

Research Paper

## Effectiveness of Reiki as an Adjunct to Psychotherapy in the Management of Obsessive Compulsive Disorder

Aditi Usha Tigga<sup>1\*</sup>, Dr. Neha Sayeed<sup>2</sup>, Dr. Basudeb Das<sup>3</sup>

### ABSTRACT

**Aim:** The purpose of this study was to assess the impact of Reiki, a complementary and alternative medicine (CAM) technique, in addition to Cognitive Behavioral Therapy (CBT) in the treatment of Obsessive-Compulsive Disorder (OCD). **Methodology:** A total of 20 participants with OCD were included and allocated to two groups. Group 1 (Control) received standard psychotherapy, while Group 2 (Reiki) received standard psychotherapy along with adjunctive Reiki sessions. Obsession, compulsion, perceived stress, anxiety, and depression were assessed at three time points: pre-intervention, post-intervention, and 3-month follow-up. Changes over time and between groups were evaluated using mixed repeated-measures ANOVA, with Greenhouse–Geisser corrections applied to within-subject effects where appropriate. **Results:** Significant main effects of Time were observed for obsession, compulsion, perceived stress, anxiety, and depression (all  $p < .001$ ), indicating substantial improvement across the assessment periods. The Group  $\times$  Time interactions were not statistically significant for obsession ( $p = .442$ ), compulsion ( $p = .920$ ), or perceived stress ( $p = .081$ ), indicating that the trajectories of improvement in these outcomes did not differ significantly between the groups. In contrast, significant Group  $\times$  Time interactions were observed for anxiety ( $p = .006$ ,  $\eta^2 = .318$ ) and depression ( $p = .014$ ,  $\eta^2 = .233$ ), with descriptive mean scores indicating greater reductions over time in the Reiki group. **Conclusion:** Adjunctive Reiki was associated with significantly different trajectories of improvement in anxiety and depression, with result indicating greater reductions in the Reiki group. However, the trajectories of change in core obsessive-compulsive symptoms and perceived stress did not differ significantly between the Reiki and control groups. Given the small sample size and non-randomized design, these findings should be considered preliminary. Reiki may warrant further investigation as a complementary intervention for comorbid anxiety and depressive symptoms in individuals with OCD.

**Keywords:** Anxiety, Complementary therapies, Depression, Mental health, OCD, Reiki, Stress

Obsessive-compulsive disorder (OCD), a disorder that was historically under-recognized, is now considered to be a prevalent, chronic, and frequently incapacitating disorder characterised by unwanted and perplexing thoughts

<sup>1</sup> Clinical Psychologist, Central Institute of Psychiatry, Ranchi University

<sup>2</sup>Ex-Associate Professor & Department of Clinical Psychology, Central Institute of Psychiatry, Ranchi University

<sup>3</sup>Ex-Director & Professor of Psychiatry, Central Institute of Psychiatry, Ranchi University

\*Corresponding Author

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(obsessions) and repetitive behaviours that the person feels obliged to carry out (compulsions) [1,2]. According to several studies, the lifetime incidence of OCD is thought to be between 1% and 3% [3,4]. It is associated with significant functional impairment [5,6] and a higher likelihood of early mortality [7]. Males are more frequently afflicted in childhood (13–18 years), while females are impacted in adolescence and adulthood at a slightly higher incidence than males [8,9].

Nearly a century after Jean-Étienne Esquirol's 1838 description of OCD appeared in the psychiatric literature, Lewis (1936) published one of the earliest family studies on the disorder [10]. Since then, it has been widely accepted that genetics has a significant influence on the onset of obsessive-compulsive disorders (OCD). OCD was categorised as an anxiety illness up until recently. With the changes in the diagnostic classification systems within the DSM-5 [11] and ICD-11 [12], OCD is now in a new class of diseases: OCD or related disorders (OCDs). Body dysmorphic disorder, hair pulling, hoarding, hypochondriasis, skin picking and olfactory reference disorders are all part of the OCDs. All of these disorders have compulsive behaviour as a common characteristic.

OCD patients present with a wide range of obsessions and compulsions, which contribute to its diverse appearance. Compulsions are behaviours that are either overt or mental practices that are usually used to lessen the discomfort caused by the obsessions. Patients with OCD often have insight (to varying degrees) about the excessiveness and irrationality of their obsessive-compulsive (OC) behaviours. Because of this, patients are occasionally categorised into more precise subgroups according to the comorbid presentation or predominant symptom type [13-21]. However, the circumstances under which symptoms present can differ depending on a number of variables, such as age, gender, and comorbidities [22].

Several evidence-based clinical recommendations have been provided for the management of OCD [23-25]. Serotonin reuptake inhibitor drugs (SRIs) [26-28] and cognitive-behavioral therapy with exposure/response prevention (ERP) [29] are the only proven first-line therapies for OCD. Between 25% to 40% of patients do not respond to either modality [30,31], and only a small percentage of patients have their symptoms completely resolved [32]. Antipsychotic augmentation is the only pharmacological treatment for OCD that has significant empirical evidence outside of SRI monotherapy, especially for individuals who also have a concomitant chronic tic condition [33-35]. However, improvements are required, according to recent opinions from stakeholders and subject matter experts (National Institute for Health and Care Excellence, 2019) [36]. The neurology of OCD is still not fully understood, which has hindered efforts to improve existing therapies or develop novel ones. Although psychotherapy is still the mainstay of treatment, alternative therapies like Reiki are gaining popularity because they may help to minimise OCD patients' psychological and energetic imbalances in addition to their other advantages.

Reiki is classified as a biofield therapy, a form of Complementary and alternative medicine (CAM). Complementary and alternative medicine (CAM) refers to a general class of alternative and non-traditional medical practices. Herbal remedies, chiropractic adjustments, alternative medical practices like Chinese medicine, mind-body therapies like biofield therapies, and meditation, which use the body's energy field to improve therapeutic benefit—may all be included. Mikao Usui of Kyoto invented it in Japan toward the close of the 1800s [37]. The expert practitioner gently places their hands on or close to the patient's

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body in a number of postures to promote the body's ability to heal itself and regain equilibrium [38]. Reiki is considered to be risk-free, affordable, and non-invasive. According to early study, it may be useful in treating a variety of conditions, including mental health issues. There are substantial evidence that Reiki has therapeutic effects. Reiki is known to induce profound relaxation that has been anecdotally claimed to reduce stress and anxiety, pain perception, and to foster a sense of psychospiritual well-being [39]. Reviews of clinical trials Reiki have been presented by Baldwin et al [40], vanderVaart et al [41], and by Lee et al [42]. These reviewers reported some potential benefits of Reiki for relaxation, anxiety, and pain reduction.

