supported by the comments made by another participant, that, whenever she does Reiki on someone, her:

> *feet for some reason go really funny. I feel a strange sensation in my feet, it starts in my feet and I get sort of incredibly hot, incredibly, incredibly hot.*

She reported that this heat could be so intense that on one occasion her father *had to ask me to stop because he couldn't stand the heat.* Two other participants referred to feeling heat and warmth during Reiki, but, paradoxically, one participant reported that clients said she had *icy cold hands* when providing Reiki.

Self-healing

Seven participants (70%) reported using, or receiving, Reiki for self-healing, as an aid for relaxation and balancing, or getting to sleep while three participants (30%)

spoke of the nature of Reiki where the practitioner receives the healing energy while channelling it to the client.

Differential experiences of Reiki

Six participants (60%) suggested that people experience Reiki differently on a total of 10 occasions (mean, 1.7; median, 1.0). It was suggested by one participant that this is because *everyone varies, everyone is different and* [have] *their own…separate needs* and therefore the Reiki *can be felt in different ways*. It was suggested by another participant that this phenomenon might be due to the fact that people have different *medication* [or] *what is actually wrong with the person*, [may be different] *whether it is dementia,* [or] *brain damage*. In addition, the individual practitioners may *have different perceptions of what they are doing and how they go about it*.

One participant said that *the effect is whatever* [the recipients] *chose it to be*. Another participant said that different people *take on board all their different needs* while another said *I can only go by what I think and what I feel and I am sure different people would have different experiences*. Another participant explained that *our physical self can be adjusted, can be healed in many different levels*.

Gentle, non-invasive

In addition to being able to promote balance within the body and mind; calming, a sense of peacefulness, relaxation, improved sleep patterns, and a decrease in stress levels as discussed above, two participants described Reiki as gentle or non-invasive. For one of these participants, Reiki was *non-invasive* because the recipient *can leave* [his or her] *clothes on* yet it is *gentle* … [and] … *powerful* …[and] … *works*. The other participant described Reiki as being *gentler* than massage and *un-invasive* because there are *no after effects*. Four participants (40%) referred to Reiki as *soothing* on a total of six occasions (mean, 1.5; median, 1.5).

Participants variously likened the use of Reiki to an intention to provide compassion, empathy, energy, goodwill, love, peace, quality time, or a pleasant event without the need to adopt a new and different set of beliefs or change existing ones.

Adaptability of Reiki

One participant spoke at length about adapting the way Reiki is used because of the recipients' *spiritual beliefs, their physical situations* [and] *their physical disabilities*.

Because *the majority of residents that* [staff in the nursing home] *work on are in bed or in a chair* [it is difficult to] *get to the position* [for a full Reiki treatment] *so*

we have to pick an area [of the resident's body to work on]. Often this is the resident's feet, so, as discussed above, this participant introduced the use of the foot reflexology points to complement the use of Reiki. Another participant specifically spoke about adapting her practice if she could not reach particular spots because the recipient is sitting *in their wheelchair* [or] *in their chair*, while a third participant spoke about the need to adapt her practices because her father did not initially like being touched.

Complementary nature of Reiki

In addition to the reported number of other therapies used by the participants (Table 8.2), the notion of complementary therapy was supported by one participant who said that Reiki can be *incorporate*[ed]*…with…any other m odality around, whether it be with modern medicine or…alterna tive therapies* [such as]*…drug …physiotherapy or Chiropractic work* [and]*…it compliments it, it doesn't interfere or aggravate* . Another participant said *I use everything I can use. I use Reiki, I use Therapeutic Touch, I use massage. Whatever fits an individual – not all people agree with the same thing*.

An interesting comment was made by one participant who said that all she needs to perform Reiki is *a person, plant, animal,* [or] *something to work on*. A second participant reported that she has *used it with animals, and they have benefited*.

Spiritual nature of Reiki

When describing Reiki, or the personal experience of Reiki:

- ☆ six participants (60%) used the word *God* on a total of 13 occasions (mean, 2.2; median, 2.5)
- ☆ one participant used the word *sacred* on four occasions
- ☆ five participants (50%) used the word *spiritual* (or a derivative) on a total of 15 occasions (mean, 3.0; median, 3.0)
- ☆ five participants (50%) referred to Reiki as being from the *universe* or *universal* in its nature on a total of nine occasions (mean, 1.8; median, 2.0)
- ☆ four participants (40%) referred to *prayer* on a total of nine occasions (mean, 2.3; median, 2.5)
- ☆ six participants (60%) used the word *love* on a total of 13 occasions (mean, 2.2; median, 2).

One participant described Reiki as a process of *sending…universal love* and *opening* [herself] *to the universe*. She believed that, when practising Reiki, *information, if you want to call it that, comes from the universe to the person or to me* [as the Reiki practitioner]. Another participant reported that, for her, *Reiki* [is a] *a gift from God*, a *Universal Energy available to all* and that *the personal belief system of the recipient does not affect the Reiki effect*. A third participant stated that *we* [the Reiki practitioners] *channel the energy and the Reiki comes from the Universe*.

Another participant saw Reiki as *a gift from God* and a *really…important part of* [her] *belief system*, while another reported that, to her, *it doesn't* [matter] *whether you call it energy or Reiki or God or love*. Another participant related that, when a *very, very strict Catholic* [who] *was in a lot of pain*, but would refuse Reiki because she had her *God*, the participant was able to offer assistance to the resident by saying *he is the same one I have…*. When challenged by *Catholics* and *Anglican priests* who thought that she did not believe in God she replied that there:

> *is a God up there, and you have your path and there are lots of paths, they all lead to the same* [end] *so it doesn't matter which path you take does it.*

When asked by the researcher about the Reiki II symbols, one participant said *I have been told they are sacred and* [I am] *not meant to just verbalise them to anybody…because they have special meanings behind them*. Another participant reported that he used Reiki for both self-healing and the healing of others *not only in a physical level but the emotional and spiritual level.* In addition, he commented that:

> *there are … residents who are quite accepting of the Reiki but they are not accepting of people seeing* [them] *receiving* [it because] *I suppose it is a very personal thing for some residents. They connect it with their spiritual bodies fairly strongly, so they tend* [to say] '*Okay can I have some Reiki but can I go into my room?' So we do.*

When asked to elaborate on what he meant by *spiritual* he said:

> *We have residents from many different paths of life, different strong religious beliefs, from Catholics to Muslims, and they quite often will integrate their religious beliefs with the Reiki when it is being applied. For example, if we had someone who has a strong Christian belief and is quite involved in regular prayer, it may not be unusual for them to say, 'Look while you are giving the Reiki can we have a prayer?' So I am quite happy to sit there and pray with them while the energy is flowing* [which] *for them…takes on that spiritual connection with their religious belief. So whether it is Christian or non, it connects and they can see that connection and will quite often talk about that connection, especially if there is a connection between their beliefs and their mental state…*

As noted above, one participant described Reiki to her mother as *a form of prayer*. Another participant reported that she *did nothing but pray, meditate and do Reiki* to calm herself before undergoing major surgery. She added that:

> *I don't know which one worked for me but I just know the combination of all three made an enormous difference personally to me and the experience that I went through.*

Without being asked about the possible spirituality of Reiki, one participant said, *If you are open to it, it can be spiritually rewarding* while another, when asked if Reiki is religious said, *Well I don't know, it can be* [but] *it is not what I would call a religion*. When questioned further, she said that she would call Reiki *spiritual*.

Another participant said that she believed that Reiki *is all from a higher source – universal energy, God, whatever you want to call it*. Elsewhere she added, *I am more spiritual than religious. Religion is only man's interpretation in what is their belief, whereas spiritual is from a person*.

When questioned about her use of the terms *energy* and *force* to describe Reiki, one respondent replied, *well it is the same thing – I mean* [my Reiki Master] *calls it an energy but I like to think of it as a God force*. Following an additional question about her religious beliefs and Reiki she said:

> *I am a Catholic and I think of it as a God force, because I believe that that universal energy is God so I don't feel like there is a struggle with my faith and with Reiki*.

She also commented that, to her, Reiki *is a love…energy as well as coming from that* [God] *force*.

When asked to expand on her interpretation of spirituality another participant said:

> *I think spirituality is a sense of wonderment, a sense of uniqueness that everybody has at one point in their life, a pivotal moment when they feel that they are happy, when they feel that they might have joy, pleasure, ecstasy, and if people get that from being under trees or being near a beach, or from being in a building or being with other people, I think that can be a spiritual experience.*

Attunements

Only one participant mentioned the Reiki attunements. She said that, from her understanding, the attunements bring the new Reiki practitioner's body into *balance* and *open up the Chakras*, which in turn gets the *vibrational energy flowing through the body and around the body* [and] *out of the hands*. However, she commented that

she *never went into the study of* [the attunements] having trained only to the Reiki II level. This feature of Reiki was not raised with the other participants.

Length of Reiki treatments

Three participants (30%) commented about the length of Reiki treatments they provide to residents. As a volunteer, one participant indicated that she tries to provide Reiki to six people per day, but seldom manages to achieve that many. She likes to spend *at least 15 to 20 minutes* [per person, but] *if they're very depressed* [she will] *spend longer because I think they need it*. Another participant emphasised that, because of work pressures, *there isn't the time span..*[to] *do a full treatment on the residents* and added that families will often pay him to provide *full treatments* for their relative in the facility in his own time. The issues relating to work pressures were supported by a third participant who said:

> *there is not enough time to give* [Reiki] *properly to residents when they need it...we have so many residents to attend to and only a limited amount of time to give each one, and that's to do with staffing numbers...*[we] *are working to a time limit all the time and...can do a little bit of Reiki...it might only be one to two minutes. A little bit is not as effective as you would like it to be.*

This participant thought that, for a Reiki session, *about 10 to 15 minutes would be nice to have, to be able to sit down and do it*.

Conversely, one participant said that she *can use* [Reiki] *at any time...I can just use it sitting and holding their hand, or while I am talking to them, or just interacting at any time*. When talking about providing Reiki to staff members, another participant reported that *if you are able to have, say, a five-minute session it is quite invigorating*.

Location for Reiki treatments

The comments made by all of the participants would appear to support one participant when she said that Reiki can be used *everywhere*. One participant indicated that *occasionally we go to their own room for quiet one on one time;* [although] *it depends on the person. Most times it will be as a group get-together within the unit lounge*. Another participant indicated that she had given herself Reiki in bed and given her clients Reiki *in the resident's room* [as well as] *sitting in a general area* although she preferred a quiet area because there is *less distraction*. Although she indicated that she had never *done it in a car or a moving vehicle* she was *sure it could be done*. Another participant said that she used Reiki *wherever* [the residents] *are sitting; in their wheelchair,* [or] *in their chair*. A fifth participant indicated that

staff trained in Reiki would use it *everywhere* [and at] *every opportunity*…because…*it is quite an accepted fact in our facility that Reiki is an option that all residents have*. One participant described Reiki as being *portable* while another said that *you don't need to withdraw the resident to use Reiki* and a third indicated that she used Reiki *even if I am just standing at the nurses' station and someone is a little bit upset*.

Having said that they can use Reiki anywhere, six participants (60%) said that, on occasions, they would use Reiki in the privacy of the resident's room because, according to one participant, there are *less distractions* and, for another participant, *for the dignity involved in palliative care*.

An insight into how practitioners think of Reiki was supplied by one participant who, when asked, "Where do you use Reiki?" replied, *Is that a trick question?* However, when the question had been explained, she responded:

> *Anywhere. There are no boundaries. Anywhere. Wherever the person is comfortable, wherever they are. There are no limitations. It could be their bedroom; it could be wherever they are at that particular time. It could be their bedroom, their lounge, outside, wherever they are. There are no limitations.*

Equipment needed to preform Reiki

In response to the direct question about any equipment needed to perform Reiki, nine participants (90%) replied that there was no need for any special equipment in order to provide Reiki to a client. One respondent said, *you don't need any equipment, just yourself and a great belief of what you are doing*. However, the tenth respondent said there is need for *a nice comfortable chair so that we can sit ourselves down and bring* [ourselves] *into the level of our residents*. This participant emphasised the need for the practitioner to be comfortable in order to provide a better service to the residents. There may be a need for special equipment for other therapies which can be used in conjunction with the Reiki. These may include oil burners, musical equipment or record players.

9.1.3.2. Use of Reiki I techniques

While six of the participants (60%) were trained beyond the beginning Reiki I level, the majority of participants appear to use predominantly Reiki I techniques of hands-on treatments. Although many of the participants were using Reiki in individual situations and therefore could make personal choices as to the techniques they use,

for one participant there was a professional need to make an active choice to use Reiki I techniques because:

> *we have to keep it very consistent,* [and] … *incorporate it into* [our] *position as a carer first and then as a Reiki practitioner* [because] *we have to adjust the Reiki to comply with what* [the industry wants] *because at the end of the day we have got to be able to prove* [what] *is worthwhile funding.*

He emphasised the need to monitor what is being done because the staff members practising Reiki are *different people* [with] *different perceptions of what they are doing and how they go about it*. A copy of a testimonial provided by the Director of Nursing and a copy of the Reiki I course outline provided by the participant are included as Appendix E.

9.1.3.3. Use of Reiki II techniques

As noted above, all participants appear to predominantly use Reiki I techniques when working with people who have dementia. However, five participants (50%) spoke about Reiki II techniques[1] such as the Reiki symbols, sending distance (or absent) healing, using Reiki to *clear* the room or *fill it with Reiki*, or using a *Reiki box*. One participant spoke about using a *Reiki box* and the Reiki symbols *to transverse time and space, connect with* [the] *person and pass on healing energy or whatever else they might be requiring*. While she tended to use Reiki II with *friends … relatives* [or] *clients* rather than in dementia care, she said that:

> *In the nursing home there is…one lady who I have in my Reiki Box and that is because she just cannot sit still. It is very sad, because she just doesn't know what to do with herself.*

When another participant provides Reiki I therapy sessions she *always* [does the] *symbols with it…to make it just that bit more powerful.* A third participant used Reiki II techniques in a family circle *to send Reiki* to *people* or the *world* and to send Reiki to her father who, initially, did not like being touched. Another participant said that, if she could not reach a particular spot on a resident's body, she would *just put* [her] *hands on them and…ask that* [the Reiki] *is sent to wherever* [the resident] *needs it the most*. One of the Reiki Masters reported that, if he cannot be personally present with a resident who is dying, he uses *absent healing to send* [Reiki] *to them to help the process*.

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[1] The literature survey conducted by the researcher indicated that, in Usui Reiki, practitioners do not progress to using distant healing techniques until Reiki II. However, recent information provided to the researcher suggests that, in some branches of Reiki, Reiki I practitioners may also be trained in distant healing techniques and learn some of the Reiki symbols (Dashorst 2005).

Four participants (40%) spoke about using Reiki II to clear negative energy from a room and variously fill it with Reiki, peace, calmness, love, and goodwill. One participant commented that using Reiki to clear negative energy is especially important *in the lock up dementia area,* [where] *the energy…is very shattered simply because every resident is emitting unusual energies* [which tend] *to collect*.

The Director of Nursing, who would have the least hands-on contact with residents, reported using Reiki II techniques in her management role to keep *the environment harmonious* and to *help* [staff members] *to work through the changes that we are working with*.

Four participants (40%) spoke about the Reiki II symbols on a total of 15 occasions (mean, 3.5; median, 3.0), with one participant using the term on eight occasions. As discussed above, this participant reported using the symbols to *boost* the energy while another participant suggested that the symbols *represent power or powering up, like pressing the button that starts something up*. She added that *time and place* [do] *not exist if you use the symbol that brings* [the practitioner into] *connection* [with the recipient].

Another participant said that the Reiki symbols are used during the attunement of a Reiki practitioner.

9.1.3.4. Reasons for using Reiki

Four participants (40%) had either heard or read about Reiki before deciding to attend training while two participants (20%) decided to learn Reiki following an experience of receiving Reiki. Another two participants worked in the facility where Reiki was taught as part of the staff development programme.

One participant had heard that Reiki could lower stress and initially used it to lower her own stress levels. For another participant, *healing touch* [had been] *a distant interest* so she learnt Reiki to use it when her mother developed dementia in order to *incorporate it as part of* [their] *time spent together*. A third participant, who had experienced 10 years of cranio-facial reconstruction following a serious car accident, felt *like a huge weight had lifted off* [her] *shoulders and…head* following a Reiki treatment. She then decided to learn Reiki because it *was just unreal* and now loves *giving people the opportunity to feel good themselves* and tries to *make them peaceful and calm and free from pain*. Another participant had read about Reiki and Therapeutic Touch and felt that Reiki was better than Therapeutic Touch because Reiki is *hands on* [and gives] *that personal human touch*. Another participant who

had been working as a volunteer doing *the odd things* such as taking residents to the hairdresser or for walks *thought* [that] *there* [had] *to be something more* she could do. She had *heard about Reiki* [and] *thought right, "That is what I want to do."*

The participant who had been a boilermaker learned Reiki after a friend provided relief from a persistent headache by giving him a Reiki treatment. Following the treatment, he felt that he had been *missing out* for many years. He initially used Reiki in the *hostile* environment of a heavy engineering firm employing *500 tradesmen*. Management was accepting because Reiki enabled them to *save…some money at the end of the day*. He emphasised that this was *a big factor for them because when* [he] *started to do Reiki on people the number of people going to physio reduced significantly*. This participant added that Reiki was *an energy that* [he could] *use without inflicting a belief.*

Another participant was *interested in the area,* [and] *thought it would be another facet to my nursing basically and allow me to do something else for someone*. Other participants reported using Reiki [because it is] *very helpful if I have a patient…in pain*; *to calm residents who are agitated and upset*; and *specifically to enhance the care of people*.

Three of the participants (30%) appear to have experienced an '*ah ah*' moment when they personally realised the potential value of Reiki. The participant who used this term added that she couldn't *think of the right words to describe it* [but that]… *it is like a bubble of time that is very different from every other bubble of time*.

9.1.3.5. Reasons for rejecting Reiki

From comments made by the participants, it would appear that reasons for not having Reiki therapy may include:

- ☆ not liking being touched
- ☆ fear of the unknown
- ☆ scepticism
- ☆ not being able to see an immediate result
- ☆ the practitioner not using terminology that is understandable to other people or pushing his or her beliefs on others
- ☆ a belief that Reiki is *hoodoo*, *voodoo* or *witchcraft*
- ☆ personal religious beliefs or the beliefs expounded by clergy from certain religious groups
- ☆ the practitioner not being sufficiently prepared

☆ having a previous negative experience with Reiki.

One participant emphasised that:

> *there is a mindset with a lot of the older men that it's not acceptable to have a hand massage, but it is acceptable to shake someone's hand or to sit there and have your hand on their shoulder or rub their knees, as long as there is a eucalyptus or a menthol smell associated with it.*

This participant went on to say that, *if we do Reiki on* [older men] *it is usually when we are doing* [secondary] *things like applying Deep Heat* and that *is quite acceptable* [to the older men] *because it is a man thing…if you smell like horse liniment, or whatever, you know…he has an injury* [which] *he must have got…playing footy*. The participant added that *the younger male residents are quite accepting of just touching, such as holding their hand or putting your hand on their knee.*

As noted above, a major contraindication to Reiki techniques involving touch was reported by one participant who found that she could not touch one resident suffering from a type of neuralgia in which damage to the client's nerve endings made any form of touch extremely painful for the resident.

9.1.3.6. Drawbacks to using Reiki

When asked if there are any drawbacks to using Reiki, one participant thought that the only drawback was *people saying, 'What are you doing?'* but the practitioner can overcome this by *using terminology that is understandable to another person*. As an example she *might say to* [her] *mother that* [Reiki] *is a form of prayer.* Another participant said that, because of the workload, *there isn't the time span* [and therefore there is the need to make] *adjustments to the way that I do treat Reiki to accommodate working in an aged care facility* [so I] incorporate *the reflexology points on people's feet so that* [I] *can cover larger areas quite quickly*. The other eight participants (80%) said that there were no drawbacks they could think of.

