

ORIGINAL ARTICLE

The Subjective Experience of Reiki is Differentially Associated with Improvements in Health-Related Symptoms

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Abstract

Background: Prior qualitative studies have described subjective experiences during Reiki, yet their quantitative relationship to symptom change has not been examined. This study evaluated whether specific subjective Reiki experiences are associated with changes in health-related symptoms using regression and mediation analyses.

Materials and Methods: The study took place at private Reiki practices across the United States. Reiki practitioners ($N = 99$) invited their clients to complete a survey before and after receiving Reiki. The Reiki sessions were conducted in person, with each session lasting an average of 60 min. Self-report measures based on the Edmonton Symptom Assessment System were used to assess physical and psychological symptoms immediately before (pre) and after (post) the Reiki session. Participants were asked to describe their experience during the Reiki session at post. Linear regression analyses were conducted to explore associations between subjective Reiki experiences and changes in well-being, pain, and anxiety, while controlling for age and gender. Mediation models tested whether pain and anxiety changes mediated the relationship between subjective Reiki experiences and improvements in well-being.

Results: A total of $N = 1,284$ Reiki sessions had both quantitative and qualitative data and were included in the analysis. Experiencing positive emotions was significantly associated with higher well-being and reduced anxiety, and experiencing body sensations was significantly associated with greater pain relief. There was a significant indirect effect of body sensations on well-being via pain relief, a significant indirect effect of positive emotions on well-being via anxiety reduction, and a significant indirect effect of emotional release on well-being via anxiety reduction.

Conclusions: The results from this linear regression and mediation analysis suggest that the subjective experience of receiving Reiki is related to changes in different psychological and physical health symptoms. More work is needed to confirm these findings while addressing the limitations of the current study.

Keywords: anxiety, mediation analysis, pain, qualitative, quantitative, reiki

Introduction

Reiki is a biofield therapy originating in Japan in which practitioners place their hands lightly on or just above a person, with the goal of directing energy to help facilitate the person's own healing response.¹ Systematic reviews and meta-analyses report that Reiki results in statistically

significant improvements in many symptoms common to a wide range of diseases, such as anxiety, depression, fatigue, pain, and nausea.^{2–8} From 1989 to 2025, approximately 150 peer-reviewed research articles have been published on Reiki in English. Of the higher-quality studies,⁹ in which Reiki was compared with sham-Reiki or standard-of-care, Reiki has been shown to significantly improve pain,^{10–14} anxiety,^{13,15,16}

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depression,^{17,18} burnout,^{19,20} and quality of life or well-being.^{21,22}

In addition to improvements in health-related symptoms, receiving Reiki can be a unique and transformative experience. This experience could guide researchers to the underlying mechanisms of Reiki's effectiveness. Previous qualitative studies of Reiki, though few, have reported themes related to feelings of relaxation and calmness; body sensations such as warmth and tingling; emotional release, defined as reports of crying; emotional catharsis; or the expression or resolution of suppressed emotions, changes in perception, and connection to spirit or a higher power.^{22–27}

The U.S. National Center for Complementary and Integrative Health (NCCIH) defines Reiki as a complementary health approach that is safe but notes that higher-quality trials are needed.²⁸ Internationally, the World Health Organization (WHO) has emphasized the need for robust research on traditional, complementary, and integrative medicine, given the increasing reliance on these approaches for the management of noncommunicable diseases, health promotion, disease prevention, and palliative care and rehabilitation.²⁹ To date, no study has quantitatively evaluated whether specific subjective experiential themes are associated with measurable changes in health-related symptoms. Addressing this gap responds to the WHO's and NCCIH's calls for mechanism-focused research in complementary therapies.^{28,29}