Due to the lack of any previous study on the therapeutic effect of Reiki on OCD, the present study aims to explore the effect of Reiki as an adjunct to Psychotherapy in the management of OCD.

### METHODOLOGY

#### *Study Design and Setting*

This was a prospective, hospital-based, controlled pretest–posttest study with an 8-week intervention period and a 3-month post-intervention follow-up, conducted at the Central Institute of Psychiatry, Ranchi, India. The study evaluated the effectiveness of adjunctive Reiki therapy, combined with standard Cognitive Behavioral Therapy (CBT), compared with standard CBT alone, in reducing obsessive-compulsive symptoms, perceived stress, anxiety, and depression among patients with Obsessive-Compulsive Disorder (OCD).

#### *Participants*

A total of 20 patients diagnosed with OCD according to DSM-5 criteria were recruited at the Central Institute of Psychiatry, Ranchi, India, using purposive sampling. Participants were aged 18 to 50 years, had a minimum illness duration of 2 years, and provided written informed consent prior to enrolment. Patients with a comorbid major psychiatric disorder, a significant comorbid medical condition, or a history of Electroconvulsive Therapy within the preceding 6 months were excluded. Concomitant pharmacotherapy, where present, was maintained at stable doses throughout the study period. Details of concomitant psychotropic medications (e.g., selective serotonin reuptake inhibitors) were recorded at baseline, and participants were instructed to maintain their current pharmacological regimens without dose adjustments throughout the 8-week intervention and 3-month follow-up periods.

#### *Group Allocation and Blinding*

Participants were allocated to Group 1 (Control, n = 10) and Group 2 (Reiki, n = 10) using purposive, consecutive non-random assignment. Allocation was not concealed from the treating clinician. Outcome assessors were not blinded to group assignment. Both groups received an identical standardized CBT with Exposure and Response Prevention protocol, Group 2 received Reiki in addition. Control group participants received no additional attention-control activity to account for non-specific attention effects.

#### *Interventions*

##### **Cognitive Behavioral Therapy with Exposure and Response Prevention**

All participants, in both groups, received standardized CBT incorporating Exposure and Response Prevention, delivered by a trained mental health professional experienced in delivering CBT with Exposure and Response Prevention for OCD. Therapy comprised eight sessions of 60 minutes each, delivered weekly over the 8-week intervention period,

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following a structured Exposure and Response Prevention protocol involving graded hierarchy construction, in-vivo and imaginal exposure, and response prevention.

### **Adjunctive Reiki Therapy**

Participants in Group 2 additionally received Reiki therapy, administered by a certified Reiki practitioner trained in the Usui Reiki system. Reiki was administered once weekly for 60 minutes over the 8-week intervention period, corresponding to eight sessions per participant. Each session followed a standardized gentle-touch or near-body protocol in which the practitioner placed hands on or just above a defined sequence of body positions, including the head, chest, abdomen, and lower body, for approximately 3 to 5 minutes per position, in a quiet, dedicated room with the participant seated or lying comfortably. Sessions were intended to promote physical and emotional relaxation and support the natural self-healing process of the participant, as an adjunct to ongoing CBT with Exposure and Response Prevention. Treatment adherence was monitored through attendance logs. All participants completed eight scheduled sessions, and no dropouts occurred.

### **Outcome Measures**

#### **Yale-Brown Obsessive-Compulsive Scale**

The severity of current OCD symptoms was assessed using the 10-item Yale-Brown Obsessive-Compulsive Scale, a semi-structured interview comprising a symptom checklist and a severity scale [43,44]. The severity scale rates obsessions and compulsions independently across five domains: time occupied, interference, distress, resistance, and degree of control. Each item is scored from 0 to 4, yielding a total score ranging from 0, indicating no symptoms, to 40, indicating extreme symptoms.

#### **Perceived Stress Scale**

Perceived stress was assessed using the 10-item Perceived Stress Scale [45], which quantifies the degree to which situations in life over the preceding month are appraised as unpredictable, uncontrollable, or overloading. Items are rated from 0, indicating never, to 4, indicating very often, and load onto two subscales: distress and coping. The original validation by Cohen and Williamson reported good internal reliability, with  $\alpha = .78$ , and two-day test-retest reliability of .85. In the present sample, Cronbach alpha values of .86 for the overall scale, .84 for the distress subscale, and .76 for the coping subscale were obtained.

#### **Beck Anxiety Inventory**

Anxiety symptoms were assessed using the Beck Anxiety Inventory, a 21-item self-report questionnaire in which each item is rated on a 4-point scale reflecting symptom severity over the preceding week. Total scores were categorized as low anxiety (1 to 21), moderate anxiety (22 to 35), or excessive anxiety (greater than 35).

#### **Beck Depression Inventory-II**

The Beck Depression Inventory-II, a 21-item self-reported questionnaire that rates each item on a 4-point scale from 0 to 3 depending on symptom intensity during the prior two weeks, was used to measure the severity of depressive symptoms. The total score ranged from 0 to 63. Depression symptoms are often classified as minor (0 to 13), mild (14 to 19), moderate (20 to 28), or severe (29 to 63). With Cronbach alpha values ranging from .92 to .93, the Beck Depression Inventory-II has shown great convergent validity compared to other standardized depression assessments and high internal consistency.

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## Ethical Considerations

The study was approved by the Institutional Ethics Committee of the Central Institute of Psychiatry, Ranchi, India. The approval number and date are documented in institutional records and can be provided upon reasonable request. The study was conducted in accordance with the ethical principles of the Declaration of Helsinki. Written informed consent was obtained from all participants prior to enrolment.

