



Published in final edited form as:

Complement Ther Clin Pract. 2013 February ; 19(1): 50–54. doi:10.1016/j.ctcp.2012.08.001.

Reiki training for caregivers of hospitalized pediatric patients: A pilot program★

Anjana Kundu^{a,b,*}, Rebecca Dolan-Oves^c, Martha A. Dimmers^d, Cara B. Towle^e, and Ardith Z. Doorenbos^{f,g}

^aDepartment of Anesthesiology and Pain Medicine, Seattle Children's Hospital, Seattle, WA, United States

^bUniversity of Washington School of Medicine, Seattle, WA, United States

^cUniversity of Washington School of Nursing, Seattle, WA, United States

^dDivision of Pastoral and Spiritual Care, Seattle Children's Hospital, Seattle, WA, United States

^eDepartment of Telehealth, University of Washington School of Medicine, Seattle, WA, United States

^fDepartment of Biobehavioral Nursing and Health Systems, University of Washington School of Nursing, Seattle, WA, United States

^gDepartment of Global Health, University of Washington School of Medicine, Seattle, WA, United States

Abstract

To explore the feasibility of a Reiki therapy-training program for the caregivers of pediatric medical or oncology inpatients, at a large pediatric hospital, a series of Reiki training classes were offered by a Reiki Master. At completion of the training, an interview was conducted to elicit participant's feedback regarding the effectiveness and feasibility of the training program. Seventeen of the 18 families agreed to participate. Most families (65%) attended three Reiki training sessions, reporting that Reiki benefitted their child by improving their comfort (76%), providing relaxation (88%), and pain relief (41%). All caregivers identified becoming an active participant in their child's care as a major gain from participation in the Reiki training. A hospital-based Reiki training program for caregivers of hospitalized pediatric patients is feasible and can positively impact patients and their families. More rigorous research regarding the benefits of Reiki in the pediatric population is needed.

★Contents of this manuscript were presented as a project submitted in partial fulfillment of the requirements for the degree of Master of Nursing (RDO) at the University of Washington 2012 (Program Authorized to Offer Degree: School of Nursing).

© 2012 Elsevier Ltd. All rights reserved.

*Corresponding author. Department of Anesthesiology and Pain Medicine, M/S W 9824, Seattle Children's Hospital, 4800 Sand Point Way NE, Seattle, WA 98105, USA. Tel.: +1 (206) 987 2704; fax: +1 (206) 987 3935. anjana.kundu@seattlechildrens.org.

Funding Funding for this project comes from Seattle Children's Hospital Institutional Intramural Funds For Excellence and in part from NCI R42 CA141875 and R01NR012450.

Contributor's statement The authors have all made substantial contributions to the conception and design of the study, acquisition of the data, analysis and interpretation of the data, writing the manuscript or revising the paper critically for intellectual content. All the authors provided final approval of the submitted version.

Conflict of interest statement The authors have no conflicts of interest pursuant to this report.

Keywords

Reiki; Caregivers; Training; Pediatric; Complementary and alternative medicine; Inpatients

1. Introduction

The hospitalization of a child is a stressful event for both the child and their family.^{1,2} Dealing with a chronic health condition requiring long-term or frequent hospitalization can heighten the stress response, resulting in negative emotional and psychological consequences for patients and families alike.³ An increase in pediatric hospitalization rates⁴ and the proportion of inpatient care associated with complex chronic conditions,⁵ has been reported over the past 15 years. With this increase in acuity and subsequent stress on families, clinical care providers seek new ways to address and support the multidisciplinary needs of chronically ill children and their caregivers, with the goal of making the hospitalization experience as positive as possible.

