

## Original Article

# Johrei Family Healing: A Pilot Study

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Johrei is a form of spiritual healing comprising “energy channelling” and light massage given either by a trained healer or, after some basic training, by anyone. This pilot trial aimed to identify any potential benefits of family-based Johrei practice in childhood eczema and for general health and to establish the feasibility of a subsequent randomised controlled trial. Volunteer families of 3-5 individuals, including at least one child with eczema were recruited to an uncontrolled pilot trial lasting 12 months. Parents were trained in Johrei healing and then practised at home with their family. Participants kept diaries and provided questionnaire data at baseline, 3,6 and 12 months. Eczema symptoms were scored at the same intervals. Scepticism about Johrei is presently an obstacle to recruitment and retention of a representative sample in a clinical trial, and to its potential use in general practice. The frequency and quality of practise at home by families may be insufficient to bring about the putative health benefits. Initial improvements in eczema symptoms and diary recorded illness, could not be separated from seasonal factors and other potential confounders. There were no improvements on other outcomes measuring general health and psychological wellbeing of family members.

**Keywords:** Johrei – spiritual healing – eczema

## Introduction

### Johrei is a Form of Spiritual Healing

Johrei healing, originated in Japan, is a form of spiritual healing comprising ‘energy channelling’ and light massage. The latter incorporates elements of Reiki and acupuncture. Energy channelling is the direction of an intangible healing energy through the hands of the healer at a distance from the person receiving healing. Practitioners differ in the emphasis given to these two components. Johrei can be learned and practised by anyone and is seen as a two-way process that heals both the healer and the person healed.

Johrei is practised within some Japanese families and, anecdotally, such families are healthier and use less medication than those who do not practise Johrei. Anecdotal evidence also supports its use as a treatment for childhood eczema.

Scientific evidence is limited and variable in quality. Naito (1) suggests a beneficial effect on stress and the immune system. Taft (2) contradicts claims that Johrei has a beneficial effect on cell death and proliferation rates of cultured human cancer cells. Johrei healing is not widely practised in the UK at present but some doctors do advocate its use arguing that it could produce general health benefits and save money for the NHS.

### Why We Have Carried Out This Study

Here, we describe a pilot study designed to explore the acceptability of Johrei healing in the UK, identify any recruitment, compliance and retention problems, identify potential health benefits including those for childhood eczema, identify suitable outcome measures, estimate effect sizes, and establish the feasibility of a subsequent randomized clinical trial (RCT). The effects of Johrei on childhood eczema specifically as well as upon general family health were considered because of favorable anecdotal reports in this condition, and because it was thought desirable to include at

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least one condition common to all the families which could be assessed using a standardized symptom score. A year-long pilot study was initiated because practitioners insisted that the benefits of Johrei would only manifest with long-term, regular practice. If this is the case then the issues of retention and long-term compliance are also important in assessing the practical application of Johrei self-healing as a health care strategy.

## Method

### Trial Design, Funding and Ethics Approval

The study was a prospective, single-center, uncontrolled pilot trial with a 12 month treatment period. The study was funded by Sekai Kyusei Kyo Izunome through the British Johrei Society. The protocol was developed in discussion with the sponsors and approved by the North and East Devon Local Research Ethics Committee.

### How we Recruited Families and Inclusion Criteria

Recruitment of volunteer families began in March 2003 through press releases and advertising in local General Practice (GP) surgeries. GP surgeries are primary care facilities provided throughout the UK as part of the National Health Service. We aimed to recruit 20 families, a number which we regarded as achievable within the 2 year time-frame of the study's funding and practical in terms of the logistics and resources available for initial training in Johrei and follow-up sessions. Inclusion criteria were as follows: (i) Families had to comprise 3–5 individuals living under one roof. (ii) Families had to include at least one child with diagnosed atopic eczema. (iii) Families had to live within 15 miles (later extended to 30 miles) of the study center in Exeter where training sessions were held. (iv) All family members, old enough to do so, had to agree to participate in the trial by learning and practicing Johrei and completing the outcome measures. All family members were required to learn and practice Johrei because it is a mutual process in which one member heals another and practitioners insist that maximum benefits for family health are enjoyed when the whole family participates.

