Reiki as a Strategy for Reducing Burnout in Community Mental Health Clinicians

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Abstract

Clinicians working in community mental health clinics are at high risk for burnout. Burnout is a problem involving emotional exhaustion, depersonalization, and reduced personal accomplishment. Reiki is a holistic biofield energy therapy beneficial for reducing stress. The purpose of this study was to determine if 30-minutes of healing touch could reduce burnout in community mental health clinicians. This quantitative study utilized a cross-over design to explore the efficacy of Reiki versus sham-Reiki, a pseudo treatment designed to mimic true Reiki, as a means to reduce symptoms of burnout in community mental health clinicians. The Maslach Burnout Inventory – Human Services Survey and several other measures were administered before and after the intervention phases throughout the study. The results suggest that hands-on interventions are beneficial in reducing stress for community mental health clinicians and that Reiki has a positive effect greater than relaxing touch alone. The findings show that Reiki reduces burnout in community mental health clinicians.

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Chapter 1: Introduction

Burnout among human service professions is a problem that has not yet adequately been addressed (Coster & Schwebel, 1997; Craig & Sprang, 2010; Emery, Wade & McLean, 2009; Harrison & Westwood, 2009; Newell & MacNeil, 2010). The risk of clinician burnout is particularly high for newer clinicians and for those practicing in community mental health (Ackerley, Burnell, Holder, & Kurdek, 1988; Adams & Riggs, 2008; Canfield, 2005; Craig & Sprang, 2010; Neumann & Gamble, 1995). Clinicians employed in community mental health settings typically work with clients who struggle with the effects of trauma, chronic mental health problems, and poverty (Harrison & Westwood, 2009; Kraus, 2005; Newell & MacNeil, 2010). This vulnerable population exposes the clinician to seemingly insurmountable issues on a daily basis (Neumann & Gamble, 1995; Rosenberg & Pace, 2006). Most often there are limited resources and training in ways to manage the stress of chronic exposure to these challenges (Pearlman & Mac Ian, 1995; Schwartz, Tiamiyu & Dwyer, 2007). Publicly funded, community-based providers deliver over 70% of psychological care nationwide (U.S. Department of Health and Human Services, 1999). Therefore, this population needs researchers further exploring factors influencing the manifestation of burnout and identifying ways of ameliorating this silent threat to mental health providers.

Reiki is a type of holistic energy work, or biofield therapy, which promotes energetic balance (Mitchell, 1994). As a holistic practice, Reiki treats the entire person incorporating the totality of one's physical, mental, emotional, and spiritual dimensions. Reiki practitioners act as conduits for Reiki energy, or *universal life-force energy*, to flow through them in order to balance and heal the recipient's energy. As a holistic practice, "it may be that healing needs to

happen first at the emotional level, with the releasing of anger, guilt or hatred, or it may be required first at the mental level, releasing negative thoughts, concepts or attitudes, before the physical symptoms can be addressed" (Quest, 2009, p. 33). The Reiki practitioner does not direct the flow of energy, but rather allows the body's innate intelligence to guide the energy to where it can do the most good.

Research demonstrates stress reducing benefits and healing properties of Reiki (Baldwin, Wagers, & Schwartz, 2008; Brathovde, 2006; Cuneo et al., 2011; Mackay, Hansen, & McFarlane, 2004; Plodek, 2011; Raingruber & Robinson, 2007; Rubik, Brooks, & Schwartz, 2006). It is noteworthy that there have been mixed results in the literature about the benefits of Reiki; the majority of concern stemming from a lack of randomized controlled trials (Jain, & Mills, 2010; vanderVaart, Gijsen, de Wildt, & Koren, 2009). However, both reviews cited here found promising results from various types of complementary interventions including Reiki and other hands-on approaches.

Hyland (2005) suggests the element of healing in both psychotherapy as well as complementary and alternative medicine is human interaction and the direct effect of the practitioner rather than the treatment, a concept also supported by Catlin and Taylor-Ford (2011). Research demonstrates the benefits of Reiki and other complimentary healing practices for reducing stress in nurses (Brathovde, 2006; Cuneo, et al., 2011; Plodek, 2011; Raingruber & Robinson, 2007; Vitale, 2008). One must wonder: can Reiki reduce stress for community mental health clinicians working in human services, ultimately reducing burnout?

Purpose of the Study

Research in the literature shows how Reiki benefits clients in community mental health (Collinge, Wentworth, & Sabo, 2005; Kelley, 2009; LaTorre, 2005), oncology patients (Bossi,

Ott, & DeCristofaro, 2008), as well as healthcare providers such as nurses (Brathovde, 2006; Cuneo, et al., 2011; Diaz-Rodriguez, et al., 2012; Plodek, 2011; Raingruber & Robinson, 2007; Vitale, 2008). The purpose of this study is to explore the usefulness of Reiki as performed by a Reiki Master, versus sham-Reiki (which involves identical hand placements performed by a volunteer who is untrained in Reiki), as an effective means to reduce the symptoms of burnout for clinicians working in community mental health.

Burnout is a significant problem among mental health clinicians (Ackerley, Burnell, Holder, & Kurdek, 1988; Summers, 2010). Engaging in self-care helps ameliorate symptoms of burnout (Neumann & Gamble, 1995; Rosenberg & Pace, 2006; Shapiro, Brown & Biegle, 2007). Neumann and Gamble (1995) emphasize that "self-care must include attention to one's interpersonal, emotional, physical, and spiritual needs" (p. 346). Reiki attends to the balancing of the physical, mental, emotional, and spiritual components of a person (Mitchell, 1994). Research demonstrating the effectiveness of Reiki in reducing clinician burnout may lead to grant funding for non-profit organizations seeking to improve employee retention and job satisfaction rates. Additionally, mental health clinicians who are not struggling with burnout can be more available to their clients, their coworkers, and their families.

Research Question

Burnout is described as emotional, mental, and physical exhaustion resulting in an inability to meets the demands of professional or personal life (Maslach & Jackson, 1986). As a holistic practice, Reiki addresses all of these aspects of an individual (Mitchell, 1994). The proposed research is guided by the following hypothesis: a 30-minute hands-on Reiki session every week for 6 weeks will reduce a clinicians' experience of emotional exhaustion,

depersonalization, and improve one's sense of personal accomplishment as evidenced by the results of the Maslach Burnout Inventory – Human Services Survey (MBI-HSS).

Definition of Terms

Burnout is a term commonly used to describe people who feel overworked and unable to maintain a healthy balance in their lives. For the purpose of this research, burnout is defined as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who 'do people work' of some kind" (Maslach & Jackson, 1986, p. 1). For further clarification, emotional exhaustion occurs when one's emotional resources are depleted by chronic needs of clients, supervisors, and agencies. Depersonalization is indicated when an individual becomes negative, cynical or emotionally detached from situations with clients and coworkers. Lastly, in terms of the MBI-HSS, a reduction in personal accomplishments refers to feelings of inadequacy when clients do not respond to treatment despite a practitioner's efforts (Maslach & Jackson, 1986).

As mentioned earlier, Reiki is a type of holistic energy work, or biofield therapy, which promotes energetic balance (Quest, 2009). It is a gentle hands-on healing technique using universal life-force energy to treat physical, mental, emotional, and spiritual ailments without using pressure, physical manipulation of the body, or massage. Reiki is a Japanese word that literally translates to *universal life-force energy*. This translation suggests the abundant availability of healing resources of the highest good. Reiki is not a religion, but rather a gentle hands-on approach to energetic healing. One becomes trained in Usui Reiki through guided instruction by a Usui Master/Teacher. There are three levels of training involving historical information, hand placements, and the understanding of the exchange and flow of energy. Each level incorporates an attunement, or energetic initiation, by the Master/Teacher for the student.

Some scientists believe "that what is being passed during the attunement process is a frequency or a set of frequencies that can be transferred from a teacher to a student via the energy field" (Rand, 2002, p. 8).

For the purposes of this study, a Reiki treatment will consist of a 30-minute hands-on chair session conducted by a trained (attuned) Reiki Master. A chair session involves the participant seated in a chair while the practitioner gently place open palms on the fully clothed participant in specific body locations. These hand placements (shoulders, top of head, forehead, neck, chest, upper abdomen, lower abdomen, and hips) are informed by Reiki traditions and align with the locations of specific energy centers of the body. Individuals untrained in Reiki, yet instructed on hand placements designed to mimic Reiki treatments, will provide the sham-Reiki sessions (Mansour, Beuche, Laing, Leis, & Nurse, 1999). The sham-Reiki provider is untrained in Reiki (meaning this volunteer will not have been attuned or trained in the teachings or principles of Reiki) and will silently count from 1 to 100 repeatedly throughout the sham-Reiki session so as to minimize conveying healing intentions to the participant.

