Elderly Reiki Intervention Program Reduces Anxiety And Depression: Randomized Clinical Trial

Programa de Intervenção Com Reiki para Idosos Reduz Ansiedade e Depressão: Ensaio Clínico Randomizado

Programa de Intervención Con Reiki para Ancianos Reduce La Ansiedad y La Depresión: Ensayo Clínico Aleatorizado

RESUMO
Objetivo: Avaliar a eficácia de um Programa de Intervenção de Reiki para Idosos na redução de sintomas de ansiedade e depressão entre idosos brasileiros. Método: Foi realizado um ensaio clínico randomizado com 49 beneficiários de serviços de atenção primária. Metade recebeu Reiki ao longo de cinco semanas. Aqueles alocados no grupo controle não receberam nenhuma intervenção. Resultados: O Reiki reduziu significativamente os sintomas de ansiedade e depressão no grupo intervenção, em comparação ao grupo controle. Conclusão: O Reiki pode ser uma intervenção eficaz de promoção da saúde mental com idosos.
DESCRITORES: Reiki; Ansiedade; Depressão; Idosos; Ensaio clínico

ABSTRACT
Objective:To assess the effectiveness of a Elderly Reiki Intervention Program with reducing anxiety and depression symptoms among elderly Brazilian people. Method: A randomized clinical trial was undertaken with 49 primary care service recipients. Half received Reiki over five weeks. Those allocated to the control group did not receive any intervention. Results: Reiki significantly reduced symptoms of anxiety and depression in the intervention group, as compared to the control group. Conclusion: Reiki can be an effective mental health promotion intervention with elderly people.
DESCRIPTORS: Reiki; Anxiety; Depression; Elderly people; Clinical trial

RESUMEN
Objetivo: Evaluar la eficacia de un Programa de Intervención de Reiki para Personas Mayores en la reducción de síntomas de ansiedad y depresión entre personas mayores brasileñas. Método: Se realizó un ensayo clínico aleatorizado con 49 beneficiarios de servicios de atención primaria. La mitad recibió Reiki durante cinco semanas. Aquellos asignados al grupo de control no recibieron ninguna intervención. Resultados: El Reiki redujo significativamente los síntomas de ansiedad y depresión en el grupo de intervención, en comparación con el grupo de control. Conclusión: El Reiki puede ser una intervención eficaz para la promoción de la salud mental en personas mayores.
DESCRIPTORES: Reiki; Ansiedad; Depresión; Personas mayores; Ensayo clínico.

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INTRODUCTION

Complementary and alternative medicine (CAM) is a group of non-pharmacological therapies used worldwide and expanded to promote health.[1-2] Among the CAM, Reiki is classified as a biofield therapy, originating in Japan during the late 19th century under the guidance of Mikao Usui from Kyoto.[3] It stands out as an intervention that uses touch or close to the hands as an energy channeling technique to eliminate toxins, balance and promote the full functioning of the body, and restore vital energy.[4] Furthermore, it is a low-cost and low-risk therapy, an excellent treatment choice when compared to conventional treatment.[5]

Evidence suggests that Reiki yields improvements in hypertension, cancer treatment side effects, insomnia, depression and anxiety symptoms, and perceived stress.[6-7] Additionally, Reiki has been shown to reduce pain, foster relaxation, and enhance self-esteem.[8-9]

Mental disorders increasingly affect the world population and are now serious public health problems. Around 970 million people in the world are affected by mental disorders; with COVID-19, there has been a 25% increase in the prevalence of anxiety and depression.[10]

Scientific findings indicate that elderly people can be more susceptible to experiencing depression and anxiety. The WHO shows that these illnesses are shaped not only by physical and social environments but also by the cumulative impacts of earlier life experiences and specific stressors related to aging.[11] Exposure to adversity, a significant loss in intrinsic capacity, and a decline in functional ability can all result in psychological distress.

Depression is one of the most incapacitating and prevalent disorders, closely linked to diminished self-esteem, disinterest in daily activities, insomnia, and a heightened risk of suicide.[12] Anxiety, an intensified and enduring response to anticipating potential threats or future situations, is now on the rise. Anxiety is associated with symptoms such as insomnia, heightened fear, feelings of guilt, palpitations, restlessness, tachycardia, and tremors.[13-14] Timely and affordable intervention is essential, as both are primary contributors to emotional distress and declines in overall quality of life.15 Reiki is a potentially impactful intervention.[8]

Alp and Yucel[16] investigated the impact of Reiki on symptoms of anxiety in 60 Turkish elderly people living in a nursing home. In this randomized, quasi-experimental study, 30 of them received Reiki for 20 minutes over 4 consecutive days, at the end the results demonstrated that Anxiety was statistically significantly lower among the Reiki group. In the same way, Erdogan & Cinar [17] and Pereira et al.[18] show the benefits of Reiki in the mental health promotion

In the Brazilian context, there is a scarcity of studies in this field. Hence, the present study investigates the effect of Elderly Reiki Intervention Program (ERIP) on depression and anxiety symptoms among elderly Brazilian people.

