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Original Research Article

Feel what you feel: What are the effects of Reiki on young people in secure and residential childcare?

Abbi Jackson

Abstract:

Action research was used to examine the potential of Reiki as a valid treatment in support of trauma recovery for young people in residential and secure care in Scotland. An explanation of Reiki is provided along with an outline of the general presentation of young people in placement in these settings. Attention is given to the preparation and risk assessment of the treatment trial in terms of safety and trauma-informed practice. Nineteen young people self-selected to participate. The relationship between the Reiki experience and the number of incidents in the care setting is considered, alongside self-report feedback and behavioural observations. Overall participants were more relaxed, and Reiki had a positive effect on wellbeing. Limitations of Reiki for this client group are noted.

Introduction

Reiki is a holistic therapy, which has been taught in the West since 1938 and in Japan since the early 1920s (Quest & Roberts, 2010). Reiki is a safe, gentle, non-intrusive healing technique for use on oneself, other people, or animals. It is a 'holistic system for harmonising body, mind, emotions and spirit, promoting relaxation and wellbeing, and encouraging self-awareness and spiritual development' (Quest & Roberts, 2010).

This paper aims to contribute to the evidence base for Reiki as a valid biofield treatment modality. Specifically, this research aims to demonstrate some possibilities for Reiki to support recovery from trauma for young people in residential and secure care in Scotland. This was a piece of action research, such that the researcher was also the therapist undertaking Reiki treatments. The

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term 'practitioner' is used throughout to indicate this role. Case studies below are written in the first person, with pseudonyms chosen by young people (supported by workers). This approach to confidentiality was taken to provide a more meaningful basis via which to acknowledge experiences, rather than, for example, referring to people using initials or other identifiers. These young people have given their consent for their comments and observations to be used in this study.

Background

Reiki is universal life force energy delivered through the hands of the giver and drawn into the client, by the client. It works on the seven chakras of the body which run along the mid-line from the bottom of the spine to the top of the head. The chakras are the energetic structures through which we organise our life force and are every bit as valid as psychological theory, but span mind, body, and spirit (Judith, 1996). They are a system of human development and can be felt and observed in people as either deficient, excessive, or balanced depending on the stage achieved in healing (Judith, 1996).

'Ki' is energy in the body operating at high vibrations and fast frequencies which makes it difficult to see, but it can be detected by various forms of electro-magnetic equipment (Quest & Roberts, 2010). Every cell in the human body is energy vibrating at a slow enough frequency to show as visible physical matter. Every person has a unique vibrational energy signature, or frequency, in the same way as we all have unique fingerprints or DNA. Reiki operates at an even higher and faster vibration than the 'Ki' that is present in the physical body and the aura, so it can move through all parts of the human energy field to penetrate energetic blockages and promote healing (Quest & Roberts, 2010).

Reiki energy is theta waves, like having a very deep relaxing sleep. The body takes as much or as little Reiki as it needs, at a pace that suits the person receiving. It does not work in any other way and cannot be forced or imposed upon someone. Some people experience tingling or soft waves going through their body; others feel heat. Sometimes blood is drawn to vital organs leaving the person with cold feet and hands. Sometimes the body becomes so relaxed that legs might jump. Other people say they feel nothing, which does not mean the Reiki is not working. Reiki can never do harm and only goes where it is needed. Sometimes clients desire one effect and experience several other positive shifts.

The giver of Reiki does not need to know the person's history or diagnosis. The receiver of Reiki does not need to 'believe' in the treatment. In addition, because the practitioner does not direct healing and does not decide what to work on, they are not in danger of taking on the karma of the client. In the same way, the ego does not play a part in the treatment. Conditions of unconditional positive regard, congruence, empathy, and compassion are naturally present in a

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treatment which supports trust building. However, the effects of these are secondary as Reiki works at a much deeper energetic level.

There are a variety of viewpoints available about the efficacy of Reiki and a definitive evidence base has not yet been established. The reliance on pharmaceuticals in Western cultures may be a prohibitive factor with respect to the lack of research into alternative therapies in general. However, Reiki has a firm place in oncology care (Alacaro & Fonseca, 2016; Demir et al., 2013; Fleisher et al., 2014; Olson & Hanson, 1997), including evidencing improvements in quality of life (Tsang et al., 2007). It is also used in the NHS in cancer and palliative care (Chang, 2018). One example is a study of children receiving palliative care, which found they reacted positively to Reiki in measures of quality of life, stress, oxygenation, heart, and respiratory rates with medium to large clinical effect sizes (Thrane et al., 2022).

