SOCIAL WORK AND REIKI: TOWARDS INTEGRATION

SOCIAL WORK AND REIKI: TOWARDS INTEGRATION

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Abstract

Complementary therapies are becoming increasingly popular among health care users and are also a growing focus of academic research. However, there has been limited attention given to the relationship between social work practice and complementary therapies.

This qualitative research involved completing interviews with four social workers who also have Reiki training. The goal was to explore the experiences of social workers in order to better understand the benefits and challenges of incorporating Reiki into social work practice and conventional medicine.

Participants identified benefits and challenges that they had experienced as a result of being a social worker with Reiki credentials and attempting to integrate Reiki within their clinical practice. Reiki was identified as being a supportive intervention that could assist both social workers and the people they serve. Participants emphasized that social workers have the necessary skill set to support the use of Reiki, and that Reiki can be a valuable addition to social work practice and conventional medicine.

Social work practice and conventional medicine need to continue to evolve to meet the diverse needs of service users who are interested in combining traditional interventions with complementary therapies, like Reiki. Integrating Reiki into social work practice and conventional medicine also supports their commitment to providing holistic services.

Social work specific research is needed on the use of Reiki within social work practice to support the move towards integration. As interest in Reiki and the connection between mind, body, and spirit increases, it will be important for social work research to re-examine the place of complementary therapies within social work practice.

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Introduction

> "Reiki can be a humanizing factor in medicine that can facilitate the delivery of conventional care and support both patients and professionals. As patients and medical caregivers reach beyond the biomedical model to access the most complete health care possible, Reiki is a natural choice" (Miles, 2008, p.243).

Complementary therapies are increasingly being integrated with conventional medicine and are a growing focus of academic research. However, there has been limited research focused on the relationship between social work practice and complementary therapies and even less research that specifically focuses on social work practice and the complementary therapy of Reiki. It is my opinion that Reiki compliments social work practice and could be a valuable support to social workers and the people we serve. As public interest grows surrounding complementary therapies, it is important that the fields of social work and conventional medicine begin to explore the benefits and challenges of integrating Reiki.

My interest in Reiki began in 2001 when I was introduced to Reiki by a co-worker and found it helpful in relieving my headaches. After receiving a number of Reiki treatments I started to take a personal interest in learning about Reiki, and I have now completed first and second levels of Reiki training. My interest in this topic is also shaped from my experiences working as a hospital social worker. In my experience,

despite claims of providing holistic and comprehensive care to patients, the traditional Western medical model, in reality, fails to accomplish this goal. It is also my experience that the medical model, and social work practice within this model, falls short in addressing the emotional and spiritual needs of patients. Despite growing public interest in complementary therapies, it is not common practice within the hospital to ask patients about their use of complementary therapies. I was also drawn to this topic out of my own concerns regarding integrating Reiki within my practice. Although I have completed Reiki training, I have always been reluctant to talk about Reiki due to concerns regarding scope of practice and professional credibility.

One of the objectives of this research is to explore the issue of integrating Reiki within social work and conventional medicine. This research also uncovers some of the benefits and challenges of integrating Reiki and social work practice. Due to the absence of literature on utilizing Reiki with social work practice, this topic was also chosen with the intention of adding to this emerging area of research. The final goal for this research is to identify opportunities for working towards the integration of Reiki and social work.

Before proceeding, it is necessary to attend to the issue of definitions. In the United States the National Centre for Complementary and Alternative Medicine (NCCAM) is a federal government agency that

was designed to sponsor and conduct research in the area of CAM. To date, the Canadian government has not established a government agency similar to NCCAM. The term complementary and alternative medicine (CAM) is commonly used within the literature and the NCCAM defines CAM as "...a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine" (National Centre for Complementary and Alternative Medicine, 2009). Table 1 provides a general overview of complementary and alternative therapy categorizations.

Table 1: Complementary and Alternative Medicine Modalities

CAM Domain	Modalities
Alternative medical systems	Traditional Oriental, ayurvedic, traditional (Native American, Aboriginal, African, Middle-Eastern, Tibetan, and Central and South American), homeopathy, and naturopathy.
Mind-body interventions	Meditation, hypnosis, dance, music, art therapy, prayer, and mental healing.
Biological-based therapies	Herbal, special dietary, orthomolecular, and individual biological therapies.
Manipulative and body-based methods	Chiropractic and massage therapies
Energy therapies	Qigong, Reiki, therapeutic touch, healing touch, and bioelectronic-based therapies.

(Roe, 2002, p.3)

Within the literature there are some discrepancies regarding how to classify Reiki. Reiki is broadly categorized as a complementary therapy, but is more specifically referred to as an energy therapy. Reiki is classified by the NCCAM as an "energy therapy," however, others have categorized Reiki as a "biofield therapy" or as "energy medicine" (Miles, 2008; Singg, 2004). For the purposes of this research, I consider Reiki to

be a complementary therapy, and will use the term CAM when referring to the broader field of complementary and alternative therapies, as this appears to be the term most commonly used within the literature.

Literature Review

Social Work and Medicine

Social service cut backs and hospital restructuring in the 1990's "...resulted in a faster paced, more cost-conscious culture in which social workers had more work to do in shorter amounts of time" (Gregorian, 2005, p.3). This had a significant impact on medical social work practice, and led to "...social workers feeling disempowered, disenfranchised, and lacking a sense of control over their workplaces" (Giles, Gould, Hart, and Swancott, 2007, p.149). Social workers are concerned about the effectiveness of their practice and question that, despite the best skills, techniques, and resources, the profession is not meeting the needs of the people we serve (Govenlock, 2007). Given the current health care environment, social work practice is now required to produce evidence to prove its efficiency and effectiveness (Giles et al., 2007). The realities of social work practice today have resulted in the profession continually having to demonstrate its evidence base, efficiency and cost effectiveness. Furthermore,

> "[g]iven recent changes in the delivery of social work services and the need to develop and/or maintain a skill set that is both marketable and congruent with the mission of the social work profession, social workers may need to consider learning more ways of helping clients facilitate change" (Finger and Arnold, 2002, p.58).

Complementary therapies may be the answer for social workers who are seeking new techniques to assist their clients and also looking for new ways to demonstrate social work's value.

Social Work and Complementary and Alternative Medicine

The social work profession is beginning to explore areas of practice that have not traditionally been considered a part of its scope of practice. Henderson (2000) studied the use of alternative therapeutic techniques by social work practitioners and acknowledged that the field of social work is rapidly evolving. Henderson explains,

> "[p]ractitioners' comfort levels with a wide range of strategies, services, and resources have expanded greatly. Practitioners' openness to the enormous potential [of alternative therapeutic techniques] brings with it exciting and enriching practice possibilities at the cutting edge of knowledge" (Henderson, 2000, p.59).

Furthermore, Henderson (2000) identifies that a number of different complementary therapies are in fact core social work methods that have been used for many years. These techniques include, support groups, self-help groups, imagery, biofeedback, art therapy, and psychotherapy (Henderson, 2000). The integration of complementary therapies into social work fosters a client centered approach to practice. In reference to social work practice, Block suggests,

> "[t]o be truly effective…in our professional role with ethnically and socially diverse clients…it is essential to reach beyond our own biomedical indoctrination and augment our understanding of divergent health philosophies and practices" (Block, 2006, p.673).

As Henderson suggests, the "...diversity of available strategies helps to prevent stereotypical responses to clients or practice from a unitary point of view. Instead, responses are chosen from a variety of interventions" (Henderson, 2000, p.59). However, there is limited research that specifically addresses the integration of Reiki into social work.

Complementary therapies, like Reiki, have not typically been considered part of social work practices and this raises some important questions about regulation and scope of practice. Henderson (2000) found that social workers may be integrating complementary therapies into practice without having sufficient knowledge about these techniques. This leads to concerns about social workers' competency, which is a requirement under the Ontario College of Social Workers and Social Service Workers Standards of Practice (see Appendix A). Grant (2008) attempted to explore the issue of integrating Reiki and social work practice by contacting the OCSWSSW to ask their opinion about using Reiki in social work. The OCSWSSW's response stated that it "...does not have a position on the use of reiki therapy in social work practice, nor does the OCSWSSW have a position on the use of any specific therapy or treatment modality" (Grant, 2008, p.11). However, the OCSWSSW specifically referred to the standards of practice regarding competency and integrity and expressed concerns regarding practitioners being trained appropriately and adhering to the standards of practice (Grant, 2008).

Grant identified, that this response, "...emphasizes standardization and professionalism in accordance with mainstream social work practice" (Grant, 2008, p.11). For Reiki and other complementary therapies to be integrated into social work practice the issues of regulation and scope of practice require further exploration.

Social Work and Spirituality

There has been an ongoing tension within the field of social work regarding the inclusion of spirituality within social work practice. Some of the concerns revolve around issues of spirituality being outside of the scope of practice, lack of workers own spiritual self-awareness, and credibility of the profession (Drouin, 2002; Canda and Furman, 1999). However, before proceeding, it is necessary to distinguish between spirituality and religion as these terms can cause confusion. According to Canda and Furman,

> "[s]pirituality relates to a universal and fundamental aspect of what it is to be human –to search for a sense of meaning, purpose, and moral frameworks for relating with self, others, and the ultimate reality. In this sense, spirituality may express through religious forms, or it may be independent of them. Religion is an institutionalized pattern of beliefs, behaviors, and experiences, oriented toward spiritual concerns, and shared by a community and transmitted over time in traditions" (Canda and Furman, 1999, p.37).

Historically, social work had strong connections to religion, as the profession originated from religious based groups. According to Coates,

> "[t]here is little doubt that the emergence of social work in Canada at the turn of the twentieth century, as in the USA and Britain, was

> heavily influenced by the Social Gospel movement, charity organizations, and settlement house movement, which had strong religious (specifically Christian) and spiritual affiliations" (Coates, 2007, p.2).

As the profession continued to develop and sought to gain professional status and credibility it began to detach itself from its religious and spiritual foundations (Coates, 2007). The profession shifted to align itself more closely with the scientifically based field of medicine. According to Ouellette, "...social work distanced itself from religious/spiritual issues, emphasized objectivity, techniques, and interventions, while neglecting the subjective, intuitive, reflective, and creative part of the person" (Ouellette, 2007, p. 89). Despite the profession's original connection to religion, social work continues to struggle with its religious and by association, its spiritual roots.

There are a number of reasons why the field of social work has struggled with its religious foundations. Social work emerged out of the late 1800s when charitable or "friendly visiting," which had strong religious associations, was developed to deal with "the problem of the poor" (Margolin, 1997). This friendly visiting provided justification for the invasion of the private sphere, primarily consisting of the poor, and included judgmental and oppressive practices (Margolin, 1997). Furthermore, in reference to residential schools, Graham, Coholic and Coates remind us, that "[r]eligion and spirituality have not always had a

positive impact as religion played a significant role carrying out the government policy of the enfranchisement of Indigenous people" (Graham et. al., 2007, p.25). Religion was a source of oppression, and resulted in abuse and destruction of aboriginal people and their culture. Some other concerns relate to religion being rigid, narrow and judgmental, and religion's role in maintaining the status quo (Drouin, 2002; Canda and Furman, 1999). Furthermore,

> "[s]ince the profession of social work has a purpose to promote individual well-being and social justice for all people, opponents argue it is not appropriate to use sectarian, judgmental, status-quo-maintaining, micro focused, fantasy-based frameworks to guide our profession" (Canda and Furman, 1999, p.66).

These concerns continue to influence current tensions related to integrating spirituality within social work practice. However, despite the opposition to integrating spirituality and religion into social work, there are also those who support their integration.

Supporters of integrating spirituality and religion into social work practice acknowledge the importance that spirituality and religion may hold for some clients. Spirituality and religion are considered by some to be key components of identity, as well as a coping strategy and source of support during difficult times. Drouin (2002) explains that there are legitimate concerns regarding the integration of social work and spirituality that have to be considered. However, some of these concerns apply

> "...to both religious and nonreligious forms of belief and behavior. Political ideologies, human behavior theories, practice models, and agency policies and procedures all can reflect rigid, punitive, judgmental, or oppressive assumptions. We need to face these biases and obstacles to human well-being and justice whenever they are found, in religious settings and elsewhere. Avoiding the topics of religion and spirituality because of these problems only allows them to continue without open examination" (Canda and Furman, 1999, p.66).

While spirituality has been criticized for focusing on the individual versus the larger macro issues, "...spirituality can help sustain social justice activity by giving higher purpose to work that often comes into conflict with dominant and mainstream paradigms and ideologies" (Graham et. al., 2007, p.34). Incorporating spirituality into social work can offer clients a more holistic service.

While social work maintains that it is a holistic practice by considering all aspects of our client's social location, some argue that spirituality continues to be marginalized by the profession (Graham, Coholic and Coates, 2007). In reference to this tension between social work and spirituality, Wagler-Martin suggests, that "...the spiritual dimension has not been fully validated in a social work context" (Wagler-Martin, 2007, p.137). Social work's separation from religion and spirituality resulted in limited research during the 1970s and 1980s that addressed issues of spirituality (Graham et al., 2007). However, Graham et al. (2007) explain that since the 1990s there has been increased attention to spirituality within social work research. This increased interest

in researching spirituality connects with the increased interest being seen in complementary and alternative medicine research that focuses on the connection between mind, body, and spirit.