## Statistical Analysis

Data were analyzed using SPSS software version 27.0. Fisher exact test was used to compare baseline categorical variables between the groups. Mann-Whitney U test was used to compare age between the groups. A two-way mixed-design repeated-measures ANOVA was used to compare obsession, compulsion, perceived stress, anxiety, and depression scores, with Group as the between-subjects factor and Time as the within-subjects factor. The three time points were pre-intervention, post-intervention, and 3-month follow-up. The Greenhouse-Geisser correction was applied where sphericity was violated. Bonferroni-adjusted pairwise comparisons were used to compare the time points. Partial eta squared was reported as the effect size estimate. Statistical significance was set at  $p < 0.05$ .

## RESULT

The table 1 represents the demographic distribution of the studied population (group 1 and group 2).

**Table 1. Distribution and association between the socio-demographic variables of patients in Group 1 (Control) and Group 2 (Reiki)**

| Variable       | Category   | Group 1 (N = 10), N (%) | Group 2 (N = 10), N (%) | $\chi^2$ / Fisher Exact Test | df | p     |
|----------------|------------|-------------------------|-------------------------|------------------------------|----|-------|
| Gender         | Male       | 5 (50%)                 | 4 (40%)                 | 0                            | —  | 1.000 |
|                | Female     | 5 (50%)                 | 6 (60%)                 |                              |    |       |
| Marital Status | Unmarried  | 4 (40%)                 | 4 (40%)                 | 0                            | —  | 1.000 |
|                | Married    | 6 (60%)                 | 6 (60%)                 |                              |    |       |
| Religion       | Hindu      | 7 (70%)                 | 7 (70%)                 | .667 <sup>a</sup>            | 2  | 0.717 |
|                | Muslim     | 1 (10%)                 | 2 (20%)                 |                              |    |       |
|                | Christian  | 2 (20%)                 | 1 (10%)                 |                              |    |       |
| Education      | Illiterate | 2 (20%)                 | 1 (10%)                 | .410 <sup>a</sup>            | 2  | 0.815 |
|                | 5th to 8th | 2 (20%)                 | 2 (20%)                 |                              |    |       |
|                | ≥9th       | 6 (60%)                 | 7 (70%)                 |                              |    |       |
| Occupation     | Unemployed | 3 (30%)                 | 4 (40%)                 | .220 <sup>a</sup>            | 1  | 0.639 |
|                | Employed   | 7 (70%)                 | 6 (60%)                 |                              |    |       |
| Domicile       | Urban      | 5 (50%)                 | 7 (70%)                 | .833 <sup>a</sup>            | 1  | 0.361 |
|                | Rural      | 5 (50%)                 | 3 (30%)                 |                              |    |       |

Gender distribution was comparable between the two groups, with 50% male and 50% female participants in Group 1, compared with 40% male and 60% female participants in Group 2. There was no statistically significant difference in gender distribution between the groups ( $p = 1.000$ ). Marital status was identical in both groups, with 60% married and 40% unmarried participants, and no statistically significant difference was observed ( $p = 1.000$ ). Regarding religion, group 1 had the consist of 70% Hindu, 10% Muslim, and 20% Christian

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participants whereas in group 2, 70% Hindu, 20% Muslim, and 10% Christian participants were included. The difference between the groups was not statistically significant ( $p = .717$ ). Educational status was also comparable: in Group 1, 20% were illiterate, 20% had education from 5th to 8th standard, and 60% had education at 9th standard and above, whereas the corresponding proportions in Group 2 were 10%, 20%, and 70%, respectively. This difference was not statistically significant ( $p = .815$ ). In terms of occupation, 70% of participants in Group 1 and 60% in Group 2 were employed, while 30% and 40% were unemployed, respectively, with no statistically significant difference between the groups ( $p = .639$ ). Similarly, domicile distribution did not differ significantly between the groups ( $p = .361$ ); Group 1 comprised 50% urban and 50% rural participants, whereas Group 2 comprised 70% urban and 30% rural participants. Overall, no statistically significant differences were observed between Group 1 and Group 2 across any of the assessed sociodemographic variables ( $p > .05$ ), indicating that the two groups were comparable in terms of their sociodemographic characteristics.

The age comparison between the control and intervention (Reiki) groups was shown in Table 2. Group 1's mean age was 30, while Group 2's mean age was 31.80 years. Given that the two groups' age distributions was statistically at par, the p-value suggests that the age distributions of the control and intervention groups are comparable ( $Z: -0.342$ ;  $P > 0.05$ ;  $U: 45.5$ ).

**Table 2. Comparison of age between control and intervention (Reiki) group**

| Variable    | Group 1 (N = 10) |           | Group 2 (N = 10) |           | Mann-Whitney U Test | Z      | p     |
|-------------|------------------|-----------|------------------|-----------|---------------------|--------|-------|
|             | Mean±SD          | Mean Rank | Mean±SD          | Mean Rank |                     |        |       |
| Age (years) | 30±7.31          | 10.05     | 31.80±7.42       | 10.95     | 45.5                | -0.342 | 0.739 |

Table 3 shows mean obsession and compulsion scores for pre-intervention, post-intervention, and follow-up assessments for both the control group and the experimental group, along with the corresponding mixed ANOVA results.