The current study is an additional analysis of a large-scale observational study of Reiki.^{27,30} In the quantitative aspect of the study ($N = 1,411$), statistically significant improvements were observed for all outcome measures, including affect, pain, drowsiness, tiredness, nausea, appetite, shortness of breath, anxiety, depression, and overall well-being (all p values <0.001).³⁰ In the qualitative component of the study, $N = 1,284$ qualitative responses were completed and included in the analysis. The analysis revealed eight major themes: (1) deep relaxation and calm (68%), (2) body sensations/somatic experiences (53%), (3) emotions (29%), (4) spiritual or symbolic significance (18%), (5) changes in symptoms (17%), (6) changes in perception (11%), (7) sleep and drowsiness (10%), and (8) changes to breathing (4%).²⁷

By integrating quantitative and qualitative data, mixed-methods approaches and quantitative measures reveal “what” changes in symptoms, while qualitative reports suggest “why and how” those changes occur.³¹ This dual approach aligns with the aforementioned priorities in complementary medicine research.^{28,29} However, prior Reiki research has not quantitatively tested associations between specific subjective experiential domains and symptom changes, nor examined whether symptom changes statistically mediate relationships between experience and well-being.

Accordingly, the present study applies linear regression and mediation analyses to evaluate whether specific subjective Reiki experiences are associated with changes in pain, anxiety, and overall well-being, and whether changes in pain and anxiety mediate improvements in well-being. To address this gap, the present study focused on three outcomes: pain, anxiety, and overall well-being. These were selected because they are among the recently examined and meaningful, with growing evidence suggesting that Reiki may be effective in alleviating them.^{3,32}

Therefore, the purpose of the current analysis was to evaluate how these themes relate to changes in health-related symptoms by analyzing the links of the “subjective experience” of receiving Reiki to the reported “effect” of Reiki. As an exploratory study, this was designed on prior qualitative literature to inform interpretive expectations regarding how psychological (e.g., anxiety) and physical (e.g., pain) experiential themes might relate to psychological versus physical outcomes.

Methods

As this is an additional analysis of a mixed methods evaluation of Reiki for psychological and physical health symptoms, further details of the methodology are published elsewhere.^{27,30}

Study design

This was a secondary analysis of an observational trial of Reiki. Linear regression analyses were conducted to explore associations between qualitative, subjective Reiki experiences and quantitative changes in well-being, pain, and anxiety, while controlling for age and gender. Pain and anxiety were selected because they are among the most reported in Reiki research and reflect key aspects of distress that are sensitive to complementary interventions. Well-being was chosen as the primary outcome because it represents a broader construct of health that integrates physical and psychological functioning, and improvements in pain and anxiety are often expected to translate into enhanced overall quality of life.

To further clarify these relationships, mediation models tested whether changes in pain and anxiety mediated the association between subjective Reiki experiences and improvements in well-being. Mediation analysis provides a rigorous statistical framework to identify whether symptom changes act as intermediaries³³ linking subjective Reiki experiences to health outcomes. This method has been increasingly applied to gain insight into mechanisms of exposure-outcome effects in observational research.³⁴

Participants and setting

The study took place at private Reiki practices across the U.S. Reiki practitioners were required to hold the level of Reiki Master and were recruited online through a professional Reiki network. No minimum years of practice was imposed; however, Reiki Master training typically involves formal instruction and practice. Ninety-nine Reiki practitioners met the inclusion criteria^{27,30} and participated in the study. There were no exclusion criteria to participate in the study as a Reiki client. There was no compensation for participating in the study as a Reiki practitioner or client. This study was approved by the Harvard University Institutional Review Board.

Reiki as a practice

In a typical Reiki session, the client or patient lies down fully clothed on a massage table, bed, or sits comfortably in a chair. A typical session lasts around 60 min, during which the Reiki practitioner places their hands above or gently touching different locations on the body while allowing the

energy to flow. The number of hand positions depends on the Reiki tradition or needs of the client. Each position is held between 1 and 5 min or until the Reiki practitioner feels that the energy has stopped.