The use of complementary and alternative medicine (CAM) for overall health and wellbeing has been gaining popularity. In a survey of CAM use by Americans conducted by the National Institutes of Health in 2007, 38% of adults and 12% children indicated that they had used at least one CAM modality in the past year.⁶ Reiki, a type of biofield therapy, was amongst the reported energy healing modalities by more than 1.2 million (0.5%) of the U.S. general adult population, in the previous year and 0.2% of children in the United States during 2007.⁶ In another survey of pediatric patients and families, biofield therapies including Reiki were amongst the reported CAM therapies sought by them after a diagnosis of cancer.⁷

Reiki, derived from a Japanese word with two syllables “Rei” (universal energy, the energy that permeates the entire universe), and “ki”, (the life energy of all living creatures), was developed by Japanese master Dr Mikao Usui in the early 1900s. Usui passed the tradition down by providing instructions to Dr Chujiro Hayashi, who then taught Hawayo Takato who in turn introduced the practice of Reiki to Hawaii and mainland United States during the 1940s.⁸ Reiki was introduced to Europe in the 1980s. The National Center for Complementary and Alternative Medicine (NCCAM) describes Reiki as an energy-based touch therapy that involves the direction of energy by the practitioner’s hands into the body, thereby rebalancing natural energy flow and enhancing the body’s capacity to heal. The goal is to improve health and wellbeing, and may be achieved by providing relaxation and stress relief.⁹

Much of the published literature examining the use and impact of Reiki is limited to either case studies describing its use for various diseases, or experimental studies with small sample sizes examining the effects of Reiki on a particular symptom or population of patients.^{10–19} This preliminary research supports Reiki as a CAM therapy that may be useful in reducing the anxiety, stress response and promoting relaxation,^{17–20,24,39} perioperative anxiety and pain,^{21–23} cancer and chronic pain^{24–26} as well as cancer related fatigue.^{27,28} Though there is variable evidence documenting the effects of Reiki on bio-physiological measures of stress and anxiety, such as blood pressure, heart rate,^{26,29–32} salivary immune globulin A, and salivary cortisol,³³ but majority of the studies report a positive impact on these parameters. A number of studies have found significant reductions in subjective measures of psychological distress after Reiki treatment,^{18,19,24,25} with a significant reduction in the levels of psychological anxiety from pre- to post-treatment. Reiki can also be practiced as a self-care treatment by patients^{34,35} and amongst people working in health or social services.^{8,36–38} This evidence tends to support the notion that Reiki may be a

beneficial therapy to offer to chronic, hospitalized pediatric patients and their families, in order to improve their psychosocial wellbeing and lessen the negative effects of hospitalization.

A number of U.S. hospitals are offering Reiki therapy to patients as a complementary component of care.^{39,40} As a non-invasive, inexpensive, technology-free modality that can be performed in a variety of settings and, is offered to patients with cancer in hospitals and hospices throughout the country.^{13,22,39–43} It is an easy intervention to learn^{44,45} and a reasonable way for hospitals to incorporate CAM into standard medical care. Reiki-trained nurses and physicians, and other hospital staff most often provide the therapy. Parents or caregivers could be included in the provision of Reiki therapy, since they are integral figures in their child's medical care, and may benefit from participating. Researchers have demonstrated that interventions designed to improve coping skills and empower caregivers to participate in their child's care can effectively lessen negative mood, depression, and anxiety.⁴⁶

The current study explores the feasibility of a hospital-based Reiki training program for caregivers of pediatric inpatients at a major metropolitan children's hospital. The Reiki training program is designed to provide caregivers with a non-invasive comfort tool that can positively impact their child's and their own experiences in the hospital and at home. A long-term goal of such a program is to empower the parents/caregivers by providing a tool for active involvement in their child's care.

2. Materials and methods

2.1. Design

A series of Reiki training classes taught by a Reiki Master was offered to participants with a goal of training the caregivers in Reiki to feel confident in utilizing it for their children's care. After completion of the training, participants completed an informal interview providing their feedback about the perceived benefits and feasibility of the Reiki training program.