Transpersonal Theory

Transpersonal theory is used as a framework to inform my research due to its focus on spirituality. Transpersonal theory evolved out of the field of psychology in the 1960s and sought to address the spiritual dimension that had been missing from clinical practice. Although transpersonal theory built on the work of many theorists, some key transpersonal theorists include; Abraham Maslow, Carl Rogers, Ken Wilber and Au-Dean Cowley (Cowley, 1996; Cowley, 1993). According to Cowley, "[p]ractitioners with a transpersonal perspective seek to help clients expand their consciousness, deal with issues of meaning and purpose in life, and legitimize their transpersonal (transrational) experiences" (Cowley, 1996, p.672). As Vaughn explained, "[t]he transpersonal approach does not attempt to supplant other approaches, but rather to complement and expand them" (Vaughn, 1986, p. 148). Transpersonal theory seeks to identify the importance of spiritual wellbeing, instead of focusing primarily on physical, emotional or mental aspects of wellbeing.

Transpersonal theory incorporates both Western and Eastern concepts, and "[s]piritual health according to this perspective occurs as a

result of spiritual practice and requires an integration of mind, body, spirit and flesh" (Cowley, 1993, p.528). Cowley defines spirituality as "the experiences of wholeness and integration, irrespective of religious belief or affiliation. Spirituality is neither seen as a statement of belief nor as a measure of church attendance" (Cowley, 1993, p.528). Furthermore, "...the transpersonal approach sees its mind-body-spirit approach as one that seeks to empower people and help them become increasingly more aware" (Cowley, 1996, p.673). Transpersonal theory's focus on the integration of mind, body and spirit connects with the fundamental principles of Reiki that also focus on the connection of mind, body and spirit.

Within the field of social work there continues to be debate over whether there is a place for spirituality within clinical practice. Cowley argues, that "...issues related to religion and spirituality have yet to be adequately addressed by the profession" (Cowley, 1996, p.664). Reiki, as well as other complementary therapies, incorporates spirituality within their theoretical basis, by highlighting the importance of the connection between body, mind and spirit. Transpersonal theory is therefore applicable to this research as it identifies the importance of a holistic approach to social work practice that includes a focus on spirituality. It also provides a framework that supports my research goal of integrating

complementary therapies like Reiki into social work practice and conventional health care.

Complementary Therapies and Medicine

Complementary therapies are increasingly being integrated within conventional medicine and are a growing focus of academic research. Complementary therapies are used in conjunction with conventional medical interventions and alternative therapies are used in place of conventional medical interventions (O'Brien King, Pettigrew, 2004). Complementary therapies "...are often implemented to relieve discomfort or secondary consequences of modern medical interventions" (Block, 2006, p.679). One of the challenges facing complementary therapies is the issue of definition. Within the literature there are a number of different terms used, which can lead to confusion. Alternative, complementary, unconventional, unorthodox, nonscientific, fringe, marginal, integrative medicine, natural medicine or holistic medicine are just some of the terms used to describe this broad field (Kelner and Wellman, 2000; Roe, 2002; Miles, 2008). Lack of consistency within the literature is understandable given that the field is rapidly evolving and has diverse cultural and historical roots (Kelner and Wellman, 2000). Despite an increased interest in complementary therapies a debate remains about their place within conventional medicine.

Although research in the area of complementary and alternative medicine (CAM) is still relatively new, alternative/complementary healing practices have a long history, some of which predates the establishment of the conventional healthcare system. Many complementary and alternative therapies "...are largely derived from indigenous medical traditions" (Miles, 2008, p.220). According to Roe, "[h]istorically, CAM is associated with natural, folk, or home remedies...This history was built on trial and error, not on scientific evidence as used today. Practices were based on handed-down logic and past experiences" (Roe, 2002, p.1). In the past, the majority of healthcare was "delivered by wise women, midwives, medicine men (shamans), family members and barbershop proprietors" (Roe, 2002, p.1). However, "[a]s science advanced, medicine became more sophisticated. Pharmaceuticals and surgical interventions became prevalent, allopathic medicine was born, and natural practices took a back seat" (Roe, 2002, p.1). According to Miles, "...approaches, techniques, or medical systems not considered to be sufficiently validated by scientific research are relegated to the status of 'unproven' and are termed 'alternative...' or 'complementary'" (Miles, 2008, p.220). It should be acknowledge that "...practices which are considered 'alternative' by the majority of people in Western society, are thought of as conventional and mainstream by people in other societies" (Kelner and Wellman, 2000, p.4).

Furthermore, some therapies that were considered alternative in the past are now gaining acceptance within the medical field.

Conventional medicine, mainstream medicine, contemporary medicine, allopathic medicine and biomedicine are the terms found within the literature that refer to the dominant model used within Western society's current health care system. Conventional medicine is provided by physicians and allied health care professionals and is based on biomedical research science (Carroll, 2007; Miles, 2008). It is important to understand the different philosophies that separate CAM and conventional medicine. According to Kelner and Wellman,

> "[c]onventional medicine typically treats disease as a breakdown in the human body that can be repaired by direct biochemical or surgical intervention. The theoretical underpinning is frequently claimed to be rational and scientific" (Kelner and Wellman, 2000, p.5).

Conventional medicine typically considers the mind and body to be separate entities and the body is treated "...as a machine with interworking but semi-independent anatomic parts" (Block, 2006, p.678). Furthermore, it views "...illness as arising from specific pathogenic agents, and views health as the absence of disease" (Kelner and Wellman, 2000, p. 5).

CAM, on the other hand, is based on a very different set of theories and assumptions. One of the fundamental assumptions is that the body,

mind and spirit are all connected (Block, 2006; Kelner and Wellman, 2000). Furthermore, CAM also

> "...covers a diverse set of healing practices, which do not normally fit under the scientific medical umbrella. Instead, these practices emphasize the uniqueness of each individual...the flow of energy as a source of healing, and disease as having dimensions beyond the purely biological" (Kelner and Wellman, 2000, p.5).

Other core assumptions are that the body has an innate potential for self-healing, and that patients are actively engaged in the healing process (Block, 2006). Patients' relationship to the practitioner is based on a partnership in the healing process (Block, 2006). Finally, it is believed that an imbalance in life force or energy causes illness and the primary objective is to achieve health and total healing (Block, 2006). An explanation of life force/energy, Ki, is provided in the following section. This section focuses on the complementary therapy that is the focus of this research, Reiki.

Reiki

Reiki (Ray-key) "...is a Japanese word, Rei meaning universal or omnipresent, and Ki meaning life force or energy" (Singg, 2004, p. 262). Reiki originated in Japan in the early 20th century and Mikao Usui is the spiritual seeker who was the founder of Reiki (Miles, 2008). Reiki was brought to Hawaii and then the United States, and Canada by Hawayo Takata (Miles, 2008; Miles, 2007; Singg, 2004; Thrapp, 2002). Reiki and other energy therapies are based on the theory that the entire universe is

made up of energy and that this energy flows through all living things (Coughlin, 2006). This energy is thought to be essential to health and healing, and supports and balances the mind, body and spirit.

Different cultures use different words to describe the concept of universal life force energy. It is similar to "…*ch'i* in Chinese, *prana* in Sanskrit, *mana* in Polynesian, *pneuma* in Greek, and *ruah* (breath of life) in Hebrew" (Singg, 2004, p. 262). While the concept of universal life force energy is well established in ancient civilizations and Eastern cultures, it is not a concept that is familiar to the West (Barnet and Chambers, 1996; Block, 2006). A similar word does not exist in Western culture, and since

> "…our culture has separated science from philosophy, based on the Cartesian separation of mind, body, and spirit, the concept of such a subtle yet powerful life-force energy has so far existed outside the theoretical framework of modern Western medicine" (Barnett and Chambers, 1996, p.2).

This poses a challenge for the integration of Reiki due to the fact that the concept of universal life force energy is beyond the understanding of conventional medicine.

Reiki is different from other energy therapies because it also incorporates an emphasis on spiritual healing. However, it is important to distinguish that Reiki is not associated with an organized religion and is not a religious practice (Thrapp, 2002). According to Miles, "Reiki is a spiritual healing practice that has no dogma, no belief system" (Miles, 2008, p.37). Miles also explains, that Reiki is more appropriately defined

as "...a spiritual healing practice that can help return us to balanced functioning on every level – physical, mental, emotional, spiritual, even social" (Mile, 2008, p.8). Reiki originated as a spiritual practice that is similar to meditation and different from other energy therapies, as it does not involve the practitioner diagnosing or manipulating energy (Miles, 2008; Miles, 2007; Singg; 2004). According to Miles, similar to meditation,

> "Reiki is a passive rather than an active skill-based practice, and both would be more accurately placed in a category of spiritual healing practice rather than under the interventionist perspective and practice of energy medicine" (Miles, 2007, p.22).

There is clearly some confusion within the literature on how to best categorize Reiki. However, whether Reiki is considered an energy medicine, an energy therapy, or a spiritual healing practice, it does not change the basic principles of Reiki or the benefits.

A typical Reiki session involves the practitioner lightly placing their hands on the recipient. However, Reiki can also be provided without touching the recipient in situations when touch is not possible or appropriate. Recipients are always fully clothed. The practitioner is a channel for universal energy, as "[r]eiki is believed to flow via hands of a practitioner to a willing recipient" (Singg, 2004, p.262). Reiki has been described as an "intelligent energy" because it is believed to flow to the parts of the body that need it the most (Singg, 2004). Reiki has many uses, which include; alleviating pain, stimulating the immune system, relieving stress, releasing emotional blockages, and accelerating the

natural healing response (Thrapp, 2002). Although individual experiences will vary, there are a number of benefits associated with receiving Reiki. According to Thrapp,

> "On a physical level, Reiki is used to induce the relaxation response…On a mental level, Reiki brings about a sense of calmness and clarity by reducing stress and agitation. On an emotional level, Reiki can assist in the release of emotions such as grief, anxiety, fear, joy, and love. Spiritually, Reiki may assist in tapping into innate intuition and higher guidance" (Thrapp, 2002, p. 98).

Reiki has many benefits that can be useful for both patients and social workers, and could be a valuable addition to social work practice.

Reiki Training and Regulation

Reiki training is provided by Reiki masters and traditional Reiki training includes 3 levels; first, second, and third (master/teacher) degrees. All levels of Reiki training include a series of attunements provided by the Reiki master. Attunement is a form of initiation that "…is believed to prime one to receive the flow of energy and empower to be able to channel this energy from the top of one's head through the palms" (Singg, 2004, p.265). Students receive a certificate of completion at the end of each level. Reiki training is not regulated, which has been a concern noted within the Reiki literature, as there is no formal structure to oversee the supervision and certification of Reiki training (Singg, 2004). Despite Reiki being considered a low-risk therapy, "…the lack of standardization creates challenges to the integration of Reiki into

conventional medical environments and public health care programs" (Horrigan, 2003, p.8). However, the Canadian Reiki Association is a voluntary professional association that is working towards regulation. The Canadian Reiki Association provides the public with a listing of registered practitioners and teachers and "...is committed to promoting ethical practices and teaching; [and] encouraging educational standards" (The Canadian Reiki Association, 2007). The Canadian Reiki Association requires members to adhere to a code of ethics (see Appendix B) and also provides the public with a method to file complaints against members. Given the concerns regarding regulation it is not surprising that Reiki, similar to the fields of social work and complementary and alternative medicine, is being influenced by an evidence based approach to practice.

Evidence Based Practice

The fields of social work and complementary and alternative medicine are both experiencing increasing pressure to incorporate an evidenced based approach to practice and research. Evidence based practice originated from evidence based medicine, and "involves using the 'best available' evidence, often interpreted to mean research based 'knowledge,' about specific types of practices with particular problems" (Witkin and Harrison, 2001, p. 293). Similar to social work research, a great deal of the literature on CAM is based on qualitative research. Research within the fields of complementary medicine and Reiki in

particular has been criticized for using anecdotal evidence (Thrapp, 2002). Randomized clinical trials occupy the highest standard of evidence, while qualitative studies, case accounts and anecdotal evidence "...occupy a lower status in the hierarchy of credible evidence" (Witkin and Harrison, 2001, p. 293). As complementary therapies become increasingly popular,

> "...growing numbers of health care providers and policy makers are calling for accountability and regulation. There is currently a lively and unresolved controversy about how best to assure the safety and test the effectiveness of complementary therapies" (Kelner and Wellman, 2000, p.9).

The increased pressures of evidence based practice are a result of the changing landscape of social work practice.

