

Extended Perception Corroboration: A Pilot Study with Energy Medicine
Practitioners

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Abstract

Reiki is a type of energy medicine with growing evidence for its benefit for various conditions and populations. The “energy” in energy medicine implies a life force rather than a conventional physics definition, and many people feel they can perceive this energy through extended perception beyond their traditional five senses. This study evaluated extended perception during Reiki energy medicine sessions. Six expert Reiki Masters gave 30-minute sessions to 40 participants. Participants had one or more of the following conditions: acute physical injury (such as broken bone), mental impairment (memory issues), and psychological symptoms (anxiety and/or depression). Six people vetted for extended visual perception made observations before, during, and after sessions using quantitative and qualitative measures. Participants and Reiki Masters also recorded their observations. Data were analyzed for corroboration: 1) within-perceivers, 2) between the Reiki Master and perceivers, 3) between the participant and Reiki Master, and 4) between the participant and perceivers. Participants’ well-being outcomes and potential predictors were also evaluated. Well-being improved after the sessions ($F(3,159) = 12.3$, $p < 0.00005$; Baseline - 55.7 ± 18.8 , Before - 58.9 ± 18.1 , After - 73.2 ± 16.2 , One-week later - 64.3 ± 20.3 ; effect size is 0.61, 95% confidence interval [0.39 to 0.59]). The perceivers generally reported similar information in free-form drawings and free text. Perceivers’ observations about the participants’ health were highly corroborated and matched participants’ self-report. No predictors revealed themselves, supporting the tradition that Reiki applies to anyone regardless of health condition. Furthermore, the symbols perceivers noted were meaningful to the participants, but perceivers did not see the same symbols nor ascribe the same meaning to them that the participants did. Future studies are needed to refine the methods developed here to continue the exploration of extended perception, its validity, and practical application in healthcare.

Introduction

In energy medicine, the word “energy” does not refer to energy as physicists commonly use it, but rather to a felt sense that therapists describe as energetic-like, magnetic-like, or tingling-like sensations in or around the body. Experimental and anecdotal reports demonstrate that physical measures correlate with these feelings, e.g., electromagnetic and magnetic fields [1,2], mechanical vibrations [3], and other less conventional approaches [4]. However, there is currently no reliable detection method to assess when the presumed energy is present.

Reiki is one such energy medicine technique that originated in Japan and is based on the principle that the therapist can channel energy into the patient, activating the natural healing processes of the patient’s body and restoring physical and emotional well-being [5]. The word Reiki is understood to mean “universally guided” or “spiritual life energy” and consists of two Japanese characters, *rei*, meaning “spiritual” or “hidden force,” and *ki* or “life energy” [6]. Reiki practitioners learn that they are not healing their patients but that this universal life energy flows through them to rebalance a recipient’s energy. Thus, it is understood within the Reiki tradition that Reiki can be applied to anyone for any condition.

Reiki has been instituted into various health care settings [6]. Multiple studies have demonstrated positive outcomes from Reiki in various conditions and populations. For example, one Reiki systematic review found significant pain outcome improvements in 9 out of the 12

randomized controlled trials included [7]. Another systematic review and meta-analysis of Reiki studies, which included four randomized controlled trials of Reiki on pain (two distant and two close distance), found a significant improvement by one point on the Visual Analog Scale of Pain Symptoms [8]. Reiki's most recent review found support for Reiki's usefulness in relieving pain, decreasing anxiety, depression, and improving quality of life [9].

We conducted a large pilot study evaluating the efficacy of energy medicine sessions to reduce hand and wrist pain. Subjective pain scores were significantly improved immediately after the sessions and remained improved three weeks later [10]. This large pilot study's improvements in pain outcomes add to the evidence base for energy medicine's clinical efficacy.

The pilot study also included an observer with extended perception skills who observed all the sessions [11]. Extended perception is the ability to perceive information beyond our traditional five senses and is present throughout humanity's recorded history [12]. Despite our lack of understanding of how extended perception might work, its veracity is demonstrated in many practical applications like predicting stock market movements [13,14], discovering archaeological sites [15], and most relevant to this study, medical diagnosis [16–19]. Qualitative thematic analysis of the perceiver's extensive observational notes during this pilot study identified six major themes [11]: "Experience of the Practitioner," "Experience of the Participant," "Space and Other Beings" (referring to the qualities of the physical space the energy medicine session occurred in, and ostensible non-physical beings present during session), "Participant-Practitioner Relationship," "Healing Process," and "Attributes of Energy." Also, from the perceiver's perspective, the practitioners individualized the sessions according to the participant's needs. One limitation of this study was that only one perceiver observed the sessions; it was impossible to tell whether their observations were purely subjective influenced by their mental filters or if some aspect of the observations could be objectively measured. Additional studies were needed to build upon these results and explore the validation of extended perception.

Thus, the goal of this exploratory study was to further this line of research by collecting more data on Reiki efficacy and extended perception. Six Reiki Masters with extensive experience gave 30-minute sessions to 40 participants. Six people vetted for extended visual perception made observations before, during, and after each session using quantitative and qualitative measurement tools. The Reiki Masters and participants also completed qualitative and quantitative measures. These data were analyzed in an exploratory fashion to answer the following research questions:

1. Do different perceivers perceive in the same way?
2. What is the degree of corroboration between each experiencer's perceptions?
3. Can perceivers accurately perceive the participant's health state before the session?
4. Does the participants' well-being improve from the session, and what, if any, variables predict those improvements?
5. What is the degree of corroboration between the symbols the perceivers noted and the meaning, if any, the participants ascribe to them?

The hypothesis, measures, and analyses details for each of these questions are included in the Methods section.

Materials and Methods

Study summary

A prospective uncontrolled study was conducted to answer the five questions noted above. Six Reiki Masters (RMs) with extensive experience gave 30-minute sessions to 40 participants. Participants had ailments related to one or more of the following categories: acute physical (injury such as broken bone), mental (memory impairment), and psychological (anxiety and/or depression). Six perceivers who claim to perceive energy made quantitative and qualitative observations before, during, and after each session. Participants and RMs also recorded their session observations. The Institute of Noetic Sciences (IONS) Institutional Review Board (IORG#0003743) approved all study activities. Before any data collection began, the study was pre-registered at the Open Science Forum [20]. The study was registered at the ISRCTN registry (ISRCTN16257705) after the study was completed because the journal's peer-review process specifically required a clinical trial registry that the Open Science Forum pre-registration did not meet. The authors confirm that all ongoing and related trials for this study are registered.

Recruitment

Participants

Forty local participants were recruited using multiple methods such as IONS membership and network, NextDoor, Craigslist, and Facebook from June 22, 2021, to August 5, 2021. Inclusion/exclusion criteria were as follows: 1) be an adult aged 18 years or older, 2) have no signs of COVID-19, 3) be comfortable receiving an energy medicine session at the study site, 4) be willing to complete all study activities, and 5) have one or more of the following conditions: current physical injury (e.g., recent sprain, strain, or broken bone) as assessed by self-report; current memory issues as assessed with a score of less than 15 on the Inoue Computerized Test Battery [20]; current anxiety as assessed with a score between 5 and 15 on the Generalized Anxiety Disorder-7 [21]; current depressive symptoms as assessed with a score between 16 and 25 on the CESD-5 [22]. Participants received \$100 for completing all study activities.

Reiki Masters

Five RMs were recruited through the IONS network, the International Center for Reiki Training, and the Center for Reiki Research. RMs had at least ten years of regular experience conducting Reiki sessions, with Reiki as their primary modality. RMs received \$1000 for the sessions and were reimbursed travel expenses if applicable. The perceivers were uncomfortable with one RMs treatments, and a sixth RM was recruited as a replacement. The RMs were five females and one male, 57.5 ± 7.6 years of age with 20.2 ± 3.4 years of education, and all but one identified as European, who identified as Middle Eastern. RMs had an average of 17.7 ± 4.7 years of experience (range 15 - 26), having conducted approximately 2333.3 ± 2137.0 sessions (range 500 - 5000). The RMs attended an orientation session prior to the study's onset to review the logistics and flow of the study, the forms they would complete, and the expectations of their role.

Perceivers

Six perceivers were recruited through the IONS network. Inclusion/exclusion criteria for perceivers were: 1) extensive professional experience providing client sessions, 2) could observe external phenomena associated with energy medicine treatments, such as colors, movement, and light, rather than perceive internal visual impressions, 3) be willing and able to stay neutral during the session (i.e., not influence the session through their potential healing abilities), 4) observe the sessions with their eyes open or closed. Perceivers were compensated \$4000 for their services and their accommodation and travel expenses paid. Twenty-nine referred perceivers were contacted. Four did not respond, and nine declined for scheduling or other reasons. Fourteen interviews were conducted. Six perceivers were selected with the following characteristics: female, 53.3 ± 14.6 years of age with 17.0 ± 3.0 years of education, and all but one identified as European, who identified as Asian. They had 13.2 ± 9.3 (range 2 - 25) years of extended perception experience and approximately client sessions (range 500 - 6,000). Two men were interviewed, but one declined participation, and the other was not skilled.

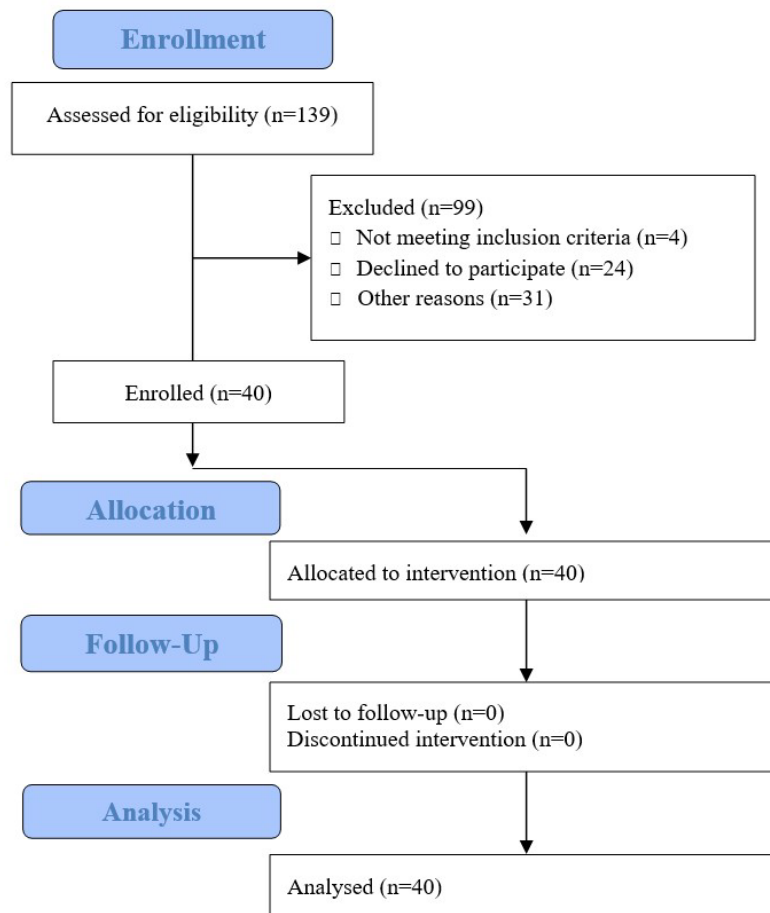
The perceivers had varied training, including the Master Certificate of Intuition Medicine from the Academy of Intuition Medicine, Barbara Brennan School, indigenous shamanic visioning skills, the Berkeley Psychic Institute, and innate abilities often starting from childhood. All perceivers endorsed seeing colors, other visual, energetic phenomena around people with their eyes open and closed. The perceivers attended an orientation session prior to the study's onset to review the logistics and flow of the study, measures they would complete, and reinforce the expectations for their role.

Study Procedures

Within 48 hours of their appointment time, participants received an email with links to complete via SurveyMonkey (www.SurveyMonkey.com) their consenting process and well-being measures (see Measures).

One hundred and seventy-four people responded to the recruitment ad between June 22, 2021, and July 21, 2021. One hundred fifty-six passed the screening criteria (English-speaker, adult, no COVID-19 symptoms, available during the study period, able to travel to the study site, willing to complete all study activities), and of those, 139 left their contact information. Scores for depression and anxiety symptoms, the memory test, and acute injury information were reviewed, and volunteers who fit the four groups were invited to participate. Volunteers were accepted on a first-come, first-serve basis until all 40 appointment slots were filled. Participants received their Reiki sessions between July 26, 2021, and August 6, 2021. The last follow-up survey was completed on August 17, 2021. Please see Figure 1 for the CONSORT flow diagram.

