

APPROACHING HEALTH: REIKI USERS PROVIDING INSIGHT ON CAM USE

FOR ACA CONSIDERATION

by

Lauren Ashley Chapman, B.A.

A thesis submitted to the Graduate Council of
Texas State University in partial fulfillment
of the requirements for the degree of
Master of Arts
with a Major in Anthropology
August 2016

Committee Members:

Emily K. Brunson, Chair

Monica Schoch-Spana

R. Jon McGee

COPYRIGHT

by

Lauren Ashley Chapman

2016

FAIR USE AND AUTHOR'S PERMISSION STATEMENT

Fair Use

This work is protected by the Copyright Laws of the United States (Public Law 94-553, section 107). Consistent with fair use as defined in the Copyright Laws, brief quotations from this material are allowed with proper acknowledgment. Use of this material for financial gain without the author's express written permission is not allowed.

Duplication Permission

As the copyright holder of this work I, Lauren Ashley Chapman, authorize duplication of this work, in whole or in part, for educational or scholarly purposes only.

ACKNOWLEDGEMENTS

I would like to express my deepest appreciation to Dr. Emily K. Brunson for her encouragement and guidance throughout graduate school and the research process. I would also like to express my gratitude to Dr. Monica Schoch-Spana and Dr. R. Jon McGee for sharing their experience, perspectives, and support.

I would like to thank my sister, Shannon Sweeney, for her time spent editing papers, and her continual support and encouragement, as well as Rex Long for his support and comradery this past year.

Lastly, I would like to thank all of the Reiki users that participated in this study. Without their time and willingness to share their experiences I could not have completed this research.

TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	iv
LIST OF ABBREVIATIONS.....	vi
CHAPTER	
I. INTRODUCTION	1
II. APPROACHING HEALTH: REIKI USERS PROVIDING INSIGHT ON CAM USE FOR ACA CONSIDERATION	4
III. APPLIED COMPONENT	40
APPENDIX SECTION	41
REFERENCES	45

LIST OF ABBREVIATIONS

Abbreviation	Description
CAMs-	Complementary and Alternative Medicine
ACA-	Affordable Care Act
ACOs-	Accountability Care Organization
HHS-	Department of Health and Human Services
AMA-	American Medical Association
AHMA-	American Holistic Medical Association
AHNA-	American Holistic Nurses' Association
NIH-	National Institutes of Health
NCCAM-	National Center for Complementary and Alternative Medicine

I. INTRODUCTION

Medicine and healing practices can be found in all cultures. It is something that is uniquely human. Most cultures have pluralistic medical systems, mean that multiple medical systems and practices are accepted and utilized. However, the US has had an atypical medical history. The rise of capitalism, the global economy, and globalism has promoted the spread and dominance of biomedicine over other medical systems in the US. Paradoxically, those same forces brought new and exotic healing practices and philosophies to the US. Such practices include acupuncture, Chinese medicine, qi gong, yoga, Ayurveda, and energy healing modalities like Reiki. These and other non-biomedical healing practices like chiropractic medicine, homoeopathy, and prayer have been grouped into a category known as complementary and alternative medicines (CAMs).

CAMs have been historically utilized by marginal population and as an adjunct for biomedicine, but the US health care is under reform and CAM practices could become incorporated into the US health care system as a result of the Affordable Care Act. The ACA has three interrelated goals: to increase access to primary care, reduce and prevent chronic conditions, and to control health and medical expenditures. However, a shortage of primary health care professionals and the rising rates of expensive chronic health conditions has initiated discussion about incorporating specific licensed CAM practitioners into the primary health care professionals.

Some CAMs, like chiropractic medicine, acupuncture, and Chinese medicine, have gained legitimacy and acceptance among the US medical community and are likely to be incorporated into the biomedical health care system as primary health care

professionals. Whereas other healing modalities like Reiki have largely been and will continue to be dismissed for their inability to be scientifically tested. Despite the lack of scientific evidence supporting Reiki it has grown and persisted in popularity. Populations that are not heavily influenced by biomedical definitions of legitimate and effective could provide valuable insight into health and the changing US health care system. The goal of this study was to evaluate Reiki users' approach to health in central Texas and to demonstrate how their approach to health could provide insight into assessing, addressing, and implementing health care reform so as to meet the health needs and goals of individuals, as well as the goals of the ACA. The ACA and subsequent health reforms have the ability transform the US health care system and research regarding CAMs is need to insure the best outcomes.

Current and previous research on CAMs is largely focused on symptom management for individuals with chronic conditions like cancer and diabetes, identifying predictive socio-demographic characteristic of CAM users, and empirically testing CAM efficacy. There are very few studies of the experiences, perspectives, and beliefs of CAM users that don't have chronic conditions and have health insurance. This is also a limitation of the current literature on incorporating CAMs into the US health care system. The literature on the incorporation and integration of CAM into the US health care system has largely focused on the benefits of integration, reducing medical costs and increasing the number of primary care professionals, as well as the struggles of integration, licensing, incorporating mixed etiologies, and efficacy testing. This literature largely ignores the human aspect of these changes including will CAMs that are integrated into the health care system be utilized, will they be compatible with the health

beliefs, values, and goals of the patient, and how can CAM users perspectives, experiences, and beliefs inform health care reform. The goal of this study was to help fill this gap in the literature and to illustrate the health perspectives and approach of Reiki users in central Texas. Therefore, I have chosen to present this research in an article style rather than the traditional thesis format to facilitate its publication. In addition, this research will be applied as an op-ed article to bring awareness to the changing landscape of the US health care system. Both these elements of my thesis are presented in the following chapters. This research can help bring awareness of and encourage discussion about the roles of CAMs in the changing landscape of US health care. Though, the perspective of this research has effectively changed twice. I believe that this is the most meaningful production of this research.

II. APPROACHING HEALTH: REIKI USERS PROVIDING INSIGHT ON CAM USE FOR ACA CONSIDERATION

INTRODUCTION

In the US there are various healing modalities, services, technologies, and products to choose from to treat illnesses and achieve health. These various medical and healing modalities are commonly grouped into two categories: biomedicine, which is also known as scientific or conventional medicine, and complementary and alternative medicines (CAMs), a catch-all that includes all non-biomedical practices such as yoga, acupuncture, chiropractic medicine, and energy healing (Eisenberg et al. 2001, Ross 2012). Despite efforts to eliminate ‘alternative’ healing modalities during the last century and a half, biomedicine has not been able to achieve complete domination in the US (Baer 2001, 2004). Instead, the relationship between biomedicine and CAMs has been marked by periods of competition, domination, assimilation, opposition, and cooperation (Baer 2001, 2004).

Currently, the US health care system is in a time of transition, with the implementation of the Affordable Care Act (ACA), which could have a significant effect on access to and use of CAMs. One of the goals of the ACA is to increase access to primary care which increases demand on an already taxed system (Thompson and Nichter 2015). One solution is to recruit specific CAM providers, like doctors of chiropractic care, acupuncturists, and doctors of osteopathy, to assist with providing primary health care (Davis et al. 2011, Goldstein 2013, Thompson and Nichter 2015). Along with the possibility of CAM practitioners providing primary care physicians, construction of future Accountability Care Organizations (ACOs) (Davis et al. 2011), work wellness

programs, and the evaluation of state benchmark insurances by the Department of Health and Human Services (HHS) (Cassidy 2013) could lead to increased access to and use of CAMs in the US.

Due to the changing health care landscape, it is important at this time of transition to study populations that choose to pursue CAMs. The perspectives, motivations, experiences, and health beliefs of individuals who currently utilize CAMs, even when they have access to biomedicine, can provide valuable insight into the shortcomings of the current biomedical health care system, how CAMs address these shortcomings, how these individuals integrate their use of multiple modalities and decide which modality to utilize, the health priorities of these groups, and potential ways to increase healthy lifestyle choices among the greater population. The insights of CAM users can help inform changes to the health care system that assist in accomplishing the ACA's goals of increasing access to primary care, reducing and preventing chronic conditions, as well as controlling health and medical expenditures.

To add the understanding of this important issue, this study examines CAM users, specifically Reiki users in central Texas, and their approach to health. The Reiki users' health approach was the result of their life experiences regarding illness and health, along with their exposure to and growing knowledge of different medical and healing practices and philosophies. The Reiki users in this study largely had negative and frustrating experiences with biomedicine, which has generally left them disenchanted. In addition, the Reiki users' exposure to other healing practices and philosophies has ingrained the importance of approaching health holistically and taking responsibility for their own health. As this study describes, the Reiki users' disenchantment with biomedicine,

holistic health approach, and expectation of individual responsibility for has resulted in their utilization of medical modalities that reflect their personal medical paradigms more often than biomedicine to maintain their health.