The rise of managerialism in social work practice and the welfare restructuring of the 1990's resulted in a shift to standardize social work practice and focus on accountability and efficiency (Aronson and Sammon, 2000; Lawler, 2000). In an attempt to increase the credibility, decrease uncertainty and improve practice, the social work profession has adopted an evidence based approach that incorporates positivist values and discourses of science (Smith, 2004; Witkin and Harrison, 2001). The social work profession has a long history of debating how to define itself and related to this is the debate of whether social work is an art or science. This recent shift "...to place social work in the mainstream of scientifically oriented professions can be considered the enactment of cultural beliefs about what a profession should do and be" (Witkin and

Harrison, 2001, p.294). Therefore, it appears that the art versus science debate is swinging closer towards social work being considered a science. However, "...what counts as evidence and the value of different types of evidence tell us [as] much about cultural beliefs and power relations as about what is real" (Witkin and Harrison, 2001, p.295). Evidence based practice restricts the type of information that can be used as evidence and supports certain practices, while undermining others (Witkin and Harrison, 2001). For example, a higher value is placed on the objective and empirically based evidence from randomized clinical trials, versus the subjective evidence from practice experience (Witkin and Harrison, 2001). This is a concern since it serves to exclude other ways of knowing and devalues the experiences of patients and social workers.

Reiki, similar to the social work profession, is currently attempting to build its evidence base and credibility in the pursuit of gaining greater acceptance within conventional medicine. Research on Reiki does not easily blend with positivist research methodologies, "...current research methodologies need to be expanded in order to accurately measure Reiki's impact on outcomes" (Barnett and Chambers, 1996, p.16). Furthermore,

> "[m]any CAM practitioners feel that EBM [evidence based medicine] – to the extent that it seeks to direct clinical practice along paths guided by positive- outcome, placebo-controlled randomized controlled trials (RCTs) – is being applied inappropriately, according to standards set within the biomedical model" (Hammerschlag and Zwickey, 2006, p. 349).

According to Keegan, "energetic therapies are perhaps the most controversial of the alternative and complementary therapies in that there is only limited scientific evidence that such an area actually exists around the human species" (Keegan, 2001, p. 247). Reiki faces many challenges as it attempts to move towards integration and increase its credibility.

Although complementary therapies, like Reiki, are becoming increasingly accepted within the medical field and by health care professionals, Reiki still needs scientific evidence that it can improve clinical outcomes and is cost-effective (Miles, 2008). Conventional medicine does not currently have a theoretical framework for understanding Reiki as a universal life force energy, and this makes researching Reiki all the more crucial in the pursuit of integration. However, some of the research challenges relate to the lack of appropriate research methodologies, lack of research training on the part of Reiki practitioners and a lack of funding to support Reiki research (Miles, 2007). Other barriers include the limited research and literature available on Reiki and the lack of educational and practice standards on Reiki (Miles, 2007). Despite these challenges, if Reiki is to be integrated within conventional medicine and social work practice more research is needed.

Towards Integration

Integrative medicine is an approach to health care that combines conventional medicine with complementary therapies (Block, 2006). According to Block,

> "[t]he integrative approach is a careful amalgam of conventional and alternative treatments intended to marshal the body's own recovery process, it maintains an openness to paradigms other than Western allopathy, focuses on the larger goal of optimal health beyond ameliorating specific disease issues, and begins by creating a partnership of provider and patient" (Block, 2006, p.680).

However, even within an integrative medical model, it is still the conventional medical model that ultimately decides what therapies are considered effective and safe to integrate (Block, 2006). Conventional medicine is already beginning to incorporate some complementary therapies, like acupuncture and therapeutic touch. Both of these therapies have a larger research base compared to Reiki, and this may be one of the reasons why they are considered to be more acceptable therapies. Historically, conventional medicine has created a hierarchical relationship where physicians and health care providers are positioned as the experts and patients and family are given a lower status in the health care partnership (Zimmerman and Dabelko, 2007). Eisenberg et al. (1993) revealed that many individuals are using complementary therapies, but are not telling their physicians. An integrative approach to health care can help balance the relationship between patient and health care provider, and hopefully improve communication. Using complementary therapies

within conventional medical settings may also help to reduce health care costs. A study from the United States in 1995 found that patients given Reiki for fifteen minutes before and after surgery used less pain medication and had shorter hospital stays. As public interest grows in complementary therapies there will be a greater demand for conventional medicine to adopt a more integrative model of care that supports the use of complementary therapies and increases patient choice.

Methodology

Social Constructionism

Theory is used in research as a lens through which the researcher looks to assist in understanding the data. Frameworks and theories are used to specify how knowledge about our social world is created (Neysmith, 1995). Social constructionism is a theory that developed out of the postmodern era that maintains "...that our social and to some extent our physical reality is humanly constructed... [and] that there are many possible realities based on many possible truths" (Freud, 1999, p. 333). According to social constructionists, knowledge is constructed based on shared understandings, practices, and language (Schwandt, 2000). Vivien Burr outlined the four key assumptions that form a social constructionist perspective: "a critical stance towards taken-for-granted knowledge, historical and cultural specificity, knowledge is sustained by social processes, and knowledge and social action go together" (Burr, 1995, p.3). To move towards integrating Reiki within social work and conventional medicine it is necessary to critically examine and understand how social work and conventional medical knowledge has evolved. It is also important to acknowledge historical and cultural differences in regards to complementary therapies and conventional medicine. Eastern and Western philosophies of health differ; however, Western medicine is beginning to acknowledge the connection between mind, body and spirit.

Social constructionism also deals with the issue of power by identifying that, "...as views of reality are socially constructed and culturally embedded, those views dominant at any time and place will serve the interests and perspectives of those who exercise the most power in a particular culture" (Patton, 2002, p.100). In relation to research on Reiki, the focus on evidence based practice and research must also be critically examined, as it devalues research and evidence that does not fit within a positivist framework. This serves to marginalize Reiki and other complementary therapies from integrating within social work and conventional medicine. A social constructionist framework was used for this research, as I not only sought to understand the experiences of participants, but also wanted to explore the dominant discourses that impact that field of social work and potentially also impact the integration of Reiki within social work practice and conventional medicine.

Epistemology

A critical social science approach was used to guide this research. Epistemology generally "refers to the theory of knowledge" (Grinnell and Unrau, 2008, p.95). Critical social science "...defines social science as a critical process of inquiry that goes beyond surface illusions to uncover the real structures in the material world in order to help people change conditions and build a better world for themselves" (Kreuger and Neuman, 2006, p.83). This study not only focused on understanding how social

workers integrated Reiki within their practice, but also sought to explore the potential challenges of integration. Critical social science takes an action oriented approach to research; "...researchers conduct research to critique and transform social relations...uncover myths, reveal hidden truths, and help people to change the world for themselves" (Neuman, 1997, p.74). My research sought to not only understand the experiences of social workers who use Reiki, but also to uncover the structural issues that impact the integration of Reiki and social work.

In contrast to a positivist, objective and value free approach to research, a critical social science researcher is positioned within their research. According to Kreuger and Neuman, "[s]ocial work research is a moral-political activity that requires the researcher to commit to a value position" (Kreuger and Neuman, 2006, p.88). This research topic was chosen because of my personal interest and connections to the area of Reiki and social work. Therefore, the critical social science approach was a good fit for my research as I felt it was important to position myself within my research.

Goal of the Study

The purpose of my thesis research was to explore an emerging area of social work that incorporates complementary therapies within clinical practice. Specifically, I wanted to speak with social workers who were also trained in Reiki to gain insights into their perspectives on

integrating Reiki into practice. My objective was to better understand some of the benefits and challenges of using Reiki. I also sought to reveal some of the structural issues that impact attempts to integrate Reiki and to challenge the field of social work and conventional health care to become more holistic.

Research Design

I chose to conduct a qualitative research study to attempt to gather detailed information from the participants about their experiences and opinions of integrating Reiki and social work practice. As Kreuger and Neuman explained, "[q]ualitative social work researchers are more concerned about issues of the richness, texture, and feeling of raw data because their inductive approach emphasizes developing insights and generalizations out of the data collected" (Kreuger and Neuman, 2006, p.8). The qualitative research design allowed for certain topics to be explored, and also provided the flexibility needed to explore topics identified by participants during the interviews (Rubin and Babbie, 2005). The qualitative research design supported the critical social science methodological framework and purpose of the study.

Sampling and Recruitment

Participants were recruited based on the criteria that they hold either Bachelor of Social Work or Master of Social Work credentials, and have also completed training in Reiki. My aim was to recruit participants who had completed master level Reiki training. However, due to the limited number of potential participants, I also included participants with level one and level two Reiki training. Due to the time constraints of this project my goal was to reach a small sample of four to six participants.

My initial recruitment strategy was chosen due to concerns regarding the challenge of finding potential participants. I completed an internet search to attempt to identify potential participants by searching the Canadian Reiki Association's website for members who also advertised their Social Work credentials. This recruitment strategy is referred to as convenience sampling: "a nonprobability sampling procedure that relies on the closest and most available research participants to constitute a sample" (Grinnell and Unrau, 2008, P. 544). I also completed an internet search looking for people who advertised their Social Work and Reiki credentials together. In the end, my internet search resulted in identifying nine potential participants residing in Canada. However, I decided to focus my recruitment in Ontario, which resulted in five potential participants being identified.

An email message was sent to all of the potential participants identified through my internet search and they were invited to contact me if they were interested in participating (see Appendix C). My letter of information/consent form and my interview guide were included in the email as an attachment (see Appendix D and E). Due to the small sample of potential participants I also used a snowball sampling technique as a second recruitment strategy. Snowball sampling is a nonprobability technique, which is used "...when the members of a special population are difficult to locate" (Babbie, 2001, p.180). Snowball sampling involves the researcher collecting "...data on the few members of the target population he or she can locate, then asks those individuals to provide the information needed to locate other members of that population whom they happen to know" (Babbie, 2001, p.180). In my email script and letter of information/consent I invited potential participants to forward my project information onto anyone they knew who might be interested in participating.

My final recruitment strategy also involved using convenience sampling, and involved using some of my personal contacts. I knew of a few social workers who also had Reiki credentials, but since they did not have internet websites they were not identified via my internet search. Prior to beginning this research I was also approach by a personal contact that was aware of my research and requested to participate in my project.

Two personal contacts were identified as potential participants and similar to the rest of the potential participants I emailed them my letter of information/consent inviting them to participate. Recruitment resulted in four participants agreeing to participate, two through the internet search and two through personal contacts.

Data Collection

Participants took part in a semi-structured interview and all interviews were between 60-90 minutes in length. A semi-structured interview format was chosen as it provided some structure but flexibility to the interviews (Grinnell and Unrau, 2008). Interviews were face to face and the interview time and location were chosen by each participant at their convenience. An interview guide was used during the interviews. With the participants permission all interviews were audio recorded using a digital recorder. Field notes were also taken during and after the interviews.

Ethical Considerations

An ethics application was submitted to the McMaster University Research Ethics Board and I received a certificate of ethics clearance prior to beginning my project (see Appendix F). Informed consent is one of the ethical principles that need to be addressed when conducting research. I used a letter of information/consent form to provide information to potential participants about the purpose of the study and to

explain issues including potential risks, confidentiality, and a participant's right to withdraw at any time from the study. I was aware that the participants recruited through my personal contacts may have felt pressured to participate, so I emphasized that they need not feel obligated to participate. I reviewed my letter of information/consent form with each participant at the beginning of each interview and had each participant sign the form. Although it was not anticipated that participants would experience any harm or discomfort from participating in the study, I explained that some questions may cause participants to experience feelings of frustration or stress from unpleasant memories. I also identified that some participants may feel anxious about being identified through their participation in the study. Participants were reminded that they could decline to answer any question and could withdraw from participating in the study at any time.

Confidentiality was another ethical principal considered throughout the study. My letter of information/consent form outlined that participants' privacy would be respected and that identifying information would not be included in any research reports. To ensure participants confidentiality all of the transcripts were reviewed and any identifying information was either removed or altered. The transcriber who was hired signed a confidentiality agreement. All of the audio recordings and transcripts were stored in a locked cabinet or in a password protected computer file.

Participants were also informed that all information would be destroyed following the completion of my research.

Data Analysis

A transcriber was hired to transcribe all of the interviews, and all interviews were transcribed verbatim. Preliminary data analysis began during the data collection phase, since qualitative data analysis is not a standardized procedure, but is a process that occurs throughout the various stages of research (Kreuger and Neuman, 2006). Once each interview was transcribed, I listened to the audio recording while reading the transcribed data to ensure accuracy of the transcription and to remove any identifying information. I proceeded with my analysis by using an open coding process and examined the interview transcripts line by line. During the open coding process "[t]he researcher locates themes and assigns initial codes or labels in a first attempt to condense the mass of data into categories" (Kreuger and Neuman, 2006, p.438). Therefore, I read through each transcript to get a general sense of the data and began to underline sections of interests and make preliminary notes in the margins regarding emerging themes.

The next phase of my data analysis was to group and revise the initial list of codes. This step is referred to as axial coding and is described as the "second pass" through the data (Kreuger and Neuman, 2006). During this process initial codes are organized, and although new

codes or ideas may emerge, the main goal is to review and examine the initial codes (Kreuger and Neuman, 2006). As I continued with data analysis I re-read the transcripts and went through the process of recoding, combining and focusing my codes. I developed charts for each of the eight major themes that included all of the smaller codes that related to each theme, which helped me organize and focus the codes. I also developed a colour coded legend and went through each transcript and coded the data according to the legend. In the final stage of analysis I looked for relationships between the themes and used the charts to count how many participants expressed a particular theme.