Figure 1. CONSORT Flow Diagram



The Reiki sessions took place in a conference room at the Hilton Hotel Sonoma Wine Country from July 26 to August 6, 2021. Perceivers were seated at six-foot conference tables arranged in a semi-circle around the room with two perceivers per table. They had adequate visibility of the treatment area approximately 10 feet away. The treatment area consisted of a reclining chair for the participant and a rolling chair for the RM. Four sessions were scheduled each day. Four RMs gave four 30-minute sessions for two days (8 total each), and two RMs gave four sessions on one day (4 total each).

Upon arrival, participants were guided to the treatment space, introduced to the RM and perceiver team, and seated upright in the reclining chair. They then completed the Credibility and Expectancy Scale [23] and the Review of Systems Symptom form (see Measures). After completing the forms, the RM helped the participant recline the chair, and the session began.

The RM administered the Reiki session as they usually would. The perceivers noted their observations during the session. After the session, the RM, participant, and perceivers completed post-session forms. After the participant left, the space was cleared before the new participant arrived. There were approximately 30 minutes between sessions to allow for post-session form completion, cleaning the space, and pre-session form completion of the next session.

The space was cleared between participants because of the common understanding among practitioners about residual energy being left in the environment from the Reiki session

process. Thus, all study staff (IONS staff, perceivers, and RMs) set the intention to clear the room after each session. In addition, study staff sprayed the room with Clean Sweep Spray (Energy Tools International, Oregon, USA).

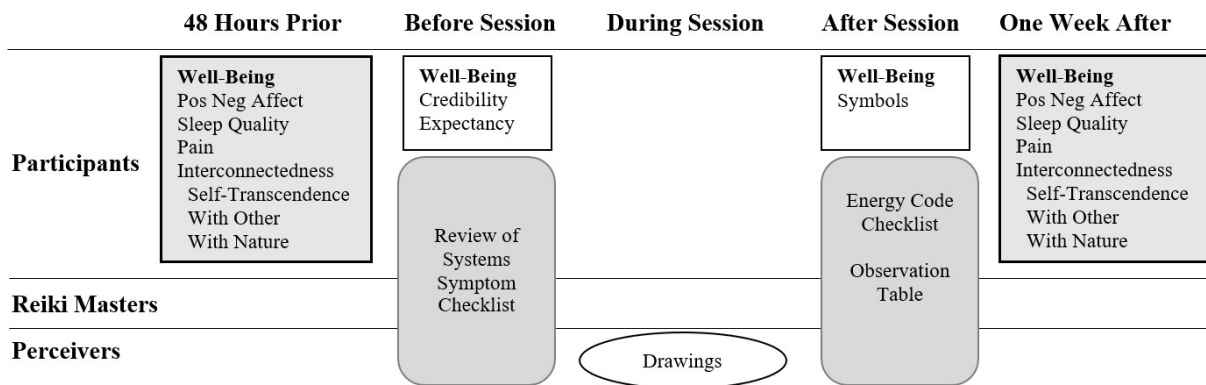
Study staff reviewed the drawing and observation table forms (see Measures) and extracted symbols the perceivers noted. These symbols were then emailed to the participants, “We hope you enjoyed your Reiki session. The observers mentioned these symbols for your session. {{symbols}} Are any of these symbols meaningful to you? Yes or No. If yes, which ones and what is their meaning to you?” This email also included after-care instructions for their Reiki session.

One week later, participants received a link to repeat the well-being measures online via SurveyMonkey.

Measures

Multiple measures were used for the study. The measures evaluating clinical outcomes are validated and widely used. The measures assessing extended perception were investigator developed as there are no instruments currently available for these purposes as far as we know. Supplemental Data includes blank versions of the investigator-developed measures. Figure 2 depicts the measures, timeline for their administration, and who completed them.

Figure 2. Measure schedule



Screening

For the acute injury screening, volunteers were asked, “Have you had an acute physical injury within the last four weeks (e.g., recent sprain, strain, fracture, or broken bone)?” If yes, they were also asked what part of the body they injured, the date of their injury, and if they had a supportive device they could remove.

Participants who endorsed current memory issues completed the Inoue Computerized Test Battery [20]. The battery includes a three-word memory test, a temporal orientation test, a three-dimensional visual-spatial perception test, and a delayed recall test completed in approximately 5 minutes. Each test item receives one point for a total of 15 maximum points possible. The battery can distinguish between people with dementia and control participants with maximum sensitivity and specificity values of 96% and 86% for the total score, respectively, with a cutoff point of 13 [20].

All participants completed the Generalized Anxiety Disorder-7 (GAD), a 7-item questionnaire that assesses current anxiety [21]. Respondents rated the frequency of their anxiety symptoms in the last two weeks on a Likert scale ranging from 0-3 (0 = not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day). The final GAD score is the sum of all item values.

All participants completed the Center for Epidemiologic Studies Depression Scale (CESD-5), a 5-item subset of the original 20-item scale. The raw score was multiplied by 4 for cutoff score criteria determination. The CESD-5 has demonstrated good sensitivity (>0.84), specificity (≥ 0.80), and high validity (>0.90) for identifying current depression symptoms by the full 20-item scale [24]. Total scores range from 0 - 60, where higher scores reflect greater depression symptoms [25].

The Credibility and Expectancy Scale measured the level of belief, or credibility, regarding the efficacy of energy medicine and their expectations that energy medicine would work for them [23]. In interventions like this, where placebo may play an important role, measuring credibility and expectancy is especially important [26]. The measurement uses a Likert scale ranging from 1 to 9, with higher scores representing higher credibility and expectancy.

Participant Outcomes

The Arizona Integrative Outcomes Scale (AIOS) was the primary outcome for well-being [27]. The AIOS is a single visual-analog self-rating scale that evaluates the overall subjective sense of well-being. Participants are asked, "Please reflect on your sense of well-being, taking into account your physical, mental, emotional, social, and spiritual condition over the past 24 hours. Please move the slider below to a point that summarizes your overall sense of well-being for the past 24 hours." The slider goes from 0 to 100, with 0 being anchored by "Worst you have ever been" and 100 by "Best you've ever been." The scale results in one value with larger values indicating greater well-being. The scale was valid in discriminating between patients and caregivers. Convergent and divergent validity was significant compared to the Global Health Index (0.38) and Global Severity Index (-0.41), negative affect (-0.41), and positive affect (0.56) of the Positive and Negative Affect Scale. The AIOS was administered within 48 hours of the session, immediately before the session, immediately after, and one week later.

Secondary outcome measures related to well-being were the Positive and Negative Affective Scale, Sleep Quality Scale, the Numeric Pain Rating Scale, Cloninger Transcendence subscale, Interconnectedness with Self, and Interconnectedness with Other. The participants completed these measures within 48 hours of the session and one week later. These secondary outcomes are related to well-being, and we have observed changes from energy medicine sessions [10] and other personal growth workshops [28].

The Positive and Negative Affective Scale (PANAS-X) is a 10-item scale rated using a 5-point Likert scale (1 - Very slightly or not at all, 2 - A little, 3 - Moderately, 4 - Quite a bit, 5 - Extremely) [29,30]. Participants are asked, "Thinking about yourself and how you normally feel, to what extent do you generally feel:...(Upset, Hostile, Alert, Ashamed, Inspired, Nervous, Determined, Attentive, Afraid, Active)." There are five items each for positive and negative affect. The scale is scored by summing positive and negative items. The scores range from 5-25 for each subscale, with higher scores representing higher positive or negative affect levels.

The Sleep Quality Scale (SQS) is a single-item 11-point numeric scale measuring acute sleep or sleep quality [31]. Participants are asked, "How would you rate the quality of your sleep

LAST NIGHT?” moving the slider for their response. The slide is anchored by “Best possible sleep” (0) and “Worst possible sleep” (10).

The Numeric Pain Rating Scale (NPRS) is a visual analog scale that reflects the respondents’ pain [32]. Participants are asked to report pain intensity “in the past 24 hours” on a slider from position 0 being “No pain” to position 10 being “Worst possible pain.” The NPRS is reliable and can detect change [33–35].

The Cloninger Self-Transcendence Scale is the 15-item self-transcendence subscale of the Cloninger 125-item Temperament and Character Inventory [36]. Cloninger et al. defined self-transcendence as “the extent to which a person identifies the self as...an integral part of the universe as a whole” [36]. Thus, a person high on self-transcendence is keenly aware of being part of a larger whole—in a spiritual union with God or nature. Participants answer each item with a slider anchored with “Definitely False” (0) and “Definitely True” (10). The scale is scored by summing all 15 items and then dividing by 10. Total scores range from 0 - 15.

Inclusion of Nature in Self (INS) [37,38] is a graphical single-item scale containing seven circle pairs with differing overlap of the two circles labeled ‘nature’ and ‘self.’ The participant to, “Please move the slider below to the picture that best describes your relationship with the natural environment. How interconnected are you with nature? (“Self” = you; “Nature” = the environment)?” Slider with a range of 0-100, with 0 being anchored by “Not at All” and 100 being anchored by “Completely.” The item results with one score between 0 and 100, with 100 representing the greatest interconnection with nature. The INS test-retest correlations are very high after four weeks. The INS scale accurately measures individual differences in connectedness with nature [38].

Inclusion of the Other in Self (IOS) [39,40] is visually the same as the INS except that “nature” is replaced by “other.” Participants are asked to “Please move the slider below to the picture that best describes your relationship with other people. How interconnected are you with others? (“Self” = you; “Others” = other people)?” Feeling connected with other people has been shown to drive outcomes related to social mobility [39] and is correlated with well-being [28].

Participant Symptoms Pre-Session

The Review of Systems Symptom Checklist (SYMPTOMS) is an investigator-designed tool to collect the participants’ symptoms prior to the session. The perceivers and RMs also completed this form, attempting to perceive the participants’ symptoms. The SYMPTOMS form includes symptoms in fourteen categories typically reviewed in a clinical setting: 1. Skin, 2. Head, 3. Eyes, Ears, Nose, Throat, 4. Neck, 5. Respiratory, 6. Cardiovascular System, 7. Gastrointestinal System, 8. Urinary System, 9. Musculoskeletal System, 10. Blood/Peripheral Vascular System, 11. Nervous System, 12. Endocrine / Immune System, 13. Reproductive, 14. Mental/Emotional. Please see Supplemental Data for a copy of the form. Each of these fourteen categories has symptoms associated with them for a total of 117 symptoms. For example, under the category “Head” is listed Headaches or Migraines, Head Injury, Hair loss, Jaw/TMJ problems. Each SYMPTOMS item resulted in a binary variable. The correspondence of these results was evaluated across the six perceivers and then pairwise between RM and participant, RM and perceiver, and participant and perceiver as described in the statistics section.

Perceiver Drawings During Sessions

During the sessions, the perceivers recorded their perceptions on a drawing form, which was primarily blank with two outlines representing the front and back of the participant. Please see

Supplemental Data for a copy of the form. Perceivers were given colored pens and asked to draw their observations on the form during the session.

Session Observations Post-Session

Immediately following each session, the perceivers recorded their perceptions on an Observation Table and an Energy Code Checklist. The Observation Table (OBSERVATION) is an investigator-designed tool to elicit session observations in text format and the meaning ascribed to these observations from perceivers, RMs, and participants after the session. Perceivers could also note on this form if their observation matched a specific element on their drawings. The Energy Code Checklist (ENERGY CODES) is an investigator-designed tool created to capture energetic observations by the study members. Please see Supplemental Data for a copy of the form. It includes six major code categories (energy attributes, symbols, participant receptivity, RM and participant rapport, other beings, and the healing process), each of which had further minor categories. For example, the energy attributes category has further minor categories of energy movement, quality of energy in the room, energy perceived as light, and quality of energy in participant/RM. These codes come from the qualitative analysis conducted in the previous pilot study evaluating one perceiver observing energy medicine sessions [11] and feedback from energy medicine practitioners as the most relevant and valuable for this study.

