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SAFETY, ELEMENTS, AND EFFECTS OF HEALING TOUCH ON CHRONIC NON-MALIGNANT ABDOMINAL PAIN

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Victoria E. Slater
May 1996

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DEDICATION

This dissertation is dedicated to my daughter and husband

Amy Elizabeth Slater

and

John Clinton Slater

who were there for every word.

ACKNOWLEDGMENTS

One does not conceive, labor, and give birth to a dissertation without many midwives. The members of my Dissertation Committee who labored with me are models of patience and gracious support. Sandra Thomas, my chair and a superb editor, sent me regular "are you still alive?" letters. H. W. Crater spent many weeks teaching me a smattering of physics. Mary Sue Younger made statistics make sense, something no one else was able to do. Sharon Scandrett-Hibdon always had an insightful answer to every question. Dava Shoffner kept fresh the knowing that energetic healing belongs wherever nurses are.

The successful birth of this work is due in no small part to Bonnie Johnson, wise woman. She regularly met with Dr. Crater and me to discuss the physics of Healing Touch and could stand in the nebulous space between Healing Touch and physics and interpret both in the other's concepts.

The Department of Defense Triservices Nursing Research Committee, through the Uniformed Services University of the Health Sciences (USUHS), awarded $20,539 for the study (96.25% of the study costs). The Gamma Chi chapter of Sigma Theta Tau provided additional funds. The awards made the study possible.

Bantam Publications gave permission to use Brennan's "Seven Layer Auric Body System".

My daughter, Amy, and husband, John, were in active labor with me throughout this birth. This was, truly, a family project.

Abstract

This experimental study examined the safety, elements, and effects of Healing Touch (HT). Recipients had abdominal surgery at least four weeks prior to admission to the study and had excessive pain at the operative site. Each received three separate thirty minute treatments: HT given by an experienced HT provider, HT given by a naive provider (the sham treatment), and an interview. Treatments were at least 24 hours apart and their order was selected randomly. HT and sham treatments combined two HT interventions, magnetic unruffling and wound sealing. The interview was the placebo control and the sham, technique control. Quantitative changes in perceived pain before and after treatments were measured by the McGill-Melzack Pain Questionnaire (MPQ). Qualitative data about providers' and recipients' experiences were obtained.

All three treatments were found to be safe for recipients and providers, but sham providers had more discomfort than HT providers. Recipients experienced more nausea, headaches, dizziness, and drowsiness after HT than after sham. Quantitative data indicated that HT and sham were followed by equal pain relief, qualitative data that HT was followed by more total pain relief and relaxation than sham. The interview was followed by less pain relief than HT or sham, indicating that HT is not simply related to the nurse's presence and attention. The differences between quantitative and qualitative results suggest that recipients may evaluate their pain using criteria other than just pain sensation.

The primary conclusion is that HT given by a naive provider is followed by essentially the same pain relief as that given by an experienced practitioner. While it is

tempting to conclude that the hand motions, alone, contributed to recipient's pain relief, other factors may have been involved. Such factors include a possible complex placebo effect of ritual and expectations, the recipient's opportunity to rest, being gently touched, some other unidentified influence, or a combination of elements.

No conclusion is possible about the effect of providers' states of consciousness on recipients' pain relief. Provider and recipient experiences during treatments were unusual and varied. Implications and recommendations for nursing care and research are included.

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Chapter 1

Introduction, Conceptual Framework, and Research Questions

Introduction to Problem

Pain relief, undoubtedly, has been a human priority since the beginning of the human species. It certainly was a priority of nurses long before the first nursing textbook, Nightingale's 1860 work, Notes on Nursing. One hundred years later, Dorothy Crowley (1962) wrote Pain and Its Alleviation, the first modern nursing book specifically concerned with pain relief in adults. The first nursing research on pain was funded in 1964. It examined nurses' actions to relieve pain (Newton, Hunt, McDowell, & Hanken, 1964). Pain relief in children was seldom discussed in nursing literature until the 1970s.

During the 1970s, four nurses brought pain concepts, definitions, and management to the forefront of nursing. In 1974, Benoliel and Crowley wrote The Patient in Pain: New Concepts, for the American Cancer Society. Jacox's (1977) exhaustive work, Pain: A Sourcebook for Nurses and Other Health Professionals is still used by nurses to understand the many aspects of pain. McCaffery (1972, 1979) redefined pain and refocused nurses' approach to pain management. She entreated nurses to define pain as "whatever the patient says it is", rather than the traditional medical view of pain as an objective clinical pathology. She urged nurses to manage patient's actual pain rather than their complaints of pain (National Institute of Nursing Research, 1994).

Healing Touch (HT) follows in the footsteps of a long history of nurses' concern with alleviating pain. Like

McCaffery, HT practitioners define pain as the patient does and are concerned with pain's relief, not just reducing complaints of pain. HT is often used by nurses to relieve pain, but no published data exists indicating that it works.

Healing Touch (HT) is categorized as a type of energetic healing (EH), specifically hand-mediated energetic healing (HMEH) (Slater, 1995). In HMEH, the practitioner uses her/his hands as the medium of healing, which is attributed to the movement of energy. Studies of HMEH effects have suggested that treatments are safe, but there has been no specific study of safety to recipient and provider of any modality, including HT. There is no published research on the effects of HT as a discrete HMEH methodology, nor are there reports on the contribution of various parts of the treatment to the whole. Practitioners believe that one must be in an altered state of consciousness, called centering, to give effective HT treatments. There is no data to support this claim.

Conceptual Frameworks

Both Eastern and Western thinkers have offered explanations for HMEH's perceived healing effects. Three conceptual frameworks will be briefly reviewed: cultural, theoretical, and physical. Krieger (1979), who developed one HMEH modality called Therapeutic Touch (TT) attributed TT's effects to the Hindu concept of "prana" (p. 12). Quinn (1984) sought a theoretical explanation and applied Martha Rogers' (1970) theory of the Unitary Human Being to TT. The North American Nursing Diagnosis Association (NANDA) expanded Quinn's application of TT to Rogers' concepts when it accepted "energy field disturbance" as a nursing diagnosis (Doenges & Moorhouse, 1996, pp. 177-180).

The third framework used for HMEH is physics. An electromagnetic field is the phenomenon most closely matching HMEH practitioners' descriptions of what they sense, but physicists have not developed tools to measure any physical phenomenon actually involved in HMEH. As yet, there is no accepted scientific understanding of HMEH.

Cultural Frameworks

Most Eastern cultures have a concept of an invisible universal life energy. For example, the Hindu concept of prana, which Krieger (1979) used to explain TT, relates to the "organizing factors that underlie what we call the life process" and is considered responsible for wound healing (p. 12). Prana was first written about in India around 5,000 B.C. (Brennan, 1993); pranic healing involves learning to access and send one's own prana to another who needs it (Sui, 1990).

The Japanese and Chinese refer to the ancient concepts of "chi" or "qi", instead of prana, and practice chi kung (qigong), acupressure, acupuncture, and T'ai chi, all designed to manipulate chi (Gelles, 1993).

An ancient Tibetan healing practice is Reiki, which means universal life energy (Baginski & Sharamon, 1988). Reiki practitioners receive a series of energetic treatments, called attunements, which are believed to prepare the initiate to be a conduit of Ki. A Reiki treatment consists of the Reiki Master laying hands on a client and allowing Ki to be pulled from the practitioner by and into the recipient. In the Hawaiian Huna tradition, health and illness are viewed as abundance or deficit of energy, or "mana"; healing requires harmonizing the energy and energizing the person (King, 1989).