As an explanation, one participant emphasised that she does not *push Reiki on people …*[but]*… will take a small step and check it out, and then take* [another] *small step*. Another participant who had said that she could not think of any drawbacks to using Reiki added that she once had:

> *a bad experience with Reiki* [after providing Reiki] *for a very young resident who was in her 50's* [and] *in a nursing facility…*[because of]*…more of a mental health illness, massive panic anxiety, agitation,* [and] *depression.*

Following this Reiki session the participant had *felt really unwell* [with a] *massive, massive, headache although* [she] *does not normally get headaches*. She added, *perhaps there are certain people that it is best not to* [Reiki].

Another participant commented that the only drawback is when you find resistance from the client or the person who resents you using it. She added, *I think a lot of this age group probably aren't aware of what Reiki is, but they respond to the touch*.

9.1.3.7. Informed consent

While individuals who have the cognitive ability can give permission for the practitioner to use Reiki, it is possible for the relatives of individuals who do not have the necessary cognitive ability to provide the required permission. One participant said, *I always have a good talk with* [the relatives] *first to get their permission*. Another participant said that she would only try Reiki after she knew the *person well enough to be able to attempt it*. She added that it is necessary to [carefully] *observe these people*.

One participant said 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]. Another participant said that if the resident is highly agitated *you are actually wasting your time, in which case you might do something else…just switch to something else*.

One senior nurse said:

> [if the resident is] *willing to hold your hand or to allow you to touch them*
> [it] *is probably permission enough.*

9.1.3.8. Providing Reiki for the carers

Six of the participants (60%) spoke about providing themselves with Reiki for a variety of reasons; including lowering personal stress levels, promoting relaxation and sleep, treating headaches instead of taking analgesics, calming, in preparation for the day, and for personal healing on the physical, emotional and spiritual levels. Four of the participants (40%) reported using (and receiving) Reiki to relieve personal stress and physical ailments caused by their caring role, personal hospitalisation, or family and study pressures. One participant emphasised that:

> *if there was more recognition for Reiki's benefits then there would be a lot less use for medication, there would be a lot less stress put on the actual workers working with people, as well as the clients themselves*.

In one facility where at least 15 staff members (including the Director of Nursing, enrolled and registered nurses, Patient Care Attendants and domestic staff) have been trained in Reiki, staff members are able to Reiki each other during breaks. A participant from this facility stated that staff members will *often* provide Reiki for each other *for 5 to 10 minutes*. Following this the recipient will often wake up and feel quite refreshed. This participant added that Reiki is *quite invigorating* and can enhance the carers' *self-worth* by providing them with a tool which *allows them to have* [a] *barrier enough to be able to observe and make sure and pick up things that maybe, quite often, they wouldn't notice with their residents* while still having *empathy and compassion* for the residents.

As has been quoted above, the Director of Nursing provided Reiki individually for her staff members and collectively for all members of the staff to enable them to cope with the changes being implemented, and to *keep the environment harmonious.*

Another participant reported listening regularly to a Reiki tape because *it takes the stresses out of my job,* [and] *it certainly reduces the ailments that my nursing history has probably given me*. She also reported giving hands-on Reiki to staff members for physical and emotional problems as well using *some absent healing for some staff who have specific problems*. In addition to working with individuals she used Reiki II techniques to:

> *keep the environment harmonious, to use it on certain groups of staff members, or to use it on situations to open up and to help* [staff members] *to work through the changes that we are working with.*

Another participant reported giving Reiki to *staff members, especially cleaning staff,* although she did not expand upon this comment. One participant said that the Reiki therapist receives the same healing energy as the recipient and so the effects are peace, calmness, enjoyment and relaxation. Another commented, *I think if you give you receive,* while a third participant commented that, following a session providing Reiki for people with dementia, she feels *good about it,* [and] *good about me*.

9.1.3.9. Helping with Reiki

Nine participants (90%) used the word *help* or *helping* on a total of 31 occasions (mean, 3.4; median, 2.0) in the context of Reiki being able to *help* heal or bring relief from some ailment as well as the practitioner being able to *help* others through the use of Reiki. One participant emphasised that when:

> *we get to the point where the person is in the process of going through the last stage of their life...we use Reiki along with things like aromatherapy*

> *and massage to help that person's transition and make it easier for them and their families.*

He added that quite often their families get as much Reiki *as…the resident* [who has] *passed away*.

9.1.4. Documenting the use of Reiki

When asked directly if they document the use of Reiki, six (60%) participants replied that they did not.

However, when working *with a client outside* [her] *family*, one participant has a card on which she *record*[s] *what happens* during a Reiki session. Another participant, a volunteer in a nursing home, reported not documenting the use of Reiki but documenting the use of *foot spas and foot massage, hand massage or flower arranging*. Subsequent to the interview, this participant advised the researcher by email, that, following her interview, she reviewed her practices and began documenting her *voluntary work as Reiki*. Another volunteer reported that she is required to record the names of the people with whom she has worked and whether she has provided additional services such as hand massages.

One participant, who was employed as a Reflexologist / Masseur in two facilities, records the results of Reiki on each resident's *care plan*. Another participant who is employed as a Diversional Therapist, said that documenting the use of Reiki was *something* [she had not] *given a lot of thought to* although it was an issue she needed to start doing something about because *we need to do it for our funding, we actually do need to have some format in place where* [we] *can record it,* [and] *try and measure and evaluate* [Reiki]. She added that she did not *know how successful that is going to be* [as] *it is a difficult thing to try and quantify.*

As a Patient Care Attendant who had introduced Reiki as a facility wide therapy, one participant examined the facility's documents and found that *at the time the area of wound management had the best documentation* and adapted the form for documenting the use of Reiki. When recording the use of Reiki, the resident's individual needs are identified, the goals / expected outcomes of the therapy stated, the interventions / actions detailed and an evaluation conducted. The form is then signed and dated by the person providing Reiki. This documentation enables staff to determine *if there is another issue, a deeper issue which maybe needs to be addressed not only with Reiki but with other therapies as well*. A copy of the Reiki Assessment form is supplied in Appendix E. Subsequent to the interview, this participant in-

formed the researcher that, since the interviews, the auditors had conducted a snap inspection of his facility and commented extremely favourably about their recording methods for Reiki. He commented that he was concerned that night staff often do not maintain the records as well as could be expected.

One participant, who spoke at length about documenting the use of Reiki said:

> *I believe that* [because] *Reiki as a complementary therapy is* [used] *in conjunct with any therapeutic relationship* [it] *should be documented more widely. I think that effects of Reiki should be documented,* [and] *recorded and I believe that if there was more recognition for Reiki's benefits then there would be a lot less use for medication, there would be a lot less stress put on the actual workers working with people as well as the clients themselves.*

Another participant said that:

> *I wasn't in a position where I would particularly record everything I did. Medications were usually recorded, and it was just, because* [Reiki] *was newly introduced it was just accepted that if you wanted to go ahead and give something just a little bit extra, as a little bit of Reiki while you were giving a sponge or comforting someone, then it was ok. You didn't record it. I think it should be recorded.*

9.1.5. Staff and family attitude towards Reiki

One participant reported that staff in the facilities with which she had been involved were generally supportive as *anybody who works with the elderly or the dying I think are very, very open, in my experiences anyway*. She indicated that *some of* [her] *family members don't understand it so they choose to ignore it*. Another participant found that, initially, *anybody who doesn't know about Reiki is likely to be a little concerned* but that concern only lasts for a short time. A third participant found that [staff] *think it is fantastic* [as] *they can see the results. They want to line up and have some* [for themselves]. A fourth participant thought that:

> *Staff members…don't really know very much about* [Reiki but] *seem to know more about Therapeutic Touch…*[because]*…Therapeutic Touch has always been* [associated] *with nursing because the ladies who teach it come from a nursing perspective.*

In addition, she reported that her *family members really enjoy it* while another participant stated that staff reaction had been *good*.

The Director of Nursing of the facility where one participant worked had previously supplied the participant with a testimonial that validated *the extraordinary effectiveness of Reiki on* [our] *Residents and Staff*. In the testimonial she stated that:

> *Staff who were involved in the training sessions have expressed how Reiki has affected their perception, increased their effectiveness and ability to offer extra care to our residents whilst increasing their own self-esteem.*

The Director of Nursing reported that the benefits of Reiki included improved pain management, improved behaviour management, increased healing (including improved granulation and functioning of the lymphatic system, improved general well-being, lowered blood pressure in hypertensive patients, increased control in diabetes management, providing an overall improvement in nervous system function, increased acceptance of terminal illness, and promoted an increased spirituality. A copy of the testimonial was provided to the researcher and has been included in Appendix E.

One participant said that *some* [staff members] *are a little bit sceptic*, [and think that Reiki is] *hoodoo, whatever*…[because they expect] *flashing lights, and something to happen* [immediately. However]…*I was taught, that you don't often see* [an] *immediate effect*. Another participant reported that other staff members are *quite impressed with* [Reiki]. *They will often ask questions of how they can get training in it and they see the results and are quite interested*.

Another participant had found that *critical* colleagues were *holding back a little bit, stepping back, watching* [but] *after a while were quietened by the obvious benefits that people were experiencing*. When this happened their reaction *turned into curiosity* [and] *as the curious people became more familiar with it, more accepting,* [they] *would ask for Reiki themselves*.

Participants said that some staff members thought that Reiki was variously *comical*, *great*, *voodoo*, or *witchcraft* and that some staff members were *suspicious* while others were *very accepting* of Reiki.

9.1.6. Medication

Because of their roles, some of the participants were not in the position of being responsible for the administration of medication and therefore unable to comment professionally about the impact Reiki may, or may not, have on the need for medication. Two participants commented on the personal use of Reiki to reduce the need for medication for *headaches* and *surgery*.

One Patient Care Attendant indicated that:

> *as carers we* [have] *no involvement with medication…*[but]*…we have a system where when we are applying Reiki our facility coordinators know that it is going on and they monitor it and see what is happening, so if there is any*

> *change or any need for a change in the medication then the doctors are brought in.*

He has found that, if staff members can intervene before a resident becomes violent or extremely depressed, then the resident is given *a lot less* [medication] *and it is a lot more effective without the side effects*. He indicated that with *somebody who is an insulin dependent diabetic…the effect of the Reiki calms them down, reduces their blood pressure and in turn that changes the level of insulin they need.*

It is possible that there may be difficulty in determining whether the symptoms displayed by a resident are due to *the natural processes of dementia…their other illnesses,* [or] *a combination of drugs*. However, this participant commented that:

> *quite often an increase in medication causes a decrease in the person's balance so they tend to have a lot more falls so they give medication for one thing and it creates problems in other areas.*

One participant working as a nurse said that if Reiki had a greater level of acceptance then there would be less need for medication but did not elaborate on the use of medication in her facility.

Another participant in a position to comment professionally about the use of medication in the care of people with dementia spoke at length about the use of medication in her facility. She reported that:

> *our Pharmacist has said we have reduced medications in the last three years since I have been here. We had a lot of psychotropic drugs on board and he has actually reviewed all that for me.*

This change was attributed to a number of reasons including:

- *different clientele*..[with] *...different types of dementias, the less aggressive, volatile dementias*
- *a whole lot of different staff, who have a different view on how and where residents fit in the scheme of life* [and who respect residents for[*what they are rather than a burden*
- [a change in] *our culture to the resident being the focus.*

This participant spoke very positively about the previous staff in the facility but thought that *we were very clinically orientated, very medically orientated to the doing, rather than allowing* [staff members] *to sit back and watch people do for themselves*. She thought that *Reiki fits very well with my philosophy...*[and]..has… *given me an extension to be able to do what I really believe in. It has opened doors for me*.

In addition, she spoke at length about a resident who had a *wound which … was down to the tendon on the top of her foot and it didn't look like it was going to heal*. The doctors told the resident that *she would lose her leg*..[but that the resident was

not] *a good candidate to amputate a leg on. So* [the resident] *had a therapist come in once a week…*[to provide]*…Reiki and massage to this leg, I mean she massaged both legs but particularly the foot with the wound on it*. She added that, *over a period of months* [the wound] *granulated and healed* [although it was] *never going to be perfect but it healed to the point where we dress*[ed] *it to keep an eye on it.* The participant *saw a great change in attitude, from being a very negative person to almost turning to be acceptable*. When the Reiki stopped because the therapist had retired *we had to go back to her psychiatrist and get her reviewed for an exacerbation of her* depression following which there was a resulting increase in medication. She added:

> *it doesn't sit well to see people come in the door and be sedated or drugged.*

9.1.7. Reiki is not a panacea

None of the participants claimed that Reiki is a panacea with the potential to cure all ills. To the contrary, one participant said that there *are times when Reiki just doesn't seem to work.* Although there are times when, even if an immediate effect can not be seen, it will be noted that problem behaviours are occurring less frequently *where instead of every two days that they are losing it, it becomes a week.*

This participant acknowledged a specific problem with dementia in *that* [a] *person* [with dementia] *is losing their brain, their brain is dissolving, so you can't give energy to something that is not there, you can only work with what you have got*.

Another participant said that, *with some types of dementia* [Reiki] *doesn't seem to do very much at all* particularly if the person has advanced dementia. She added that, *the brain just doesn't seem to compute somehow, it is as if they have a short in their wiring*. Another participant reported that with a resident who was:

> *quite demented* [Reiki] *didn't have any effect, it didn't cease her anxieties and her wishes to get out of bed in the middle of the night, it didn't help her at all*.

Another participant commented that it depends on how Reiki *is received…*[and] *… if they are not open to it, it doesn't change them or their behaviour or feelings, but if they are receptive to it, it can be useful*. She commented that Reiki *is not going to stop* [the residents] *from doing something that they want to do.*

One participant commented that people who are *really agitated and hyped up* would often refuse Reiki.

9.1.8. Training and monitoring of Reiki practitioners

Off-tape one participant indicated that she had learned more from a book by Dianne Stein (Stein, 1996) than she had from her Reiki teacher and another said *it would be nice if…more training was done…and…perhaps…it…could incorporate a number of different things* [such as aromatherapy]*, so you just have a better result*. As a Reiki Master/Teacher who has trained staff in his facility, one participant indicated that:

> *in training the staff I did have to make adjustments to the way that I…treat Reiki to accommodate working in an aged care facility so I not only had to train* [staff members] *in the traditional way but* [also in] *using things like the reflexology points on people's feet so that* [the practitioners] *can cover larger areas quite quickly and that has been quite effective*.

He pointed out that it is very important to monitor how staff members are using Reiki because there are *15…different people…all trained as carers and Reiki pract i-tioners, dealing with the same people* [but who] *have different perceptions of what they are doing and how they go about it*.

Following the interviews, the researcher was advised by email that the other Reiki Master/Teacher involved in the interviews had commenced teaching Reiki at the request of the facility where she worked as a volunteer.

9.1.9. Other issues

One participant reported that, among other things, she has become ***more centred*** within herself since learning Reiki.

As noted above, another participant commented on the **guilt** families often feel *about putting their family in places like* [nursing homes]. When asked if he had trained residents to perform Reiki on themselves he said,

> *No,* [where I work] *is* [a] *high care facility so the ability of the residents to actually be able to apply the energy themselves is very, very limited simply because of not only mental conditions but physical conditions as well, and the residents that are capable of it don't want that because then they lose the one on one* [contact with other people] *and that is very, very important*.

Four participants (40%) used the word **heal** on a total of 37 occasions (mean, 9.3; median, 9.0) and the Director of Nursing who supplied the testimonial discussed above (see also Appendix E), listed *improved granulation* and *improved function of the lymphatic system* under the general heading of *healing*. One participant spoke about *healing touch* and *healing* a person's '*dis-ease*' (which was, to her, the root of '*disease*'). She said *I am not trying to heal somebody's dementia; I am trying to i m-prove their quality of life*. Another participant spoke of Reiki as a *healing* energy, but believed that he could not call himself a *healer* as he is *only channelling the en-*

ergy. He added that, *whether you call it cure or whether you call it heal, it doesn't matter; the end result is that person has benefited from that process*. Two other participants spoke of Reiki as a *healing energy*. Various participants spoke about using Reiki for *self-healing* on a *physical*, *emotional*, and/or *spiritual* level. One participant spoke about the use of Reiki to assist with wound healing. Two participants spoke about the practitioner receiving the same healing energy as the recipient.

One participant spoke of a **close connection** that can develop between the Reiki practitioner and the resident when he commented that:

> *there are quite often situations where* [we] *wouldn't notice that a resident is anxious until they really start to get into the higher scale but when* [we] *are doing Reiki on them* [we] *are actually there, talking with them, and* [we] *tend to pick up other things, and so we pass that onto our superiors and try to take some sort of affirmative action if* [we] *can.*

This notion of being *actually there* with a client was supported by another participant who reported that Reiki enabled her to *focus…on the client and not on my children or whatever has happened to me during the day*. She added that the ability to focus on the client provided *clarity about what…the client needs at that time*. A third reported that she enjoys *the close interaction* [Reiki] *allows me to have with other people* and added that Reiki had enabled her relationship with her husband to become closer.

One participant, who had had 10 years of reconstructive surgery following a severe car accident, reported an initial **adverse reaction** when first receiving Reiki. She reported that she *was actually experiencing that* [she] *was trapped in the car from when* [she] *was in a car accident*, however, as reported above, following the Reiki session she felt as if *a huge weight had* [been] *lifted off* [her] *shoulders…and head and everything*.

Four participants (40%) used the word ***amazing*** on a total of seven occasions (mean, 1.8; median, 1.5) when describing Reiki and its effects. One participant said Reiki *brings amazing clarity*, while another described Reiki as an *amazing gift.* A third participant said that Reiki is *an amazing tool that does amazing things*, and the fourth considered it *amazing* that she can use Reiki for *relaxation*.

Three participants (30%) used the word ***relief*** (or a derivative) on a total of nine occasions (mean, 3.0; median, 3.0). One reported that, by using Reiki, she was able to provide *great relief* for a 27 kg woman who was extremely deformed because of arthritis and whose *body wouldn't have been any longer than the width of this* [the

participant's dining room table] *table*. The other two participants reported that Reiki could give relief from pain.

One participant spoke of a ***cleansing*** period which can be experienced after being attuned to Reiki. She said that this cleansing could be experienced *in different ways*, such as *an emotional release or…ailments…or headaches* which the individual may have experienced in the past and which *may come back* as the *body comes* [into] *balance while the new Reiki practitioner is getting used to the new energy*. For this respondent, publishing a collection of poems written during her reconstructive surgery and raising money for the Cranio Facial Foundation, assisted her emotional release.

A '***domino***' effect was reported by two (20%) participants. As has been noted above, one respondent reported the flow-on effect within a resident and said that *Reiki calms them down, reduces their blood pressure and in turn that changes the level of insulin they need*. He reported a domino effect occurring between residents where the calming effect of Reiki on one resident will produce a *rippling* or *flow-on effect* …[and create] *one of those nice circles we like to see, not one of those vicious circles*. This effect was supported by another participant who reported that Reiki *makes a more tranquil setting and* [then we] *have the other residents reacting to what their behaviour is so overall everybody is calmer*. She added that this domino effect *makes it easier and…saves time* [because we] *don't have to talk them around or persist with them; they are more receptive to what needs to be done*.

One participant described Reiki as *a **reservoir**, an endless reservoir or energy that we are able to access* and described the Reiki practitioner as *a vehicle for giving it to someone by enabling ourselves to open up to* [the energy]. The clients then become *the receivers of this energy*.