**Table 3. Obsession and compulsion levels of control and intervention group**

| Variables          | Groups       | Pre Levels  | Post Levels | Follow-up  | Pairwise Comparisons (p)*                                     | Group p Effect, F(df), p, $\eta^2$             | Time Effect, F(df), p, $\eta^2$                          | Group × Time, F(df), p, $\eta^2$                       |
|--------------------|--------------|-------------|-------------|------------|---------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------|
| Obsession (Y-BOCS) | Control      | 14.8 ± 2.30 | 8.5 ± 2.01  | 7.1 ± 2.47 | < .001 <sup>a</sup> ; < .001 <sup>b</sup> ; .050 <sup>c</sup> | F(1, 18) = 2.362, $p = .142$ , $\eta^2 = .116$ | F(1.453, 26.150) = 115.541, $p < .001$ , $\eta^2 = .865$ | F(1.453, 26.150) = 0.750, $p = .442$ , $\eta^2 = .040$ |
|                    | Experimental | 14.1 ± 2.13 | 6.4 ± 2.80  | 5.8 ± 3.01 | < .001 <sup>a</sup> ; < .001 <sup>b</sup> ; .279 <sup>c</sup> |                                                |                                                          |                                                        |

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|                   |              |                   |               |               |                                                                  |                                                                               |                                                                                                 |                                                                                              |
|-------------------|--------------|-------------------|---------------|---------------|------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <b>Compulsion</b> | Control      | 16.7<br>±<br>3.09 | 9.9 ±<br>1.79 | 8.8 ±<br>1.40 | < .001 <sup>a</sup> ; <<br>.001 <sup>b</sup> ; .032 <sup>c</sup> | <i>F</i> (1,<br>18) =<br>2.465<br>, <i>p</i> =<br>.134,<br>$\eta^2$ =<br>.120 | <i>F</i> (1.71<br>0,<br>30.778<br>) =<br>112.28<br>9, <i>p</i> <<br>.001,<br>$\eta^2$ =<br>.862 | <i>F</i> (1.71<br>0,<br>30.778<br>) =<br>0.059,<br><i>p</i> =<br>.920,<br>$\eta^2$ =<br>.003 |
|                   | Experimental | 15.5<br>±<br>2.84 | 8.5 ±<br>2.92 | 7.2 ±<br>2.49 | < .001 <sup>a</sup> ; <<br>.001 <sup>b</sup> ; .140 <sup>c</sup> |                                                                               |                                                                                                 |                                                                                              |

Values are mean ± SD.  $\eta^2$  = partial eta squared.

<sup>a</sup> Pre vs. Post; <sup>b</sup> Pre vs. Follow-up; <sup>c</sup> Post vs. Follow-up.

Table 3 shows changes in obsession and compulsion scores across pre-intervention, post-intervention, and follow-up assessments. For obsession, the control group decreased from  $14.8 \pm 2.30$  at pre-intervention to  $8.5 \pm 2.01$  at post-intervention and  $7.1 \pm 2.47$  at follow-up. Significant reductions occurred from pre- to post-intervention ( $p < .001$ ) and from pre-intervention to follow-up ( $p < .001$ ), while the post-intervention to follow-up comparison was at the conventional threshold of statistical significance ( $p = .050$ ). The experimental group similarly decreased from  $14.1 \pm 2.13$  to  $6.4 \pm 2.80$  and  $5.8 \pm 3.01$ , respectively. The pre-post and pre-follow-up comparisons were significant (both  $p < .001$ ), whereas the additional reduction from post-intervention to follow-up was not statistically significant ( $p = .279$ ).

The mixed repeated-measures ANOVA showed a significant main effect of Time for obsession,  $F(1.453, 26.150) = 115.541$ ,  $p < .001$ ,  $\eta^2 = .865$ , demonstrating a substantial overall change in obsession scores over time. However, the Group main effect was not significant,  $F(1, 18) = 2.362$ ,  $p = .142$ ,  $\eta^2 = .116$ , and the Group  $\times$  Time interaction was also not significant,  $F(1.453, 26.150) = 0.750$ ,  $p = .442$ ,  $\eta^2 = .040$ . Therefore, although the experimental group had numerically lower scores at post-intervention and follow-up, the trajectory of improvement did not differ significantly between groups.

For compulsion, the control group decreased from  $16.7 \pm 3.09$  at pre-intervention to  $9.9 \pm 1.79$  at post-intervention and  $8.8 \pm 1.40$  at follow-up. All three pairwise comparisons were statistically significant (pre vs. post,  $p < .001$ ; pre vs. follow-up,  $p < .001$ ; post vs. follow-up,  $p = .032$ ). The experimental group decreased from  $15.5 \pm 2.84$  to  $8.5 \pm 2.92$  and  $7.2 \pm 2.49$ , respectively. Significant reductions occurred from pre- to post-intervention and from pre-intervention to follow-up (both  $p < .001$ ), whereas the post-intervention to follow-up change was not statistically significant ( $p = .140$ ).

The mixed ANOVA demonstrated a significant Time effect for compulsion,  $F(1.710, 30.778) = 112.289$ ,  $p < .001$ ,  $\eta^2 = .862$ . In contrast, neither the Group effect,  $F(1, 18) = 2.465$ ,  $p = .134$ ,  $\eta^2 = .120$ , nor the Group  $\times$  Time interaction,  $F(1.710, 30.778) = 0.059$ ,  $p = .920$ ,  $\eta^2 = .003$ , was statistically significant. Thus, both groups demonstrated substantial improvement in obsession and compulsion over time, but there was no evidence that the experimental intervention produced a significantly different trajectory of improvement in core OCD symptoms compared with the control condition.

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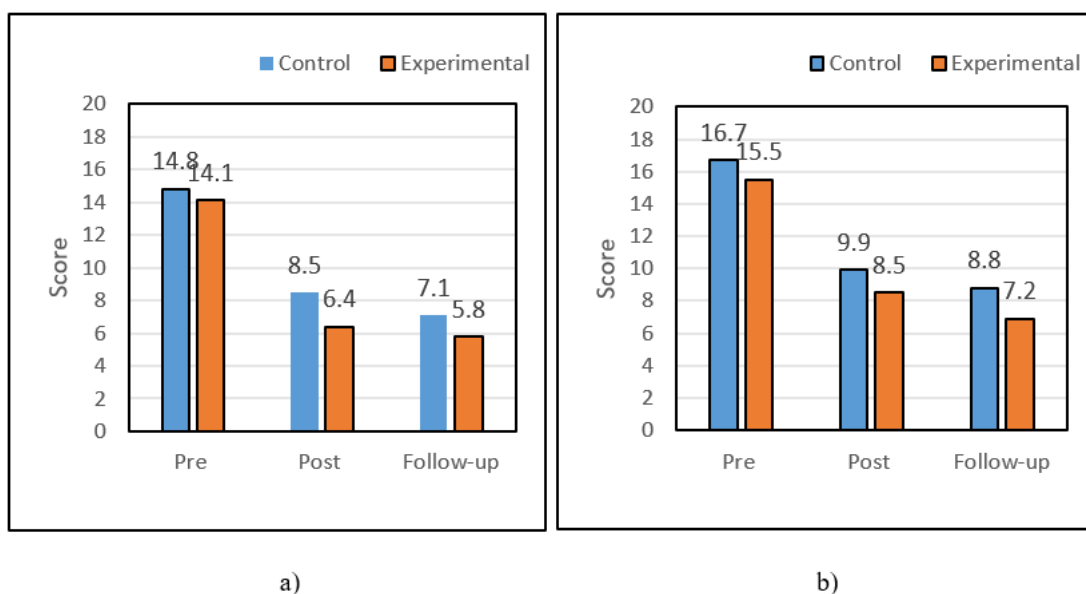