BACKGROUND

Medical Pluralism to the Dominance of Biomedicine and Back Again

Prior to and during the 19th century, the US had a pluralistic medical system, meaning multiple medical systems were utilized and accepted. These include but not limited to, homeopathy, hydrotherapy, osteopathy, and chiropractic medicine (Baer 2001). During this time medical professionals lacked power in the form of wealth and status to promote any one system (Baer 2001, Ross 2012). As a result, multiple and often conflicting etiologies existed simultaneously (Baer 2001).

During the 19th century conventional medicine allied with sciences which resulted in the medical practice now known as biomedicine (Baer 2001). The affiliation between science and biomedicine presented biomedicine as superior to other medical practices as it was based on science and therefore apart from culture (Berliner 1984, Baer 2001, Ross 2012, Baer et al. 2013, Glasgow and Schrecker 2014). This perception of biomedicine as superior, as well as the development of capitalism in the US, promoted the dominance of biomedicine in this area (Baer 2001, Baer et al. 2013). Capitalism provided biomedical professionals and benefactors with the wealth and status needed to organize and promote biomedicine (Baer 2001). In addition, aspects of the medical paradigm of biomedicine has assisted in it being commodified (Baer et al. 2013).

The formation of the American Medical Association (AMA) and the publication of the Flexner Report in 1910 – an evaluation of medical schools in the US and Canada –

furthered the domination of biomedicine (Salmon 1984, Baer 2001). The AMA successfully promoted biomedicine as it brought together like-minded individuals and provided a structure that enabled financial and political power. Whereas, the Flexner Report served to unite the scientific medical community, including medical professionals and benefactors (Baer 2002). The formation of the AMA and the Flexner Report resulted in the standardization of medical education, which aligned medical schools in support of the ideals and interests of biomedicine including minimizing competition from practitioners deemed “less legitimate” (Berliner 1984). Practitioners that were targeted included alternative medicine practitioners and biomedical practitioners with informal or less prestigious medical educations (Baer 2001). Licensing and ostracization through prohibiting biomedical professionals from conferring with alternative medical practitioners, were also implemented by the AMA and Flexner Report to reduce competition (Baer 2001). By removing or reducing the competition from other practitioners the biomedical community acquire the capital of new patients.

Aspects of biomedicine’s medical paradigm made it highly adaptable to capitalism and commodification. Diseases and illnesses, for instance, are depoliticized by biomedicine’s monocausal etiology, reductionist and mechanical theory of body, and belief of mind-body dualism. Monocausal etiology is the belief that illnesses and diseases have a single cause (Baer 2001). Whereas the reductionist and mechanical theory of body is the conceptualization of the body as having individual parts which can be acted upon individually without affecting the other parts, much like a machine (Berliner 1984, Baer et al. 2013). Mind-body dualism is an extension of the reductionist theory of body in that the mind and the body are separate and do not influence each other (Berliner 1984).

These perceptions of health and the body are focused on the individual person or even a single part of an individual which disassociate social factors from disease and illness. Depoliticization of disease and illness reduces the likelihood of costly intervention at the social, political, and economic level to improve health by the government and those that benefit the most from capitalism (Meiwald 1997, Baer 2001, Baer et al. 2013). In the case of obesity, the government has placed responsibility solely on individuals as their health is reflective of their life-style choices and not social, political, or economic circumstances (LeBesco 2010). However, obese individual might not be able to make healthy life-style choices as they experience structural barriers including, limited access to healthy foods as result of food deserts and poverty. They may also have limited time and places to exercise due to long working hours or multiple jobs, raising children, and unsafe neighborhoods (LeBesco 2010). To address these factors, which are unquestionably contributing to obesity, would be costly to local and national government, therefore shifting responsibility to individuals removes the necessity for intervention at the social, economic, and political level.

While overall CAM use decreased after the publication of the Flexner Report, the dominance of biomedicine was incomplete. Some alternative medical systems were resilient, growing in popularity in the face of opposition. Chiropractic medicine and osteopathy, for instance, gained legitimacy through education, licensing, and money (Baer 2001). Both of these medical systems modified their medical curriculum to reflect those of biomedical schools, thus lessening the divergence between their medical paradigms and biomedicine's (Baer 2001). In addition, chiropractic medicine has since

gained legitimacy and acceptance through experimental studies that provide measurable results akin to biomedicine (Caplan 1984, Kelner and Wellman 1997).

Another reason CAMs continue to be used is because people pursue them. Upper and middle-class persons have and continue to utilize and financially support CAMs as a way to compensate for biomedicine's short comings, including ignoring social components of healing and disease, the use of invasive and sometime harmful procedures, and focus on diagnosis and cure instead of holistic healing (Berliner 1984, Baer 2001, Baer et al. 2013). The shortcomings of biomedicine, as well as disenchantment with the bureaucratic nature of biomedicine in the 1970s resulted in a dramatic increase in CAM use identified as the holistic health movement. This movement advocated back-to-nature mentalities, rejection of materialism and mainstream culture, dismissal of mind-body duality, wholeness of body and mind, and individual responsibility and active participation in health, among other things (Berliner 1984, Baer 2001).

Though the holistic health movement promoted a holistic health approach, it was severely limited as it did not strongly associate health with political, economic, or social factors (Baer 2005). The emphasis on mind, body and spirit connection, as well as individual responsibility for health minimized the recognition of social influence on health. In this way the holistic health movement depoliticized disease and illness of which was consistent with biomedical perspectives and practice (Baer 2001).

Prior to and during the holistic health movement biomedical professionals, including physicians and nurses, started adopting a holistic approach to health and healing (Baer 2004). The biomedical professionals that prescribed to the holistic health

philosophy organized to establish the American Holistic Medical Association (AHMA) in 1978 and the American Holistic Nurses' Association (AHNA) in 1981 (Baer 2004). The establishment of the AHMA and the AHNA represented the biomedical community's interest in CAMs, as well as an intention to explore holistic health approaches (Baer 2001).

As demonstrated by the names of these associations CAMs at this time were referred to as holistic medicine, but the term quickly changed to alternative medicines as the National Institutes of Health (NIH), established the Office of Alternative Medicine in 1992 (Baer 2004, 2005). The change from holistic to alternative medicine illustrates the relationship the NIH wanted to construct. Alternative medicine encompasses all non-biomedical medical systems and practices that are utilized exclusively, whereas holistic medicine suggests multiple medical approaches to address all aspects of health (Baer 2002, 2004).

The Office of Alternative Medicine was established for the purpose of legitimizing and disproving CAMs through evidence-based testing (Baer 2005). By 1999 the NIH's Office of Alternative Medicine was renamed the National Center for Complementary and Alternative Medicine (NCCAM) (Baer 2002, 2004, 2005), which was reflective of the increase in CAM use during the 1990s (Eisenberg et al. 1998). The evolution of terminology again demonstrates the relationship the government and large portions of the biomedical community wanted with CAMs. The addition of complementary to the title emphasizes the perception that CAM use is supplemental to biomedicine, the primary medical system, and is often sought when biomedicine proves ineffective (Baer 2001).

Biomedical and government interest in CAMs was also demonstrated in other ways besides the establishment of legitimizing associations and changes in language. Following the creation of the AHMA, AHNA, and the NCCAM there was an increase in number of biomedical and nursing schools that offered courses on CAMs and medical institutions that conducted research on CAM practices (Baer 2004). In addition, the NCCAM received more funding to conduct research on CAMs each year, rising from a couple million in 1993 to over 100 million in 2003 (Baer 2004). Regardless of the interest in CAMs by these associations and other institutes, the AMA has continued to caution consumers about CAMs and advocate for “the scientific evaluation of CAMs” (Baer 2004).

Yet, the interest in CAMs by the public and biomedical professionals increased and a new term, integrative medicine, has been introduced (Adler 2002). Integrative medicine is the notion that biomedicine and CAMs can be utilized together and equally in order to provide individualized and effective care. The premise is that the collaboration of multiple medical systems can meet the patients’ health needs and overcome the limitations of utilizing a single system (Adler 2002, Baer 2004, 2005). More and more, centers of integrative medicine are being established to meet the needs and wants of health care consumers (Baer 2004).

The involvement of biomedical professionals and government institutions with CAMs has been for some a pursuit of a more holistic approach to health, and to others a necessity to satisfy the upper-class patients and to minimize loss of patients to CAM practitioners (Baer 2005). Regardless of the reasoning, the government and biomedical community’s involvement with CAMs in the form of associations, research, and

terminology has subdued the holistic health movement, a progressive movement, into CAMs or integrative medicine, a professional entity (Baer 2005). Among numerous medical social scientists there is concern that biomedicine is co-opting alternative medicine (Baer 2004).