Other comments made by individual participants included

- ☆ *the more we give the Reiki the more **experienced** we become…the…easier* [Reiki] *starts to come through*
- ☆ *people can be … totally **unaware** that you are Reiking them* [but they] *still benefit from it, especially if they have dementia or brain injuries*
- ☆ *Reiki is about treating people as people, as **individuals**, and* [with a] *holistic view, you are not just treating a clinical wound, you are treating the whole person*. This participant added that *we have changed our culture to the resident being the focus* and:

> *I…have* [a] *very, very strong belief that every time we interact with residents it is in their space, in their time, not in ours. It is about improving their lives… they might come to us with a multitude of problems, with their dementias…but if we can slow those processes and give them something better to hang onto, then I am all for it.*

One respondent made an interesting comment about an aspect of Aromatherapy when she said:

> *Our kitchen is in the centre of our nursing home and whilst our cook would like to move it to the back I have a great belief that having it in the centre is homely. We always probably in our life, sat at the kitchen table and smelt the smells of home, and always associate it with food, and I think that is an opening for discussion, it opens up people's tastebuds, it opens up their willingness to partake in things.*

She felt that to *take away that smell of normal life…*[can] *make* [life] *very sterile…*[and] *very empty*.

Earlier she had commented that when she arrived in the home approximately three years earlier that *there was something with the residents and I couldn' t put my finger on what it was.* When she spoke with the Diversional Therapist about her feelings, the therapist *pointed to the lounge and said, 'Go and have a look'*. The respondent then:

> *realised [that the residents] were all sitting like stunned mullets…they were expressionless, there was nothing in their lives, they were just sitting. Although we have got a wonderful view they were just sitting, and there didn't seem to be any interest or any focus on anything at all, they didn't seem to be enjoying what they were doing which was doing nothing.*

She further thought *that there was definitely a big hole here* and wondered what the residents *were missing out on.*

9.1.10. What sets Reiki apart from other complementary healing modalities?

In response to the direct question as to what sets Reiki apart from other complementary healing modalities no common explanation emerged from the interviews. The participants variously identified the *symbols, training,* and the *non-invasive, gentle, portable,* and *hands-on* nature of the Reiki therapy. In addition, participants commented that Reiki can be *received how a person wants to take it,* that there are *no after effects,* and can be used *any time,* and is *like a surge of power.*

Two participants commented on the *non-invasive* nature of Reiki while another two commented on Reiki being a *hands-on* therapy.

10. Discussion

10.1. Introduction

Initially it had been intended to analyse the findings from the questionnaires and interviews separately. However, it was soon evident that there was considerable repetition. Therefore this discussion will analyse the responses from both the questionnaires mailed to South Australian High Care Residential facilities and the interviews with Reiki practitioners working in dementia care.

Unfortunately, the discrepancy in numbers between the analysed responses to the questionnaires (n=81) and the Reiki practitioners interviewed (n=10), precludes the compilation of any statistically meaningful correlations between the various results. In addition, it is doubtful that a valid comparison can be made between the responses of the two groups when the Reiki practitioners were asked direct questions about issues that were not specifically posed in the questionnaires distributed to nursing homes.

Having recognised these difficulties, an attempt will be made to compare and contrast the information gained from these two sources as appropriate.

10.2. The respondents

Because of their respective roles within the facilities, eight of the ten Reiki practitioners interviewed (80%) were more likely to be working on a one-to-one basis with people with dementia than were the majority of the people who responded to the questionnaires. Of these eight, three were Patient Care Attendants. Two of the interview participants, the Director of Nursing and the Diversional Therapist, were more likely to be working with groups of people within their facilities.

Fifty-five Directors of Nursing (67.9% of the respondents to the questionnaires – n=81, 35 alone and 20 in conjunction with other staff) and 15 Diversional Therapists (18.5%, n=81) were involved in formulating responses to the questionnaires. However, no Patient Care Attendants were involved (Section 3.5.17) yet Patient Care Attendants formed 67.9% of the people reportedly providing complementary therapies (Figure 3.3).

Therefore, it could be argued that, as 'hands-on' carers, the majority of Reiki practitioners interviewed may have very different concerns than the majority of respondents to the questionnaires and that any perceived effects of complementary therapies will vary accordingly. In addition, it could be hypothesised that the carers

of people with dementia will choose complementary therapies which suit their personal philosophies, needs and working conditions.

10.3. Agitated behaviours which cause concern

A higher percentage of Reiki practitioners rated *attention seeking, intrusiveness, resistance,* and *sexual behaviour* as causing concern than did the respondents to the questionnaires. Approximately the same percentage in both groups expressed concern about *physical and verbal aggression,* and *wandering*. Issues relating to *absconding* and *moving furniture* appear not to be of major concern to either group. The greatest difference between the two groups occurred with *attention* seeking, with 80% of the Reiki practitioners and 2.6 % of the questionnaire respondents listing it as a problem. As discussed in Section 10.2, these discrepancies could possibly be attributed to the participants' differing roles within the facilities.

The responses from Reiki practitioners and nursing homes regarding selected aggressive or non-aggressive behaviours which caused concern have been combined in Figure 10.1.

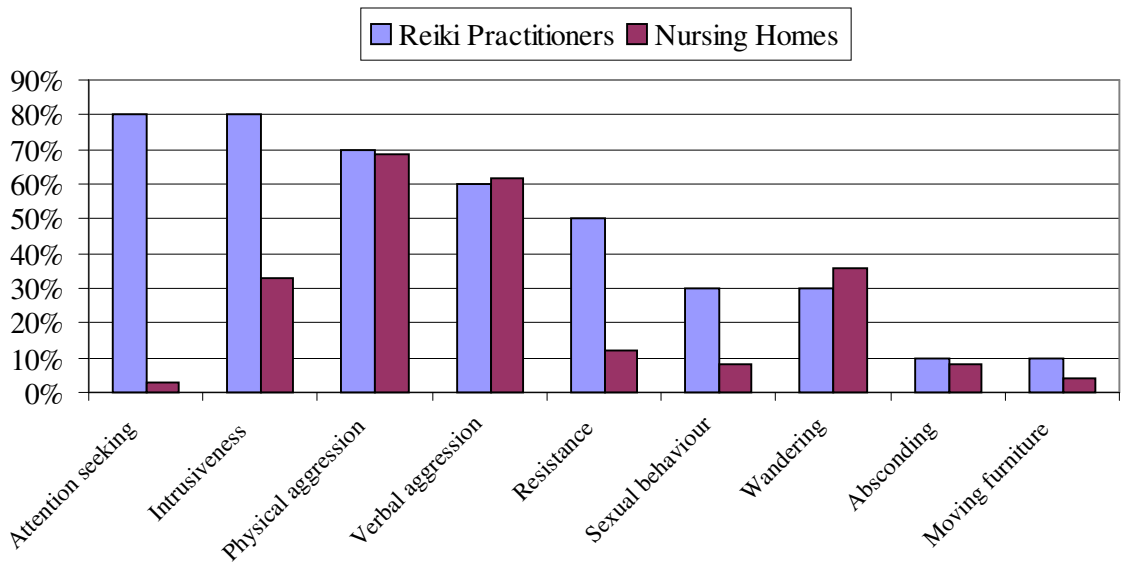


Figure 10.1: Comparison of aggressive or non-aggressive behaviours which caused concern for Reiki practitioners (Table 8.3) and nursing homes (Figure 3.4)

As can be seen from Figure 10.1 both groups rated *physical aggression* high on the lists of behaviours which cause concern. This aggression can include biting, grabbing, hitting, kicking, pinching, punching, spitting, and throwing food. It may be aimed at other residents and/or staff and may constitute a danger to self or others. Residents may demonstrate aggressive physical behaviour several times an hour

even if physically restrained, unable to walk, or unable to manoeuvre their wheelchair (Cohen-Mansfield 1999, pp. 47-48). Therefore, it can be argued that simply restraining residents through physical or chemical means will not enhance the quality of life of the people concerned.

If Reiki is able to alleviate the display of physical and/or verbal aggression, then it has the potential to improve staff morale, free staff time which would have been diverted from other tasks, and reduce staff absences and medical expenses which may have resulted from the bruises, cuts, scratches, and/or sprains which staff members reportedly sustain when forced to cope with agitated residents.

It would appear that many of these behaviours reach levels beyond what could be considered as part of the normal fluctuations in daily life. As such, they have the potential to threaten the safety and quality of life of the individuals, their carers and their family members. If Reiki is able to reduce the incidences of aggressive and non-aggressive agitated behaviours it will, in turn, improve the quality of life for residents, their family members, and staff members.

10.4. Complementary therapies

10.4.1. Perceived benefits of complementary therapies

A higher percentage of Reiki practitioners listed *1:1 interaction,* improved *quality of life,* and improved *behaviour management* as outcomes of complementary therapies than did the respondents to the questionnaires. As with the perceptions regarding agitated behaviours, these discrepancies could possibly be attributed to the participants' differing roles within the facilities. It could be proposed that people with 'hands-on' roles are possibly more likely to be interested in the 1:1 interaction aspect of complementary therapies than are those with responsibilities for groups of clients.

The responses from Reiki practitioners and nursing homes regarding the benefits of using complementary therapies have been combined in Figure 10.2.

As can be seen from Figure 10.2 both groups rated the *calming* effects of complementary therapies high on their list of benefits with 100% of the Reiki practitioners and 61.8% of the respondents to the questionnaires commenting on the calming effect of Reiki. If Reiki is able to promote calming in the residents, then it has the potential to reduce negative behaviours and hence reduce carer burden, promote staff and resident safety, reduce corresponding negative effects on other residents, reduce stress, reduce the time needed to respond to negative behaviours, reduce

wandering, reduce resident resistance, and reduce expenses related to staff absence, WorkCover and Occupational Health and Safety compliance.

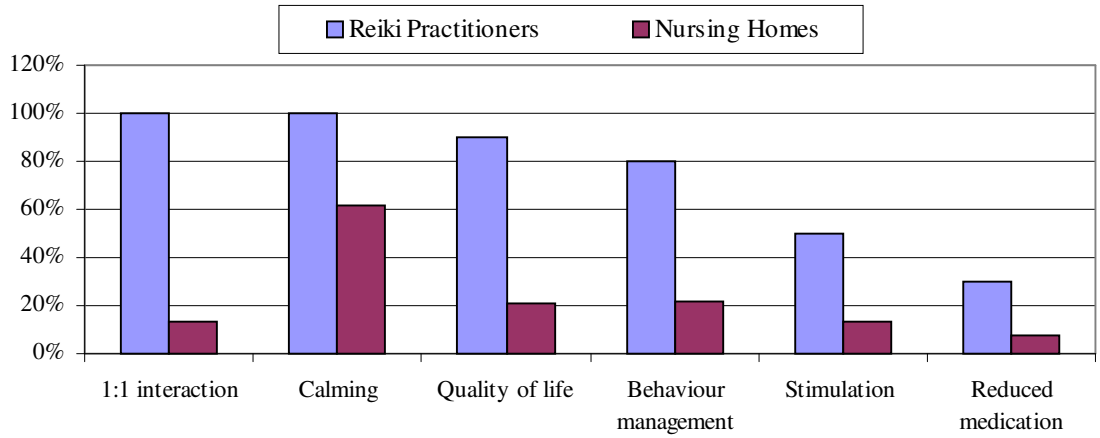


Figure 10.2: Comparison of benefits of using complementary therapies as expressed by Reiki practitioners (Table 8.4) and nursing homes (Figure 3.2)

The carers with the closest day-to-day contact with the residents often have to perform tasks which may embarrass or bring discomfort to the residents. They also have to work within tight time frames imposed by staffing numbers and management requirements. 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, and, as noted above, "Rushed, task-orientated behaviour by the caregiver" can result in agitated behaviour in the person with dementia (Kovach & Meyer-Arnold 1997, p. 114). Therefore, it could be suggested that, as a therapy which can be used *anywhere, anytime,* and *with other activities*, Reiki touch has the potential to be an extremely valuable therapeutic tool in the repertoire of professional and volunteer carers.

If the use of Reiki can reduce the incidences of agitated behaviours, it has the potential to reduce the time required to perform the necessary, routine daily tasks and free both the residents and the carers to be involved in more pleasant and rewarding activities.

10.4.2. Subsidiary benefits of complementary therapies

It could be expected that any therapy used in the management of dementia will need to provide direct positive outcomes for the individual with dementia and improve their quality of life. In addition, it could be argued that, if the therapy reduces prob-

lem behaviours then there will be a subsequent reduction in the work-load of the carers thus reducing stress and 'creating' time for more quality 1:1 interaction with residents.

Conversely it could be argued that, simply removing the adverse safety effects of problem behaviours by the use of physical and/or chemical restraints, will not improve the quality of life of the individual being restrained.

From the comments made by respondents to the questionnaire it would appear that, in addition to reducing inappropriate behaviours, complementary therapies can: calm, reduce anxiety, give residents a feeling of being valued, improve self-esteem, promote restful sleep, reduce reliance on medication, provide an outlet for grieving, and/or relieve staff stress. The notion that complementary therapies can provide subsidiary benefits for carers is supported by the findings of Rowe and Alfred (1999) and Chitsey et al. (2002).

10.4.3. Possible hazards in the uses of complementary therapies

An amateur carer who wishes to use some form of complementary therapy may make a choice simply because the proposed therapy looks good, smells pleasant, feels nice, is easy on the ear and/or has been recommended by a friend. However the professional carer will need to use a carefully reasoned and scientific approach to the selection of an appropriate therapy for the individual as well as those associated with the client.

Although a wide range of complementary therapies is used in the management of dementia in at least 50% of South Australian High Care Residential Facilities, eleven of those facilities (13.6%, n=81) preclude particular (unspecified) complementary therapies because of lack of staff training; four (4.9%, n=81) because of difficulty in attracting specialist staff or volunteers; and two (2.5%, n=81) because of doubts about their efficacy. Therefore, it is necessary to consider possible hazards inherent in some of the complementary therapies reportedly used in the care of people with dementia.

10.4.3.1. Aromatherapy

Aromatherapy in the form of vaporising and/or massage is the most frequently used complementary therapy reported by respondents. However, if the oils used in Aromatherapy are not selected carefully, there is the potential for harm to the recipient. It is crucial that only 'pure essential oils' be used as products labelled as 'aromatic'

or 'fragrant' may contain toxic chemicals (South Australian Health Education Centre [SAHEC], 1997). Even if pure essential oils are used, it is still necessary to ensure that the oil selected is appropriate for the individual – for instance: Rosemary (*Rosemarinus officinalis*) is contraindicated for persons who are epileptic (Lawless, 1992), or have high blood pressure (SAHEC, 1997); cypress (*Cupressus sempervirens*) is contraindicated for persons who have high blood pressure (SAHEC, 1997); and bergamot (*Citrus bergamia*) is photosensitising, in concentration and over time, and should not be applied when the individual will be exposed to sunlight (Lawless, 1992; SAHEC, 1997). If the oils are vaporised, there is the possibility of the effect being spread throughout the facility via the air-conditioning and, therefore, an allergic person a distance away from the source of the vapour could possibly be affected adversely. Conversely, a drop of lavender (*Lavandula angustifolia* - Lawless, 1992) on the pillow of an individual resident (Hudson, 1996) will probably affect only the individual.

10.4.3.2. Massage

With massage it is essential that the practitioner working with clients who have special physiologic and/or neurologic needs, be trained in the correct procedures required in order to avoid possible injury to the client (Webber & Yeoman, 2000). Although the issue of special training was not canvassed through the questionnaire, the researcher was aware from private conversations that some nursing homes do provide special training for people providing massage in their establishments.

As part of the Nationally Recognised *Certificate IV in Massage*, students from the South Australian Health Education Centre (SAHEC) who have completed a massage modality may elect to study a unit called *Massage from Birth to Elderly* which incorporates issues relating to physical disability, spinal injury, aged care and palliative care. A planned component relating to intellectual disabilities did not eventuate due to lack of numbers (SAHEC, 2005).

In addition, massage may be contraindicated if the resident is highly agitated (Rowe & Alfred, 1999).

10.4.3.3. Touch

The perceived experience of touch therapy is individualistic and may be gender based (Routasalo, 1991; Snyder et al., 1995). Therefore the implementation of any touch therapy (massage, Healing Touch, Reiki, reflexology, Chiropractic etc) will

need to be carefully monitored to ensure that adverse reactions do not occur in individual residents or that carers do not unintentionally communicate a personal bias against touch.

10.4.3.4. Music

As with touch, if used without reference to the needs of the individual, music therapy whether voice, instrumental or recorded, may produce adverse reactions such as agitation. The suggestion that response to music is based on individual perceptions (Kramer, 2001) is supported by the reports of two questionnaire respondents about individual preferences for Beatles, rock-n-roll or WWII music in their facilities.

10.4.3.5. Prayer

Although prayer is the fifth most frequently used complementary therapy in South Australian High Care Residential Facilities (50, 61.7%, n=81) and no reference to possible contraindications was found in the literature survey nor in the responses to the questionnaire, it could be possible that individual reactions to prayer may vary according to the person's religious background, particularly if their long-term memory is intact.

10.4.3.6. Other therapies

There may be a degree of risk associated with the implementation of other complementary therapies such as: *cooking* – the possibility of burns or scalding; *gardening* – the possibility of injury from the use of tools or spiky plants; *pet therapy* – the possibility of bites, scratches and allergic reactions; and *hot towels* – the possibility of burns or scalding.

10.4.4. The range of complementary therapies used by carers

The rich variety of therapies being used in dementia care is emphasised by the fact that, the nursing homes and Reiki practitioners combined, listed a total of 36 individual complementary therapies being used in South Australian High Care Residential Facilities.

From a list of 17 therapies supplied by the researcher (Appendix A), the questionnaire respondents indicated that all 17 listed therapies were being used in their facilities and added another 16 therapies. The Reiki practitioners reported using a total of 12 of the listed therapies and added a further three therapies. The responses from Reiki practitioners and nursing homes have been combined in Table 10.1.

Table 10.1: Comparison of complementary therapies used by Reiki practitioners and nursing home staff		
Therapy	**Reiki Practitioners (n=10)Table 8.2**	**Nursing Homes (n=81)Table 3.2**
Reiki	100%	18.5%
Music (recorded)	70%	71.5%
Massage	70%	70.4%
Aromatherapy (vaporising)	60%	88.9%
Aromatherapy (massage)	50%	79.0%
Prayer	50%	61.7%
Reflexology	50%	7.4%
Music (voice)	40%	46.9%
Meditation	40%	7.4%
Music (instrumental)	30%	60.5%
Behaviour Therapy	20%	38.3%
Healing Touch	20%	21.0%
Therapeutic Touch (Krieger/Kunz method)	20%	16.0%
Tai Chi	10%	7.1%
Awareness of the environment	10%	0.0%
Spiritual Healing	10%	0.0%
Relaxation	10%	0/0%
Light Therapy	0%	13.6%
Reminiscence Therapy	0%	7.3%
Pet Therapy	0%	6.5%
Snoezelen	0%	6.5%
1:1 activities	0%	3.7%
Cooking	0%	3.7%
Validation Therapy	0%	3.7%
Chiropractic	0%	2.5%
Doll Therapy	0%	2.5%
Gardening	0%	2.5%
Red Cross (hand & nails)	0%	2.5%
Church Services	0%	1.2%
Craft	0%	1.2%
Hair Dresser	0%	1.2%
Hot Towel	0%	1.2%
Laughter	0%	1.2%
Multi-sensory	0%	1.2%
ThreePhase Therapy	0%	1.2%
Visits (outings)	0%	1.2%

From Table 10.1, it can be seen that more respondents to the questionnaires reported using *aromatherapy vaporising, prayer, instrumental music,* and *light therapy* than did the Reiki practitioners. It could be reasoned that these therapies have value as group activities as well as individual activities and therefore might possible be utilised to a greater extent as cost saving activities.

Almost as an aside, two participants in the interviews reminded us that seemingly ordinary things like the smell of a *kitchen*, *Deep Heat*, or *horse liniment* can have therapeutic befits. One participant suggested that the smell of a preparation that resembles the smell of *Deep Heat* or horse liniment can remind certain people with dementia of the happy times associated with *playing footy*. Another participant pointed out that the smells from the facility's kitchen can remind residents of *home, food*, and *normal life*. Thus aromatherapy does not necessarily have to be limited to the use of expensive essential oils.