Analyses

Multiple qualitative and quantitative analyses evaluated the corroboration of the perceiver, RM, and participant data. The research questions and hypotheses and then the qualitative and quantitative methods to evaluate these questions are described below. In general, percentages, means, and standard deviations were calculated and described where appropriate. The number of participants was determined with a power calculation using a standard deviation of 0.30 on Krippendorff's alpha interrater reliability score (Kalpha). With 33 participants, we could detect a 0.15 difference in the overall mean compared to the hypothesized mean at 80% power. Forty participants were chosen to account for potential dropouts.

Research Questions and Hypotheses

1. Do different perceivers perceive in the same way? This question was explored with three types of data: a) OT, b) ENERGY CODES, c) Drawing Content, and d) Drawing Timeline. The hypotheses are:
 - a. OBSERVATION: The perceivers' average correspondence score will be three or above averaged over all the sessions for observation, meaning, and overall score and no significant difference by RMs in the ANOVA.
 - b. ENERGY CODES: The perceivers will have an average Kalpha ≥ 0.80 by session and overall.
 - c. Drawing Content: The perceivers' correspondence score will be three or above averaged over all the sessions and no significant difference by RMs in the ANOVA.
 - d. Drawing Timeline: There will be similar elements drawn or noted within 2 minutes of each other for at least two or more perceivers in a majority of the sessions.
2. What is the degree of corroboration between each experiencers' perceptions (RM and perceiver; RM and participant; perceiver and participant)? The hypotheses are:
 - a. SYMPTOMS: The Kalpha is above 0.80 for each code and by session and in a pairwise fashion using a one-sample *t*-test assuming a normal distribution.

- b. ENERGY CODES: The Kalpha is above 0.80 for each code and by session and in a pairwise fashion using a one-sample *t*-test assuming a normal distribution.
 - c. OBSERVATION: The average correspondence scores will be three or above for the pairwise comparisons for the three observation table parameters (observation, meaning, overall).
3. Can perceivers accurately pick up the health state of a participant before the Reiki Session? The hypothesis is that the perceivers will average $K_{\alpha} \geq 0.80$ by session and overall on the SYMPTOMS form.
4. Do the participants receive any benefit from the session, and what, if any, variables predict those benefits? The hypotheses are:
- a. The primary well-being measure will be significantly improved from before the session to one week later (four time-points for the primary outcome, AIOS).
 - b. The personality trait of openness and health categories will be significant predictors.
5. What is the degree of corroboration between the symbols noted by the perceivers and the meaning, if any, the participants ascribe to them? The hypotheses are:
- a. Three or more out of the six perceivers will observe similar symbols.
 - b. Participants will report that at least 25% of the symbols perceivers observe are meaningful to them.
 - c. 25% of the participants will note a similar meaning of the symbols observed by the perceiver.

Qualitative Correspondence Judging

Qualitative correspondence judging evaluated the drawings and OBSERVATION. Three judges reviewed the material and rated correspondence according to the following seven-point scale:

- 7 Excellent correspondence with essentially no differing information.
- 6 Good correspondence with relatively little differing information.
- 5 Good correspondence with unambiguous unique matchable elements, but some differing information.
- 4 Good correspondence with several matchable elements intermixed with some differing information.
- 3 Mixture of matching and not matching elements, but with enough matching to indicate that the answers are similar.
- 2 Some matching elements, but not sufficient to suggest results beyond chance expectation.
- 1 Little correspondence
- 0 No Correspondence

The judges reached a consensus for each rating. In cases where two judges had differing ratings than a third, they discussed the material until reaching a consensus. This process resulted in one score between 0 and 7. The qualitative judging graded the correspondence of the drawing content and the OBSERVATION parameters (observation, meaning, and overall) for each session. The perceivers' drawings were considered together and compared to each comparator for the pairwise comparisons.

A score of three was the cutoff for correspondence in this exploratory study's hypotheses. Considering that there should be no correspondence between the perceivers' observations if they

could not observe external phenomena associated with energy medicine treatments, the similarity required for a three was deemed the lowest threshold to consider a positive correspondence.

Drawing Timelines

Three cameras were ceiling-mounted above the tables where the perceivers drew during the sessions. The video recording included a timestamp on the screen. A video editor time-locked all six video streams, observing when perceivers made a similar mark either in color, in area of the body, or both within two minutes of each other. Please see Supplemental Data for a screenshot of the video editing process. The number of marks per session and overall was calculated. The research team chose the two-minute window as a reasonable time frame for synchronicity drawing marks.

Quantitative Inter-Rater Reliability

Kalpha was chosen to calculate the inter-rater reliability of the SYMPTOMS and ENERGY CODES across the six perceivers and then in a pairwise fashion between RM and participant, RM and perceiver, and participant and perceiver in the pre-registration. One value was calculated for each item, for each session. A Kalpha was then calculated for all codes per session and each code for all sessions. Mean and standard deviations were also calculated. All data visualization was performed using the R package *ggplot2* [41]. Kalpha values were calculated using the R package *irr* [42]. Gwet AC1 values were calculated using the R package *irrCAC* [43]. Results were saved to Excel workbooks using the R package *openxlsx* [44].

Traditionally, alphas greater than ≥ 0.80 would be considered acceptable, between 0.80 and 0.67 questionable, and less than 0.67 low inter-rater reliability [45,46]. Thus, 0.80 was the pre-registered threshold for hypothesis testing of correspondence. Kalpha values were assessed for normality using the Shapiro-Wilk test and examining a histogram of the data. Normally distributed data were analyzed with a one-sample *t*-test using the alternative hypothesis that μ is greater than or equal to 0.80. Non-normally-distributed data were analyzed with the one-sample Wilcoxon signed-rank test with the alternative hypothesis that the true location is greater than or equal to 0.80.

After the data was collected and Kalphas calculated, there was a clear issue with the values (i.e., there was high percent agreement but low Kalphas). For example, when six perceivers had the same value, the Kalpha was 1, and the percent agreement was 1. However, when five perceivers had the same answer, the Kalpha was -0.16 and the percent agreement was 0.83. The Kalpha was also -0.16 for 4/2 (0.67 agreement) and 3/3 (0.50 agreement). Kalpha was not accurately reflecting the raw data in our data's case. Kalpha is a commonly used reliability measure and a logical choice for calculating reliability prior to observing the marginal distributions of the data, and we included it in the pre-registration plan. However, marginal distributions and the level of difficulty of the tasks (and their interaction) impact the calculation of chance agreement. Specifically, when the value of kalpha is inordinately lower than the percent agreement, this indicates the marginal distribution may be too uneven.

A Gwet AC1 calculation was attempted to remedy this because the chance agreement calculated for Gwet's AC1 is impacted by the marginal distribution and is positively correlated with the difficulty of coding tasks, making it superior to Kalpha. In particular, in a situation where marginal distributions are uneven and prevalence tends towards extremes (complete agreement or complete disagreement; [45]). However, the Gwet AC1 also did not provide a robust measure of reliability across types of marginal distributions. For example, when five

perceivers had the same answer, the Gwet AC1 was 0.54 and the percent agreement was 0.83, 0.04 for 4/2 (0.67 agreement), and -0.16 for 3/3 (0.50 agreement). There was not a single measure that was appropriate both when marginal distributions were even and uneven. The best representation across marginal distributions was simple percent agreement, calculated by dividing the number of perceivers with the same value by six. Consequently, results are provided only for Kalpha and percent agreement. Percent agreement values for the perceivers represent the following inter-rater agreement: 100% = 6/6; 83% = 5/6; 67% 4/6; 50% = 3/3.

The perceivers' values were aggregated using majority rules for the pairwise comparisons. For instances where 4, 5, or 6 seers gave the same value, that value was used (i.e., 0 or 1). In cases where the perceivers were evenly split between 0 and 1, e.g., 0, 0, 0, 1, 1, 1, the value of 1 was used, knowing that either value chosen would introduce some error.

Well-Being Changes and Predictors

RM as a potential predictor for correspondence measures: Analyses of variance (ANOVA) to evaluate differences in correspondence ratings by RM were pre-registered. Some variables were not normally-distributed and resisted normalization through transforms, and where noted, a Kruskal-Wallis equality-of-populations rank test was conducted. The correspondence score was the dependent measure, and RM was the independent measure for each analysis.

Well-Being: Variables were evaluated for normality using the Shapiro-Wilk test for normality. A repeated-measures ANOVA evaluated changes over time. Non-normal variables were transformed to normalize them. If normalization was not possible using transforms, the Friedman test, a non-parametric version of a repeated-measures ANOVA, was used. The repeated-measures ANOVA for the AIOS included four time-points (baseline, pre-session, post-session, 1-week follow-up), with post-hoc comparisons for time-point pairs. The other well-being measures used two time-points, baseline to 1-week follow-up. Hedges's *g* effect size and 95% confidence intervals were calculated using an effect size calculator (<https://effect-size-calculator.herokuapp.com/>).

ANOVA evaluated potential predictors with AIOS change scores as the dependent variable, with each potential predictor as the independent variable (demographics, personality, paranormal belief and experiences, credibility, and expectancy). The False Discovery Rate (FDR) multiple comparison correction to establish significance for these 16 total models was $p \leq 0.0051$.

Finally, the pre-registration included one repeated measures model with four predictors (Health category (acute injury, mental (memory impairment), anxiety (GAD), depression (CESD-5), Practitioner (1-5), Credibility, and Expectancy) to evaluate their influence on the outcomes together and their interactions with each other. However, because health categories were not discrete and participants met cutoff thresholds for multiple categories, injury (binary), memory, GAD, and CESD-5 (continuous) were included as separate variables in a linear mixed-effects model to evaluate the relationship between AIOS score and time (before/after the session), practitioner, credibility, expectancy, acute injury, memory, CESD, and GAD. The model was fit with random intercepts for each individual using the R package *nlme* [47]. One model was fit without interactions, and post-hoc pairwise comparisons were generated to compare practitioners using the R package *emmeans* [48]. A second model was fit, including interactions between practitioner and credibility and practitioner and expectancy.

Results

Participants

Table 1 depicts the final participants' characteristics. While the study intended to enroll participants who matched the criteria for only one health category group (depression, anxiety, memory issues, and acute injury) and despite rigorous recruitment efforts, participants met criteria for multiple health categories. Twenty-six people met the criteria for the depression group, 25 for anxiety, 12 for injury, and 12 for memory. Rather than creating artificial health group categories, the participants were grouped as a whole, and the four health variables were included in analyses separately rather than as one 4-level factor variable.

Table 1. Participant characteristics (N = 40)

Characteristic	Mean or N	SD or %	AIOSΔ* <i>F</i> (1,39), <i>p</i>
Age	55.0	12.3	0.88, 0.35
Gender			4.93, 0.01
Male	12	30.0	
Female	27	67.5	
Another gender	1	2.5	
In Relationship	19	47.5	3.79, 0.06
Education	17.2	3.0	4.25, 0.05
Race ^a			1.03, 0.41
Native American	5	12.5	
Asian	2	5.0	
African	3	7.5	
Middle Eastern	1	2.5	
Latin	4	10.0	
European	30	75.0	
Resources	63.4	17.7	1.64, 0.21
Depression (CESD)	16.8	8.8	1.1, 0.31
Anxiety (GAD)	6.7	8.8	0.58, 0.45
Memory (Inoue)	13.3	2.5	2.70, 0.11
Injury	12	30.0	0.09, 0.76
Personality			
Extraversion	3.6	1.1	0.11, 0.74
Agreeableness	3.6	0.7	1.58, 0.22
Conscientiousness	4.0	0.8	0.39, 0.54
Neuroticism	3.1	0.1	1.83, 0.18
Openness	4.0	0.9	0.29, 0.59
Paranormal Beliefs	77.9	19.7	1.12, 0.30
Paranormal Experiences	54.6	19.3	0.46, 0.50
Credibility	6.3	2.0	0.19, 0.66
Expectancy	5.3	2.3	0.03, 0.87

^a Participants could check more than one race.

SD – Standard Deviation; N – Participant number endorsing that characteristic; CESD - Center for Epidemiological Studies Depression Scale – 5; GAD - Generalized Anxiety Disorder-7; and Inoue - Inoue Computerized Test Battery. The AIOS change score was calculated immediately before to after the session. None of these predictors was significant with an FDR multiple comparison correction.

Question #1. Do different perceivers “see” the same way?