Health Care in the US: A Changing Landscape

Access to biomedicine in the US is based on the possession of health insurance, which has become predominantly employer-based private insurance (Sered and Fernandopulle 2005). During WWII employer-based private insurance was used as an incentive to attract employees and after the war the practice was continued. When employer-sponsored health insurance became the norm, the elderly and poor could not afford biomedical services or prescriptions which resulted in government welfare programs (Berliner 1984). The cost of health care was raised to cover the health expenses of the elderly and poor, which resulted in less people being able to afford health care and more people need to on government programs, culminating in a serious financial problem (Berliner 1984). Thus, the implementation of these government programs has initiated a cycle which has significantly contributed to the rising cost of health care. Also contributing to the US health care financial problem is the rise of chronic health conditions among Americans because they are expensive to treat and are most prevalent among individuals whose income is below the poverty line (Berliner 1984, Bodenheimer 2009).

Though employer-sponsored health insurance has been the norm for decades, only about 60% of individuals obtain their health insurance from their employer (Anderko et al. 2012). Furthermore, employer-sponsored health insurance has become increasingly

inappropriate as it has become unattainable for large portions of the population due to the changing landscape of employment and family structure (Sered and Fernandopulle 2005). Fewer individuals occupy long-term jobs and employers reduce hours to avoid paying for health insurance, among other things (Sered and Fernandopulle 2005).

The ACA was implemented in 2014. Its purpose was to address these issues by increasing access to primary care, thereby reducing and preventing chronic conditions among Americans, and addressing the rising cost of health care in the US (Thompson and Nichter 2015). To achieve health care reform, the ACA has put forth measures and plans including making health insurance plans accessible to individuals and small business (Cassidy 2013), constructing Accountable Care Organizations (ACOs) (Davis et al. 2011), and implementing workplace wellness programs.

To increase access to primary care, the ACA has modified the health insurance market place by making insurance plans accessible to individuals and small business that consist of a minimum package of services called the ‘essential health benefits’ (Cassidy 2013). Health insurance plans were selected by each state to serve as a benchmark for the services and coverage essential to health maintenance, treatment, and promotion (Cassidy 2013). However, increasing access to primary care places more stress on an already taxed system. The US health care system is experiencing a shortage of primary care physicians and professionals as more medical students are pursuing specialized medical professions (Bodenheimer et al. 2009, Goldstein 2013). One solution to the primary care crisis is to recruit specific CAM providers, like doctors of chiropractic care, acupuncturists, and doctors of osteopathy, to assist with providing primary health care (Davis et al. 2011, Goldstein 2013, Thompson and Nichter 2015). Evaluation of state benchmark insurances

by the Department of Health and Human Services (HHS) and the state of the primary health care practice will inform future insurance coverage and could lead to increased access and use of CAMs in the US (Cassidy 2013).

Other ways in which CAMs may be incorporated into the US health care system and insurance coverage is through the construction of Accountable Care Organizations (ACOs) and workplace wellness programs (Davis et al. 2011, Anderko et al. 2012). ACOs are endorsed by the ACA to improve population health, quality of care, and control spending and will likely shape the way health care insurances operate (Davis et al. 2011). Workplace wellness programs is another public health strategy that aspires to create a culture of health to reduce and prevent the prevalence of chronic conditions (Anderko et al. 2012). Workplace health is being targeted as the workforce is getting older and the presence of and likeliness of chronic conditions increases causing productivity loss (Anderko et al. 2012). Discussions about whether and how to incorporated CAMs into ACOs and workplace wellness programs is still being assessed. However, practitioner-bases CAMs supported by empirical evidence are being considered (Davis et al. 2011, Anderko et al. 2012, Thompson and Nichter 2015)

As mentioned before, specific CAMs could address the primary care crises that the US is experiencing but integrating CAMs into the US health care system could have the added benefit of decrease medical expenditures (Davis et al. 2011, Goldstein 2013, Thompson and Nichter 2015). CAMs have not increased in cost as biomedical services have, CAM services are generally cheaper, and the integration of CAMs into the health care system could increase communication among practitioners and physicians to reduce service duplication and provide effective care (Davis et al. 2011, Goldstein 2013).

However, individuals that utilize CAM services visit their CAM practitioners more often than their primary care physician (Eisenberg et al 1993, Thompson and Nichter 2015). This could be costly but it is also beneficial as these could be opportunities to reinforce the message of healthy life-style choices (Thompson and Nichter 2015).

Currently, the most widely spread CAM covered by insurance is chiropractic services, but other licensed practices have been included as well (Clement et al. 2006, Davis et al. 2013). Aetna, a major insurance company in the US, covers Chiropractic services, acupuncture, biofeedback, and electrical stimulation (Aetna 2001). All other CAMs are considered experimental and investigational as there is “inadequate evidence in the peer-reviewed published medical literature of their effectiveness” (Aetna 2001). The number of insurance companies and plans that cover CAMs is bound to increase as a result of the ACA’s non-discrimination provision (section 2706) which prevents the discrimination of “health care providers who is acting within the scope of that provider’s license or certification under applicable State law” by insurers (ACA 2012). However, CAMs that are covered by insurances are and will probably continue to be determined by the State (Thompson and Nitcher 2015).

To be accepted by the biomedical community and insurance companies CAMs are submitted to efficacy studies through randomized, double blind, placebo-controlled, clinical trials (RCTs) most of which are conducted by the NCCAM (Baer 2004). For most CAMs, double blind testing is difficult if not impossible, but dual-blindness has been implemented to accommodate CAM practices (Caspi et al. 2000). Dual blindness as a testing modality allows for the caregiver to be knowledgeable about the treatment, as opposed to blind as in double-blind testing, but the subject and an observer are blind or

unknowledgeable (Caspi et al. 2000). Though this method of testing allows for more CAMs to be tested, there are still issues with testing including difference in epidemiology, the inability to measure emotional, mental, and spiritual benefits, and this form of testing excludes self-care practices (Baer 2004, 2005).

In addition, research conducted on CAMs is biased in that the research institutions and associations are predominantly composed of biomedical professionals (Baer 2005) and have been biased toward “serving the interests of the dominant class in capitalistic society” (Singer 1992:401). The NCCAM director, for example, has been biomedical physician, and 11 out of 13 of the NCCAM-funded research centers are in biomedical institutions (Baer 2005). In addition, other CAMs or integrative health centers, organizations, committees, and NIH policy-making positions are most commonly directed by, composed of, or held by medical doctors (MDs) or biomedical affiliated individuals (Singer 1992, Baer 2005).

Despite the lack of evidence for most CAM practices and the skepticism or dismissal of CAMs by the biomedical community, CAMs have been commodified and are available on the free market economy as fee for service practices (Baer 2001, Thompson and Nitcher 2015). Though CAMs generally do not prescribe to monocausal etiologies or reductionist and mechanical theory of body, CAMs are compatible with capitalism as they emphasize individual responsibility (Baer 2001).

CAM Use and Users

Motivations identified in the literature for using CAM therapies include: health promotion and prevention, to treat a specific health condition, or some combination of both (Eisenberg et al. 1993, Astin 1998, Garrow and Egede 2006, Davis et al. 2011), to

help individuals gain control over their health (Sivén and Mishtal 2012), and to participate a medical system that reflect their health belief systems (Astin 1998, Sivé and Mishtal 2012). The participants from previous research shared an understanding that CAMs were better suited for and addressed health needs not undertaken by biomedicine including emotional, mental, spiritual, and physical health.

Though dissatisfaction with or distrust of biomedicine seems like a common motivation for CAM use as it was the catalyst for the holistic health movement (Baer 2001, 2002), previous studies have found that most CAM users utilize both biomedicine and CAMs (Astin 1998, Caspi et al. 2004, Eisenberg et al. 1991, 1998, 2001, Goldstein 2013). Though some CAM populations have expressed their dissatisfaction and distrust of biomedicine it is not a consistent motivation and maybe associated with temporal shifts (Eisenberg et al. 1998, Sivén and Mishtal 2012).

In addition to assessing motivations for using CAMs, numerous national surveys have been conducted to quantify and identify individuals that utilize CAM practices. However, these studies have produced conflicting results in terms of socio-demographic characteristics that are predictive of CAM use. The most consistent characteristics are higher incomes and education (Eisenberg et al. 1993, 1998, Astin 1998, Wooton and Sparber 2001, Garrow and Egede 2006, and Clarke et all 2015). Income has been considered an important characteristic of CAM users as participants have to pay for CAM services out of pocket, as they are not covered or are marginally covered by health insurance (Kelner and Wellman 1997, Eisenberg et al. 1993, Eisenberg et al. 1998). As for education one study proposed that correlations between education and CAM use is due to exposure to alternative medicine in college, with college educated individuals

having an inclination to self-educate, as well as being taught to question expert knowledge (Astin 1998).

As for other demographic characteristic, like age, gender, and health status there has been conflicting results. Race and ethnicity were not significant predictors in most of these studies, however, ethnic and low-income groups were consistently underrepresented (Adler 1999, Wootton and Sparber 2001, Eisenberg et al. 1998, Astin 1998). In other research, Wootton and Sparber state that they suspect that ethnic and low-income groups make up a large portion of the CAM user population (2001).