Theoretical Framework

Rogers (1990) proposed that a human is an "irreducible, indivisible, multidimensional energy field" (p. 7); Quinn (1984) suggested that TT's effects were the "outcomes of the unique interaction of [healer's and subject's] energy fields" (p. 45). Meehan (1990) pointed out that TT practitioners often mix Rogers' and Krieger's explanations and argued that the two were incompatible. She suggested that Krieger's concepts of prana and the exchange of energy between practitioner and recipient could be changed to Rogers' concepts. Therapeutic Touch would be redefined "as a knowledgeable and purposive patterning of patient-environmental energy field process in which the nurse assumes a meditative form of awareness and uses his or her hands as a mediating focus in the continuing patterning of the mutual patient-environmental energy field process" (p. 74). Any effect of TT, according to Meehan, may be reinterpreted as "change which occurs in the human-environmental energy field patterning".

Quinn (1984; Quinn & Strelkauskas, 1993), a student of both Rogers and Krieger, has consistently depicted TT in Rogerian terms, to the extent that some TT researchers describe a Rogerian-Quinn framework (Olson, Sneed, Bonadonna, Ratliff, & Dias, 1992). Other students of Rogers and Krieger, such as Macrae (1987), continue to describe TT as does Krieger, using the concepts of prana and energy transfer. TT practitioners do not, as a group, use a consistent framework.

NANDA's nursing diagnosis, "Energy Field Disturbance", presumably derived from the Rogerian-Quinn framework, is defined as "a disruption of the flow of energy (aura) surrounding a person's being that results in a disharmony of

the body, mind and/or spirit" (Doenges & Moorhouse, 1996, p. 177). Energy field disturbance is classified in the physiological domain involving neurological functions. Its major defining characteristic is a "block in the energy field" that is objectively sensed through temperature changes, visual changes, sounds, "disruptions in the field (vacant/hold/spike/bulge)," and/or "movement (wave/spike/tingling/dense/flowing)" (Doenges & Moorhouse, p. 178). TT and acupressure are listed as suggested interventions.

Tentative Scientific Frameworks

Some HMEH practitioners assume that traditional explanations and healing systems are based upon an awareness of and sensitivity to some kind of universal natural phenomenon. Two such phenomena are electromagnetic fields and the newly discovered property of biophoton emissions, or the property of living tissue to emit light. Each will be discussed briefly.

Electromagnetism and the electromagnetic human.

Most electromagnets have iron cores encircled by electrical coils. When electricity is turned on, an electromagnet can lift objects or, when the current is shut off, let them go. It produces a (1) radiating, (2) concentric, (3) magnetic field that periodically reduces in density.

Compare these characteristics to the human, who has an inner circulating iron core (hemoglobin) surrounded by electricity (neuronal activity). When alive, electricity surges through the body producing electromagnetism. A diminishing concentric magnetic field may produce what has recently and traditionally been described as a person's aura, or energetic bodies.

Brennan (1987), Gerber (1988), and Kunz (1991) each describe layers of energy, called energetic bodies, surrounding the physical body. Authors differ in their interpretations of energetic bodies, but not in their depictions of the general structure. The models reflect characteristics of an electromagnet and physicists' descriptions of the decreasing density of concentric magnetic fields surrounding an electromagnet. Each model includes concentric layers of decreasing density surrounding the physical body (See Figure 1).

Other features of electromagnets fit human experience. An electromagnet's strength varies with changes in electrical input, allowing it to be stronger than a permanent magnet, such as a refrigerator magnet.It can be turned on and off; a permanent magnet cannot be. Finally, an electromagnet's polarity can be reversed by changing the current's direction (Freeman & Durden, 1990), a characteristic Becker (Becker & Selden, 1985) discovered humans can learn to do. These characteristics fit aspects of the human, an amazingly strong collection of bones and muscles whose strength can be controlled by external applications of energy, such as food and exercise. Death is the equivalent of turning off the electromagnet.

Bioelectromagnetism.

The new science of bioelectromagnetism, which blends biology and human electromagnetic (EM) characteristics, provides another approach to understanding HMEH. Low level EM fields have been shown to have an effect on living tissue. Studies include EM's effects on the nervous and endocrine systems, bone growth, the immune system, reproduction and development, wound healing, and reduction of withdrawal symptoms from addictive substances (de

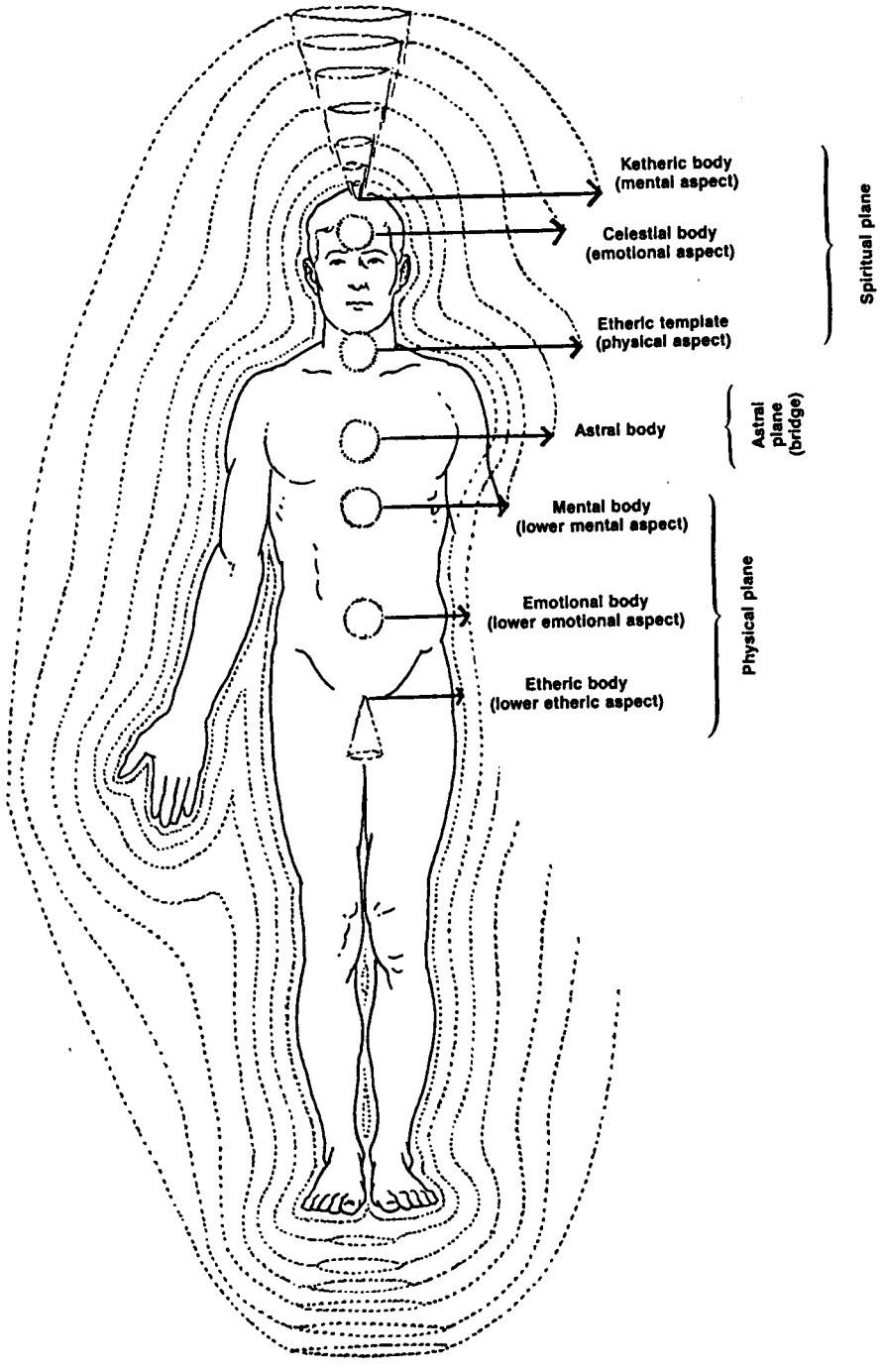

Figure 1. The Seven Layer Auric body System
From B. Brennan, Hands of Light, with permission.