Assumptions

Reiki is shown to reduce stress in lab rats (Baldwin, Wagers, & Schwartz, 2008) and improve growth of heat-shocked bacterial cultures (Rubik, Brooks, & Schwartz, 2006). Reiki reportedly alleviates tension and anxiety, decreases the perception of pain, and improves overall communication between client and clinicians while reducing emotional distress (Brathovde, 2006; Cuneo et al, 2011; Mackay, Hansen, & McFarlane, 2004; Plodek, 2011; Raingruber & Robinson, 2007). Reiki promotes relaxation in burned-out health care professionals (Diaz-Rodriguez, et al. 2012). It is predicted that Reiki will benefit community mental health clinicians

by reducing emotional distress and improve communication between client and clinician resulting in an increased sense of personal accomplishment.

There are stress reducing and pain relieving benefits to light touch (Rand, 2002), therefore it is predicted that clinicians working in community mental health will show a decrease in symptoms of burnout. It is suspected that the healing provided through the extremely low frequency range emitted from the hands of the attuned Reiki Masters will demonstrate a significant reduction in symptoms of burnout as compared to the sham-Reiki.

Chapter 2: Literature Review

Burnout in Mental Health Profession

Burnout is a problematic phenomenon known to many professionals working in high stress environments, particularly mental health professions (Ackerley, Burnell, Holder, & Kurdek, 1988; Adams & Riggs, 2008; Canfield, 2005; Craig & Sprang, 2010; Harrison & Westwood, 2009; Neumann & Gamble, 1995; Newell & MacNeil, 2010; Rosenberg & Pace, 2006; Summers, 2010). It has been an important area of exploration since the term was first coined (Freudenberger, 1975) resulting in a large body of research demonstrating the negative impact burnout has on employees as well as on the individuals being served (Anderson, 2008).

Leading researchers describe burnout as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who 'do people work' of some kind" (Maslach & Jackson, 1986, p. 1). The most common factors for professional burnout are organizational issues, individual difficulties, and/or related specifically to working with clients. Human service work is the largest risk factor for professional burnout (Newell & MacNeil, 2010) meeting the afore mentioned criteria for professional burnout with problematic issues including chronic demand for empathy, overflowing case loads, lack of influence in agency policy, and limited opportunity for camaraderie.

Combating Burnout

Newell and MacNeil (2010) highlight the importance of educating practitioners about the risk factors for burnout when working with high-risk populations. Training programs for human service providers often do not emphasize enough the symptoms and warning signs of trauma-related stress conditions (Harrison & Westwood, 2009; Pearlman & Mac Ian, 1995). It is often

the newer clinicians and those who are untrained in evidence-based practices who struggle most with burnout (Craig & Sprang, 2010; Emery, Wade, & McLean, 2009). A review of the literature addressing the problem of burnout in clinical professionals points to the need for clinicians to engage in self-care practices to ameliorate the potential negative effects (i.e., burnout and compassion fatigue) when treating clients coping with trauma (Canfield, 2005; Mahoney, 1997; Sapienza, & Bugental, 2000; Shapiro, Brown, & Biegle, 2007; Voss Horrell, Holohan, Didion, & Vance, 2011). Therefore, focusing interventions for burnout on clinicians in the mental health professions is fundamental in understanding how to address this professional problem.

Effects of Reiki

Laboratory studies have demonstrated the beneficial effects of Reiki. Rubik, Brooks, and Schwartz (2006) found that Reiki improved the growth of heat-shocked bacterial cultures as compared to heat-shocked cultures that did not receive the Reiki condition. In another study, heart rate and diastolic blood pressure in human subjects decreased significantly in the Reiki group, as compared to both placebo and control groups, indicating that Reiki has some effect on the autonomic nervous system (Mackay, Hansen, & McFarlane, 2004). Baldwin, Wagers, and Schwartz (2008) determined that Reiki is effective in modulating heart rate in stressed and unstressed rats, supporting its potential as a stress reducer for humans.

A recent study determined that the practicing of Reiki does not produce high electromagnetic fields from the palms (Baldwin, Rand, & Schwartz, 2012) as some have suspected. However, James Oschman, a leading authority on the science of understanding hands-on healing, stated in an interview that it is the "extremely low frequency (ELF) range" of energy emitted by palms of hands-on healers that is important for stimulating tissue repair (Rand, 2002).

Reiki Research and Burnout

Plodek (2011) conducted a small study (n = 22) evaluating the effectiveness of daily Reiki self-treatments to reduce perceived levels of stress among nurses. The qualitative data gathered from the focus groups showed decreases in perceived stress levels, a decrease in pre-existing physical symptoms, as well as increases in relaxation. Vitale (2008) conducted a qualitative study exploring the experiences of nurses who practice Reiki for self-care. In-person interviews of eleven nurses revealed thematic categories including the importance of using Reiki for daily stress management, self-healing, and spirituality. Vitale's (2008) research found an improvement in the participants' experience of interconnectedness of self, others and beyond which may decrease one's sense of depersonalization which is one of the factors for measuring burnout.

Another study sought to determine if Reiki Level I training for self-care would change caring perceptions in healthcare providers. At follow-up three months post training, the participants expressed changes in their own perceptions, as well as increased caring in their practice with patients as judged by increased scores on questions pertaining to a semi-quantitative caring efficacy scale (Brathovde, 2006).

Cuneo, et al. (2011) taught nurses Reiki Level I to assess the impact of Reiki education, training, and practice on work-related stress. The results showed a statistically significant decrease in the Cohen's Perceived Stress Scale (PSS) assessment score from baseline to follow-up. This study lends support to using self-Reiki as a possible method for reducing work-stress. A study by Raingruber and Robinson (2007) evaluated the benefits of instituting a self-care program in the workplace for nurses involving Yoga, Tai Chi, Meditation classes, and Reiki

healing sessions. The results of their research suggest that hospitals willing to invest in self-care options for nurses can anticipate patient and work related benefits. Perhaps community mental health organizations will show interest in providing self-care practices in the workplace to reduce human service worker burnout and enhance client care.

A recent study conducted at the University Hospital San Cecilio in Granada, Spain analyzed the immediate effects of Reiki on 21 health care professionals experiencing burnout by measuring heart rate variability, body temperature, and salivary flow rate and cortisol levels. The crossover design called for two 30 minute sessions one week apart with the participants successfully blinded to which intervention they were receiving, Reiki or placebo Reiki. The placebo Reiki was administered by a nurse with no Reiki training. She imitated the hand positions of the Reiki practitioner while maintaining focused attention on neutral stimulus with no healing intentions during the session. This procedure for placebo Reiki informs the design of the current research study by using untrained individuals who will act as sham-Reiki, or placebo, providers. Investigators in this placebo-controlled, repeated measures, crossover, single-blind, randomized trial determined that Reiki effects the parasympathetic nervous system, thereby promoting relaxation for healthcare professionals with burnout (Diaz-Rodriguez, et al., 2011).

Chapter 3: Methodology

This researcher aimed to assess the benefits of Reiki treatments for reducing burnout for community mental health clinicians.

Research Design

This study utilized a repeated measures, cross-over design to determine the effect of Reiki on clinician burnout. This design was one in which different treatments are compared on the same subjects during different time periods to determine effects within groups and between groups (Hills & Armitage, 1979). Participants were blind to the order of the interventions they received, while the crossover design allowed for all participants to receive both Reiki and placebo interventions during the course of the study (see Table 1). The Maslach Burnout Inventory – Human Services Survey (MBI-HSS) served to measure burnout - the dependent variable - and was administered at each assessment interval. Additionally, the other measures selected for this study include the General Perceived Self-Efficacy Scale, Measure Yourself Medical Outcome Profile (MYMOP-2), Rosenberg Self-Esteem Scale, and the Social Readjustment Rating Scale (SRRS). There were four (4) intervals when participants completed survey packet during the study (see Table 1): prior to Phase 1 (survey packet), at completion of Phase 1 (survey packet), prior to Phase 2 (survey packet), and at completion of Phase 2 (survey packet).

A cross-over design prevented the control group from being intrinsically different from the treatment group. Participants were randomly assigned to one of two groups. Group 1 received Reiki treatments during Phase 1, followed by a rest or washout period, and then received sham-

Reiki during Phase 2. Group 2 began with sham-Reiki sessions, followed by the washout period, and then received Reiki treatments during Phase 2 (see Table 1).

The MBI-HSS produces scores in three categories: emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA). These categories are the dependent variables. The Maslach Burnout Inventory – Humans Services Survey (MBI-HSS) is a valid and reliable measure for burnout with the human service provider population measuring emotional exhaustion, depersonalization, and personal accomplishment. It is assumed that participants will respond truthfully and not lie simply to please the researcher. The independent variable for this study was the treatment condition, Reiki or sham-Reiki, to determine the effect of Reiki on clinician burnout. One advantage of a cross-over design was a comparison of treatments on the same subjects which was likely more precise than between subjects comparisons. The cross-over design increases the power of a study with fewer participants.