Reiki has also been found to reduce depression and stress (Zadro & Stapleton, 2022) and improve mood in randomised controlled studies (Bowden et al., 2011). In addition, Morero (2021) found, in a systematic review of eleven studies, that Reiki has potential benefits in mental health care. This also aligns with findings of a study of 1411 Reiki sessions where statistically significant improvements were observed for measures in negative affect, pain, drowsiness, tiredness, nausea, appetite, shortness of breath, anxiety, depression, and overall well-being (Dyer et al., 2019).

This evidence, and previous anecdotal experience of the practitioner, led to the proposal for this research with young people in residential and secure care. In general terms the client group in this study have had significantly impactful traumatic experiences and some of their care needs have previously been unmet. They are placed by local authorities in this care setting because they meet the relevant criteria for secure care. According to the Secure Accommodation (Scotland) 2013 regulations, this means they might have absconded, and are likely to abscond again, and if that were to happen their physical, mental, or moral welfare would be at risk. They may also have engaged in self-harming conduct or may be likely to cause injury to another person.

Some of the participants in this study did not meet the specific secure criteria defined in legislation and were looked after in the residential care campus in the same establishment. These young people presented an equally high level of needs. They all may have experienced adversity, and relational and material poverty of varying impacts, and some may have experienced physical, sexual, and emotional abuse and neglect. It is recognised that this client group are vulnerable to poor physical and mental health, and many have been in local authority care previously.

The predominant interventions in this setting are safety/stabilisation, and behavioural modification techniques. The onsite psychological intervention service offers programme work and specialist advice to caregivers and young

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people, as well as providing assessment of need and intervention plans. All young people are subject to ongoing comprehensive risk assessment and management.

Methodology

The researcher is qualified to deliver Reiki at Level 2. Supervision is received as required from a Reiki Master, whose lineage is 7 from Dr Mikao Usai (originator of Reiki). Her experience includes lecturing on biofield treatment modalities at a Scottish university and involvement in the ongoing professional development of independent practitioners. This supervision and guidance focuses solely on practice improvement and no personal details are included.

A risk assessment for the delivery of Reiki in this setting was considered as follows:

Risks	**Mitigation**
Young people might be worried about what Reiki will do to them.	What Reiki is, what they might experience, and that they are always in control will be explained in a way that suits the young person. They will be offered the opportunity to ask any questions beforehand. They can ask for the treatment to stop at any time. General safe caring best practice will be observed in line with agency policy.
Young people do not like to be touched.	Reiki can be delivered hands off or hands on depending on preference. Most people find hands on more reassuring as they can close their eyes knowing where the practitioner is. However, this will all be discussed with the person. Young people will not be touched in the torso area as an absolute rule. However, it should be noted that Reiki sometimes brings strange feelings in parts of the body not being touched.
Language use by staff - for example claims that Reiki can 'cure' self-harm are both reductionist and inaccurate.	Laminated sheets describing Reiki will be provided. Care staff will be briefed to ensure appropriate wrap around care.
Some young people may seek to have their own needs validated as more important than others and request that they are prioritised for treatment.	This will need to be managed in line with group dynamics and overall service priorities at the time. Familiar ways of team working would need to be used to de-escalate issues.

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Negative energy backflow must be prevented.	This is not an issue as Reiki energy is channelled through the practitioner rather than from the practitioner. Empathy is present but must be set aside.

Young people were given background information on Reiki and the practitioner (UK Reiki Federation, 2021) and encouraged to ask questions. Some young people took a 10-minute trial, while others did not. All participants self-selected to take part. Offering choice fits with both the model of Reiki itself, and with the trauma-informed practice necessary for delivering good quality childcare. Young people were advised that they could stop a session at any time (UK Reiki Federation, 2021).

Half-hour sessions were offered on a weekly basis. Sessions were booked by the young people in advance. A degree of flexibility was needed as young people changed their minds, and others decided they would like a session on the spur of the moment. Young people were asked to sign consent forms and offered the opportunity to ask further questions prior to the delivery of Reiki.