Quincey, 1993; Walleczek, 1993). Currently, EM applications have limited use in the clinical setting and few clinical studies have been replicated. Most research on electromagnetic (EM) fields for clinical use is still at the basic level of determining the most effective signal characteristics needed to achieve a desired effect.

Within bioelectromagnetism is the study of biophoton emissions, or the emission of a photon by a living organism. All life forms appear to emit invisible ultraweak light. The light's intensity has been measured from a few to several thousand photons per second per cm^2 and is influenced by temperature, oxygen, carbon dioxide, integrity of the organism, and other features. It crosses the range of visible light from ultraviolet to infrared.

Studies throughout the world have discovered that a wide variety of species of plants and animals emit ultraweak light. Single cells, yeast, seedlings, blood, a beating heart separated from a frog and human breath emit this light. Tumor tissues emit a different light pattern than normal tissue. Damaged and dying cells, regardless of cause of death, have been found to emit an intense burst of light, called degradation radiation (Rubik, 1993).

Ultraweak light has been implicated in behavior of cell cultures. Two cultures can be separated by a glass or quartz window and one culture poisoned. Under specific circumstances, the healthy culture will become ill and may die, just as the poisoned culture did. The inference is that the dying culture communicated a long-range ultraviolet signal to the healthy culture, which responded to the information in the signal.

Beverly Rubik (1993), Director of the Center for Frontier Sciences at Temple University, suggested that

biophoton emissions may indicate an "endogenous, innate, electromagnetic field pervading the entire organism, which may act as both sender and receiver of the biophotons that are 'electromagnetic bioinformation' used in regulating life processes" (p. 12). Such bioinformation indicates that there is a "central control within the living state that is nonlocal and possibly electromagnetic in nature" (p. 12). Perhaps what has historically been called the aura and/or energetic bodies is/are the same phenomenon as biophoton emissions within an endogenous electromagnetic field pervading the entire organism.

The possibility that an electromagnetic field and/or biophoton emissions are involved in healing is partially supported by Benor's (1993) meta-analysis of worldwide scientific studies of people called healers, practitioners of some variety of HMEH. Half of the more than 150 controlled experiments on the healers' effects showed statistically significant results. Effects were demonstrated on enzyme activity, bacterial, fungal, yeast, and plant growth, and wound healing in mice and humans. Humans exhibited changes in blood cell and hemoglobin levels, blood pressure, asthma, vision, epilepsy, leukemia, headaches, pain, anxiety, personal relationships, and more. The studies Benor analyzed were conducted in many cultures with many different belief systems about healing, suggesting that the mechanism underlying energetic healing's effects is a natural phenomenon.

Research on bioelectromagnetics and biophoton emissions, called by Rubik (1993) "biocommunication" (p. 14.), suggests that information may be encoded and carried on electromagnetic signals within the human body. As Rubik pointed out, studies of biocommunication are very difficult

to do. Although direct evidence is lacking, a great deal of indirect evidence indicates that living systems, including humans, respond to extremely weak light and electromagnetic fields. In 1989, Popp, Warnke, Koenig, and Peschka proposed that bioinformational electromagnetic interactions govern living functions from molecular to intercellular and from intracellular to intraorganism.

Whether biophoton emission, bioelectromagnetics, and bioinformation help explain any effects of energetic healing remains to be seen. If bioelectromagnetic signals do carry information, perhaps, as de Quincey (1993) speculates, bioinformation may be the intersection between consciousness and biological matter.

HT philosophy is that prana, chi, qi, ki, mana, and similar concepts are the same phenomenon: a subtle universal energy, with discernable physical properties, that underlies everything. HT and many other healing modalities are based on the belief that unseen organizing factors of the universal life force, whether or not electromagnetic or bioelectromagnetic, can be accessed, altered, and/or transmitted by conscious choice. HT practitioners believe they can alter their own bioelectromagnetic state through centering and, when in such a state, understand information within and influence the bioelectromagnetic field of another, possibly effecting relief of pain.

The investigator proposed an explanation for HMEH (Slater, 1995a, 1995b) based on the premise that HMEH is a type of energetic healing using natural phenomena that physics, currently, describes as electromagnetic and/or quantum. She proposed that at a level of consciousness other than one's day-to-day awareness all individuals interact with the natural physical phenomena to alter their

physical and/or emotional states; with practice, one can learn to do so deliberately. Physicists described such interactions as the quantum theory of "consciousness-created reality" (Herbert, 1985). Centering was likened to a type of biofeedback in which one specifically learns to be sensitive to and adjust one's own electromagnetic field for the goal of assisting another to heal.

Summary

The three types of conceptual frameworks used to explain HMEH--cultural, theoretical, and physical--have one commonality. Each is based upon an unseen, subtle force. The cultural explanations, largely Eastern in origin, are founded on the belief in a universal process that underlies life. One can facilitate healing by interacting with this process called prana, chi, ki, qi, and mana, among other names.

Rogers' theoretical explanation proposes that human beings are interacting energy fields. In using Rogers' explanation, Quinn (1984) implied that healing occurs when one field (one human) alters the energetic pattern of another human resulting in a more healed state for the recipient. As with prana and other cultural explanations, the medium of healing is unseen.

The scientific explanations of electromagnetic and bioelectromagnetic processes rely on unseen but potentially measurable physical forces. Slater (1995a) based her explanation for HMEH on the premise that the force underlying healing was physical, detectable, and ultimately measurable, even though as yet unseen. She expected that the scientific explanation for HMEH will emerge from physics. The present study does not actually test any of

the three conceptual frameworks, which, at the current stage of science, cannot be empirically tested.

Problem Statement, Research Questions, and Significance

Problem Statement

HMEH practices are believed to involve at least three elements: (1) the presence and attention of a nurse (caring presence), (2) required hand movements, and (3) an altered or non-ordinary state of consciousness called centering. Detractors attribute the results credited to HMEH modalities to the placebo effect, such as presence and attention of a nurse, and believe that hand movements and provider's state of consciousness are irrelevant. Practitioners of HMEH techniques believe that the nurse's presence and required hand movements, alone, are insufficient to achieve optimum results but must be accompanied by the practitioner being in a non-ordinary state of consciousness.