Locating the Researcher

Due to my connections to the research topic I felt it was important to engage in the process of self reflection and locate myself within the research. Mays and Pope (2000) discuss the importance of reflexivity when conducting qualitative research and explain that a researcher's personal and intellectual biases need to be clearly identified to increase the credibility of the research findings. Similar to the research participants, I am also a social worker with Reiki credentials. I felt it was important to disclose at the outset of the project my connection to the research topic. Therefore, in my letter of information/consent form and my email script I identified myself as a social worker that also had training in

Reiki. My relationship to the research topic relates to the research debate over insider verses outsider researchers.

The debate over insider verses outsider research is connected to the debate regarding the issue of research objectivity. LaSala explores the issues surrounding the insider/outsider researcher,

> "Up until the mid-twentieth century, it was believed that insiders could not perform unbiased research within their own groups. It was thought that the feelings and commitments of inside investigators to fellow group members would interfere with their ability to remain objective" (LaSala, 2003, p.17).

It has been argued that social science should be objective and unbiased; while others believe that it is impossible for social science to be objective and value-free (Kreuger and Neuman, 2006). Researchers are at the same time both insiders and outsiders to some degree (LaSala, 2003; Narayan, 1993). In some respects due to my social work and Reiki credentials I am an insider in relation to the research participants. On the other hand, being a researcher places me in an outsider role. Throughout the research process it was important to continue to reflect on my position within the research as both an insider and an outsider.

Maintaining a reflective approach was at times challenging, but essential throughout each stage of the research process. During the interviews I wanted to hear from the participants about their experiences and perspective. I did not want to lead the interviews or make comments that could potentially influence the participant's responses. This was

difficult to do at times, due to my relationship to the research topic and my attempts to keep a conversational flow to the interviews. Being reflective was especially crucial during the analysis phase, since I did not want my preconceived biases and assumptions to influence my analysis of the data. I wanted to remain open to new ideas and valued the participants' unique perspectives. However, despite my attempts to not influence the interview process, during the analysis stage I identified moments in the interviews where I was leading the conversation based on my own assumptions. I spent extra time during the analysis stage reading the transcripts in an attempt to identify moments where I was influencing the interviews, and in some cases needed to recode the data to reflect this. I also used my thesis supervision at times to discuss some of these insider/outsider challenges as it was extremely important to my learning and to the research process to remain reflective.

Findings and Analysis

The Research Participants

A total of seven potential research participants were contacted, and five people responded to my recruitment email. However, at the end of my recruitment, four participants agreed to participate in the study and all were female. Two of the participants were identified through my internet recruitment strategy and the other two were identified through personal contacts. Of the four participants, three had their MSW and one had their BSW; their years of experience ranged from twelve to twenty-five years. All four participants were members of the Ontario College of Social Workers and Social Service Workers.

The participant's Reiki experience varied ranging from three to eleven years. Two of the four participants had completed the master level training, and one was about to start. The other participant had completed first and second degree training. Two of the participants were members of the Canadian Reiki Association.

One of the participants was working solely in a private practice. Two participants worked within a hospital setting and within a private practice. The fourth participant worked within a social service agency, as well as in private practice. Interestingly, all of the participants' private practices were organized quite differently. One participant offered both

social work and Reiki services, and would combine social work and Reiki with her clients' permission. Another participant had just developed her private practice, and had not used Reiki, but used other complementary therapies and discussed using Reiki within her practice in the future. One participant's private practice was solely a Reiki based service. Finally, the last participant provided both Reiki and social work services, but chose to keep these services separate and did not combine the two services.

Also of interest was that all of the participants had training in other types of complementary therapies and talked about using some of these techniques within their social work practice. All of the participants had training in using some form of meditation, three participants used visualization techniques, and two participants had training in or were starting to learn about the emotional freedom technique. The participants received other training including: transformative self healing, transformative mindfulness, Reiki drum healing and Shamanism.

Integrating Reiki and Social Work

Participants Introduction to Reiki

I was interested in learning about how the participants were introduced to Reiki and how they initially started integrating Reiki and social work. Two of the participants were introduced to Reiki through their

workplaces. In one case, the participant had an opportunity to experience Reiki during an education session at a previous workplace and decided she wanted to learn more about it. In the other case, the participant was introduced to Reiki by a coworker at a social gathering. The participant had hurt herself, and the coworker offered her Reiki to relieve the pain. Another participant explained that she was looking for a place to do her own "personal work" and decided to try Reiki after a friend told her about it. The final participant knew a Reiki master and this person encouraged her to try Reiki to help her cope with a painful health issue. Of the four participants, three were clearly drawn to learn more about Reiki for their own personal use, and then, over time, began to use it within their social work practice. The other participant did not specify if she initially learned about Reiki for her own personal or professional use. The literature on Reiki encourages starting with self practice prior to using Reiki on others, which is consistent with the participants experiences. The literature also suggests that it is easier to understand Reiki by experiencing a Reiki treatment, as it can be challenging to explain and difficult for people to comprehend. The participants' integration of Reiki within their professional social work roles emerged out of their personal experiences of practicing Reiki for self use. This could potentially be viewed as a concern if social workers are thought to be imposing their personal beliefs or values on their patients. However, the impact of personal beliefs and

values is not a new concern within the field of social work. As the participants explain in the following section, it appears that careful consideration is given before Reiki is introduced within their clinical practice.

Experiences of Integrating Reiki and Social Work in a Medical Setting

Three participants first started integrating Reiki and social work while they were working in a hospital setting; the fourth participant never worked within a hospital. All three participants who had worked in a hospital setting were working within a palliative care program. These three participants also explained that they only used Reiki occasionally; it was not something they used on a regular basis. It is interesting that all three participants were working within palliative care, which, as one participant mentioned, may be a more acceptable environment for the use of complementary therapies. Within palliative care, the focus tends to be on providing comfort and maximizing quality of life. It could be argued that conventional medicine is more comfortable with the integration of Reiki and other complementary therapies within palliative care, because all other medical interventions have been exhausted.

The participants who were using Reiki and social work together were asked to describe how they went about integrating Reiki. Two participants indicated that, at times, they would refer to therapeutic touch when they were trying to explain Reiki to patients or to coworkers. One

participant stated, "I kind of use...[therapeutic touch] as a jumping off point." All three participants indicated that before discussing Reiki they had built rapport and were familiar with their patients. One participant emphasized that she primarily used Reiki with patients with whom she had developed a close relationship and she knew they had either used Reiki, or were familiar with Reiki. There are many factors that influence the decision to include Reiki within social work practice; "...the relationship of the therapist and client, the client's perception of Reiki, and the timing of the introduction of Reiki" (Barnett and Chambers, 1996, p.79). Participants suggested that establishing a strong relationship of mutual trust between themselves and their patients was an important factor in whether they would introduce the topic of Reiki with patients. Despite the participants' personal beliefs and values about Reiki, it appears that they were very careful in their decision of when, and if, they would offer Reiki as a treatment option with patients. Participants appeared to be cautious about discussing Reiki, and may have been more comfortable introducing therapeutic touch as it felt safer given its nursing origins and its current use within conventional medicine.

Two of the three participants, who practiced in a medical setting, discussed the importance of completing their social work assessment prior to discussing or offering Reiki. As one participant stated, "I'm very much aware of the assessment process before you do anything...I'm always

assessing where they are, what they need, what can I offer them…my social work skills are always working." Also, two of the three participants working within a medical setting asked patients about complementary therapy use as part of their social work assessment, although one indicated that this was not always her practice. Another participant asked patients about religious/spiritual value systems and found this helpful in assessing a patient's "openness." The participants appeared to be using their assessment skills to identify issues that they may be able to address, and to determine if Reiki may be an appropriate intervention.

When discussing their initial use of Reiki within the hospital, two participants referred to offering it to patients who were experiencing physical pain in an attempt to provide comfort or symptom relief. Another two participants referred to using it with patients or family members of patients when they were experiencing some sort of emotion; whether they were stressed, anxious, crying, or overwhelmed. Two participants also talked specifically about using Reiki and counseling at the same time. As one participant explained, "I'm sort of talking, teaching and treating all at the same time. I am using the energy; I'm using the position of my hands to settle the physical reaction of the anxiety." The other stated, "I'm doing Reiki and they're talking. So that has been amazing because when they're really upset…I could go to their heart or I could go to different parts of their body that needs to help them to release." All of the participants also

indicated that at times they would just offer Reiki to patients if they thought the individual would benefit from some relaxation or if talking was not appropriate based on the patient's situation. For example, if the patient was unable to engage in a verbal conversation due to their emotional state, or as a means of relaxing the patient so that they are better able to attend to the conversation. Reiki appears to have been offered to patients as a means of providing some comfort and support.

Hidden Aspect of Practice

Of the three participants who were integrating Reiki and social work, all three made comments implying that integrating Reiki was a hidden part of social work practice. One participant explained that she felt a need to be secretive as Reiki had not been legitimized by her employer. This individual went on to explain that, within her hospital, she found out that there was a list of staff (mostly nursing) that were trained in therapeutic touch; "So they kept this unofficial list so that if a patient identified wanting it then they might call upon you as a volunteer, but not as a staff member." She thought this sent a mixed message to staff as "...it wasn't official." Another participant used the word covert to describe her use of Reiki, and went on to explain, "I was really trying to keep a low profile...everybody knew that I was doing it, I didn't do it behind their back, but everybody was looking the other way." The other participant did not talk personally about feeling the need to hide her use of Reiki, but she did

refer to others doing it "under the radar, because they're just afraid of...what the hospital would say." Considering that two of the participants were working in hospitals without a policy addressing the integration of complementary therapies by staff, it is not surprising that the participants were apprehensive about their use of Reiki. It appears that the lack of acknowledgment on the part of the hospital contributed to the participants feeling unsupported and without the validation of hospital policy, the participants may have been concerned about the possible repercussions of using Reiki. This connects to the issue of how the participants dealt with what could be seen as a professional tension and how they navigated their professional identities.

Navigating Professional Identity

A significant theme that emerged during all of the interviews was related to the participants' professional identity. Two of the participants stressed the importance of their social work identity. As one participant explained,

> "So the professional part of me wants to put out to the world that you can be professional and be a Reiki practitioner. So I want to maintain my professionalism, and also...maintain my membership in the College of Social Workers, because social work is important to me. I really define myself as a social worker."

Finally, another participant appeared to be concerned about potentially being judged by others; "Getting back to my fear of merging the

two…there are people out there who think it's crazy, Reiki." The participants seem to be struggling with integrating their social work identity with their Reiki identity. It also appears that the participants are concerned about being judged by the College of Social Workers and Social Service Workers, patients, co-workers, and their employers, which could also contribute to participants feeling the need to hide their use of Reiki.

All of the participants referred to tensions that they experienced as a result of using Reiki and being a social worker. Two participants spoke about feeling more comfortable talking about or integrating meditation or guided visualization over Reiki. When talking about introducing Reiki into a new work place, one participant said, "It is a process, that's why I decided to start with the most palatable one which is meditation and guided imagery…because it is more mainstream." Since three of the four participants were working within a medical setting it may have been more acceptable and less threatening to use meditation and visualization, as Reiki has less research and evidence to prove its effectiveness. Lack of support and acknowledgment appeared to also cause some tension for two participants. At times participants indicated that they felt their use of Reiki was supported by their co-workers, and at other times it was not considered a valid use of their time and they appeared to worry about being judged. Participants were looking for acknowledgement to

legitimize their use of Reiki, and the lack of acknowledgement they experienced could have contributed to some participants feeling apprehensive about the integration of Reiki.

Three of the participants also appeared to be struggling with the issue of social work scope of practice. One participant talked about getting mixed messages within her workplace about using Reiki. As she explained, Reiki was considered "nice to have", but when there was pressure to deliver services Reiki did not appear to be a priority. One participant commented on the tension within the field of social work about macro versus micro focused practice. As she explained,

> "...some of the clinical interventions many people believe have a blame the client attitude not looking at the structural inequalities...If we start saying Reiki is a form of client intervention there could be that criticism, you're moving away from social work as fighting the system...we have to be careful about that, it could be seen as we're putting the onus on the client."

Concerns regarding whether Reiki fits with social workers' scope of practice is understandable given that two of the participants were working without any policies to support their work. It also appears that participants were getting inconsistent messages from co-workers and management that using Reiki was okay as long as it did not get in the way of doing the "real" work. It is interesting that one participant commented on the long standing debate in social work of individualized versus structurally focused social work practice, as Reiki is an individually focused therapy.

Despite some of these tensions, two of the participants spoke about how they were moving forward and dealing with the issues of navigating their professional identities. As one participant explained,

> "I'm starting to be a lot more open about what I do…For me especially, in the beginning, I was a little worried about being judged so it felt a little like being in the closet, the closet Reiki Master. And I thought, oh this is silly I am who I am so I'm starting to be more comfortable about that."

The other participant stated, "I would say the more confidence I gain in my practice as a Reiki practitioner the more I think it just will be right." It appears that the participants are regularly experiencing professional tensions and are looking to find some balance between their social work identity and their Reiki identity. This is a similar tension that any social worker may encounter when faced with an issue that challenges their personal values and identity against their professional identity.