10.4.5. Awareness of the environment

Although only one interview participant referred directly to *awareness of the environment* as a complementary therapy, the ambience of the environment may be important when trying to determine the efficacy (or otherwise) of Reiki. One of the interview participants spoke directly about the need for the practitioner to be comfortable, as did Kruger (2003). While there may be a need for the practitioner to be comfortable, this may also be an issue for the client. The recipient's reaction to Reiki may vary considerably depending on the location which might include such diverse settings as a day (or common) room, the recipient's bedroom, a massage room, or the bathroom.

Issues relating to the environment can have both practical and emotional, or psychological, aspects. Three interview participants had spoken about *clearing the room of negative energy* and *filling it with Reiki* and *good intentions of peace and calm, love and goodwill* thus *changing the energy to one that is even more relaxing*. In addition, environmental issues were of special concern to four of the questionnaire respondents who reported that physically aggressive residents could cause damage to walls, carpets, furniture and others' personal belongings. These issues were supported by a search of the Alzheimer's Australia web site (2005) which revealed the Alzheimer's Association had 16 'Help Sheets' dealing with practical issues relating to the "environment and dementia". Some of the issues addressed in the 'Help Sheets' related to items such as:

- ☆ Creating a calming environment by eliminating confusing patterns on carpets and furniture, disorienting shadows and glare, and agitating loud noises.
- ☆ Respecting the individual's privacy.
- ☆ Making bathing relaxing and enjoyable.
- ☆ Creating a physically safe environment by removing loose floor coverings, covering slippery floors, removing clutter and hazardous substances, turning appliances off at the wall and removing electrical leads, installing grab rails, and smoothing or covering sharp corners.
- ☆ Installing door signs with words and symbols or pictures, installing arrows pointing to the toilet, and leaving appropriate lights on.

While it is important to have a pleasant and safe physical environment the comment from one interview participant that *Although we have got a wonderful view* [the residents] *were just sitting, and there didn't seem to be any interest or any focus on anything at all* reminds us that this, by itself, is not enough.

As reported by a number of the respondents to the questionnaire, the type of music, if any, playing in the background may affect the individual. It should be noted here that 70% of the interview participants reported using some form of music therapy in addition to Reiki. Olson and Hanson (1997) recognised that it was difficult to interpret their results because, among other things, music was played during the Reiki sessions which were conducted in a soundproof room.

Because the majority of the Reiki interviews (70%) were not conducted in the practitioner's work environment, the researcher was unable to make any observations as to the ambience of the eight facilities represented by the interviews. Therefore, it is possible that the ambience of the environment could vary considerably.

10.4.6. The Reiki practitioners and complementary therapies

The interview participants did not claim to use Reiki as a 'stand-alone' therapy or as a substitute for 'normal' medical procedures. They viewed Reiki as only one of a number of tools which they could use to support their work with people with dementia. Even the one participant, who did not claim to use any complementary therapies besides Reiki, had learnt Reiki to complement other activities such as *taking residents to the hairdresser* or *for walks*. These activities may be considered as part of the 'normal routine' within the residential facility and therefore may not viewed as therapies by the majority of respondents.

The willingness of the participants to use Reiki to complement other therapies and recognise that there may be times when Reiki will not work reflects the call by Reiki practitioners such as Barnett and Chambers (1996), Ellyard (2002), Rowland (1998) and Webber (1998) for Reiki to be used as a complementary therapy. However, this will make it difficult to isolate the effect of Reiki from the effect of other therapies in any future research into the use of Reiki with people who have dementia.

10.5. Time management

Considerations of time factors in the management of dementia and the use of complementary therapies can be contradictory. Eleven respondents to the questionnaires (13.6%, n=81) reported the preclusion of certain (unspecified) complementary therapies due to the time necessary to implement them. However others reported the use of complementary therapies because of the time that can be spent with individual residents.

The time required for the implementation of a given therapy will vary considerably according to a number of factors:

- ☆ A slow stroke massage (Rowe & Alfred, 1999) may require more carer time than a hand massage (Snyder et al., 1995). A hand massage or other comfort touch therapy (Butts, 2001) could be provided in as little as five minutes.
- ☆ Glider swing therapy (Snyder et al., 2001) and Tai Chi (Chen et al., 2001) may necessitate the relocation of the participant for the therapy thus adding to the time factor.
- ☆ As it does not require any special equipment, a simple hand massage or similar form of touch therapy (including the slow stroke massage described by Rowe and Alfred (1999) can be provided immediately and in any location thus saving time for the carer.
- ☆ It is possible that some forms of therapy can be combined thus saving time and conceivably enhancing positive outcomes. Simple touch therapy could be used while reminiscing with the resident, for example. Likewise validation, reminiscing and/or touch therapy could be used to divert a resident's attention during, possible unpleasant, routine procedures.

As problem behaviours displayed by one resident may disturb, disrupt and/or agitate others thus setting off other behaviours, any complementary therapy that defuses these behaviours may save the time that would have been necessary to calm the

other residents. In addition, if the therapy diverts the attention of the individual before the developing behaviour can become a problem (Giuliano, 1996), it may reduce significantly the time needed to manage the situation and free staff for other duties and more positive interactions with residents.

10.5.1. Time management and the flexibility of Reiki

Spending 'quality' time with residents was important to the interview participants. However, issues relating to time management, particularly with employed staff, appear to be significant. Lack of staff and having insufficient time to provide 'full' Reiki treatments have meant that the practitioners had to change how they use Reiki, change the length of time spent on a treatment, or incorporate Reiki into other activities.

This apparent flexibility supports the assertions made by Ellyard (2002); Honervogt (1998); Petter (1997) and Smillie (1998) that some Reiki practitioners will elect to combine Reiki with other therapies. It is a reflection on the assertion that it is natural that the practice of Reiki has, and will, evolve over time (Petter, 1997 & 1998; Rowland, 1998).

The ability to adapt the use of Reiki to suit both the individual's needs and the setting for the treatment could explain why Reiki is reportedly being used in operating theatres, hospital wards, dentist's surgeries, ambulances (Barnett & Chambers, 1996; Tattam, 1994; Wirth et al., 1993; Young, 1998), and dementia care. Since completing the interviews, the researcher has become aware that Reiki is being offered as a complementary therapy in some of the wards and operating theatres, and is being taught in the Staff Training Department, of the Royal Adelaide Hospital (Dashorst, 2005; Dashorst & Ammann, 2005).

In residential facilities catering for a large number of people with differing needs it may be necessary for Reiki practitioners to heed the idea expressed by Ellyard (2002) that a little Reiki often is better than a lot of Reiki infrequently. If used in this fashion before problems emerge, Reiki may indeed save time as the reported 'domino effect' either eases the distress of other residents or prevents other incidents of agitated behaviour from occurring.

10.5.2. Timing of the therapy

It is possible that the timeliness of a therapy may affect the efficacy of the therapy. As one questionnaire respondent commented, *the time* [that] *the medication is given*

affects effectiveness. This is supported by the interview participant who variously commented that: it is necessary to try to pre-empt a situation and use Reiki in the early stages *before* [residents get] *wound up*; *once* [the residents] *are wound up you are battling uphill*; and if the resident is highly agitated *you are actually wasting your time, in which case you might do something else…just switch to something else*.

However, if applied at the correct time the therapy may *divert* [the resident's] *attention and provide relaxation*, which, in turn, may result in residents being given *a lot less* [medication which then may be] *a lot more effective without the side effects*.

The suggestion that the timeliness of a therapy may be important is supported by the work of Rowe and Alfred (1999) who found (as quoted above) that the provision of massage was contraindicated when the recipient was "agitated to the point of aggression" (p. 33). Snyder et al. (2001) specifically provided glider swing sessions in the afternoon when agitated behaviours tend to be highest and Hudson (1996) found that placing lavender essential oil on subjects' pillows at night not only improved sleep quality in 84% of subjects but increased daytime alertness in 70% of subjects.

In addition, it is possible that timely adjustment of "normal" routine if a person is agitated may assist to avert troubled behaviours. As one respondent to the questionnaires commented, *it is hard but happening with education that it is not a sin if someone doesn't have a shower occasionally* This is a proposition endorsed by Kovach and Meyer-Arnold (1997).

These findings would tend to indicate that if staff members are not generally trained in complementary therapies, trained staff are off duty, and/or the facility has to rely on visiting specialists then the complementary therapies may not be available when required to ensure the maximum efficacy.

It may be necessary to implement the therapy as soon as possible because of the reported 'delay' in observable effects of Reiki discussed by Miles and True (2003) which is supported by one interview participant who was taught that *you don't often see* [an] *immediate effect* with Reiki.

10.6. Staffing, physical and financial resources

It has been found that carer attitude plays a significant role in the effective implementation of complementary therapies (Downie, 1994; Tuohy, 1994; Snyder et al., 1995; Giuliano, 1996; Hyde, 1996; Martinez, 1996; Kovach and Meyer-Arnold, 1997; Normann et al., 1998; Geriaction, 2001b; Geriaction, 2001c).

In South Australian High Care Residential Facilities a wide range of internal staff, volunteers, family, friends, and visiting specialists provide complementary therapies. Naturally these individuals will have differing training, knowledge, skills, experiences, duties, time commitments, and personal philosophies regarding the use of complementary therapies in the management of dementia. Therefore, it is not surprising that, when respondents to the questionnaires provided information about the preclusion of complementary therapies, lack of staff training was cited as a major concern (11, 73.3%, n=15).

Respondents to the questionnaire reported that problem behaviours displayed by people with dementia play a major role in staff stress and contribute significantly to the possibility of physical harm to carers. Staff may feel *guilty at* [the] *lack of attention for the not-so-demanding resident*. Therefore, if the complementary therapy brings about a reduction in the frequency of stressful events, the carers benefit (Rowe & Alfred, 1999) because of a corresponding "improvement in staff morale and patient and staff relationships" (Chitsey et al., p. 47).

10.6.1. Reiki and staffing

Because by Directors of Nursing, Nurses, Patient Care Attendants, other therapists, volunteers, and family members can apparently use Reiki effectively for different reasons, it is not necessary for residential facilities to employ additional staff to provide Reiki. In addition, there may be a reduction in costs related to issues such as staff stress and time management if residential facilities encouraged the training of their staff members in the use of Reiki.

If, as reported by the practitioners, the use of Reiki needs no special equipment and can be performed anywhere at anytime, this may provide a cost benefit to the residential facilities.

10.6.2. Physical and financial resources

Complementary therapies will vary considerably in their requirement for physical resources, initial capital input, and on-going funding. Examples could include the requirement for:

- **physical resources**: Snoezelen (and other multi-sensory therapies), hydrotherapy, instrumental and recorded music, any form of massage which requires a massage table, and storage facilities for medication

- ☆ **initial capital input to provide the therapy**: Snoezelen (and other multi-sensory therapies), hydrotherapy, changes to the physical environment, carer education, instrumental and recorded music, any form of massage which requires a massage table, and storage facilities for medication
- ☆ **on-going funding for maintenance and/or the purchase of expendables**: hydrotherapy, carer continuing education, instrumental and recorded music, aromatherapy, dietary supplements, and medication.

In South Australian High Care Residential Facilities funding for complementary therapies is provided by: the facility's budget, Medicare and private health funds, fundraising, staff personal expenditure, and/or donations. Therefore, it is not surprising that some complementary therapies are precluded because of financial constraints.

Twenty-two of the facilities that responded to the questionnaires (27.2%, n=81) reported using visiting specialists for the provision of complementary therapies. The need to use visiting specialists would, undoubtedly, place an additional financial burden on either the facility's budget and/or the individual resident's f inances.

10.7. Medication

10.7.1. Temazepam and oxazepam

The use of medication, like any other therapy, may carry its own drawbacks.

As can be seen from the results of the questionnaire, temazepam and oxazepam are the two most commonly used medications for people with dementia in South Australian High Care Residential Facilities. Temazepam, which is formed as an intermediate in the metabolism of diazepam to oxazepam, is listed as a sedative/hypnotic and indicated as an adjunctive, ***short-term***, therapy for the management of insomnia in adults. Oxazepam is listed as an anxiety agent and indicated for the ***short-term*** relief of the symptoms of anxiety (MediMedia, 2002 – emphasis added).

Unfortunately MIMS 2002 did not provide a detailed, tabulated list of reported side effects for temazepam and oxazepam as MIMS 2001 did for alprazolam, which is also a member of the benzodiazepine family of drugs, and sertraline hydrochloride. Therefore the following information has been adapted from MIMS 2002:

- ☆ The exact mechanism of benzodiazepine action has not yet been elucidated.
- ☆ Contraindications include known hypersensitivity to benzodiazepines; chronic obstructive airways disease with incipient respiratory failure; as sole therapy in

psychosis including primary depressive disorders (temazepam); and sleep apnoea (oxazepam).

- ☆ Abilities may be impaired on the day following use.
- ☆ There may be abnormalities in blood counts, hepatic and renal functions.
- ☆ Because of atropine-like side effects, caution should be exercised in the treatment of people with acute narrow angle glaucoma.
- ☆ Temazepam can produce **paradoxical reactions** of acute rage, stimulation or excitement.
- ☆ When temazepam is prescribed for the elderly, the dose "should be limited to the smallest effective amount to preclude possible ataxia, giddiness or oversedation which could increase the possibility of accidental falls" (MediMedia, 2002, p. 3-247).
- ☆ High dosages of oxazepam may cause an increase in testicular interstitial tumours, thyroid cystadenomas and/or prostatic adenomas.
- ☆ Continued use may lead to dependence.

In addition to the information summarised above, possible adverse reactions common to temazepam, and benzodiazepines generally, are detailed in Table 10.2 and reported adverse reactions to oxazepam are detailed in Table 10.3.

Table 10.2: Reported adverse reactions to temazepam

biochemical abnormalities (elevated serum alkaline phosphates, AST, BUN, bilirubin, proteinuria, neutrophil leucocytosis)	blurred vision	breathlessness
confusion	depression	disorientation
dizziness	dry mouth	dyspepsia
faintness	gastrointestinal upset	hallucinations
headache	hyperexcitability	increased anxiety
insomnia	irritability	leg cramps
loss of taste	macular rash	muscle spasticity
muzziness	nausea	palpitation
pruritus	sciatica	sleep disturbances
tachycardia	tremor	vertigo
vivid dreams	vomiting	weakness

Adapted from MIMS Annual, 2002

Table 10.3: Reported adverse reactions to oxazepam		
aggression	altered libido	ataxia
fever	hypersensitivity	hypotension
jaundice	lethargy	leucopenia
mild drowsiness	oedema	paraesthesia
skin rashes (morbilliform, urticarial and maculopapular)	slurred speech	syncope
unpleasant dreams		
Adapted from MIMS Annual, 2002		

10.7.2. Benzodiazepine

As both temazepam and oxazepam are derivatives of benzodiazepine it is informative to consider the following information which has been adapted from MediMedia (2002):

- ☆ Benzodiazepine was not recommended as the primary therapy for depressed, anxious, or psychotic people as suicidal tendencies may occur.
- ☆ Benzodiazepine may produce amnesia, both anteretrograde and sometimes extending to the period before use.
- ☆ Benzodiazepine can cause increased arterial carbon dioxide tension and decreased arterial oxygen tension.
- ☆ Benzodiazepine can provoke minor EEG changes.
- ☆ Benzodiazepine should only be prescribed for short periods from two to four weeks.
- ☆ Abrupt benzodiazepine withdrawal in individuals with convulsive disorders may be associated with temporary increase in the frequency of seizures and there may be symptoms similar to barbiturate and alcohol withdrawal.

Benzodiazepine prescription was recommended for short periods of only two to four weeks. Longer use is specifically not recommended and possible overdose symptoms of benzodiazepine which physicians should be aware of are detailed in Table 10.4.

In addition, it is necessary to consider if there are derivatives of benzodiazepine other than temazepam and oxazepam which may possibly be used as a medication for people with dementia.

Table 10.4: Reported overdose symptoms of benzodiazepine		
ataxia	blurred vision	cardio-vascular and respiratory depression
coma	confusion	depressed reflexes
extreme drowsiness	somnolence	
Adapted from MIMS Annual, 2002		

10.7.3. Benzodiazepine derivatives

MIMS Annual (MediMedia, 2002) listed **eleven** derivatives of benzodiazepine including alprazolam, bromazepam, clobazam, diazepam, flunitrazepam, lorazepam, midazolam, nitrazepam, oxazepam, temazepam, and triazolam which were marketed under **twenty-four** different brand-names including Aldorim, Alepam, Antenex, Ativan, Diazepam injection, Ducene, Euhypnos, Frisium, Halcion, Hypnodorm, Kalma, Lexotan, Midazolam injection, Mogadon, Murelax, Nocturne, Normison, Serepax, Tamaze, Temtabs, Valium, Valpam, and Xanax.

Therefore, given that:

- ☆ benzodiazepine should only be prescribed for short periods from two to four weeks
- ☆ at least six of the medications used in South Australian facilities are benzodiazepine derivatives
- ☆ continued use of benzodiazepine may lead to dependence
- ☆ there is an extensive list of reported side-effects to benzodiazepine derived medications
- ☆ the overdose symptoms of benzodiazepine can include ataxia, blurred vision, cardio-vascular and respiratory depression, coma, confusion, depressed reflexes, extreme drowsiness, and somnolence
- ☆ withdrawal from benzodiazepine may cause symptoms similar to barbiturate and alcohol withdrawal

it could be argued strongly that there is a need for continued and careful monitoring of the resident by the consulting physician who is responsible for the prescription of medication for that resident.

10.7.4. Polypharmacy

Given that it is possible that the majority of people in South Australian high level residential care facilities are prescribed three or more medications, the need to consider the possible effects of polypharmacy as discussed by Lim and Mason (2000) is

highlighted by the advice that, "The possibility of multiple drug ingestion should always be considered as additive toxicity is possible." (MediMedia, 2002, p. 3-247).

10.7.5. Falls with medication

The observation made by one interview participant that:

> *quite often an increase in medication causes a decrease in the person's balance so they tend to have a lot more falls so they give medication for one thing and it creates problems in other areas*

is consistent with findings reported by Lim and Mason (2000) that polypharmacy can lead to an increase in the number of falls, a reduction in cognitive ability and an increase in aggressive behaviour. As noted above, temazepam can produce side effects such as ataxia, giddiness or oversedation which, in turn, can increase the possibility of accidental falls" (MediMedia, 2002, p. 3-247). Given the frequency of medication reported by the respondents to the questionnaires, the issue of medication in dementia care needs further investigation.

It could be contended that, if Reiki is able to reduce the need for medication, there will be a corresponding emotional, physical and cost benefit for the residents, the carers, the residential facilities, and the government.

10.7.6. Other issues

In addition to the need to monitor individual reactions to any medication prescribed, added burdens may be placed on staff of residential facilities by the need to: provide correct storage facilities for the various medications prescribed for residents; conduct accurate and regular stock takes of medications to ensure there has been no misuse or misappropriation of medication; ensure that the timing of medications is appropriate for individual needs; and ensure the correct medications are issued to individual residents.

10.8. Self-esteem

Dementia is a degenerative condition for which there is currently no cure and the loss of self-esteem for the person with dementia was emphasised by Hyde (1996) and the respondents to the questionnaires who reported feelings of *disempowerment* and *guilt* resulting from an inability to communicate with people and alleviate their anxiety. Therefore, if "skin-to-skin touch for the sole purpose of comfort" (Butts, 2001, p. 180) and complementary therapies generally, as reported by three respondents to the questionnaires (Section 3.5.2), can improve the self-esteem of people

with dementia and Reiki can improve the self-esteem of torture victims (Kennedy, 2001), then it could be anticipated that, as a touch therapy, Reiki will be able to improve the self-esteem of people with dementia and their carers. All ten of the interview participants spoke about the ability of Reiki to make people feel good about themselves, whether it is the person receiving Reiki or the person providing Reiki. One participant indicated that being able to provide Reiki made her feel good about both the Reiki and herself.

In addition to the comments made by the interview participants, documentation supplied by a Director of Nursing who was not an interview participant (Appendix E) emphasised the ability of Reiki to improve the self-esteem of the practitioners using it in her facility. It was claimed that Reiki provided them with a tool which has enhanced their *perception* and *increased their effectiveness and ability to offer extra care to…residents*.