The study investigated the influence of the three presumed elements--i.e., hand movements, the nurses presence, and/or an altered state of consciousness--to perceived changes in recipients' chronic non-malignant abdominal pain following treatments. It also tested whether or not HT was safe for provider and recipient. In addition, experiences of providers and recipients were collected to provide a glimpse into HT experiences.

All subjects had chronic non-malignant abdominal pain they associated with a previous abdominal surgery. Non-malignant pain once was called benign pain, to distinguish it from cancerous pain. The terminology was changed when it became evident that chronic pain was never benign, i.e., that it was not harmless or innocuous. Rather, never-ending pain was more often considered malicious, punishing, and harsh, words that are antonyms of "benign". The study

tested the effects of HT on chronic ongoing abdominal pain that was not related to cancer but was related to surgery.

Research Questions

The experimental, counterbalanced, quantitative and qualitative study of HT was designed to answer six questions.

(1) Is HT safe for recipients and providers?

(2) Is a sham treatment, provided by a nurse not trained in any HMEH modality, safe for recipients and providers?

(3) Do recipients perceive that their pain changed from pre-treatment states after HT, sham, and an interview?

(4) Do perceived effects following HT differ from those following the sham treatment or interview?

(5) Is the provider's state of consciousness significant or are hand motions alone sufficient for perceived results (sham vs. experimental treatment)?

(6) What are the experiences of providers and recipients during HT and sham treatments?

Significance

The lengthy history of nurses' focus on pain relief and thirty years of nurses' research on approaches to pain management were foundational to the present study. The unique significance of this investigation was in its potential to examine HT's safety, effects, and elements through a scientifically sound empirical investigation and to describe recipients' and providers' experiences. A growing number of nurses see clients in private HT practices; others use HT in their practices in hospitals, clinics, physicians' offices, and in industry. However, no research has been published on the safety of HT or risks to

either recipients or providers. The study was the first clinical investigation to do so.

It was the first study to investigate the contribution of (a) the placebo effect, defined as the presence of and interaction with a caring nurse; (b) HT and sham providers' hand and arm movements; and (c) providers' states of consciousness to HT treatments. Each element of the HT process was evaluated with respect to recipients' reports of pain relief. Finally, the study was the first to compare HT subjects' and provider's experiences during treatments.

Summary

Healing Touch interventions have never been studied in their own right; claims of their safety and effectiveness have relied on personal testimony and on research done on other HMEH modalities, such as TT. No studies have been published on the effects of any hand-mediated energetic healing modality on chronic nonmalignant pain.

If HMEH practices are healing, they must be followed by physical, emotional, or spiritual evidence of one or more of the three aspects of the definition of healing: becoming well, restoring damaged tissue to its normal condition, and/or easing pain (Lexicon, 1989). If energetic healing involves conscious and/or physically perceptible phenomena, practitioners' and recipients' reports of their experiences will reflect those phenomena.

Three explanations for energetic healing were presented: cultural, theoretical, and electromagnetic/ bioelectromagnetic. Four broad questions addressed (1) whether HT, sham and the interview were safe; (2) effects of the three treatments on chronic nonmalignant abdominal pain; (3) whether presence, hand motions, or centering were required; (4) and providers' and recipients' experiences.

Chapter 2

Review of the Literature

Three areas of literature and research were reviewed. This chapter is organized according to the topics of Therapeutic Touch and other HMEH modalities; chronic nonmalignant pain; and placebo, caring, and presence.

Therapeutic Touch and other HMEH Modalities Research

No previous research has been done on Healing Touch to date. HT practitioners believe that HT and the Krieger-Kunz method of Therapeutic Touch (TT) are closely related variations of HMEH practices. Accordingly, HT practitioners assume that the research on TT applies to HT modalities. It may not. However, TT research is the primary source of empirical evidence available on HMEH at this time.

Krieger (1979) described TT as a five step process involving centering, assessing, unruffling, modulating, and terminating. The area of treatment was defined as being no higher than six inches above the surface of the physical body. Healing Touch, which uses TT as its base, expands the two treatment steps, unruffling and modulating, to include other interventions. HT also extends the treatment area as far as needed above the body. Some HT interventions are done three or more feet beyond the skin's surface.

Research on TT in humans has demonstrated that TT significantly relieves state anxiety ($p<.001$) among patients in a cardiovascular unit as measured by Spielberger's State-Trait Anxiety Inventory (STAI) (Heidt, 1981; Quinn, 1984). In Heidt's (1981) study, subjects who received TT had a significantly greater reduction in post-test anxiety ($p<.01$) than subjects in the placebo and sham treatment groups. Quinn (1984) replicated Heidt's study with the exception

that subjects were not touched. She demonstrated that recipients need not be touched during TT to experience a statistically significant reduction in state anxiety.

Guerrero (1986) found responses similar to Heidt's in oncology patients receiving chemotherapy ($p<.05$). TT has been shown to relieve tension headache pain ($p<.0001$) (Keller & Bzdek, 1986) and was followed by significant changes in neonate behavior (Fedoruk, 1985). However, TT has been tested against post-operative narcotics for pain relief and findings were nonsignificant (Meehan, 1985).

Wirth (1992) found that the rate of wound healing was more rapid following TT. Forty-four male volunteers received identical punch biopsies and half received TT to the wounds. On day 16, 12 of the 23 subjects who received TT had completely healed wounds. None of the wounds in the non-TT control group were healed. Thirty years earlier, Grad (Grad, Caboret, & Paul, 1961) did a similar test using 300 mice; results were similar to Wirth's.

Findings from other TT studies have been inconsistent. Roughly half of the studies of physiological responses to TT, such as pulse, galvanic skin response, peripheral skin temperature, muscle tone, electromyography, and skin conductance, had nonsignificant findings (Post, 1990); half had significant ones (Kramer, 1990; Quinn, 1988). Studies in which findings were not statistically significant used healthy volunteers as subjects; those in which results were significant used real patients in real-life situations, such as hospitalization. Randolph (1984) suggested that the choice of ill versus well subjects may influence the significance of findings in TT studies.

Quinn and Strelkaukas (1993) used a real patient population to test whether there were immunological effects

following TT. Two TT providers gave four recently bereaved recipients a series of TT treatments and found one discernable change--suppressor T cells in recipients were diminished. The effect is the equivalent of enhancing the immune system because the immune system's self-suppression mechanism is retarded.

Effects of TT on behavior of inpatient psychiatric patients were tested. Subjects treated with TT were more alert, less passive, more amenable to talking, calmer, more self-disclosing, and more cooperative than normally. Subjects took fewer cigarette breaks and wandered less during group process (Kline & Durham, 1992; Potter Hughes, Meize-Grochowski, & Harris, 1996). Several adolescents recognized that the treatments made a difference: one requested additional sessions and two asked to be removed from the TT part of the study because the treatments were disturbing (Potter Hughes, Meize-Grochowski, & Harris, 1996).

Anecdotal reports of responses to TT abound. Payne (1989) credited TT with enhancing clearer speech in expressive aphasic clients and improving ability to void after difficulty starting a stream of urine following Foley catheter removal. Macrae (1979) concluded that one pediatric patient's appetite improved after receiving TT. In Therapeutic Touch, How to Use Your Hands To Help Or To Heal, Krieger presented practitioners' reports of the results they perceived after using TT. Pain from rheumatoid arthritis, a fractured ankle, muscle spasm, and headache were reported relieved after a 20 minute TT intervention. The rapid decrease in a child's elevated temperature was attributed by the mother (a nurse) to her use of TT. Four reports of stress relief following TT were vividly

recounted. Krieger (1990), who claimed that bone fractures heal at twice the usual rate with TT, assigned "third place to healing *per se*, because the relaxation response and the pain amelioration have such high reliability" (p. 86).