Benefits of Using Reiki and Social Work

All of the participants had a lot to say about the benefits of Reiki. A general benefit that three of the four participants identified was that Reiki worked well within conventional medicine. As one participant mentioned, "It's complimentary. It doesn't take the place of medicine, it doesn't take the place of doctors…it works with it beautifully." A theme that kept coming up throughout three of the interviews was that traditional social

work counseling was not always helpful and that participants found Reiki to be of assistance in these cases

When Talking Doesn't Work

During the interviews, an interesting theme emerged about Reiki being beneficial when counseling or psychotherapy is not an option or when it no longer worked. All three participants, who were using Reiki within their social work practice, commented on Reiki being of assistance when words and talking were not. One participant explained that if a person was stressed, overwhelmed or in a heightened emotional state at the beginning of a session she would sometimes use Reiki to relax them before they started talking. Another participant commented, "Body mind, spirit, all that stuff is so connected, there is way more that you can't just get at through talk." The other participant said about a patient, "She had never been able to go to that place when we were intellectually processing it through talking therapy…I don't know how to describe it other than to say when the hurt is so deep that you can't get at it from an intellectual level, the Reiki helps them access it at another level." As Barnett and Chambers identify,

> "Reiki accelerates the process of psychotherapy by eliciting additional insights regarding the client's situation as well as by allowing the emotional residue to gently release from the body's cells. The result is a sense of well-being and empowerment" (1996, p.76).

Three participants spoke about Reiki's ability to help people gain insight, clarity and focus. As one participant explained, "...when you're in the Reiki mode you may gain insight or access to information that you wouldn't normally get." Furthermore, all four participants commented on how quickly Reiki works, "I just think it allows you to get to the core feeling level quicker than the cognitive work." One participant shared some powerful feedback from a patient,

> "I can't believe what we've gone through in the first hour and a half, the things that I've been able to understand and that you've understood...I've been with a psychiatrist for twenty-five years and I got more out of this hour and a half than I did out of twenty-five years of therapy."

In relation to how quickly Reiki works, two participants also commented on how this can result in decreased time needed for counseling, which could be seen as a benefit for both patients and practitioners. Based on these comments, it appears that Reiki can assist the counseling process and may also be considered a cost effective strategy to potentially decrease the length of time needed for counseling.

Benefits for Patients

All of the participants commented that Reiki helped people who were experiencing pain (physical, emotional or existential pain). All four of the participants suggested that Reiki also helped with relaxation. As one participant said, "I just think it's so beneficial because you've got the ability with your hands to relax another person. How great is that?" Connecting

to this benefit of assisting with relaxation, two participants stated that Reiki helped with sleep. As one participant explained, "I've given people Reiki and they've gone to sleep and they haven't slept for a long time." Anxiety was another issue that participants commented on, "I found that Reiki would bring her heightened anxiety down to a manageable level...she was calmer...[and]...the nurses could do what they needed to do." These comments are consistent with literature on the benefits of Reiki; "For the most part, those clients who are anxious, stressed, depressed, or in chronic pain seem to benefit from introducing Reiki into the therapeutic interaction" (La Torre, 2005, p.185). The participants also identified that Reiki helped people with the connection of mind, body and spirit. One participant emphasized the benefit of touch for some of her patients based on their feedback, "I haven't felt this relaxed in so long and I haven't been touched in a nice way for so long, it feels so good to feel your touch." Not only does Reiki provide comfort and relief to patients, but it may also aid health care professionals in providing care to patients who may be challenging to help due to their heightened emotional state.

Reiki – A Tool for Patients

All of the participants suggested that Reiki was a technique that could be used by patients. Two participants talked about Reiki being "empowering" to enable "people taking ownership over their health...it's a tool some people may choose to use." Another participant talked about

Reiki as a coping strategy, "I'll teach them Reiki, so then they can use it to help themselves, to calm themselves down…to do what they need to do." The theme of Reiki being empowering may look attractive to people searching for a means of gaining control over their health. The literature also states that Reiki can be a source of empowerment. As Barnett and Chambers explain,

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

Similar to concerns within social work literature regarding the concept of empowerment, it is also a controversial issue within the field of complementary therapies. The notion of people taking responsibility for healing is a common philosophy within Reiki and other complementary therapies. However, if Reiki is presented as a self healing practice, it could be argued that there is the potential that this could be interpreted as blaming the patient. The concern is that "…many alternative therapies place an onus on individuals to take responsibility for their health, thus directing attention from the social and political causes of ill health" (Lupton, 2003, p.138). This contributes to the social construction of illness as being the individual's responsibility and blaming people for having done something wrong if they become ill. Reiki may be a useful tool for some patients to learn, but it is also important that social workers are careful not

to contribute to the individualization of illness. Social workers must be cautious about promoting Reiki as a tool to assist individuals in taking responsibility for their health, and must also attend to the social, environmental and political causes of illness.

Benefit for Social Workers

All of the participants had something to say about how using Reiki also had benefits for themselves as practitioners. The participant who had not integrated Reiki within her social work practice explained the benefits she has experienced;

> "Reiki is a tool for myself, for my professional development…following the daily principles of Reiki and meditating every day and doing Reiki every day grounds me and I'm more able to use empathy and I'm more able to be present with clients. It has brought my private practice to a whole new level that I wasn't at ever before Reiki."

A similar comment was made by another participant; "…the longer I work…with energy work…whether I'm not even using Reiki in my practice…I feel like I move into a different space in the session and I pick up and understand at a really deep level really fast." One participant commented on how Reiki could be used as a self-care technique for social workers that "...would probably help keep us from getting burned out." Social workers could use Reiki throughout the day to help them cope with the stress and demands of their jobs and it could also be used to assist with relaxation at the end of a busy day. Finally, two participants identified how Reiki helped them remember that they are not the "experts" and one

talked about feeling more comfortable with not having all of the answers. As one explained, "I think a lot of times…social workers…feel like crap. 'I just can't fix this thing, I'm missing something, what's going on?'…and it's not ours to fix…it's about going into the unknowing, and just sitting with not knowing." Interestingly, the participants identified a connection between their professional development and their use of Reiki. Although the integration of Reiki, at times, appeared to cause some tensions for the participants professionally, it appears, for some, to be a self-care technique that may help participants cope with some of these tensions.

Reiki - A Tool for Social Work Practice

All three of the participants who were integrating Reiki commented that they considered Reiki to be a "tool" for social work practice; "Reiki is just another tool that I will offer." These participants discussed Reiki in terms of being another treatment modality or technique that practitioners can use with clients, similar to using cognitive behaviour therapy (CBT), art therapy or journaling, "You went for cognitive behavioural therapy training, I went for Reiki." The participant who was not currently integrating Reiki into social work commented, "I would like to see it fully integrated [as]…a valid mode of practice just as CBT or narrative therapy." Social workers do not all practice from the same theoretical base and may have specific training in various different social work approaches. For these participants, Reiki is a good fit for their social work practice. Two

participants also felt Reiki was beneficial because of how easy it is to use, "it's so accessible you don't need equipment." The identification of Reiki being a cost effective technique could assist in the integration of Reiki within conventional medicine as cost containment continues to be a primary concern.

Challenges and Barriers to Integration

Stereotypes and Stigma

All of the participants referred to some of the stereotypes about Reiki during the interviews. Stereotypes noted by the participants included referring to Reiki as, "quackery," "flaky Reiki," and "crazy." One participant explained, therapeutic touch is "...more medicalized, where this is perceived as more mystical." None of the participants commented about experiencing any direct stigma as a result of integrating Reiki and social work. However, one participant talked about the "internal stigma" that she struggles with. She referred to an internal struggle that was connected not only to Reiki, but to the "new spirituality." She mentioned specifically the stereotypes of crystal cruncher and witch and the lack of understanding within society which worries her at times. These stereotypes are a challenge for the integration of Reiki, and, it appears, may contribute to the professional tensions that the participants identified.

Challenging these stereotypes can be difficult due to the lack of understanding on the part of others.

Lack of Understanding

All four participants made references to the challenges of integrating Reiki due to a lack of understanding on the part of others. As one participant stated, "...calling something Reiki is a barrier in and of itself, because people don't know what that is." Some of the participants explained that the best way to help people understand Reiki is to let them experience Reiki, as oppose to trying to explain Reiki. A number of the participants stated that they offered mini Reiki sessions to staff in an attempt to improve their understanding and give them an opportunity to experience Reiki. Another participant felt that since Reiki was offered by volunteers in some settings this was a challenge for social workers, because "...they put Reiki in the same category as the volunteer, peer support, friendly visiting...the lay professional...I think that's another obstacle." This lack of understanding relates to the difficulties of explaining Reiki, and to the fact that it is a relatively new concept to the Western world. It could also be argued that the lack of research on Reiki contributes to this lack of understanding. Therefore, Reiki continues to be viewed as an illegitimate complementary therapy and not a potential aspect of social work practice.

It is interesting to note that three participants made references to witchcraft during the interviews. Two participants specifically spoke about how witches were persecuted due to others' fears and lack of understanding. One participant talked about witches after commenting about needing to be careful about the language she used, as someone pointed out to her "not everybody talks like that, you need to be careful." In relation to this concern she stated,

> "I think this goes back to the witch burning days. You know...that's not that long ago in our history...So I think part of my worry about it is...that...people get persecuted for what others don't understand. And this is not tangible. You know Reiki's probably one of the most intangible."

Similar concerns can be found within the literature specifically related to the integration of spiritual healing and talking therapies. As West cautions,

> "[a]ny consideration of spiritual healing has to take into account the cultural context. For instance, in Britain, spiritual healing was illegal until the late 1950s under the Witchcraft Act, and the laying of hands as a form of spiritual healing remains illegal in many parts of Europe. There is also a strong link made in people's mind between spiritual healing and madness" (West, 2005, p.41).

For these participants, it appears that this fear of being judged or persecuted remains a concern and it could be argued contributes to Reiki being a hidden aspect of social work practice for the participants.

The Challenges of Language

Three of the four participants commented on how difficult it was to explain Reiki. As mentioned earlier, two participants, at times, referred to

Therapeutic Touch when talking about Reiki, as they felt this was more acceptable within conventional medicine. As one participant explained, "...my challenge has been how to describe it...how do you explain it without sounding like a nut bar?" The other participant was looking for help with finding a way to "...describe it to the doctors in a language they're more comfortable with." It appears that the participants are struggling with finding words to describe Reiki in ways that are more inline with conventional medical terminology and understanding. This may contribute to some participants being more comfortable integrating and talking about other complementary therapies that are more concrete and easier to describe, which, again, may contribute to Reiki being a hidden aspect of practice.

Bureaucratic and Environmental Challenges

All of the participants commented on bureaucratic or environmental barriers. Two participants were working in hospitals that did not have a policy or standards of practice regarding the use of complementary therapies within the hospital. One participant commented, "I wasn't breaking a rule, but there wasn't a rule." This lack of policy does not support the integration of Reiki and, it appears, could contribute to some tensions for social workers' professional identities. Social workers are left feeling unsupported and unacknowledged by the organization, which again can contribute to a concern that Reiki needs to remain a hidden part

of their practice. Three of the participants commented on how challenging it felt to integrate Reiki into a bureaucratic hospital environment; "...the hospital moves at a snail's pace" and "...it felt like there would be a lot to push through to get it as a mainstream treatment option." Hospitals are large bureaucracies and it can be difficult for the voices of a small number of people advocating for the integration of Reiki to be heard in such a large institution. One participant spoke specifically about the environmental challenges within the hospital, "...constant interruptions...little privacy...noise...the [hospital] beds." The busy and hectic hospital environment is a potential barrier to the integration of Reiki. Although it is not essential, ideally a Reiki session would take place in a quieter environment to assist with promoting relaxation. However, this hectic environment is potentially also one of the reasons why Reiki should be integrated within hospital settings, as a means to help patients cope with these environmental factors.

Scope of Practice and Time Limitations

Issues surrounding scope of practice and time limitations also surfaced as challenges for integration. One participant explained that she initially was "trying to keep a low profile" and "covering" herself, because she felt she "...was doing something maybe out of the scope of social work." This appeared to be a valid concern, as her supervisor was concerned about the use of touching in Reiki, "...the problem was you

were not supposed to touch as social workers...she was very concerned...because Reiki is a touching modality." The issue of touching within psychotherapy and other helping professions is controversial and typically is considered inappropriate (Sollod, 2005; Barnett and Chambers, 1996). However, it also needs to be acknowledged that some patients may be deprived of touch and actually craving a physical connection. Despite the concerns regarding touch, "[t]ouch is a basic, powerful way to communicate caring. The relaxation response elicited by caring touch underscores the fundamental relationship between touch and health" (Barnett and Chambers, 1996, p.64).

Another participant spoke about time limitations and the priority on discharge planning and completing long term care admission applications; "If it's between doing placement papers and Reiki, I've got to do the placement papers because the other part isn't valued as much." The welfare state restructuring that occurred in the 1990's resulted in hospital social workers experiencing increased demands including, higher volume of patients, decreased length of stay, increased pressure to discharge patients, decreased time for psychosocial assessments and interventions, and increased complexity of clinical problems (Globerman, White and McDonald, 2002). The result of these pressures is that social work becomes more focused on task completion and there is little, if any space left within the day for social workers to provide psychosocial support to

patients or offer "extras" to their patients like Reiki or other supportive interventions.