The very positive attitude of the ten interview participants (100%) towards their work with people with dementia could be interpreted as a measure of the personal self-esteem that comes from their ability to assist the people for whom they care. One participant's reference to the *dignity* involved in the palliative care situation emphasised the fact that self-esteem can be promoted and maintained in very difficult situations. Reiki could possibly be one tool which is able to assist the practitioner working in dementia care.

If, as reported by the participants, Reiki is able to provide carers with a simple tool which can calm agitated behaviour, relax both residents and carers, reduce stress, improve sleep patterns, reduce pain and improve relationships, then it could be contended that an improved perception of self-worth will be a significant subsidiary benefit of Reiki.

10.9. Reiki and self-healing

The reported use of Reiki for self-healing by the interview participants would appear to support the claims made by Barnett and Chambers (1996); Ellyard (2002); Lorenzi (1999); Nield-Anderson and Ameling (2000 & 2001); Rand (1998); Rivera (1999); and Stein (1996). If Reiki can be used for self-healing then it has the potential to reduce staff stress and sickness and create a significant cost saving for the residential facilities. This saving could accrue from a reduced need to employ replacement staff and lowered WorkCover fees. It is also possible that the use of Reiki could reduce staff turn-over by preventing staff disenchantment and burn-out.

10.10. Simplicity of Reiki

The purported simplicity of Reiki, which "can be done anywhere and at any time" (Ellyard, 2002, p. 267) and can be adapted to suit the particular requirements of the situation (Section 6.1.12) would appear to be supported by the interview participants who are able to:

- ☆ 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
- ☆ easily incorporate Reiki with other complementary therapies to enhance the quality of life of the people for whom they care.

The simplicity of Reiki was emphasised by the fact that interview participants reported that no special equipment was needed when practising Reiki and it is non-invasive as was claimed by Alandydy and Alandydy (1999).

The demands placed on staff time by residents exhibiting problematic behaviours were stressed by 25% of respondents to the questionnaire. Therefore, a simple therapy which can reduce the frequency of episodes of agitated behaviour, has the potential to substantially relieve the work-load of staff members who may have as little as 25% of their time for "direct patient care" (Daley, 1996, p. 1124).

10.11. Informed consent

> [If the resident is] *willing to hold your hand or to allow you to touch them* [it] *is probably permission enough.*
>
> *(Comment made by one interview participant.)*

The doctrine of informed consent requires that the client must have the right to refuse treatment (Wardell & Engebretson, 2001b) and that the needs and wishes of the individual must be respected (Meehan 2002). Treatment refusal can be stated either verbally or by changes in body language if the intended recipient does not have sufficient skills to provide their response verbally. All participants appear to abide by this principal in their use of Reiki with clients.

However, it could be reasoned that training in the interpretation of body language should be provided to all staff and volunteers working in residential care. If potential incidents of agitated behaviour are recognised early and appropriate strategies put in place to prevent escalation of these incidents, there is the potential to greatly increase the quality of life for all people involved.

10.12. Reiki is not a panacea

Often exaggerated claims about the efficacy of therapies such as Reiki are made in the 'popular press', in 'new age' public ations and on self-aggrandising web sites. However, as recognised above, none of the ten interview participants claimed that Reiki was a panacea able to rectify all ills. Barnett and Chambers (1996) support this attitude when reporting their use of Reiki in homes, hospitals, and hospices. They maintain that Reiki "works to enhance and accelerate the normal healing pro cess of the body and the mind" (p. 25). One interview participant reminded us that it is i mpossible to *give energy to something that is not there* and a therapist *can only work with what* [is there].

The Reiki practitioners appear to recognise that each patient is an individual, will have individual preferences for the type of therapy, will experience the therapy individually, and therefore must be treated as an individual. This attitude supports the views expressed by the American Medical Association (1997), Daley (1996), Richardson (2000), and Routasalo (1999) that clients must be treated as individuals. It would appear then, that the use of Reiki should be considered as only one tool available to paid staff and volunteers involved in the care of people with dementia.

In addition, it could be claimed that the purported efficacy of Reiki is simply related to the practitioner having "compassion, intent ion [to assist], and even sometimes…a lo ving thought" (Daley, 1996, p. 1127).

10.13. Stress levels

Stress can be a cyclic phenomenon with potentially snowballing effects. Over 40% of respondents to the questionnaires reported that resident's ag itated behaviours add to the stress levels of carers, yet Kovach and Meyer-Arnold (1997) claim that staff stress can invoke agitation in people with dementia. If, as was claimed by six (60%) of the interview participants, Reiki has the potential to reduce or relieve stress in both the resident and their carers, then it is possible that other benefits will accrue from the use of Reiki.

10.14. Deconstructing the notion of 'disease'

There is no known cure for degenerative dementias such as Alzheimer's disease (Collins, 2001; Jorm, 2002; Rowe & Alfred, 1999). It is expected that the resident with dementia will not recover. It is also expected that, once persons with dementia enter a High Care Residential Facility, they will spend the rest of their life in a facil-

ity. Is it then possible to bring some relief to the person suffering with dementia and provide them with a high quality of life?

Allopathic procedures may prevent agitated behaviour but may do nothing to improve the quality of life of the person with dementia or the carers. Hyde (1996) described his distress at his wife's "zombie" like behaviour following the prescription of Serenace (p. 23). It could be proposed that, in this case, the prescription of a medication did nothing to promote his wife's quality of life or enhance her relationships with the people around her. The "zombie" like behaviour discussed by Hyde (1996) is supported by the comment made by one interview participant, who was a Director of Nursing, that the residents:

> *were all sitting like stunned mullets...they were expressionless, there was nothing in their lives, they were just sitting. Although we have got a wonderful view they were just sitting, and there didn't seem to be any interest or any focus on anything at all, they didn't seem to be enjoying what they were doing which was doing nothing.*

When a person with the 'disease' of dementia is admitted to a residential facility there is the potential for everyone involved, the individual him or herself, the individual's family members, the staff members of the facility and the volunteers, to experience considerable 'dis-ease'. This may be in the form of stress for the staff members and/or guilt or distress for the resident's family members. Therefore, the notion of deconstructing 'disease' into 'dis-ease', as suggested by one participant, then applying a therapy (or therapies) which will bring 'ease' to the recipient as an adjunct to simply treating identifiable symptoms with allopathic procedures could assist in the development of a care plan for a person with dementia.

Before developing a care plan it is necessary to consider the needs of **all** of the people involved. If, as reported by the interview participants, Reiki is able to: reduce stress levels and agitation; lower blood pressure and heart rates; promote calming, relaxation, [emotional] balance, peace, tranquillity, and soothing; improve sleep patterns; promote self-worth; improve relationships; and ease the fear and anxiety associated with a resident's passing for both residents, staff members and volunteers, then it will in turn reduce the degree of 'dis-ease' experienced by individuals and promote the quality of life of all of the residents, carers and family members who may be involved.

10.15. "You can't see pain relief."

After this statement had been made in one interview, the researcher was prompted to speak with a number of nurse educators and conduct a mini literature review to determine if there were ways to 'see' an individual's pain when he or she is not able to verbally express his or her discomfort.

There are easy to use tools such as the ***Abbey Pain Scale*** (Abbey, Piller, De Bellis, Esterman, Parker, Giles & Lowcay, 2004), which is recommended by the Dementia Training Institute of Australia (no date), readily available for use within dementia care. Therefore, it would appear to be essential that all carers working with these people are trained in detecting pain and suffering by observational methods. It could be argued further that training in this area would assist all Reiki practitioners to gauge the efficacy of their therapies.

10.16. The spiritual nature of Reiki

The observation made by one participant that members of some Christian denominations challenge her use of Reiki is reflected in comments such as: "...there is no place in the profession of nursing for a new-age religion masquerading as science." (Lewis, 1996, p. 10); "We only allow the laying on of hands, in the name of Jesus." (Martinez, 1996, p. 10); and Reiki equates with "occult practices" (Whitsitt, 1998, p. 13). These comments were found in the original literature surveys and have been cited in earlier chapters.

However, contrary to these beliefs, six (60%) of the interview participants appear to believe that the Reiki energy is a gift from God. Subsequently, a search of the Internet uncovered writings by Kurtze (no date), Lyles (no date), Mebane (no date) and White (no date) which support the notion that the practice of Reiki is not incompatible with a Christian belief and practice.

While all ten participants acknowledged the spiritual nature of Reiki, they appeared to have remained 'grounded' in their attitude towards Reiki and its workings. They do not seem to have "replace[d] one set of neuroses with another" (Ellyard, 2002, p. 323) as could be inferred from some of the claims made about Reiki in the 'popular press' and on some web sites.

10.17. Reiki practitioner expertise

While the perceptions expressed by each interview participant are equally pertinent to an understanding of the place of Reiki in dementia care, it is natural that those

perceptions will vary according to the individual's role within the facility and his or her experience in dementia care and Reiki. Individual expertise in both domains varied considerably in both content and length of service.

Volunteers would probably spend less time per week in dementia care than the professional carers, while Diversional Therapists would perhaps spend less time giving individual care than Patient Care Attendants. Patient Care Attendants may be required to spend considerable time 'forcing' residents to perform 'unwanted' tasks, while the volunteers and masseur could be providing 'enjoyable' activities. Furthermore, the professional carers and volunteers may be able to maintain a personal 'distance' from their clients while the family member caring for a person with dementia is more likely to be profoundly emotionally involved in the situation. Therefore, it can be assumed that the experience of Reiki will be highly individual and may produce apparently paradoxical outcomes, a finding reported by Engebretson and Wardell (2002).

The wide variety of experiences and ideas about the use of Reiki in dementia care reported by the participants would suggest that there may be no single easily identifiable outcome from the use of Reiki in residential care.

10.18. Reiki as a 'touch' therapy

Given that people in hospitals are touch deprived (Oz et al., 1999, p. 120) or that much of the touch experienced in patient care is routine and task orientated (Routasalo, 1999), it could be assumed that a similar situation may exist in a residential care facility. This was supported by one of the interview participants who commented directly about the loss of caring touch in institutionalised care while nine of the participants (90%) stressed the importance of Reiki as a touch therapy.

In nursing studies, touch is regarded as a "non-verbal, non-vocal form of communication" (Routasalo, 1999). It could therefore be argued 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.

If, as reported by Oz et al. (1999), "a simple touch of a hand on the skin can lower blood pressure and heart rate" then Reiki, as a touch therapy, will have benefit for those people who have high blood pressure and/or fast heart rates.

10.19. Paradoxical effects of Reiki and medication

Engebretson and Wardell's (2002) findings that people receiving Reiki often used diametrically opposed descriptions of *heaviness - weightlessness*, *heat - coldness*, *fear - safety*, *slow - very fast*, *vulnerability - safety*, *giving - receiving*, *addle-brained* - clarity, *secure - panicky* to described their experience of the Reiki session is supported by the interview participants. While the interview participants did not describe as many of the extremes, they reported that Reiki is variously able to instigate sensations of *belonging,*[feeling] *better, calmness, cold*[ness], *confidence,* [feeling] *good, heat,* [being] *less agitated, love, pulsating,* [being] *relaxed, stimulation*, *tingling, tired*[ness], *warmth, well-being,* and/or [being] *worn out*.

Engebretson and Wardell (2002) hypothesised that the paradoxical nature of the participants' reactions may be attributed to the "balancing" nature of Reiki. Individual interview participants suggested that the differential experiences of Reiki may be because *everyone varies, everyone is different and* [have] *their own…separate needs* and therefore the Reiki *can be felt in different ways,* or *the effect is whatever* [the recipients] *chose it to be,* or *different people take on board all their different needs.* As another participant explained, *our physical self can be adjusted, can be healed in many different levels*.

The experience of paradoxical effects is not limited to complementary therapies because temazepam can produce paradoxical reactions of acute rage, stimulation or excitement (MediMedia, 2002) and people taking alprazolam and sertraline hydrochloride can, individually, experience the multitude of adverse reactions as detailed in Tables 3.1 and 3.2.

These findings are consistent with the notion that each patient is an individual, will have individual preferences for the type of therapy, will experience the therapy (or medication) individually and therefore must be treated as an individual (American Medical Association, 1997; Daley, 1996; Oz et al., 1999; Richardson, 2000; Routasalo, 1999).

10.20. Adaptability of Reiki

The information supplied by the interview participants is consistent with the various findings that:

- ☆ Reiki can be adapted to suit the needs of the individual client (Kennedy, 2001).
- ☆ Paradoxical results have been found by researchers (Engebretson & Wardell, 2002).

- ☆ The practitioners' level and experience may vary from newly attuned Reiki I practitioners to Reiki Masters with 20 years of experience (Table 6.1).
- ☆ The frequency and duration of treatments may vary (Alandydy & Alandydy, 1999; Engebretson & Wardell, 2002; Mansour et al., 1999; Shiflett et al. 2002; Wirth et al., 1993).
- ☆ The number of hand positions used during treatment may vary (Mansour et al., 1999; Shiflett et al., 2002).

10.21. Documenting the use of Reiki

While one facility involved in the Reiki interviews has developed a specific tool for recording the use of Reiki (Appendix E), six out of ten of the people interviewed said that they did not record their use of Reiki. However, as noted above, after her involvement in the interviews, one of the six introduced her own recording procedure. Even where set procedures have been established by a facility, it is quite possible that individual carers will fail to comply with requirements, particularly if workloads are high.

It could be hypothesised, that if complementary therapists wish to be treated seriously and have their therapy recognised by mainstream medical practitioners, then they must implement formal recording procedures.

10.22. The domino effect and the 'Web-of-Life' in dementia care

> *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.*

When analysing the comments made by the Reiki practitioners it was apparent that there was a belief that Reiki has the potential to work across multiple domains simultaneously, particularly if distant healing methods are used. An example of this would be that; if Reiki can lower stress then it has the potential to simultaneously lower stress for the clients, their family members, other carers, the practitioners themselves, and the practitioners' family members. This complex relationship can be represented graphically as in Figure 10.3.

Even if the individual practitioner is only giving Reiki directly to an individual client, if the Reiki can calm the agitated resident then there is the potential that other carers and family members who may be present will experience less stress than

would have been the case if the resident's agitation had continued, and perhaps escalated.

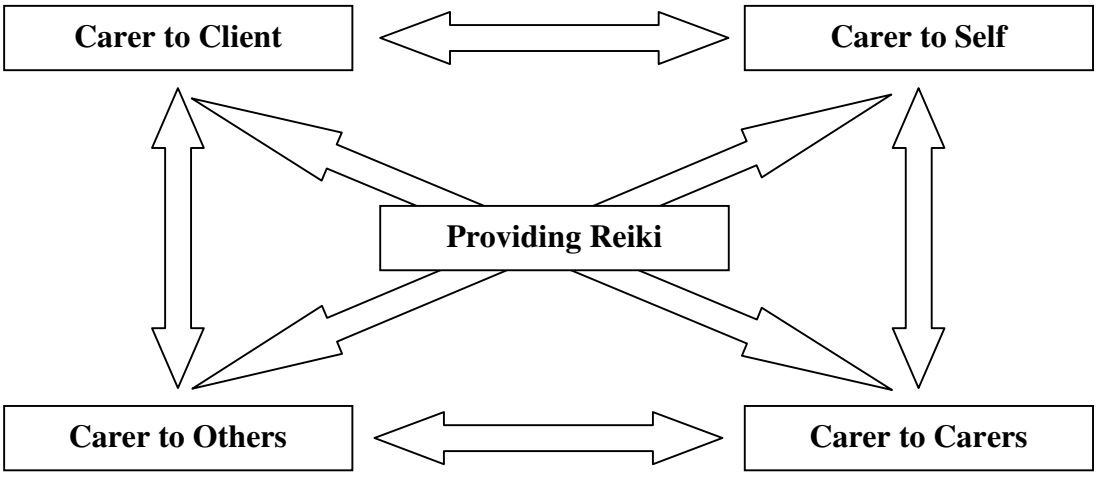


Figure 10.3: The multiple dimensions of Reiki therapy

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. A stressed Director of Nursing may inadvertently add to the frustration level of a Patient Care Attendant. The carer may then transmit this frustration to a resident who, in turn, becomes agitated, resulting in a domino effect which eventually exacerbates the behaviour of other residents and staff. The converse is equally valid. This web-of-life, to which we all belong (Davies, 2000) and the interaction between the elements can be illustrated graphically as in Figure 10.4.

While it must be remembered that the individual with dementia will not 'recover' but will continue to decline as their dementia progresses, changes that will enhance their current quality of life can be made. If Reiki is able to alleviate one symptom in the web, then this may, in turn, bring benefit to all other elements within the web through a reversal of the 'domino' effect referred to by the majority of respondents to the questionnaire and which one interview participant likened to a *fog* that moves through the residence. Creating an improvement in individual elements of the web, whether within the people with dementia, their family members, or their carers, has the potential to improve the overall quality of life for all people affected.

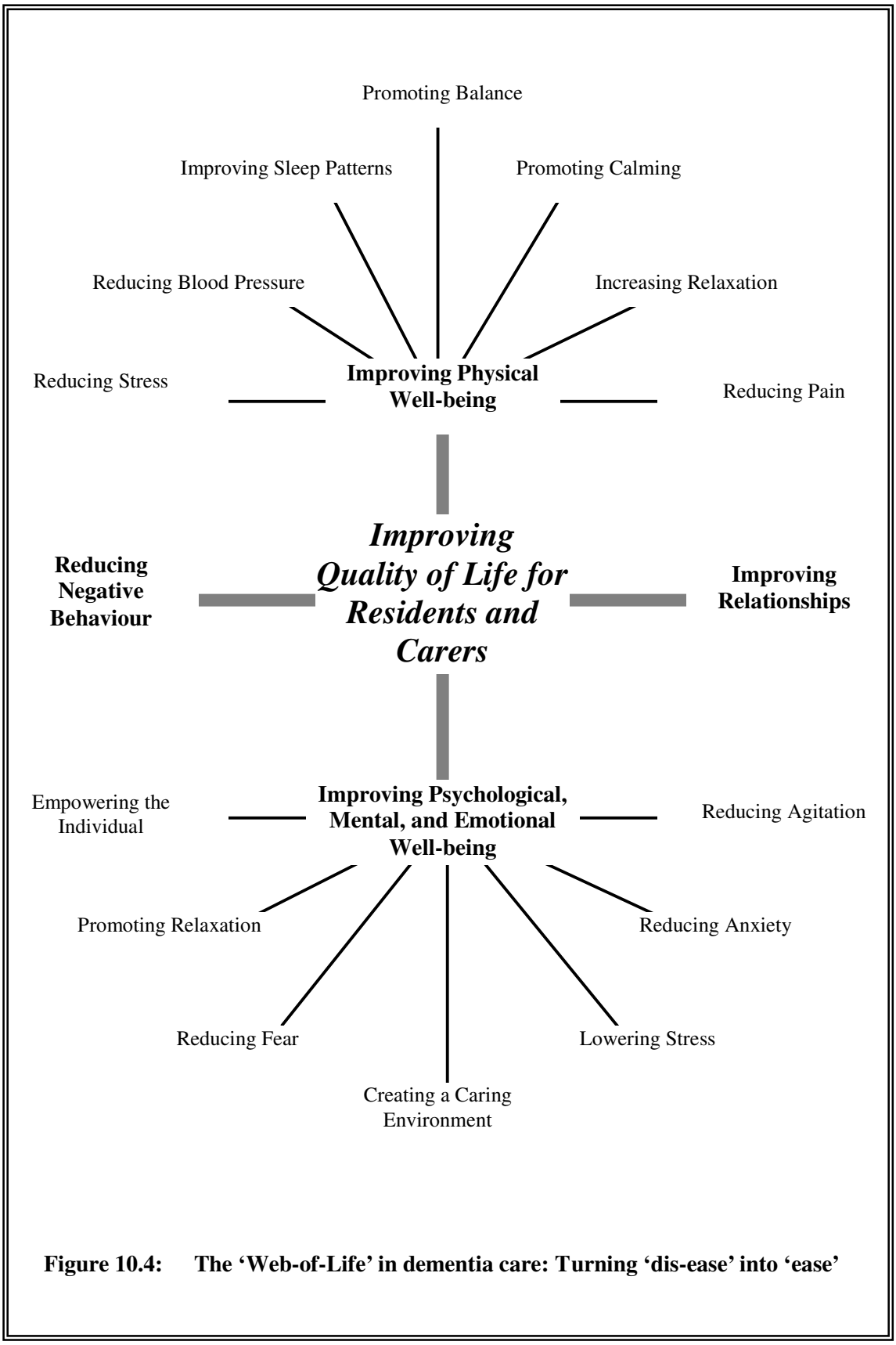


Figure 10.4: The 'Web-of-Life' in dementia care: Turning 'dis-ease' into 'ease'

With the correct approach to caring, it is even possible to generate "spontaneous" episodes of lucidity (Normann, et al., 1998) when both the individual and the carers can enjoy the moment, no matter how brief it may be.