In the main, Reiki was delivered 1:1 in a room set up with a massage table on which the young person could lie down. It had low lights, a blanket if required, and soft theta wave music playing. Again, flexibility was needed, however, to give the widest possible access to Reiki treatments. Sometimes sessions happened in houses across the campus, if the young person was not permitted to come to the therapy room for safety reasons, or when they opted to stay in their house.

Reiki can also be delivered as a 'Reiki share' to groups of people. Although this was not the intended model for the current study, a session was delivered to two young people and a care worker on one occasion, as this was fit for purpose at the time (see case study 3 below). One young person also wished to be accompanied by a care worker.

The young people were given the option of being touched or not. A similar hand positioning was undertaken with most young people to offer predictability in subsequent sessions. This is consistent with trauma-informed practice (Scottish Government, 2021). However, it should be noted that, although the hand positions were similar, Reiki was not directed but was available to different parts of the physical and emotional body during this time, as per the individual presentation. A clear pathway for the flow of Reiki was made possible by personal grounding and pre-setting appropriate auric boundaries, including using symbols, as per Reiki training. The practitioner delivered Reiki with eyes closed. This helped concentration and focus, but also might have meant less pressure for the person receiving as they could experience the session with less intensity of social interaction and 'just be'.

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After the session the energy flow was managed by gently and methodically closing the exchange. The young person was invited to describe how they felt and what they had experienced. The practitioner also offered observation to the young person. Often, some self-care tips were offered, based on the information available on the various chakras during the session. The young person was always told what would be written in their 'wellbeing' notes and advised to drink water and relax for the rest of the evening. The confidentiality policy of the overall care establishment was observed to offer best care, as opposed to the normal UK Reiki Federation Code of Ethics and Professional Practice (2021) where no information is shared with anyone other than the client. Using the existing format of client records in the setting was best practice in this situation.

The factors associated with researcher characteristics were considered. Care was taken to build enough rapport so young people felt safe to attend a session. As well as one or two visits to their houses for introduction and explanation, young people were collected from and returned to their houses by the practitioner.

It was not intended for this study to be about the effect of relationships, so attempts were made by the practitioner to keep these at a superficial level. However, it proved inevitable that trust would be built, and relationships would develop to a degree over time. It would have been negligent for the practitioner not to respond to cues from the young people, however there were no in-depth conversations. No background information was sought on the presenting issues of the young person, albeit some workers and young people shared brief information in the appropriate context of the session observations. Some background information became known to the practitioner and was accepted but not discussed with the young person. The observations of the sessions were recorded at face value with no interpretation.

It was important to be clear with the young people that this was a research trial, and it would only last twelve weeks. Attention was paid to the way in which expectations were set up to avoid disappointment and shame of abandonment for young people. This fits with trauma-sensitive practice, particularly for those who have attachment difficulties.

Results

Nineteen young people chose to have Reiki in the twelve-week trial period. They all accessed sessions in a random pattern. One young person had eight sessions, one had five, and one had four sessions. Four young people had three sessions, three had two each and nine had single sessions. One young person took a deep interest in the chakra system. At his request further information was produced and a basic book was recommended (Corr, 2015).

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The following was found:

Number of incidents involving the young person on the evening they had Reiki compared to the number of incidents involving these young people in the two weeks preceding the Reiki treatment.
The types of incidents ordinarily recorded in this care setting are those involving violence and aggression, self-harm, and concerns for health and safety. Incidents involving two out of the nineteen young people who accessed Reiki were recorded on the nights of the treatment itself. In the two weeks prior to the treatment, one of these young people was involved in eleven incidents (four on one day, two on another, and five incidents on a single other day). The other young person was recorded as having been involved in six incidents in the two weeks prior to the Reiki treatment. There were no incidents recorded for the other seventeen young people in the sample on the night they received Reiki. In the two-week period prior to the Reiki treatment there had been the following number of incidents recorded for nine of these individuals respectively: 3, 3, 5, 3, 1, 1, 2, 1, 2.
Description of presentation after Reiki
The following observational notes are available: • Relaxed (n= 8) • At ease, engaging with activities with peers. • Complexion was smooth and demeanour calm. • Calm, chatty and good company. • Positive engagement with staff after Reiki sessions. • Good mood. Willing to participate in activities. • Appeared in 'good form'. • Positive engagement with staff. In addition to these positive observations one young person was self-conscious around others and hypervigilant following a Reiki treatment. She usually presents in this way. She said that she could not feel anything during Reiki. It was explained to her that Reiki would be there even though she did not feel much. She responded that she has ADHD (attention deficit hyperactivity disorder) and an eating disorder. It may be that feeling nothing was a symptom of general disconnection between mind and bodily sensations, although this hypothesis was not shared with her.