Populations that are often characterized as CAM users are typically lower social classes, racial and ethnic minorities, and women (Adler 1999, Baer 2001). These groups of people are often characterized as having limited access to biomedicine as a larger portion of these populations are uninsured. For this reason, CAM use has often been identified as a cultural strategy for marginal populations without access to biomedicine to maximize their health realizations as CAMs have historically been cheaper than biomedical services (Ross 2012, Salmon 1984).

Reiki

Reiki, a Japanese word, translates to universal energy (Ross 2012). Miles and True define Reiki as “a vibrational or subtle energy therapy most commonly facilitated by light touch, which is believed to balance the biofield and strengthen the body’s ability to heal itself” (2003:62). Biofield is the term for energy fields that, in Reiki, are proposed to surround and penetrate the body (Baldwin et al. 2013).

Reiki was created in Japan in the early 20th century by Mikao Usui, a practitioner of Buddhism (Miles and True 2002, Ross 2012). His intention was for Reiki to be a

practice of spiritual development, while any physical or emotional healing would be a byproduct (Miles and True 2003). One of Mikao Usui students, Chujiro Hayashi, later developed Reiki into a healing technique (Miles and True 2003). Reiki was brought to the US in 1937 by Mrs. Hawayo Takata, a first generation Japanese American, who went to Hayashi's clinic in Japan for health complaints and later became a student (Miles and True 2003).

Reiki generally utilizes light, non-manipulative touch to initiate energy transfer (Ross 2012, Miles and True 2003). A Reiki treatment usually includes placing the hands in twelve positions on the head and both sides of the torso (Ross 2012) in a process that lasts between 45 and 75 minutes (Miles and True 2003). There are different perceptions of where the energy comes from. Some believe that the energy comes from concrete concepts like sun exposure, breathing, drinking water, eating raw foods, and sleep (Ross 2012). Others conceptualize that the energy flows into the Reiki practitioner during treatment as needed from the universe or divine presence (Baldwin et al. 2013).

The treatment itself is highly individualized, whether it is used for self-care or practitioner based service. Energy is thought to be drawn through the practitioner by the recipient according to their needs, which results in hands being placed in different positions or held for varying times (Miles and True 2003).

Empirical evidence-based testing, required for legitimization by the biomedical community, necessitates the standardization of a Reiki session, meaning practitioners perform the same hand placements for the same amount of time on each recipient, which eliminates the individualized nature of Reiki (Engebretson and Wardell 2002). Presently, there are few studies on the efficacy and therapeutic effects of Reiki and those studies

provide conflicting or inconsistent results (vanderVaart et al. 2009). Reiki appears to be effective at reducing anxiety, stress, and perhaps even pain. It also has been found to increase relaxation, wellbeing, and mental clarity, and lower blood pressure (Miles and True 2003, Engebreston and Wardell 2002, Baldwin et al. 2013).

The lack of clinical evidence and the inability to produce measurable results through clinical studies has influenced perceptions of Reiki as less legitimate. Therefore, Reiki should be dismissed as illegitimate and opposed by biomedicine. However, it and other energy healing modalities have persisted in the US (Eisenberg 1998, vanderVaart et al. 2009, Baldwin 2013). This might be due in part to the fact that Reiki adheres to an individualist philosophy that makes it easily commodified and compatible with capitalism.

Reiki was selected for this study for a number of reasons. First and foremost as an energy healing modality, currently lacks legitimacy from the biomedical community, and is not likely to be covered by health insurance plans. However, the landscape of health care is changing with the implementation of the ACA and all approaches to health should be considered. Users practices deemed less legitimate, like Reiki, have perspectives, motivations, experiences, and health beliefs that are important to understand. Furthermore, Reiki has increased in popularity and use in hospital settings (Eisenberg 1998, vanderVaart et al. 2009, Baldwin 2013). In addition, Reiki is quite common and accessible in central Texas, as there are many practitioners, classes, and groups that can provide valuable insight into the shortcomings of the current biomedical health care system, how CAMs address these shortcomings, how these individuals integrate their use of multiple modalities and decide which modality to utilize, the health priorities of these

groups, and potential ways to increase healthy life style choices among the greater population. The insights of the Reiki users in central Texas could help inform changes to the health care system that assist in accomplishing the ACA's goal of reducing and preventing chronic diseases.

METHODS

Participants for this study were Reiki users living in central Texas, including Hays and Travis counties, between June and August 2015. Central Texas was chosen for this study because Reiki groups and practitioners are widely available. Central Texas includes urban and rural populations, as well as a diverse population in terms of socio-demographic factors such as age, ethnicity, and socio-economic status.

To be eligible for this study participants needed to have previously participated in Reiki. Specifically, this study accepted individuals that received Reiki treatments from a practitioner, used Reiki for self-care, participated in a Reiki circle/group, and/or identified themselves as a Reiki practitioner. Other eligibility requirements included that participants spoke English and were 18 years of age or older.

Recruitment for this study was achieved primarily through contacting Reiki practitioners via online resources, such as Facebook, business emails, and messaging through Yelp. Practitioners were informed about the study and asked for assistance by participating and/or sharing recruitment materials with their clients.

Data collection methods included interviews as well as direct and participant observation. Semi-structured interviews were utilized as the primary data collection method for this study. While interviews were most often held at coffee shops, a number of individuals were comfortable with interviews being held in their homes, and some of

interviews took place at the practitioners' place of business. Interview topics included, but were not limited to: Reiki experience, biomedicine experience, personal medical philosophy, and motivations for using Reiki. At the end of each interview, a short survey focusing on demographic characteristics of the informants was administered.

Direct observation and participant observation were used as secondary means of data collection. Five Reiki sessions were observed being performed, and the researcher received four Reiki sessions. The direct observations provided valuable first-hand knowledge of the procedure of a Reiki session and the participant observations provided personal insight into the experience described by others. Both of these methods aided in developing a deeper understanding of Reiki.

All data derived from these methods were evaluated through content analysis. Interviews were recorded and transcribed verbatim. Transcripts of interviews and field notes from observations were read through multiple times and then coded. Through the coding and re-coding process themes were uncovered that suitably represented Reiki users approach to health.

RESULTS

In all, 24 individuals participated in interviews. The majority of the participants were female (19 females, 5 males) and White (15 White, 9 non-White). The participants as a group were highly educated. All but one participant had completed some college and 18 participants had a Bachelors or Master's degree. All but 2 participants had health insurance. Almost all of the participants had some training in Reiki and were able to practice Reiki on themselves and others. Also, all of the participants utilized other CAM

therapies including but not limited to massage, acupuncture, chiropractics, nutrition, yoga, qi gong, and meditation. Details on the study population are reported in Table 1.

Table 1. Demographic Characteristics

Gender	
Male	5 (20.8%)
Female	19 (79.2%)
Age	
18-25	1 (4.2%)
26-35	6 (25%)
36-45	6 (25%)
46-55	7 (29.2%)
56+	4 (16.7%)
Race/Ethnicity	
White	15 (62.5%)
White/Minority	3 (12.5%)
Hispanic	3 (12.5%)
Other	3 (12.5%)
Education	
High school	1 (4.2%)
Some college	5 (20.8%)
BA/BS	9 (37.5%)
Graduate degree	9 (37.5%)
Income	
unknown	2 (8.3%)
<25,000	5 (20.8%)
25-50,000	9 (37.5%)
50-75,000	4 (16.7%)
75-100,000	4 (16.7%)

The participants' motivations and the catalysts for using Reiki were diverse, ranging from physical symptoms to emotional trauma to personal or spiritual growth. Reasons provided for continued use of Reiki are just as diverse and changed over time. Molly, a 45 year-old Reiki user explained during her interview:

When you start on the Reiki journey you think maybe you're motivated because you're ill, or because you're stressed, or you're sad, or, you know, there might be some motivating factor but when you really engage in the Reiki journey you realize that it is about so much more. It is about everything in your life and you realize that you're sad or sick or whatever

it is that motivated you in the first place has roots in all these other aspects that get healed and addressed while you're on the journey.

Though the participants in this study used Reiki in unique and individual ways, they expressed similar health care beliefs and approaches to health. The three health care beliefs that were expressed most readily and most often by the participants in this study were disenchantment with biomedicine, a holistic health approach, and individual responsibility for health.