2.2. Sample

All interested caregivers of pediatric patients inpatient medical and oncology units at a tertiary care children's hospital were invited to participate. Participants were required to attend at least one of the four 3-h Reiki training classes either held in a designated room in the hospital, or in their child's hospital room. They were required to be age 21 years or older, closely involved in the care of the hospitalized child, and fluent in English or Spanish. Since the hospital's diverse ethnic patient population includes a large number of Hispanic patients (13% of admissions), a Spanish interpreter was available during the training sessions for the Spanish-speaking caregivers, and a Spanish translation of all written study materials was provided to the caregivers. The target sample size was 20 participants with an expectation of 80% recruitment rate.

2.3. Procedures

After obtaining approval from the institutional review board, the study staff communicated with the pediatric pain service, social work, and chaplain staff in order to identify eligible caregivers to approach for study participation. To respect the families' privacy and to avoid any feelings of coercion, the primary nurse, chaplain, or social worker introduced the study, outlined its purpose and activities, and obtained verbal consent for a visit from study staff to discuss participation. The study staff subsequently contacted the caregivers interested in participation in Reiki training to assess their eligibility, obtain consent, and answer questions

about the study. Demographic information about the participant caregiver and their child was also obtained at this time.

A Reiki Master already employed by the children's hospital as a chaplain taught all Reiki classes. The Reiki Master was responsible for the content of the Reiki training, and for following the code of ethics and standards of practice defined by the International Center for Reiki Training.⁴⁵ Four, 3-h long, Reiki training classes were held in a meeting room, allowing a maximum of 8 participants in each class. However, to respect participants' privacy and minimize stress of leaving their child for several hours at a time, Reiki training was also made available in their child's hospital room at a mutually convenient time for the Reiki Master and the caregiver. Upon completion the training program by the caregiver or upon their child's discharge from the hospital, an interview with the caregiver to capture perceived benefits of the Reiki training program and total number of training sessions completed were recorded.

2.4. Measures

2.4.1. Demographics—Age, gender, race/ethnicity, primary language spoken at home, relationship of the caregiver to the child, diagnosis, length of hospital stay at the time of treatment, and anticipated total length of hospital admission were collected.

2.4.2. Caregiver's Reiki experience—An informal interview with caregivers at completion of the Reiki training program consisted of open-ended questions created to assess the feasibility and perceived benefits of participation in the program. While interview questions were not standardized, the questions asked from the caregivers to elicit their feedback about the perceived benefits of the Reiki program are listed in Appendix 1.

During the interviews, the investigators' record looked for common themes in the participants' feedback. For assessment of the participants' feelings of competence and confidence regarding their use of Reiki following the training 0–10 Likert-type scale (0 = not at all competent/confident, and 10 = extremely competent/confident) was utilized.

2.5. Data analysis

No formal statistical measures were employed to analyze this data since this was a descriptive pilot study. Data was analyzed using simple means and percentages.

3. Results

Seventeen of 18 approached caregivers agreed to participate in the Reiki trial, for a recruitment rate of 94.4%. One family was very interested in Christian Laying on of Hands (another comfort therapy) instead of learning Reiki. Of the participating 17 families, 9 families had Spanish as their primary language. Of the children whose families participated in the study, 65% (11/17) were females, with an age range of 2–18 years. Most children were admitted to the hospital for an average of 7–40 days. The diagnoses associated with these admissions were mostly oncological (82%) or chronic life-limiting medical conditions (18%). Most families (14/17 or 82%) preferred to receive Reiki training in their children's hospital room or on the same floor to maintain proximity to their children. A total of 37 Reiki sessions were offered for the 17 families. Most families (11/17, or 65%) attended 3 Reiki training sessions. Two families attended only one Reiki training session (11.7%), and five (23.5%) families attended 4 sessions.

While rating their feelings of competence and confidence with Reiki following the training, participants indicated more confidence about using Reiki therapy for their children if they

received 2 or more training sessions (70%, Likert scale score = 6), if they themselves had experienced Reiki therapy (52%, Likert scale = 6), and when instructions were provided in their primary language (100%, Likert scale = 6).

