



DOSSIER · THERAPY

Reiki

Reiki is classified in the specialist literature as a biofield therapy and is performed in sessions with hands placed on or held close to the body. Human research focuses on pain, anxiety, fatigue and cognition. The most frequently cited controlled trial is a pilot study on cancer-related fatigue; the central open question is whether Reiki works beyond a sham treatment.

133

STUDIES IN
TOTAL

108

IN HUMANS

73

OF WHICH
CONTROLLED

0

IN ANIMALS

1

IN THE LAB

Figures from the IHR study database · Last updated 2026-10-04

How to Read This Dossier

ESTABLISHED

measured in humans, with a comparison group

PLAUSIBLE

supported by mechanism, animal studies or observation

HYPOTHESIS

a likely connection that still needs to be tested

Reiki at a Glance

ORIGIN:

Reiki is classified in the literature as a biofield therapy and is delivered in sessions with hands placed on or held just above the body; several sessions are usual. Reiki is not a substance and not a dose but a procedure; therefore studies examine procedures, hand positions, number of sessions and the question of who delivers the treatment.

EVIDENCE BASE:

133 evaluated papers · 73 controlled human studies · 35 observational studies · 8 reviews · 0 animal studies · 0 cell-culture studies

STRONGEST EVIDENCE:

- Pain: The 2018 meta-analysis pooled four randomised controlled trials with 212 participants; the standardised mean difference on the VAS pain score was -0.927 (95 % CI: -1.867 to 0.0124).
- Pain and anxiety: The 2014 review calculated effect sizes from seven randomised trials; within-group values ranged from $d = 0.24$ to $d = 2.08$ and between-group values from $d = 0.32$ to $d = 4.5$.
- Pain and anxiety: The 2010 best-evidence synthesis evaluated 66 clinical studies on biofield therapies including Reiki and found strong evidence for reduction of pain intensity in pain populations.
- Postoperative pain management: The 2015 randomised controlled trial in 90 women after caesarean section found significant between-group differences in pain intensity, anxiety score, respiratory rate and timing and number of analgesic doses.
- Fatigue: The 2021 randomised, single-blind study in 42 caregivers reported declining CSI scores in the Reiki group compared with the sham-Reiki group.

LIMITATIONS:

- Oncology: The most-cited controlled study from 2007 is a pilot trial with 16 patients; reported results on fatigue, pain and anxiety for this study are still pending.
- The 2011 pilot RCT in prostate cancer found no significant differences at any time point on STAI, CES-D and FACT-G between Reiki, relaxation-response therapy and wait-list.
- The 2008 review found no single condition with multiple independent replications; such replications remain outstanding.

CLASSIFICATION:

Reiki is a biofield therapy that is tested predominantly as an adjunct to standard care; whether it exerts effects beyond a sham procedure remains an open question.

1. What Reiki Is

Reiki is classified in the literature as a biofield therapy. Treatment takes place in sessions in which the practitioner places the hands on or holds them just above the body; several sessions are usual. The procedure is described as complementary to medical treatment, not as a substitute for it. The 2003 review places Reiki in the context of history, theory, practice and research and is one of the most-cited works in the field. Important for classification: Reiki is not a substance and not a dose but a procedure. Therefore studies examine procedures, hand positions, number of sessions and the question of who delivers the treatment. Controlled trials test Reiki predominantly as an adjunct to standard care, for example in oncology, pain management and fatigue. Some studies examine not patients but practitioners, such as a 2011 study on heart-rate variability, cortisol and body temperature in nurses with burnout.

For the interpretation of all studies the question of control is decisive. Reiki is difficult to blind: the recipient notices whether hands are placed. Therefore controlled trials use sham treatments in which the same hand positions are performed without therapeutic intention. One 2011 study directly compares standard care, sham Reiki and Reiki. Measurements are predominantly subjective variables such as pain, anxiety and fatigue as well as physiological markers such as heart-rate variability, cortisol and body temperature. Markers and disease course are not the same: a changed cortisol value or changed heart-rate variability is not yet evidence of a changed disease course. Readers of the studies must therefore distinguish between what was measured immediately after a session and what occurred over weeks in the participants' daily lives.

2. What the Studies Show in Detail

The key human studies and the most important reviews — by indication, with population, duration, preparation, outcome measure and result as reported in the original papers. Numbers appear only where the study states them.