The notion of carers experiencing positive results through the use of appropriate complementarity therapies is consistent with the findings of Rowe and Alfred (1999). It is possible that this may be achieved despite the feelings of frustration and helplessness which carers may live through (One questionnaire respondent; Rauckhorst, 2001; Rudd, 1990). It may also be achieved through the reduction of *fear, anxiety, and tension* which is achieved through complementary therapies *that engage the mind* (Oz, Arias & Oz, 1999, p. 8).

Energy healing cannot be dismissed simply because we cannot see the energy. Even if positive outcomes from the use of Reiki are limited to the placebo effect it has the potential to enable the persons with dementia, their family members and their carers to *feel supported and socially confident* which, according to Younger and Martin (2000), is the essence of good dementia care.

10.23. Limitations of the research

The researcher has identified a number of limitations to the research as a whole, to the interviews with Reiki practitioners in particular, and to the questionnaires sent to South Australian High Care Residential Facilities. These limitations are detailed below.

10.23.1. General limitations

This research has not proven the efficacy, or otherwise, of Reiki when used as a complementary therapy in the care of people with dementia. Due to the discrepancy in numbers between the analysed responses from the questionnaires sent to Residential High Care facilities (n=81) and the Reiki practitioners interviewed (n=10), it is not possible to produce any statistically meaningful comparisons between the results obtained from the two groups. The researcher was unable to verify what the participants reported by interviewing residents, observing residents' behaviour patterns, analysing residents' records, or talking with residents' family members. While 15 facilities reported people were using Reiki, and the people interviewed represented only eight facilities, the anonymity afforded to the people completing the questionnaires precluded cross matching the questionnaires and the interviews in an effort to

contact the other Reiki practitioners. Nor was it possible to conduct a detailed review of the facilities' policies regarding the use of complementary therapies.

10.23.2. The interviews

All three raters independently found difficulty assigning some key words and concepts to individual categories. They felt that some comments might fit equally well into several domains. Consequently it was not possible to avoid repetition. Issues relating to medication and measurable physiological reactions to the use of Reiki cannot be addressed adequately because there were insufficient participants employed in a position that would allow them to comment with authority on these aspects. Because the researcher was unable to interview or observe the participants' clients, the perceptions expressed by the participants cannot be compared with the reality expressed by their clients. Participants were not asked to which 'branch' of Reiki they were attuned so no comparison can be made of possible differences in Reiki practice.

10.23.3. The questionnaires

The handwriting of some respondents was so poor that their comments were extremely difficult to understand. The researcher, a colleague working in the disability field, and a professional educator crosschecked these responses in order to minimise the possible loss of useful data. Despite providing a limited space for comments/explanations in the questionnaires, a number of comments from respondents were extremely long. Therefore, the field length limitations of *Microsoft Access* ® and the researcher's programming limitations meant that some comments had to be either shortened or paraphrased when being entered into the database. In order to minimise possible loss of data or errors arising from this process, any abbreviation of comments was marked clearly and the original forms were checked as this report was being written. Although an active decision was made to not have any identifying information on the questionnaires to ensure the total confidentiality of information provided by respondents, the lack of this information made it impossible to follow-up with individual respondents to clarify difficult to understand comments.

11. Conclusion

> *So whether it be Reiki or chemotherapy, at the end of the day if it saves that person's life and gives them a quality of life that is acceptable to them, that is fine, but if you can combine the two that is brilliant, so if you can use chemotherapy and then use Reiki on top of that to reduce the effects of the chemotherapy, you are giving that person such a great opportunity to heal within themselves and use the energies and medicines around them to advance that situation for them, or it even boils down to just a quality of life*
>
> *(Comment made by one interview participant).*

11.1. Introduction

This study has demonstrated that:

- ☆ Reiki was being used in at least 15 South Australian High Care Residential Facilities.
- ☆ Reiki was being used as a holistic complementary therapy in the care of people with dementia by at least: one Director of Nursing, one Enrolled Nurse, three Patient Care Attendants, two other Complementary Therapists, two volunteers, and one family member in eight South Australian High Care Residential Facilities.
- ☆ Reiki was being used as a complementary therapy in at least two major South Australian hospitals.
- ☆ Reiki was being taught as part of the staff development programme in at least one High Care Residential Facility prior to the study commencing. As a direct response to one volunteer participating in the interviews, another High Care Residential Facility added the study of Reiki to their staff development programme.

The study has also demonstrated that:

- ☆ The Reiki practitioners interviewed believed that Reiki can improve the quality of life of both the residents with dementia and their carers.
- ☆ Reiki can be adapted to suit the needs of the individuals, the environment and time constraints imposed by the staffing levels in the facilities.
- ☆ Reiki can produce apparently paradoxical results depending on the needs of the individual.
- ☆ Reiki can be used as a stand-alone therapy, but, in dementia care, should be considered as only one of a range of therapies available to the caring practitioner.
- ☆ The use of Reiki need not conflict with the religious beliefs of either the residents or the carers.

- ☆ Improvements need to be made in the procedures for documenting the use of, and efficacy of, Reiki used in South Australian High Care Residential Facilities.
- ☆ The participants viewed the resident 'holistically' and aimed to care for the whole person, not just the condition.

It can be argued that, as mainly hands-on carers with between one and 12 years (mean, 6.4; median, 7.0) in the care of people with dementia, the Reiki practitioners involved in the interviews will have conceivably amassed "a…reservoir of empirical medical knowledge gained through time-proven direct observation and clinical assessment" (Daley, 1996, p. 1124). Therefore their comments regarding the use of Reiki with their clients and for themselves must be recognised as a valuable contribution to scientific knowledge.

11.2. Benefits gained from the research thus far

As outlined above, the validity of a qualitative research project may be judged by the degree in which participants "benefit as a result of their experience in the research" (Heppner et al., 1999, p. 250). It could be argued that this includes the researcher.

Since the commencement of this research in 2002:

- ☆ One of the interview participants changed her processes relating to documenting the use of Reiki, expanded her volunteer work in the residential facility, and was invited to teach Reiki as part of the home's staff development programme. (This facility is the one that has offered tentative support for the proposed quantitative research detailed below.)
- ☆ The use of complementary therapies in South Australian High Care Residential facilities has been publicised through the researcher's presentations to the:
  - Second State Conference of the *Disability and Rehabilitation Professionals' Association* in January 2005.
  - *Counterpoints 2003: Celebrating Diversity in Research*, Flinders University, 25th and 26th September 2003, (This paper was available at http://ehlt.flinders.edu.au/projects/counterpoints/Proc_2003/A6.pdf, accessed on 24/10/2005, and requests for further information have come from as far a field as Canada).
  - Annual General Meeting of the *Integrative Healing Practitioners Network Inc. of SA* (Now the Krieger / Kunz Therapeutic Touch Association of Australasia), 12th Feb 2004.

- ☆ Information from this research has been used by the developers of an application for a Government Accredited *Certificate IV in Natural Health Management and Practice (Reiki)* and may be used as part of the justification for the inclusion of Reiki in the National Health Training Package and by a national committee developing a proposal to have Therapeutic Touch included in the National Health Training Package at the Diploma level.
- ☆ The researcher gained the National Competency CHCA15A in Dementia Care in 2003 and has since been contracted by a Private Registered Training Organisation to conduct training in the National Competency. He is able to base much of his training material on the findings of this research. This training has been at the Certificate III level and he has been requested to conduct training at the Certificate IV level in 2006.
- ☆ Information has been supplied to a national committee investigating the gaining of a medical provider number for suitably qualified Reiki practitioners.
- ☆ Information from this research was used in discussions about the introduction of complementary therapies into the wards and operating theatres of the Royal Adelaide Hospital (Dashorst, 2005) and in an article published in the ACORN Journal (Dashorst & Ammann, 2005).
- ☆ The researcher was contracted by the Dementia Training Institute of Australia to write a training package on the use of Complementary Therapies in Dementia Care. Unfortunately the project did not proceed following a change of management.

11.3. Is there a 'perfect' complementary therapy?

There is probably no such thing as a 'perfect' complementary therapy (nor a 'perfect' allopathic therapy for that matter) as all therapies may cause an adverse reaction, however minor, depending on the individual receiving the therapy and how that therapy is applied.

Nevertheless, from the discussion above, it could be hypothesised that a 'perfect' complementary therapy could be one which is effective and:

- ☆ can be applied when necessary with minimum interruption to routine
- ☆ can be combined with other therapies and/or normal routine
- ☆ can be learned and then used by the majority of carers
- ☆ can prevent the developing behaviour from becoming a problem
- ☆ can reduce stress levels in *both* carers and residents while it is being used

- ☆ does not require extensive carer training
- ☆ has few or no adverse reactions
- ☆ is acceptable to residents and carers regardless of their gender and/or religious persuasion
- ☆ is acceptable to the carers who will implement it
- ☆ is fast acting
- ☆ is inexpensive to implement and maintain
- ☆ is holistic
- ☆ is simple to administer
- ☆ is one which the person with dementia can learn and use for him or herself
- ☆ provides maximum subsidiary benefits to both residents and carers
- ☆ reduces the workload of carers
- ☆ reduces reliance on medication
- ☆ as Freeth (1994) reminds us, that the children of the person with dementia are affected, is easily learned and used by children.

11.3.1. Is Reiki a 'perfect' therapy?

From the analysis of responses from ten Reiki practitioners who have used Reiki in the care of people with dementia, it could be proposed that Reiki approaches the definition of a 'perfect' complementary therapy which was developed above because it is considered to be effective and:

- ☆ can be applied when necessary with minimum interruption to routine
- ☆ can be combined with other therapies and/or normal routine
- ☆ can be fast acting
- ☆ can be learned and then used by the majority of carers
- ☆ can prevent the developing behaviour from becoming a problem
- ☆ can reduce stress levels in *both* carers and residents while it is being used
- ☆ does not require extensive practitioner training
- ☆ has few or no adverse reactions
- ☆ is acceptable to most residents and carers regardless of their gender and/or religious persuasion
- ☆ is acceptable to the carers who will implement it
- ☆ is holistic
- ☆ is inexpensive to implement and maintain
- ☆ is simple to administer

- ☆ provides maximum subsidiary benefits to both residents and carers
- ☆ reduces reliance on medication
- ☆ reduces the workload of carers.

Aspects of a possible 'perfect' complementary therapy which have not been addressed through the comments made by the participants include:

- ☆ can Reiki be easily learned and used by children? It is possible that this could be an important issue because it has been found that the children of people with early onset dementia experience a multitude of difficulties (Freeth, 1994)
- ☆ can the person with dementia learn and use Reiki for him or herself?

11.4. Implications for practice

Although drug induced symptoms of dementia may apparently be 'cured' by removing the offending drug, there is currently no cure for the degenerative dementias (Collins, 2001; Jorm, 2002; Rowe & Alfred, 1999). However … *it is possible for a patient to feel healed even when a cure is no longer possible* (Achilles, 2000). Accepting this fact and adopting caring processes which make the person with dementia *feel supported and socially confident* (Younger & Martin 2000, p. 1210) will improve the quality of life for the person or persons with dementia, their family members, and the carers.

Adopting this attitude has the potential to substantially reduce the feelings of anxiousness, disempowerment, and frustration which were reported by respondents to the questionnaire. Carers working with people who have dementia should treat their clients holistically, be multi-skilled, and recognise that Reiki is but one tool in their repertoire of complementary (and traditional) therapies (Eliopoulos, 1999; Rauckhorst, 2001).

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 move out of the realm of *folk art* (Usui Reiki Practitioner Alliance, 2003) and into the 'mainstream' alongside of therapies such as massage and Naturopathy. This can be achieved, in part, by ensuring that the study of Reiki is incorporated into the Australian National Training Framework, professional registration is available for suitably qualified practitioners, and suitably qualified practitioners are able to obtain Provider Numbers for Medicare rebates. In addition, it is recommended that the use of Reiki in professional set-

tings be recorded and that individual facilities, as well as the various Nurses' Boards, develop policies regarding the use of Reiki as a complementary therapy.

Because professional carers in nursing and medical situations are using Reiki, it is also recommended that the study of Reiki (and other complementary therapies) be included in medical and nursing courses (Lewith, 2000). Even if professional carers personally choose not to use Reiki they need to be able to *discuss such issues with their patients on* [a scientifically] *informed basis* (Australian Medical Association, 2002, p. 4).

12. Suggestions for Further Research

Good dementia care is that which enables a person to feel supported and socially confident (Younger & Martin 2000, p. 1210).

12.1. Introduction

The research described in Chapters 1 to 9 of this thesis was built on three basic questions:

1. Is Reiki used as a therapy for the treatment of dementia in South Australian nursing homes?
2. Is there any evidence for the efficacy of Reiki in the treatment of dementia?
3. How do residents, family and staff members in nursing homes perceive the effectiveness of Reiki?

It has clearly demonstrated that the use of complementary therapies in aged care is a common practice and that Reiki is one of the complementary therapies used. There was little in the scientific literature about the use of Reiki as a complementary therapy, and there was nothing in the scientific literature describing the use of Reiki in dementia care. This lack of published research has recently been confirmed by Dougherty & Katz (2005).

As detailed above, the responses from the questionnaires indicated that Reiki was being used in at least 15 nursing homes across South Australia. The interviews with Reiki practitioners have shown that staff and volunteers in nursing homes, as well as relatives of people with dementia, are using Reiki as a complementary therapy to assist in the care of people with dementia.

Having established that Reiki is being used as a complementary therapy in the care of people with dementia, and while there is little research into the use of Reiki as a complementary therapy, it can be argued that **there is a moral obligation to conduct further research into the phenomenon**.

Further research could possibly focus on issues such as:

- ☆ Can people with dementia use Reiki effectively? This may be an important issue for residents who are in the early stages of dementia compared to those in the end phase of dementia.
- ☆ Can the children and other relatives of people with early onset dementia use Reiki effectively?
- ☆ The need for in-house Reiki training and support.

- ☆ The special needs of people with early onset dementia and how this may affect carers' work.
- ☆ Comparing and contrasting the views of people with dementia, their family members, and their carers who chose the have (or use) Reiki with those of people who choose not to have (or use) Reiki.
- ☆ Individual facility and system policies on the use of Reiki and other complementary therapies in aged care.
- ☆ Medical evidence for the efficacy, or otherwise, of Reiki.
- ☆ Determining if the ownership of a facility influences policies relating to the use of Reiki and other complementary therapies.

Two possible research studies are detailed below.

12.2. A possible further *mixed method* research project

12.2.1. Introduction

With the assistance of staff, residents and family members in the 31-bed nursing home where Reiki was being used by at least 15 staff members and is officially sanctioned by management, it is possible to expand on the information already supplied by the interview participants from this facility.

12.2.2. Aims

This project will aim to:

- ☆ Examine the personal perceptions and attitudes of clients, family members and carers who have chosen to have Reiki.
- ☆ Examine the personal perceptions and attitudes of clients; family members and carers who have chosen not to have Reiki in the aged care facility.
- ☆ Triangulate the qualitative data gained through interviews and/or focus groups with quantitative data obtained by examining existing medical records and care plans.

12.2.3. Method

Depending on the numbers involved and time constraints, in-depth interviews and or focus group discussions will be held with:

- ☆ Staff members who are trained in and using Reiki.
- ☆ Staff members who have actively decided not to be involved with Reiki.
- ☆ Residents who have chosen to have Reiki if they have the cognitive ability to respond.

- ☆ Residents who have actively chosen not to have Reiki if they have the cognitive ability to respond.
- ☆ Family members who support the use of Reiki for their relative(s).
- ☆ Family members who have actively rejected the use of Reiki for their relative(s).

Currently available records will be examined to provide triangulation of data.

This study will enable an in-depth investigation into the use of Reiki as an established procedure in a residential care facility. It is anticipated that there will be a mixture of experienced and inexperienced Reiki practitioners providing services to people with dementia.

12.3. A possible *quantitative* research project

12.3.1. Hypotheses

The findings of this thesis have indicated that it is possible to conduct a rigorous quantitative research based on the hypotheses that:

- ☆ Professional carers providing Reiki for people with dementia will experience less work related stress when compared to the control condition; and
- ☆ Residents receiving Reiki will display less agitation and fewer sleep disturbances when compared to the control condition.

12.3.2. Methodology and control variables

By using a "single subject" (Barlow & Hayes, 1997), "condition change interactions" (Ulman & Sulzer-Azaroff, 1975, in Barlow & Hayes, 1997) research method with a pre-test/post-test format and staggered baseline assessments, the individual participants will become their own control. This design removes the problems associated with controlling for inter-subset variability and provides for the possibility of a treatment/no-treatment comparison over time if staff rosters provide for a rotation of Reiki trained with non-Reiki trained staff members. This design avoids ethical issues which may be inherent in actively withholding a treatment which may be seen to provide benefits. It acknowledges that each person with dementia is a unique individual with unique conditions requiring personalised individual care plans and that each individual is already receiving a set of interventions, which must be maintained during the research unless the care plans are amended as per normal routine.

12.3.3. Treatment Integrity

- ☆ The proposed quantitative research will take place in a 57-bed High Care Residential Facility in the Southern Region of Adelaide. Thus any problems, which could occur if the research were to be conducted in a number of facilities, are removed. (This is a different facility to the 31-bed home discussed above and Reiki is not established as a facility-wide therapy.)
- ☆ The carers providing Reiki will be trained, supervised, and supported by the Reiki Master/Teacher who herself is a volunteer carer in the 57-bed facility and has seven years experience in caring for people with dementia as well as three years experience as a Reiki Master/Teacher. The form of supervision will need to be negotiated with the Director of Nursing, the Reiki Master and the staff concerned. It must comply with current procedures in the nursing home but all attempts will be made to ensure that staff using Reiki will receive regular supervision and advice on their Reiki techniques.
- ☆ Reiki will be provided on a needs basis and recorded, as is the case with PRN medication and incorporated into the carer's normal routine.

12.3.4. Testing the hypotheses

Hypothesis 1: Professional carers providing Reiki for people with dementia will experience less work related stress when compared to the control condition.

- ☆ **The power of the study**: Two groups of three to four carers will be trained approximately four weeks apart to provide a staggered baseline. An attempt will be made to ensure that both day and night staff members are trained at the same time to enable 24-hour application of Reiki. Final numbers of participants to be included in the study will be negotiated with the Director of Nursing and the Reiki Master/Teacher.
- ☆ **Outcome Measures**: The professional carers will be assessed on four occasions (pre Reiki training, then three weeks, six-months, and twelve-months after the Reiki training) using the *Spielberger State-Trait Anxiety Inventory* (Magnuson 2003; Thornton, 1991) and the 10-point self-reporting Likert scale which was used in the interviews with Reiki practitioners. In addition, it may be possible to analyse existing staff leave records if the Director of Nursing and the participants agree.

Hypothesis 2: Residents receiving Reiki will display less agitation and fewer sleep disturbances when compared to the control condition.

☆ **The power of the study**: Reiki will be introduced to between six and eight residents with dementia on a staggered baseline basis. Final numbers of participants to be included in the study will be negotiated with the Director of Nursing and the Reiki Master.