### How Families Learned and Practised Johrei

Representatives from each family were required to attend three group meetings led by a trained Johrei teacher to learn the healing techniques. They were then asked to practise with other family members at home on a regular basis. Families were encouraged to attend monthly group follow-on sessions with the Johrei teacher to review the healing procedure and discuss their experiences. Groups of families were trained in three cohorts and follow-on sessions involved families from all three cohorts.

## We Measured Health, Well-being and Eczema Symptoms every 3 Months

General health and psychological well-being were assessed at baseline, 3, 6, 9 and 12 months using the validated quality of life questionnaires WHOQOL-BREF (3) and SF-36 (4), the Significant Others Scale (SOS) (5), a measure of social support and the Perceived Stress Scale (PSS) (6). Eczema symptoms were assessed by physically examining the child every 3 months using a validated clinical assessment procedure, the Six Area Six Sign Atopic Dermatitis (SASSAD) score (7) and an eczema-specific questionnaire, the Childrens Dermatology Life Quality Index (CDLQI) (8). The SASSAD scoring was carried out by a Research Assistant trained in its use. Six signs of eczema (erythema, lichenification, excoriation, dryness, cracking and exudation) were scored by physical examination of six areas of the body (head and neck, hands, arms, trunk, feet, and legs). The SASSAD score is the total score for all signs in all areas. The maximum score, corresponding to the most severe eczema, is 108. The CDLQI is a validated questionnaire for children aged 5–16. It comprises 10 questions about the degree to which the child's skin problems have affected various aspects of their daily life including discomfort/pain, embarrassment, friendships, clothing choices, play, sports, schoolwork, teasing/bullying, sleep and treatment. Each answer is scored from 0 to 3 with 3 indicating more of a problem and a maximum score of 30 representing the biggest interference with daily life. Families also kept diaries recording periods of illness, days off work or school and regularity of Johrei practise. Families completing the 12 month trial were interviewed following a structured procedure and medical records were accessed for the year preceding the trial and the year of the trial itself. The Research Assistant kept in regular telephone contact with all families, reminding them to attend training sessions and monthly follow-on sessions and to return diary data and completed questionnaires. Particular attempts were made to contact and encourage families who appeared to be on the point of dropping out or who were not returning data.

## Results

### Recruitment, Retention and Compliance were all Problematic

Despite several press releases, newspaper advertisements, advertising in GP surgeries and an increase of the initial catchment area from a 15 mile radius around Exeter to a 30 mile radius, recruitment proved difficult. After 12 months there were a total of 94 telephone and e-mail enquiries from potential recruit families. Telephone interviews established that 29 of these 94 families did not meet the inclusion criteria. After receiving detailed written information about Johrei, the teaching protocol and what was involved in the trial, 46 of the remaining 65 families decided not to participate and 2 families could not be contacted again.

**Table 1.** Consenting families

<i>n</i>	Outcome	Reasons given for withdrawal
4	Failed to attend Johrei training	Separation ( <i>n</i> = 1), illness ( <i>n</i> = 1), illness and husband changed his mind ( <i>n</i> = 1), no reason given ( <i>n</i> = 1)
4	Withdrew after second training session	Moved house ( <i>n</i> = 1), time commitment too great ( <i>n</i> = 1) no reason given ( <i>n</i> = 2)
3	Dropped out at 3 months	Emigrated ( <i>n</i> = 1), could not fit Johrei into routine ( <i>n</i> = 1), husband lost interest ( <i>n</i> = 1)
1	Dropped out at 6 months	Pressure of work ( <i>n</i> = 1)
1	Dropped out at 9 months	No reason given ( <i>n</i> = 1)
4	Completed 12 month trial	n/a