OBSERVATION: The average correspondence scores for all sessions was 4.6 ± 0.7 for the observation text, 3.5 ± 1.5 for the meaning text, and 4.4 ± 0.7 for the overall score, supporting our hypothesis of having a score three or above for the three OBSERVATION measures. The observation text showed differences by RM ($X^2 = 16.4$, $p = 0.006$), with correspondence being lower for RM1 sessions than the others (RM1 – 3.6 ± 0.9 , RM2 – 4.3 ± 0.5 , RM3 – 4.6 ± 0.5 , RM4 – 5.0 ± 0.0 , RM5 – 5.0 ± 0.0 , RM6 – 5.0 ± 0.0). The meaning text showed differences by RM ($F(5,34)=8.90$, $p>0.00005$), driven mostly by lower scores for RM4 and 6 (RM1 – 5.0 ± 0.0 , RM2 – 4.5 ± 1.0 , RM3 – 3.9 ± 1.4 , RM4 – 2.9 ± 1.6 , RM5 – 3.3 ± 0.5 , RM6 – 1.9 ± 0.64). The overall score did not show any differences by RM ($X^2 = 8.6$, $p = 0.13$)

ENERGY CODES: The most commonly endorsed energy codes are listed here, followed by the number of endorsements by the perceivers (total possible is $6 \times 40 = 240$): 1) The participant being receptive (count – 224), 2) The energy moving from the RM to the participant (220), 3) Energy is blocked (218), 4) The rapport between the RM and participant being good (212), 5) That healing occurred (211), 6) That the quality of the energy in the room was safe (205), 7) that energy was moving out of the participant (discharge, clearing, releasing) (198), 8) Emotional and psychological healing occurred (194), 9) That the quality of the energy being transmitted by the RM was safe, calm, relaxed (193), and 10) That the participant’s systems are calmed or soothed.

Table 2 depicts the average percent agreement and Kalphas. The average percent agreement was 0.70 by code, 0.56 by session, and 0.74 overall, and the average Kalpha was -0.01 by session, 0.19 by code, and 0.04 overall. None of the Wilcoxon one-sample t -tests evaluating if values were greater than 0.80 were significant.

Table 2. Perceiver correspondence for the Code Checklist

	Percent Agreement Mean \pm SD	KAlpha Mean \pm SD
By Code	0.70 ± 0.12	-0.01 ± 0.05
By Session	0.56 ± 0.04	0.19 ± 0.07
Overall	0.74 ± 0.16	0.04 ± 0.44

Drawing Content: The sessions’ average correspondence score was 4.7 ± 0.6 , supporting our hypothesis of having a score of three or above over all the session drawings. A Kruskal-Wallis equality-of-populations rank test evaluated differences in these scores by RM, and none were found ($X^2 = 5.4$, $p = 0.37$). See Supplemental Data for completed drawing form examples.

Drawing Timeline: In total, 34 sessions were video recorded, two with only four perceivers, and are included in the analysis. Power issues to the ceiling-mounted cameras prevented recording six of the sessions.

Thirty-four sessions (100% of videotaped sessions) had at least one instance where two or more perceivers drew a similar element within two minutes of each other, supporting our hypothesis. There were 94 instances of similar elements drawn, 20 with three perceivers, one with four perceivers, and none with more than four perceivers. Thirty instances were for color, 41 were for part of the body, and 23 were for both. The average number of similar elements in each session was 2.8 ± 1.5 (range 1-7).

Most of the similar elements (66 or 70%) were made in the first 10 minutes of the session (see Supplemental Data for similar element timings). Also, despite explicit instructions to only

draw during the 30-minute Reiki sessions, some perceivers drew before the session officially began (i.e., when they were supposed to be completing the SYMPTOMS), after the session was over, and during break periods.

Question #2. What is the degree of corroboration between each experienter's perceptions?

SYMPTOMS and ENERGY CODES Pairwise Correspondence

Table 3 presents the means, standard deviations, and ranges of the percent agreement and Kalphas for the SYMPTOMS and ENERGY CODES forms. Each pairwise comparison value is presented (e.g., perceiver and RM; perceiver and participant, and RM and participant) by code, session, and overall. The tests evaluating the ENERGY CODES percent agreement and Kalpha values being ≥ 0.80 were not significant (all p 's = 1).

Most of the percent and KAlpha values for the SYMPTOMS form were significant: perceiver and RM percent agreement by session, and percent agreement and Kalpha overall; perceivers and participant by session, and percent agreement and Kalpha overall, perceiver and RM percent agreement by session, and percent agreement and Kalpha overall; RM and participant percent agreement by code and session, and RM and participant overall (Table 3).

Table 3. Kalpha means, standard deviation, and range for the Review of Systems Symptom Checklist and Code Checklist pairwise comparisons for Perceivers and Reiki Masters, Perceivers and Participants, and Reiki Masters and Participants.

	Review of Systems		Code Checklist	
	% Agreement Mean \pm SD	Kalpha Mean \pm SD	% Agreement Mean \pm SD	Kalpha Mean \pm SD
Perceivers and RM				
<i>By Code</i>	0.68 \pm 0.11	-0.29 \pm 0.21	0.70 \pm 0.13	-0.39 \pm 0.22
<i>By Session</i>	0.84 \pm 0.07 ^a	0.18 \pm 0.12	0.60 \pm 0.05	0.29 \pm 0.15
<i>Overall</i>	0.90 \pm 0.20*	0.79 \pm 0.41*	0.83 \pm 0.24	-0.13 \pm 0.00
Perceivers and Participant				
<i>By Code</i>	0.67 \pm 0.11	-0.29 \pm 0.20	0.65 \pm 0.11	-0.44 \pm 0.22
<i>By Session</i>	0.84 \pm 0.07*	0.16 \pm 0.14	0.63 \pm 0.07	0.17 \pm 0.16
<i>Overall</i>	0.89 \pm 0.21*	0.78 \pm 0.41*	0.81 \pm 0.24	0.62 \pm 0.49
RM and Participant				
<i>By Code</i>	0.88 \pm 0.11*	0.80 \pm 0.29	0.78 \pm 0.34	-0.03 \pm 0.13
<i>By Session</i>	0.88 \pm 0.06*	0.12 \pm 0.14	0.71 \pm 0.08	0.21 \pm 0.16
<i>Overall</i>	0.91 \pm 0.19*	0.82 \pm 0.38*	0.84 \pm 0.23	0.68 \pm 0.46

^a = 0.0001 * < 0.00005

RM – Reiki Master; SD – Standard Deviation; % - Percent

Observation Table Pairwise Correspondence

The average number of text characters for a perceiver's OBSERVATION was 720 \pm 641, whereas the average for participants was only 238 \pm 343, and for RMs was only 120 \pm 52. The perceivers had significantly more text in their OTs by session than the participants, and RMs did as analyzed by an ANOVA ($F(2,133)=10.92$, $p<0.00005$). Thus, correspondence values between the text on the perceivers' OTs scored low primarily because of text volume. Table 4 presents the correspondence scores, none reaching the threshold of three to support our hypothesis.

Table 4. Observation Table pairwise correspondence

	Observation	Meaning	Overall
Perceivers and RM	0.6 ± 0.9	0.1 ± 0.3	1.2 ± 1.4
Perceivers and Participant	0.1 ± 0.3	0	0.2 ± 0.5
RM and Participant	0	0	0
Average	0.2 ± 0.3	0.03 ± 0.1	0.5 ± 0.5

Question #3 Do perceivers pick up the same health state of the participant before the Reiki Session?

The percent agreement and Kalph values for the SYMPTOMS form are displayed in Table 5. The average percent agreement ranged from 0.77 to 0.82, and the Kalphas ranged from 0.16 to 0.25 by session, code, and overall. The overall percent agreement was significant for being ≥ 0.80 .

Table 5. Perceiver correspondence for the Review of Systems Symptom Checklist

	Percent Agreement Mean ± SD	KAlpha Mean ± SD
By Code	0.78 ± 0.12	0.06 ± 0.08
By Session	0.77 ± 0.06	0.16 ± 0.07
Overall	0.82 ± 0.17*	0.25 ± 0.56

*Wilcoxon one-sample *t*-test significant *p*-value <0.00005. All others were not significant (*p*'s 0.85 to 1.0).

Question #4 Do the participants receive any benefit from the session, and what, if any, variables predict those benefits?

There were no adverse events or unintended effects from the Reiki sessions. There was also no missing data for the the primary and secondary outcomes. The primary outcome AIOS well-being significantly changed over the four time-points, supporting our hypothesis that there would be improvements from the sessions ($F(3,159) = 12.3, p < 0.00005$; Baseline - 55.7 ± 18.8 , Before - 58.9 ± 18.1 , After - 73.2 ± 16.2 , One-week later - 64.3 ± 20.3 ; *n*=40). The effect size is 0.61, 95% confidence interval [0.39 to 0.59]. Post-hoc analyses revealed significant differences from baseline to post-session and baseline to after-session (Figure 3).

Figure 3. Well-being changes over time

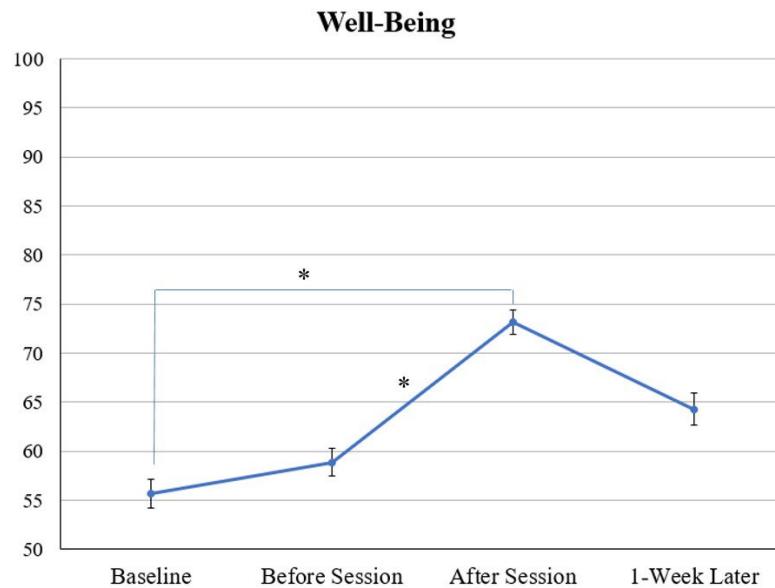


Figure 3 Legend - Notes. Well-being was measured using the Arizona Integrative Outcomes Scale. Scores range from 0 to 100, with 0 anchored by “Worst I’ve ever been” to 100 anchored by “Best I’ve ever been.” Each point represents average scores with standard error bars. For pairwise comparisons, baseline to after session significant $t = 4.25$ $p < 0.00005$, before session to after session significant $t = 3.48$ $p = 0.004$.

Table 6 presents the means, standard deviations, and statistical tests evaluating changes for the secondary well-being outcomes. Positive affect and sleep quality were normally distributed; self-transcendence and negative affect required transformations to achieve normality. Pain resisted transformation, and thus, and Wilcoxon signed-rank test was performed. Negative affect demonstrated significant improvement (decrease), which persisted after the multiple comparison correction.

Table 6. Secondary well-being outcomes

Measure	Baseline Mean \pm SD n=40	1-week Mean \pm SD n=40	Stats $F(1,79), p$	Hedge’s g [95% Confidence Interval]
Self-Transcendence (square)	10.4 \pm 2.0	10.4 \pm 2.8	0.06, 0.82	0 [-0.17 to 0.17]
Positive affect	16.6 \pm 3.9	16.9 \pm 3.6	0.29, 0.59	-0.08 [-0.34 to 0.18]
Negative affect (log)	10.2 \pm 3.5	8.4 \pm 2.5	8.79, 0.0051*	0.58 [0.19 to 0.99]
Sleep Quality	3.7 \pm 2.3	4.0 \pm 2.2	0.77, 0.38	-0.13 [-0.48 to 0.21]
Pain	4.1 \pm 2.9	3.2 \pm 2.6	Z = 2.0, 0.05	0.32 [0.01 to 0.64]

Notes. Positive and negative affective well-being - PANAS-X; Sleep Quality - Sleep Quality Scale; Pain - The Numeric Pain Rating Scale; Self-Transcendence - Cloninger Transcendence subscale. FDR = $p \leq 0.0051$ cutoff for significance. Square - square transformation was used to achieve normality. Log - log transformation was used to achieve normality. Z - Wilcoxon signed-rank test because the pain score was not normally distributed despite various transformations.