Thirteen of the 17 (76%) participating caregivers reported that Reiki had benefitted their child by improving their comfort, and providing relaxation (15/17 or 88%), and pain relief (7/17 or 41%). One caregiver reported cessation of her child's leg shaking. Most caregivers (82%) reported their own use of a CAM therapy. Following this training, 10 caregivers (59%) reported regular use of the Reiki therapy with their children. Six of these 10, were directly observed providing therapy for their children, by the Reiki master. An interest in further participation in Reiki training was expressed by the majority of caregivers (10/17), including a specific request for an advanced level Reiki training by one.

All caregivers reported a feeling of becoming an active participant in their child's care, after this training. The presence of an interpreter providing instructions in their primary language was reported as a strength of this training, allowing better understanding of the training. Caregivers also reported the flexibility of the training sessions' location as a major positive for this training program. Other comments by the participating families included requests for more information on CAM therapies available at the institution, and suggestion for the therapy and training be offered to all caregivers and clinical providers.

4. Discussion

This pilot program was successful in providing Reiki training to caregivers of pediatric inpatients at a tertiary care children's hospital, thereby providing them with a non-invasive comfort tool with the ability to positively impact their experiences in the hospital and at home. Our experience demonstrates that such a program is feasible, in terms of planning, recruitment, and execution. Our program also empowered caregivers to be active participants in their child's care.

4.1. Feasibility

Reiki is a noninvasive, relatively portable therapy that requires minimal equipment and can be done in a variety of settings as demonstrated by our flexible training schedule and locations. The ability of our Reiki master, to accommodate participants' wishes to learn Reiki in their child's hospital room to maintain proximity to their child was a major factor in participation. The training sessions put little strain on the hospital's resources, and were easy to incorporate into day-to-day hospital life. It could pose a challenge to maintain this degree of individual participant attention if the program is implemented on a larger scale and may require, an additional Reiki master to meet the needs of each participant in an efficient manner.

4.2. Acceptability

Our recruitment methods were successful in acquiring a number of participants (17) close to our original sample goal of 20, with a recruitment rate of 94.4%. Since hospital staff who may have already been familiar with the families on the units did the identification of potential participants, there may have been a selection bias toward families that were thought to be receptive to CAM therapies. Since 82% of participating caregivers reported use of some form of CAM themselves, this characteristic could have influenced their receptivity to learning Reiki.⁴⁷ Use of CAM therapies may vary based on geographic location and patient population.⁴⁸⁻⁵¹ The degree of interest, and the number of participants in our program demonstrates a high rate. Our participants also demonstrated a 59% rate of continued use of Reiki after completing training, and expressed an interest in further Reiki

training. Further expansion of the program may yield a variable degree of interest, in which case it might be prudent to take measures to increase awareness of the availability and potential benefits of the program.

4.3. Participant feedback and perceived benefits

The most frequently reported perceived benefits were increases in the child's comfort and relaxation (76% and 88%, respectively). Our findings of these perceived benefits are consistent with previous research findings on the benefits of Reiki.^{8–25} This is encouraging, as it was one of our primary goals to provide an effective comfort tool for caregivers to use with their children. The self-reports from caregivers about this program serving as a way for them to actively participate in their child's care is also an equally important finding.

Being a feasibility study, it lacks the rigorous design, randomization, controls, blinding or quantitative data collection. However, the feedback from participants encourages us to recognize a promising area for future research involving CAM and pediatrics, a population with which little Reiki research has been done.

The participant feedback will also assist us in tailoring our program to better meet the needs of future participants, as it is our hope that the established training program will become permanently incorporated into the hospital's teaching offerings. We also hope to extend the training to clinicians and other hospital staff. Our program may serve as a prototype that can be utilized in other institutions.

5. Conclusions

Based on the successful completion of this pilot program, we conclude that a hospital-based Reiki training program for caregivers of hospitalized pediatric patients is feasible, and may realistically be incorporated into a hospital's teaching offerings. We also conclude that such a program is able to positively impact and empower patients and their families. While participants in our program subjectively reported perceived benefits, there is a need for more rigorous trials to assess the benefits of Reiki in the pediatric population.