**Figure 1. Pre-intervention, post intervention and follow-up scores of, a) Obsession and b) Compulsion**

Table 4 shows the mean scores in stress, anxiety, and depression for the control and intervention groups at studied time intervals.

**Table 4. Stress, anxiety and depression levels of control and intervention group**

| Variable s    | Groups       | Pre Levels      | Post Levels     | Follow-up       | Pairwise Comparisons (p)*                                       | Group Effect, F(df), p, $\eta^2$            | Time Effect, F(df), p, $\eta^2$                       | Group $\times$ Time, F(df), p, $\eta^2$             |
|---------------|--------------|-----------------|-----------------|-----------------|-----------------------------------------------------------------|---------------------------------------------|-------------------------------------------------------|-----------------------------------------------------|
| Stress (PSS)  | Control      | 28.4 $\pm$ 2.80 | 18.6 $\pm$ 4.06 | 16.4 $\pm$ 4.12 | < .001 <sup>a</sup> ; < .001 <sup>b</sup> ; < .001 <sup>c</sup> | F(1, 18) = 4.790, p = .042, $\eta^2$ = .210 | F(1.205, 21.696) = 229.703, p < .001, $\eta^2$ = .927 | F(1.205, 21.696) = 3.202, p = .081, $\eta^2$ = .151 |
|               | Experimental | 26.9 $\pm$ 3.98 | 14.3 $\pm$ 4.35 | 11.8 $\pm$ 4.18 | < .001 <sup>a</sup> ; < .001 <sup>b</sup> ; < .002 <sup>c</sup> |                                             |                                                       |                                                     |
| Anxiety (BAI) | Control      | 31.2 $\pm$ 5.33 | 22.9 $\pm$ 5.34 | 21.9 $\pm$ 5.47 | < .001 <sup>a</sup> ; < .001 <sup>b</sup> ; < .074 <sup>c</sup> | F(1, 18) = 4.174, p = .056, $\eta^2$ = .188 | F(1.213, 21.826) = 167.047, p < .001, $\eta^2$ = .903 | F(1.213, 21.826) = 8.398, p = .006, $\eta^2$ = .318 |
|               | Experimental | 29.2 $\pm$ 7.60 | 16.3 $\pm$ 6.78 | 14.4 $\pm$ 6.10 | < .001 <sup>a</sup> ; < .001 <sup>b</sup> ; < .007 <sup>c</sup> |                                             |                                                       |                                                     |
| Depressi      | Control      | 24.2            | 17.5            | 14.4 $\pm$      | < .001 <sup>a</sup> ; <                                         | F(1,                                        | F(1.57                                                | F(1.57                                              |

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|          |                  |                       |                       |                   |                                                                   |                                        |                                                          |                                                       |
|----------|------------------|-----------------------|-----------------------|-------------------|-------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------|-------------------------------------------------------|
| on (BDI) |                  | $\pm$<br>4.32         | $\pm$<br>4.03         | 3.89              | .001 <sup>b</sup> ; <<br>.001 <sup>c</sup>                        | 18) =<br>5.285                         | 9,<br>28.429                                             | 9,<br>28.429                                          |
|          | Experimen<br>tal | 22.7<br>$\pm$<br>4.95 | 12.9<br>$\pm$<br>4.56 | 8.9 $\pm$<br>2.38 | < .001 <sup>a</sup> ; <<br>.001 <sup>b</sup> ; <.004 <sup>c</sup> | , $p$ =<br>.034,<br>$\eta^2$ =<br>.227 | ) =<br>182.49<br>4, $p$ <<br>.001,<br>$\eta^2$ =<br>.910 | ) =<br>5.481,<br>$p$ =<br>.014,<br>$\eta^2$ =<br>.233 |

Note. Values are mean  $\pm$  SD.  $\eta^2$  = partial eta squared.

<sup>a</sup> Pre vs. Post; <sup>b</sup> Pre vs. Follow-up; <sup>c</sup> Post vs. Follow-up.

For perceived stress (PSS), the control group's mean score decreased from  $28.4 \pm 2.80$  at pre-intervention to  $18.6 \pm 4.06$  at post-intervention and  $16.4 \pm 4.12$  at follow-up, with all pairwise comparisons statistically significant ( $p < .001$ ). The experimental group showed a larger descriptive reduction from  $26.9 \pm 3.98$  to  $14.3 \pm 4.35$  and  $11.8 \pm 4.18$ , respectively; pre-post and pre-follow-up differences were significant at  $p < .001$ , while the post-follow-up comparison was also significant ( $p = .002$ ). The mixed ANOVA demonstrated a significant Group effect,  $F(1, 18) = 4.790$ ,  $p = .042$ ,  $\eta^2 = .210$ , and a strong Time effect,  $F(1.205, 21.696) = 229.703$ ,  $p < .001$ ,  $\eta^2 = .927$ . However, the Group  $\times$  Time interaction was not statistically significant,  $F(1.205, 21.696) = 3.202$ ,  $p = .081$ ,  $\eta^2 = .151$ . Thus, despite numerically lower stress scores in the experimental group, the data do not establish a significantly different trajectory of stress reduction between the groups.