Study procedure

Reiki practitioners were instructed to hand an information sheet about the study to their client, which invited them to complete a survey before and after their Reiki session. Clients that agreed to take the survey completed the survey immediately before (pre) and after (post) the Reiki session online using Qualtrics survey software licensed to Harvard University (www.qualtrics.com). The surveys took approximately 10 min to complete.

Quantitative and qualitative health measures

The study employed a mixed-methods assessment that combined quantitative symptom ratings with qualitative descriptions of participants' subjective experiences. For the quantitative measures, items were adapted from the Edmonton Symptom Assessment System (ESAS)³⁵ to assess symptom severity in a nonclinical Reiki population. It is important to highlight that the ESAS has been used as symptom indicators rather than diagnostic measures. This was done to assess a range of symptoms immediately before (pre) and after (post) the Reiki session. Physical and psychological health-related measures included pain, tiredness, drowsiness, nausea, appetite, shortness of breath, depression, anxiety, and overall well-being, which were all assessed on an 11-point Likert scale ranging from 0 (no, e.g., pain) to 10 (worst possible, e.g., pain). For the current analysis, anxiety, pain, and well-being were the focus.

Immediately after the Reiki session (post), Reiki clients were asked: *Please describe what you experienced during the Reiki session.* Answers were provided in an open text box without a word limit. After the coding described in data analysis, four categories of subjective experiences were selected: relaxation, body sensations, positive emotions, and emotional release.

Data analysis

Descriptive statistics, including frequencies, means (*M*), and standard deviations (*SD*), were computed for Reiki client demographics. Changes in physical and psychological health measures from pre- to post-session were previously analyzed using paired samples *t* tests.³⁰ The current study had a reduced sample that completed the qualitative assessment (91% of full sample); therefore, the quantitative values were computed for this subset. Qualitative data were previously analyzed to identify major and minor themes²⁷ using a grounded theory approach.³⁶

Linear regression analyses were conducted to evaluate the relationship between themes and changes in symptoms, specifically anxiety, pain, and overall well-being. Mediation analysis models then tested whether pain and anxiety changes mediated the relationship between subjective Reiki experiences and well-being improvements. Significance level was set to $p < 0.05$. Data were analyzed using IBM SPSS statistical software version 29.0 (Geneva, Switzerland). Regression analysis and mediation analyses were performed in R

(version 4.3.2; R Foundation for Statistical Computing, Vienna, Austria) via RStudio (version 2024.12.1 + 563, Posit Software, Boston, MA), using bias-corrected bootstrap confidence intervals (5,000 resamples) to estimate indirect (Average Causal Mediation Effect [ACME]) and direct (Average Direct Effect [ADE]) effects. The independent variables in the regression analysis were age and gender, as these are reliably associated with differences in pain, anxiety, and well-being across populations.

All regression and mediation analyses were conducted using the quantitative and qualitative data ($N = 1,284$). Subjective experiential themes were coded as present or absent, and analyses examined changes in pain, anxiety, and well-being from pre- to post-session using linear models.

Results

Participants

There were 1,284 Reiki clients that provided both quantitative and qualitative data (91% of the total sample). Reiki client demographics are displayed in Table 1.

Changes in pain, anxiety, and well-being

The mean and median changes in pain, anxiety, and well-being from pre- to post- are displayed in Table 2. Participants reported reductions in pain and anxiety and improvements in well-being following a single Reiki session.

Qualitative experience of reiki

The number and percentage of reported experiences of relaxation, positive emotions, body sensations, and emotional release during the Reiki session are displayed in Table 3.

Linear regression analysis

Linear regressions were conducted to examine associations between subjective Reiki experiences and changes in pain, anxiety, and well-being, while controlling for age and gender. Body sensations significantly predicted greater reductions in pain ($B = 0.30$, 95% CI: [0.08, 0.52], $p = 0.007$), indicating that participants who reported somatic experiences such as tingling or warmth experienced greater relief.