The use of repeated measures, change scores from baseline, and multi-level modeling allowed control for differences in initial MBI-HSS scores both by center and by individual. Repeated measures on the same subject, change scores, and a cross-over design increased power to detect an effect with a smaller sample size and allowed for comparisons of between groups and within groups interactions.

Participants

Since the focus of this research was on the potential use of Reiki treatments as a strategy to reduce burnout in mental health clinicians working at community mental health organizations, participants were recruited from community mental health agencies in New England. Eligible participants were at least Master's level clinicians who worked a minimum of 30 hours per week with at least fifty percent of that time in direct service with clients. In order to draw this target

population, Organizational Recruitment Letters (see Appendix A) were presented to community mental health agencies in western Massachusetts, northern Connecticut, and southern Vermont. Individual participants were recruited by convenience sampling based on participation from clinicians employed by the involved organizations. The researcher attended staff meetings at the agencies and presented the study requesting that interested clinicians volunteer. All participants and practitioners received the appropriate Informed Consent Form (see Appendices B, C and D). The study benefited from participants from each organization totaling *n*=45 participants. Approximately half of the participants from each organization were randomly (flip of a coin) assigned to either Group 1 or Group 2.

Materials

The following instruments captured the participants' experience throughout the duration of this study:

Maslach Burnout Inventory-Human Services Survey (MBI-HSS). Newell and MacNeil (2010) have suggested that the Maslach Burnout Inventory (MBI) be used in human service agencies to assess for burnout and other trauma-related conditions in their health service providers. In this well validated 22-item survey (Kalliath, O'Driscoll, Gillespie, & Bluedorn, 2000; Koeske & Koeske, 1989; Maslach & Jackson, 1981), respondents rate their frequency of experience in response to each statement on a 7-point Likert scale from Never to Everyday. The MBI measures three components of burnout identified as Emotional Exhaustion (EE), Depersonalization (DP), and reduced sense of Personal Accomplishment (PA). The MBI-HSS produces three scores and the breakdown of questions per score is as follows: Emotional Exhaustion (nine items reflecting fatigue or stress), Depersonalization (five items referring to feelings of callousness or indifference in regards to recipients or students), and Personal

Accomplishment (eight items about feelings of enthusiasm and effectiveness in working with the people). The administration of this instrument requires no training, can be completed in a group, and takes approximately 10 minutes for participants to complete.

Rosenberg Self-Esteem Scale. This scale is widely used in social science research and consists of ten items answered on a four-point Likert scale from strongly agree to strongly disagree. The original sample for which the scale was developed consisted of 5,024 high school juniors and seniors from 10 randomly selected schools in New York State (Rosenberg, 1965). It has been translated into 28 languages and is used across 53 nations. The scale has demonstrated good reliability and validity across a large number of different sample groups (EMCDDA, 2011), including adults and the elderly. It has been validated with substance abusers and other clinical groups, and is regularly used in treatment outcome studies.

MYMOP-2. The Health Services Research Collaboration of the United Kingdom's Medical Research Council has put together an individualized self-report measure called the MYMOP (Measure Yourself Medical Outcome Profile). This well-validated patient-centered outcome asks the patient to select 2 symptoms to monitor --- things that matter to him/her (Paterson, 1996). They also monitor 2 other things: an activity, and general sense of wellbeing. Medications are monitored as well. The MYMOP-2 was found to be effective as a measure for the benefits of CAM treatments (Hyland, Lewith & Wheeler, 2008).

General Perceived Self-Efficacy Scale. The scale was originally developed by Jerusalem and Schwarzer in 1981, first as a 20-item scale later reduced to 10 items. The original German instrument was shown to be reliable and valid in a variety of clinical situations and has been validated with 26 different cultures and languages (*Schwarzer, 1993)*. Internal consistencies of the scale have been reported with its alpha ranged from 0.75 to 0.91. These findings have been

used to support the idea that self-efficacy may be a universal construct, applicable to many cultures, and measurable in a variety of languages.

Social Readjustment Rating Scale (SRRS). The Life Events Inventory of Holmes and Rahe (1967) is one of the most widely cited measurement instruments in the stress literature (Scully, et al., 2000). Renamed the Social Readjustment Rating Scale, Scully, et al. evaluated content-related criticisms, including differential prediction of desirable relative to undesirable life events, controllable relative to uncontrollable life events, and contaminated relative to uncontaminated life event items and found that the SRRS remains a useful tool for stress researchers and practitioners with high levels of validity and reliability. It consists of a checklist of 50 items that commonly happen to people during life.

Procedure

All participants signed the informed consent form (see Appendix B) acknowledging that they would receive two series of Relaxing Touch treatments and complete all required paperwork, knowing that they can discontinue with the study at any time. Data was collected from participants completing the following self-report measures at the four intervals outlined in Table 1: General Perceived Self-Efficacy Scale, Maslach Burnout Inventory-Human Services Survey (MBI-HSS), Measure Yourself Medical Outcome Profile (MYMOP-2), Rosenberg Self-Esteem Scale, and the Social Readjustment Rating Scale (SRRS). In addition, each participant completed the Background Questionnaire (see Appendix E) to capture basic demographic information. Participating clinicians were volunteers solicited from community mental health agencies in southern Vermont and western Massachusetts.

The researcher recruited both Reiki practitioners and individuals untrained in Reiki to act as sham-Reiki practitioners for this project. Sham-Reiki providers had no prior training in Reiki

practices. All practitioners were instructed by the researchers in performing identical hand positions for a relaxing 30-minute hands-on chair session. The practitioners lightly placed the open palms of their hands on the participants at specific locations correlating with energy centers of the body according to the Usui Reiki tradition (Mitchell, 1994). The Reiki and sham-Reiki practitioners performed identical hand positions so as to blind the participants to the intervention they received.

The researchers administered the Background Questionnaire (see Appendix E) and the first series of measures prior to Phase 1 treatments to all participants: General Perceived Self-Efficacy Scale, MBI-HSS, MYMOP-2, Rosenberg Self-Esteem Scale, and the SRRS. Then those participants randomly assigned to Group 1 received weekly 30-minute hands-on Reiki treatments over a six-week period. The Group 2 participants received weekly 30-minute hands-on sham-Reiki treatments mimicking Group 1. The sham-Reiki providers were pretending to perform Reiki and maintained mental arithmetic throughout the sessions to assuage positive and/or healing intentions toward the participant. For all sessions, participants were seated in a chair during the Reiki/sham-Reiki interventions that occurred on-site at their workplace.

At the culmination of Phase 1, the participants in each group again completed the survey packet (General Perceived Self-Efficacy Scale, MBI-HSS, MYMOP-2, Rosenberg Self-Esteem Scale, and the SRRS) administered in the presence of the researcher (see Table 1). A washout period occurred between Phase 1 and Phase 2 of treatments meaning there was no interaction between practitioners and participants for at least 6 weeks. At the end of the washout period, the participants again completed the survey packet (General Perceived Self-Efficacy Scale, MBI-HSS, MYMOP-2, Rosenberg Self-Esteem Scale, and the SRRS) prior to entering Phase 2. During Phase 2, participants received six weeks of the opposite treatment (cross-over) meaning

Group 1 received sham-Reiki sessions and Group 2 received Reiki treatments. The study concluded at the end of Phase 2 when participants completed the final series of measures (General Perceived Self-Efficacy Scale, MBI-HSS, MYMOP-2, Rosenberg Self-Esteem Scale, and the SRRS) administered by the researchers.

Analysis

Multilevel models have the same assumptions as other major general linear models (e.g., ANOVA, regression), but some of the assumptions are modified for the hierarchical nature of the design (i.e., nested data). Some advantages of utilizing multilevel models for analysis over other common approaches include:

1) Non-linearity: Non-linear relationships can be modeled.
2) Normality: The assumption of normality states that the dependent variable is normally distributed for each of the populations, as defined by different levels of each factor (Salkind & Green, 2004). Generally, normality is desired for MLM as well and therefore each variable will be assessed for normality and transformed if necessary.
3) Homoscedasticity: The assumption of homoscedasticity, also known as homogeneity of variance, assumes equality of population variances (Salkind & Green, 2004). In actuality, units of observations in the same group are more similar than those in different groups, violating this assumption. MLMs are designed to deal with this intraclass correlation, which assumes that data from the same context is more similar than data from different contexts. Multilevel modeling analysis serves to measure variability within contexts.
4) Independence of observations: Independence is an assumption of general linear models, which states that cases are random samples from the population and that

scores on the dependent variable are independent of each other (Salkind & Green, 2004). While groups are independent of each other, observations within a group share values on variables, and are not independent.