Disenchantment with Biomedicine

Negative experiences with biomedicine, whether these were personal or testimonials from others, shaped the Reiki users' opinions about biomedicine and supported their reasoning for utilizing CAMs. Such experiences included ineffective treatment of chronic conditions, not being heard by biomedical professionals, and death or disablement of family members. A number of the experiences provided by Reiki users centered on illnesses or ailments in which biomedicine prescribed treatment based on the symptoms being expressed, without further investigation into what was causing the illness or ailment. This occurred with back pain, chronic conditions such as ear infections and rosacea, among other ailments. Morgan, a 30 year-old Reiki user, described her experience:

Basically I didn't have a period for two years and there was something obviously wrong. So I went to several doctors and they all just wanted to put me on birth control because they were like at least that will give you a period, but I was like there is a reason why. I was so determined to find that reason... Finally, I went to a nutritionist and did all kinds of things... I basically found out that I had an iron and vitamin D deficiency and that was the reason why I wasn't having my cycle. Once I fixed that I just had one. So this definitely shapes my opinion.

Morgan, as well as other Reiki users, were interested in understanding their bodies and what is causing them to be unhealthy. They found it frustrating that biomedicine seemed to only treat the symptoms of their ailments, while uninterested in discovering the root cause. These Reiki users believed that to be healthy, the root cause must be addressed. In this way, biomedicine does not correlate with the Reiki user's health beliefs, which has resulted in frustrating and negative experiences that has supported their decision to use CAMs.

In addition to biomedical professionals' tendency to treat symptoms and not causes, participants believed that biomedicine was ineffective because they perceived it to be reductionist and specialized. Most Reiki users in this study were frustrated with biomedicine's mechanical theory of body because it conflicted with their own notions of the body as a whole integrated system. The participants felt that biomedicine's reductionist beliefs were also manifested as specialization of biomedical professions and the resulting compartmentalization of treatment, knowledge, and the system. Leah, a 40 year-old Reiki practitioner, explains:

I think that western medicine has gotten very specialized and looking at the whole person, the whole body, and the whole picture is lacking, which makes it hard for them to figure out what is really going on and hard for them to help the patient, which makes the patient frustrated because you know, then it's like I don't know what is wrong with me and I keep going to doctor after doctor but nobody is like, it's like nobody is talking to each other. So the right hand doesn't know what the left hand is doing.

Leah, along with other Reiki users in this study, were frustrated with biomedicine's predisposition to reductionist beliefs and tendency to specialize health professions. These aspects of biomedicine's medical paradigm conflicted with the Reiki users' beliefs about the body. Specialization also resulted in experiences of reduced communication between

medical professions which resulted in ineffective or delayed care for these Reiki users. Therefore, Reiki users pursued CAMs to obtain the most effective care for them, as well as a system that reflects their own medical paradigm.

Other Reiki users expressed their frustration with biomedicine as they described their experiences in which biomedicine was actually causing or exacerbating their illnesses or resulted in the harm of others. Antibiotics, analgesics, and other pharmaceuticals are often cited as having caused health problems. These experiences also confirmed their belief that the root cause of illnesses and ailments needs to be addressed for true healing to occur. Hannah, a 41 year-old Reiki user, describes her experience, “So I had had long standing health problems [rosacea] and conventional medicine, doctors, are the ones that put me on antibiotics and that was actually what was causing the problem...those health issues are related to a gut dysbiosis, which is caused by the antibiotics killing off the healthy flora.” Here again, the participant expressed her experience with biomedicine’s lack of interest in understanding the patient’s body and the cause of the illness, and in this case exacerbated the participant’s illness. The Reiki users in this study believed that treating symptoms is not an effective way to achieve health and can have harmful side-effects, especially with biomedicine’s reliance on pharmaceuticals. These frustrating experiences shaped Reiki users approach to health and resulted in them seeking out CAMs.

The participants felt that biomedicine is prone to treat symptoms and cause harm because it is closely associated with capitalism. Brianna, a 58 year-old Reiki user explained, “It’s [biomedicine] very much into big business. Pharma is really into making money and there are more diseases than we have ever had before. There’s always

something on the market so there's a drug for it." The participants found it hard to believe that biomedicine would prescribe them the best treatment when biomedical professionals' treatments, perspectives, and knowledge are influenced by pharmaceutical companies eager to make a profit from people being sick. This distrust of the intentions of biomedical community shaped these Reiki users approach to health and often motivated them to seek out CAMs.

The participants' frustration with and distrust of biomedicine was apparent. However, when the participants in this study talked about biomedicine they recognized biomedicine as legitimate, and having value and purpose. Hannah, who's suffered at the hands of biomedical professionals, states, "I think that we are all here today and have a long life because of advancements in medicine like vaccines and there are medications that people need." Though the Reiki users in this study valued biomedicine, their disenchantment strongly influenced their individual decision-making processes about their health and wellbeing. Biomedicine was generally not the first medical system they utilized. In fact, the only time that biomedicine was expressed as being utilized first was for massive physical trauma, like a car accident, surgery, or illnesses that require antibiotics. Molly stated that "broken bones still require radiology and casts (laugh). Every once in a while you really need that high power antibiotic, you know, but when 18 out of 20 issues can be dealt with at home then we choose that option." Though, the Reiki users valued biomedicine they were more likely to utilize CAMs as they reflected their medical paradigms and had provided the most effective care for them.

The Reiki users in this study were disenchanted with biomedicine. When asked about biomedicine the participants reflect on their experiences with biomedicine and how

it failed them. Stating that biomedicine only treats symptoms, that it has even been harmful to them, and that it cannot be trusted because it is easily manipulated for capitalistic gain. Despite these poor experiences with biomedicine the participants did not exclusively use CAMs and affirmed that biomedicine has a purpose.

Holistic Approach to Health

Throughout the interviews, as shown in quotes from the previous section, the Reiki users expressed concern that biomedicine was not assessing and treating the whole body or whole person. The participants in this study believed that the body is a whole, integrated system, meaning that mental, emotional, physical, and spiritual health are equally important and interconnected. This is the premise for holistic health, which is contradictory to the reductionist and mechanical theory of body, as well as the medical belief of mind-body dualism that are at the core of biomedicine. Specifically, Reiki users believed that emotions can produce physical symptoms. Meredith, a 31 year-old Reiki user, explained:

I believe that a lot of your physical ailments stems from emotional issues... There have been studies about people who are chronically stressed out, their mitochondria is like messed up from stress. So obviously if you can heal yourself emotionally that it going to translate into your physical [health].

In addition to being concerned with emotional health issues manifesting themselves as physical symptoms, the participants in this study also expressed concern with external factors that can influence emotional or mental health. Physical trauma, for example, can cause detriment to emotional health. Molly gave a fictional but relatable example:

So while it is highly important to make sure that a severe break is attended to it's also necessary to apply stress relief measures and compassion and excellent nutrition to aid the body in recovery. You know, that broken leg may mean a loss of work, more financial burdens, loss of mobility, can

lead to feelings of loss of independence and reliance on somebody else. Those are all some pretty major emotional and spiritual things that should be addressed as well.

These beliefs about the body and health have influenced the participants' approach to health, contributed to their disenchantment with biomedicine, and resulted in the use of CAMs.

The Reiki users in this study acknowledged that all medical systems (i.e. biomedicine and CAMs) have limitations and there is not one complete system, meaning that one system or modality cannot address all aspects of health and that integrative medicine was the best practice. This is reflected by one participant's (Meredith) assertion that "you can't rely solely on one mode of anything". Therefore, multiple medical systems are needed to address all elements of health, to maximize health potential, and to achieve and maintain health. In pursuit of addressing all aspects of health, Reiki users practiced integrative medicine by utilizing multiple CAMs, including Reiki, as well as biomedicine.

As mentioned previously, the participants in this study used Reiki for a variety of different reasons and health concerns. Though Reiki is generally considered a modality for spiritual or emotional healing, a number of the participants in this study used Reiki for digestive issues, physical pain such as headaches and old injuries, allergies, kidney stones, and other physical health concerns. The participants also used Reiki treatments to manage and maintain their emotional and spiritual health including: stress, anxiety, heart break, depression, mental/emotional disorders, and personal growth. Though Reiki is used by the participants for physical, emotional, and spiritual health Reiki is not believed to be a complete modality. Haley, a 31 year old Reiki user stated, "Reiki is not a

complete system. Well, okay, I shouldn't say it so directly... [It's] just one slice of the pie, [it's] just one tiny fragment of a whole system that should be studied... So it's not an end all."

Reiki users in this study practiced and valued a holistic health approach. They believed that health was not only physical but mental, emotional, and spiritual, and that these factors are interconnected. These views reject the reductionist, mechanical, and mind-body duality beliefs promoted by biomedicine. The participants in this study believed that there is not one complete medical system and that to address all aspects of health they need to utilize multiple medical modalities and therapies. The Reiki users' recognition that all medical systems have limitations, but also value, has resulted in the conflicting attitudes towards biomedicine as expressed above.