**Table 2.** Diary estimates of mean number of Johrei sessions per individual, per week

Month	Families with data	Individuals with data	Min	Max	Mean	SD
1	8	31	0	6	2.2	1.8
2	9	35	0	7	2.1	2.1
3	7	35	0	5	1.6	1.9
4	7	27	0	6	1.8	1.8
5	6	23	0	6	1.7	1.9
6	5	19	0	6	1.6	2.1
7	6	23	0	6	1.8	2.1
8	5	19	0	6	1.9	2.3
9	4	16	0	6	2.3	2.3
10	3	11	0	6	2.3	2.1
11	4	15	0	5	1.4	1.6
12	3	11	0	5	2.0	1.9
Overall	9	35	0	7	1.8	1.5

The reasons given for declining were husband or partner refused (*n* = 9), other family members refused (*n* = 4), time commitment too great or conflict with husband/wife's work pattern (*n* = 11), family member ill or going into hospital (*n* = 2), planning overseas trip (*n* = 1), Exeter too far to travel for Johrei training (*n* = 1), advised by hospital not to participate (*n* = 1), family member not wanting to be touched or massaged (*n* = 2), opted to take part in another trial (*n* = 1), not happy with medical records being accessed (*n* = 1), legal guardian of child would not consent (*n* = 1), no specific reason given (*n* = 4) and failed to respond to follow-on contacts (*n* = 8).

The outcome for the 17 families who gave written consent to participate in the trial is shown in Table 1.

Diary estimates showed that for the nine families who completed training and stayed in the trial for at least 3 months, the mean number of healing sessions was 1.8 per week. Table 2 shows the range, mean and standard deviations for number of practise sessions per individual per week in each month of the trial. Overall, the mean number of sessions shows no trend to

increase or decrease over the course of the trial. Subgroup analysis revealed that the mean number of Johrei sessions per week was 2.3 for mothers, 1.0 for fathers, 2.1 for children with eczema and 1.6 for children without eczema.

### Evidence for General Health Benefits was Limited

The family diaries indicated no obvious trend towards an increase or decrease in GP visits or use of complementary or alternative medicine practitioners during the period of the trial. Figure 1 shows that the mean number of days ill reported by families declined during the study. Data are presented separately for the nine families who completed training in Johrei and for the subgroup of four families who completed the full 12 month trial (completers). It should be noted that six of the nine families belonged to the second and third cohorts who began training in October and November. The remaining three families began training in June and only one of these was still enrolled in the trial beyond 3 months. The data for the second half of the trial are, therefore, almost entirely summer data.

Illness sufficiently serious to cause days off work or school, showed no clear trend to increase or decrease over the course of the trial. There were 9 days of illness requiring hospital treatment among all nine families in the 12 month period and no particular trend was evident in the data.

### Eczema Symptoms Improved Initially in some Children but this may be due to Seasonal or Other Factors

A total of 18 children diagnosed with eczema were enrolled in the trial and baseline data were obtained for 15 children. There were 10 children with eczema in the 9 families who completed Johrei training. As shown in Fig. 2, the mean SASSAD scores fell between baseline and 3 months and then rose again between 9 and 12 months. The individual data (Fig. 3) shows that the rise in mean eczema severity between months 6 and 12 is largely due to the deterioration in symptoms of one child.

For these 10 children, the change in total SASSAD score from baseline to 3 months and the number of Johrei sessions reported for that child during the first 3 months were not correlated at a statistically significant level (Pearson  $r = 0.379$ ,  $P = 0.28$ ). The correlation between change in total SASSAD score from baseline to 3 months and number of sessions per family, adjusted for number of people in the family, during the first 3 months was higher but still did not reach statistical significance (Pearson  $r = 0.474$ ,  $P = 0.166$ ).

The CDLQI was administered at baseline to the five children in the study who met the age qualification stipulated. These five children came from five different families but only three of these families completed the training. Figure 4 indicates a short-term fall in the mean CDLQI score at 3 months for these three children.