Multilevel modeling (MLM), also known as hierarchical linear models, nested models, mixed models, random coefficient models, random-effects models, random parameter models, or split-plot design models, are statistical models of parameters that vary at more than one level (Bryk & Raudenbush, 2002). These models can be seen as generalizations of linear models (in particular, linear regression), although they can also extend to non-linear models. SPSS allows non-linear multilevel modeling. The possibility for non-linear relationships within the data will be assessed using SPSS tools during exploratory data analysis.

Multilevel models are particularly appropriate for research in which data for participants is organized at more than one level (i.e., nested data) (Fidell & Tabachnick, 2007). The units of analysis are usually individuals (at a lower level) who are nested within contextual/aggregate units (at a higher level) (Luke, 2004). While the lowest level of data in multilevel models is usually an individual, in this study it will be repeated measurements done on the same individuals as well as their status in sham-Reiki (control) or Reiki (treatment) group. Multilevel modeling is an alternative to ANCOVA, where scores on the dependent variable are adjusted for covariates (i.e., individual differences) before testing treatment differences (Cohen & Cohen, 1975). Multilevel models are able to analyze these experiments without the assumptions of homogeneity-of-regression slopes required by ANCOVA (Fidell & Tabachnick, 2007). Additionally, MLMs are a superior alternative to repeated measures analysis of variance in that they do not require the intervals between data points to be the same for each subject.

Multilevel modeling as implemented in the Mixed Procedure of SPSS version 21 was used for analyzing the collected data. The general model placed individuals and the treatments they received on level 1 nested by differences between people on level 2. Sidak corrections were made in level of statistical significance due to the number of permutations of models that were explored. Random errors were modeled on 2 levels. The researcher aimed to find the lowest level of the -2 Restricted Log Likelihood while maintaining good theoretical sense. The repeated covariance type was AR(1). Type III sum of squares was used for Fixed Effects. An unstructured covariance matrix was used for random effects.

In this study, nested within each individual are multiple measurements and treatment or control group status (see Figure 1). Mixed modeling techniques were ideal because these measurements did not occur at exactly the same intervals for each subject, due to variance in scheduling and other activities in participants' lives. No difference was found between facilities, so nesting individuals within facilities was not necessary. Demographic variables were included as covariates.

In a two level, linear MLM, the Level 1 regression equation is represented as:

$$Yij = \beta 0j + \beta 1j(X1ij) + \beta 2j(X2ij) + eij$$

In the above equation: Yij refers to the score on the dependent variable for an individual observation at Level 1 (subscript i refers to individual case, subscript j refers to the group), which is the outcome variable at each moment of measurement; Xij refers to the Level 1 predictor, which is the condition in which the individual is assigned (sham-Reiki or actual Reiki); β0j refers to the intercept of the dependent variable in group j (Level 2, which represents the level of the individual (and the level of non-facility related co-variates); β1j refers to the slope for the relationship in group j (Level 2) between the Level 1 predictor and the dependent variable, and

eij refers to the random errors of prediction for the Level 1 equation. At Level 1, the intercepts and slopes in the groups will be assumed to be randomly varying (meaning that the intercepts and/or slopes are different in the different groups, and that each have their own overall mean and variance) (Fidell & Tabachnick, 2007).

The dependent variables are the intercepts and the slopes for the independent variables at Level 1 in the groups of Level 2. The Level 2 regression equation is represented as:

$$\beta 0j = \gamma 00 + \gamma 01 Wj + u0j$$

$$\beta 1j = \gamma 10 + u1j,$$

where $\gamma 00$ refers to the overall intercept (the grand mean of the scores on the dependent variable across all the groups when all the predictors are equal to 0); Wj refers to the Level 2 predictor (the individual); $\gamma 01$ refers to the overall regression coefficient, or the slope, between the dependent variable and the Level 2 predictor; u0j refers to the random error component for the deviation of the intercept of a group from the overall intercept; $\gamma 10$ refers to the overall regression coefficient, or the slope, between the dependent variable and the Level 1 predictor; and u1j refers to the error component for the slope (meaning the deviation of the group slopes from the overall slope) (Fidell & Tabachnick, 2007). Random intercepts and slopes models used here are the most realistic, although the most complex (Cohen & Cohen, 1975).

Validity and Reliability

The Maslach Burnout Inventory (MBI) is a highly validated and reliable burnout instrument measuring three constructs which are described as emotional exhaustion, depersonalization, and reduced sense of personal accomplishment. It is the tool most commonly utilized in the field to measure burnout. Additionally, factors other than those measured by the MBI could influence the outcome of this experiment. Reiki treatments were used with the

experimental group, yet there was no way to prevent extraneous environmental factors from confounding the study. In a six week span of time participants may encounter a multitude of situations affecting one's levels of stress potentially inflating the determinants of burnout (emotional exhaustion, depersonalization, and personal accomplishment) such as unexpected family illness, organizational restructuring, unforeseen household expenses, etc. This highlights the importance of maintaining two groups in a cross-over design while using the scores from the MBI-HSS compared over time. The additional measures like the SRRS and the MYMOP-2 utilized in this study aided in gathering this information.

Chapter 4: Results

Participant Demographics

The demographics table outlines the composition of the participants in the study (see Table 2). The total participants (n = 45; 33 females, 12 males) for the study were self-selected volunteers from the four participating agencies. In an effort to streamline the results, only significant outcomes are reported below and expressed in the tables.

The dependent variable (burnout) was represented by the Emotional Exhaustion (MBI_EE), Depersonalization (MBI_DP), and Personal Accomplishment (MBI_PA) scores measured using the Maslach Burnout Inventory – Humans Services Survey (MBI-HSS). Level 1 of the nesting consisted of the individuals' repeated outcome measures, nested by whether or not they received Reiki first or second on Level 2 (see Figure 1). Level 3 consisted of the demographic variables that might have generated differences among them.

Maslach Burnout Inventory

On MBI_EE (see Table 3), the intercept was significant, meaning that people started at very different levels of MBI_EE, an average of -39.69, when all other variables were held to zero. People significantly improved over time, (beta = -1.64, SE = 0.30; $p < 0.001$; 95% CI = -2.24 to -1.03). Older age was associated with lower rates of improvement (beta = 1.12, SE = 0.10, $p < 0.001$; 95% CI = 0.91 to 1.32) meaning younger participants improved more than older participants. Reiki was more effective than sham-Reiki (beta = -2.03; SE = 0.79; $p = 0.011$, 95% CI = -3.58 to -0.47). An order effect was found. Reiki worked better when it was received after sham-Reiki (beta = -25.04, SE = 10.23; $p = 0.016$; 95% CI = -45.92 to -4.88). People with the most years of experience in mental health had greater improvement during the study (beta = -

1.67, SE = 0.43; $p < 0.001$; 95% CI = -2.54 to -0.81). Working high numbers of hours per week mitigated against improvement (beta = 0.96, SE = 0.30, $p = 0.002$; 95% CI = 0.36 to 1.57).

For MBI_DP (see Table 4), the intercept was not statistically significant, meaning that there was no difference in where people began on this scale. A statistically significant change occurred in MBI_DP over time (estimate = -1.50, SE = 0.41; $p < 0.001$; 95% CI = -2.31 to -0.69). For this variable, Reiki decreased the MBI_DP score only in single people (code 1) (estimate = -63.55, SE = 5.16, $p < 0.001$, 95% CI from -73.77 to -53.34). Overall, sham-Reiki had a statistically significant effect on reducing the Depersonalization score (estimate = -50.27; SE = 4.38; $p < 0.001$; 95% CI = -58.95 to -41.60), with a greater impact in the first session than the second session (estimate = -5.57, SE = 0.23; $p < 0.001$; 95% CI = -9.23 to -1.90). White ethnicity was associated with a higher MBI_DP score (estimate = 55.12, SE = 4.93, $p < 0.001$; 95% CI = 45.35 to 84.89). Lesser degrees of past experience with Reiki were associated with greater reductions in the MBI_DP score (Score 0 had an estimate of -42.52, SE = 4.38, $p < 0.001$; 95% CI = -49.87 to -35.17; Score 1 had an estimate of -31.55, SE = 3.20; $p < 0.001$; 95% CI from -37.88 to -25.22). Expecting that one was receiving sham-Reiki was associated with less change on the MBI_DP score (estimate = 31.76, SE = 2.36; $p < 0.001$; 95% CI = 27.08 to 36.44). Greater years of experience were associated with greater reductions in the MBI_DP score (estimate = -2.61; SE 0.23; $p < 0.001$; 95% CI = -3.06 to -2.16). Greater hours of work per week were associated with higher MBI_DP scores (estimate = 1.90, SE = 0.17, $P < 0.001$. 95% CI from 1.57 to 2.24). The greater the years in Community Mental Health, the higher the MBI_DP score (estimate = 2.85, SE 0.23, $p < 0.001$, 95% CI from 2.40 to 3.31).