Individual Responsibility

Almost all of the Reiki users in this study expressed the desire to be active participants in their health or detailed examples of when they were active participants. In order to determine the best care for themselves, the Reiki users needed to become educated in health matters. The participants used multiple resources including internet searches, consulting medical and health professionals, books, and health magazines and articles. Kelsey, a 28 year-old Reiki user, for example, recalled a number of the resources that she used as she started to take a more active role in her health to lose weight, resolve some skin issues, as well as to address her depression and anxiety.

Most of what I learned was self-research, where I found a magazine on yoga or went and talked to a lady in a health food store about what supplements to try. I was working out every day in various ways. I learned about meditative walks online and I was like "that's free I'll do that" you know. So anything that would come up, like the Reiki thing, she offered it for free and I was like "okay I'll try it". I found a book on acupressure. I

was like “cool for like 12 dollars I can read this book and try all these things” and that was totally worth it to me.

The resources available to the participants in this study contributed to their knowledge about health matters. Their research influenced and supported their decisions as an active participant in their health.

In addition to doing research, the majority of the Reiki users in this study expressed a willingness to try new health modalities and therapies. Hannah divulged that when she went to her first Reiki session she had not done any research: “I wasn’t seeking out anything else because I hadn’t read about it. I didn’t know what the possibilities were. I was just opening to, like open to whatever happen happened.” The experience of the health modality informs the participants about significant health benefits, if it reflected their medical paradigm, and if it addressed their individual health needs.

The Reiki users in this study believed that they were the best equipped to make decisions about their health because they are the only ones that can say what they are experiencing in their bodies. Reiki practitioners felt that it was important to listen to the body to decide what was needed. Brianna, for example asserted that: “You need to listen to your own body and what it needs. Like right now I feel like I need an adjustment so Reiki is not going to help me with that. I’m going to feel good [from Reiki] but an adjustment that is something separate and I will get it because I feel like I need that.” Listening to their bodies or engaging in self-reflection provided the Reiki users in this study with information about what action to take as well as giving them ownership and authority over both their body and health.

Some of the Reiki users expressed that Reiki had increased their awareness and ability to listen to their bodies. Morgan for example, describes how Reiki has increased

her awareness of her body: “I think it did make me more aware of my body and of sensations, of feelings, which makes sense because you’re focusing on that. Building that skill.” Reiki use was not only an example of the participants exhibiting control over their health, but it also has the potential to inform them about their bodies as it has in Morgan’s case.

The Reiki users in this study were very active in their quest for health. So much that the participants wanted to learn Reiki to practice on themselves and for others instead of relying on seeing a practitioner. Naomi, a 22 year-old Reiki user, stated that she wanted to learn Reiki because: “I want to be able to take action. It’s just more control, more ability, more skills on my part in my life time.” Leah had a similar sentiment:

If you know Reiki yourself and you can treat yourself, I feel like that is very empowering right, cause you have something you can do regardless of what anyone else says or you know can do for you. That you are kind of in more control of your own, you know, taking more control of your own health.

According to the Reiki belief system, everyone possesses the ability to practice Reiki and these individuals have taken full advantage of that by becoming Reiki practitioners.

Reiki was not the only CAM that these individuals learned to do for themselves. Some had learned about herbalism, qi gong, acupressure, massage, nutrition, meditation, along with other modalities and therapies. The participants in this study often stated that they had a tool box of skills for maintaining their health. Ways in which they were active participants in their health, not only in decision-making process of what they need to achieve and/or maintain health, but in that they are the practitioner, as Kelsey detailed in her interview:

So, now knowing Reiki and having that in my little tool box it’s like if I notice if something is getting off balanced a little bit, like a little bit of

pain or I'm getting frustrated or irritable or whatever. If I can remember to tap into it for just a few minutes even if it doesn't go all the way away it lessens the severity of whatever I am dealing with.

The Reiki users in this study are not only active participants in their health by becoming educated about health matters, but also by becoming practitioners of multiple modalities. The Reiki users can select the CAM from their tool box that they feel fits best to their health needs without consulting others.

The participants' belief in personal responsibility for their own health has motivated them to become educated in health matters, increase the number of medical systems/therapies that they can use on themselves, make decisions about which modalities to utilize, as well as to assume authority over their own health.

DISCUSSION

Central Texas Reiki Users Providing Insight to CAM Use for ACA Consideration

The ACA has three primary interrelated goals as a health care reform: increase access to primary care, reduce and prevent chronic conditions, and control health and medical expenditures (Thompson and Nitcher 2015). Current literature indicates that a possible solution to address these goals is to integrate specific licensed CAM practitioners, such as chiropractors and acupuncturists, into the US health care system (Davis et al. 2011, Thompson and Nitcher 2015). It is imperative that CAM practitioners recruited for primary care services are licensed and knowledgeable, but as for addressing the other two goals of the ACA, a larger adoption of CAM practices, specifically holistic and self-care practices like Reiki, should be considered, as the Reiki users' experiences and approach to health in this study suggest.

CAMs Addressing Chronic Conditions

A limitation of only integrating empirically proven CAMs, like chiropractic medicine, into biomedical care is that they, like biomedicine, focus primarily if not exclusively on physical health. However, not all chronic conditions are physical as the literature (Bodenheimer et al. 2009, Anderko et al. 2012) and the results from this study suggest. In fact, more holist CAMs, like Reiki, may be better suited to address emotional and mental health issues like stress, anxiety, and depression as the case of Kelsey suggests. She states that she taps into Reiki maintain balance. If she feel frustrated or irritable Reiki lessens the severity of the situation and makes it manageable.

The integration of CAMs into the US health care system may also have positive effects on health care behaviors. Ross states in her book, *The Anthropology of Alternative Medicine*, that alternative medicines can be utilized to reclaim authority over health (2012). The NCCAM has found that CAM users present more health-seeking behaviors, including seeking health promoting care and actions that alter personal behavior and environment to promote health, than individuals who don't use CAMs (Hawk et al. 2011). Patients with chronic conditions are more likely to improve their health if they are active participants in their health. Exposure to and education on CAMs in an integrated health care system could increase patient participation, as the experiences of Reiki users in this study suggests.

Many of the Reiki users in this study, like many Americans in general, valued their personal responsibility for health. Utilizing Reiki, however, furthered their control over their health. Morgan, for instance, described how Reiki had increased their awareness which promoted ownership and authority of their body and health. In addition, the Reiki users, like Leah, felt empowered that they could affect their own health after

learning Reiki. Incorporating other CAMs into the US health care system, and specifically self-care CAMs like Reiki, could further improve patient participation, personal responsibility, and health seeking behaviors.

CAMs Addressing Health Costs

One of the benefits of incorporating CAMs into the US health care system is that CAMs services have not increased in cost in the last 10 years and are generally cheaper than biomedical services (Hawk et al. 2011). As the Reiki users have inadvertently demonstrated, as they pursued greater responsibility over their health by learning a CAM that can be utilized for self-care, they has the added benefit of no longer needing to continue to pay for services. Therefore, providing self-care courses could improve health and reduce expenditures on practitioner and provider visits.

Another one of the benefits of integrating CAMs into the US health care system could be that it will reduce service duplication, meaning reducing number of visits to practitioners and physicians for the same health issue or condition. However, if most CAMs are not included in the integration, the system will remain fragmented as health care consumers will seek out CAMs on the free market economy. As is demonstrated by Morgan's experience of trying to determine why she wasn't having here period. She visited multiple doctors who could give her an explanation and ultimately resulted in her consulting a nutritionist.

Concern of Biomedicine Co-opting CAMs

The literature on the incorporation and integration of CAM into the US health care system has largely focused on the benefits of integration, reducing medical costs and increasing the number of primary care professionals, as well as the struggles of

integration, licensing, incorporating mixed etiologies, and efficacy testing (Bodenheimer et al. 2009, Hawk et al. 2011, Davis et al. 2011, Anderko et al. 2012, Goldstein 2013, Cassidy 2013). Assessing the literature on CAM integration as a result of the ACA through the lens of the Reiki users' approach to health has revealed some limitations and leaves the question of 'Would patients utilize CAM practitioners?' unanswered.

The existing literature suggests because the CAM practices being considered for integration, like Chiropractic care, already address primary health care, have longer and more personal appointments, and meet with patients more often than biomedical professionals that they would be idyllic primary care providers (Davis et al. 2011). However, the literature does not detail how the CAM practices and belief systems will likely change as a result of providing primary care services. This study's population disenchantment and distrust of biomedicine and the biomedical community could lead to skepticism of integration with biomedicine. In order for the CAMs that are integrated in the US health care system to be utilized by this population, they must maintain their holistic approach to health, individualistic philosophies, and promotion of personal responsibility and authority over health. Yet, there is concern among medical social scientists that biomedicine has been co-opting CAMs and stimulating conformity with the mono-causal and reductionist beliefs and practices of biomedicine (Baer 2004, Baer et al. 2013). As demonstrated by the Reiki users in this study, some people purposely seek medical systems that are congruent with their belief in holistic health. Changing this aspect of CAMs to make health care more biomedical-like including methods of health assessments, diagnosis, and treatment. Specifically, the Reiki users in this study were frustrated by the tendency for biomedical professionals to only treat symptoms and not

cause of their ailments, that biomedical treatments have been harmful to them, and that the biomedical community cannot be trusted because it is easily manipulated for capitalistic gain.