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Description of presentation over 1- 2 weeks after Reiki

There was no noticeable difference in presentation over the two weeks following Reiki treatment for 12 young people.

Positive observations were offered for three young people:

- 'Generally calmer and more likely to resist involvement in negative behaviours.'
- 'Engaged in positive interactions with others and appeared to maintain a calm demeanour.'
- 'Appeared more calm than normal the next day but no noticeable change in presentation after this.'

There was no worker observation for three young people for the 1-2 weeks following Reiki treatments.

Sleep

The sleep patterns of young people in the sample were studied. There were 12 young people who were reported to sleep well generally. It is recorded that five young people fell asleep earlier than usual on the nights they had Reiki, including two who normally had difficulty settling to sleep. Some young people commented ahead of sessions that if they had Reiki they would sleep well.

Manager's comments

Deputy service manager's comments:

Residential care

Young people appeared to really enjoy the sessions. In one house a particularly influential young person attempted to dissuade peers from trying something that was 'not cool'. This is thought to be due to the group dynamics in the house at the time rather than what the young person herself thought of Reiki. The sessions had a positive influence on young people's interactions with others. I would like Reiki to be offered again and for a longer period of time. I wondered if it would help if staff modelled behaviour by trying it out and then discussing with young people.

Secure care

Reiki was brilliant for the young people. They were so much more relaxed after participating in a session and for some of them, their whole demeanour changed afterwards. Would definitely recommend having more sessions in the future. It would also be beneficial to offer sessions to staff to promote wellbeing.

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Duty manager's comments:

- 'Really good. The young people responded really well. They were a lot more relaxed.'
- 'Anything that decreases incidents and helps young people sleep is good evidence – We would much rather see them relaxed. It's certainly helped me in my role.'
- 'Very positive feedback from young people. They said it made them totally relaxed and generally they had a good night's sleep after they had a session.'
- 'On the whole, the young people really enjoyed the sessions and said that they were relaxed. To my memory there were no incidents for these young people on the nights I was there when they had Reiki.'

Night care manager's comment:

The nights I was on the young people had a good night's sleep. They were more chilled and relaxed, some of them were asleep before the day staff left. Nothing negative to say about it.

Care workers' comments

In the beginning most workers were curious about Reiki and were engaged with young people in discussions around it. Three workers advised they were 'skeptical' but also that they themselves had not tried Reiki. All workers encouraged young people to try it if they wished and some actively promoted it. There were lots of comments by workers about the change in demeanour of the young people after treatment.

On every evening that Reiki was delivered the practitioner had requests from care workers to deliver it to them as well as the young people. Sometimes this ran to multiple comments and requests per evening in the different houses across both residential and secure services. However, this Reiki trial was only targeted at young people.

Comment example:

I don't always believe in this stuff (gave dismissive hand wave). It's all a bit weird, but when you see the kids come back and you see the difference – I would definitely put my name down for it if I had the chance!

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Young people's comments after sessions

'Sign me up every week, bro!'
'I feel relaxed for the first time ever.'
'Peaceful. Thank you for the peace.'
'Weird but good.'
'The most relaxed ever in my life.'
'Relaxed.' (x 2)
'I feel numb. I can't lift my arms, but I don't want to. I would do it again.'
'Amazing.'
'I feel tired. Bro, give me more!!'
'Feels like everything is in my head at once. Not sure, but I think that is good?'
'Can I come again next week?'
'Totally chilled'
'I feel relaxed. I will get a brilliant sleep the night. I will be coming for more.'
'Amazing and weird.'
'I had forgotten how calming it is.'
'Calm and soothing.'
'I feel like I could sleep for a week.'
'I will take all the Reiki I can get.'
'Is it witchcraft?'
'I feel lighter, in a better mood. I feel younger, like a child or a toddler.'
'I couldn't feel anything, then at the last minute I felt tingles in my legs. I'm definitely coming back. Can I?'
'I loved it, it was great.'
'Gwen (peer who had received Reiki) said she had a bad thumb and Reiki healed it the next day. It was unreal!'
'I had to keep checking I was still on the bed. When you moved hand positions, it was like I was coming back down. I feel tired and chilled.'
'I feel more emotional tonight than I did last time.'
'Reiki helps me sleep better'
'I feel floaty.'