Predictors for well-being change

None of the potential predictors were significant for predicting AIOS change after correction for multiple comparisons when examined in separate models (see column 3, Table 1 for statistics).

Similarly, there were no significant predictors in the combined predictor model, including RM, credibility, expectancy, or health category (see Supplemental Data for statistical output).

Question #5 What is the degree of corroboration between the symbols noted by the perceivers and the meaning, if any, the participants ascribe to them?

An average of 6.5 ± 2.7 (range 1-13) symbols were noted each session. Perceivers rarely noted the same symbol. The number of seers that saw the same symbol was 0.83 ± 1.11 , range 0-3. More perceivers reported similar symbol categories, e.g., animal, geometry, face (1.05 ± 1.08 , range 0-3). These results did not reflect our hypothesis that three or more out of the six perceivers would observe similar symbols.

However, the participants found the symbols reported to them meaningful, supporting our hypothesis. Thirty-five participants (88%) noted that at least one of the perceiver observed symbols was meaningful to them. Overall, there were 243 symbols reported by the perceivers, 110 of which were reported as meaningful to the participants (45.3%). If more than one symbol was reported, $47\% \pm 35\%$, range 0 - 100% of the symbols were meaningful to the participant.

Only in one session did the meaning the perceiver gave the symbol match what the participant said. The perceiver mentioned a male/female triangle that represented imbalance in masculine and feminine, and the participant recounted being in the process of separating from her husband of 23 years. These results do not support our hypothesis that the perceivers would note similar meanings of the symbols as the participants.

There were, however, numerous instances where the perceivers mentioned angels. In these instances, the participant also thought of them as guides and helpers. Of the 40 sessions, angels were explicitly mentioned in 23 sessions. In these cases, the meaning ascribed to angels by perceiver and participant were the same.

Examples of some unique matches include “lightning,” which the participant related to a recurring dream their sister had about being hit by lightning, or “lucky charms,” which the participant related to a conversation they had with their coworkers about “lucky charms” the week before.

Discussion

In summary, this exploratory study evaluated qualitative and quantitative data collected before, during, and after 30-minute Reiki sessions in 40 participants with various health systems. The participants’ well-being improved from the sessions, maintaining gains one week later. Multiple research questions and hypotheses were tested. The perceivers generally perceived similar information as noted in free-form drawings and free text and had high percent agreement in the energy codes (0.74 percent agreement overall). Perceivers’ perceptions about the participants’ symptoms before the session were highly corroborated and matched participants’ self-report. No predictors revealed themselves, supporting the tradition that Reiki is applicable to anyone regardless of health condition. Furthermore, the symbols perceivers noted were meaningful to the participants, but perceivers did not see the same symbols nor ascribe the same meaning to them that the participants did. Table 7 broadly summarizes the research questions and the results. Further discussion of the study procedures, research questions, and analyses are detailed below.

Table 7. Research questions and general summary of results

Research Question and Hypotheses	General Result	<i>A priori</i> Hypothesis
1. Do different perceivers perceive in the same way?		
a. OBSERVATION	4.4 ± 0.7 overall correspondence score	Supported; Some differences by RM
b. ENERGY CODES	74% percent agreement overall	Not supported
c. Drawing Content	4.6 ± 0.6 correspondence score	Supported; No difference by RM
d. Drawing Timeline	All videotaped sessions have an instance with a similar element drawn	Supported
2. What is the degree of corroboration between each experiencers' perceptions?		
a. SYMPTOMS	88-91% percent agreement overall	Supported
b. ENERGY CODES	81-84% percent agreement overall	Not supported
c. OBSERVATION	0.03-0.5 average correspondence score	Not supported
3. Can perceivers accurately pick up the health state of a participant before the Reiki Session?		
	82% percent agreement overall	Supported
4. Do the participants receive any benefit from the session, and what, if any, variables predict those benefits?		
a. Well-being	Well-being score increases	Supported
b. Predictors	No significant predictors	Not supported
5. What is the degree of corroboration between the symbols noted by the perceivers and the meaning, if any, the participants ascribe to them?		
a. Perceivers see the same symbols.	Observe different symbols	Not supported
b. Participants find them meaningful	Participants find them meaningful	Supported
c. Participants and perceivers report similar meanings	Participants and perceivers do not report similar meanings	Not supported

OBSERVATION – Observation Table; ENERGY CODES – Code Checklist; SYMPTOMS – Review of Systems Checklist

Participants

Enthusiasm for the study was high. Participants were generally middle-aged to older, college-educated, mostly women of European descent. One issue with participant recruitment was that we could not find participants who only endorsed one of the health categories. For example, many participants had high anxiety and depression scores or, if they had memory issues, also had high anxiety and depression scores. This likely represents the high co-morbidity of these conditions, especially in older adults, which was the average age range of our participants [49,50]. Our original statistical plan included one factor variable for each health category, but this goal did not consider these ubiquitous co-morbidities. The approach to include the health outcomes (depression, anxiety, memory, and acute injury) as separate potential predictors better reflects these symptoms' co-morbidities. Most important in recruiting these four symptom categories was ensuring that we had a diverse population of participants with different health conditions. That is, we did not just want people with physical health conditions. We wanted mental and emotional conditions for the RM to treat, thus evaluating if there were outcome differences by health category. Interestingly, the health category was not a significant predictor, supporting the notion promoted in the Reiki tradition that the Reiki energy affects the receiver in the ways most needed regardless of any specific pathology. That is, it can be universally applied to any health condition to support health promotion.

Credibility and expectancy also did not predict the well-being outcome. Namely, whether participants believed in the efficacy of Reiki or felt it would help them did not predict their improvement in well-being, supporting the idea that while placebo effects often influence mind-body medicine and energy medicine studies [26], they were likely not at play in the well-being improvement noted in this study.

Reiki Masters

The RM recruitment was smooth with numerous highly qualified practitioner applications. They were receptive to the research setting and requirements for the study (e.g., having six observers) unfamiliar to them. There was an unexpected occurrence that arose associated with one of the RMs. After the day's second session, one of the perceivers approached the principal investigator with the concern that they felt very uncomfortable with the RM's energy. They shared that the RM had a malevolent spirit attachment preventing them from perceiving what was going during the session. A meeting with all the perceivers was held to determine if others were perceiving the same situation. The perceivers corroborated that they felt something blocking them related to the RM and requested that the RM not return for the second day. While it is impossible to verify if the RM did have a spirit attachment, the phenomenon is well-known in many cultures and spiritual traditions worldwide [51]. Considering that the study's primary purpose was to evaluate the perceivers' corroboration, the study team decided to find a replacement RM for the second day of sessions to eliminate any potential impairment to their ability to perceive during the Reiki sessions. Finding a replacement proceeded with ease because of the numerous well-qualified RMs that had applied.

Perceivers

Numerous applications were received for the perceivers as well. One inclusion criterion was the ability to perceive externally (i.e., endorse seeing energy, its color, texture, and movement). This criterion assumed the traditional understanding in energy medicine that this "energy" exists and that skilled people can observe it.

While all the perceivers endorsed seeing this way, the data revealed they also perceived in other ways. The perceiver notes included mental, emotional, spiritual, and physical information from the participant's past and present, in addition to what was occurring during the session. This study's *a priori* research questions and hypotheses focused on the degree of content perceiver corroboration rather than the content itself, and thus, this paper does not include results about the content. Future analyses of this rich dataset will include qualitative analyses of the content.

The volume of information the perceivers received and conveyed was problematic in that it was challenging to distinguish the signal from the noise. Future studies would also benefit from clarifying what the perceivers observe in a stepwise fashion. For example, rather than asking the perceivers to record all they observed during the 30 minutes, it would be advised to begin with someone who was not receiving a session. Then ask the perceivers to give information about their emotional state at the moment, then their mental state, then their physical state, naming each body system in turn. Also, many perceiver training systems include the ancient chakra system as a model for the body's energy system [52]. Asking for a percentage open or other quantitative types of information about each chakra's state would also be helpful. Finally, after a detailed static read of the participant was complete, the session could begin. The session instructions would then be to only focus on the energy movement, color, texture, etc.,

through their external sight perception and ignore all other information. In this way, the information received would be organized to allow corroboration more easily.

Also, while the vetting process included the perceivers agreeing that they could and would contain their energy to not interfere with the energy medicine session or their fellow perceivers, future studies would consider having the perceivers observe from separate rooms through closed caption video as an extra measure. Not having the perceivers in the room would also support the RMs who expressed some minor nervousness at being observed for their first sessions. Some participants also mentioned feeling uncomfortable with the perceivers even though they were made aware of the observers through the consenting procedures.

The perceivers committed not to discuss the sessions, and there is no reason to believe they did not follow this expectation. However, they did eat meals together in between treatment sessions and developed a sense of community and positive regard towards each other. This congeniality raises the question of whether their interactions outside of the treatment sessions interfered with their ability to perceive independently from each other. The mechanism for how extended perception work is unknown, and thus, proximity between perceivers may not influence the results. A brief, informal data review shows that perceivers sitting at the same table do not always report similar information. However, more formal data analyses and future study designs where perceivers are physically isolated will help elucidate whether the proximity of the perceivers influences the results.

Study Procedures

Having the entire study in the same place with all study staff present supported excellent data collection. There was no missing data from any forms, which is rare in clinical studies. There were missing video recordings because of a power issue. The video cameras being suspended from the ceiling made it more challenging to ensure the devices' proper functioning. Future studies might consider electronic recording devices, such as tablets with drawing capabilities, that could also record the timing of marks made. Also, other textual programs might be used that could allow for timestamps of entered data. Alternatively, if the perceivers are in separate rooms, they could audio record their impressions that could later be transcribed with timestamps. The timestamp issue is only relevant for observing a live healing session and is not an issue for future studies asking perceivers to observe a participant not undergoing a healing session. This application is especially intriguing as it could be paired with relevant clinical outcomes that could be verified with biological testing. For example, participants with specific ailments with gold-standard testing such as computerized tomography or x-ray or bloodwork would be vital to assessing the validity of extended perception readings. The capacity to perceive information about the body in this way, sometimes called medical intuition, is likely the most practical and easily verifiable application of extended perception and should be strongly considered to move the field of extended perception forward. A few studies have been conducted on this application [16–19,53], but more are needed.

Question #1. Do different perceivers “see” the same way? and Question #3 Do perceivers pick up the same health state of the participant before the Reiki Session?

The corroboration amongst perceivers was evaluated in a few ways. The SYMPTOMS had a high percent agreement (0.78 to 0.82), meeting our hypothesized threshold of 0.80 for the overall

scores. The by code and session evaluation for percent agreement and all Kappa values did not reach our hypothesized 0.80 threshold. The ENERGY CODES percent agreement ranged from 0.56 to 0.74, but neither these nor the Kappa reached our 0.80 threshold in hypothesis testing. The drawing and OBSERVATION perceptions received during the Reiki sessions corroborated across perceivers above our hypothesized threshold of three. In addition, the drawing timeline analysis revealed that perceivers were making similar marks at similar times.

The qualitative judging, SYMPTOMS, and timeline analyses support our hypotheses for Question #1, evaluating if perceivers perceive in the same way, as does the high percent agreement for most of the calculated values. Some might argue that the 0.80 threshold level is too high to expect with just a complex information source and that cutoff scores for interrater reliability measures are arbitrary. For example, Landis suggests a very different strength of agreement criteria for the kappa statistic for categorical data (< 0.00 Poor, 0.00-0.20 Slight, 0.21-0.40 Fair, 0.41-0.60 Moderate, 0.61-0.80 Substantial, 0.81-1.00 Almost Perfect) for categorical data [54]. In this case, the 0.80 we chose for our pre-registered hypotheses thresholds would reflect the almost perfect agreement rating. The lowest percent agreement for our analyses was 0.56, representing moderate agreement with Landis' criteria. The somewhat arbitrary nature of the 0.80 cutoff should be considered when reviewing the results of this study.

Question #2. What is the degree of corroboration between each experimenter's perceptions?