Previous Research on CAMs

Though previous research on CAMs conduct in the 1990s found that CAM users were not dissatisfied or distrustful of biomedicine (Eisenberg et al. 1993, 1998, 2001, Astin 1998), more recent research has challenged these findings. In fact a recent study on yoga and CAM use in Florida found nearly identical results to this study (Sivé and Mishtal 2012). Sivé and Mishtal found that CAM users were disenchanting with biomedicine's tendency to treat symptoms, overprescribe medications, and inclination to be iatrogenic (2012). Additionally, CAM users were concerned with the for-profit health care system in the US. They felt that it resulted in less effective care for individuals (Sivé and Mishtal 2012). The results of Sivé and Mishtal's research are consistent with this study's findings. The Reiki users in this study shared frustrating and disappointing experiences with biomedicine, which has influenced their opinion of it and resulted in them seeking out CAMs.

Difference between previous and Sivé and Mishtal as well as this one in terms of perspectives of biomedicine could be influenced by temporal changes, research methodology bias, perceived cultural expectations of the participants, and participant's experiences conflicting with their own medical paradigm. In this study, for instance, disenchantment with biomedicine was simultaneously expressed with acceptance of biomedicine as a valued and functional component of a wider medical system which is consistent with their holistic health beliefs. Believing that biomedicine had value and/or a

purpose might explain why previous research has determined that CAMs are not disenchanted with biomedicine and that most often CAMs are utilized as complementary, not as an alternative, to biomedicine (Astin 1998, Eisenberg 2001).

Strangely enough, in this study the Reiki users' holistic health beliefs legitimized biomedicine but it is also instigated their disenchantment with biomedicine, as the medical paradigm is not consistent with their holistic health approach. Previous research found that having a holistic health philosophy was a significant predictor for CAM use (Astin 1998, Sivé and Mishtal 2012). The participants from previous research shared an understanding that CAMs were better suited for and addressed health needs not undertaken by biomedicine including emotional, mental, spiritual, and physical health. The presence of holistic health philosophy could suggest a cultural shift in understanding health (Astin 1998), which could have a great impact on how health and medicine is approached and purchased in the future.

Previous research has identified income as a predictor of CAM use because participants have to pay for CAM services out of pocket, as they are not covered or are marginally covered by health insurance (Kelner and Wellman 1997, Sirois and Gick 2002, Eisenberg et al. 1993, Eisenberg et al. 1998). While, the majority of the Reiki users in this study indicated that they had lower incomes than previous research had indicated for CAM users, they seemingly have adequate income to pursue CAMs for health matters and in some instances experimentally as a way to educate themselves. However, learning to practice Reiki and other CAMs has the added benefit of no longer needing to continue to pay for services. Therefore, having the tools to improve health can have financial gains.

Previous research has identified that having chronic health conditions, poorer health, and/or multiple health issues are predictive of CAM use (Kelner and Wellman 1997, Sirois and Gick 2002). However, less than a third of the individuals in this study reported that they had a chronic health condition suggesting the majority of this population utilize CAMs for health management, prevention, health promotion, and/or for short-term health issues. This is consistent with Hawk et al. findings that large portion of the study population used CAMs for preventions and health promotion and not for treatment (Hawk et al. 2011).

CONCLUSION

The Reiki users in this study expressed and demonstrated that their approach to health was influenced by their disenchantment with biomedicine, holistic health philosophies, and individual responsibility for health. The health approach of the Reiki users was used to assess current literature on incorporating specific licensed CAM practitioners into US primary health care. This research advocates for a larger adoption of CAM practices by the US health care system and specifically self-care practices to improve health, reduce and prevent chronic conditions, and to control health and medical expenditures. This research also caution against the biomedical community co-opting integrated CAM practices. These finds, along with future research on CAM users and non-CAM users' acceptance and concerns with CAM primary care providers, can help inform future health care reforms.

III. APPLIED COMPONENT

In order to make the most of the narratives of the participants of this research and to bring awareness to the changing landscape of health care, this project has an applied component. Many of the participants detailed the benefits and their experiences of being able to perform Reiki and other self-care CAMs. Which by itself is worth sharing with others, but with the changes and deliberations currently being conducted more discussion needs to be stimulated. The ACA and subsequent health reforms have the potential to change the face of medicine, but the public needs to be aware of the opportunities they have to express their health care desires and effect change. The article will be submitted to local newspapers for publishing. It is also included as Appendix A.

APPENDIX SECTION

A: ARTICLE

APPENDIX A: ARTICLE
THE CHANGING LANDSCAPE OF HEALTH CARE: CONSIDERING CAMS FOR
PRIMARY HEALTH CARE

The ACA could increase the accessibility and use of complementary and alternative medicines (CAMs). The US health care system is in crisis, financially and structurally. The rate of expensive chronic health conditions is rising and there is a shortage of primary health care professionals. As a response to this crisis the US government has implemented the Affordable Care Act. The ACA has three interrelated goals: to increase access to primary care, reduce and prevent chronic conditions, and to control health and medical expenditures. Though increasing access to primary care will help improve population health the, current system, as a result of the shortage of primary care professionals, cannot be sustained. One possible solution is to recruit licensed CAM practitioners, like chiropractors and acupuncturist, to provide primary care services. In addition, utilizing CAM practitioners for primary care could reduce health and medical expenditures as CAMs are generally cheaper than biomedical services.

I argue, based on my research with Reiki users in central Texas, that more CAM services, and specifically self-care practices, should be integrated into the US health care as a way to promote health, reduce medical expenses, and empower individuals to assume authority over their health.

Reiki is an energy healing modality that is largely known for spiritual or emotional healing. However, the Reiki users in central Texas used Reiki for a variety of different reasons and health concerns including: digestive issues, physical pain such as headaches and old injuries, allergies, kidney stones, and other physical health concerns.

The participants also used Reiki treatments to manage and maintain their emotional and spiritual health including: stress, anxiety, heart break, depression, mental/emotional disorders, and personal growth. It is clear that there are many benefits of Reiki, and can assist in managing and promoting health.

The Reiki users studied didn't just receive Reiki though. They learned Reiki as a way to take control over their health, as they no longer had to rely on a practitioner to treat them. Leah described her experience, "If you know Reiki yourself and you can treat yourself, I feel like that is very empowering right, cause you have something you can do regardless of what anyone else says or you know can do it for you. That you are kind of in more control of your own... taking more control of your own health". According to the Reiki belief system, everyone possesses the ability to practice Reiki and the Reiki users in central Texas have taken full advantage of that by becoming Reiki practitioners.

Reiki was not the only CAM that these individuals learned to do for themselves and the Reiki users often stated that they had a tool box of skills for maintaining their health. Ways in which they were active participants in their health, not only in decision-making process of what they need to achieve and/or maintain health, but in that they are the practitioner.

As illustrated by these Reiki users, learning self-care CAMs can increase authority and responsibility over health. These are essential characteristics of an active participant in health care. Active participants assume authority over their health which requires them to be educated on health matters to make educated decisions on their health. As oppose to passive participants which largely follow biomedical professionals'

assessments and treatments unquestioned. Active participants in health have better health outcomes.

In addition to promoting health and increasing personal responsibility for health, learning self-care CAMs has a financial benefit. As the Reiki users have demonstrated learning a CAM that can be utilized for self-care has the added benefit of no longer needing to continue to pay for services. Therefore, providing self-care courses could improve health and reduce expenditures on practitioner and provider visits.

Though integrating self-care CAMs will not assist in solving the primary care shortage, they can improve health, increase responsibility and authority over health, and reduce health and medical expenditures by eliminating the need for a practitioner, but also by improving health and reducing doctor visits. Based on these benefits self-care CAMs should be considered for integration into the US health care system and insurance coverage.