Distribution of **controlled human studies** by application area — the numbers are not additive, as one study can be assigned to multiple areas:

APPLICATION AREA	CONTROLLED STUDIES
Cognition and Psyche	36
Fatigue and Stress	36
Oncology	18
Safety and Tolerability	10

APPLICATION AREA	CONTROLLED STUDIES
Heart and Circulation	8
Gut and Microbiome	3
Immune system	3
Musculoskeletal System	3

Oncology

The 2007 pilot study compared Reiki with an equally long rest period in a balanced crossover design in cancer-related fatigue²³. In the Reiki condition five consecutive daily sessions were followed by a one-week wash-out without treatment, two further Reiki sessions and two weeks without treatment. In the rest condition participants rested for approximately one hour on each of five consecutive days, then one week without planned rest and a further week without treatment. Before and after all sessions the fatigue subscale of the FACT-F and the FACT-G for quality of life were recorded; before and after each session daily fatigue, pain and anxiety were additionally recorded on a visual analogue scale of the Edmonton Symptom Assessment System. Sixteen patients, including 13 women, participated. This provides a carefully controlled design for a small sample; reported results on fatigue, pain and anxiety for this study are still pending.

The 2011 pilot RCT tested relaxation-response therapy and Reiki in men undergoing external-beam radiotherapy for prostate cancer²⁷. Participants were randomised to weekly relaxation-response therapy, twice-weekly Reiki or a wait-list control group. Anxiety (STAI), depression (CES-D) and quality of life (FACT-G) were assessed at randomisation and at three further time points. No statistically significant between-group difference appeared at any time point for the total scores of STAI, CES-D and FACT-G. At the end of the intervention a significant improvement on the emotional-well-being subscale of the FACT-G was found in the relaxation-response group compared with Reiki and control ($P = .01$). Among participants classified as anxious at baseline the relaxation-response group improved significantly ($P = .02$); a positive trend appeared in the Reiki group ($P = .10$).

The 2021 randomised, single-blind study examined Reiki in women who were primary caregivers for cancer patients³¹. The Reiki group received Reiki at nine main points for 45 minutes once weekly for six weeks; the sham-Reiki group received the same points over the same period without initiation of an energy flow. The Caregiver Strain Index (CSI) and salivary cortisol were measured at baseline and at the end of the study; systolic and diastolic blood pressure and pulse were measured before and after each weekly application. The study was completed with a total of 42 caregivers. Sample size was calculated on the basis of the difference in CSI scores; the power analysis at $\alpha = 0.05$ and $\beta = 0.20$ yielded an effect size of 1.71 and a power of 99 %. After the intervention CSI scores declined in the Reiki group compared with the sham group. In addition, semi-structured interviews explored the experiences of the Reiki group.

The 2014 review calculated effect sizes of Reiki for pain and anxiety from randomised clinical trials identified in PubMed, ProQuest, Cochrane, PsychInfo, CINAHL, Web of Science, Global Health and Medline²⁴. After removal of duplicates 49 articles were screened, twelve underwent full-text assessment and seven met the inclusion criteria: four examined cancer patients, one postoperative patients and two community-dwelling older adults. Effect sizes (Cohen's d) for within-group differences ranged from $d = 0.24$ for reduction of anxiety in women during breast biopsy to $d = 2.08$ for reduction of pain in community-dwelling adults; for between-group differences from $d = 0.32$ for pain reduction in cancer patients receiving Reiki versus rest to $d = 4.5$ for pain reduction in community-dwelling adults. The 2010 best-evidence synthesis evaluated 66 clinical studies on biofield therapies including Reiki³⁵. It covers several biofield therapies, so its results cannot be attributed to Reiki alone. It found strong evidence for reduction of pain intensity in pain populations, moderate evidence for inpatient and oncology populations and for reduction of anxiety in inpatients and of negative behavioural symptoms in dementia; evidence for fatigue and quality of life in cancer patients was inconclusive. What is missing is an independent replication of the oncology fatigue and quality-of-life data with fully reported effects.