The degree of corroboration between the perceivers, RMs, and participants was high for the SYMPTOMS prior to the session (range 0.68 to 0.91), meeting our hypothesized threshold for the percent agreement and the Kappa overall scores. The agreement was lower for the ENERGY CODES (range 0.60 to 0.84) but still in the moderate to almost perfect agreement range using Landis criteria. Despite the high percent agreement, the statistical tests did not meet our hypothesized threshold.

On the qualitative data, the low agreement was likely because there was very little data for the RM and participant OBSERVATION, and thus, their correspondence is necessarily low. However, for the SYMPTOMS and ENERGY CODES, everyone was given the same codes and thus, had the same probability of marking yes or no for each one. Thus, we would anticipate that there would be greater correspondence for these measures. Likely, the ENERGY CODES items were not familiar to the participants because they are specific to energy characteristics, although the RM would be familiar with the ENERGY CODES concepts.

The SYMPTOMS was likely more straightforward for the participant to complete regarding what they know about their physical health. We see this reflected in the greater correspondence on this form. The perceivers' observations of the participants' health prior to the session highly agreed with the participants' self-report, meeting our hypothesis threshold. Thus, not only did the perceivers have a high agreement with each other overall, but they also had high agreement with the participants. These results support the idea that perceivers can detect information about the people they view.

Question #4 Do the participants receive any benefit from the session, and what, if any, variables predict those benefits?

The participants benefited from the sessions, as evidenced by the well-being score and negative mood improvement and reflecting other Reiki studies demonstrating various outcome

improvements [9]. The forty participants were diverse in age and race, supporting the generalizability of the well-being improvement results. Notably, many participants were visibly affected by the sessions. Most felt very relaxed but also “out of it,” such that they had to sit quietly for 10-15 minutes before they could resume their normal activities and drive.

The non-significant predictor results did not support our hypothesis that openness and specific health categories would benefit more than other participants. However, they do support the idea that Reiki can be beneficial to any individual and that a recipients’ beliefs or expectations about Reiki, other paranormal phenomena, or their personal characteristics do not influence any potential benefits Reiki may impart. This aligns with traditional teachings about Reiki and its universal application, as noted in the Introduction.

Question #5 What is the degree of corroboration between the symbols noted by the perceivers and the meaning, if any, the participants ascribe to them?

Perceivers often mention symbols in the field of those they are reading when giving sessions. Thus, this exploratory study included this question to evaluate if perceivers observed similar symbols. We found that they did not. Nevertheless, the symbols observed were meaningful to the participant. Perhaps the participants wanted to please the study staff by reporting positive meaning to the symbols. However, some were unique, such as the lightning or lucky charms examples given.

The angel or guide symbol was ubiquitous in almost all the sessions. The idea of spiritual helpers is as old as humanity’s written record. While we cannot confirm or deny the presence of spiritual beings supporting the Reiki session, the fact that perceivers observed them was meaningful to the participants and imparted a sense of comfort and healing. The symbol analysis highlighted that perceivers “see” differently and that some symbols they observe are meaningful to the participants.

Limitations

Several limitations of the study should be considered when reviewing the results. First and foremost, this is an exploratory study. None of the analyses here were meant to be definitive. The study was uncontrolled, and thus, we cannot rule out the possibility that data generated with mock perceivers would yield similar results. Similarly, we cannot be sure if well-being improvements were not placebo or natural progression. The placebo explanation is not supported by the lack of significance of credibility and expectancy as predictors, but future controlled studies will help elucidate whether placebo influences Reiki session benefits as noted in mind-body medicine trials [26]. Also, the health categories for the participants were evaluated using validated self-report screening tools. There was no attempt to verify any diagnoses or evaluate the participants’ health conditions more fully.

The Kalpha interrater reliability measure was appropriate for the study design and data type; however, our data distribution did not allow for the proper implementation of this statistical analysis. We could not have known that until we collected the data. Percent agreement is a valid and commonly used measure of inter-rater reliability [45] and we could have easily chosen percent agreement rather than Kalpha for our statistic. Thus, while many of our Kalpha values do not support our *a priori* hypotheses, we invite the reader to reflect on the larger picture of

corroboration from the qualitative judging and percent agreement in interpreting the findings and planning for future studies.

The study authors conducted the qualitative judging, introducing possible bias because the research team was familiar with what perceivers were observing and the study's hypotheses. A future study could have an independent team do this analysis.

The amount of data we received from the RM and participants was low compared to the perceivers, which led to low corroboration scores on the qualitative judging because of mismatched volume. Future corroboration studies would take this into account.

Conclusions

Participants' well-being improved from a 30-minute Reiki session, maintaining improvements one week later. There was evidence from multiple data and analyses that perceivers observe similar information during Reiki sessions. Furthermore, there was correspondence between the perceivers' observations of the participants' health condition and participants' self-reported health. Future studies are needed to refine the methods developed here to continue the exploration of extended perception, its validity, and practical application in healthcare.

Data availability

The data for this project is publicly available on the Figshare Repository
[10.6084/m9.figshare.17251811](https://figshare.com/data/articles/10.6084/m9.figshare.17251811)

Conflicts of interest

All authors declare that there are no conflicts of interest regarding the publication of this article.

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Supplemental Data

[Review of Systems Symptom Checklist \(SYMPTOMS\)](#)

[Drawing Form](#)

[Energy Code Checklist \(ENERGY CODES\)](#)

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Review of Systems Symptom Checklist (SYMPTOMS)

StudyID# _____

Session# _____

Review of Systems Symptom Checklist (ROS)

Please check all that apply under each system representing the participants currently experiencing symptoms.

1. Skin

- ☐ 1.1 Rashes
- ☐ 1.2 Dryness
- ☐ 1.3 Eczema, hives
- ☐ 1.4 Night sweats
- ☐ 1.5 Acne, boils
- ☐ 1.6 Itching
- ☐ 1.7 Skin cancer

2. Head

- ☐ 2.1 Headaches or Migraines
- ☐ 2.2 Head Injury
- ☐ 2.3 Hair loss
- ☐ 2.4 Jaw / TMJ problems

3. Eyes, Ears, Nose, Throat

- ☐ 3.1 Impaired/Blurred vision
- ☐ 3.2 Eye pain/discomfort
- ☐ 3.4 Impaired hearing
- ☐ 3.5 Ringing ears
- ☐ 3.6 Frequent colds
- ☐ 3.7 Nose bleeds
- ☐ 3.8 Stuffiness / Sinus problems
- ☐ 3.9 Loss of smell
- ☐ 3.10 Frequent sore throat
- ☐ 3.11 Loss of taste
- ☐ 3.12 Teeth grinding
- ☐ 3.13 Sore tongue/mouth
- ☐ 3.14 Gum problems
- ☐ 3.15 Allergies

4. Neck

- ☐ 4.1 Lumps
- ☐ 4.2 Swollen glands
- ☐ 4.3 Goiter
- ☐ 4.4 Pain or stiffness

5. Respiratory

- ☐ 5.1 Cough
- ☐ 5.2 Difficulty / Pain on breathing
- ☐ 5.3 Asthma
- ☐ 5.4 Shortness of breath
- ☐ 5.5 Shortness of breath at night

6. Cardiovascular System

- ☐ 6.1 Angina
- ☐ 6.2 High / low blood pressure
- ☐ 6.3 Fainting
- ☐ 6.4 Palpitations / fluttering
- ☐ 6.5 Chest pain

7. Gastrointestinal System

- ☐ 7.1 Trouble swallowing
- ☐ 7.2 Indigestion / Heartburn
- ☐ 7.3 Constipation
- ☐ 7.4 Belching or passing gas
- ☐ 7.5 Gallstones
- ☐ 7.6 Ulcer
- ☐ 7.7 Hemorrhoids / fissures
- ☐ 7.8 Hernia
- ☐ 7.9 Nausea
- ☐ 7.10 Irritable bowel/diarrhea

8. Urinary System

- ☐ 8.1 Pain on urination
- ☐ 8.2 Kidney stones

9. Musculoskeletal System

- ☐ 9.1 Joint pain or stiffness
- ☐ 9.2 Arthritis
- ☐ 9.3 Muscle spasms or cramps
- ☐ 9.4 Sciatica
- ☐ 9.5 Backache
- ☐ 9.6 Sprained/strained muscle
- ☐ 9.7 Fractured bone
- ☐ 9.8 Broken bone

10. Blood/Peripheral Vascular System

- ☐ 10.1 Easy bleeding or bruising
- ☐ 10.2 Anemia
- ☐ 10.3 Deep leg pain
- ☐ 10.4 Cold hands / feet
- ☐ 10.5 Varicose veins
- ☐ 10.6 Slow wound healing
- ☐ 10.7 Thrombosis/blood clot

11. Nervous System

- ☐ 11.1 Muscle weakness
- ☐ 11.2 Numbness or tingling
- ☐ 11.3 Vertigo or dizziness
- ☐ 11.4 Speech problems
- ☐ 11.5 Fainting

12. Endocrine / Immune System

- ☐ 12.1 Fibromyalgia
- ☐ 12.2 Hypothyroid
- ☐ 12.3 Diabetes Type 1 or 2
- ☐ 12.4 Hyperthyroid
- ☐ 12.5 Heat or cold intolerance
- ☐ 12.6 Fatigue
- ☐ 12.7 Seasonal depression
- ☐ 12.8 Chronic fatigue syndrome
- ☐ 12.9 Hypoglycemia

13. Reproductive

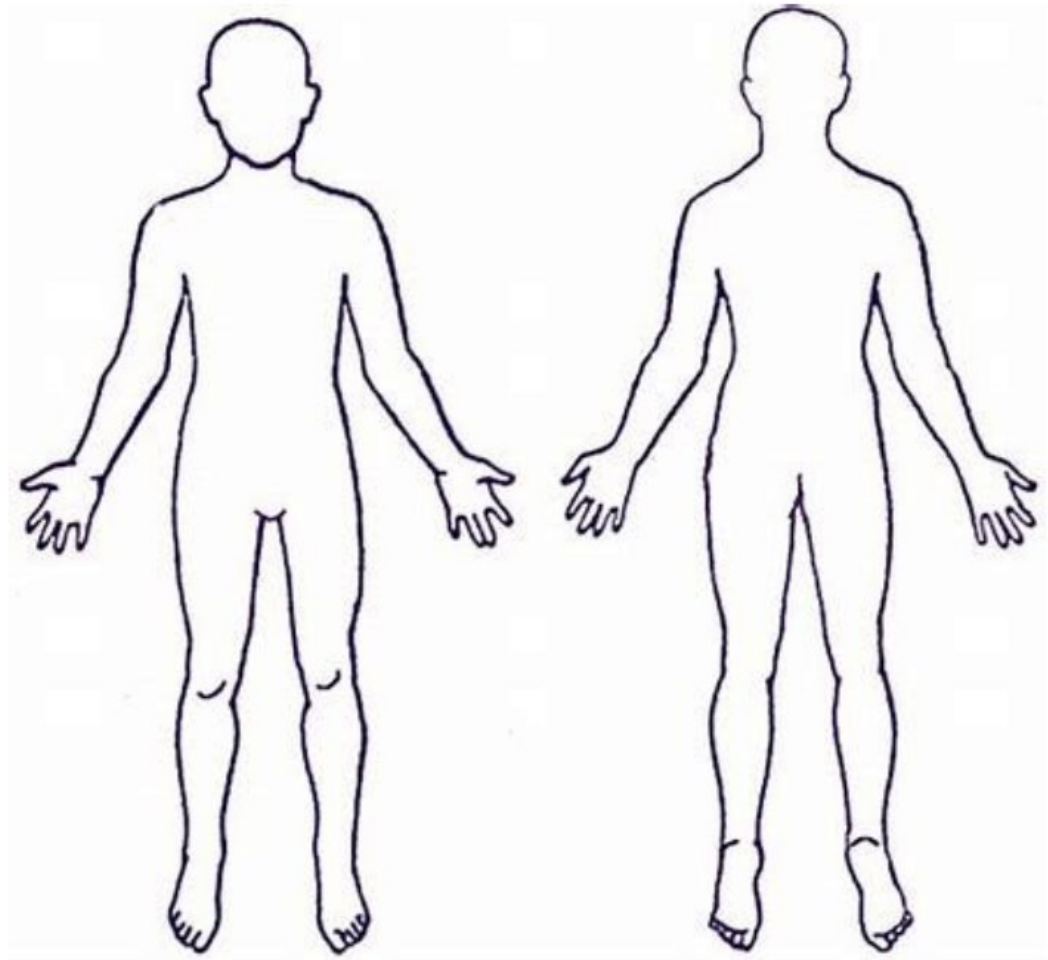
- ☐ 13.1 Infertility
- ☐ 13.2 Male - Hernias
- ☐ 13.3 Male - Testicular pain or masses
- ☐ 13.4 Male - Prostate enlargement or disease
- ☐ 13.5 Female - Premenstrual Syndrome
- ☐ 13.6 Female - Fibrocystic breast disease
- ☐ 13.7 Female - Endometriosis
- ☐ 13.8 Female - Uterine fibroids
- ☐ 13.9 Female - Ovarian cysts
- ☐ 13.10 Female - Cervical dysplasia
- ☐ 13.11 Female - Vaginal itching
- ☐ 13.12 Female - Yeast infections
- ☐ 13.13 Female - Menopausal symptoms