Detractors and Rebuttals

Detractors of HMEH have argued that its perceived results are due to delusion (Oberst, 1995), fraud (Hoover, 1993a, 1993b), or the placebo effect (Clark & Clark, 1984a). A group called The Rocky Mountain Skeptics and various authors published in Skeptical Inquirer and Skeptic have maintained a continuing attack on TT. Sarner, a Rocky Mountain Skeptic, labeled TT "pseudo-science, something that pretends to be science" (Hoover, 1993b) and Aldorfoer said it is a ceremonial ritual in which the "person conducting the ceremony is a performer, not a practitioner" (Hoover, 1993a, p. 3C). Renner, of the Consumer Health Information Research Institute in Kansas City, said that "[calling] this a proven thing is a bunch of horse feathers" (Hoover, 1993b, p. 3C). In an article in Skeptic, Rosa (1995) declared TT faith-healing and threatening to nursing. Oberst (1995), editor of Research in Nursing and Health Care, equated effects of TT to healing effects of apricot pits and maintained that TT was scientifically unsubstantiated.

Metzger (1995), editor of The Quest, labeled contributors to skeptical magazines "professional skeptics", and wondered about the intensity of the rage exhibited against TT by its detractors. Comparing professional skeptics' approaches to both alternative treatments and conventional medicine, he noted that they were unwilling to look at existing evidence supporting alternative treatments or questioning conventional ones. Hoover (1993a) made the same point about the Rocky Mountain Skeptics, who "are very

selective in their skepticism". They say nothing about the overuse of medical tests, of the harm associated with fetal monitoring, or of the use of Tamoxifen for healthy women at risk of breast cancer when the drug's "longterm effects are as unknown as the mechanism by which it works" (p. 3C).

Quinn pointed out that TT "is not a cure for anything but is used instead as a healing technique. It's an approach we use as a complement to traditional nursing interventions. There is no downside to this, so I don't understand what the issue is" (Hoover, 1993a). Metzger (1995) considered the issue one of fundamentalism. He said that "[skeptics] share with fundamentalist Christians a hostility toward alternative treatments like TT, perhaps because, for scientism, science is a religion, unassailable by scientific curiosity" (p. 13).

The Colorado Board of Nursing (Wittman, 1993) held that TT was an aspect of the art of nursing, which involves being sensitive to nuances, as well as of its science, the empirical arm of nursing. The Rocky Mountain Skeptics, according to Wittman (1993), mocked the Board's characteristic of nursing as an art, as well as a science. Jones, a teacher of philosophy of science at Berkeley, asked if the Rocky Mountain Skeptics were "using the appropriate standards of proof? . . . The theory might be loony, but it might work anyway. The way a science like medicine develops is trial and error. It evolves a lot out of folk remedy" (Wittman, 1993). Metzger (1995) lamented professional skeptics' lack of curiosity, intellectual arrogance, and lack of a genuine spirit of scientific inquiry. Straneva (1995) was troubled that nurses, like Oberst, judged whether a phenomenon was worthy of study, rather than discussing the best research designs and methods.

Even if TT is merely a ritualistic and ceremonial aspect of the art of nursing, many patients like it. Reed-Sleeper, who received TT after a mastectomy, said "[it] was really wonderful. Emotionally, it was great for me. It felt very healing. I think it strengthened me and gave me positive energy. I felt it helped me with my healing and outlook. It made me feel free" (Hoover, 1993b). If TT has an empirical base, quality research is needed to identify and describe it. Research findings help delineate a phenomenon, but each study, also, leads to more questions and helps refine methodology.

Methodological Critique

Quinn (1989c) identified four primary confounding influences in TT research. One is using healthy volunteers to study stress responses pre- and post-TT treatments. A second problem may be the brief length of treatments. TT treatments during research have been limited to five minutes. Quinn (1989c) found that unregulated TT treatments ranged from 9 to 32 minutes in length. Even the shortest treatment was longer than any of the TT treatments in published studies.

A third concern in TT studies is controlling the placebo effect. Many TT study recipients who received mock TT (MTT) described it as "peaceful," "indescribable," "safe". One said to the practitioner, "You have a very soothing, healing presence" (Quinn, 1989b, p. 86). Quinn suggested MTT treatments may have been perceived as soothing because experienced TT practitioners gave the MTT treatments. She learned that experienced TT practitioners are unable to avoid centering and sending energy, even when trying not to do so. "It appears that TT . . . can occur 'automatically' when the body and hands assume the position

associated with the treatment" (p. 22). She questioned the TT assumption that "intentionality is a completely conscious process, that is, one which can be 'turned on or off' by conscious choice or will" (p. 22). Quinn suggested that MTT be given only by persons not experienced with TT.

Finally, she recommended that the investigator not provide any TT treatment in research studies. HMEH practitioners are taught to try to have no expectations for the outcome of a treatment, only that results will be for the client's optimal healing, without defining optimal healing. In a research study, the researcher has a vested interest in the results. S/he may not be able to maintain the ideal practitioner's observer mind set while administering the treatment and studying the results.

Another methodological concern is control of extraneous variables. Articles about TT by enthusiastic supporters often blend non-TT modalities with TT without distinguishing between them. Boguslawski (1980) discussed using counseling, meditation, and visualization as adjuncts to TT and attributed the results of her treatments to TT. Snyder (1985) used color therapy during TT treatments and attributed the results to TT. Extraneous variables, such as adjuvant modalities, must be controlled for during research.

Pain

Chronic Non-Malignant Pain

Despite the universal experience of pain, there is no universal definition of pain. McCaffery (1979) defined it as "whatever the experiencing person says it is, existing whenever he says it does" (p. 11). This definition diverges from previous ones that emphasize tissue damage. For example, the International Association for the Study of Pain defined it as "an unpleasant sensory or emotional experience

associated with actual or potential tissue damage or described in terms of such damage" (Merskey, 1979, p.250). McCaffery's definition is more appropriate for nurses, who deal with patients' symptoms and expressions of pain rather than cause.

As noted on page 11, chronic non-malignant pain is not associated with cancer, nor is it benign. Chronic non-malignant pain is ongoing, there has been no additional injury to physically exacerbate it since its origin, it is resistant to treatment, there is no known cure, and no healing or relief is occurring. Frequently, it is associated with anxiety and depression and can be incapacitating (McCaffery & Beebe, 1989; Sternbach, 1986; Sternbach, 1990). Examples of chronic non-malignant pain are arthritis, headaches, phantom limb pain, fibromyalgia, Crohn's disease, chronic pancreatitis, and Raynaud's disease (McCaffery & Beebe, 1989). Some cases of chronic nonmalignant pain follow major surgeries, organ transplantation, and chemotherapy (Bonica, 1992). Melzack and Wall (1983) describe such pain as a pain syndrome that is intolerable and serves no useful purpose. Bonica (1992) defines chronic nonmalignant pain as pain lasting three to four weeks longer than expected.

Victims of chronic pain seldom display signs associated with acute pain: they do not have increased heart and respiratory rate or blood pressure, pupillary dilation, palmar and plantar sweating, or changes in oxygen consumption rates. The person's body adjusts to the continuing presence of a pain that has no biological function; the psyche does not appear to do so.