MBI_PA (see Table 5) improved over time (estimate = 0.72, SE = 0.19; $p < 0.001$; 95% CI from 0.34 to 1.10). Reiki was not statistically significantly different from sham-Reiki except

when Reiki was received before sham-Reiki (estimate = 25.62, SE = 6.51, $p < 0.001$, 95% CI from 12.57 to 28.67). Being older was associated with higher MBI_PA scores (estimate = 0.33, SE = 0.06; $p < 0.001$; 95% CI from 0.20 to 0.46). Being white was associated with a higher MBI_PA score (estimate = 23.06, SE = 6.78, $p < 0.001$, 95% CI from 9.46 to 36.66). Being partnered was associated with a higher MBI_PA score (estimate = 37.34, SE = 7.86, $p < 0.001$, 95% CI from 21.57 to 53.11). Having no past experience with Reiki was associated with a lower MBI_PA score (estimate = -16.42, SE = 4.76; $p = 0.001$, 95% CI from -25.97 to -21.57). Total hours worked per week was associated with lower Personal Accomplishment Scores (estimate = -0.40, SE = 0.19, $p = 0.042$; 95% CI from -0.78 to -0.02).

Using a randomized, cross-over design minimized error generated by individual differences since participants were being compared to themselves as well as to others. The multilevel modeling procedure further allowed the researcher to assess whether higher initial levels of self-esteem or perceived self-efficacy as well as higher perceived quality of life (MYMOP-2) or lower perceived symptom load (MYMOP-2) affected the response to Reiki. Other covariates included type of degree, years working in community mental health, age, sex, years working at current facility, marital status, and other caretaking responsibilities (ailing parents, ailing animals, handicapped children, etc.). The data gathered from the MYMOP-2, Rosenberg Self-Esteem Scale, and the SRRS also represents dependent variables for evaluating the effects of the treatment on symptom change.

MYMOP-2

For the MYMOP-2 variables, the structure of the data was better modeled by a scaled identity matrix for both fixed and random effects.

MYMOP1 - For the rating of the most bothersome symptom (see Table 6), change did occur over time (estimate = -0.26, SE = 0.07, $p < 0.001$, 95% CI from -0.40 to -0.13). Reiki was associated with a statistically significant improvement only for single people (estimate = -0.89, SE = 0.38, $p < 0.001$, 95% CI from -1.64 to -0.14). Past experience with Reiki (score 1) was associated with a higher symptom rating (estimate = 0.77, SE = 0.35, $p = 0.03$, 95% CI from 0.07 to 1.46). Total hours worked was associated with lower ratings of symptom severity (estimate = -0.06, SE = 0.07, $p < 0.001$, 95% CI from -0.09 to -0.03). Non-whites had lower symptom scores than whites (estimate = -2.54, SE = 0.35, $p < 0.001$, 95% CI from -3.23 to -1.86).

MYMOP2 - The MYMOP2 score which consisted of ratings for the second most bothersome symptom (see Table 7) also improved over time (estimate -0.52, SE 0.10, $p < 0.001$, 95% CI from -0.72 to -0.32). Reiki had a statistically significant effect only for people who had no previous experience with Reiki (estimate = -1.18, SE = 0.47, $p = 0.013$, 95% CI from -2.11 to -0.26). Believing that one had not received Reiki was associated with improvement (estimate = -1.57, SE = 0.34, $p < 0.001$, 95% CI from -2.23 to -0.90). Total years experience in counseling was associated with lower MYMOP2 scores (estimate = -0.05, SE = 0.02, $p = 0.013$, 95% CI from -0.09 to -0.01). Total hours worked per week was associated with higher symptom ratings (estimate = 0.04, SE – 0.02, $p = 0.027$, 95% CI from 0.005 to 0.08).

MYMOP3 – The MYMOP3 measured improvement in activities that were being restricted or curtailed by the symptoms (see Table 8). This didn't change statistically significantly over time. Overall, having more years of experience was associated with less restriction (estimate = -0.46, SE = 0.26, $p = 0.005$, 95% CI from -1.09 to 0.16). Working more hours per week was associated with more restrictions (estimate = 0.07, SE = 0.01, $p = 0.002$, 95% CI from 0.034 to 0.101). However, both sham-Reiki and Reiki were associated with higher

restrictions for single people (sham, estimate = 2.48, SE = 0.74, p = 0.002, 95% CI from 0.98 to 3.98; Reiki, estimate 0.98, SE = 0.37, p = 0.014, 95% CI from 0.22 to 1.75). Reiki was associated with improvement for partnered people (code 2) (estimate -2.87, SE = 0.70, p < 0.001, 95% CI -4.28 to -1.45). People with no past experience with Reiki receiving sham-Reiki tended to improve (estimate -1.83, SE = 0.36, p = 0.005, 95% CI from -2.79 to -0.87) as did people who had previously received Reiki (estimate -2.04, SE = 0.42, p = 0.023, 95% CI from -3.48 to -0.59). People attuned in Reiki did not improve with sham-Reiki.

MYMOP4 – The MYMOP4 is a measure of quality of life (see Table 9). This improved over time (estimate = -0.25, SE = 0.09, p = 0.005, 95% CI from -0.42 to -0.08). Total hours worked was associated with a lower quality of life (estimate = 0.03, SE = 0.01, p < 0.001, 95% CI = 0.01 to 0.04). Sham-Reiki among people with no experience with Reiki was associated with worsening of quality of life (estimate = 1.47, SE = 0.33, p < 0.001, 95% CI from 0.82 to 2.18). Similarly people who had previously received some Reiki were also associated with a worsening quality of life when receiving sham-Reiki (estimate = 1.36, SE = 0.30, p < 0.001, 95% CI from 0.76 to 1.96).

General Perceived Self-Efficacy Scale

The Perceived Self-Efficacy Scale (PSE) and Rosenberg Self-Esteem Scale (RSE) data fit better a scaled identity covariance matrix with unstructured covariance matrix for random effects. PSE (see Table 10) decreased significantly over time (estimate = -0.52, SE = 0.15, p = 0.001, 95% CI from -0.81 to -0.23). Overall, Reiki did not statistically significantly change PSE, though sham-Reiki first was associated with an increase in PSE (estimate = 11.48, SE = 4.63, p = 0.016, 95% CI from 2.19 to 20.78). White race was associated with lower PSE (estimate = -20.15, SE = 4.91, p < 0.001, 95% CI from -30.00 to -10. 31). Years working in community

mental health were associated with lower PSE scores (estimate = -0. 68, SE = 0.19, p = 0.001, 95% CI from -1.07 to -0.30). Being single was associated with higher PSE (estimate = 15.21, SE = 5.67, p = 0.01, 95% CI from 3.84 to 26.58).

No previous experience of Reiki was associated with a higher PSE (estimate = 10.80, SE = 3.39, p = 0.002, 95% CI from 3.99 to 17.61), and previous Reiki treatment was associated with a higher PSE, as well (estimate = 10.38, SE = 2.55, p < 0.001, 95% CI from 5.25 to 15.50). Expecting that one was receiving sham-Reiki was associated with a lower PSE (estimate = -5. 29, SE = 2.57, p = 0.41, 95% CI from -10.54 to -0.23). More years of experience were associated with higher PSE (estimate = 0.82, SE = 0.20, p < 0.001, 95% CI from 0.42 to 1.21). Total hours worked per week was associated with lower PSE (estimate = -0.66, SE = 0.14, p < 0.001, 95% CI from -0.93 to -0.39). Higher SRRS scores are associated with lower PSE scores (estimate = -0.02, SE = 0.003, p < 0.001, 95% CI from -0.02 to -0.01).

Rosenberg Self-Esteem Scale

For RSE, no significant change occurred over time or in conjunction with Reiki overall (see Table 11). Both Sham-Reiki and no past experience with Reiki were associated with a lower RSE score (estimate = -4.08, SE = 1.11, p < 0.001, 95% CI from -8.13 to – 3.31). Sham-Reiki with previous Reiki (category 1) was associated with a lower RSE score (estimate = -5.48, SE = 1.22, p < 0.001, 95% CI from -7.89 to -3.08). Being single was associated with a higher RSE score (estimate = 2.08, SE = 0.83, p = 0.014, 95% CI from 0.43 to 3.72). More hours total worked was associated with a higher RSE score (estimate = 0.11, SE = 0.03, p < 0.001, 95% CI from 0.43 to 3.72).