For anxiety (BAI), the control group's mean score decreased from  $31.2 \pm 5.33$  to  $22.9 \pm 5.34$  and  $21.9 \pm 5.47$ . The pre-post and pre-follow-up reductions were statistically significant (both  $p < .001$ ), but there was no significant additional change between post-intervention and follow-up ( $p = .074$ ). In contrast, the experimental group decreased from  $29.2 \pm 7.60$  at pre-intervention to  $16.3 \pm 6.78$  at post-intervention and  $14.4 \pm 6.10$  at follow-up, with all pairwise comparisons significant, including the post-follow-up comparison ( $p = .007$ ). Mixed ANOVA demonstrated a significant Time effect for anxiety,  $F(1.213, 21.826) = 167.047$ ,  $p < .001$ ,  $\eta^2 = .903$ . The overall Group effect narrowly failed to reach statistical significance,  $F(1, 18) = 4.174$ ,  $p = .056$ ,  $\eta^2 = .188$ . Importantly, the Group  $\times$  Time interaction was statistically significant,  $F(1.213, 21.826) = 8.398$ ,  $p = .006$ ,  $\eta^2 = .318$ . This indicates that the trajectory of anxiety reduction differed significantly between groups, with the descriptive means showing a greater reduction in the experimental group.

For depression (BDI), mean scores in the control group decreased from  $24.2 \pm 4.32$  at pre-intervention to  $17.5 \pm 4.03$  at post-intervention and  $14.4 \pm 3.89$  at follow-up, with all pairwise comparisons significant ( $p < .001$ ). The experimental group showed a reduction from  $22.7 \pm 4.95$  to  $12.9 \pm 4.56$  and  $8.9 \pm 2.38$ , with significant pre-post and pre-follow-up reductions (both  $p < .001$ ) and a significant further reduction from post-intervention to follow-up ( $p = .004$ ). Mixed ANOVA showed significant effects of Group,  $F(1, 18) = 5.285$ ,  $p = .034$ ,  $\eta^2 = .227$ , and Time,  $F(1.579, 28.429) = 182.494$ ,  $p < .001$ ,  $\eta^2 = .910$ . The Group  $\times$  Time interaction was also significant,  $F(1.579, 28.429) = 5.481$ ,  $p = .014$ ,  $\eta^2 = .233$ . Thus, the trajectory of depression scores differed significantly between groups, with the descriptive data indicating greater improvement in the experimental group.

All five psychological outcomes improved significantly over time. However, the interaction results distinguish the intervention-specific pattern: Group  $\times$  Time was significant for anxiety and depression, but not for obsession, compulsion, or perceived stress. Therefore,

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the raw-data analysis supports a differential improvement associated with the experimental condition for anxiety and depression, while the improvements in core OCD symptoms and perceived stress were not statistically distinguishable between groups over time.