METHODS

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Trial Design

A randomized clinical trial (RCT) was conducted in keeping with the Consolidated Standards of Reporting Trials (CONSORT).19 This study was a controlled, randomized, clinical trial (intervention group "IG"' with treatment versus control group "CG" without treatment).

Participants and Recruitment

Following approval by the Brazilian Ethics Committee (protocol number 22130619.3.0000.5393) people over 60 years were recruited from a Primary Care Service in Brazil. All participants signing an informed consent form were approached by a team of researchers and asked to complete a sociodemographic questionnaire, the Depression Anxiety, and Stress Scale (DASS-21), and a Brief Symptom Inventory (BSI). The data were collected from September to November of 2021.

Consenting persons who met one or two of the following exclusion criteria were also not eligible: (1) acute phase of any clinical condition, with a history of untreated psychopathologies, (2) self-reported suicidal ideations (assessed using the BSI instrument, - Brief Symptom Inventory); (3) flu syndrome, (4) previous contact with Reiki, and (5) using some integrative and complementary therapy, such as meditation, acupuncture, and others, in the last 12 months. Participants self-reporting suicidal ideations were excluded and immediately directed to a specialized service. A total of 50 subjects were randomized either to the intervention group (IG) (participated in the 5-week ERIP) or to the control group (CG) (waiting list). Following the 5-week IG assessment period, the 25 people in the CG were invited to participate in the very same program.

Randomization and Blinding

The sample was by convenience. The number of enrolled participants was obtained based on the practicality and viability of available resources at the time of the study. The pairing of the groups was considered, and participants were randomized in a 1:1 ratio. Considering all the requirements mentioned above, available participants (n = 50) were randomly assigned either to receive the 5-week Reiki program or to a CG . The allocation list was generated manually by adding cards numbered from 1 to 50 in a box, and the first number selected was allocated to the IG, the second to the GC, and so on, therefore without self-selection.

The instruments were applied as follows: Initially, all participants filled out the sociodemographic questionnaire, the BSI scale, and the DASS, then manual randomization was carried out and the following day the participants were contacted and informed where they would be allocated GI or CG (waiting list). For those in the CG, at the end of the ERIP (1 month), they were invited to fill out the DASS scale again to assess whether there was a change in the levels of depression and anxiety. For the IG, in addition to these two measurement moments, at the end of each ERIP, the DASS was applied, in order also to measure the depression and anxiety variables throughout the sessions.

This intervention could not be masked (participants knew which group they were in, and the therapist knew they were carrying out the intervention). To avoid research bias, the therapist had no contact with the data or any approach to the procedures related to the research.

Psychometric Assessment

Depression and anxiety were assessed by the Depression, Anxiety, and Stress Scale (Dass-21).[20] The Dass-21 has been validated for use in Brazil.[21] It contains 21 items, distributed evenly across the three dimensions: (1) depression; (2) anxiety; and (3) stress. All items are summed within each dimension. Scores, therefore, range from 0 to 21. The highest scores correspond to the most negative affective states.

Suicidal ideation was assessed by the Brief Symptom Inventory (BSI).[22] It consists of 21 questions, each on a scale ranging from 0 (not at all) to 3 (extremely). Scores range from 0-63 and produce a total severity score. High scores indicate a greater risk of suicidal ideation. Individual items can be used to assess different aspects of suicidality, including the frequency and intensity of suicidal thoughts, specific plans for suicide, and previous suicide attempts.

Elderly Reiki Intervention Program Protocol

Participants randomized to the 5-week ERIP attended weekly in-person 30-minute individual sessions for 5 consecutive weeks.

The ERIP protocol consisted of hand application for 3 minutes in the following areas: occipital region, umbilical region, laryngeal cardiac region, epigastric region, and umbilical region. These specific areas correspond to the main chakras, which represent the locations of the organs comprising the endocrine and lymphatic systems.

The participants lay on the stretcher in a supine position, with eyes closed, in a silent environment, with the lights off, preserving only the natural light from the half-open window. Positions were the same in all sessions and for all subjects. Consultations were carried out in a private room, in a seldom-populated area, where confidentiality could be maintained. Materials for applying the ERIP, including a stretcher and auxiliary ladder, and disposable sheets, were also readily available.