Cognition and Psyche

The 2022 systematic review asked whether Reiki improves psychological symptoms beyond the placebo effect⁴⁰. Reiki is described therein as an energy-healing technique or biofield therapy in which an attuned practitioner places the hands on or near the body and sends energy to stimulate self-healing powers and restore balance. The review searched PubMed, PsycINFO, MEDLINE, CINAHL, Web of Science, Scopus, Embase and ProQuest for randomised placebo-controlled trials in adults. Fourteen studies met the inclusion criteria; risk of bias was assessed with Cochrane's revised ROB-2 tool followed by a GRADE evaluation. This constitutes a methodologically broad appraisal of the question whether Reiki exerts effects on psychological symptoms beyond placebo.

The 2008 systematic review pooled randomised clinical trials on Reiki from 23 databases without language restriction, assessed with the Jadad score⁷. Of 205 potentially relevant papers nine RCTs met the inclusion criteria. Two RCTs indicated favourable effects versus sham for depression, one RCT reported no between-group differences; for pain and anxiety one RCT showed differences versus sham. For stress and hopelessness another RCT reported effects of Reiki and distant Reiki versus distant sham. No between-group differences were found for functional recovery after ischaemic stroke, nor for anxiety in pregnant women during amniocentesis; in diabetic neuropathy no effect on pain was observed, and in women during breast biopsy one RCT showed no effects on anxiety and depression versus conventional care. No single condition had multiple independent replications; such replications remain outstanding.

The 2018 meta-analysis pooled four randomised controlled trials with 212 participants on the effect of Reiki on pain, identified in Pubmed, ISI Web of Sciences and Google Scholar⁴. The VAS pain score after the last Reiki application was evaluated; comparison of the Reiki group ($n = 104$) with the control group ($n = 108$) yielded a standardised mean difference of -0.927 (95 % CI: -1.867 to 0.0124), which the authors describe as a statistically significant reduction of the VAS score. **Hypothesis:** Because the confidence interval extends close to zero, a replication with a larger number of participants would be appropriate to strengthen the estimate. The 2002 pilot study tested Reiki in addition to standard rehabilitation in 50 inpatients with subacute ischaemic stroke, 31 men and 19 women²⁸. Reiki master, Reiki practitioner, sham Reiki and a historical control group without treatment were compared, with up to ten treatments over two and a half weeks. On the Functional Independence Measure and the CES-D scale no Reiki effects appeared, while the usual effects of age, sex and time in rehabilitation were detectable. Blinded practitioners could not recognise their own group assignment.

The 2015 randomised controlled trial examined Reiki on postoperative days 1 and 2 after caesarean section in 90 women who were allocated, matched for age and parity, to a Reiki or a rest control group ²⁶. Both groups received 30 minutes of treatment on ten defined body regions for three minutes each in the first 24 and 48 hours after delivery. Reiki once daily within four to eight hours after intravenous administration of a standard analgesic. Statistically significant between-group differences over time were found for pain intensity ($p = .000$), anxiety score ($p = .000$) and respiratory rate ($p = .000$) as well as for timing ($p = .000$) and number ($p = .000$) of analgesic doses. The 2011 guideline on the treatment of painful diabetic neuropathy listed Reiki massage among the non-pharmacological procedures it systematically reviewed ³⁴. A Reiki-specific single result is not reported in the summary. This guideline has been withdrawn.

Further Investigations

The 2014 review evaluated randomised controlled trials on biofield therapies that operate exclusively without physical contact, including Reiki, Healing Touch, Johrei, Therapeutic Touch and external qigong ¹. Of 90 RCTs on the efficacy of a biofield therapy in humans, 28 studies with 1775 participants met the additional inclusion criteria, chiefly the clearly reported omission of physical contact. The designs differed markedly with regard to the condition treated and the number and duration of treatments. Assessment used a modified five-item Jadad scale and twenty criteria that also take account of the early phase of such studies. The 2009 review examined the therapeutic effects of Reiki in Medline, EMBASE, Cochrane Library and Google Scholar and assessed reporting quality with modified CONSORT criteria as well as methodological quality with the Jadad score ⁸. All twelve included studies showed gaps in at least one of the three core areas randomisation, blinding and accountability for all patients; nine of the twelve reported a significant therapeutic effect. This raises the question of how reporting and methodological quality can be further developed so that effects can be clearly attributed.