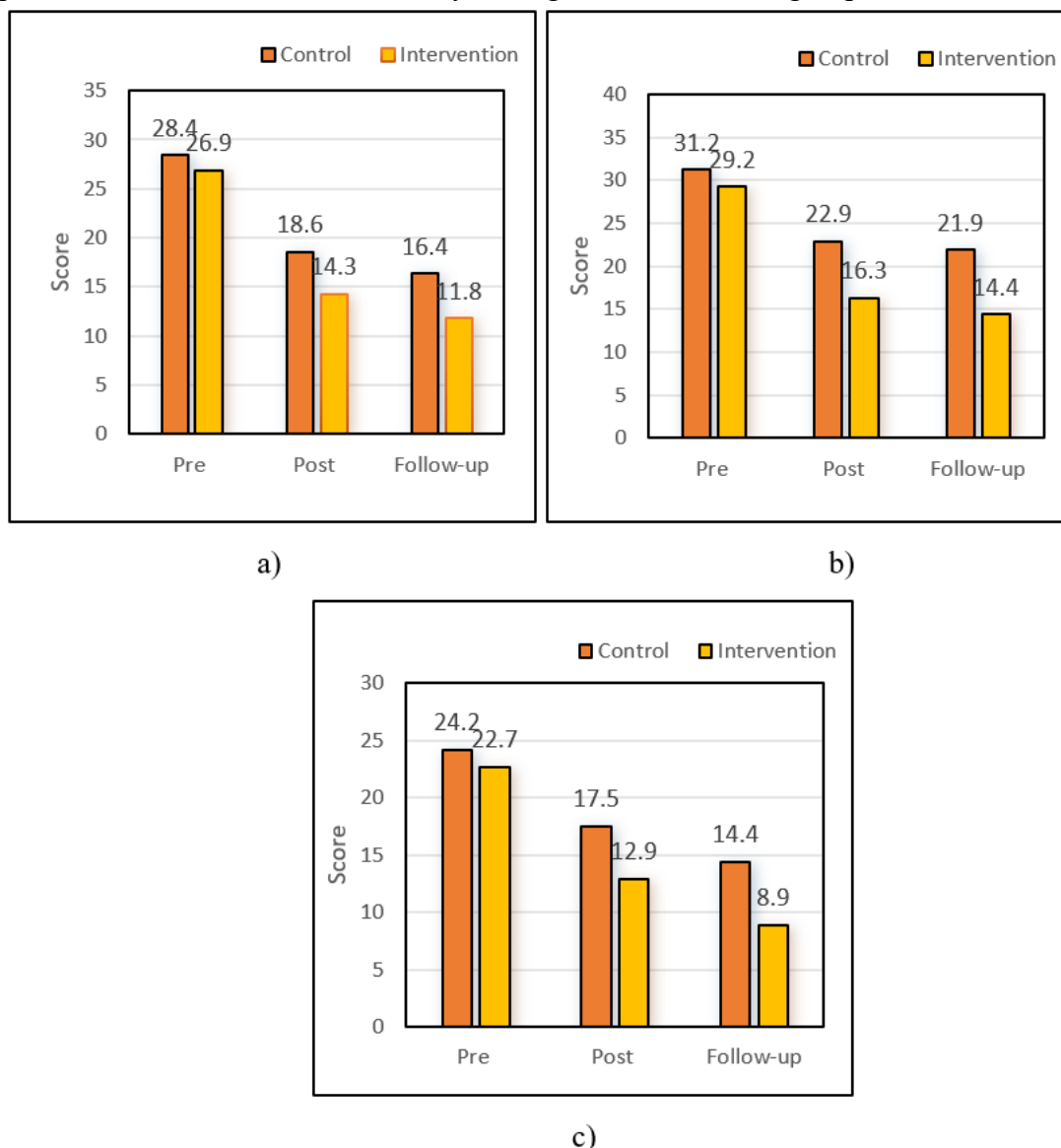


**Figure 2.** Pre-, post-intervention and follow-up scores of a) Stress, b) Anxiety and c) Depression

## DISCUSSION

This present study aimed to evaluate the effectiveness of Reiki therapy as an adjunctive treatment for obsession, compulsion, perceived stress, anxiety and depression. The present study demonstrated substantial improvements over time across all psychological outcomes in both the control and Reiki groups. However, the pattern of change differed according to the outcome assessed. Significant Group  $\times$  Time interactions were observed for anxiety and depression, with the descriptive means indicating greater reductions in the Reiki group. In contrast, the Group  $\times$  Time interactions for obsession, compulsion, and perceived stress were not statistically significant, indicating that the trajectories of improvement in these outcomes did not differ significantly between the groups. These findings suggest that

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adjunctive Reiki may have additional benefits for affective symptoms, particularly anxiety and depression, while no differential effect was demonstrated for core OCD symptoms or perceived stress. The findings suggest that adjunctive Reiki may be useful for reducing affective distress and emotional dysregulation but they do not indicate that Reiki directly modifies the core cognitive behavioral mechanisms that underlie obsessive-compulsive disorder (OCD) itself. A comparison of the demographic data of Group 1 (Control) and Group 2 (Reiki) showed no statistically significant difference in all the individual variables ( $p > 0.05$ ) (Tables 1 and 2). The small sample size, however, should be interpreted as being not significant when making baseline comparisons, as such comparisons cannot be interpreted as evidence of equivalence. As a result the possibility of baseline differences cannot be totally ruled out and the results presented should be regarded as preliminary. Demographic and clinical data showed no marked differences between the groups, but the groups were not randomly assigned to treatment and the numbers were small, which restricts the power of the causal inference.

Both the control and experimental groups demonstrated substantial reductions in obsession and compulsion scores across the three assessment periods. The mixed repeated-measures ANOVA showed significant main effects of Time for both obsession,  $F(1.453, 26.150) = 115.541$ ,  $p < .001$ ,  $\eta^2 = .865$ , and compulsion,  $F(1.710, 30.778) = 112.289$ ,  $p < .001$ ,  $\eta^2 = .862$ , indicating substantial overall improvement in core OCD symptoms over time. However, neither the Group effects nor the Group  $\times$  Time interactions were statistically significant for obsession or compulsion. Thus, although the Reiki group showed numerically lower obsession and compulsion scores at post-intervention and follow-up, the trajectories of improvement did not differ significantly between the groups. Notably, the additional change from post-intervention to follow-up was not statistically significant in the Reiki group for either obsession ( $p = .279$ ) or compulsion ( $p = .140$ ), suggesting that most of the observed improvement had already occurred by the post-intervention assessment. These findings are consistent with the neurobiological and psychotherapeutic literature on Obsessive Compulsive Disorder (OCD). The core defect in OCD is in hyperactivity of rigid cortico-striato-thalamo-cortical circuits (CSTC) underlying behaviors associated with habit formation, error detection, and behavioral inhibition [46]. The disruptive behavior loops and rewiring CSTC circuitry is a gold-standard treatment that is specifically designed to treat these maladaptive behavior loops, namely Exposure and Response Prevention (ERP). Relaxation-based therapies, on the other hand, are used as a foundation of Reiki and have been historically proven to be less effective than ERP in directly reducing core OCD symptoms [47]. Recent comprehensive reviews support the use of relaxation strategies, biofield therapies and mindfulness as helpful adjunctive modalities to cope with the distressing symptoms of OCD, but not to restructure the core OCD thoughts or the compulsive rituals [48]. It is also important to note that the reduction in the control group was also profound and sustained over time with regard to all measured variables. The strong therapeutic response is indicative of a high efficacy standardized CBT with ERP protocol received at the Central Institute of Psychiatry. The improvement in the control group was significant, which demonstrates that the basic evidence-based care was effectively delivered and serves as a strong control group to measure the additional benefit of Reiki.

The Cochrane Database of Systematic Reviews (CDSR) by Joyce and Herbison (2015) [49] also identified flaws in the current evidence base for the effectiveness of Reiki on anxiety and depression, such as the lack of sufficient numbers and methodological rigor of controlled studies reviewed. The present results have to be interpreted with caution due to

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the limited evidence base and the need for adequately powered randomized controlled trials. Therefore, the significant, but moderate, improvement seen in both groups was likely due primarily to the standard clinical care provided with treatment, but may also be due to natural symptom fluctuation. There were no significant Group  $\times$  Time interactions for either the obsession or compulsion scores, which means that the scores for those symptoms showed a statistically similar pattern of change as the control group, regardless of whether Reiki was added.