☆ **Outcome measures**: Prior to commencing Reiki treatments and regularly during a six to twelve month period, the residents receiving Reiki will be assessed by one or more of the following methods:

- analysis of existing records relating to medication, blood pressure and incidents of agitated behaviour if approval is given by both the nursing home and the individual residents (or their families)
- the four common Lifestyle Assessment Tools used by Kruger and Warburton in their work with renal patients in the Flinders Medical Centre
- the *Dementia Care Mapping* tool (Younger & Martin, 2000)
- the *Abbey Pain Scale* (Abbey et al., 2004)
- observation logs recommended by the Dementia Training Institute of Australia
- the tools used by Butts (2001) to assess *self-esteem, well-being and social process, health status, life satisfaction and self-actualisation,* and *faith or belief and self-responsibility*
- the *Cohen-Mansfield Agitation Inventory* (Cohen-Mansfield, 1999)
- a purpose designed observation tool as shown below (Figure 12.1).

Resident					
Date	**Time**	**Activity**	**Behaviour**	**Duration of behaviour**	**Signature**

Figure 12-1: Possible format for documenting incidents of agitated behaviours

12.3.5. Some limitations to the proposed quantitative study

☆ The design necessitates the use of inexperienced Reiki practitioners.

☆ Pre-existing care procedures will need to be maintained during the trial period unless the care plans are amended as per normal routine.

12.4. Special considerations for research into Reiki

Any further research into the use of Reiki in the care of people with dementia will need to be structured to account for the:

- ☆ reported 'delay' in observable effects of Reiki as discussed by Miles and True (2003)
- ☆ paradoxical nature of the participants' reactions which may be attributed to the "balancing" nature of this type of healing (Engebretson & Wardell, 2002)
- ☆ effect of the ambience of the setting and other therapies applied by the practitioners
- ☆ possible continuing decline in the cognitive function of the residents du to the 'normal' progression of dementia
- ☆ variations in the practitioner's application of Reiki depending on the nature of their training if all of the practitioners involved have not been trained by the same Reiki Master
- ☆ realisation that a reductionist approach may not be appropriate for the study of complementary therapies (American Medical Association, 1997)
- ☆ possibility that the practitioner may be an integral part of the therapy (Richardson, 2000).

13. 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.

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) (Seniors Information Service).

Aromatherapy: The use of aromatic oils obtained from the flowers, fruit, leaves, bark and wood of a wide range of herbs, bushes and trees for therapeutic purposes. French chemist and perfumer Gattefossé is accredited with coining the term 'aromatherapy' in 1928. Although 'aromatherapy' is a modern term, the use of aromatic oils for their curative properties has been widespread throughout history. Hippocrates, who is considered to be the 'father' of modern medicine, prescribed the use of aromatic oils in massage and baths and the Roman, Vedic, Chinese and Egyptian civilisations made extensive use of aromatic oils. Frankincense and myrrh were given as treasures to the infant Jesus and frankincense is used for purification during the modern Catholic Mass (Lawless, 1992; Robins, 1999).

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 (Lorenzi, 1999), activate the Reiki energy (Whelan & Wishnia, 2003), and enable the Reiki practitioners to channel this energy (Anderson, 2001).

Aura Soma colour therapy: A "vibrational energy" therapy connecting "light energy with body energy" through the use of "liquids containing organically cultivated plants, herbs and essential oils" (Childs, no date, p. 1).

Balancing: According to the context, references to balance may pertain to:

- adopting a balanced approach towards individuals and treating them as whole persons (Pond, 1994)
- maintaining a balance between technical intervention and a humanistic approach to patients (Clark, 2002)
- maintaining a person's physical balance and thus preventing falls (Chen et al., 2001)
- promoting a homeostatic state within the individual (Barnett & Chambers, 1996) physically, mentally, emotionally and spiritually.

Behaviour Therapy (Cognitive Behaviour Therapy): Founded in 1955 by American psychotherapist Dr Albert Ellis, rational emotive behaviour therapy was the first of the cognitive behaviour therapies. Behaviour therapy aims to "force" people to change their behaviour and is derived from active-directive therapy (Halasz, 2004).

Centering: "An act of self-searching, a going within to explore the deeper levels of yourself…[an]…act of journeying inward …to trace or follow the energy flows of your own consciousness in a quest to understand your own being and your relationship to the universe." (Krieger, 1993, p. 17).

Chakras, Chakra Balancing: Chakras are "energy epicentres or vortexes …ass ociated with certain organs and regions of the body" (Nield-Anderson & Ameling, 2001, p. 201). There are seven main chakras on the human body and knowledge of the chakras derives from Hindu teachings (Stein 1996). Chakra Balancing involves implementing techniques designed to 'balance' the energies entering or leaving the chakras.

Chiropractic: A therapy of (mainly spinal) manipulation and adjustment based on the theory that the nervous system can be compromised by misalignment of the skeletal structure. This misalignment leads, in turn, to other poor health issues (MedicineNet.com, 2005).

Clinical Nurse: A job specific role description in which an experienced, advanced practitioner (usually a Registered Nurse with post-graduate qualifications) has a supervisory, mentoring, educational, and clinical role within the facility (Personal discussion with a representative of the Nurses Board of South Australia, August 2005).

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 (Personal discussion with a representative of the Nurses Board of South Australia, August 2005).

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 (My Future, no date).

Doll Therapy: Using a doll as a surrogate to divert attention and encourage purposeful activity (Godfrey, 1994).

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 (Woodward, 2004). 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 (Barnett & Chambers, 1996).

Ear Candling: Using a specialty, hand-made candle of unbleached linen and bees-wax to draw toxins and waxes out of the ear by a process of convection. This therapy reportedly dates back to Egypt in 2,500 BCE (The Colon Therapists Network, 2005).

End phase: A descriptive term relating to the latter stages of dementia and/or a person's life.

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 (Nursing, no date; Personal discussion with a representative of the Nurses Board of South Australia, August 2005).

Essential Oil Notes: According to their volatility, essential oils are classified as having a Top (High), Middle, or Bottom (Low) note. As an example, Eucalyptus is a Top Note oil, Lavender is a Middle Note oil, and Frankincense is a Bottom Note oil. When preparing a treatment, the therapist will attempt to have a balance of these qualities in the oils used (SAHEC, 1997).

Grounded, Grounding: To be grounded means to be connected with the Earth. In energetic healing techniques, grounding can be accomplished by imagining growing roots from the feet and connecting with the Earth and feeling the Earth energies flowing into the body (Brennan, 1988; Honervogt, 1998). "To have one's feet on the ground," means to be sensible and level-headed (The Macquarie Dictionary, 1981).

Healing Touch: An energy based complementary therapy developed by an American Registered Nurse, Janet Mentgen, in 1980 (Rainbow Connection, 2004). From personal discussions with practitioners the researcher believes that Healing Touch derives from Therapeutic Touch (Krieger/Kunz method).

Homeopathy: Based on a system developed by Christian Samuel Hahnemann (1755-1843), homeopathy uses highly diluted preparations with properties similar to the disease to stimulate the body's immune system to overcome the disease. This principle was recognised by Hindu physicians, Aristotle, Hippocrates and Paracelsus (MacIvor & LaForest, 1990).

Hot Towel Therapy: Using hot towels to provide relaxation and relief from certain unspecified conditions (personal experience and discussions with practitioners). The researcher has been unable to locate a definitive description of this therapy.

Holistic, Holism: Considering the whole person rather than individual parts in isolation (American Medical Association, 1997; Chang, 2001b; Hepworth et al. 1996; Mornhinweg & Voignier, 1995; Robins, 1999; Young, 1998).

Humoral immunological functioning: The circulation of antibodies in the blood stream (Oxford Concise Colour Medical Dictionary, Third Edition, 2002).

LeShan healing: Developed by humanistic psychologist, Dr Lawrence LeShan, LeShan healing "emphasizes that the healer must attain an elevated state of conscious awareness characterized by a flow process reality in order for healing to occur." LeShan believed that "all healing is a natural ability shared by all human beings" (Wirth et al., 1993, p. 134).

Light Therapy: Using coloured lights to produce positive changes in the psyche and body. The practice has been traced back to the Egyptians who hung coloured cloths over wall openings to project coloured light to the person inside. Pythagoras, Goethe and Rudolph Steiner are cited as light therapy practitioners. With modern lighting techniques the therapy can be adjusted to suit the individual client's needs. When the light is directed specifically into the client's eye the process is described as Ocular Light Therapy (Deppe, 2000a & 2000b). Light therapy can be used as a stand-alone therapy or integrated into a multi-sensory program.

Medicare: Australia's "Universal Health Care System" which *ensures that all Australians have access to free or low-cost medical, optometrical and hospital care while being free to choose private health services and in special circumstances allied health services* (Your Health, 2005).

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 (Burns, Cox & Plant, 2000; Holloway, 1997). Often associated with Snoezelen ® rooms.

Naturopath: A health practitioner who practices Naturopathy which is a system of health care based on a belief in the "Healing Power of Nature" and that "living systems have an inherent ability to establish, maintain, and restore health". The naturopath will:

- *Treat the underlying cause of illness*
- *Treat the whole patient*
- *Educate the patient about their illness and how to care for themselves*
- *Develop strategies so that future illness can be prevented or likelihood of occurrence reduced* (Australian Naturopathic Network, 2002).

Nursing Home: The former name for a South Australian High Care Residential Facility providing services for aged people (Seniors Information Service).

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.

Pastoral Care: Providing care which recognises the spiritual needs of the client and calls for services to be provided by clergy, chaplains and pastors as well as doctors and nurses (Hudson, 2000).

Private Health Fund: An organisation that provides services for people wishing to insure against possible future hospital and medical expenses.

Reflexology: A foot (or hand) massage therapy based on the belief that various zones on the feet (and hands) correspond to particular areas of the body. It is claimed that, by massaging the appropriate zone on the foot, positive effects can be created elsewhere in the body. While the founding of modern reflexology is accredited to Dr Fitzgerald in 1902, foot and hand reflexology is illustrated in Egyptian wall paintings from the period 2,330 BCE (Byers, 1991).

Registered Nurse: A nurse with a degree in nursing (or its equivalent) who is trained to work in a variety of health care situations (Nursing, no date).

Reiki (Ray-key): A system of channelling universal energy to promote healing developed in Japan by Dr. Mika Usui (Stein, 1996).

Reminiscence Therapy: A therapy which invokes a client's memories of past interests through talking about past experiences in life. This involves taking the client to visit familiar places from his or her past and/or having access to photograph albums and other familiar objects from the client's early life. It aims to reduce agitation and stimulate involvement when short-term memory fades but long-term memory remains active. The client can "re-live, re-experience and savour" past experiences (Hyde, 1996, p. 39).

Snoezelen ®: A multi-sensory environmental approach to working with people with disabilities. Originally developed in Holland (Holloway, 1997) and introduced into Australia in the Mudingburra Special School in 1993 (Burns et al., 2000). See Multi-sensory.

Sundowning: A descriptive 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 (The Macquarie Dictionary, 1981). In Reiki it refers to the belief that the practitioner receives healing at the same time as the client (Nield-Anderson & Ameling, 2000).

Tai Chi: A form of low-intensity exercise involving relaxation techniques and continuous, fluid, dance-like movements (Cheng et al., 2001).

Therapeutic Touch (Krieger/Kunz method): An energetic therapy developed in 1972 by Professor Dolores Krieger, PhD (Professor of Nursing at New York University) and Dora Kunz. Despite its name, Therapeutic Touch techniques involve working with the client's aura to 'smooth out' any irregularities and promote healing (Krieger, 1993).

ThreePhase Therapy: A complementary therapy developed by an Australian nurse specialising in the care of aged people with dementia. It involves the "specific and varied use of Touch, Singing, and Spiritual Care" (Giuliano, 1996, p.164).

Validation Therapy: Founded in the 1960s by Naomi Feil, Validation Therapy is based on the belief that: all people, no matter what their level of disorientation, are valued; that there must be a reason for their behaviour; and that this behaviour must be accepted as it cannot be changed if the client does not wish to

change. The carer enters 'the time and place of the confused resident" (McMullen, 1996, p. 34), reorientates their attitudes, judgements and expectations and becomes an empathetic listener (Campbell, 1994).

WorkCover: "WorkCover [Corporation] provides a workers rehabilitation and compensation scheme for the South Australian community and promotes workplace health & safety) (WorkCover South Australia, 2005).

Appendix A:

Dementia Questionnaire: High Care Residential Aged Care Facilities

FLINDERS UNIVERSITY
ADELAIDE • AUSTRALIA

Department of Disability Studies
School of Medicine
Faculty of Health Sciences

GPO Box 2100
Adelaide 5001 Australia

Telephone: (+61 8) 8201 3745
Fax: (+61 8) 8201 3646
Email: Verity.Bottroff@flinders.edu.au

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 is working on a Thesis entitled:

Early Onset Dementia: Are Complementary Therapies a Viable Intervention?

The attached questionnaire is designed to ascertain what complementary therapies are currently being used in the treatment regime of people with dementia in South Australia.

Once the information gained through the survey has been analysed, it will be used to develop a more intensive and directed qualitative study of complementary therapies being used in the management of dementia in South Australia and their effect on the quality of life of people with early onset dementia and their carers.

We can assure you that any information you provide will remain strictly confidential. Any enquiries you may have concerning this research project should be directed to me at the address given above or by telephone on 8201 3745, fax 8201 3646 or e-mail Verity.Bottroff@flinders.edu.au.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of this Committee can be contacted on 8201-3513, fax 8201-3756, E-mail Lesley.Wyndram@flinders.edu.au.

Thank you for taking the time to assist Graham in his research.

Yours sincerely,

V. M. Bottroff

Dr Verity Bottroff
Head, Department of Disability Studies,
School of Medicine,
Faculty of Health Sciences.

Dementia Questionnaire:

High Care Residential Aged Care Facilities

Thank you for taking the time to complete this questionnaire.

The information gathered by this questionnaire will be used to perform a quantitative analysis of the use of complementary therapies currently used in the management of dementia in South Australia. It will also be used to assist in the design of a more intensive and directed qualitative survey into the impact that complementary therapies have on the quality of life of people suffering from dementia, professional carers and family carers.

You do not have to answer any of the questions. Any information you do provide will remain strictly confidential.

Please return the completed questionnaire to me at Flinders University in the reply paid envelope provided by September 30th 2002.

If you choose not to complete the questionnaire, I would appreciate you returning the blank form in the envelope provided.

Graham R Webber

Graham R. Webber (*DipT, GradDipEd, MDisSt.*)
Research Higher Degree Candidate,
School of Medicine, Department of Disability Studies,
Flinders University,
GPO Box 2100
Adelaide 5001

1. Does your facility have resident(s) with dementia ❒ Yes ❒ No

If you answered "No" to this question you do not have to answer any further questions. Please return the questionnaire in the envelope provided.
Thank you once again for your assistance in my research.

Section 1: Complementary Therapies

Independent research in the USA and Australia indicates that people are increasingly seeking complementary (non allopathic) therapies. This section is designed to determine which complementary therapies, if any, are currently being used for the management of dementia in High Care Residential Facilities in South Australia.

2. Which of the following therapies, if any, are available to residents in your facility?

❒ Aromatherapy (massage)
❒ Aromatherapy (vaporising essential oils)
❒ Behaviour therapy
❒ Chiropractic
❒ Healing Touch
❒ Light therapy
❒ Massage
❒ Meditation
❒ Music (instrumental)
❒ Music (recorded)
❒ Music (voice)
❒ Prayer
❒ Reflexology
❒ Reiki
❒ Tai Chi
❒ Therapeutic Touch (Krieger/Kunz method)
❒ ThreePhase Therapy
❒ Other therapies – please specify:

3. Do you personally use any complementary therapies in the course of your normal duties? ❒ Yes ❒ No

4. If you personally use complementary therapies in the course of your duties please briefly list the therapies you use.

5. Do you consider complementary therapies have a place in the management of dementia? ❒ Yes ❒ No

Please briefly explain:

6. If complementary therapies are used in your facility are they provided by:

❒ Nursing staff (Registered or Enrolled Nurses)
❒ Patient Care Attendants
❒ Diversional Therapist
❒ Resident's friends and/or relations
❒ Visiting specialists
❒ Volunteers
❒ Other staff – please specify:

7. Is the provision of complementary therapies funded by:

   ❒ Your facility's budget

   ❒ Individual residents

   ❒ Other means – please specify:

   _____

   _____

   _____

8. Does your facility have a policy on complementary therapies? ❒ Yes ❒ No

9. If your facility has a policy on complementary therapies, is that policy supportive of complementary therapies? ❒ Yes ❒ No

10. If your facility specifically precludes any complementary therapies is this because of:

    ❒ Doubts about their efficacy

    ❒ Lack of staff training

    ❒ Religious considerations

    ❒ Time constraints

    ❒ Other reasons – please specify:

    _____

    _____

    _____

    _____

    _____

    _____

Section 2: The Residential Facility and the Impact of Dementia

This section is designed to determine the current incidence of dementia in High Care Residential Facilities in South Australia and the effect that may have on staff.

11. How many residents are there in your facility? _____

12. How many of these residents have dementia? _____

13. Are the residents with dementia accommodated:

    In a secure dementia area only? ❒ Yes ❒ No

    In a non-secure area only? ❒ Yes ❒ No

    A combination of both? ❒ Yes ❒ No

14. Are there provisions for residents to move from a non-secure area to a secure area as the need arises? ❒ Yes ❒ No

15. Are there any aggressive or non-aggressive agitated behaviours displayed by residents with dementia which cause problems/concerns for your facility and/or staff? ❒ Yes ❒ No

16. If you answered, "Yes" to the previous question, can you please list three behaviours which cause the most problems/concerns:

    _____

    _____

    _____

    Can you please briefly describe how these behaviours cause problems/concerns for your facility and staff?

    _____

    _____

    _____

    _____

    _____

    _____

17. What is the age range of residents with dementia?

Youngest _____ Oldest _____

18. Research in Australia has shown that the incidence of Early Onset Dementia (in people under the age of 65 years) is increasing. If you have any residents under 65 and have dementia has this caused any specific problems/challenges in your facility? ❒ Yes ❒ No

Please explain: _____

_____

_____

_____

_____

_____

_____

19. Do you find any agitated behaviours to be gender specific? ❒ Yes ❒ No

20. If you answered, "Yes" to the previous question can you please provide a brief explanation?

_____

_____

_____

_____

_____

_____

Section 3: Medication

This section is designed to provide an oversight of the current use of medication for people with dementia in High Care Residential Facilities in South Australia. The results will be used as background information when structuring the qualitative survey.

21. Information provided by the Alzheimer's Association of New South Wales lists the following medications as being possible options for people with dementia. Please indicate which, if any, of these medications are used in your facility (Proprietary names have been deliberately avoided).

❒ amitriptyline	❒ carbamazepine	❒ chlordiazepoxide
❒ chlorpromazine	❒ citalopram	❒ desipramine
❒ diazepam	❒ dothiepin	❒ doxepin
❒ flunitrazepam	❒ fluoxetine	❒ fluvoxamine
❒ haloperidol	❒ imipramine	❒ lorazepam
❒ mianserin	❒ moclobemide	❒ nefazodone
❒ nitrazepam	❒ nortriptyline	❒ olanzapine
❒ oxazepam	❒ paroxetine	❒ phenelzine
❒ quetiapine	❒ risperidone	❒ sertraline
❒ sodium valproate	❒ temazepam	❒ thioridazine
❒ tranylcypromine	❒ venlafaxine	

Do you have any comments to make about medication? _____

_____

_____

_____

22. What is the approximate average number of medications (including ones not listed above) used by people with dementia in your facility?

❒ 0 ❒ 1 ❒ 2 ❒ 3 ❒ more than 3

Section 4: The Respondent(s)

23. Was this questionnaire completed by (please tick multiple responses if this was a joint effort):

- ❒ The Director of Nursing
- ❒ A Registered Nurse(s)
- ❒ An Enrolled Nurse(s)
- ❒ A Patient Care Attendant(s)
- ❒ The Diversional Therapist

Thank you once again for your assistance in my research.