The 2011 double-blind randomised controlled trial examined Reiki in an outpatient chemotherapy centre ¹⁶. 189 participants were randomly assigned to actual Reiki therapy, a sham-Reiki placebo or standard care; a demographic instrument and pre-post tests were administered before and after the chemotherapy infusion. Reiki increased comfort and well-being after treatment statistically significantly, yet so did the sham-Reiki placebo. In the standard-care group comfort and well-being did not change during the infusion. The authors conclude that the presence of a nurse providing one-to-one support during chemotherapy raised the scores, with or without the attempt to create a healing energy field. For attribution of an effect to the Reiki application itself an independent examination with a different design is the next task.

The 2017 review asked whether Reiki goes beyond a placebo effect ³⁷. It considered English-language, peer-reviewed clinical studies with more than 20 participants in the Reiki arm that controlled for a placebo effect. Of 13 eligible studies, eight showed superiority of Reiki over placebo, four found no difference with questionable statistical power, and only one provided clear indications of an absent benefit. In summary, the author sees fairly strong support that Reiki is more effective than placebo and describes Reiki as a safe and gentle complementary therapy that activates the parasympathetic nervous system. The 2010 literature review on energy healing and pain from 1980 to 2008 recommends larger and more diverse samples as well as comparisons between the individual modalities ⁴¹. The 2021 systematic review on the use of Reiki in mental health care included eleven studies and sees in the results a possible benefit, together with the recommendation to continue with large-scale samples, consistent randomised controlled trials and uniform protocols ⁴².

The 2006 review on complementary modalities in epilepsy classifies Reiki among the mind-body modalities and points out that individualised therapies such as homeopathy and Reiki cannot be compared in the conventional pharmaceutical model with medicinal products ³². It advocates designing studies and endpoints to suit these modalities and planning future studies with qualified practitioners of the respective modality. The 1997 survey in a large Canadian city examined, with 300 patients, 60 per practitioner group, who uses alternative offerings ³⁹. Reiki patients had a higher level of education and more often held managerial or academic positions than other patients of alternative modalities; nearly all patients of alternative modalities also consulted general practitioners. The 2017 integrative review on Reconnective Healing names Reiki, Therapeutic Touch and Johrei as biofield modalities already reviewed elsewhere; its own results relate to Reconnective Healing and not to Reiki ⁴⁴. The 2025 integrative review on the NANDA-I nursing diagnosis "Imbalanced Energy Field" screened 524 articles and selected 14, three of which contained Reiki results, thereby contributing to the conceptual and operational definition of the diagnosis ⁴⁵. What is missing are studies that report Reiki results separately rather than bundling them with other modalities or concomitant measures.

Fatigue and Stress

The placebo-controlled, randomised crossover study of 2011 with single-blind design examined immediate effects of Reiki in 21 health-care professionals with burnout syndrome ²⁵. The participants attended two laboratory visits one week apart and were randomly assigned the order in which they received a Reiki session from an experienced practitioner and a placebo treatment from a person without Reiki knowledge who mimicked the treatment. Temperature, Holter ECG recordings with SDNN, RMSSD, HRV index as well as low- and high-frequency components, salivary flow rate and cortisol value were measured at baseline and after the intervention by an assessor blinded to group allocation. SDNN and body temperature were significantly higher after the Reiki treatment. Whether this yields a robust association for fatigue itself is the open follow-up question.

The 2021 quasi-experimental study with pre-post design examined Reiki and guided imagery for pain and fatigue in oncology patients ²⁹. It was conducted with 180 patients at the oncology clinic of Dicle University Hospital in Turkey between July 2017 and February 2018; the patients were allocated to three groups of 60 each: Reiki, guided imagery and control. The Reiki and the imagery group received their respective intervention on three consecutive days separately from each other; 25 to 30 minutes are stated, with a mean of 15.53 minutes. Both interventions reduced pain and fatigue. Because allocation was not randomised, a randomised replication is the next step.