Acknowledgments

We wish to posthumously acknowledge Ms. Katherine (Kate) O'Sullivan-Stygall, Reiki Master for this project, for the conception of this project and her expertise to provide the training to the participants of this project.

Appendix

Appendix 1:

Questions administered to caregivers at completion of the Reiki training or at the time of their child's discharge from the hospital:

- Have you had any previous experience with other types of complementary or alternative medicine (e.g. massage, acupuncture, etc.)?
- On a scale of 0–10 (0 = not at all, 10 = extremely), how competent and confident do you feel using Reiki therapy with your child, having completed this training program?
- Do you feel that learning and/or practicing Reiki has benefitted you or your child? If your answer is yes, please describe the benefits you have noted.
- Have you used Reiki since completing the training? If yes, how frequently?

- Do you have a desire to participate in further Reiki training?
- What did you like about the Reiki training program?
- What could have been done better, or differently?
- Are there any other comments or suggestions you'd like to share with us?

Abbreviations

CAM	complementary and alternative medicine
NCCAM	National Center for Complementary and Alternative Medicine

References

1. Commodari E. Children staying in hospital: a research on psychological stress of caregivers. *Ital J Pediatr.* 2010; 36:40–9. <http://dx.doi.org/10.1186/1824-7288-36-40>. [PubMed: 20500854]
2. Coyne I. Children's experiences of hospitalization. *J Child Health Care.* 2006; 10:326–36. <http://dx.doi.org/10.1177/1367493506067884>. [PubMed: 17101624]
3. Hopia H, Tomlinson PS, Paavilainen E, Astedt-Kurki P. Child in hospital: family experiences and expectations of how nurses can promote family health. *J Clin Nurs.* 2005; 14:212–22. [PubMed: 15669930]
4. Burns KH, Casey PH, Lyle RE, Mac Bird T, Fussell JJ, Robbins JM. Increasing prevalence of medically complex children in US Hospitals. *Pediatrics.* 2009; 126(4):638–46. <http://dx.doi.org/10.1542/peds.20085383> [PubMed: 20855383]
5. Simon TD, Berry J, Feudtner C, Stone BL, Sheng X, Bratton SL, et al. Children with complex chronic conditions in inpatient hospital settings in the United States. *Pediatrics.* 2010; 126(4):647–55. <http://dx.doi.org/10.1542/peds.2009-3266>. [PubMed: 20855394]
6. Barnes PM, Bloom B, Nahin RL. Complementary and alternative medicine use among adults and children: United States, 2007. *Natl Health Stat Rep.* 2008; 12:1–24.
7. McLean TW, Kemper KJ. Lifestyle, biomechanical, and bioenergetic complementary therapies in pediatric oncology. *J Soc Integr Oncol.* 2006; 4(4):187–93. Fall. [PubMed: 17022926]
8. Whelan KM, Wishnia GS. Reiki therapy: the benefits to a nurse/Reiki practitioner. *Holist Nurs Pract.* 2003; 17(4):209–17.
9. National Center for Complementary and Alternative Medicine. Reiki: an introduction. 2009. Retrieved from: <http://nccam.nih.gov/health/reiki/introduction.htm>
10. Nield-Anderson L, Ameling A. The empowering nature of Reiki as a complementary therapy. *Holist Nurs Pract.* 2000; 14:21–9. [PubMed: 12119625]
11. Nield-Anderson L, Ameling A. Reiki. a complementary therapy for nursing practice. *J Psychosoc Nurs Ment Health Serv.* 2001; 39:42–9. [PubMed: 11324176]
12. Miles P, True G. Reiki—review of a biofield therapy history, theory, practice, and research. *Altern Ther Health Med.* 2003; 9(2):62–72. [PubMed: 12652885]
13. Williams AM, Davies A, Griffiths G. Facilitating comfort for hospitalized patients using non-pharmacological measures: preliminary development of clinical practice guidelines. *Int J Nurs Pract.* 2009; 15(3):145–55. [PubMed: 19531072]
14. Schlitz MJ, Braud WG. Reiki-plus natural healing: an ethnographic/experimental study. *PSI Res.* 1985; 4(3):100–23.
15. Dressin LJ, Sing S. Effects of Reiki on pain and selected affected and personality variables of chronically ill patients. *Subtle Energies Energy Med.* 1998; 9(1):53–82.
16. Wirth DP, Barret MJ. Complementary healing therapies. *Int J Psychosom.* 1994; 41(1):61–7. [PubMed: 7843869]
17. Vitale AT. An integrative review of Reiki touch therapy research. *Holist Nurs Pract.* 2007; 21(4):167–79. [PubMed: 17627194]