Chapter 5: Discussion

Challenges of Completing the Study

The study was originally designed to include 100 community mental health clinicians to establish power. Three major community mental health agencies had expressed interest in participation with the study, which would have given the researcher access to hundreds of clinicians. However, two of those agencies withdrew from the study; one withdrew because the administration was uncomfortable with endorsing Reiki as a potential stress-reducing intervention and the other withdrew because they were already actively participating in a research study about yoga and stress reduction and they didn't want to confound the findings.

The researcher explored many other avenues to increase agency participation with very little success. Many local agencies stated their support and encouragement for the concept of the study, but did not believe there was time in their employee's work week to incorporate 30-minutes of relaxing touch. Many agency representatives expressed concerns related to their clinician's working fee-for-service and feeling uncertain about how clinicians would make their billable hours if they were to participate in the study. As a result, four smaller agencies participated in the study and therefore the total number of participating clinicians capped at 45. Despite these challenges, the findings from this study showed statistical significance.

Findings

The primary hypothesis, that Reiki will reduce a clinician's experience of burnout symptoms, was confirmed. This was shown by reductions in areas of emotional exhaustion and depersonalization symptoms for burnout and improvements in personal accomplishment as measured by the Maslach Burnout Inventory. A number of secondary hypotheses were also

supported, though they were subsidiary to the primary hypothesis. For example, the more hours a clinician works each week correlates to higher levels of reported burnout symptoms. Younger participants improved more overall than older participants. Single people benefited from participating in the study more than did partnered people. In keeping with current research, clinicians with more experience endorse higher levels of personal accomplishment (Emery, Wade, & McLean, 2009; Harrison, & Westwood, 2009) which is a protective factor against burnout symptoms. This study also found that White participants reported higher experiences of personal accomplishment than non-White participants.

Overall, the results of this study support the primary hypothesis: 30-minutes of weekly healing touch for six weeks reduces burnout symptoms in community mental health clinicians. Furthermore, Reiki performed better than sham-Reiki in reducing symptoms of burnout.

Limitations

As is the case with all research, there were limitations to this study. A cross-over design runs the risk of a carryover effect, meaning that the effect of Phase 1 may 'carry over' into the Phase 2 treatment condition. One way to ameliorate this carry over effect was to imbed a washout period between phases. The wash out period appears to have been effective in preventing a carry-over effect since Phase 1 of the intervention was more effective overall than Phase 2, regardless of the intervention. Rather than a carry-over effect, this may indicate a novelty effect. The first phase of hands-on intervention, whether it was real Reiki or sham-Reiki, resulted in decreased reports of burnout.

Another important limitation of this study to consider is the potential for the Hawthorne Effect. Participants may report an improvement in symptoms of burnout as a result of choosing to participate in a research study targeting relaxation with a goal of reducing burnout. This may

have influenced their perceived benefit or inflated their experience of the interventions. The design of the study utilized volunteers as the participants which skews the participant groups to those who are more inclined to perceive a benefit from alternative healing strategies.

Additionally, due to the length of the study and the commitment required from the participants working in a high stress environment, it was likely that there would be a high dropout rate thereby limiting the implementation of the cross-over design. Two participants dropped out of the study prior to completion. One left the study after participating in only the first session (Reiki). She decided that she could not commit her time (30 minutes a week) for this project due to her busy caseload. The other participant left the study after completing Phase 1. She was unable to continue participating in Phase 2 after the wash-out period due to difficulties in her personal life.

The researcher recruited Reiki Masters and individuals untrained in Reiki to act as sham-Reiki practitioners for this project. All practitioners were instructed in performing hands-on hand positions for a 30-minute chair session. The Reiki and sham-Reiki practitioners, the clinicians, and the organization administrators needed to be flexible around scheduling treatment sessions at the participants' place of work. There were frequent and many scheduling conflicts as well as unexpected crises that interfered with scheduled treatment session times. This was expected when one considers the populations with whom community mental health clinicians serve, however schedule inconsistency presented challenges for all parties involved in the study and it is unclear how that may have impacted the results.

Future Research

The cross over design provided each participant with both interventions (Reiki and sham-Reiki) which increased the power, showing an effect among a small sample. Repeating the study

with a larger sample could elicit more information about the benefits of hands-on stress reducing interventions in the workplace. A longitudinal design to capture how long the benefit of reduced burnout lasts following an intervention will further inform clinicians about developing long-term strategies for self-care as well as influence agency policy regarding self-care programming.

The findings show that the initial phase of the intervention, regardless of whether it was Reiki or sham-Reiki, had the greatest effect. A future study design with three randomly assigned groups (Group 1: Reiki; Group 2: sham-Reiki; Group 3 control group/wait list) might produce evidence for the importance of community mental health agencies bringing hands-on stress-reducing interventions into the workplace. Perhaps a study with a focus on understanding employee productivity, as it correlates with reducing symptoms of burnout, would entice employers into developing programs to provide stress-reducing interventions for their employees. Considering the high operational costs associated with training new employees, it would be interesting for researchers to track possible changes in agency morale or potential improvements in employee retention rates when agencies incorporate stress-reducing interventions for their employees.

The results of this study show that Reiki has an effect on reducing stress, particularly for un-partnered clinicians. One might speculate that partnered people receive positive, gentle touch in their intimate relationships and therefore the measurable benefits of hands-on healing are less dramatic. Future research could focus more specifically on the differences between single and partnered people who are employed in stressful careers, gathering more information about their experience and/or frequency of touch in their lives. This could lead to a deeper understanding of how important a role touch plays in reducing stress.

The specific benefits of Reiki are difficult to pinpoint when there are so many factors mediating a person's experience. More randomized controlled trials designed to understand how Reiki reduces stress could provide evidence for implementing Reiki, and other stress-reducing practices, for employees working in community mental health clinics. However, it is exciting to report that the primary hypothesis of this proposed research was supported: Reiki had a positive effect on reducing burnout in community mental health clinicians.

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Tables

Table 1. Study design.

	Group 1	Group 2
First Assessment	Survey Packet	Survey Packet
Phase 1	Reiki Intervention	Sham-Reiki Intervention
Second Assessment	Survey Packet	Survey Packet
Washout Period	Neither Reiki Intervention	Neither Reiki Intervention
Third Assessment	Survey Packet	Survey Packet
Phase 2	Sham-Reiki Intervention	Reiki Intervention
Fourth Assessment	Survey Packet	Survey Packet

Table 2. Demographics.

		Subjects	Mean	SE of Mean	Median	SD
Total (*n*)		45				
Location	1	6				
	2	5				
	3	11				
	4	23				
Gender	Female	33				
	Male	12				
Ethnicity	White	30				
	Non-White	15				
Yrs clinical experience			15.18	2.10	1	11.56
Yrs in CMH			11.82	1.68	9	9.62
Hrs direct services/wk			25.55	1.76	29	10.09
Total hrs worked/wk			46.82	2.31	45	13.22

Table 3. Maslach Burnout Inventory_Emotional Exhaustion (MBI_EE).

	β estimate	SE	P value	95% CI
Time	-1.64	0.30	$p < 0.001$	-2.24, -1.03
Age	1.12	0.10	$p < 0.001$	0.91, 1.32
Reiki	-2.03	0.79	$p = 0.011$	-3.58, -0.47
Order Effect	-25.04	10.23	$p = 0.016$	-45.92, -4.88
Yrs MH experience	-1.67	0.43	$p < 0.001$	-2.54, -0.81
Hrs/wk worked	0.96	0.30	$p = 0.002$	0.36, 1.57

Table 4. Maslach Burnout Inventory_Depersonalization (MBI_DP) (*only in single people).

	β estimate	SE	P value	95% CI	
Time	-1.50	0.41	$p < 0.001$	-2.31,	-0.69
Ethnicity	55.12	4.93	$p < 0.001$	45.35,	84.89
Reiki*	-63.55	5.16	$p < 0.001$	-73.77,	-53.34
Order Effect	-5.57	0.23	$p < 0.001$	-9.23,	-1.90
Sham-Reiki	-50.27	4.38	$p < 0.001$	-58.95,	-41.60
No prior experience	-45.52	4.38	$p < 0.001$	-49.87,	-35.17
Some prior experience	-31.55	3.20	$p < 0.001$	-37.88,	-25.22
Expecting Sham-Reiki	31.76	2.36	$p < 0.001$	27.08,	36.44
Yrs work experience	-2.61	0.23	$p < 0.001$	-3.06,	-2.16
Hrs/wk worked	1.90	0.17	$p < 0.001$	1.57,	2.24
Yrs MH experience	2.85	0.23	$p < 0.001$	2.40,	3.31

Table 5. Maslach Burnout Inventory_Personal Accomplishment (MBI_PA).