REFERENCES

- Aetna
2001 Complementary and Alternative Medicine. Electronic document, http://www.aetna.com/cpb/medical/data/300_399/0388.html, accessed July 10, 2016.
- Adler, Shelley R.
2002 Integrative Medicine and Culture: Toward an Anthropology of CAM. *Medical Anthropology Quarterly* 16(4):412-414.
- Adler, Shelley R.
1999 Complementary and Alternative Medicine use among Women with Breast Cancer. *Medical Anthropology Quarterly* 13(2):214-222.
- American Chiropractic Association
2012 Supreme Court Upholds Health Reform Law. Electronic document, <http://www.acatoday.org/News-Publications/News/News-Releases/Supreme-Court-Upholds-Health-Reform-Law>, accessed July 9, 2016.
- American Chiropractic Association
2010 House Passes Health Care Reform Bill. Electronic document, <http://www.acatoday.org/News-Publications/News/News-Releases/House-Passes-Health-Care-Reform-Bill>, accessed July 9, 2016.
- American Chiropractic Association
2010 NACA Applauds Non-Discrimination in Health Care Reform. Electronic document, <http://www.acatoday.org/News-Publications/News/News-Releases/NACA-Applaud-Non-Discrimination-in-Health-Care-Reform>, accessed July 9, 2016.
- Anderko, Laura, Jason S. Roffenbender, Ron Z. Goetzl, John Howard, Francois Millard, Kevin Wildenhaus, Charles Desantis, and William Novelli
2012 Promoting Prevention through the Affordable Care Act: Workplace Wellness. *Preventing Chronic Disease* 9:E175-E175.
- Astin, JA
1998 Why Patients use Alternative Medicine - Results of a National Study. *Jama-Journal of the American Medical Association* 279(19):1548-1553.
- Baer, Hans
2004 *Toward an Integrative Medicine: Merging Alternative Therapies with Biomedicine*. Walnut Creek, California: AltaMira Press.

- Baer, Hans A.
2001 *Biomedicine and Alternative Healing Systems in America: Issues of Class, Race, Ethnicity, and Gender*. Madison, Wisconsin: The University of Wisconsin Press.
- Baer, Hans, Merrill Singer, and Ida Susser
2013 *Biomedical Hegemony in the Context of Medical Pluralism*. In *Medical Anthropology and the World System Critical Perspectives*. Pp. 359. Santa Barbara, California: Praeger.
- BAER, HANS A.
2005 *Social Scientific and Historical Studies of Complementary and Alternative Medicine in Anglophone Countries: A Multi-Book Review; Orthodox and Alternative Medicine: Politics, Professionalization and Health Care; A Diagnosis for our Times: Alternative Health from Lifeworld to Politics; Borderland Practices: Regulating Alternative Therapies in New Zealand; the Politics of Healing: Histories of Alternative Medicine in Twentieth-Century North America; Mainstreaming Complementary and Alternative Medicine: Studies in Social Context*. *Medical Anthropology Quarterly* 19(3):350-356.
- Baer, Hans A.
2005 *Trends in Religious Healing and the Integration of Biomedicine and Complementary and Alternative Medicine in the United States and Around the Globe: A Review*. *Medical Anthropology Quarterly* 19(4):437-442.
- Baer, Hans A.
2002 *The Growing Interest of Biomedicine in Complementary and Alternative Medicine: A Critical Perspective*. *Medical Anthropology Quarterly* 16(4):403-405.
- Baldwin, Ann Linda, Kirstin Fullmer, and Gary E. Schwartz
2013 *Comparison of Physical Therapy with Energy Healing for Improving Range of Motion in Subjects with Restricted Shoulder Mobility*. Hindawi Publishing Corporation: *Evidence-Based Complementary and Alternative Medicine*:1-9.
- Caplan, Ronald Lee
1984 *Chiropractic*. In *Alternative Medicines Popular and Policy Perspectives*. Warren J. Salmon, ed. Pp. 80. New York, NY: Tavistock Publications.
- Caspi, O., M. Koithan, and MW Criddle
2004 *Alternative Medicine Or "Alternative" Patients: A Qualitative Study of Patient-Oriented Decision-Making Processes with Respect to Complementary and Alternative Medicine*. *Medical Decision Making* 24(1):64-79.

- Caspi, O., C. Millen, and L. Sechrest
 2000 Integrity and Research: Introducing the Concept of Dual Blindness. How Blind are Double-Blind Clinical Trials in Alternative Medicine? *Journal of Alternative and Complementary Medicine* (New York, N.Y.) 6(6):493-498.
- Cassidy, Amanda
 2013 Health Policy Brief: Essential Health Benefits. Electronic document, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=68, accessed July/9, 2016.
- Davis, Matthew A., Alan N. West, William B. Weeks, and Brenda E. Sirovich
 2011 Health Behaviors and Utilization among Users of Complementary and Alternative Medicine for Treatment Versus Health Promotion. *Health Services Research* 46(5):1402-1416.
- Davis, Matthew A., James M. Whedon, and William B. Weeks
 2011 Complementary and Alternative Medicine Practitioners and Accountable Care Organizations: The Train is Leaving the Station. *Journal of Alternative & Complementary Medicine* 17(8):669-674 6p.
- Eisenberg, D. M., R. C. Kessler, C. Foster, F. E. Norlock, D. R. Calkins, and T. L. Delbanco
 1993 Unconventional Medicine in the United States. Prevalence, Costs, and Patterns of use. *The New England Journal of Medicine* 328(4):246-252.
- Eisenberg, DM, RB Davis, SL Ettner, S. Appel, S. Wilkey, M. van Rompay, and RC Kessler
 1998 Trends in Alternative Medicine use in the United States, 1990-1997 - Results of a Follow-Up National Survey. *Jama-Journal of the American Medical Association* 280(18):1569-1575.
- Eisenberg, DM, RC Kessler, MI Van Rompay, TJ Kaptchuk, SA Wilkey, S. Appel, and RB Davis
 2001 Perceptions about Complementary Therapies Relative to Conventional Therapies among Adults Who use both: Results from a National Survey. *Annals of Internal Medicine* 135(5):344-351.
- Engebretson, J., and D. W. Wardell
 2002 Experience of a Reiki Session. *Alternative Therapies in Health & Medicine* 8(2):48-53.
- Garrett, Catherine
 2001 Transcendental Meditation, Reiki and Yoga: Suffering, Ritual and Self-Transformation. *Journal of Contemporary Religion* 16(3):329-342.

- Garrow, D., and L. E. Egede
2006 National Patterns and Correlates of Complementary and Alternative Medicine use in Adults with Diabetes. *Journal of Alternative & Complementary Medicine* 12(9):895-902.
- Glasgow, Sara, and Ted Schrecker
2016 The Double Burden of Neoliberalism? Noncommunicable Disease Policies and the Global Political Economy of Risk. *Health & Place* 39:204-211.
- Goldstein, M. S.
2013 A Timely Opportunity: Fostering New Roles for Complementary and Alternative Health Care Providers in Meeting the Nation's Need for Primary Health Care. *Explore-the Journal of Science and Healing* 9(6):344-347.
- Hawk, C., H. Ndetan, and M. W. Evans J.
2012 Potential Role of Complementary and Alternative Health Care Providers in Chronic Disease Prevention and Health Promotion: An Analysis of National Health Interview Survey Data. *Preventive Medicine* 54(1):18-22.
- Kelner, Merrijoy, and Beverly Wellman
1997 Health Care and Consumer Choice: Medical and Alternative Therapies. *Social Science & Medicine* 45(2):203-212.
- LeBesco, Kathleen
2011 Neoliberalism, Public Health, and the Moral Perils of Fatness. *Critical Public Health* 21(2):153-164.
- Miewald, CE
1997 Is Awareness enough? The Contradictions of Self-Care in a Chronic Disease Clinic. *Human Organization* 56(3):353-363.
- Miles, Pamela, and Gala True
2003 Reiki--Review of a Biofield Therapy History, Theory, Practice, and Research. *Alternative Therapies in Health and Medicine* 9(2):62-72.
- Ross, Anamaria Iosif
2012 *The Anthropology of Alternative Medicine*. New York, NY: Bloomsbury Academic.
- Salmon, Warren J.
1984 Introduction. *In Alternative Medicines Popular and Policy Perspectives*. Warren J. Salmon, ed. Pp. 1. New York, NY: Tavistock Publications.
- Sered, Susan and Fernandopulle, Rushika
2005 *Uninsured in America: Life and Death in the Land of Opportunity*. Berkeley and Los Angeles, California: University of California Press.

- Singer, Merrill
1992 Biomedicine and the Political Economy of Science. *Medical Anthropology Quarterly* 6(4):400-404.
- Sivén, Jacqueline Marie, and Joanna Mishtal
2012 Yoga as Entrée to Complementary and Alternative Medicine and Medically Pluralistic Practices. *Human Organization* 71(4):348-357.
- Thompson, Jennifer Jo, and Mark Nichter
2016 Is there a Role for Complementary and Alternative Medicine in Preventive and Promotive Health? An Anthropological Assessment in the Context of U.S. Health Reform. *Medical Anthropology Quarterly* 30(1):80-99.
- vanderVaart, S., VMG Gijzen, SN de Wildt, and G. Koren
2009 A Systematic Review of the Therapeutic Effects of Reiki. *Journal of Alternative & Complementary Medicine* 15(11):1157-1169.
- Wootton, JC, and A. Sparber
2001 Surveys of Complementary and Alternative Medicine: Part I. General Trends and Demographic Groups. *Journal of Alternative and Complementary Medicine* 7(2):195-208.