The 2010 single-blind randomised study tested Reiki and positive imagery for well-being and salivary cortisol in 35 healthy psychology students ³⁰. Participants were randomly assigned to a non-contact Reiki or a no-Reiki condition while their attention was directed to one of three self-hypnosis or relaxation tasks. Ten sessions of 20 minutes each took place over a period of two and a half to twelve weeks; Reiki was guided by the experimenter behind the participants' backs. Self-assessment of illness symptoms, mood and sleep as well as salivary cortisol were recorded before and after the intervention. In the Reiki group there was a tendency toward a decrease in illness symptoms, whereas in the no-Reiki group a clear increase occurred. A nearly significant comparative reduction was also found for stress, although the Reiki group had shown significantly higher baseline values for illness symptoms and stress. Blinding was successful: the groups did not differ statistically in their assumptions about group membership. The authors interpret the results as an indication that Reiki buffered the marked health decline over the course of the academic year. What is missing is a replication in larger samples with balanced baseline values.

Safety and Tolerability

The 2008 review examined touch modalities, including Healing Touch, Therapeutic Touch and Reiki, for their effect on acute and chronic pain as well as adverse effects¹¹. Searched were, among others, the Cochrane Library, MEDLINE, EMBASE, CINAHL and AMED from their respective inception to June 2008; included were randomised controlled trials and controlled clinical trials that examined the effect of touch on any form of pain, and only with sham placebo or a no-treatment control. Extracted was mean pain intensity after completion of all treatment sessions; values from different pain scales were standardised to a common scale and the modalities compared. For the safety question it is decisive that adverse effects were explicitly listed as an outcome measure; systematic recording of side effects across several modalities remains an open task.

The 2008 randomised, sham-controlled study with factorial design examined Reiki as an adjunct treatment in fibromyalgia¹⁵. Participants, data collection and data analysis were blinded to group allocation; the study was conducted in private medical practices in the greater Seattle, Washington area. One hundred adults with fibromyalgia were allocated to four groups that received treatment twice weekly for eight weeks from a Reiki master or an actor, randomised to direct contact or non-contact as distant treatment. The primary endpoint was subjective pain on a visual analogue scale at weeks 4, 8 and 20, i.e. three months after the end of treatment; secondary outcomes included physical and mental functioning, medication use and physician visits. Blinding and adverse effects were recorded by self-report; analysis followed the intention-to-treat principle. Neither Reiki nor touch showed an effect on pain or any of the secondary endpoints; all outcome measures were nearly identical across the four groups over the study course. This carefully controlled work is an important reference point for any further examination because it treats contact itself as a separate condition.

Heart and Circulation

The 2016 single-blind, randomised study with double control examined Reiki at the surgical wound after caesarean section³³. Forty-five patients, matched for age and number of births, were randomly assigned to the Reiki, sham-Reiki or control group. Treatment was applied to the wound area for 15 minutes in the first 24 and 48 hours after surgery and within four to eight hours after administration of standard analgesics. A patient follow-up questionnaire and a visual analogue scale were recorded. Mean VAS values differed significantly by group and time point ($P < .05$). In the Reiki group a pain reduction of 76.06 % was recorded between the pre-treatment measurement on day 1 and the post-treatment measurement on day 2. Mean respiratory rate and systolic blood pressure differed significantly between the groups ($P < .05$), and the Reiki group used fewer analgesics over the study period and required them later than the sham and control groups ($P < .05$).

The 2004 blinded pilot study examined changes in the autonomic nervous system during a Reiki treatment in a quiet room of an outpatient clinic³⁶. Forty-five persons were randomly assigned to three groups: no treatment other than rest, Reiki by an experienced practitioner, or a placebo treatment by a person without Reiki knowledge who mimicked the treatment. Heart rate, cardiac vagal tone, blood pressure, cardiac sensitivity to the baroreflex and respiratory activity were recorded continuously for each heartbeat, and values during and after treatment were compared with baseline. Heart rate and diastolic blood pressure decreased significantly more in the Reiki group than in the placebo and control groups. The authors classify the findings as an indication of an influence of Reiki on the autonomic nervous system and at the same time point out that the sample size was small and the changes relatively modest; they therefore justify further, larger-scale investigations into the biological effects of Reiki. How these autonomic changes translate into clinical endpoints is the next question.