### Quality of Life Measures showed No Improvements

When scores were analyzed for either all families completing training (*n* = 9) or for those families completing the trial

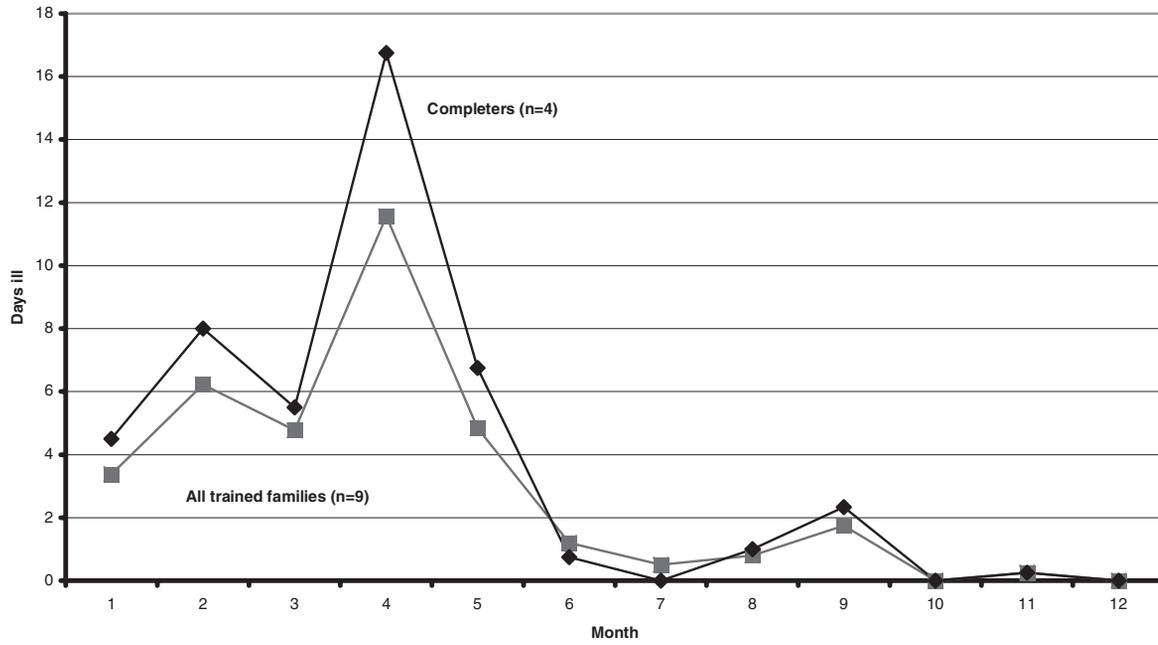


Figure 1. Mean number of days ill per family, per month, as reported in diaries.