	β estimate	SE	P value	95% C.I.
Time	0.72	0.19	$p < 0.001$	0.34, 1.10
Order Effect	25.62	6.51	$p < 0.001$	12.57, 28.67
Age	0.33	0.06	$p < 0.001$	0.20, 0.46
Ethnicity	23.06	6.78	$p < 0.001$	9.46, 36.66
Partner status	37.34	7.86	$p < 0.001$	21.57, 53.11
No prior experience	-16.42	4.76	$p = 0.001$	-25.97, -21.57
Hrs/wk worked	-0.40	0.19	$p = 0.042$	-0.78, -0.02

Table 6. MYMOP 1 (* only in single people).

	β estimate	SE	P value	95% CI
Time	-0.26	0.07	$p < 0.001$	-0.40, -0.13
Reiki*	-0.89	0.38	$p < 0.001$	-1.64, -0.14
Some prior experience	0.77	0.35	$p = 0.030$	0.07, 1.46
Hrs/wk worked	-0.06	0.07	$p < 0.001$	-0.09, -0.03
Ethnicity	-2.54	0.35	$p < 0.001$	-3.23, -1.86

Table 7. MYMOP 2.

	β estimate	SE	P value	95% CI
Time	-0.52	0.10	$p < 0.001$	-0.72, -0.32
No prior experience	-1.18	0.47	$p = 0.013$	-2.11, -0.26
Expecting Sham-Reiki	-1.57	0.34	$p < 0.001$	-2.23, -0.90
Yrs work experience	-0.05	0.02	$p = 0.013$	-0.09, -0.01
Hrs/wk worked	0.04	-0.02	$p = 0.027$	0.01, 0.08

Table 8. MYMOP 3 (*only in single people).

	β estimate	SE	P value	95% CI
Yrs work experience	-0.46	0.26	$p = 0.005$	-1.09, 0.16
Hrs/wk worked	0.07	0.01	$p = 0.002$	0.03, 0.10
Sham-Reiki*	2.48	0.74	$p = 0.002$	0.98, 3.98
Reiki*	0.98	0.37	$p = 0.014$	0.22, 1.75
Partnered	-2.87	0.70	$p < 0.001$	-4.28, -1.45
No prior experience	-1.83	0.36	$p = 0.005$	-2.79, -0.87
Some prior experience	-2.04	0.42	$p = 0.023$	-3.48, -0.59

Table 9. MYMOP 4.

	β estimate	SE	P value	95% CI
Time	-0.25	0.09	$p = 0.005$	-0.42, -0.08
Hrs/wk worked	0.03	0.01	$p < 0.001$	0.01, 0.04
No prior experience	1.47	0.33	$p < 0.001$	0.82, 2.18
Some prior experience	1.36	0.30	$p < 0.001$	0.76, 1.96

Table 10. General Perceived Self-Efficacy Scale (PSE).

	β estimate	SE	P value	95% CI
Time	-0.52	0.15	$p = 0.001$	-0.81, -0.23
Order Effect	11.48	4.63	$p = 0.016$	2.19, 20.78
Ethnicity	-20.15	4.91	$p < 0.001$	-30.00, -10.31
Yrs MH experience	-0.68	0.19	$p = 0.001$	-1.07, -0.30
Partner Status	15.21	5.67	$p = 0.010$	3.84, 26.58
No prior experience	10.80	3.39	$p = 0.002$	3.99, 17.61
Some prior experience	10.38	2.55	$p < 0.001$	5.25, 15.50
Expecting Sham-Reiki	-5.29	2.57	$p = 0.410$	-10.54, -0.23
Yrs work experience	0.82	0.20	$p < 0.001$	0.42, 1.21
Hrs/wk worked	-0.66	0.14	$p < 0.001$	-0.93, -0.39

Table 11. **Rosenberg Self-Esteem Scale (RSE)**.

	β estimate	SE	P value	95% CI
No prior experience	-4.08	1.11	$p < 0.001$	-8.13, -3.31
Some prior experience	-5.48	1.22	$p < 0.001$	-7.89, -3.08
Partner Status	2.08	0.83	$p = 0.014$	0.43, 3.72
Hrs/wk worked	0.11	0.03	$p < 0.001$	0.43, 3.72

Figures

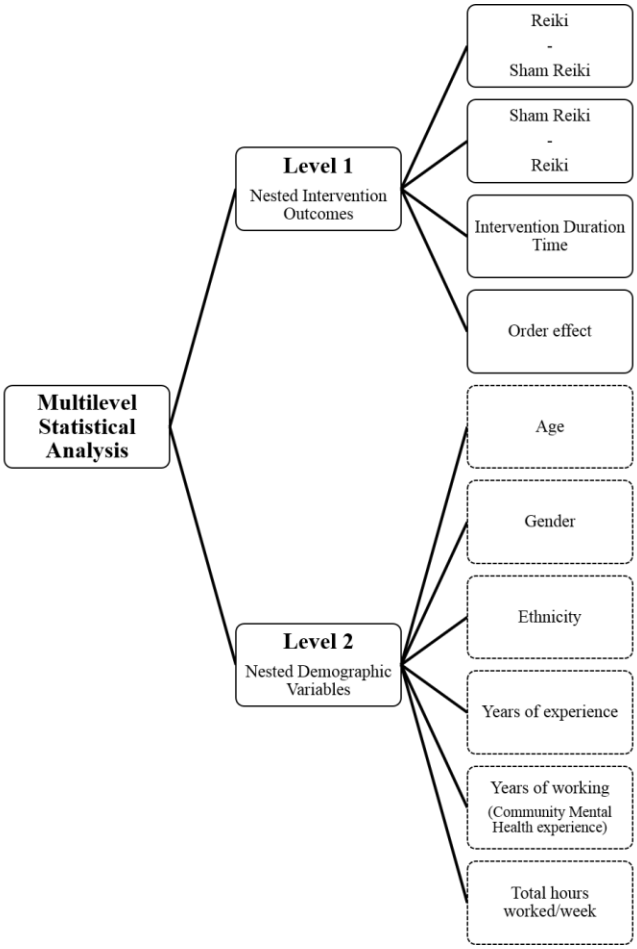

Figure 1. Nested multilevel statistical analysis.

Appendices

Appendix A: Recruitment Letter

Letter for Organization Assistance in Recruitment

Dear: _____

I am a 4th year doctoral student of clinical psychology at the Union Institute & University and I am conducting a research study for my dissertation. This research will be supervised by the dissertation chair and core faculty member, Dr. Lewis Mehl-Madrona.

I am interested in exploring Reiki, a biofield therapy, for reducing burnout in community mental health clinicians. I am recruiting participants who are currently working fulltime (a minimum of 30 hours per week) as clinicians in community mental health settings who spend at least 50% of their work time in direct service to clients.

All participants will complete a short Background Questionnaire for demographic information and then several brief questionnaires before, during and after the study: General Perceived Self-Efficacy Scale, Maslach Burnout Inventory-Human Services Survey (MBI-HSS), Measure Yourself Medical Outcome Profile (MYMOP-2), Rosenberg Self-Esteem Scale, and the Social Readjustment Rating Scale (SRRS). Please know that all documents related to this study will be stored in a secure location and will contain no identifying information. I am committed to protecting confidentiality.

Participants will spend 30 minutes per week for 6 weeks sitting quietly in a chair while a practitioner performs Reiki hand positions. It is preferable to conduct the sessions on-site for clinician convenience. Some participants will receive Reiki energy and others will not, but the participants will not know the difference since the practitioners will perform identical procedures. After a rest period of several weeks, the procedure will be repeated in the reverse, meaning those participants who didn't receive the Reiki energy will and those who did will not. The total involvement period will be approximately 5 months.

I am writing to inquire if your agency will participate with this important research on clinician well-being. I am happy to provide in advance any materials related to the study design and purpose, as well as the study instruments approved by the University. Please let me know if you are able to assist me in this matter and feel free to forward this information to any other persons within the organization that you deem appropriate. Do not hesitate to contact me through either the phone number or email listed below with any questions. Thank you in advance for your time and consideration. I greatly appreciate any assistance you can provide.

Sincerely,
Renee M. Desmarais

Renee M. Desmarais, LMHC
Renee.Desmarais@email.myunion.edu

(413) 221-3094

Appendix B: Informed Consent – Participant.

Informed Consent Form: Relaxing Touch vs. Reiki

Dear Participant,

You are invited to participate in a research project for my doctoral dissertation in clinical psychology at the Union Institute & University in Brattleboro, VT. The purpose of this research project is to determine the effectiveness of Reiki for reducing clinician burnout. All information obtained will be treated confidentially. All documents will be stored in a secure location known only to me and all identifying information will be removed from them. I am committed to protecting your anonymity.