The 2017 systematic review with meta-analysis compared Reiki and prayer with pharmacological pain management during a hospital stay for caesarean section⁴³. Searches up to March 2016 were conducted in MEDLINE, Embase, LILACS and CENTRAL for randomised controlled trials in English or Portuguese; two reviewers independently screened the studies, extracted the data and assessed risk of bias, supplemented by a GRADE table. For pain reduction by Reiki and prayer versus the protocol group, evidence with high risk of bias and statistical significance was found: mean difference -1.68 , 95 % confidence interval -1.92 to -1.43 , $P < 0.00001$, $I^2 = 92$ %. For heart rate as well as systolic and diastolic blood pressure no statistically significant difference was shown. The authors conclude that the evidence with high risk of bias suggests a possible association of Reiki and prayer meditation with pain reduction. Because both modalities were combined in the analysis, the effect cannot be attributed to Reiki alone; a separate examination would be the next step.

Skin

The 2007 integrative review classified Reiki touch therapy as a complementary biofield energy modality in which the hands are used to support the body's healing capacity³⁸. It describes a growing interest among nursing staff in using Reiki in patient care and as self-care. The aim of the work was to begin the systematic process of evaluating the published Reiki research. Selected studies on Reiki for stress, relaxation, depression, pain and wound-healing management as well as further fields were summarised and presented in an overview table with study descriptions and the respective treatment protocols used. This provides an ordered compilation of treatment protocols that is needed for the comparability of future studies.

Whether and how Reiki influences wound healing remains an open, testable question. A study that pre-specifies wound-healing parameters in a defined sample, tests Reiki against a sham condition and uniformly reports treatment duration and number of sessions would clarify it.

Overall Picture

Across the areas a recurring pattern emerges: where Reiki was tested against a sham or rest condition, the differences between Reiki, sham and attention control often coincide. The chemotherapy study with 189 participants¹⁶ and the fibromyalgia study with 100 adults¹⁵ are the clearest examples; in both works the positive effect appears more strongly linked to the attentive accompaniment than to a specific energy process. At the same time there are studies that report differences beyond the control, for example in pain after caesarean section³³ or in autonomic measures such as heart rate and diastolic blood pressure³⁶. Both directions belong to the picture and should not be played off against each other: they show how strongly the result depends on the chosen control procedure.

For practice this means choosing the target variable carefully. Subjective measures such as comfort, well-being, anxiety and pain are sensitive to attention and expectation; physiological measures such as SDNN, heart rate, diastolic blood pressure, salivary cortisol or salivary flow rate are less susceptible, yet not automatically clinically meaningful^{25 36}. The review of randomised studies supports Reiki for pain intensity and anxiety in certain populations²⁴; the best-evidence synthesis³⁵ covers many biofield modalities and treats Reiki as only one of them, while fatigue, quality of life and functional recovery remain inconclusive^{7 28 35}. **Hypothesis:** Part of the dispersion is explained by the fact that Reiki was tested in different settings, with different protocols and with practitioners of varying experience.

Methodology of the evidence base

The works range from pilot studies with 16 to 50 participants through randomised controlled trials with 90 to 189 participants to systematic reviews and meta-analyses ^{23 26 16 24}. Typical protocols comprise five daily sessions, weekly applications over six weeks, twice-weekly treatments over eight weeks or up to ten sessions over two and a half weeks; individual applications last 15 to 45 minutes ^{23 31 15 28 33}. Endpoints are predominantly self-reports on visual analogue scales and validated questionnaires on pain, anxiety, fatigue and quality of life, supplemented by autonomic measures and laboratory values such as salivary cortisol ^{26 25 30}. Recurring open points are the reporting of randomisation, blinding and completeness of patient follow-up ^{8 7}.

Reiki works beyond a sham treatment

This thesis stands at the centre of the field. An observational work from 2017 carries it in the title and describes Reiki as broadly applicable. A 2022 review, by contrast, explicitly asks whether Reiki improves psychological symptoms beyond placebo — the question is therefore treated as open, not as answered. Meta-analyses on pain and anxiety calculate effect sizes that go beyond the individual study. Decisive here is what was compared: against wait-list, against standard care or against a sham treatment with the same touch and attention.

This is precisely where the difficulty lies. If the sham treatment contains the same hand positions, the same session duration and the same attention, then the comparison measures only the ascribed meaning of the modality. If it turns out more cursory, it also measures touch and attention. Both errors are possible, and both distort in different directions. In addition, many studies measure immediately after the session. What happens over weeks is recorded less frequently. The question of an effect beyond a sham treatment therefore cannot be answered with a single study, but only with several independent studies that use the same sham condition.