Some of the other young people could not describe how they felt. It is important to note, however, that the observed body language of these young people did not suggest that they did not enjoy their session and no young people were emotionally dysregulated immediately following their treatment.

NOTE: These comments were provided by young people who have asked to be identified as Julia, Dustin, Gwen, Louise, Warner, Queen, Kev, Barbara, Sandy, Lilmik and Joe

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The following case studies are examples of sessions experienced by the young person and practitioner:

Case study 1

Barbara
Her presentation within the session was evidencing that she physical head pain although she had not mentioned this. She confirmed it verbally afterwards. She was transferring some of this pressure to me and I felt that there was an intense halfmoon shape sensation internally in the middle of my forehead. This is unlike any headache I normally experience. I had a clear head at the beginning of the session, so it was definitely transference from Barbara. She was also transferring little flutters of panic sensations. This was involuntary from Barbara and not coming from any panic I was experiencing for myself. I offered further sessions to see if this could be improved, but Barbara did not take up any further sessions in the duration of the trial.

Case study 2

Lilmik
He had a half-hour Reiki session in the therapy room. He was fidgeting like he was fighting sleep. He muttered under his breath a couple of times. He said he liked it.
Later, in the house, another young person became agitated, and Lilmik was asked by workers to go through to his room and change into pyjamas. He refused initially and the other young person began trying to physically lash out at him unprovoked. Lilmik agreed to go to his room if he could have Reiki in there (at his suggestion). To de-escalate things, care workers agreed. A worker was present to observe the Reiki session. In his room, Lilmik immediately said, '*Here, you can have classical music if you want,'* and put this on his TV. He pulled his mattress down on the floor and effectively created his own therapy space, completely using his own initiative. He then went on to be fully engaged in the Reiki session provided, with the care worker, continually present. Lilmik had laughed loudly when Reiki was explained to him initially but went on to have five sessions in total.

Discussion

An overarching theme emerging from these findings is of a more relaxed state for each of the young people receiving Reiki. This was a primary aim of this action research, as Rothschild (2010) advises: 'The first goal of trauma recovery should and must be *to improve your quality of life on a daily basis*.' This was considered fundamental to the care of young people, and their positive comments show this was achieved.

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It is acknowledged that this group of young people's life experiences have clearly had an extensive adverse effect on their presentation and development, which is the reason they have been placed in this care setting. The trauma they have suffered is 'not just an event that took place in the past, it is also the imprint left by that experience on the mind, body and brain' (van der Kolk, 2014). For many of these young people, it is likely that stress on their developing nervous system as infants has resulted in adaptations to the brain architecture, making them vulnerable to these later difficulties (Gerhardt, 2014) so the need for stabilisation and attuned caregiving at this point in their lives is paramount. Workers in this care context recognise that people do not need to talk about traumatic experiences, which is thought to reinforce preoccupation and fixation (van der Kolk, 2014). Sometimes, during Reiki treatments, memories of any kind do surface, and this is considered part of healing. However, it is understood that remembering traumatic events might evoke shame and confusion making it difficult for people to function (Rothschild, 2010). The residential care model was available to offer appropriate care to young people if this had been the case, albeit there was no evidence of this in the sample at the end of the Reiki sessions, and no further mention of this by workers.

Some young people in this setting also present with additional difficulties of a genetic or neurodivergent nature. They all need multi-agency support and resources upon leaving the care setting, and a large majority have required this on a lifelong basis. They need carefully planned transitions to future services by people who understand their vulnerabilities and strengths in depth. This level of overall need cannot be underestimated and the nearly 100% positive comments about Reiki were not anticipated. Indeed, it could not be anticipated in any group at this stage in their development as teenagers.