14. Mental/Emotional

- ☐ 14.1 Memory problems
- ☐ 14.2 Mood swings
- ☐ 14.3 Anxiety or nervousness
- ☐ 14.4 Poor concentration
- ☐ 14.5 Depression
- ☐ 14.6 Tension and / or stress
- ☐ 14.7 Phobias
- ☐ 14.8 Insomnia
- ☐ 14.9 Psychosis (i.e., hallucinations or delusions)
- ☐ 14.10 Dissociation

Drawing Form

StudyID #_____ Session #_____



Observation Tables (OBSERVATION)

Table 1. Perceiver/Reiki Master Observation Table

# from Drawing**	Observation	Type*	Meaning

***How did you observe this?**

Sight - Observed visually in the external field

Internal Clairvoyance - Visuals in the mind

Clairsentient - feeling in body

Claircognizant - information coming to the mind

**This column only included for Perceiver

Table 2. Participant Observation Table

Experience	Meaning	How?**

****How did you observe this?** Physically in body, Emotionally, Mentally, Spiritually

Energy Code Checklist (ENERGY CODE)

Study ID# _____

Session #: _____

Code Checklist

1. Energy Movement, General

Energy Moves...

- ☐ 1.1 from RM to ppt
- ☐ 1.2 from ppt to RM
- ☐ 1.3 out of ppt (discharge, clearing, releasing)
- ☐ 1.4 out of ppt to below (grounding)
- ☐ 1.5 out of ppt to above (connecting)
- ☐ 1.6 into ppt from above
- ☐ 1.7 into ppt from below
- ☐ 1.8 into ppt from the sides
- ☐ 1.9 into room around RM & ppt
- ☐ 1.10 into room from above
- ☐ 1.11 into room from below
- ☐ 1.12 into room from the sides
- ☐ 1.13 out of the room
- ☐ 1.14 other _____

2. Quality of energy in the room

- ☐ 2.1 Sacred
- ☐ 2.2 Grounded
- ☐ 2.3 Chaotic
- ☐ 2.4 Bright
- ☐ 2.5 Stuck
- ☐ 2.6 Heavy
- ☐ 2.7 Light
- ☐ 2.8 Invigorating
- ☐ 2.9 Draining
- ☐ 2.10 Safe
- ☐ 2.11 Unsafe
- ☐ 2.12 Other _____

3. Energy Perceived As Light

- ☐ 3.1 Black
- ☐ 3.2 Red
- ☐ 3.3 Orange
- ☐ 3.4 Yellow
- ☐ 3.5 Green
- ☐ 3.6 Blue
- ☐ 3.7 Purple
- ☐ 3.8 Pink
- ☐ 3.9 Rose Gold
- ☐ 3.10 Gold
- ☐ 3.11 Silver
- ☐ 3.12 Rainbow
- ☐ 3.13 White
- ☐ Other _____

4. Energy Quality

- ☐ 4.1 Negative
- ☐ 4.2 Different Dimensions
- ☐ 4.3 Hot
- ☐ 4.4 Cold
- ☐ 4.5 Holiness/Spiritual
- ☐ 4.6 Intensity
- ☐ 4.7 Love
- ☐ 4.8 Safe/Calm/Relaxed
- ☐ 4.9 Scent
- ☐ 4.10 Shapes/Patterns/Visuals
- ☐ 4.11 Sound
- ☐ 4.12 Vibration
- ☐ 4.13 Coarse
- ☐ 4.14 Smooth
- ☐ 4.15 Thick
- ☐ 4.16 Thin
- ☐ 4.17 Dynamic
- ☐ 4.18 Sparkly
- ☐ 4.19 Cloudy
- ☐ 4.20 Other _____

5. Symbols

- ☐ 5.1 Animals
- ☐ 5.2 Geometric shapes
- ☐ 5.3 Nature
- ☐ 5.4 Faces/People
- ☐ 5.5 Symbolized Concept
- ☐ 5.6 Sacred geometry
- ☐ 5.7 Other _____

6. Non-Physical Beings Present

- ☐ 6.1 Angelic Presence/Beings
- ☐ 6.2 RM's Guides
- ☐ 6.3 Ppt's Guides
- ☐ 6.4 Unspecified spiritual being/helper
- ☐ 6.5 Extraterrestrial Intelligence
- ☐ 6.6 Unhelpful being (e.g. spirit attachment)
- ☐ 6.7 Other _____

7. Other Being Functions in Healing Session

- ☐ 7.1 Working through RM's body
- ☐ 7.2 Applying/directing energy to ppt directly
- ☐ 7.3 Observing session
- ☐ 7.4 Teaching other non-physical beings
- ☐ 7.5 Unhealthfully attached to ppt
- ☐ 7.6 Other _____

8. Healing Occurred?

- ☐ 8.1 Yes
- ☐ 8.2 No

9. What Happened To Create Healing?

- ☐ 9.1 Energy unblocked, pathways opened
- ☐ 9.2 Energy moving out of ppt (cleared, dissipated, etc)
- ☐ 9.3 Energy moving into ppt
- ☐ 9.4 Energy is being balanced/aligned
- ☐ 9.5 Systems are calmed or soothed
- ☐ 9.6 Systems are invigorated
- ☐ 9.7 "Psychic Surgery" (physical object removed)

10. Ppt Receptivity

- ☐ 10.1 Receptive ☐ 10.2 Not Receptive

11. RM-Ppt Rapport

- ☐ 11.1 Rapport Good
- ☐ 11.2 Rapport Poor

12. Root Cause of Ppt Issues

- ☐ 12.1 Physical (Disease, etc.)
- ☐ 12.2 Energetic (Energy blocked, etc.)
- ☐ 12.3 Mental
- ☐ 12.4 Emotional/psychological
- ☐ 12.5 Spiritual (Past Lives, etc.)
- ☐ 12.6 Relational
- ☐ 12.7 Environmental

13. What Was Healed? (Physical)

- ☐ 13.1 Skin
- ☐ 13.2 Head
- ☐ 13.3 Eyes
- ☐ 13.4 Ears
- ☐ 13.5 Nose and Sinuses
- ☐ 13.6 Mouth and Throat
- ☐ 13.7 Respiratory system
- ☐ 13.8 Cardiovascular system
- ☐ 13.9 Gastrointestinal system
- ☐ 13.10 Urinary system
- ☐ 13.11 Musculoskeletal system
- ☐ 13.12 Blood/peripheral vascular system
- ☐ 13.13 Nervous system
- ☐ 13.14 Endocrine system
- ☐ 13.15 Immune system
- ☐ 13.16 Reproductive system
- ☐ 13.17 Other _____

14. What was healed? (non-physical)

- ☐ 14.1 Environmental
- ☐ 14.2 Mental
- ☐ 14.3 Emotional/psychological
- ☐ 14.4 Spiritual (Past Lives, etc.)
- ☐ 14.5 Energetic (Energy blocked, etc.)
- ☐ 14.6 Relational

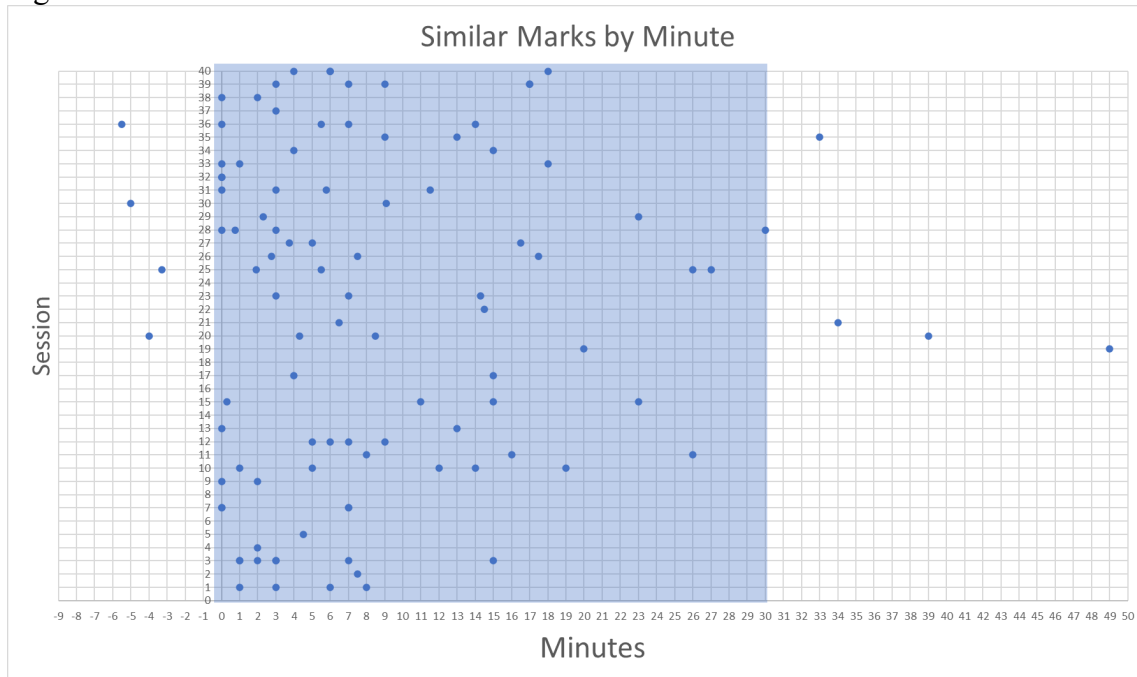
Large model predictor analysis statistical output

Table 3. Results of the linear mixed effects model with response variable AIOS and dependent variables time, practitioner, credibility, expectancy, injury, MCI, CESD, and GAD.

Fixed Effects:					
Variable	Value	Std. Error	DF	<i>t</i>-value	<i>p</i>-value
(Intercept)	44.86	10.73	39	4.18	0.0002
Time = After Session	14.33	2.13	39	6.71	0.00
Prac = 2	-14.02	9.52	28	-1.47	0.15
Prac = 3	1.35	7.41	28	0.18	0.86
Prac = 4	-7.67	7.68	28	-1.00	0.33
Prac = 5	-7.81	9.67	28	-0.81	0.43
Prac = 6	-3.77	7.30	28	-0.52	0.61
Cred	1.90	1.92	28	0.99	0.33
Exp	1.89	1.61	28	1.17	0.25
Injury = 1	-2.47	5.76	28	-0.43	0.67
MCI = 1	5.62	5.93	28	0.95	0.35
CESD	-0.09	0.31	28	-0.28	0.78
GAD	-0.49	0.60	28	-0.82	0.42
Random Effects:					
	Intercept	Residual			
Std. Dev.	12.10	9.54			

Time Distribution of Similar Elements

Figure 1. Time Distribution of Similar Elements.



Notes. The x-axis represents the minutes before, during, and after the session. The y-axis represents the session number. Similar elements include marks made of a similar color on the same part of the body. The blue dots represents instances where two or more perceivers made a mark of similar color, on the same part of the body, or both within two minutes of each other.

Screenshot of Video Timing Analysis

Figure 2.