3. How Robust the Research Is

The controlled human studies are distributed across a few areas. The most frequently investigated are cognition and fatigue, followed by oncology, then safety and cardiovascular. Gut, immune system, musculoskeletal system, bones and skin are represented with individual studies. Observational studies complement the picture, including a frequently cited investigation into changes in the autonomic nervous system during a Reiki treatment. The review articles primarily bundle pain and anxiety as well as psychological symptoms. The distribution of citations is striking: the most cited work in the entire field is a withdrawn guideline on painful diabetic neuropathy, which does not examine Reiki itself. The citation success of a field therefore says little about the number of its own controlled studies.

Methodologically the field is heterogeneous. There are randomised controlled trials, systematic reviews and meta-analyses, alongside many pilot studies with small groups. The most cited controlled study is explicitly a pilot study. Several reviews calculate effect sizes for pain and anxiety; such calculations pool heterogeneous studies and depend heavily on how the sham treatment was designed. Where sham Reiki includes touch and attention, the comparison does not test Reiki against nothing, but Reiki against another form of attention. The safety data form a separate strand. The most robust evidence comes from the reviews on pain and anxiety; for individual applications it remains to be clarified how many independent controlled studies exist in each case.

4. What Is Frequently Claimed — and What the Data Provide

STATEMENT	STUDY SITUATION
Reiki reduces pain	A 2018 meta-analysis summarises pain studies, and reviews calculate effect sizes. Pain is a subjective marker; these studies do not indicate whether the course
Reiki helps against tumour-related fatigue	The most cited controlled study from 2007 is a pilot study with crossover design; a later controlled, non-randomised study from 2021 examines pain and fatigue
Reiki works beyond placebo	Reviews from 2017 and 2022 pose the question but answer it differently. The comparison depends on how the sham treatment is designed.
Reiki is a safe procedure	Ten controlled studies address safety as a separate topic. Safety is thus a distinct research strand, not merely a by-product of efficacy studies.

5. The Most Robust Studies

Ordered by strength of evidence, not by prominence: review articles and studies with many participants first. The complete evaluation includes significantly more studies; the most robust ones are listed here.

Controlled Human Studies

- ¹ Nontouch biofield therapy: a systematic review of human randomized controlled trials reporting use of only nonphysical contact treatment (2014) — review article, 1,775 participants
- ² Effects of Reiki therapy on quality of life: a meta-analysis of randomized controlled trials (2025) — review article, 661 participants
- ³ The Effect of Reiki on Pain Applied to Patients With Cancer: A Systematic Review (2023) — review article, 572 participants
- ⁴ The effect of reiki on pain: A meta-analysis (2018) — review article, 212 participants
- ⁵ The effects of Reiki practice on breast cancer patients: a systematic review (2026) — Systematic review, 339 participants
- ⁶ Reiki and Therapeutic Touch for symptom burden and quality of life in palliative settings: A systematic review (2026) — Systematic review, 415 participants
- ⁷ Effects of reiki in clinical practice: a systematic review of randomised clinical trials (2008) — Systematic review
- ⁸ A systematic review of the therapeutic effects of Reiki (2009) — Systematic review
- Could complementary health approaches improve the symptom experience and outcomes of critically ill adults? A systematic review of randomized ... (2019) — Systematic review, 19 participants
- ⁹ Complementary and Alternative Medicine to Treat Fibromyalgia Symptoms. A Systematic Review (2024) — Systematic review
- ¹⁰ The Effect of Reiki on Fatigue Symptoms of Cancer Patients: A Systematic Review (2026) — Systematic review
- ¹¹ Touch therapies for pain relief in adults (2008) — 1.153 participants
- ¹² The effects of Reiki and back massage on women's pain and vital signs post-abdominal hysterectomy: A randomized controlled trial: The Effects of ... (2022) — 2.018 participants
- ¹³ The Effect of Reiki on the Self-Efficacy, Death Anxiety, and Sleep Quality of Patients Diagnosed With Chronic Obstructive Pulmonary Disease: A ... (2026) — 2.019 participants
- ¹⁴ Does Reiki Therapy Reduce Preoperative Anxiety and Postoperative Pain in Third Molar Surgery? A Randomized Controlled Trial (2026) — 2.023 participants
- ¹⁵ Reiki for the treatment of fibromyalgia: a randomized controlled trial (2008) — 100 participants
- ¹⁶ Investigation of standard care versus sham Reiki placebo versus actual Reiki therapy to enhance comfort and well-being in a chemotherapy infusion ... (2011) — 189 participants
- ¹⁷ Self-Efficacy for Coping with Cancer Enhances the Effect of Reiki Treatments During the Pre-Surgery Phase of Breast Cancer Patients (2017) — 110 participants
- ¹⁸ The effects of Reiki and hand massage on pain and fatigue in patients with rheumatoid arthritis (2023) — 105 participants
- ¹⁹ The Effect of Reiki on Anxiety, Stress, and Comfort Levels Before Gastrointestinal Endoscopy: A Randomized Sham-Controlled Trial (2023) — 159 participants
- ²⁰ Massage and Reiki to reduce stress and improve quality of life: a randomized clinical trial (2020) — 122 participants
- ²¹ [Effectiveness of implementing the reiki method to reduce the weaning failure. A clinical trial] (2016) — 256 participants
- ²² Randomized Controlled Trial of the Psychological and Clinical Outcomes of Reiki Plus Manual Therapy After Open Heart Surgery (2026) — 272 participants
- ²³ Pilot crossover trial of Reiki versus rest for treating cancer-related fatigue (2007) — 13 participants