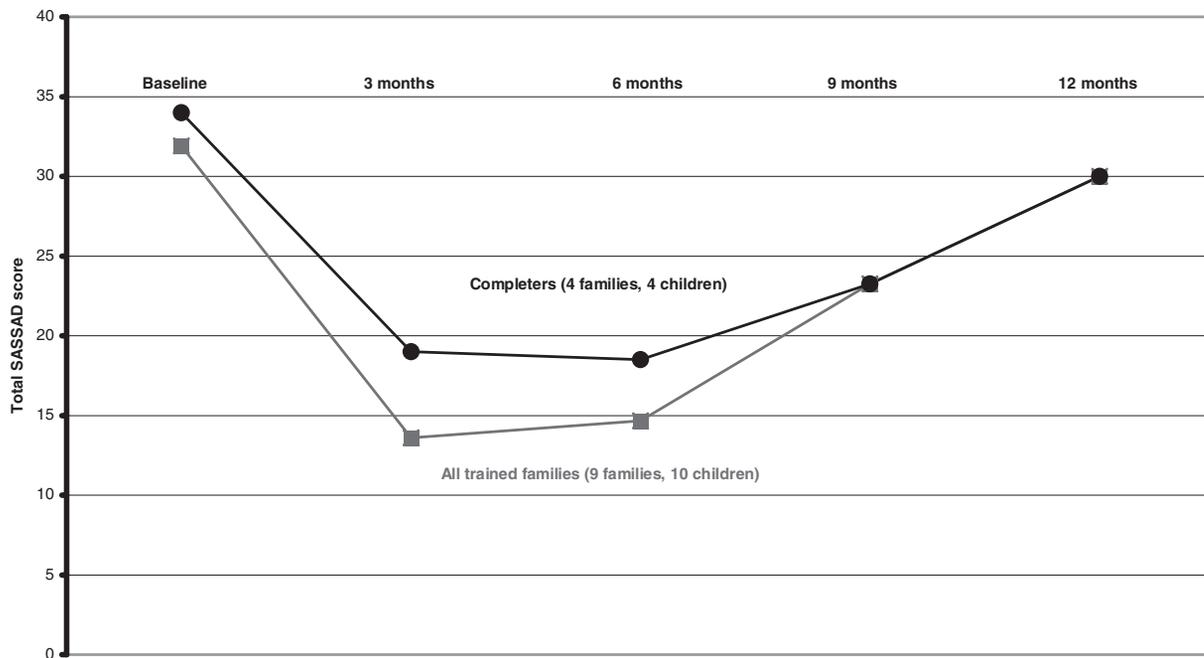


Figure 2. Eczema severity as measured by clinical examination (mean SASSAD score).

(n = 4) there were no signs of improvement or deterioration in scores on the SF-36, WHOQOL-BREF, SOS or PSS.

**Medical Records Indicated No Improvements**

For the four families who completed the trial, GP records were compared for the 12 months preceding entry to the trial

and for the 12 month period of the trial. Number of consultations, number of recorded illnesses, number of prescribed medicines and number of certified days off school or work were recorded for each period. Figure 5 shows that there were slightly more consultations, recorded illnesses and prescribed medicines during the year of the trial than during the preceding year.

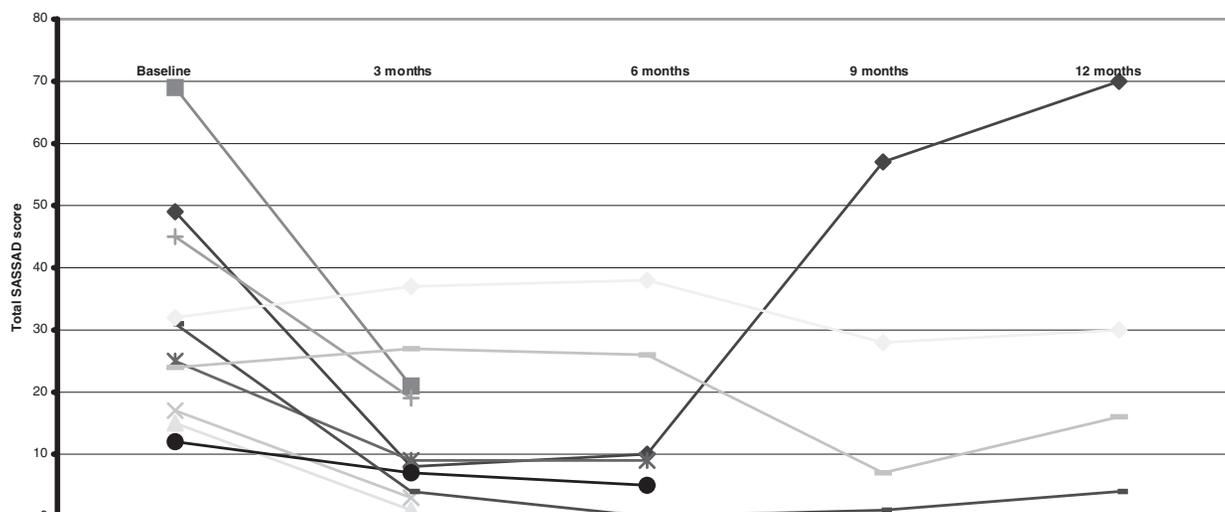


Figure 3. Eczema severity as measured by clinical examination (mean SASSAD score) for individual children.