Statistical analysis

A descriptive analysis of relative frequencies and central tendencies was undertaken. Group comparisons were made using Pearson's Chi-square for categorical variables. Otherwise, an ANOVA was undertaken to evaluate mean differences. These were pre- and post-intervention comparisons.

RESULTS

There were 49 individuals in the ERIP; 24 were in the IG and 25 were in the CG. One participant withdrew from the IG for personal reasons. Demographic characteristics are shown in Table 1.

Due to randomization, no remarkable differences were found based on sex, age, marital status, education, children, occupation, living, and exercise across the two study groups.

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Table 1-Distribution of frequencies and sociodemographic characteristics of the elderly in the intervention group and the control group in a Primary Care Service, IG (N = 24), CG (N = 25), 2022

Characteristics	Intervention group (IG) N (%)	Control group (CG) N (%)	P-value
Sex			0.72
Female	20 (83)	19 (76)	
Male	4 (17)	6 (24)	
Mean age	68	70	0.17
Marital status			0,39
Single/divorced	4 (16)	4 (16)	
Married	11 (46)	16 (64)	
Widow	9(38)	5 (20)	
Education			0.81
Primary education	7 (29)	9 (36)	
High school	10 (42)	11 (44)	
University	7 (29)	5 (20)	
Children			0.52
Yes	19 (80)	17 (68)	
No	5 (20)	8 (32)	
Occupation			1.00
Working	4 (17)	5 (20)	
Retired	20 (83)	20 (80)	
Living			0.41
Family	22 (92)	20 (80)	
Alone/ friends	2 (8)	5 (20)	
Exercise			0.19
Yes	4 (17)	9 (36)	
No	20 (83)	16 (64)	

Source: prepared by the author, 2024.

Table 2 - Depression Levels over time in the Elderly Reiki Intervention Program

Depression	T0	T1	T2	T3	T4	T5	p-value
Mean	16.83	14.25	13.58	12.08	10.50	9.33	0.00001
Standard deviation	13.45	14.74	13.25	12.82	11.83	10.68	
Minimum	2.00	0.00	0.00	0.00	0.00	0.00	
Maximum	42.00	42.00	40.00	38.00	36.00	34.00	

Note: p.value 0,005; TO; T1;T2;T3;T4;T5 = time between each ERIP section

Elderly Reiki Intervention Program in the Intervention Group

Depression levels

Participants in IG receiving Reiki showed a statistically significant reduction in their depressive symptoms consistently throughout the ERIP (Table 2)

As shown in Figure 1, depression levels at T0 were significantly higher than in the other five sessions. The ERIP was most beneficial between T0 and T2 (P=0.006), and T0 and T3 (p=0.0003).

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Figure 1 - Depression Levels over time in the Elderly Reiki Intervention Program