18. Richeson NE, Spross JA, Lutz K, Peng C. Effects of Reiki on anxiety, depression, pain, and physiological factors in community-dwelling older adults. *Res Gerontol Nurs*. 2010; 3:187–99. [PubMed: 20635803]
19. Shore AG. Long-term effects of energetic healing on symptoms of psychological depression and self-perceived stress. *Altern Ther Health Med*. 10:42–8. [PubMed: 15154152]
20. Miles P. Preliminary report on the use of Reiki HIV-related pain and anxiety. *Altern Ther Health Med*. 2003; 9:36. [PubMed: 12652881]
21. Wirth DP, Brenlan DR, Levine RJ, Rodriguez CM. The effect of complementary healing therapy on postoperative pain after surgical removal of impacted third molar teeth. *Complement Ther Med*. 1993; 1:133–8.
22. Alandydy P, Alandydy K. Using Reiki to support surgical patients. *J Nurs Care Qual*. 1999; 13(4): 89–91. [PubMed: 10330795]
23. Vitale AT, O'Connor PC. The effect of Reiki on pain and anxiety in women with abdominal hysterectomies: a quasi-experimental pilot study. *Holist Nurs Pract*. 2006; 20:263–72. [PubMed: 17099413]
24. Bullock M. Reiki: a complementary therapy for life. *Am J Hosp Palliat Care*. 1997; 14(1):31–3. [PubMed: 9069762]
25. Olson K, Hanson J. Using Reiki to manage pain: a preliminary report. *Cancer Prev Control*. 1997; 1(2):108–13. [PubMed: 9765732]
26. Olson K, Hanson J, Michaud M. A phase II trial of Reiki for the management of pain in advanced cancer patients. *J Pain Symptom Manage*. 2003; 26(5):990–7. [PubMed: 14585550]
27. Pierce B. The use of biofield therapies in cancer care. *Clin J Oncol Nurs*. Apr; 2007 11(2):253–8. [PubMed: 17573275]
28. Tsang KL, Carlson LE, Olson K. Pilot crossover trial of Reiki versus rest for treating cancer-related fatigue. *Integr Cancer Ther*. Mar; 2007 6(1):25–35. [PubMed: 17351024]
29. Baldwin AL, Wagers C, Schwartz GE. Reiki improves heart rate homeostasis in laboratory rats. *J Altern Complement Med*. May; 2008 14(4):417–22. [PubMed: 18435597]
30. Sharma VG, Sanghvi C, Mehta Y, Trehan N. Efficacy of Reiki on patients undergoing coronary artery bypass graft surgery. *Ann Card Anaesth*. Jul; 2000 3(2):12–8. [PubMed: 17848766]
31. Mackay N, Hansen S, McFarlane O. Autonomic nervous system changes during Reiki treatment: a preliminary study. *J Altern Complement Med*. Dec; 2004 10(6):1077–81. [PubMed: 15674004]
32. Witte D, Dundes L. Harnessing life energy or wishful thinking? Reiki, placebo Reiki, meditation, and music. *Altern Complement Ther*. 2001; 7:304–9.
33. Wardell DW, Engebretson J. Biological correlates of Reiki touch(sm) healing. *J Adv Nurs*. 2001; 33:439–45. [PubMed: 11251731]
34. Schmeh R. Enhancing the treatment of HIV/AIDS with Reiki training and treatment. *Altern Ther Health Med*. 2003; 9(2):118–20.
35. Engebretson J, Wardell DW. Experience of a Reiki session. *Altern Ther Health Med*. 2002; 8(2): 48–53. [PubMed: 11890385]
36. Brathovde A. A pilot study: Reiki for self-care of nurses and healthcare providers. *Holist Nurs Pract*. Mar-Apr;2006 20(2):95–101. [PubMed: 16518156]
37. DiNucci EM. Integrating energy healing in new environments and for self-care. *Beginnings*. 2006; 26(1):10–1. Winter. [PubMed: 16463717]
38. Raingruber B, Robinson C. The effectiveness of Tai Chi, yoga, meditation, and Reiki healing sessions in promoting health and enhancing problem solving abilities of registered nurses. *Issue Ment Health Nurs*. Oct; 2007 28(10):1141–55.
39. Barnett, L.; Chambers, M. *Reiki energy medicine: bringing healing touch into home, hospital and hospice*. Healing Arts Press; Rochester, VT: 1996.
40. Center for Reiki Research. Reiki in hospitals. 2011. Retrieved from: http://www.centerforreikiresearch.org/Articles_ReikiInHosp.aspx
41. Bossi LM, Ott MJ, DeCristofaro S. Reiki as a clinical intervention in oncology nursing practice. *Clin J Oncol Nurs*. Jun; 2008 12(3):489–94. [PubMed: 18515247]