Although it is important to recognise the needs of the participants in this group for research context, in contrast, it is not necessary for a Reiki practitioner to understand where biology, trauma, abuse and neglect has resulted in impaired executive functioning or social presentation. Unlike the programme work within the care setting, Reiki is not cognitively led. The young people do not need to think their way better. Therefore, in Reiki they do not need to confront emotionally painful material that is inherent in behaviour modification intervention, nor feel shame when they cannot access the recommended coping strategies when in a triggered state. To access the benefits of Reiki treatment, they do not need to understand or accept where their beliefs need to change, or wrestle with their developing identity. Instead, Reiki is a possible modality to reach young people with functional impairments of any sort and to promote healing and growth. The results of this brief study indicate that, for these participants, behaviour change may be possible through intrinsic processes underpinned by working on balancing the chakras through Reiki. More relaxed young people may bring about improved relationships with workers and, in turn,

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impact positively on their future development. It can also potentially contribute to increased confidence in young people benefiting from positive risk taking.

Similarly, the young people were curious about how Reiki works. Some were disbelieving of the explanation, as many people are. As much as people try to rationalise Reiki and look for quantifiable evidence, it needs to be accepted that it is firmly a 'bottom-up' modality and the qualitative experience for the individual is the best measure. This also fits with Rothschild's (2010) subjective measures of trauma recovery. Therefore, the young people were encouraged, rather than interpreting science or analysing their own experiences, just to feel what they felt. People who are traumatised are understood to have a poor sense of connection between body and mind (Heller & LaPierre, 2012), such that acknowledging any visceral feelings is considered to enhance healing (van der Kolk, 2014). To support this reactivation of the self-sensing system, the practitioner took time after the session (where helpful) to tell the young person the sensations she had experienced during their session. Playful metaphors were used to give examples of how the sensations could be expressed - like 'fizzy feet', 'bouncy heart', and 'tiny butterflies.' Some young people offered their own expressions of their experience, while some could not find the language. Children with histories of abuse and neglect often have few words to describe what they feel (Hughes, 2012), so this was to be expected. It should be noted that it is not uncommon for the general population to find it difficult to describe what Reiki feels like too.

Care was also taken with the young people who were curious about the chakras and how they work. Where useful, brief connections were shared with them between observations of their session and the chakra system. This was done in very broad terms. One of the common presentations of traumatised people is to present psychosomatic symptoms (Afari et al., 2014, Barends et al., 2022) so it would be unwise to encourage self-diagnosis in this client group as it may have unintended behavioural implications. On the other hand, if a young person accepted the information about the chakras, it may have also brought them to consider the 'treatment' options – all of which may have a healing effect, and potentially suggested self-care strategies for life. Experiencing mastery through self-help could be regarded as empowering for young people who have been 'done to' in the care system. It is also hoped that the Reiki sessions have opened a door to alternative self-care more widely, in terms of combatting the global over-reliance on suppressing discomfort with chemicals rather than addressing underlying causes.

Overall, the results show that Reiki brought about a general calming effect in group living environments. Many of this client group struggle with self-regulation and the atmosphere can be volatile at times. However, it may be that those who had Reiki were able to cope better with triggers. This self-report comment supports this theme:

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'When people speak to me after Reiki I just say "whatever". I don't want to get involved with their stuff.'
Joe (eight sessions of Reiki)

Only two out of 19 young people were involved in incidents on the night after they had a Reiki session. It is not possible to relate this finding directly to the effect of Reiki as there are many other reasons for incidents and there cannot be controls for myriad other variables. It is notable however, that the Reiki treatment coincided with a day where some young people who had previously had been were not involved in incidents, and that the young person who was involved in multiple incidents on single days previously, was only involved in one incident on the night they had Reiki, followed by a settled night. These findings should be treated with respectful caution and considered in relation to comments made by individual young people. The circular benefits of fewer incidents in general though, would be that care workers experience less situational stress and other young people would not be further traumatised through witnessing incidents.

Bessel van der Kolk (2014) notes that for real trauma recovery to take place, the body needs to learn that danger has passed, and the present is safe. Reiki has offered a key contribution in making the care service 'safer' overall. In addition, this discussion would be incomplete without acknowledgement that the Reiki sessions would have provided a safe experience of human touch which may have been lacking for some young people previously in their lives. The effect of oxytocin on the nervous system (Baylin & Hughes, 2016) is a clear component of the overall Reiki experience.

The most rewarding aspect from the practitioner's viewpoint was that most young people's facial complexions changed after a Reiki session. They arrived tense, with their complexions fixed and rigid. It is understood that this is likely to be a result of the stressors in their life, including the challenges of living in a group and needing to adapt quickly to unfamiliar rules and cultures (Smith et al., 2013). After Reiki their complexions had softened, their skin appeared smoother and sometimes plumper, and their eyes had lost their tense expression. This was remarkable and was noticed by workers when some of the young people returned to their houses after sessions.