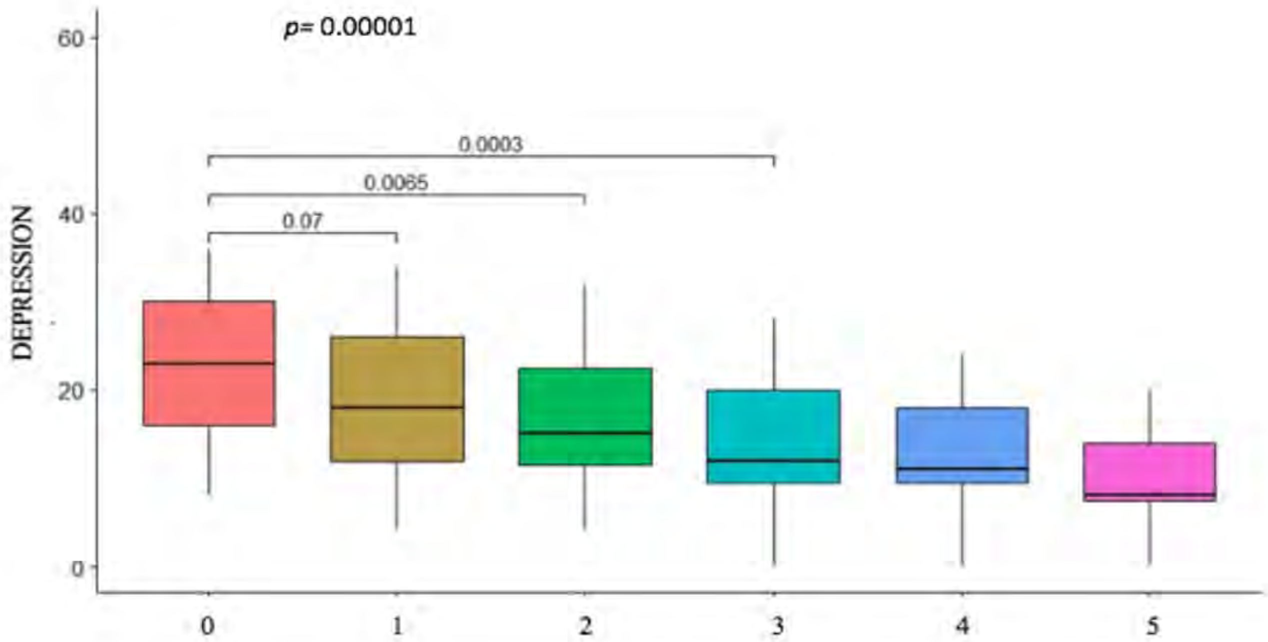

Table 3 - Anxiety Levels over time in the Elderly Reiki Intervention Program

Anxiety	T0	*T1*	*T2*	*T3*	*T4*	*T5*	*p-value*
Mean	*26.17*	*21.00*	*18.58*	*16.0*	*13.92*	*11.50*	*0.00002*
Standard deviation	*7.89*	*8.06*	*7.42*	*6.21*	*5.76*	*5.05*	
Minimum	*12.00*	*6.00*	*4.00*	*4.00*	*4.00*	*4.00*	
Maximum	*38.00*	*36.00*	*34.00*	*28.00*	*28.00*	*22.00*	

Note: p.value 0,005; TO; T1;T2;T3;T4;T5 = time between each ERIP section

Anxiety levels

Participants in the IG and therefore receiving Reiki experienced statistically significant reductions in anxiety throughout the program.

As shown in Figure 2, anxiety levels at T0 were significantly higher than in any of the other five sessions. The ERIP was most beneficial between T0 and T1 (p = 0.038), T0 and T2 (p = 0.024), and T0 and T3 (p=0.0019).

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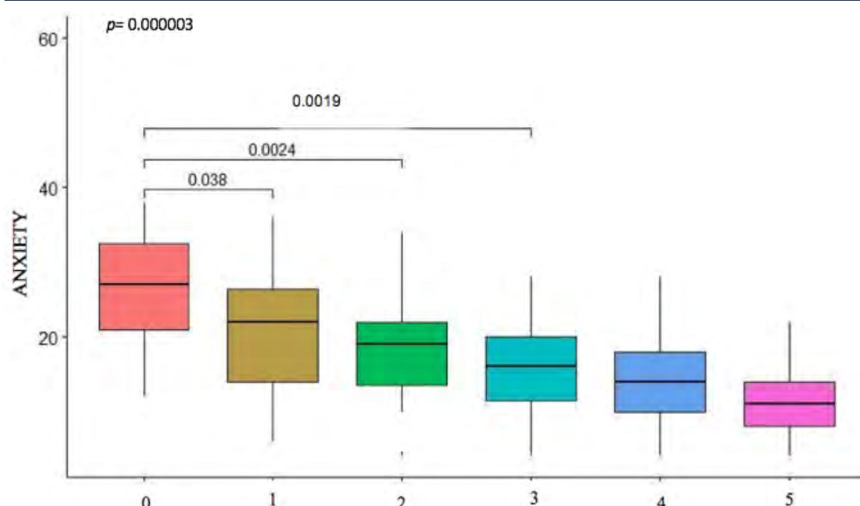
Figure 2 - Levels of Anxiety over sections of the Elderly Reiki Intervention Program Intervention and Control Groups



Depression by time and by group

With respect to symptoms of depression between IG and CG, Table 4 shows that there were no statistically significant differences between the IG and CG groups at TO (pre-intervention). After the ERIP, there was (p = .0065). The IG experienced half the number of depression symptoms (OR = 0.5264) as the CG.

Table 4 – Comparison of the prevalence of Depression in the intervention and control group by time

Variável	Contrast	Time	Ratio	SE	z.ratio	p-value
Depression	*Intervention/control*	*Pre*	*1.0604*	*0.2393*	*0.2600*	*0.7949*
	Intervention/control	*Post*	*0.5264*	*0.1241*	*-2.7216*	*0.0065*

Source: prepared by the author, 2024.

There were no statistically significant differences in symptoms of depression within the CG, both before and after the IG received the Reiki intervention. For the IG, symptoms of depression scores were statistically significantly different (p= 0.0084) (Table 5).

Table 5 – Comparison of the prevalence of Depression in the intervention and control by group

Variable	Time	Group	Ratio	SE	z.ratio	p-value
Depression	*pos/pre*	*Control*	*1.0838*	*0.2366*	*0.3686*	*0.7124*
	pos/pre	*Intervention*	*0.5380*	*0.1266*	*-2.6352*	*0.0084*

Source: prepared by the author, 2024.