People with chronic pain experience sleep disturbances, social isolation, fatigue, exhaustion, irritability, anger,

depression, and a decreased pain tolerance (Hayes, McAlary, Popovsky, & Zappolo, 1992). Pain related depression is characterized by loss of appetite, despair, hopelessness, decreased pleasure, and a preoccupation with pain (Melzack & Wall, 1983). Pain that has become chronic often involves numerous psychological and life-style changes, including social, recreational, employment, financial, appetite, and self-esteem (Hayes, McAlary, Popovsky, & Zappolo, 1992).

McCaffery and Beebe (1989) reported four stages of dealing with chronic nonmalignant pain. In the early weeks and months of pain, people hope and expect it will go away, then begin to seek a cure for it. After pain-filled months, the second stage evolves. People begin to ask whether they were misdiagnosed or received inappropriate treatments, but their expectations are still centered on cure. The third stage occurs when it becomes apparent the pain is permanent. People tend to become angry, depressed, resentful and begin to more actively look for ways to manage the pain, rather than cure it. The fourth stage of adapting to ever-present pain occurs after years of being in pain. People, then, are likely to make permanent alterations in life-style to accommodate the pain's demands and to accept and/or seek strategies to help deal with the pain.

Those still oriented to cure will be more accepting of physical therapy, medications, transcutaneous electrical nerve stimulation (TENS), and other tangible approaches, including multiple surgeries. People who are less cure oriented are more accepting of self-management techniques, such as relaxation, imagery, hypnosis, biofeedback, distraction, heat and cold, massage, and acupuncture (McCaffery & Beebe, 1989; Curtis & Curtis, 1990).

In 1992, one-third of the American population were estimated to suffer from chronic pain, with more than 50 million people either partially or totally disabled by pain for periods ranging from a few days to permanently. Chronic pain was estimated to cost over 550 million work days and $65-$75 billion dollars annually. Bonica (1992) believes these costs are underestimated.

He suggested a number of reasons why chronic pain is inadequately managed medically. Few medical and dental schools have formal courses on chronic pain that review the differences in effect and treatment of chronic and acute pain. Physicians and dentists learn to use pain as a diagnostic tool, and many are taught to treat all pain with approaches that work for acute pain, primarily medications. Patients with many chronic nonmalignant pain syndromes do not respond to standard acute pain treatments and suffer drug toxicity, drug dependency, and multiple operations, some of which are useless.

Few physicians outside of pain clinics do an adequate workup, which involves analysis of every facet of a person's life (Bonica, 1992). This problem is exacerbated by physicians' and nurses' not believing patients' reports of their continuing pain. Chronic pain patients, often, are labeled in various derogatory ways, such as hypochondriacs, malingerers, controlling, wanting to keep the pain, unmotivated, noncompliant, and "crocks" (McCaffery & Beebe, 1989).

Patients often seek treatment for their pain from one physician after another; when relief is not obtained, patients may become bitter and resentful toward physicians as individuals and as a group. In time, a significant number of chronic pain patients abandon medical care

(Bonica, 1992). Nurses, then, are more likely to see these patients than are physicians.

Nurses approach pain diagnosis differently than physicians. They would tend to agree with Wolff (1978), who believes that the most accurate indication of pain is a person's statement of the presence of pain. He doubts that many people distort reports of their pain experiences. McCaffery and Beebe (1989) list eighteen nursing diagnoses that are appropriate for patients with pain, including anxiety, fear, powerlessness, social isolation, sleep disturbances, self-care deficits, ineffective coping, spiritual distress, and altered thought processes (p. 36).

Nurses, also, treat pain differently than physicians. The National Institute of Nursing Research report on Symptom Management: Acute Pain (1994) listed thirty-two studies of nonpharmacologic approaches to pain management, many of which nurses have incorporated into their practices. Included were relaxation, imagery, information imparting, self-hypnosis, progressive muscle relaxation, music, support groups, heat versus cold, distraction, position change, massage, and exercise. McCaffery and Beebe (1989) discussed a variety of nursing approaches to pain relief, including cutaneous stimulation through massage, pressure, and menthol. They offer eight specific relaxation techniques, including deep breathing, humor, jaw, meditative, and progressive. Krieger (1979) specifically listed pain relief and relaxation as effects of TT. Because nurses are not legally required to document their uses of nonpharmaceutical strategies to manage pain, an accurate picture of their uses of nonpharmaceutical measures in practice is unavailable.

Pain Dimensions

For many years, pain was considered in Western cultures to be a specific entity, like sight or smell, and was described as one of only four cutaneous stimuli, the others being warmth, cold, and touch. In 1992, McGuire identified six dimensions of pain: physiologic, sensory, affective, cognitive, behavioral, and sociocultural. The physiologic dimension contains the physical, neurologic, and biochemical aspects of pain. It is reflected in the International Association for the Study of Pain's definition of pain as "associated with actual or potential tissue damage or described in terms of such damage" (Merskey, 1979, p.250).

The sensory dimension is the pain's location, what it feels like, and its intensity. Perceived intensity is often described by words such as mild, severe, or intolerable. It is influenced by the pain's origin, the person's pain threshold, the meaning of the pain to the patient, how tired or alert the patient is, the patient's mood, medications, and social environment. It is the best understood of the six dimensions (National Institute of Nursing Research, 1994).

The affective dimensions comprises emotional responses to pain. It may be displayed as depression, anger, anxiety, expectations, relief, or mood changes and may be related to personality traits. A feeling of helplessness and suffering are affective responses. Less is known about the affective dimension than about the physiologic and sensory.

The cognitive dimension of pain involves how the person thinks about the pain, its meaning, beliefs and attitudes about pain and treatments, coping strategies, preferences, and knowledge. Techniques such as distraction, coping, selective inattention, and reinterpretation of pain

sensations are cognitive strategies. Research has addressed only a few components of the cognitive dimension, primarily the meaning of pain. This dimension is not well understood.

The behavioral dimension contains observable actions, such as grimacing, body movements, moaning, medications taken, sleep, and self-massage. Most behavioral indicators of pain are less important in chronic pain than in acute pain, but communication of pain and pain control behaviors are more important.

The sixth dimension, sociocultural, comprises the person's demographic, ethnic, cultural, spiritual, religious, and social environments as well as his/her recreation/leisure and home/work activities. The relative importance of the dimension to pain in different conditions is unknown, but research findings indicate that there is a strong sociocultural influence in many painful conditions. (National Institute of Nursing Research, 1994)

The multidimensional concept of pain involves the supposition that the six dimensions are interactive and integrative and that ideal pain relief approaches may entail more than one of the dimensions. Because pain involves emotions, cognitive interpretations of pain, and personality characteristics interacting with pain sensations, it is a uniquely personal and subjective experience and is not directly measurable (Nigl, 1986). A number of tools have been developed to assess aspects of pain. Some of them measure only one dimension; others test several.

Placebo, Caring, and Presence

Placebo

Some of the detractors of TT have labeled its perceived effects placebo. Placebo is defined as "a medically inert medication, preparation, treatment, technique, or ritual

that has no specific effects on the body and is intended to have no therapeutic value" (Guzzetta, 1995, p. 198). Roberts (1995) called placebo effects "nonspecific" effects of treatments, as opposed to specific treatment effects. Placebo effects also are called the general healing response.