Positive emotions showed a near-significant association with reduced anxiety ($B = -0.38$, 95% CI: [-0.77, 0.01], $p = 0.052$). Although the effect size suggested a near-meaningful trend, it supported the decision to further test this pathway in

TABLE 1. DEMOGRAPHICS OF REIKI CLIENT PARTICIPANTS

Variable	N (%)
Sex	
Female	1,044 (81.8)
Male	218 (17.1)
Age	
Mean (range)	49.2 (18–89)
18–29	128 (10.1)
33–44	303 (23.8)
45–59	474 (37.3)
60–74	318 (25.0)
75+	48 (3.8)

TABLE 2. MEAN AND MEDIAN CHANGES IN PAIN, ANXIETY AND WELL-BEING FROM PRE TO POST ($N = 1,284$)

Outcome variable	Mean change	Median change	Min	Max
Pain	-1.82	-2	-10	7
Anxiety	-2.57	-2	-10	6
Well-being	1.91	2	-10	10

Negative values for pain and anxiety change indicate symptom reduction.

mediation models. Emotional release also demonstrated a weaker but directionally consistent relationship with anxiety reduction ($B = -0.24$, 95% CI: $[-0.53, 0.02]$, $p = 0.093$).

In contrast, relaxation, although the most reported subjective experience, was not significantly associated with changes in pain, anxiety, or well-being (all $p > 0.59$). This finding challenges assumptions that relaxation alone accounts for Reiki's effects, suggesting that other subjective experiences may be more critical.

Across models, gender consistently predicted outcomes, with female participants reporting greater improvements in well-being compared with males ($B \approx 0.53$, $p = 0.017$ – 0.021). Age effects were also observed: older age groups, particularly those aged 60 and above, tended to report higher anxiety scores post-session compared with younger adults (e.g., age 60–74: $B = +1.03$, 95% CI: $[0.48, 1.58]$, $p < 0.001$).

Together, these regression findings highlight that body sensations were most strongly linked to pain reduction, while positive emotional responses were linked to anxiety reduction, providing the rationale for testing mediation pathways with pain and anxiety as potential mechanisms leading to improvements in overall well-being.

Mediation analysis

Mediation models tested whether changes in pain and anxiety explained the association between subjective Reiki experiences and improvements in well-being. The results are presented in Table 4.

Model 1 (body sensations → pain → well-being). Participants who reported body sensations (e.g., warmth, tingling) experienced greater reductions in pain, which in turn predicted higher well-being. The indirect effect was significant (ACME = 0.084, 95% CI: $[0.025, 0.161]$, $p < 0.001$), while the direct effect of body sensations on well-being was not significant after accounting for pain (ADE = 0.030, 95% CI: $[-0.291, 0.342]$, $p = 0.876$). This suggests that pain

relief fully mediated the effect of body sensations on well-being.

Model 2 (positive emotions → anxiety → well-being). Reporting positive emotions was indirectly associated with higher well-being through reduced anxiety (ACME = 0.159, 95% CI: $[0.014, 0.321]$, $p = 0.030$). The direct effect was not significant (ADE = 0.226, $p = 0.360$), indicating that the well-being benefit of positive emotions was primarily explained by their impact on anxiety reduction.

Model 3 (emotional release → anxiety → well-being). Emotional release also predicted improvements in well-being through reduced anxiety (ACME = 0.207, 95% CI: $[0.045, 0.393]$, $p = 0.012$), with no significant direct effect (ADE = 0.240, $p = 0.346$). This suggests that emotional release enhanced well-being mainly by decreasing anxiety.

Taken together, these models indicate that Reiki's subjective effects on well-being are not direct but rather operate through changes in key symptoms: pain and anxiety functioned as mediators linking subjective experiences to broader improvements in well-being.

Discussion

This is the first study investigating the relationship between the subjective experience of Reiki, or any biofield therapy, and changes in symptoms. The regression analyses suggested that not all subjective Reiki experiences contributed equally to symptom improvements. Positive emotions were associated with higher well-being scores, whereas body sensations were linked to greater pain relief, supporting the idea that emotional and sensory engagement represent distinct but important pathways of benefit. Demographic variables also played a role: women tended to report greater well-being and pain relief, and younger participants experienced larger reductions in pain, while older adults showed higher post-session anxiety.