Regulation and Surveillance

Interestingly, all four participants suggested that they had some concerns about the College of Social Workers and Social Service Workers (OCSWSSW) in relation to the integration of Reiki. The participant who was keeping her Reiki and Social Work practices separate admitted,

> "I don't want to get in trouble…I don't want to go outside my field of practice. So I'm a little paranoid about that and I want to maintain professionalism…I'm afraid that if I advertise promoting myself as a social worker and said…part of my social work interventions will be Reiki or if I really played that up more, then I really do fear that might be called under criticism by the College or by the OASW, they might very well say that's not social work."

However, despite these concerns about the College, this participant also talked about using Reiki towards the new Continuing Competency requirements set out by the College, "I'm definitely going to put that Reiki is an important part of my professional development." Another participant, after being asked about whether they thought the OCSWSSW was supportive of integrating Reiki and social work jokingly responded, "I try not to think about it…They're not supportive of me." It appears that, for some participants, the OCSWSSW may contribute to professional tensions and concerns about scope of practice, which, could be argued, perpetuate Reiki being a hidden aspect of practice.

All of the participants referred to some ethical issues that related to the integration of Reiki. In relation to the social work code of ethics, one participant explained, "I don't believe there's a conflict with the code of ethics...Like if you look at the principles, the precepts of Reiki...I mean it's not like there's a conflict." As previously discussed, one participant spoke about giving consideration to the issue of touching and explained, "I've always done it with people's permission." Also in relation to the issue of touching, this same participant referred to the Canadian Reiki Association's code of ethics as holding members accountable, since it outlines what is considered to be inappropriate touching (see Appendix B). Two participants also talked about the possibility of having people sign consent forms, although only one participant who was working in private practice mentioned that she used consent forms, but not consistently. All of the participants acknowledged or implied that they had given some consideration to ethical issues related to the use of Reiki within social work. Social workers are well positioned due to their concern for ethics and adherence to their own code of ethics to offer Reiki as a social work intervention.

Another interesting point, raised by all of the participants referred to the importance of their social work skills when using Reiki. One participant explained, that although Reiki can be a relaxing experience, "...I'm also very aware...that it can be very traumatic." Reiki can cause

people to experience emotions that may be upsetting and painful, especially if the individual is not prepared for this possibility. The participant who kept her Reiki services separate explained, "...when you're giving Reiki sometimes there's an emotional release and I feel like my social work skills are really used. So I do feel like I'm doing social work with Reiki." Another participant stated,

> "...I have concerns about...[a lay person] opening a practice and doing sole Reiki...because...it's not benign work...sometimes in a treatment [they] get to a wound...whether you opened it in social work practice through our normal skills or whether its opened through a Reiki treatment its opened...you have to be a skilled counselor to deal with that."

From a social work perspective there is an obligation to deal with or close anything that has been opened during a session. This connects back to the issue of Reiki being provided by volunteers and lay professionals in some settings as being a barrier for implementation. The participants' comments suggest that social workers have the necessary skill set to support the use of Reiki and respond to the needs of patients following a Reiki session.

It was surprising that only one participant spoke to the challenges of regulating Reiki, since this was a concern addressed in the literature. From this participant's perspective, "I think the hugest challenge is going to be the regulation of it, because how do you regulate it?" This participant appeared to be struggling with differences between

philosophies of Reiki and social work in regards to the issue of regulating Reiki. She appeared to be torn between the need for the regulation of Reiki, due to the lack of training standards, and the non judgmental philosophy or "spirit" of Reiki. The lack of regulation could be an issue within a hospital environment that typically values standardization and accountability. It may be a necessary requirement that practitioners be members of the Canadian Reiki Association for the integration of Reiki to move forward.

Spirituality

Surprisingly, given the spiritual origins of Reiki, participants did not have much to say about issues regarding spirituality in relation to Reiki and social work. One participant commented, Reiki "...is spiritually based, although, you don't have to be spiritual to derive benefits from it. But as you study it, it really is a spiritual practice." Three of the participants made some reference to incorporating spirituality into social work practice. Two participants indicated that they asked about spirituality or religion as part of their social work assessment. However, one participant commented, "I was trained to look holistically at the person, but when we talk about holistic social work we don't talk about spiritual. Like it's a no-no; it's taboo. And I see the reasons why, but I think it's time to open that door." As reflected in the literature, one participant talked about spirituality not

being a valued part of social work. Reiki could be a support to social workers as an intervention that can incorporate a spiritual dimension back into practice. During the interviews I did not ask participants questions about the connection between Reiki and spirituality, which may have contributed to the limited comments about spirituality.

Evidence Based Practice and Research

All four of the participants spoke to the need for research to demonstrate the benefits of Reiki. One participant explained, "...in a hospital people are medically trained, they're scientific, they want the research. Show me the research." While talking about research and the need for evidence one participant stated, "I do think that's what changes it in our world, that is what makes a difference...I wish we didn't live in a world that needed that all the time, but we do." Another participant thought more research was needed to move the integration of Reiki forward, "I think we would have to do a good job showing outcomes." Similar to these comments, the literature also calls for further research to prove the effectiveness or benefits of Reiki.

One participant specifically commented on the current Reiki literature being based on subjective evidence. Speaking about the current emphasis on evidence based practice, she explained,

> "I don't have a problem with it, I think it's wonderful. Except...you can't always find evidence for things that work. I totally agree, look

> for the evidence, but a lot of the times the evidence is subjective, and what's wrong with that?"

An evidence based approach to researching Reiki at times can be attractive due to the potential research has for increasing credibility. However, it is important to acknowledge, as this participant commented, that qualitative research based on subjective evidence is also valuable.

Hope for the Future

All of the participants expressed hope for the future of integrating Reiki and social work. Two participants referred to there being an increased interest in people looking for services that provide a mind, body, spirit focus. As one participant states, "...people are opening up, there are more and more people who are becoming more open to body, mind, spirit work." Another participant said, "I think it's going to soar. I really think that as more practitioners become aware of it...once they experience it, I think that they'll use it as another tool." Despite all of the challenges and tensions identified during the interviews, participants remained hopeful and positive about the future of Reiki.

One participant had concerns that social workers would continue to keep Reiki "under the radar" and that another profession "...psychiatry...chaplaincy or nursing will grab it, research it and make it theirs." However, two participants actually indicated that they had plans for how they might individually work to further the integration of Reiki and

social work. One participant said, "...how I plan to do it, in a very little way...[is to] give talks on it if I'm given the opportunity." The other participant's plan was to start working on developing "...a network of holistic social workers, and we should put our heads together around getting some of that research going." By sharing their experiences and perspectives, the participants have provided important insights into how Reiki can be integrated into social work and conventional medicine and have revealed some of the challenges and benefits of integration.

Limitations

It is important to acknowledge some of the limitations of the research design. One of the limitations relates to my personal connection to the research topic, since I am also a social worker with Reiki training. I felt it necessary to disclose to the participants my connection to the research topic. However, this may have influenced the participants' responses to the research questions. My connection to the research may have also influenced how I responded to participants' comments during the interviews and my analysis of the research data.

Another limitation of my study relates to the sampling techniques used during recruitment. Since I used nonprobability sampling techniques, including convenience and snowball sampling, my participants' experiences may not be representative of the general population. Using the internet to search for potential participants that met the social work and Reiki credential requirements is also a limitation. It may be difficult to replicate the internet search and using the internet to identify potential participants excludes people who do not advertise on the internet. In the future recruitment strategies could be improved by directly recruiting within hospital settings and other social service agencies. Recruitment could have also been improved by using the Reiki and Social Work professional associations as a potential avenue for advertising the research project.

Discussion and Implications

The purpose of this research was to explore the experiences of social workers who were also trained in Reiki to learn about how Reiki could be integrated with social work practice and conventional medicine. The participants identified a number of benefits and challenges in relation to combining Reiki and social work, and their comments provide useful insights into the implications for the field of social work.

The participants experienced a number of challenges that may have been reduced if they had been working in settings in which there were policies supporting the use of complementary therapies by staff. It appears that working in a setting without policies to support the use of Reiki and social work caused tensions for the participants, which resulted in Reiki being a hidden or peripheral aspect of their practice. If Reiki and potentially other complementary therapies are to be integrated within social work and conventional medical settings it will be important for agencies to consider developing policies. However, it is quite likely that social workers interested in using Reiki or other complementary therapies will need to take a lead role advocating within their own agencies for this policy development. Social workers should begin by "building allies" within their workplaces (Baines, 2007; Mullaly, 1997; Bishop, 1994). One method, which was also mentioned during the interviews, is to offer mini Reiki sessions to staff during their lunch breaks. This provides an

opportunity for staff to experience Reiki, and also provides social workers with an opening to attempt to identify potential allies within their workplaces.

All of the participants appeared to experience some form of tension in relation to their professional identity of being a social worker and Reiki practitioner. One participant suggested developing a "network of holistic social workers," which as she suggested could provide an opportunity to work on research initiatives. However, this network could also potentially serve as a forum to help social workers deal with any tensions they are experiencing professionally. Bringing social workers together would provide an opportunity for mutual support and allow for discussions regarding the integration of Reiki and social work. This may help reduce the potential feelings of isolation that some social workers may experience, and would also provide a forum for the development of this emerging area of practice. Another suggestion for dealing with some of the tensions experienced by the participants is to use Reiki for self care and professional development.

Regulating Reiki training and practice may be a necessary requirement to further the integration of Reiki into social work and conventional medicine. Since Reiki can be difficult to explain, especially within Western culture that is not familiar with Reiki's theoretical basis, regulation may provide some reassurance to those who are skeptical or

equate Reiki with being "quackery" or "crazy." Moving "...towards credentialism may offer protection to the consumer by the assurance of the attainment of a minimum level of knowledge and skills" (Lupton, 2003, p.137). However, Lupton (2003) cautions that professionalization can lead to a similar power dynamic found in conventional medicine that places the doctor or health care professional in the position of expert and this may result in complementary and alternative therapies losing some of their appeal. Furthermore, Schiller (2003) argues that unregulated practitioners should not be marginalized by conventional medicine. The Canadian Reiki Association is working towards regulation, and Reiki practitioners can voluntarily become members. To advance integration, social workers using Reiki within their workplaces may be required to hold membership with the Canadian Reiki Association to ensure accountability and standardization, which are both highly valued principles within conventional medicine. It is clear that the issue of regulation is a contested issue that will continue to be debated as Reiki and other complementary therapies become integrated within social work and conventional medicine.

The participants all agreed that more research was needed on Reiki, which is a consistent recommendation within the literature. Compared to other complementary therapies, such as Therapeutic Touch, Reiki research is still in its infancy. Social work research on the use of

complementary therapies "... is virtually non-existent and is needed to contribute to the knowledge base of our profession" (Finger and Arnold, 2002, p.69). Although future research needs to demonstrate the clinical outcomes and benefits of Reiki, it is essential not to lose sight of the importance of patients' and practitioners' subjective experiences. Miles and True (2003) suggest using a mixed methodological design that includes both qualitative and quantitative approaches in future research on energy medicine. The literature also suggests the need to expand the definition of outcome measures to include the patients' experiences, including the impact on the therapeutic relationship and increased sense of spiritual well-being (Schiller, 2003; Miles and True, 2003). Research that also demonstrates outcomes of increased efficiency, improved patient care and satisfaction, and decreased length of stay and costs, will support the integration of Reiki within social work and conventional medicine, as these outcomes are highly valued within a health care setting.

For the purpose of this research project I specifically sought to speak with social workers who also had training in Reiki. However, it would be interesting to conduct another research project that studied a general sample of social workers in order to explore their views on the integration of Reiki and other complementary therapies within social work. In relation to my own recruitment strategies for this research, I would suggest expanding recruitment beyond convenience sampling, which was

chosen for this project due to time limitations and concerns regarding identifying potential participants. Other strategies could include recruiting through the Canadian Reiki Association, the Ontario Association of Social Workers, hospitals, and community health centres. Research is also needed to determine how many social workers are actually using Reiki as one of their social work interventions, and to explore clients' perspectives on the use of complementary therapies. Within a hospital setting, one of the initial steps social workers can take is to ensure that they are documenting their use of Reiki within the patients' charts. This will at least provide some basis for future research.

The integration of spirituality within social work has been debated in the past and is a complicated issue. However, the fact that it is complicated does not mean that it should be ignored. It is interesting that I overlooked the theme of spirituality during the interviews, as some of the literature on Reiki also seems to overlook or only briefly comment on Reiki's origin as a spiritual healing practice. However, I wonder if, at times, the issue of spirituality is overlooked or skimmed over due to concerns regarding credibility and the need for evidence based research to support the integration of Reiki. It appears that the field of Reiki may also need to re-examine its spiritual foundations. As public and professional interest grows in complementary therapies and the notion of mind, body, and spirit connection, it will be important for social work and

conventional medicine to re-examine the issue of spirituality. Asking about spirituality during the social work assessment provides an opening to explore a patient's spiritual views and beliefs, and it may also be a more comfortable opportunity to introduce Reiki as a possible social work intervention. Spirituality is experiencing a resurgence of interest, and it appears that future research on Reiki and social work practice will need to explore their spiritual origins.