The effect of placebo interventions on pain has been well documented. In drug studies, about thirty-five percent of patients reported marked relief of all pain after being given a placebo analgesic rather than morphine. As Melzack and Wall (1983) pointed out, "[t]his is a strikingly high proportion because morphine, even in large doses, relieves severe pain in only about seventy-five per cent of patients" (p. 41). Even in double-blind drug experiments, placebos' effectiveness is always about fifty percent of the effectiveness of the analgesic to which it is compared.

Placebo analgesics are more effective for severe pain than for mild pain and work better when a patient experiences severe stress and anxiety than when calm. It is widely assumed that placebos work by decreasing anxiety; patients relax because they believe something is being done to relieve the pain. Placebo-induced analgesia has been found to be unrelated to subjects' suggestibility or to hypnotic susceptibility.

Placebo responses to new promising medical treatments are even higher than to analgesic placebos. Roberts (1993, 1995) reported an analysis of results of almost 7000 patients who received one of five worthless treatments for asthma, herpes simplex virus, or duodenal ulcers. Forty percent of the patients obtained excellent results, 30 percent had good results, and only 30 percent had poor responses to these treatments.

Roberts (1995) proposed several reasons inefficacious treatments might have such a high success rate, including "demand characteristics of the situation," "psychophysiologic states", and "patient and doctor expectations" (pp. 40-41). Demand characteristics are social pressures on patients and health care providers. Roberts suggests that patients report positive outcomes in an effort to be polite to the physician. Psychophysiologic states include anxiety, depression, relaxation effects, and autonomic nervous system changes. Such states may change during the course of a treatment, influencing perceived responses to the treatment. When both patient and health care provider expect a treatment to work, changes in the patient's psychophysiologic state are enhanced and patients more readily report positive outcomes.

Roberts (1995) gives most of the credit for nonspecific treatment effects to patients' and physicians' beliefs that the treatments were valuable. Guzzetta (1995) came to similar conclusions. She proposed that the root of the placebo effect is intensified when the patient has a positive attitude and/or a positive attitude is conveyed by the health care provider. When their expectations are high, all other contributing factors are enhanced.

According to Roberts (1995), "one can commonly expect improvements of up to 70 percent of patients treated even when the treatment is entirely nonspecific" (p. 39). Measuring nonspecific effects, he said, was like to trying to measure a moving target, one that moves just as one is trying to measure it. Despite that, he proposed that "[if] nonspecific treatment effects can be as powerful as demonstrated in enhancing positive outcomes to treatment, it would be poor practice to try to avoid them" (P. 41).

Krieger would agree. She wrote that:

> . . . even if Therapeutic Touch was found to be just placebo, research has demonstrated that placebo can be helpful to a significant sector of ill people. . . . Learning to systematically maximize this process through . . . Therapeutic Touch . . . would in itself be a significant contributor to nursing (Krieger, Peper, & Ancoli, 1979, p. 296).

Caring and Presence

One contributor to the placebo effect in TT may be the presence of a caring nurse. Caring was one of the predominant themes Lionberger (1985) found in discussions with TT practitioners. Nurses interviewed believed that (1) a caring interpersonal attitude facilitates healing, (2) TT is a caring intervention, and (3) a TT practitioner's caring attitude will facilitate healing. When asked how TT differed from other experiences with nurses, recipients mentioned a difference in the attitude of caring between the two experiences. One man described the difference as "in the quality of the caring interaction rather than in its presence or absence" (p. 55).

Because caring, which is intuitively understood, is difficult to operationalize, the concept of presence is more useful to an understanding of HMEH. Doris Hines (1992) has analyzed presence, especially presence of the nurse, and describes it as leading to a shared situation that becomes an interactive process or event. "The aim of the shared situation is to produce well-being, comfort, growth, and a relationship between the patient and the nurse" (p. 294). Alternate words for presence include the nouns attendance, fusion, or blend and the verbs engage, permeate, or dwell.

Hines notes that descriptors of presence provided by *Roget's Thesaurus* are "being at hand, proximity in time or space, a person's manner or carrying self (countenance), and inhabited" (Dutch, 1965, p. 295).

Hines (1992) defined attributes of the concept of presence: (1) time with another; (2) unconditional positive regard; (3) transactional speaking with, being with, doing with; (4) encounter that is valued; (5) connectedness (essence linking); and (6) sustaining memory. Gardner (1985) proposed six antecedents and consequences of presence. The antecedents are (1) ability to care; (2) self-awareness; (3) commitment to helping; (4) knowledge and expertise; (5) listening and touching skills (6) and other awareness. Proposed consequences are (1) support, (2) comfort, (3) sustained assistance or goal attainment, (4) encouragement, (5) motivation, and (6) invigoration.

Hines (1992) characterized presence as "a mode of being available in a situation with the wholeness of one's unique individual being; a process resulting in an exchange of authentic meaningful awareness and essence linking and thus more being (ultimate realization of human potential)" (p. 298). Her descriptions reflected nuances of HMEH that caring does not. HMEH may be a temporary fusion or blending and an engagement with the essence of another person. It requires being at hand in time and space and evolves from the manner in which the practitioner carries him/herself. It involves the wholeness of one's unique being.

The presumed antecedents of a HMEH intervention are similar to those of presence. They require that the practitioner has the ability to care, be self-aware, be committed to helping, have knowledge and expertise, skills of listening and touching, and other awareness. HMEH

requires that the practitioner be available with the wholeness of his/her being, which permits an engagement of the essences of the practitioner and recipient. Presence, therefore, may be the activity of the practitioner implicated in the placebo effect. The role of presence needs to be separated from the effect of HMEH interventions.

Summary

This chapter has reviewed TT and pain research, pain dimensions, and the differences between caring and presence. TT research supports practitioners' beliefs that TT can be followed by decreased pain perceptions and increased relaxation. TT has been shown to increase the rate of wound healing and to suppress suppressor T cells. It is followed by inpatient psychiatric patients being more amenable to therapy. Differences between HMEH techniques, such as those between TT and HT, are unclear. To further the development of the optimal research methodology for TT and HMEH, Quinn offered four suggestions for research design.

Characteristics of chronic non-malignant pain and the six dimensions of pain were discussed, as was the four stage adjustment process people undergo when experiencing chronic pain. Differences in nurses' and physicians' approaches to pain were mentioned, including nurses frequent use of nonpharmacological approaches to pain management.

Changes following HMEH have been attributed to the placebo effect, which includes ritualistic behavior and the presence of a caring health care practitioner. Placebo effects also have been called the "general healing response" and "nonspecific effects", which may account for up to 70% of treatment efficacy even with otherwise useless treatments. The important factor in nonspecific effects may be the provider's and/or recipient's belief in the approach.

Research results suggested that HMEH techniques have a useful contribution to make to the nursing care of patients. There has been no study of the long-term effects on chronic pain of any HMEH modality nor has an attempt been made to isolate the contribution of the various elements of HMEH techniques. No studies have been done on subjects' subjective responses while receiving HT or of novices providing treatments. Whether effects attributed to HMEH are due to placebo, nonspecific effects, or some unidentified physiological change remains to be determined.