These findings should be interpreted cautiously, however, given the demographic profile of the sample, which was predominantly female (82%) and middle-aged (45–59 years: 37%). This composition is consistent with prior studies of complementary and integrative medicine, where women are significantly more likely to seek such therapies, but it limits study generalizability.^{37–40} Importantly, while regression analyses identified these associations, the mediation models provided a more nuanced picture, showing that well-being improvements occurred primarily through indirect pathways via pain and anxiety rather than as direct effects of the subjective experience.

In addition, in the mediation analysis, relaxation was not associated with significant changes in outcomes. Reiki commonly promotes relaxation, and this is often discussed as a means of improving outcomes through eliciting the relaxation response and parasympathetic nervous system.³² In the present study, “relaxation” was considered as participant-reported experiences of relaxation/calmness (e.g., “deep relaxation,” “calm,” “peaceful”). Despite this, relaxation was not found to be related to improvements in outcome measures. This suggests that relaxation during a Reiki session may be a common background experience, whereas emotional release or bodily sensations may represent more

TABLE 3. NUMBER AND PERCENTAGE OF REPORTED EXPERIENCES DURING THE REIKI SESSION ($N = 1,284$)

Subjective experience	Reported	Not reported
	N (%)	N (%)
Relaxed	871 (67.8%)	413 (32.2%)
Body sensations	588 (45.8%)	696 (54.2%)
Positive emotions	203 (13.5%)	1,081 (86.5%)
Emotional release	168 (13.1%)	1,116 (86.9%)

TABLE 4. MEDIATION MODELS TESTING ASSOCIATIONS BETWEEN REIKI EXPERIENCES AND CHANGES IN WELL-BEING (OUTCOME) ($N = 1,284$)

Model	Experience (X)	Mediator (M)	ACME (indirect) [95% CI], p	ADE (direct) [95% CI], p	Total effect [95% CI], p
1	Body sensations	Pain	0.084 [0.025, 0.161], <0.001	0.030 [-0.291, 0.342], 0.876	0.114 [-0.203, 0.447], 0.474
2	Positive emotions	Anxiety	0.159 [0.014, 0.321], 0.030	0.226 [-0.270, 0.718], 0.360	0.384 [-0.135, 0.902], 0.122
3	Emotional release	Anxiety	0.207 [0.045, 0.393], 0.012	0.240 [-0.234, 0.678], 0.346	0.448 [-0.034, 0.887], 0.080

ACME, Average Causal Mediation Effect; ADE, Average Direct Effect.

specific pathways linked to symptom improvement. Another possibility is that relaxation occurs early in the session and helps enable other processes, such as emotional release, which may be more directly related to reductions in anxiety and improvements in well-being. Supporting the interpretation of relaxation as a background experience, one study found that Reiki was more effective than placebo, music, or meditation in producing physical relaxation but did not differ from these conditions in mental relaxation.⁷ In the present study, self-reported relaxation, although very common, did not independently predict changes in pain, anxiety, or well-being when considered alongside other subjective experiences. Taken together, these findings suggest that factors beyond general relaxation may contribute to the effects of Reiki, although further research is needed.

Reiki's benefits for well-being appear to be driven by psychological processes, particularly reductions in anxiety, rather than direct effects of the experience. Emotional experiences such as positive emotions and emotional release are key drivers of these psychological improvements. Emotional release, although reported by only 13% of participants, showed the strongest indirect effect on well-being via reductions in anxiety. This pattern suggests that emotional release may represent a mechanism comparable with catharsis or emotional processing observed in psychotherapy and other mind-body practices.⁴¹

On the physical side, body sensations such as warmth or tingling were linked to pain relief, which in turn enhanced well-being. This pathway is consistent with other complementary interventions (e.g., acupuncture, mindfulness), where embodied sensory experiences mediate improvements in pain perception.^{42–44} However, because of the observational, pre-post design, reverse causality cannot be excluded; symptom relief may also influence the perception of bodily sensations such as warmth or tingling. Nonetheless, the finding that body sensations functioned as a bridge to pain relief underscores the importance of subjective bodily experience as part of the therapeutic process in Reiki.