Implications for practice

There are never any guarantees of outcomes from Reiki (UK Reiki Federation, 2021). Therefore, discussing what the person seeks from treatment is perhaps more about putting the person at ease, so they are ready to receive Reiki, than about directing the energy. People should be invited to just 'feel what they feel' and judge outcomes for themselves. For young people this promotes a sense of

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self-efficacy by default and to trust one's own judgement of the experience is validating and healing.

Reiki could be offered routinely or at the point of agitation before distress, to calm the emotional tempo of individuals and groups and to add to a more therapeutic milieu (Trieschman & Whittaker, 2017). It could be offered to people who are overwhelmed with significant events in their lives which have impacted on their ability to cope. It should be acknowledged, however, that the full benefits of Reiki will not be felt by anyone, in any care giving milieu where the needs of the people being cared for are greater than the ability of the carers to meet these.

It should also be recognised that there are many things Reiki cannot do for this client group.

- It cannot undo the impact of years of neglect and abuse.
- It cannot claim to resolve matters for the young person that are making them angry (or would make any person angry).
- It cannot improve environmental factors that are triggering distress (albeit Reiki supports coping strategies).
- It does not claim to change the person's underlying health profile - but can help them to cope with their condition.
- It cannot intend to reduce behaviours which serve a function for the young person (although it will work on improving emotional resilience which may mean that the behaviours no longer serve the same function).

For good aftercare, the practitioner advised young people to drink water and relax for the rest of the evening. In reality it was impossible for them to relax as they were required to re-join the group and become physically and mentally alert again; perhaps their nervous systems were again 'swamped' by the need to navigate existing social dynamics. It is acknowledged that in residential and secure care this is unavoidable.

Recommendations

1. Reiki can be used in conjunction with relational recovery and other interventions.
2. Effective Reiki services for young people in secure and residential care should be delivered by practitioners who are not intimidated by the behavioural presentation of young people who have experienced relational and developmental trauma.
3. Some planning of Reiki appointments is necessary so young people can have advance notice. On the other hand, flexibility is necessary so that ad hoc requests can be accommodated.
4. Although it may not be practical for workers to receive Reiki as individual appointments during their shift, further benefit could be explored by offering

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Reiki shares. This would also support care giving approaches that promote trust and offer safe opportunities for physical closeness and emotional availability (Schofield & Beek, 2015).

5. All questions about Reiki should be answered in ways that make sense to the person. However, it is important people learn to trust Reiki without fully understanding how it functions. Sometimes the effects cannot be readily explained. The self-report feedback and observations must stand on their own merit without further analysis.

End note: Detailed appendices are available from the author.

References

Afari, N., Ahumada, S. M., Wright, S., Mostoufi, G., Golnari, V., Reis, V., & Gundey C. J. (2014). Psychological trauma and functional somatic syndromes: A systematic review and meta-analysis. *Psychosomatic Medicine, 76*(1), 2-11. https://journals.lww.com/psychosomaticmedicine/abstract/2014/01000/psychological_trauma_and_functional_somatic.2.aspx

Alacaro, Z., & Fonseca, J. R. S. (2016). The effect of reiki therapy on quality of life of patients with blood cancer: Results from a randomized controlled trial. *European Journal of Integrative Medicine, 8*(3), 239-249. https://doi.org/10.1016/j.eujim.2015.12.003

Barends, H., van der Wouden, J. C., van Dessel, N. C., Twisk, W. R., van der Horst, H. E., & Dekker, J. (2022). Potentially traumatic events, social support and burden of persistent somatic symptoms: A longitudinal study. *Journal of Psychosomatic Research, 159* 110945 https://doi.org/10.1016/j.jpsychores.2022.110945

Baylin, J., & Hughes, D. (2016). *The neurobiology of attachment-focused therapy.* New York: W.W. Norton and Company.

Bowden, D., Goddard, L., & Gruzelier, J. (2011). A randomised controlled single-blind trial of the efficacy of reiki at benefitting mood and well-being. *Evidence-Based Complementary and Alternative Medicine, 2011 381862* https://doi.org/10.1155%2F2011%2F381862

Chang, M. (2018) *Reflections on reiki therapy in a clinical NHS setting*. Barts Health NHS Trust. https://www.reikicouncil.org.uk/reiki-research

Connelly, G., & Milligan, I. (2012). *Residential childcare: Between home and family*. Edinburgh: Dunedin Academic Press.