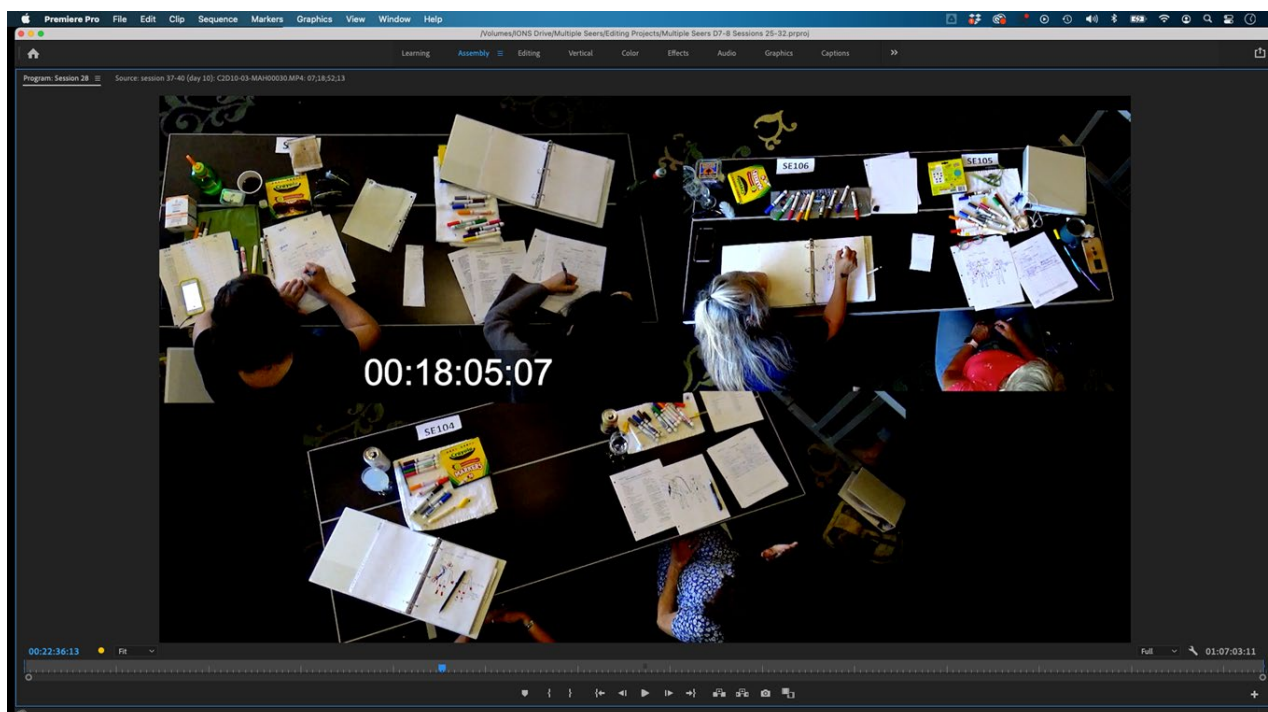


Figure 3. Completed drawing forms for session 21.



Observation Table Completed Examples

Figure 4. Completed Observation Tables for session 21.

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StudyID# SE101 Session# 21

Seer Observation Table

Draw #	Observation	Type*	Meaning
①	Very powerful solar plexus		Sometimes sensitive stomach to
②	2nd chakra pouch is filled		doesn't want to be completely revealed in this area
	male/female energies not wanting to be revealed		hesitant, something very painful inside
	something about a cracked tubercule, or organ		and a bit red inflamed in that area, prostate?
③	All of a sudden a stream of little children, little girl spirits, some of them of all the same identity FLOODED in and around him		all around him
④	continued - perhaps something with a lower intestine or hernia? something in the lower ribs cracked on the left but filled		
⑤	Heart shield, pain something going on with the actual organ		shield over his heart
	Some sort of accident or hospitalization with the heart in past		
⑥	A stream of high frequency, almost ET-like energy running through his 5th chakra from front to back. RM cleared it		
⑦	Guides surrounding him with light		going off around him and streams of light

*How did you observe this? Sight - Observed visually in the external field, Internal Clairvoyance - Visuals in the mind, Clairsentient - feeling in body; Claircognizant - information coming to the mind.

attached to his head

Seer Docs p. 5

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SE101

Draw #	Observation	Type *	Meaning
⑦	Lots of lower back rigidity		Stiffness or pain
⑧	6th chakra expansiveness		Clear sight
⑨	An old device on top of		5th opening, running on something old in programming, needs to be pulled off and the message needs to be
			Upgraded
⑩	However, streams of light coming in over 7th		
⑪	#4 cont. A lot of old cords, remnants of old stories that need to be cleared or are in the process of being cleared		
⑫	Something about his ankles & feet not functioning properly, possible past life or past injury		

*How did you observe this? Sight - Observed visually in the external field, Internal Clairvoyance - Visuals in the mind, Clairsentient - feeling in body; Claircognizant - information coming to the mind.

SE101

21

Something about doing
a golf move where
he pulled his ball
while playing golf

Astral body not matching up with physical
Astral cord filled with some interference
Right when healing began, spirit went straight
into body, returned

His spirit says, "I'm a master of light"

Some heart chakra blockage

Vibrates between being full of light and then
moves energy very rapidly through his body

Has cleared a lot of karma + fast liver
work

There are dragon type entities assisting
in clearing the work

Some guides circling and all around him

A female guide with long hair, dress and
blue standing nearby

Shooting pain that comes up from 1st chakra
down in the sacral, bottom of spine

PPT is also without effort doing healing

In his own session, probably ~~was~~ automatic
by his spirit

RM works with energy through her and
she + PPT have guides assisting everywhere
in the room

After session is over, guides still working on PPT

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StudyID#

SE102

Session#

21

Seer Observation Table

Draw #	Observation	Type*	Meaning
1	Blue swirl above abdomen	VM feel	think this may be influence from karmic, since she never done this 4
2	image of green trees. pt in center of it	VM	seeking (spiritual) not sure on next steps waiting, testing , a little lost misinterpreting
3	looking at foot, not picking wearing it		
3	see root dump from sun to floor to earth	VM	growing grounding
4	pt trying to fill all relationship needs = his spiritual work his body/psyche/soul is missing physical relationship = quarter person in human form	known	
5	"trust"	hear in mind	Childhood issues to his mother
6	feel relationship issues deficiency of getting his needs met in his abdomen	feel	He would rather look to spiritual for answers. Resistance/obstacle to physical world needs/answers
7	floating floating pt is lifted about 1-3 feet above table	feel VM	pt likes this is comfortable = it, loves spiritual occurrences like this - always seeking - wanting to get to them. Almost a little addictive Always trying to get back to high of family "spiritual" experiences vibrationally high experiences

*How did you observe this? Sight - Observed visually in the external field, Internal Clairvoyance -
Visuals in the mind, Clairsentient - feeling in body; Claircognizant - information coming to the mind.

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*How did you observe this? *Sight* - Observed visually in the external field, *Internal Clairvoyance* - Visuals in the mind, *Clairsentient* - feeling in body; *Claircognizant* - information coming to the mind.

Session# 24

Draw #	Observation	Type*	Meaning
1	Heaven begin at head Energy flowing into ppt		There's a warmth of energy rushing from head into ppt Heart - Golden Energy
2	Rt foot Chakra slightly Blocked/same w/ side of Body		Imbalance L/R Sides of Body's energy
3	1st Chakra tilted To Left		
3	2nd Chakra - cords		
3	3rd Chakra - vibration L side		
3	4 Chakra - Smoothly/quiet		
3	5 Chakra - some leakage		
4	Rt Telepath/very stimulated		ed - Too much info for 3rd c causing disturbance energy
4	6 Chakra - cord Rt side		over stimulates 6th Chakra Heaviness glowing on left side opp head/cant identify inner vision
5	Outside Aberrant Energy picked up		cloudy dissonant energy
6	Near/Base of Skull super-tight - pulse top Rt of Head		
7	Rt should-clogged energy		stops creativity/ability to free flow intuitive information Stiffness - result of vaccine/pulse vibrations
8	Prostate off balance		Energy held on rt, side lower Body takes left Chakra energy causing imbalance in male/female energy system
9	clearing frontal lobe		Brain Fog lifted
3	Post session		much calmer energy in 3rd & 2nd Chakra helped w/ Brain fog cleared telepaths
	Feet Chakra Open/cleared		

*How did you observe this? *Sight* - Observed visually in the external field, *Internal Clairvoyance* - Visuals in the mind, *Clairsentient* - feeling in body; *Claircognizant* - information coming to the mind.

StudyID# SE104

Session# 21

Seer Observation Table

Draw #	Observation	Type*	Meaning
1	PPT - A Saturation of Life force Energy	All	PPT has a lot of Vitality, Physical Energy
2	Wide Aura, filling w/ Gold		PPT + RM are both running high frequency energy in the field
3	PPT balances left + Right Channels		Equal Energy Pulsing balances through Meridians, Male + Female
4	Reiki Energy upgrades 2nd chakra		Denser Energies clear Emotional / old info grounds out
5	PPT upgrades Grounding		Deeper healing / More relaxed
6	Misty Energy in field		Clearing, burning old info / contracts
7	PPT is Just receiving Energy		More light on a cellular level, Systems brought into Presence
8	Heart feels more Present / centered		PPT Gently Integrating Session
←	Session doesn't feel opened / closed properly		The energy in the field feels leaky.

*How did you observe this? Sight - Observed visually in the external field, Internal Clairvoyance - Visuals in the mind, Clairsentient - feeling in body; Claircognizant - information coming to the mind.

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StudyID# SE104

Session# 21

Seer Observation Table

Draw #	Observation	Type*	Meaning
1	Bright light surrounding PPT's body	Visual	overall joyful, happy PPT
2	Heart chakra is bright & very open	All	PPT is very compassionate. Very loving - yet I sense something which is hard to see
3	Tightness in the Solar plexus area - Muddy looking - sluggish chakra w/ inward spin -	Sentient	Acid in the digestive track - Heartburn - Discomfort - stored gas etc
4	slow moving blood cells - lethargic feel to his cardio. system	Sentient	Bruises easily - old emotional pain -
5	Tightness / past life event (trauma) stored deep in the heart - heaviness - Deep Emotional Pain	Sentient	keeps old memories / sadness / loss deep inside his heart - doing his best to live a full life
			but memories keep him stuck - ungrounded - Emotional - childhood memories -
6	ungrounded. As he relaxes in the chair, his essence is 1/2 way in the body. Doesn't pass his Solar plexus.	All	likes to reside up in the Ether - Has a better time being connected to his higher self than being fully in the body. Although he is physically active, it's not enough
7	Hides well - Pressure on top chakra / top of head -	All	- Deep in the mind - Intense thinker - Reviews past - Temper - Mood swings from calm to intense - working w/ worth issues, He is as broken as he is a channel for love/light -
8	Slow 1st chakra Tight 2nd chakra	All	- lack of activity in 1st & 2nd - Abandonment - Desire for love & companionship - Loneliness - constipation on 2nd ch -
	Beautiful soul doing beautiful things in the world - He battles w/ his mind which could affect his health in the long run		

*How did you observe this? Sight - Observed visually in the external field, Internal Clairvoyance - Visuals in the mind, Clairsentient - feeling in body; Claircognizant - information coming to the mind.

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StudyID# RM102Session # 21

Reiki Master Observation Table

Observation	Type*	Meaning
<i>lots of energy around his head</i>		<i>seems like he is worried</i>
<i>Energy around Right Knee</i>		<i>old running injury</i>
<i>Energy around jaw</i>		<i>grind teeth - stress</i>
<i>Energy near heart</i>		<i>old relationship issues</i>

*How did you observe this? Traditional five senses. *Sight* - Observed visually in the external field, *Internal Clairvoyance* - Visuals in the mind, *Clairsentient* - feeling in body; *Claircognizant* - information coming to the mind.

StudyID# M5121Session # 21

Participant Observation Table

Observation	Type*	Meaning
<i>Right side of</i>		<i>See Sensation</i>
<i>my Bsd / more physical</i>		<i>on the right side</i>
		<i>I noticed more in my Body.</i>
<i>left side more</i>		<i>images came to me</i>
<i>visual</i>		<i>when working on the left side.</i>
<i>Top of head tingling</i>		<i>I felt energy release</i>
		<i>from the top of my head and</i>
		<i>it made me feel calm.</i>

*How did you observe this? *Sight* - Observed visually in the external field, *Internal Clairvoyance* - Visuals in the mind, *Clairsentient* - feeling in body; *Claircognizant* - information coming to the mind.