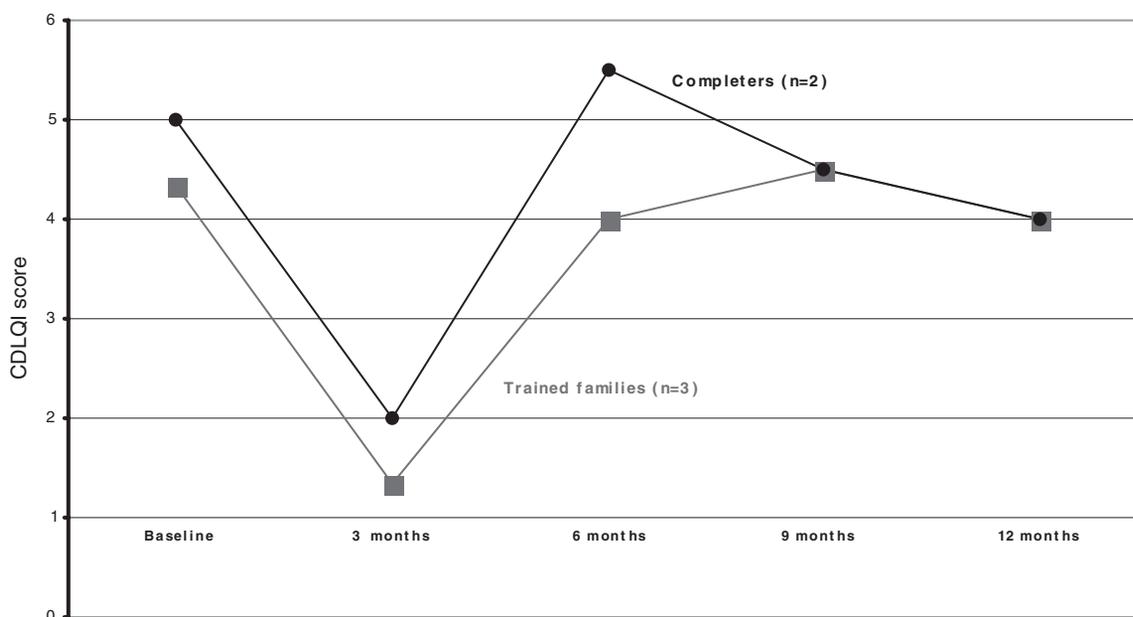


Figure 4. Mean CDLQI score in children aged 5-16 with eczema.

### Most Families were Sceptical in Final Interviews

Semistructured interviews conducted by the Research Assistant at the homes of the four families completing the trial were recorded and transcribed. The main themes to emerge were (i) families enrolled in the trial to seek help for their child's eczema. Even though some of them were sceptical or suspicious, they were willing to try anything; (ii) families were pleased with the way Johrei training sessions were conducted except that several were concerned about a change of teachers part way through the trial. Some felt consistency

and developing a relationship with the teacher was important; several families mentioned changes in style between hands-on and hands-off healing between teachers; (iii) healing was usually centered around the mother and was most usually practised by the mother on the child with eczema; (iv) several families thought their child's eczema may have improved somewhat during the trial but they were reluctant to attribute improvement to Johrei and mentioned growing out of it, changes in medication and other factors which may have been important; (v) similarly, two families noticed changes in how relaxed or well they felt generally but mentioned other factors such as exercising more or changes in their