Corr, K. M. (2015). *Reiki: A complete guide to real reiki: How to increase vitality, improve your health and feel great*. California: CreateSpace Independent Publishing Platform.

ISSN 2976-9353 (Online)
celcis.org

Demir, M., Can, G., & Celek, E. (2013). Effect of reiki on symptom management in oncology. *Asian Pacific Journal of Cancer Prevention*, *14*(8), 4931-4393 https://doi.org/10.7314/apjcp.2013.14.8.4931

Dyer, N. L., Baldwin, A. L., & William, L. R. (2019). A large-scale effectiveness trial of reiki for physiological and psychological health. *The Journal of Alternative and Complimentary Medicine*, *25*(12), pages unavailable.https://doi.org/10.1089/acm.2019.0022

Fleisher, K. A., Mackenzie, E. R., Frankel, E. S., Seluzicki, C., Casarett, D., & Mao, J. (2014). Integrative reiki for cancer patients: A program evaluation. *Integrative Cancer Therapies, 13*(1), 62-67.https://doi.org/10.1177/1534735413503547

Hughes, D. (2012). *Emotional and behavioural difficulties.* London: CoramBAAF.

Judith, A. (1996). *Eastern body western mind. Psychology and the chakra system as a path to the self*. New York: Celestial Arts Random House.

LaPierre, A. (2012). *Healing developmental trauma.* Berkeley: North Atlantic Books.

Morero, J. A. P., Pereira, S. D. S., Esteves, R. B., & Cardoso, L. (2021). Effects of reiki on mental health care – A systematic review. *Holistic Nursing Practice, 35*(4), 191-198. https://doi.org/10.1097/hnp.0000000000000456

Olson, K., & Hanson, J. (1997). Using reiki to manage pain: A preliminary report. *Cancer Prev Control*. Jun *1*(2), 108-13. PMID: 9765732.

Quest, P., & Roberts, K. (2010). *The reiki manual, A training guide for reiki students, practitioners and masters.* London: Piatkus.

Reiki Federation (2021). Code of ethics and professional practice for reiki. https://www.reikifed.co.uk/code-of-ethics-and-professional-practice/

Rothschild, B. (2010). *8 keys to safe trauma recovery*. New York: W.W. Norton & Company.

Schofield, G., & Beek, M. (2015). *The secure base model.* London: BAAF.

Scottish Government (2021). *Trauma-informed practice toolkit. Scottish Government.* https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/pages/6/

Secure Accommodation. (Scotland). 2013 Regulations

Smith, M., Fulcher, L. & Doran, P. (2013). *Residential childcare in practice: Making a difference.* Bristol: Policy Press

ISSN 2976-9353 (Online)
celcis.org

Thrane, S. E., Williams, E., Grossoehme, D. H., & Friebert, S. (2022). Reiki therapy for very young hospitalized children receiving palliative care. *Journal of Pediatric Hematology/Oncology Nursing, 22*(29), 15-29. https://doi.org/10.1177/27527530211059435

Trieschman, A., & Whittaker, J., (2017). *The other 23 hours: Childcare work with emotionally disturbed children in a therapeutic milieu*. London: Routledge.

Tsang, K. L., Carlson, L. E., & Olson K. (2007). Pilot crossover trial of reiki versus rest for treating cancer-related fatigue*. Integrative Cancer Therapies, 6*(1), 25-3525. https://doi.org/10.1177/1534735406298986

Zadro, S., & Stapleton, P. (2022). Does reiki benefit mental health symptoms above placebo? *Psychology for Clinical Settings*, *13* Article 897312 https://doi.org/10.3389/fpsyg.2022.897312

About the author

Abbi Jackson has worked in children's services for around 25 years. She has been a foster carer and has worked in secure care and children's residential care. She spent time as a social worker in a statutory team, as an independent Form F assessor and a supervising social worker. She has led large-scale practice audits in children's services and adult protection. She has been a senior planning officer and is currently an interim CEO in the third sector. Abbi is also an active practice educator and lectures in critical social work practice. She has an interest in early intervention with young people experiencing emerging mental health concerns.

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