This study is designed to measure whether various interventions help reduce burnout for clinicians working in community mental health. The research will be supervised by the dissertation chair and core faculty member, Dr. Lewis Mehl-Madrona (802-254-0152 ext. 8402).

For this project, you will be asked to complete a brief background questionnaire. Additionally, you'll complete the General Perceived Self-Efficacy Scale, Maslach Burnout Inventory-Human Services Survey (MBI-HSS), Measure Yourself Medical Outcome Profile (MYMOP-2), Rosenberg Self-Esteem Scale, and the Social Readjustment Rating Scale (SRRS) at 4 different intervals during the process. You will participate in weekly 30-minute chair sessions of relaxing touch for 6 weeks while a trained practitioner performs Reiki hand positions. There will be a short rest period for a few weeks, and then you'll receive another 6 weeks of relaxing touch sessions. The total estimated time of involvement in this study is about 10 hours over 5 months.

You are free to withdraw your participation at any time. You will not receive any financial compensation for your participation nor will you incur any costs as a result of your participation in this research. If you have any questions or concerns, please email me at Renee.Desmarais@email.myunion.edu or contact me over the phone at (413) 221-3094. You are also invited to contact the University with any questions or concerns at Lewis.Mehl-Madrona@myunion.edu. I hope you will enjoy this opportunity to be a part of research. Thank you very much for your help.

Sincerely,

Renee M. Desmarais, LMHC
4th year doctoral student
Psy.D. Clinical Psychology

_____
Participant's Name (Print)

_____
Signature of Participant Date

_____
Signature of Researcher Date

Note: You may contact the individuals listed on this form with any questions about this study. You may also contact the IRB Director at Union Institute & University with any questions about your rights as a participant at 800.861.6400, ext. 1153, or at irb@myunion.edu. In the event of a study-related emergency, contact the individuals listed on this form and the IRB Director within 48 hours.

Appendix C: Informed Consent – Reiki Provider.

Informed Consent Form – Reiki Practitioners

Dear Reiki Practitioner,

You are invited to participate in a research project for my doctoral dissertation in clinical psychology at the Union Institute & University in Brattleboro, VT. The purpose of this research project is to determine the effectiveness of Reiki for reducing clinician burnout. All information obtained will be treated confidentially. All documents will be stored in a secure location known only to me and all identifying information will be removed from them. I am committed to protecting your anonymity.

This study is designed to measure whether various interventions help reduce burnout for clinicians working in community mental health. The research will be supervised by the dissertation chair and core faculty member, Dr. Lewis Mehl-Madrona (802-254-0152 ext. 8402).

For this project, you will be asked to provide four 30-minute Reiki chair sessions a week for the next 6 weeks. There will be a rest period of several weeks, and then you will provide another series of four 30-minute Reiki chair sessions a week for 6 weeks. The total estimated time that you will be involved in this study is approximately 24 hours over a five month period. You will be contributing to much needed research about the benefits of Reiki.

You are free to withdraw your participation at any time. You will not receive any financial compensation for your participation nor will you incur any costs as a result of your participation in this research. If you have any questions or concerns, feel free to email me at Renee.Desmarais@email.myunion.edu or contact me over the phone at (413) 221-3094. You are also invited to contact the University faculty with any questions or concerns at Lewis.Mehl-Madrona@myunion.edu. I hope you will enjoy this opportunity to be a part of research. Thank you very much for your help.

Sincerely,

Renee M. Desmarais, LMHC
4th year doctoral student
Psy.D. Clinical Psychology

_____
Participant's Name (Print)

_____
Signature of Participant Date

_____
Signature of Researcher Date

Note: You may contact the individuals listed on this form with any questions about this study. You may also contact the IRB Director at Union Institute & University with any questions about your rights as a participant at 800.861.6400, ext. 1153, or at irb@myunion.edu. In the event of a study-related emergency, contact the individuals listed on this form and the IRB Director within 48 hours.

Appendix D: Informed Consent – Sham-Reiki Provider.

Informed Consent Form – sham-Reiki Practitioners

Dear sham-Reiki Practitioner,

You are invited to participate in a research project for my doctoral dissertation in clinical psychology at the Union Institute & University in Brattleboro, VT. The purpose of this research project is to determine the effectiveness of Reiki for reducing clinician burnout. All information obtained will be treated confidentially. All documents will be stored in a secure location known only to me and all identifying information will be removed from them. I am committed to protecting your anonymity.

This study is designed to measure whether various interventions help reduce burnout for clinicians working in community mental health. The research will be supervised by the dissertation chair and core faculty member, Dr. Lewis Mehl-Madrona (802-254-0152 ext. 8402).

For this project, you will be instructed on how to provide four 30-minute sham-Reiki chair sessions a week for the next 6 weeks while silently counting from 1 to 100 repeatedly. This will involve learning traditional Reiki hand positions, but you will not be attuned to Reiki energy. There will be a rest period of several weeks, and then you will provide another series of four 30-minute sham-Reiki chair sessions a week for 6 weeks. The total estimated time that you will be involved in this study is approximately 24 hours over a five month period. You will be contributing to much needed research about the benefits of relaxing touch and taking restorative breaks during the work day.

You are free to withdraw your participation at any time. You will not receive any financial compensation for your participation nor will you incur any costs as a result of your participation in this research. If you have any questions or concerns, feel free to email me at Renee.Desmarais@email.myunion.edu or contact me over the phone at (413) 221-3094. You are also invited to contact the University faculty with any questions or concerns at Lewis.Mehl-Madrona@myunion.edu. I hope you will enjoy this opportunity to be a part of research. Thank you very much for your help.

Sincerely,

Renee M. Desmarais, LMHC
4th year doctoral student
Psy.D. Clinical Psychology

_____
Participant's Name (Print)

_____
Signature of Participant Date

_____
Signature of Researcher Date

Note: You may contact the individuals listed on this form with any questions about this study. You may also contact the IRB Director at Union Institute & University with any questions about your rights as a participant at 800.861.6400, ext. 1153, or at irb@myunion.edu. In the event of a study-related emergency, contact the individuals listed on this form and the IRB Director within 48 hours.

Appendix E: Background Questionnaire.

Background Questionnaire

[*code:* _____]

Professional degree: _____

Gender: _____ Age: _____

Number of years in the field: _____

Race/Ethnicity: _____

Marital Status: _____

Number of years in Community Mental Health: _____

Average number of direct service hours per week: _____

Average number of hours spent working each week: _____

What experience, if any, have you had with Reiki? _____

_____

_____

What are your expectations of this study? _____

_____

_____

Appendix F: MYMOP2.

*** MYMOP2 ***

Full Name ..... Date of birth.....

Address and postcode.....

.....

Today's date ..... Practitioner seen .....

Choose one or two symptoms (physical or mental) which bother you the most. Write them on the lines.

Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

SYMPTOM 1: 0 1 2 3 4 5 6
..... As good as it As bad as it
..... could be could be

SYMPTOM 2: 0 1 2 3 4 5 6
..... As good as it As bad as it
..... could be could be

Now choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

ACTIVITY: 0 1 2 3 4 5 6
..... As good as it As bad as it
..... could be could be

Lastly how would you rate your general feeling of wellbeing during the last week?

0 1 2 3 4 5 6
As good as it As bad as it
could be could be

How long have you had Symptom 1, either all the time or on and off? Please circle:
0 - 4 weeks 4 - 12 weeks 3 months - 1 year 1 - 5 years over 5 years

Are you taking any medication FOR THIS PROBLEM ? Please circle: YES/NO

IF YES:
1. Please write in name of medication, and how much a day/week

.....

2. Is cutting down this medication: Please circle:
Not important a bit important very important not applicable

IF NO:
Is avoiding medication for this problem:

Not important a bit important very important not applicable

Appendix G: Maslach Burnout Inventory sample questions.

License for Renee Desmarais to reproduce/administer up to a quantity of 150 within one year of September 5, 2012.

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www.mindgarden.com

To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material for his/her research:

Instrument: ***Maslach Burnout Inventory, Forms: General Survey, Human Services Survey & Educators Survey***

Authors

MBI-General Survey: Wilmar B. Schaufeli, Michael P. Leiter, Christina Maslach & Susan E. Jackson

MBI-Human Services Survey: Christina Maslach & Susan E. Jackson

MBI-Educators Survey: Christina Maslach, Susan E. Jackson & Richard L. Schwab

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Three sample items from a single form of this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any published material.

Sincerely,

Robert Most
Mind Garden, Inc.
www.mindgarden.com

SAMPLE: The participants are directed to rate their personal experience at their job on 22 items from 0 (never) to 6 (every day):

I feel emotionally drained from my work.
I feel used up at the end of the workday.
I feel frustrated by my job.