One of the concerns raised by this research relates to the pursuit of social justice. One participant expressed concerns about Reiki being an individualized intervention that could potentially be criticized for ignoring structural issues. Literature on complementary and alternative therapies also expresses similar concerns. According to Lupton,

> "It is claimed that the alternative therapies often join scientific medicine in not sufficiently acknowledging the important link between an individual's health and the broader social milieu in which he or she lives (such as the impact of social class), and thereby serves as merely one facet of the institution of medicine's role in legitimizing and obscuring the prevailing social inequalities leading to ill health" (Lupton, 2003, p.136).

Furthermore, extending the "medical gaze" into all aspects of patients' personal lives, including mind, body and spirit, could possibly be interpreted as contributing to the medicalization of western culture and viewed as an extension of power (Lupton, 2003). It is also important to consider who is excluded from benefiting from Reiki and other complementary therapies. Reiki and many other complementary

therapies are not currently covered by public or private insurance plans and therefore, people who are unable to pay out of pocket for these services are excluded. However, if Reiki was provided within hospitals or other mainstream medical settings then more people would have access to its benefits. These concerns are all valid and need to be given careful consideration. However, as the participants suggested, Reiki is only one of many interventions that social workers can draw upon.

Maintaining a social justice perspective in day to day social work practice can be challenging for all social workers regardless of the interventions they use with clients. All social workers have a responsibility to incorporate social justice strategies within their daily practice and to work towards social change. However, working towards macro level changes, such as integrating Reiki within conventional medicine, can be an overwhelming task. Incremental changes are typically more realistic and manageable to pursue given the current context of social work practice. Many of the people, who access health and social services, including newcomers and aboriginal people, may come from cultures that value alternative healing practices. The pursuit of integrating complementary therapies within social work can be considered an incremental change that acknowledges the diversity of the people we serve and the need to "adapt intervention protocols to meet the needs of ethnically diverse groups" (Finger and Arnold, 2002, p.72). However,

social workers need to be careful about focusing on the potential cost effectiveness of integrating Reiki within conventional medicine. Although this language is clearly embedded within hospital and conventional medicine discourse, it is also crucial that social workers drawn attention to the need to increase access to health care services that meet the needs of marginalized groups. If a network of holistic social workers was developed this could potentially also be a forum for coalition building in regards to access to health care for ethnically diverse groups. Working towards integrating Reiki and other complementary therapies within social work and health care is essential to providing socially just and holistic services that meet the needs of all service users.

Conclusion

Exploring the participants' experiences and their perspectives on the opportunities and challenges of integrating Reiki with social work has revealed how Reiki can compliment social work practice. The participants identified exciting opportunities for working towards the integration of Reiki, and were hopeful about the future of Reiki and social work. It appears that social work is well positioned to take the lead on integrating Reiki within conventional medicine. However, it will be up to those interested in using Reiki within social work practice to continue to work towards Reiki being acknowledged as a legitimate social work intervention. Historically, social work has been uncomfortable with promoting itself, however, it is critical that we highlight our role and value, and claim our areas of expertise (Gregorian, 2005). It is also crucial that the field of social work begins to explore not only the integration of Reiki, but other complementary therapies that might be more congruent with our patients/clients beliefs and values. According to Finger and Arnold,

> "[w]hile social workers historically have employed a holistic approach to treatment, specialized training and the formal use of mind-body techniques by social work practitioners may need to be expanded in order for the profession to be acknowledged as a legitimate provider of such services" (Finger and Arnold, 2002, p.70).

Social work has evolved over time and will continue to evolve. For social work to be marketable and competitive in the future it will need to expand beyond traditional social work definitions and roles (Dziegielewski, 1998).

As public interest continues to grow in the use of complementary therapies, health care users will increasingly be seeking services that integrate complementary therapies with conventional medical interventions. Furthermore, it will become even more vital for conventional medicine and social work to provide holistic services that meet the unique needs of service users as the population continues to become increasingly diverse. Integrating Reiki and social work practice supports the profession's commitment to providing holistic services to the people we serve and its obligation to advocate for social change. Despite the limitations of this project, this research has added to the small, but hopefully growing, body of research on Reiki and social work practice. Further research is needed to continue to explore the use of Reiki within social work and to support its integration within conventional medicine.

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Appendix A

PRINCIPLE II:

Competence and Integrity

College members maintain competence and integrity in their practice and adhere to the College standards in the *Ontario College of Social Workers and Social Service Workers Code of Ethics*, the *Standards of Practice Handbook* and the College's by-laws.

Interpretation

2.1 Competence

College members are committed to ongoing professional development and maintaining competence in their practice.

2.1.1 College members are responsible for being aware of the extent and parameters of their competence and their professional scope of practice and limit their practice accordingly.[1] When a client's needs fall outside the College member's usual area of practice, the member informs the client of the option to be referred to another professional. If, however, the client wishes to continue the professional relationship with the College member and have the member provide the service, the member may do so provided that:

i) he or she ensures that the services he or she provides are competently provided by seeking additional supervision, consultation and/or education; and

ii) the services are not beyond the member's professional scope of practice.

Recommendations for particular services, referrals to other professionals or a continuation of the professional relationship are guided by the client's interests as well as the College member's judgement and knowledge.

2.1.2 College members remain current with emerging social work or social service work knowledge and practice relevant to their areas of professional practice. Members demonstrate their commitment to ongoing professional development by engaging in any continuing education and complying with continuing competence measures required by the College.

2.1.3 College members maintain current knowledge of policies, legislation, programs and issues related to the community, its institutions and services in their areas of practice.

2.1.4 College members ensure that any professional recommendations or opinions they provide are appropriately substantiated by evidence and supported by a credible body of professional social work knowledge or a credible body of professional social service work knowledge.[2, 3]

2.1.5 As part of maintaining competence and acquiring skills in social work or social service work practice, College members engage in the process of self review and evaluation of their practice and seek consultation when appropriate.

2.2 Integrity

College members are in a position of power and responsibility to all clients.[4] This necessitates that care be taken to ensure that these clients are protected from the abuse of such power during and after the provision of professional services.

College members establish and maintain clear and appropriate boundaries in professional relationships for the protection of clients. Boundary violations include sexual misconduct and other misuse and abuse of the member's power. Non-sexual boundary violations may include emotional, physical, social and financial violations. Members are responsible for ensuring that appropriate boundaries are maintained in all aspects of professional relationships.

2.2.1 College members do not engage in professional relationships that constitute a conflict of interest or in situations in which members ought reasonably to have known that the client would be at risk in any way. College members do not provide a professional service to the client while the member is in a conflict of interest.[5] College members achieve this by:

i) evaluating professional relationships and other situations involving clients or former clients for potential conflicts of interest and seeking consultation to assist in identifying and dealing with such potential conflicts of interest;

ii) avoiding conflicts of interest and/or dual relationships with clients or former clients, or with students, employees and supervisees, that could impair members' professional judgement or increase the risk of exploitation or harm to clients[6, 7]; and

iii) if a conflict of interest situation does arise, declaring the conflict of interest and taking appropriate steps to address it and to eliminate the conflict.

2.2.2 College members do not have sexual relations with clients (See Principle VIII: Sexual Misconduct, especially Interpretations 8.6, 8.7 and 8.8 and footnote 1 thereto.) In other professional relationships, College members do not have sexual relations with any person where these relations, combined with the professional relationship, would create a conflict of interest. (See Interpretation 8.9 under Principle VIII: Sexual Misconduct)

2.2.3 College members do not use information obtained in the course of a professional relationship, and do not use their professional position of authority, to coerce, improperly influence, harass, abuse or exploit a client, former client, student, trainee, employee, colleague or research subject.

2.2.4 College members do not solicit or use information from clients to acquire, either directly or indirectly, advantage or material benefits.

2.2.5 When a complaint investigation is underway or a matter has been referred to the Discipline Committee or the Fitness to Practise Committee for a hearing, College members co-operate fully with all policies and procedures of the Complaints, Discipline and Fitness to Practise Committees, and conduct themselves in a manner which demonstrates respect for both the complainant and the College.[8]

2.2.6 College members do not engage in the practice of social work or social service work,

i) while under the influence of any substance, or

ii) while suffering from illness or dysfunction,

which the member knows or ought reasonably to know impairs the member's ability to practise.

2.2.7 College members do not misrepresent professional qualifications, education, experience or affiliation. (See also Principle VI: Fees and Principle VII: Advertising)

2.2.8 In the practice of social work or social service work, College members avoid conduct which could reasonably be perceived as reflecting negatively on the professions of social work or social service work.

2.2.9 College members promote social justice and advocate for social change on behalf of their clients. College members are knowledgeable and sensitive to cultural and ethnic diversity and to forms of social injustice such as poverty, discrimination and imbalances of power that exist in the culture and that affect clients. College members strive to enhance the capacity of clients to address their own needs.

College members assist clients to access necessary information, services and resources wherever possible. College members promote and facilitate client participation in decision making.[9]

2.2.10 If there is a conflict between College standards of practice and a College member's work environment, the College member's obligation is to the *Ontario College of Social Workers and Social Service Workers Code of Ethics* and the *Standards of Practice Handbook*.[10]

FOOTNOTES

1. The scope of practice statements describe the professions' scope of practice, but do not exclusively limit the performance of the activities described therein to social workers and social service workers. Such statements provide three types of information — what the profession does, the methods the profession uses, and the purpose for which the profession does it. There is a scope of practice statement for social work and a scope of practice statement for social service work set out in the *Standards of Practice Handbook*. Note that the scope of practice differs from a job description, in which an employer defines the parameters of the various roles and duties to be performed by social workers and social service workers they hire. An employer is not obligated to allow a social worker or social service worker to perform all of the activities described in the scope of practice statement. Additionally, an employer may require a social worker or social service worker to perform activities that are not described in their scope of practice provided that the College member is permitted by law to perform those activities and the College member is competent to do so.
2. "Evidence" refers to information tending to establish facts. For College members, evidence can include, but is not limited to: direct observation; information collected in clinical sessions; information collected in professional meetings; collateral information; information from documents; and information gathered from the use of clinical tools (eg. diagnostic assessment measures, rating scales).
3. Each of the phrases "body of professional social work knowledge" and "body of professional social service work knowledge" relates to both theoretical and practical understanding. A body of knowledge can be attained through education, professional experience, consultation and supervision, professional development and a review of relevant research and literature. Professional social work knowledge and professional social service work knowledge draw upon the knowledge base of other professions including sociology, psychology, anthropology, medicine, law and economics as well as their own respective distinct bodies of knowledge.
4. See the discussion of the term "client" in the Explanatory Note to the Standards of Practice. While portions of Principle II refer separately to clients, students, employees and supervisees, the term "client" refers to any person or body that is the recipient of social work or social service work services, and may include students, employees and supervisees.
5. See also Principle VIII: Sexual Misconduct, Interpretation 8.5.
6. "Conflict of Interest" is defined as a situation in which a member has a personal, financial or other professional interest or obligation which gives rise to a reasonable apprehension that the interest or obligation may influence the member in the exercise of his or her professional responsibilities. Actual influence is not required in order for a conflict of interest situation to exist. It is sufficient if there is a reasonable apprehension that there may be such influence.

One of the hallmarks of a conflict of interest situation is that a reasonable person, informed of all of the circumstances, would have a reasonable apprehension (in the sense of reasonable expectation or concern) that the interest might influence the member. The influence need not be actual but may simply be perceived. However, a mere possibility or suspicion of influence is not sufficient to give rise to a conflict of interest. The interest must be significant enough to give rise to a "reasonable apprehension" that the personal, financial or other professional interest may influence the member in the performance of his or her professional responsibilities.

7. "Dual Relationship" is defined as a situation in which a College member, in addition to his/her professional relationship, has one or more other relationships with the client, regardless of whether this occurs prior to, during, or following the provision of professional services. A dual relationship does not necessarily constitute a conflict of interest; however, where dual relationships exist, there is a strong potential for conflict of interest and there may be an actual or perceived conflict of interest. Relationships beyond the professional one include, but are not limited to, those in which the College member receives a service from the client, the College member has a personal, familial or business relationship with the client, or the College member provides therapy to students, employees or supervisees. Members embark on an evaluation of whether a dual relationship might impair professional judgment or increase the risk of exploitation or harm to clients.
8. College members are cognizant of their influential position with respect to witnesses or complainants in complaint, discipline and fitness to practise proceedings.
9. Where the client is competent and able to give instruction, advocacy should be on direction of the client.
10. A social worker or social service worker shall advocate for workplace conditions and policies that are consistent with the *Code of Ethics and Standards of Practice of the Ontario College of Social Workers and Social Service Workers*. A social worker or social service worker will use professional judgement in determining how to advocate. Such advocacy may take the form of documenting concerns and discussing them with a supervisor or manager, or other key person in the organization.