42. Burden B, Herron-Marx S, Clifford C. The increasing use of Reiki as a complementary therapy in specialist palliative care. *Int J Palliat Nurs*. May; 2005 11(5):248–53. [PubMed: 15944500]
43. Miles P. Palliative care service at the NIH includes Reiki and other mind-body modalities. *Adv Mind Body Med*. 2004; 20(2):30–1. Summer. [PubMed: 15356954]
44. Fleming D. Reiki: a gift and a skill anyone can learn. *Beginnings*. Jan-Feb;2003 23(1):12–3. [PubMed: 12592974]
45. International Center for Reiki Training Association. ICRT Reiki Membership Association code of ethics and standards of practice. 2011. Retrieved from: http://www.reikimembership.com/Code_of_Ethics.aspx%23standards
46. Melnyk BM, Alpert-Gillis L, Feinstein NF, Crean HF, Johnson J, Fairbanks E, et al. Creating opportunities for parent empowerment: program effects on the mental health/coping outcome of critically ill young children and their mothers. *Pediatrics*. 2004; 113:e597–607. [PubMed: 15173543]
47. Birdee GS, Phillips RS, Davis RB, Gardiner P. Factors associated with pediatric use of complementary and alternative medicine. *Pediatrics*. 2010; 125:249–56. [PubMed: 20100769]
48. Hughes SC, Wingard DL. Children’s visits to providers of complementary and alternative medicine in San Diego. *Ambul Pediatr*. 2006; 6:293–6. [PubMed: 17000420]
49. Ottolini MC, Hamburger EK, Loprieto JO, Coleman RH, Sachs HC, Madden R, et al. Complementary and alternative medicine use among children in the Washington, DC area. *Ambul Pediatr*. 2001; 1:22–5.
50. Sawni A, Ragothaman R, Thomas RL, Mahajan P. The use of complementary/alternative therapies among children attending an urban pediatric emergency department. *Clin Pediatr*. 2007; 46:36–41.
51. Neuhouser ML, Patterson RE, Schwartz SM, Hedderson MM, Bowen Dj, Standish LJ. Use of alternative medicine by children with cancer in Washington state. *Prev Med*. 2001; 33:347–54. [PubMed: 11676573]