This study is a novel contribution to biofield therapy research in several ways. First, it explores how Reiki works through specific psychological and physical pathways through employing a mediation analysis to quantify both indirect and direct effects, providing robust empirical support for the underlying mechanisms. Second, this study integrates both psychological (anxiety) and physical (pain) mediators, offering a more holistic understanding of Reiki's effects. Third, it offers a framework to provide evidence for Reiki's acceptance in clinical settings by linking subjective experiences to measurable changes in physiological and psychological health.

Importantly, by identifying how Reiki may exert its effects (e.g., through pain relief or anxiety reduction), this analysis begins to answer the “why” question often missing

in complementary and integrative medicine research. Understanding not only whether Reiki improves outcomes, but also how and why it does so, is central to advancing the evidence base for complementary and integrative medicine.²⁹ Most prior Reiki research has demonstrated symptom improvements without clarifying the underlying processes. By employing mediation analysis, the present study provides a step toward explaining the why. When participants experience physical sensations (such as warmth or tingling), this is linked to reductions in pain, which in turn enhances overall well-being. Similarly, when participants experience positive emotions or emotional release, these appear to lower anxiety, which then improves well-being. In this way, the “how” is represented by the mediating pathways (pain relief, anxiety reduction), while the “why” lies in the role of subjective experience as the active ingredient that drives those changes. This shift from describing Reiki's effects to explaining them is a step toward building evidence and integrating Reiki into broader models of health care.

Limitations

The limitations of the original study are discussed in detail in the previous two publications,^{27,30} but we briefly restate them here. First, this was a pragmatic design assessing the effect in clients seeking Reiki, increasing the likelihood of expectation effects and bias. Future work will include measures of clients' expectation and/or recruiting clients without prior experience with Reiki. Second, we did not assess whether Reiki clients had multiple sessions. Future work will track these data or exclude multiple sessions. Furthermore, because the question about the subjective Reiki experience was an open text box, it is likely that some experiences were not captured. Future work will investigate the relationship between changes in symptoms and the subjective experience using a checklist of themes identified from the qualitative component of this study. In addition, symptom outcomes were assessed using items adapted from the ESAS for a non-clinical Reiki population. While the ESAS has established validity in clinical settings, results should be interpreted as indicators of symptom change rather than clinical measures. Also, because this was a single-session, pre-post design, the findings cannot establish long-term effects of Reiki or determine causality. Longitudinal and randomized controlled studies are needed to validate these pathways.

Lastly, future research should examine spiritual and symbolic experiential themes reported during Reiki sessions, as these experiences may reflect processes that were beyond the scope of the present analysis and would be better addressed as a separate research question.

Conclusions

This study is the first to link the subjective experience of Reiki with measurable changes in symptoms. It was found that Reiki's effects on well-being are not direct but occurred mainly through reductions in anxiety and pain, driven by emotional release, positive emotions, and physical sensations. In contrast, relaxation, though the most common experience, did not predict improvements.

This study responds to the WHO's call for research on traditional, complementary, and integrative medicine and aligns with global priorities on well-being outlined in the United Nations Sustainable Development Goals. Reiki may therefore hold particular value as a complementary approach for managing anxiety and pain and improving overall well-being. Future longitudinal and controlled studies are required to inform the integration of Reiki into supportive and integrative care.

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Authors' Contributions

E.C.G. conducted the secondary analysis and wrote the article. A.A. conducted the original qualitative analysis and edited the article. N.L.D. conceived of the design, conducted the main study, and wrote the article.

Author Disclosure Statement

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