Anxiety by time and by group

With respect to symptoms of anxiety between IG and CG, Table 6 shows that there were statistically significant differences between the IG and CG groups at TO (pre-intervention). After the ERIP, there was (p = .0000). The IG experienced half the number of anxiety symptoms (OR = 0.5341) as the CG.

Table 6 - Comparison of the prevalence of Anxiety in the intervention and control group by time

Variável	Contrast	Time	Ratio	SE	z.ratio	p-value
Depression	*Intervention/control*	*Pre*	*1.3820*	*0.1208*	*3.7005*	*0.0002*
	Intervention/control	*Post*	*0.5341*	*0.0565*	*-5.9281*	*0.0000*

Fonte: Preparado pelo autor, 2024.

There were no statistically significant differences in symptoms of anxiety within the CG, both before and after the IG received the Reiki intervention. For the IG, symptoms of anxiety scores were statistically significantly different (p= 0.0000) (Table

Table 7 – Comparison of the prevalence the Anxiety in the intervention and control by group

Variable	Time	Group	Ratio	SE	z.ratio	p-value
Depression	*pos/pre*	*Control*	*1.1369*	*0.1028*	*1.4184*	*0.1561*
	pos/pre	*Intervention*	*0.4394*	*0.0452*	*-7.9928*	*0.0000*

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DISCUSSION

This study revealed that the ERIP reduced levels of depression and anxiety in IG among elderly brazilian people. Moreover, reductions in depression levels were observed throughout the sessions, with the most significant reduction occurring after the second Reiki session and after the third session. The most reduction of anxiety levels was observed after the first, second and third session.

In a non-randomized clinical study focusing on reducing anxiety and depression and increasing well-being in preoperative patients, anxiety and depression levels were much lower in Reiki recipients.[23] In Watt et al. [24] study, Reiki was more effective in reducing depressive symptoms in people with dementia than pharmacological intervention. The same trend was observed for anxiety levels, particularly and the first three sessions (T1, T2, and T3). Corroborating these findings, Gálvez Escudeiro and Reyes-Bossio[25] showed that even remotely, Reiki intervention was effective in reducing COVID-19-related anxiety in Peruvian participants.

In this study, the ERIP yielded remarkable reductions in elderly people's depression levels, with a decrease of almost 50% in symptoms between the IG and the CG. Scandiuzzi[8] also reported a progressive and significant reduction in symptoms of depression (an average reduction of 15.1 down to 7.6 on the Dass-21) .

Reiki appears to be a salutary therapy for elderly people and warrants further attention in clinical settings. This non-pharmacological intervention could be integrated as a complementary practice in managing depression, particularly for elderly people seeking alternatives to conventional medical treatments. Reiki is relatively cost-effective and specialized equipment is not required.

Reiki could play a crucial role in alleviating anxiety as well. Scandiuzzi research revealed statistically significant declines in elderly people's anxiety levels throughout multiple Reiki sessions.8 We report similar patterns of findings for anxiety. This duality of benefits makes Reiki a viable and less invasive alternative in clinical settings where the goal of care is to reduce patient medication loads.

CONCLUSION

This study provides compelling evidence that the ERIP is a promising non-pharmacological approach to improving mental health outcomes for elderly individuals. The significant reductions in depression and anxiety symptoms observed in the intervention group highlight the potential of Reiki to serve as an effective adjunct in the management of mental health in older adults. The integration of Reiki into nursing practice aligns well with the core principles of holistic care, offering a non-invasive, accessible, and cost--effective method for enhancing the well-being of elderly patients.

One of the key strengths of this study is the inclusion of both an IG and a CG, which allowed for a robust comparison of the effects of Reiki. The findings suggest that Reiki can play a vital role in reducing symptoms of depression and anxiety, promoting a more comprehensive approach to elderly care that addresses not just physical health but also emotional and spiritual well-being.

Despite some limitations, such as the sample size, the results are promising and warrant further exploration. Future research should consider larger, more diverse samples and explore the long-term effects of Reiki on mental health outcomes in older adults. Additionally, the potential for integrating Reiki into routine care, particularly in community and primary care settings, should be further explored.

In conclusion, Reiki represents an important tool for mental health care, providing a valuable alternative or complement to conventional treatments for depression and anxiety. As the healthcare system continues to evolve, the adoption of holistic, non-pharmacological interventions like Reiki could be key in enhancing the mental and emotional health of elderly individuals, offering a more balanced and patient-centered approach to care.

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