Appendix B

The Canadian Reiki Association Code of Ethics

(Must be signed by ALL Members)

CRA

1. The health and well being of the client/student is the prime consideration of the member.
2. The client is entitled to truth, confidentiality, and the respect of their human dignity.
3. The client has the right to accept or refuse any form of treatment.
4. Members shall not refuse a client on the basis of sex, race, religion, sexual orientation, or political belief. However, notwithstanding this clause, members reserve the right to refuse a client for reasons of personal safety and/or other reasons, which do not contravene the aforementioned item.
5. Members should retain accurate and up-to-date records on their dealings with the client. These records should be maintained in a secure location and must be considered confidential. No information contained within the records should be released without the written consent of the client.
6. Members shall dress in a professional manner conducive to the holistic service being provided and be neat and clean in his/her own personal hygiene.
7. Members shall ensure that their professional conduct is beyond reproach. They shall not take physical, sexual, psychological or financial advantage of the client. They must not interfere in the client's personal affairs.
8. Members shall not practice or teach Reiki if they are in any condition, which compromises the quality of their services, such as inebriation, or if their mental faculties are lessened for any reason whatsoever and they shall never offer liquor to their clients.
9. Members will never ask a client to disrobe and will not allow such action to take place, nor will the member touch the genital area or anal area or the breasts or areola of their client, nor will the client be allowed to touch the practitioner in such a manner.
10. When the client has given permission for "hands on" therapy, members shall use light hand pressure when placing hands on the client's body. There will never be a need to rub or manipulate of any body part. If the client has not given permission for "hands on" therapy, the member will complete the entire Reiki session with hands above the body at all times.
11. Members shall not refuse or withdraw services without justifiable cause. Such reasons include but are not limited to conflict of interest between the member and the client that jeopardizes the professional relationship or illegal or unjust or fraudulent actions taken or proposed by the client.
12. Members must recognize their limits of competence and must not undertake issues for which they have no training. Members will not claim that Reiki can cure, nor will they diagnose any medical problems or prescribe, nor will they ever advise a client to stop taking medications, unless qualified to do so. When it is in the client's interests, members should refer the client on to another practitioner or organization that has the training appropriate to the client's needs.
13. Members should continually make an effort to improve their knowledge and professional skills. They should also encourage the public to become educated and informed about the practice and teaching of Reiki and about the development of a health-enhancing lifestyle in general.
14. Teaching members should not encourage the practice of Reiki by persons who are not competent or who have insufficient training or certification. They should not grant certificates of attendance or competence to anyone whose skills and/or ethical conduct they have a valid reason to doubt. Teaching members should report any such cases to the CRA.
15. Members are responsible for reporting any member of the CRA who does not respect this code of ethics. This requirement aims to ensure the protection of the public interest and also to protect the good name and professional reputation of the CRA.
16. Members agree that failure to abide by the terms, conditions, and stipulations of this code of ethics **will** leave them subject to action, whether legal or other, by the CRA. Action may include but is not limited to: temporary or permanent suspension of membership, public notification of a member's transgression, and/or suspension of membership, legal action. **In addition, members understand that breaching any or all of code numbers 7, 8, 9 and 10 will result in immediate termination of their membership.**
17. Members acknowledge that a code of ethics cannot cover every case of what is ethical and what is not. Therefore, it is understood that members must behave in accordance with the ethical standards of the province and country in which they reside.
18. It is understood that the CRA is hereby saved harmless from liability of any kind whatsoever for the actions or lack thereof of its Registered Practitioners and/or Registered Teachers in fulfillment of their association membership.

I have completed the CRA Membership Application form accurately and honestly and I agree to abide by the CRA Code of Ethics listed on this form. I understand it is my responsibility to abide by any local or Provincial laws and rules, if any, regarding Reiki as well as any other complimentary integrative modality that I practice. I have no knowledge of any incident, suit, pending claim or license revocations or ethics hearing violation against me. I have never been the subject of any investigation in connection with any sexual misconduct or act, molestation or assault. I attest that no issued documentation for licensing, certification or registration has been revoked and no disciplinary action is pending against me in relation to my trade's specialty. I attest that I have completed all of the required training and certification for Reiki and the integrative modalities I have listed on this application and that I practice. I understand my signature is considered legal and binding and that it verifies I have completed this form completely and honestly.

Signed _____ Dated _____

Reference Authorization – RP and RT ONLY

I authorize the Canadian Reiki Association to give my name and phone number to members of the public.
I understand that any references made by the CRA to me are undertaken solely at my own risk and that the CRA is not responsible for the consequences thereof in any way whatsoever.

I will treat at: (RP / RT) ☐ Client's Location (Travel = Yes) ☐ My Location

I will teach at: (RT only) ☐ Student's Location (Travel = Yes) ☐ My Location (Refer=Yes)

_____
Signature

Appendix C

McMaster University
Inspiring Innovation and Discovery

Recruitment – Email Script

Subject Line: Integrating Reiki and Social Work:
Participants being sought for a research study.

Hello {insert name of potential participant},

My name is Jackie Fox and I am a Masters student in the School of Social Work, at McMaster University. My background is in social work, but I have an interest in Reiki and have completed some Reiki training. I obtained your name and email address from your website on the internet. As part of my thesis research, I am conducting interviews with social workers who are also trained in using Reiki to discover their perspectives on the benefits and challenges of incorporating Reiki within social work practice.

Your website indicated that you have a background in social work and Reiki. I am currently looking for participants and was hoping to speak with you about your perspectives on using Reiki and social work together and the potential benefits and challenges.

If you are remotely interested and would like to know more about the study I have attached my letter of information/consent form and a sample of my interview questions. If you are interested in participating or have any questions about the study, you can either call me at (905) 719-6440 or send me an email at foxjm@hotmail.com.

If you know of someone else who may also be interested in participating in this study please feel free to forward this email or give them my contact information and/or a copy of my letter of information/consent so that if they are interested they may contact me directly.

This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

Thank you for your time and consideration!

Jackie Fox
School of Social Work
McMaster University
Hamilton, ON
MSW Thesis
(905) 719-6440
foxjm@hotmail.com

Appendix D

April 2009

Letter of Information /Consent Form

Integrating Reiki in Social Work: Opportunities and Challenge

Investigator: Jackie Fox, MSW Candidate
School of Social Work
McMaster University
Hamilton, ON, Canada
(905) 719-6440
foxjm@hotmail.com

Research Supervisor: Sheila Sammon
School of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 23780

Purpose of the Study

In this study, I want to hear from social workers who are also trained in Reiki to learn about how Reiki could be integrated with social work practice. I am a social worker who also has some Reiki training. I currently work in a hospital setting and have been approached by patients who have expressed an interest in incorporating some form of complementary therapy into their care plan. However, complementary therapies are rarely discussed with patients in the hospital or included in care plans. I am hoping to learn about your experiences of using Reiki and your opinion about the potential opportunities and challenges of incorporating Reiki into social work practice. I hope to draw conclusions from your feedback about the potential for integrating Reiki within the health care system.

Procedures involved in the Research

If you volunteer for this study, you will be asked to participate in one 60-90 minute interview. The interview will take place either by telephone or in person, as you wish. It will take place at a time that is convenient for you. With your permission, I would like to audio tape the interview.

You will be asked questions about your experiences as a social worker and Reiki practitioner. I will be interested in learning about your opinion in relation to the benefits of integrating Reiki and social work, as well as some of the barriers or challenges. I will also

ask you for some demographic information like your age, education, years of experience, and general information about places of employment (for example: hospital setting, private practice, community agency).

Potential Harms, Risks or Discomforts:

It is not likely that there will be any harms or discomforts associated with your participation in this study. Some of the questions I ask may cause you to experience stress or frustration from unpleasant memories or cause you to feel anxious in relation to concerns about being identified by participating in the research.

Please remember, however, that you do not need to answer questions that make you uncomfortable or that you do not want to answer. Also, you are free to take a break or stop the interview entirely at any point.

The steps I am taking to assure your privacy are discussed in the confidentiality section of this letter.

Potential Benefits

Although the research will not benefit you directly, I hope that what I learn will help me understand more about the benefits and challenges of integrating Reiki and social work practice. Your feedback could contribute by helping to further research in this field and may also guide practice and policy recommendations.

Payment or Reimbursement:

Participants will not receive payment for participating in this study.

Confidentiality:

In order to respect your privacy, I will not use your name, or any identifying information in any research reports or presentations I make. Your participation in this study will remain confidential.

The information obtained by me will be kept in a locked cabinet and will only be available to me and my research supervisor. Any information stored on a computer will be password protected. The interview audio recordings may be transcribed by a professional transcriber, but no identifying information will be included in the recordings and the transcriber will be signing a confidentiality agreement. The information will be destroyed following the completion of my research project.

Participation:

Your participation in this study is voluntary. If you decide to participate, you can decide to stop at any time, even after signing the consent form or part-way through the study. If you decide to stop participating, there will be no consequences to you.

In cases of withdrawal, any data you have provided to that point will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Information About the Study Results:

You may obtain information about the results of the study by contacting me directly and I will provide you with a 1-2 page summary of the findings. The summary will be available to those who are interested in September 2009.

Information about Participating as a Study Subject:

If you have questions or require more information about the study itself, please feel free to get in touch with me directly or contact my faculty supervisor.

If you know of someone else who may also be interested in participating in this study please feel free to give them my contact information and/or a copy of my letter of information/consent so that if they are interested they may contact me directly.

Student Investigator: Jackie Fox (905) 719-6440, foxjm@hotmail.com
Faculty Supervisor: Sheila Sammon (905) 525-9140 ext. 23780

This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

CONSENT

I have read the information presented in the information letter about a study being conducted by Jackie Fox of McMaster University. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so, and I agree to participate in this study. I have been given a copy of this form.

_____

Name of Participant (Please print)

_____

Participant's Signature

_____

Research's Signature

Appendix E

McMaster University

Inspiring Innovation and Discovery

Interview Guide

- Please be aware that it is my intention that the interviews will be semi-structured and that these questions are only a guide and subject to change.

Background

What level of social work education have you completed (BSW/MSW)?

Are you a member of the College?

How many years have you been working as a social worker?

Are you currently working as a social worker?

What types of settings have you worked in?

What level and style of Reiki training have you completed?

How long have you been practicing Reiki?

When and how were you first introduced to Reiki?

Reiki and Social Work

Do you use Reiki within your social work practice? Are there other setting that you have worked in and used Reiki? When did you begin to use reiki and social work together?

If you use Reiki and Social Work together, how do you use them together? Who would you use Reiki with and for what purposes? When would you not suggest Reiki to a service user?

If you practice Reiki outside of your social work practice, do you incorporate social work analysis and interventions into your Reiki practice?

Do you think that Reiki can be integrated into social work practice? How do you see this unfolding? Do you see benefits to integrating Reiki and social work? If so, what would you say are some of the benefits?

Client's perspectives

Do clients talk to you about the benefits of Reiki for them? If so, could you give me some examples?

Have clients been dissatisfied with Reiki? If so, could you give some examples?

Challenges

When and how did you begin to integrate Reiki? Did you experience any challenges, resistance or barriers and how did you handle this?

Do you think there are challenges to integrating Reiki and social work practice? If so, how would you describe the challenges?

How do you see Reiki fitting with the college of social workers and SSW code of ethics –scope of practice?

What are your views on the impact of evidence based practice in relation to integrating reiki and social work?

Are there other areas, besides social work, that you think Reiki could be integrated?

Do you use other forms of energy work with social work?

What are your thoughts on integrating Reiki within the health care system (e.g in hospitals, long-term care homes, home care services)? Do you think it is being used, are you aware of

What are your views on research related to integrating reiki and social work?

What do you see as the future direction of Reiki and social work practice?

Appendix F

McMaster Research Ethics Board

McMaster University Research Ethics Board (MREB)
c/o Office of Research Services, MREB Secretariat, GH-305/H, e-mail: ethicsoffice@mcmaster.ca

CERTIFICATE OF ETHICS CLEARANCE TO INVOLVE HUMAN PARTICIPANTS IN RESEARCH

Application Status: New ☑ Addendum ☐ Renewal ☐ **Project Number** 2009 016

TITLE OF RESEARCH PROJECT:

Integrating Reiki and Social Work Practice: Opportunities and Challenges

Faculty Investigator (s)/ Supervisor(s)	Dept./Address	Phone	E-Mail
S. Sammon	Social Work	23780	sammon@mcmaster.ca
Student Investigator(s)	**Dept./Address**	**Phone**	**E-Mail**
J. Fox	Social Work	905-388-4608	foxjm@hotmail.com

The application in support of the above research project has been reviewed by the MREB to ensure compliance with the Tri-Council Policy Statement and the McMaster University Policies and Guidelines for Research Involving Human Participants. The following ethics certification is provided by the MREB:

☑ The application protocol is approved as presented without questions or requests for modification.

☐ The application protocol is approved as revised without questions or requests for modification.

☐ The application protocol is approved subject to clarification and/or modification as appended or identified below:

COMMENTS AND CONDITIONS: Ongoing approval is contingent on completing the annual completed/status report. A "Change Request" or amendment must be made and approved before any alterations are made to the research.

Reporting Frequency:	Annual:	Other:

Date: March 7, 2009 Dr. D. Maurer, Chair/ Dr. D. Pawluch, Vice-chair:

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