There was no difference between the groups in terms of core OCD symptoms, but anxiety and depression showed a different pattern. For anxiety, there was a significant main effect of Time,  $F(1.213, 21.826) = 167.047$ ,  $p < .001$ ,  $\eta^2 = .903$ , together with a significant Group  $\times$  Time interaction,  $F(1.213, 21.826) = 8.398$ ,  $p = .006$ ,  $\eta^2 = .318$ . Similarly, depression showed a significant main effect of Time,  $F(1.579, 28.429) = 182.494$ ,  $p < .001$ ,  $\eta^2 = .910$ , and a significant Group  $\times$  Time interaction,  $F(1.579, 28.429) = 5.481$ ,  $p = .014$ ,  $\eta^2 = .233$ . These significant interactions indicate that the trajectories of anxiety and depression differed between the control and Reiki groups over time. The descriptive means showed greater reductions in the Reiki group, with follow-up anxiety scores of  $14.4 \pm 6.10$  compared with  $21.9 \pm 5.47$  in the control group and follow-up depression scores of  $8.9 \pm 2.38$  compared with  $14.4 \pm 3.89$  in the control group. The results of the present study are very consistent with the literature on integrative medicine and give an insight into the mechanism of Reiki. In a randomized controlled trial, Bowden et al. (2011) found that those with high anxiety and depression who were treated with Reiki experienced progressive and significant changes in overall mood relative to controls [50]. The improvements observed in anxiety and depression are consistent with previous studies reporting mood-related benefits of Reiki [50]. Some prior research has suggested that Reiki may influence autonomic arousal, heart rate variability, cortisol levels, and parasympathetic activity [51–53]. However, these physiological markers were not measured in the present study. Therefore, such mechanisms remain hypothetical, and the present findings cannot confirm a specific biological mechanism of action. Clinically, this allows Reiki to be an ideal complementary intervention in psychiatric care to support psychiatric patients in achieving a better quality of their life and their well-being [49]. These results are in line with the literature that has been published on Reiki as a stress reducing and relaxation technique. For example, Bukowski (2015) studied the effect of Reiki for stress reduction and employed the Perceived Stress Scale (PSS) to assess perceived outcomes, finding that Reiki interventions significantly reduced stress and increased relaxation [54]. Likewise, Cuneo et al. (2011) assessed the impact of Reiki on registered nurses' work-related stress by measuring change in PSS scores before and after Reiki and found that registered nurses who received Reiki had significantly lower scores on the PSS after Reiki than at baseline [55]. Moreover, a systematic integrative review conducted by Thrane and Cohen (2014) found Reiki therapy repeatedly to be effective in reducing the physiological and psychological stress responses in various clinical groups [56].

However, the important main effect of Group in our study is consistent with the seminal study by Shore (2004) who showed that an energetic healing technique such as Reiki led to significant and long lasting decreases in self-perceived stress when compared to control conditions [57]. For perceived stress, the mixed ANOVA demonstrated a significant main effect of Time,  $F(1.205, 21.696) = 229.703$ ,  $p < .001$ ,  $\eta^2 = .927$ , indicating substantial reductions in perceived stress over time. A significant Group main effect was also observed,  $F(1, 18) = 4.790$ ,  $p = .042$ ,  $\eta^2 = .210$ . However, the Group  $\times$  Time interaction was not

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statistically significant,  $F(1.205, 21.696) = 3.202$ ,  $p = .081$ ,  $\eta^2 = .151$ . Therefore, although the Reiki group showed numerically lower stress scores at post-intervention and follow-up, the evidence does not demonstrate a significantly different pattern of stress reduction over time compared with the control group. Accordingly, the significant Group main effect should be interpreted cautiously in the absence of a significant Group  $\times$  Time interaction. Future studies with larger samples are needed to clarify whether Reiki provides a clinically meaningful additional benefit for perceived stress.

### *Proposed Mechanisms of Action*

The difference between OCD symptoms and affective symptoms is very important and allows for understanding of the mechanism of Reiki. Reiki is not regarded as a specific cognitive restructuring technique but could serve mainly as an add-on relaxation and emotional-regulation technique. OCD can be exhausting and chronic and often causes patients to have a high level of comorbid anxiety and depression. With its calming and emotional balancing properties, Reiki can also alleviate the secondary burden of emotions that can arise from OCD. In previous studies, it has been suggested that there are possible mechanisms, including decrease in cortisol levels or alterations in the activity of the hypothalamic-pituitary-adrenal axis, which were not evaluated in the present study. This proposed interpretation is supported by the large Group  $\times$  Time interaction effects that were found for anxiety and depression; there was no significant differential effect for obsession and compulsion. Yet due to the lack of direct assessment of the proposed physiological mechanisms in the present study, they can be only considered as potential mechanisms that could underlie a particular effect. The varied results of this study could have implications for the possible use of adjunctive biofield therapies within psychiatric facilities. Clinicians should not use Reiki as an alternative to ERP or cognitive restructuring for the purpose of targeting the core OCD pathology. Due to the fact that most patients with OCD experience significant autonomic hyperarousal and affective exhaustion, however, they may find it difficult to bear the pain of ERP exercises. Reiki is therefore a relaxation technique that could be explored as a preparatory or concurrent relaxation technique with evidence-based OCD treatment, especially for patients with comorbid symptoms of anxiety and depression. Future research is needed to explore if a reduction in affective distress correlates with treatment adherence, fewer dropouts and increased tolerance for ERP.

### *Strengths, Limitations and Future Directions*

The longitudinal design of this study was one of its strengths, with a follow-up assessment to assess changes in psychological outcomes over time. The within subject effect was analyzed with a mixed repeated-measures ANOVA (when necessary, Greenhouse–Geisser corrections were used). However, limitations exist. The high dropout rate, resulting in a small number of participants in both groups (20 in each), reduced the statistical power, precision of the estimated intervention effects, and generalizability of the results. Thus, nonsignificant results (Group  $\times$  Time interaction for perceived stress) should be viewed with some caution. Additionally, non-randomized design and lack of sham Reiki control preclude causal inferences and make exclusion of non-specific attention effects challenging. More research is required to effectively and objectively show autonomic changes using larger multi-center randomized controlled trials with active control groups and physiological measures (such as HRV, Salivary Cortisol) to prove the effectiveness of Reiki.

## **CONCLUSION**

The results of this preliminary study showed significant Group and Time interactions for anxiety and depression. The descriptive mean scores suggested that there were more reductions across time in the Reiki group. The interaction between Group and Time was not statistically significant for obsessive symptoms, compulsion, and perceived stress, suggesting that there were not significantly different trends of change across the Reiki and control groups for these outcomes. The two groups showed significant and long-lasting improvement in every variable measured, which are consistent with positive changes throughout comprehensive care. The results herein are suggestive that Reiki could be potentially beneficial to complement mental health treatments in an integrative approach, especially for the treatment of OCD patients with comorbid anxiety and depressive symptoms. Due to the small sample size and non-randomized design, however, these results are preliminary. To validate these findings, more extensive and varied studies with active control conditions, consistent Reiki protocols, physiological indicators and with larger samples are required to understand how Reiki has potential therapeutic effects and to better understand the mechanisms by which Reiki works.

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### ***Conflict of Interest***

The author(s) declared no conflict of interest.

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