6. Summary

Proven first is the nature of the field: Reiki is conducted as a biofield therapy in sessions with hands placed on or held close to the body and is predominantly tested as an adjunct to standard care, for example in oncology, in pain therapy and for exhaustion. The best-evidence synthesis from 2010, which includes several biofield therapies, found strong evidence overall for these therapies for the reduction of pain intensity in pain populations and moderate evidence for inpatient and oncological populations as well as for the decrease of anxiety in inpatients. The 2018 meta-analysis pooled four randomised controlled trials with 212 participants on pain.

Plausible is that part of the observed effect depends on attention and touch: Where sham Reiki includes touch and attention, the comparison does not test Reiki against nothing, but Reiki against another form of attention. The double-blind study from 2011 in the chemotherapy centre fits this: Reiki increased comfort and well-being statistically significantly, yet the sham Reiki placebo was also statistically significant. **Hypothesis:** It follows from this for the classification that the design of the sham treatment co-determines what a study can demonstrate at all.

What remains to be clarified is the central open question of whether Reiki works beyond a sham treatment. The systematic review from 2022 asked exactly that and included fourteen randomised placebo-controlled trials, assessed with ROB-2 and GRADE. For the oncological fatigue and quality-of-life data, an independent replication with fully reported effects is lacking; for no single disease were there several independent replications. A study that would clarify this question would have to design the sham treatment so that touch and attention are comparable between the groups and report the effects fully.

7. What Remains Open

- **Sham Condition:** Which sham treatment fairly represents Reiki — same hand position, same duration, same attention? Only then can the effect be tested beyond placebo.
- **Duration:** Most measurements take place immediately after the session. Which study records changes over weeks in the everyday life of those treated?
- **Areas of Application:** For the bowel, immune system, musculoskeletal system, bones and skin, individual studies exist. Which controlled study tests one of these areas with sufficient group size?

Frequently Asked Questions

How is Reiki performed in the studies?

In the controlled studies Reiki takes place in sessions in which the practitioner places the hands on or holds them close to the body. Several sessions are usual, often as an add-on to standard care. Comparisons are made against waiting list, standard care or a sham treatment with the same hand position. Session duration and number of sessions vary between studies, which complicates comparison.

What does the research measure in Reiki?

The measurements are predominantly subjective parameters such as pain, anxiety and fatigue, alongside physiological markers such as heart-rate variability, cortisol and body temperature. These markers are not equivalent to disease progression. Some of the studies examine practitioners rather than patients, for example nurses with burnout. For interpretation it matters whether measurements were taken immediately after the session or over a longer period.

Is Reiki better than placebo?

This question is explicitly posed and answered differently in the literature. An observational study from 2017 affirms it in the title; a 2022 review asks about psychological symptoms beyond placebo. Meta-analyses on pain and anxiety calculate effect sizes. The decisive factor is the sham condition: if it includes touch and attention, the comparison tests something different from a minimal control.

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