Graham R. Webber

Appendix B:

Letter of Thanks and Summary Report Distributed to High Care Residential Aged Care Facilities

FLINDERS UNIVERSITY
ADELAIDE • AUSTRALIA

Department of Disability Studies
School of Medicine
Faculty of Health Sciences

GPO Box 2100
Adelaide 5001 Australia

Telephone: (+61 8) 8201 3745
Fax: (+61 8) 8201 3646
Email: Verity.Bottroff@flinders.edu.au

A Letter of Thanks

Dear Sir/Madam,

Graham Webber is a Research Higher Degree student in the Department of Disability Studies at Flinders University. He is working on a Thesis entitled:

Early Onset Dementia: Are Complementary Therapies a Viable Intervention?

In August 2002 Graham distributed 162 questionnaires designed to ascertain what complementary therapies are currently being used in the treatment regime of people with dementia in South Australian High Care Residential Facilities.

Attached is a brief summary of the information gained from the survey. I am sure you and your staff will find the results informative.

Any enquiries you may have concerning this research project should be directed to me at the address given above or by telephone on 8201 3745, fax 8201 3646 or e-mail Verity.Bottroff@flinders.edu.au.

The research project had been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of this Committee can be contacted on 8201-3513, fax 8201-3756, E-mail Lesley.Wyndram@flinders.edu.au.

Once again I wish to thank you for taking the time to assist Graham in his research.

Yours sincerely,

Dr Verity Bottroff
Head, Department of Disability Studies,
School of Medicine,
Faculty of Health Sciences.

Early Onset Dementia:

Are Complementary Therapies a Viable Intervention?

A Summary Report for Residential High Care Facilities

July 2003

Principal Supervisor: – Dr Verity Bottroff

Co Supervisors: - Dr Brian Matthews, and Associate Professor Sally Borbasi

Graham R. Webber

DipT, GradDipEd, MDisSt.

Reiki Master/Teacher, Seichim

Therapeutic Touch (Beginners Level)

Certificate II in Massage (Aromatherapy)

54 Young Street, Seacliff, South Australia 5049

☎ (08) 8296 0210

Email: AstroAcademy@bigpond.com

Acknowledgements

I am indebted to the 117 individuals who assisted in the completion of the questionnaires. This included: 55 Directors of Nursing, 31 Registered Nurses, 15 Diversional Therapists, nine Clinical Nurses (including CNCs), three Care Managers, two Enrolled Nurses, one Patient Care Attendant, and one Manager: Residential Aged Care.

Questionnaire distribution

During August 2002 the questionnaire was posted to the 162 South Australian metropolitan and country high care residential aged care facilities (formerly called nursing homes) as identified by the Seniors Information Service on the 2nd October 2001. A total of 91 questionnaires (54.3% of the mail-out, n=162) were returned. Of these: six were blank; one was marked "Return to Sender" by Australia Post (a subsequent attempt to telephone the facility determined that the telephone number had been disconnected thus suggesting that the facility had closed since the compilation of the Seniors Information Service list of 2nd October 2001); one was returned with a note that the facility had closed; one facility returned a completed questionnaire but indicated that the facility was "Low Care" only; and one facility did not have any residents with dementia.

Analysis of responses

Information from 81 questionnaires (50.0% of the mail-out) was entered into a Microsoft Access ® database for analysis.

In addition to providing valuable information about the use of complementary therapies in aged care, the response has highlighted the fact that growing numbers of people under the age of 65 years are being placed in High Rare Residential facilities which have traditionally been aged care facilities. The resident profile is detailed in Table 1.

Table 1: Profile of residents in South Australian residential high care aged care facilities (n = 81)

Number of residents (n=75) [1]	4,741
Residents with dementia (n=75) [1]	2,443
Percentage of residents	51.5%
Age range of youngest residents with dementia (n=77) [2]	39-85
Mean	66.4
Age range of oldest residents with dementia (n=77) [2]	86-105
Mean	97.0
Facilities reporting early onset dementia [3]	25
Percentage of returns analysed (n = 81)	30.8%

1 Six facilities with 42, 70, 80, 100, 110 and 115 residents respectively did not report the number of residents with dementia so these have not been included in the totals.
2 Four facilities did not report ages.
3 A further six facilities reported youngest residents with dementia aged 65 years.

While I had been aware, through anecdotal evidence prior to the survey, that complementary therapies were being used in Residential Facilities the information provided by respondents has shown that a very broad range of therapies are used across the state. Therapies used are detailed in Table 2.

Table 2: Complementary therapy use in residential high care facilities in South Australia (n = 81)

Therapy	Number	Percentage	95% Confidence Interval
Aromatherapy (vaporising)	72	88.9%	82.1%, 95.7%
Music (recorded)	65	80.2%	71.5%, 88.9%
Aromatherapy (massage)	64	79.0%	70.1%, 87.9%
Massage	57	70.4%	60.4%, 80.3%
Prayer	50	61.7%	51.1%, 72.3%
Music (instrumental)	49	60.5%	49.8%, 71.1%
Music (voice)	38	46.9%	36.0%, 57.8%
Behaviour Therapy	31	38.3%	27.7%, 48.9%
Healing Touch	17	21.0%	12.1%, 29.9%
Reiki	15	18.5%	10.0%, 27.0%
Therapeutic Touch (Krieger/Kunz method)	13	16.0%	8.0%, 24.0%
Tai Chi	12	14.8%	7.1%, 22.5%
Light Therapy	11	13.6%	6.1%, 21.1%
Meditation	6	7.4%	1.7%, 13.1%
Reflexology	6	7.4%	1.7%, 13.1%
Reminiscence Therapy	9	7.3%	1.6%, 13.0%
Pet Therapy	8	6.5%	1.1%, 11.9%
Snoezelen	8	6.5%	1.1%, 11.9%
Validation Therapy	3	3.7%	0.0%, 7.8%
Cooking	3	3.7%	0.0%, 7.8%
1:1 activities	3	3.7%	0.0%, 7.8%
Chiropractic	2	2.5%	0.0%, 5.9%
Doll Therapy	2	2.5%	0.0%, 5.9%
Gardening	2	2.5%	0.0%, 5.9%
Red Cross (hand & nails)	2	2.5%	0.0%, 5.9%
Church Services	1	1.2%	0.0%, 3.6%
Craft	1	1.2%	0.0%, 3.6%
Hair Dresser	1	1.2%	0.0%, 3.6%
Hot Towel	1	1.2%	0.0%, 3.6%
Laughter	1	1.2%	0.0%, 3.6%
Multi-sensory	1	1.2%	0.0%, 3.6%
ThreePhase Therapy	1	1.2%	0.0%, 3.6%
Visits (outings)	1	1.2%	0.0%, 3.6%

It is possible that many of the activities listed above are used as part of normal routine in many more facilities and therefore were not reported as "therapies". However the ingenuity of staff is highlighted by the comments of one respondent who stated "...one resident used to be a furniture removalist - we use maps when he becomes agitated and this calms him down."

Individual facilities reported using complementary therapies because they:

- are calming, soothing and settling (61.8%);
- improve behaviour management (22.0%);
- enhance quality of life (20.6%);
- provide opportunities for 1:1 interaction (13.2%);
- stimulate interest and senses (13.2%); and/or
- reduce the need for medication (7.4%).

Within the facilities, complementary therapies are provided by:

- Diversional Therapists (85.2%):
- Nursing staff (Registered or Enrolled Nurses) (75.3%):
- Patient Care Attendants (67.9%):
- Volunteers (61.7%):
- Resident's friends and/or relations (34.6%):
- Visiting specialists (27.2%); and/or
- Other staff including massage therapists, aromatherapists, a physio-aid, a naturopath, religious nuns, a chaplain, occupational therapists, a minister of religion, a palliative care professional, and a pastoral care professional (21.0%).

The next stage of the project

As I am particularly interested in the use of Reiki, which is not well reported in the scientific literature, the next stage of my thesis will be to interview practitioners who are using Reiki with people who have dementia.

I am currently preparing an interview protocol and will be piloting it in 2003 ready for major interviews in 2004.

As the original questionnaires did not have any identifying information I am not able to contact those 15 facilities which reported the use of Reiki. Therefore if you, or someone in your facility, would be willing to participate can you please contact me at either the university or my private address.

Conclusion

The results of the survey vividly demonstrate the time and care that staff in High Care Residential facilities put into ensuring the highest possible quality of life for their clients.

In addition to thanking all respondents I also wish to thank those people who contacted me and offered to participate in the next phase of my research. I do apologise if I have not yet contacted you, but as I am only studying part-time I have not yet been able to respond individually to everyone who contacted me.

Graham R. Webber (*DipT, GradDipEd, MDisSt.)*
26 July 2003

Appendix C:

Interview Protocol for Reiki Practitioners Caring for Person(s) With Dementia

FLINDERS UNIVERSITY
ADELAIDE • AUSTRALIA

Department of Disability Studies
School of Medicine
Faculty of Health Sciences

GPO Box 2100
Adelaide 5001 Australia

Telephone: (+61 8) 8201 3745
Fax: (+61 8) 8201 3646
Email: Verity.Bottroff@flinders.edu.au

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 is working on a Thesis entitled:

Early Onset Dementia: Are Complementary Therapies a Viable Intervention?

Graham has recently competed the analysis of a questionnaire designed to ascertain which complementary therapies are currently being used in the treatment regime of people with dementia in South Australia.

The questionnaire demonstrated that a wide range of complementary therapies is being used in the management of dementia in South Australia. It also indicated that Reiki is being used in approximately 18.5% of Nursing Homes.

As the next phase of his research, Graham will be conducting a series of interviews with people using Reiki as part of their treatment regime for people with Dementia.

We can assure you that any information you provide will remain strictly confidential. Any enquiries you may have concerning this research project should be directed to me at the address given above or by telephone on 8201 3745, fax 8201 3646 or e-mail Verity.Bottroff@flinders.edu.au.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of this Committee can be contacted on 8201-5466, fax 8201-2035, E-mail Lesley.Wyndram@flinders.edu.au.

Thank you for taking the time to assist Graham in his research. When Graham has transcribed your interview he will send a copy to you at the address you nominate during the interview (this can be either your work or home address as you prefer). He will also notify you in writing when his research has been completed and advise how you may obtain a copy of his final report.

Yours sincerely,

V M. Bottroff

Dr Verity Bottroff
Head, Department of Disability Studies,
School of Medicine,
Faculty of Health Sciences.

FLINDERS UNIVERSITY
ADELAIDE • AUSTRALIA

Department of Disability Studies
School of Medicine
Faculty of Health Sciences

GPO Box 2100
Adelaide 5001 Australia

Telephone: (+61 8) 8201 3745
Fax: (+61 8) 8201 3646
Email: Verity.Bottroff@flinders.edu.au

CONSENT FORM FOR PARTICIPATION IN RESEARCH

I _____

being over the age of 16 years hereby consent to participate as requested in the **interview** for the research project on **the use of Reiki in dementia 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 my information and participation being recorded on tape
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 interview 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.
6. I **agree/do not agree** to the tape being made available to a professional typist for transcribing, on condition that my identity is not revealed.

Participant's signature _____ **Date** _____

I 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 7 and 8, as appropriate.

7. 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** _____

8. 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** _____

Early Onset Dementia: Are Complementary Therapies a Viable Intervention?

Note: The researcher will complete all statistical information during the interview and other responses will be recorded without identifying the interviewee on tape.

Thank you for agreeing to be interviewed about your use of Reiki in the care of a person, or persons, with Dementia.

This interview follows the analysis of a questionnaire distributed to all South Australian High Care Residential Facilities in 2002, which demonstrated that Reiki is being used in approximately 18.5% of facilities across the state.

If you do not wish to, you do not have to answer all of the questions. Any information you do provide will remain strictly confidential.

If you wish to withdraw from the interview, you may do so at anytime without the need to supply any reasons for your withdrawal.

The first page will be removed and stored separately from the rest of the form to ensure the confidentially of the information you provide.

Name: _____

Address: _____

_____

_____

Telephone: _____

Email: _____

Graham R. Webber

Department of Disability Studies, School of Medicine
Flinders University
GPO Box 2100
Adelaide 5001
(08) 8201 3745
Email: WEBB0077@flinders.edu.au

1. Personal Details

1.1. In which age range do you fit?

❒ 16-35 ❒ 36-55 ❒ 56-75 ❒ 76-95 ❒ 95+

1.2. Gender

❒ Male ❒ Female

1.3. What is your role?

❒ Diversional Therapist
❒ Nursing staff
❒ Patient Care Attendant
❒ Volunteer
❒ Visiting specialist
❒ Relation of a person with dementia
❒ Friend of a person with dementia
❒ Other:

If "Other", please detail _____

1.4. If you are a family member of a person with dementia, what is your relationship with that person? _____

1.5. How long have you been involved in dementia care? _____

1.6. What are your qualifications? _____

_____

1.7. In addition to Reiki, 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) _____

1.8. 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

1.9. As a carer, what are the major factors contributing to your stress?

2. Facility Details

2.1. The Facility

❒ Number of residents with Dementia: _____
❒ Age of youngest resident with dementia: _____
❒ Age of oldest resident with dementia: _____
❒ Secure only / Non-secure only / Combination

2.2. Does the facility have a Policy re the use of Complementary Therapies?

❒ Yes ❒ No ❒ Don't know

Is it possible for me to have a copy of the policy? (It will not be for publication. Please delete any identifying feature before providing me with a copy to ensure confidentiality.)

❒ Yes ❒ No

3. Dementia

3.1. The following questions are based on the results of my questionnaire to nursing homes.

3.2. Which, from this list of behaviours, cause you the most concern? Do not identify individuals or individual incidents. (Multiple responses permitted.)

❒ Absconding
❒ Intrusiveness
❒ Physical aggression
❒ Sexual behaviour
❒ Wandering
❒ Attention seeking
❒ Moving furniture
❒ Resistance
❒ Verbal aggression
❒ Other

Can you please comment?

3.3. What, from this list of benefits, do you believe accrue from the use of Reiki? (Multiple responses permitted.)

❒ 1:1 interaction
❒ Calming
❒ Quality of life
❒ Other
❒ Behaviour management
❒ Reduced Medication
❒ Stimulation

Can you please comment?

4. Reiki

4.1. When did you first train in Reiki? _____

4.2. What is your level of training in Reiki?

❒ Reiki I (1 day training) ❒ (more than 1 day)
❒ Reiki II (1 day training) ❒ (more than 1 day)
❒ Reiki Master/Teacher (Length of training _____)

4.3. Who is your Reiki Master? _____

4.4. What is your Reiki lineage?

My lineage is: Dr Usui - Chujiro Hayashi - Hawayo Takata - Reverend Beth Gray - Mackenzie Clay - Mike and Mary Shaw - Christine Henderson - Beryl Barker.

4.5. What are your personal reasons for using Reiki?

4.6. What personal experiences have you had with Reiki?

4.7. What makes Reiki different from other therapies?

4.8. From what you have observed, what effects does Reiki have on the person(s) for whom you care?

4.9. What effects does Reiki have on the therapist?

4.10. Do you record the use of Reiki? If so, how?

4.11. Do you record the effects of Reiki? If so, How?

4.12. What equipment do you need in order to perform Reiki?

4.13. Where do you use Reiki?

4.14. What is the attitude of other staff members towards Reiki? / Or: What is the attitude of other family members towards Reiki?

4.15. Are there any drawbacks in using Reiki? Please explain.

4.16. Do you have any other comments?

Thank you once again for assisting me in my research.

Appendix D:

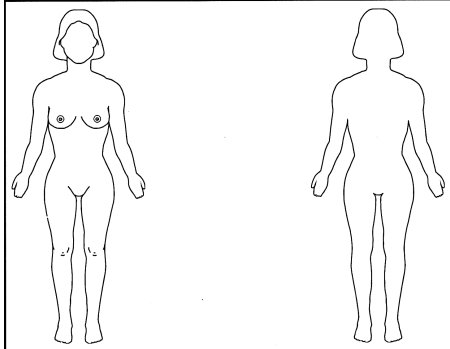
The Current Author's Massage/Reiki Session Record Sheets

Crystal Key Associates - Massage / Bodywork Client Notes

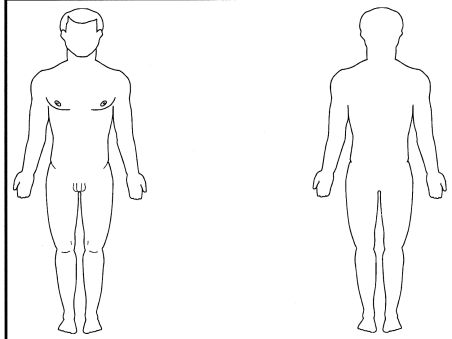
Name:		Date:
Address: PC		
Phone (Home):	Phone (Work):	
Age:	Occupation:	
Purpose of Visit:	Referral:	
Other Practitioners being consulted:		
Medical History (Including Childhood): Recent Injuries/operations: Time of injury etc:		
Family History:		
Allergies:	Alcohol:	Smoking:
Circulation:	Digestion:	
Marital Status: Children:	Headaches:	
Medication:		
Muscular/Skeletal:		
Respiratory:	Reproductive:	
Sleep Pattern:	Urinary:	
Skin Type, Face: Body:	Stress Level:	
Sporting Activities:		
Client's view of their health:		
Is this consultation a compensation claim / Workcover claim / third party claim?		
How did you hear about us?:		
Is this your first visit to a massage practitioner?		
Other Notes:		
Client Signature:	Date:	

Crystal Key Associates - Massage / Bodywork Client Notes

Name:



Name:



Crystal Key Associates - Massage / Bodywork Client Notes

Name:

Appendix E:

Support Documentation Provided by One Interview Participant

Notes:

1. Letterheads and names have been removed from the following documents to protect participant privacy. Letterheads, names and signatures are included on the documents supplied to the researcher.
2. The first document is a letter supplied by the facility's Director of Nursing to the interview participant.
3. The second document is a copy of the contents of the Reiki recording sheet used within the facility.
4. The third document is a copy of the contents of the Reiki training conducted as part of the facility's staff developme nt programme.

I would like to take the opportunity to write this testimonial to validate the extraordinary effectiveness of Reiki on our Residents and Staff.
Staff who were involved in the training sessions have expressed how Reiki has affected their perception, increased their effectiveness and ability to offer extra care to our residents whilst increasing their own self esteem.

Some of the main areas that it has been used are

- Pain management

including - pain reduction
- pain tolerance

- Behaviour management

Including - anxiety
- mental stability (delusions)

- Healing

including - increased healing time
- improved granulation
- improved function of the lymphatic system

- General well being

Including - overall increase in energy
- Improved well being
- lowering of high blood pressure in hypertensive patients
- increased control in diabetes management
- overall improvement in nervous system

- Palliative care

Including - acceptance of terminal illness
- increased spirituality

Staff who have received a treatment from you have also commented on their improvement and generalized well being.

COURSE

REIKI LEVEL ONE PRACTITIONER
REIKI NATURAL METHOD OF HEALING

OBJECTIVES

THE OBJECTIVE OF THE 2 DAY COURSE FOR THE PARTICIPANTS, IS TO LEARN THE METHODOLOGY AND TERMINOLOGY OF REIKI. AS WELL AS THE TECHNIQUES OF THE HANDS ON HEALING METHODS IN AN EFFECTIVE AND EFFICIENT FASHION WITHIN THE AGE CARE INDUSTRY.

CONTENTS

OVERVIEW

THE COURSE HAS 3 PARTS:

1. **METHODOLOGY AND TERMINOLOGY**
2. **INSTRUCTIONAL USE OF THE MANUAL**
3. **AN ASSESSMENT AT THE END OF THE COURSE TO ENSURE THE PRACTITIONER HAS A CLEAR UNDERSTANDING OF THE REIKI NATURAL HEALING METHODS.**

Appendix F:

Ethics Committee Approvals

15. References

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