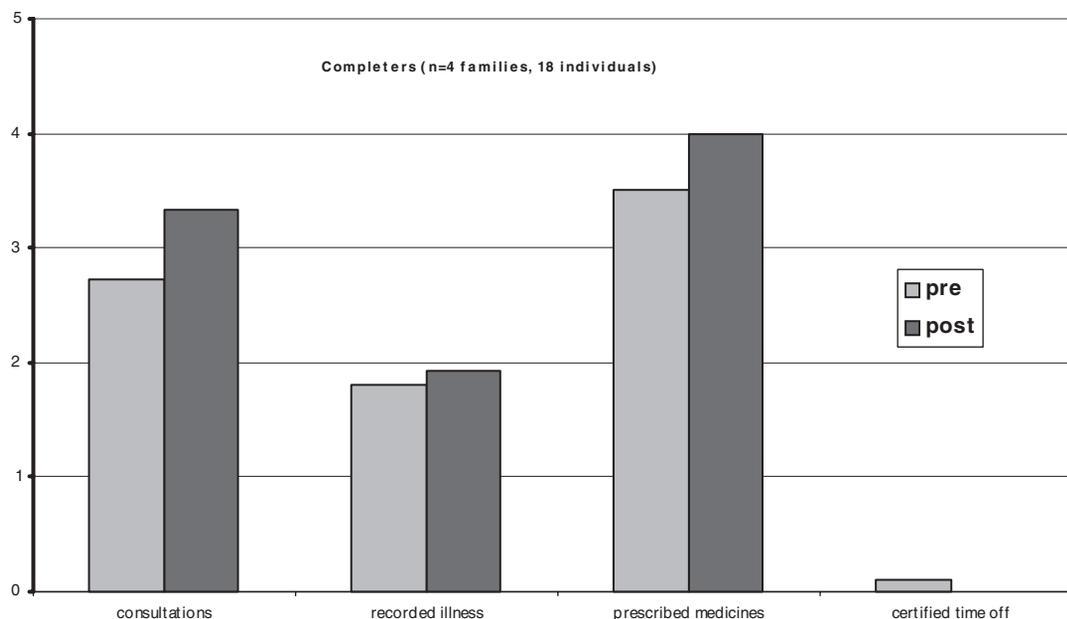


Figure 5. Mean number of GP consultations, recorded illnesses, prescribed medicines and doctor-certified days off work or school, per individual for completers.

diet. There were no negative effects noticed by any of the families; (vi) attitudes towards Johrei did not change markedly. Initially sceptical fathers remained sceptical; (vii) at least one member of each family said that they would like to continue to practise Johrei but were not certain they would actually do so without some support; (viii) traveling to the training sessions and getting babysitters so that both adults could attend training and follow-on sessions was a problem for at least one family; (ix) most families thought it would be better to receive healing from a trained and qualified practitioner; (x) families were happy with the questionnaires, diaries and eczema examinations which were required as part of the trial protocol.

## Discussion

This pilot study has used diverse outcome measures in the form of diary records, questionnaires, clinical examination, semistructured interview and data extracted from GP records. As an uncontrolled pilot study it was designed to identify any trends in data which could feasibly be attributed to the intervention in order to inform the design of a future RCT.

### Is Johrei Effective?

It is not possible to conclude that Johrei healing is either effective or ineffective from this data, as there are several alternative explanations for the pattern of data observed. In particular, the lack of a control group means that any trends observed should be interpreted with great caution. For example, the incidence of illness reported in the family diaries declined, but these data are influenced by the fact that most families started the trial in the autumn or winter months

when we would expect illnesses to occur more frequently. It is also inconsistent with the data from GP medical records of the four families completing the trial. Eczema severity appeared to fall during the first 3 months of the trial but again there may be a seasonal effect with symptoms improving during what was for most children enrolled in the trial, the winter months at the start of the trial. Some studies report increased symptom severity associated with the release of pollen during spring (10) while others report worse symptoms in winter associated with low sun exposure and low temperature (11). A specific effect of Johrei on eczema is difficult to reconcile with the fact that several families dropped out at 3 months despite this apparent improvement. Even among the families who completed the trial, most were reluctant to say unequivocally that there had been a marked effect on their child's eczema, or that any effect seen was due to Johrei. An optimistic interpretation would be that the improvement in symptoms during the first 3 months led to the withdrawals at this stage but this is not mentioned among the reasons given for withdrawing (Table 1). Correlation coefficients describing the relationship between number of Johrei sessions in the first 3 months and change in eczema symptom scores were not statistically significant when considering either practise sessions specifically with the child or those practised by the whole family. These correlation coefficients suggest that only between 0.14 and 0.22 of the variance ( $r^2$ ) is accounted for by the differences in level of practise. The CDQLI data available for three children also showed an improvement during the first 3 months but this observation is subject to the same reservations arising from the lack of a control group. Furthermore, any inferences made on the basis of data obtained from such an extremely small sample size are highly unreliable.

### Feasibility of a Future Randomized Clinical Trial

Despite our best efforts, recruitment to this trial was difficult. There were two main reasons for this. Either a family member, usually the husband, did not find the idea of Johrei acceptable or the time commitment required to learn and practice Johrei on a regular basis was too great. It appears that Johrei healing is not easily acceptable in the UK. The idea of spiritual healing arouses scepticism and suspicion, particularly among men. The main reason that families agreed to participate was because they were desperate to try anything which might help their child's eczema. Families frequently cited the husband's work schedule as being incompatible with regular practice of Johrei. Of the 94 original enquiries, 90 came from the mother of the family and only 4 from the father. It was mainly women who attended the training sessions. We conclude from this, and from data on who practised most, that, in the UK, Johrei is more acceptable to women and that women are more likely to practise it in the home. Any future research should consider how crucial family participation is to the practise of Johrei. There are several implications of this recruitment problem for any future research into Johrei. Even a large-scale clinical trial, if it encountered similar reticence, but continued long enough or recruited widely enough to achieve a sufficiently large sample, would risk ending up with a highly selected sample. The generalizability of results from such a trial would be questionable. It would be criticized for recruiting a specialized population favorably predisposed towards Johrei, for whom expectations of benefit and likely placebo response might be considered particularly high.

Of the 17 families who consented to join the trial, 13 attended any of the training sessions, 9 completed the training and only 4 stayed in the trial for the full 12 months. This retention problem, if repeated in any future controlled trial, would further limit the generalizability of its findings. High drop-out rates are not uncommon in trials of interventions requiring self-motivation and regular practise as for example in trials of meditation (9) and may compromise the randomization process by introducing systematic differences between experimental and control groups during the course of the trial.

Having childhood eczema as one of the inclusion criteria restricted the pool of families from which to recruit and a research focus on the general health effects of the intervention might improve recruitment prospects. However, it was concern about the child's eczema which brought families into the study despite initial scepticism. Recruitment might also be helped by asking people to commit to a shorter trial. Several families in the trial stated that they would prefer to receive healing from a qualified practitioner, instead of, or in addition to the family healing, and this may have made the trial more attractive to prospective recruits. It would also have made the intervention more standardized.

### Did Families Practise Johrei Enough to Enjoy the Putative Benefits?

Most families who stayed in the trial continued to practise throughout with a fairly constant regularity. Whether two

sessions per individual per week on average is sufficient for any expected benefits to manifest themselves is a moot point. However, it is clearly the level which we can realistically expect from the average family asked to practise Johrei at home—if benefits do not manifest themselves at this level of practice, then it is not an effective health strategy in practice. For some families at least, it became apparent that the length of sessions was highly variable and was sometimes just a few minutes at a time.

### What Would be a Suitable Control Procedure for Johrei?

The most difficult aspect of designing an RCT to test Johrei will be to choose an adequate control procedure. It should be possible to blind subjects as to whether they are receiving Johrei or a control procedure. In part this depends upon what is considered to be the essential and characteristic component of Johrei healing. If it is the healer's intention to heal and the putative energy transmitted during the channelling procedure, then a control procedure involving only touch delivered by actors or sham healers (12) could be used. If a specific type of touching is an essential part of Johrei, an adequate control could be non-specific touch or a specifically different type of touch. There needs to be similar time spent with individuals or in groups, similar opportunities for feedback and discussion of the health issues being researched and measures taken by those conducting the control procedure to create the feeling that a real and plausible intervention is being made.

### Conclusions

People in the UK, particularly men, are sceptical about Johrei healing. It is presently not generally an acceptable form of treatment and scepticism about Johrei is presently an obstacle to recruitment and retention of a representative sample in a clinical trial, and to its potential use in GP. The frequency and quality of practise at home by families may be insufficient to bring about the health benefits claimed for regular Johrei practise. Only 17 of the 65 families who expressed an initial interest in the trial and were eligible for inclusion were actually persuaded to enroll, and of these only 9 families completed the training and the first 3 months of the trial. While children in seven of these nine families apparently experienced improvement in their eczema symptoms, seasonal changes and other potential confounders mean that these changes cannot be attributed with any confidence to the practice of Johrei. From the four families who participated in the trial for the full 12 months, only one child showed a consistent improvement in eczema symptoms while for another early improvement was lost in the second 6 months of the trial. Convincing evidence for a positive effect on general family health was also lacking.

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