Chapter 3
Methodology
Study Design

The experimental study used a counterbalanced design in which three different treatments were given all subjects, permitting subjects to act as their own controls. The three treatments were Healing Touch, a sham HT treatment, and an interview. Each treatment was designed to highlight one of the three study elements--presence, hand movement, or the provider's conscious involvement. Sessions were no closer than 24 hours apart to allow the effects of a previous treatment to "wash out" prior to the next treatment. A table of random numbers was used to randomly assign subjects to treatment sequence. There were six possible treatment sequences, as depicted in Table 1.

Each treatment recipient completed two McGill-Melzack Pain Questionnaires (MPQ) before and after each treatment, one for surgically related abdominal pain and one for any other pain being experienced at the moment. Additional pain was surveyed to reduce the possibility that a subject would globally rate all pain, rather than just the surgically related abdominal pain that was the focus of the study. After completing the post-treatment MPQs, each subject tape recorded his/her impressions of the intervention. A pilot study tested six subjects, one for each treatment schedule.

Data were collected in eight sites--Albuquerque, New Mexico; Boulder, Colorado; Atlanta, Georgia; Belleville, Illinois; Nashville, Tennessee; Clarksville, Tennessee; Knoxville, Tennessee; and Springfield, Virginia. In each site, a local nurse coordinated the study, hired and trained providers, solicited and admitted subjects, and organized

data collection. All treatments were provided by female registered nurses.

Table 1

Treatment Sequences

Treatment Sequence No.	Treatment		
1	HT	Sham	Interview
2	Sham	Interview	HT
3	Interview	HT	Sham
4	HT	Interview	Sham
5	Sham	HT	Interview
6	Interview	Sham	HT

To ensure that all providers received similar instructions, the investigator prepared three types of video tapes, each discussing and demonstrating one of the three interventions. HT and sham providers' videos demonstrated identical treatments, but instructions for hand movements were more detailed in the sham tape. Sham providers were not taught to center or cognitively influence the subject's energy field but were instructed to wear a tape recorder and headphones and listen to a story while administering the sham treatment. HT providers were reminded to center and to follow the study protocol, to make no movements other than those involved with the HT treatment. The instruction for interviewers was a taped sample interview.

Providers were given copies of the appropriate tape and practiced their particular intervention with the site coordinator. Written guidelines further ensured that all providers' techniques were within study boundaries (see

Appendices K, L, & M). Neither the investigator nor the site coordinators provided treatments. Coordinators were given written instructions regarding their tasks and copies of the three types of training videos (see Appendix N).

Subjects

Twenty seven women and one man were successfully solicited for the study, but five women did not complete all three treatments. Subjects were required to be over 18 years of age, read English, and identify themselves as having chronic pain after abdominal surgery. Subjects' ages ranged from 19 to 73 years, with a mean age of 42 years, and education ranged from 8 to 27 years, with a mean of 15. Subjects had been in pain from 6 weeks to 9 years, 9 months. Fourteen of the 23 subjects who completed the study had been in pain longer than one year.

Chronic pain was defined as pain that remained four or more weeks after abdominal surgery. Four weeks was chosen because the researcher's experience is that few patients have severe surgically related pain at that time. Length of time in pain was irrelevant as long as the subject believed the remaining pain was related to the surgical experience. Other criteria for selection were: (1) the wound looked free from infection and (2) the person did not mind being touched lightly on the surgical site. Criteria for exclusion were: (1) temperature greater than 99.5 degrees Fahrenheit; (2) aversion to being touched; (3) unavailable for three separate treatments.

Recipient subjects were solicited through letters to physicians and to nurses and nursing organizations; the site coordinators speaking to support groups; word of mouth; and newspaper advertisements. Any recipient still under a physician's care for the surgical intervention was asked to

provide the investigator/coordinator with the physician's name. Letters were sent to those physicians informing them of the subject's participation in the study. No payment or other incentives were offered, other than the possible benefit of pain relief.

Treatment providers were also considered subjects, because they wrote notes about their experiences during the interventions. They were solicited through word of mouth and newspaper advertisements. All thirty two providers were female nurses: ten gave HT treatments, twelve gave sham treatments, and ten interviewed recipients. Civilian providers were paid from funds awarded by the Department of Defense Tri-Service Nursing Research Committee and provided by the Uniformed Services University of the Health Sciences.

When providers were admitted to the study, they listed their energetic training and experiences (se Appendices C and D). Sham and interview providers could have no energetic healing training. HT providers were required to be prepared to at least Level IIA of the AHNA program, Healing Touch for Health Care Practitioners and have a minimum of one year's HT experience. Five of the HT providers had studied only HT; three had studied HT and were second degree Reiki masters. One practiced Touch for Health as well as HT. The most experienced provider had taught HT for 3 years and was a first degree Reiki master (Reiki is a Japanese/Tibetan modality with three levels of training). In addition, she had studied with faculty or graduates of two well known schools of healing, Rosalyn Bruyere's and Barbara Brennan's.

Procedure

Admission.

Once a recipient contacted the coordinator, they met at a location convenient to the recipient in which privacy was available, usually the recipient's home. The coordinator's initial tasks were to explain the recipient's role in and time required by the study, to determine if s/he met the criteria for admission, and to ascertain whether s/he continued to be interested in participating. The coordinator briefly demonstrated the hand movements of the HT and sham treatments. Because of initial confusion regarding use of a massage table, coordinators stressed that recipients would not get a massage or receive any deep touch. They would be lightly touched for fifteen minutes in the area over the surgical site.

If the recipient agreed to be available and participate in three treatments and a final interview, the coordinator took the subject's temperature and visually inspected the surgical site. If the wound appeared infected or if the person had a fever, s/he was not admitted to the study. If the wound was healed or healing properly, the coordinator had the recipient read and sign the informed consent form (see Appendix B).

The coordinator collected the following demographic information: race, age, gender, number of years of formal education, date and type of surgery, reason for surgery, type of anesthesia (general or other), and medications (see Appendix E). Recipients were asked if they had tried any alternative treatments for the pain and the results. They were taught how to properly score and, then, completed two McGill-Melzack Pain Questionnaires (see Appendix F). The first MPQ was for pain associated with the surgical site

only; the second, for any pain experienced in other sites, such as toothache, arthritic pain, or aching muscles. In each case, they were to describe the pain they were having at that moment, not the usual or worst pain.

General method.

After recipients were admitted to the study and randomly assigned to one of the six treatment orders, the coordinator contacted three providers, one for each treatment. Each provider arranged with the recipient a mutually convenient time for the intervention. Providers were not told the order in which recipients received the three interventions, but were requested to assume that they provided the first one.

Each provider met and introduced herself to the recipient, briefly explained the treatment to be given (interview or session on the massage table), and answered any pertinent questions the recipient had about the upcoming treatment. All providers were instructed to tell recipients that any questions about the study other than "What are you going to do to me today?" be referred to the coordinator. Each provider asked the recipient the condition of the surgical site, the length of time since surgery, and the type, dose, and time of the last pain medication (see Appendix G). At no time did providers either encourage or discourage recipients from taking pain medication. Next, the recipient completed two MPQs, one for abdominal pain and one for other pain. The provider set the timer for 30 minutes and began the intervention.

When being interviewed, recipients and interviewers sat a comfortable distance apart. When receiving HT and sham interventions, recipients were in a comfortable supine position on a massage table. At no time were recipients

asked to undress or rearrange any clothing. During the HT and sham treatments, recipients were on a massage table and were covered with a sheet or blanket unless they preferred otherwise.

Recipients were informed that the difference between the two HT interventions was to determine if what providers heard influenced the outcome of the intervention; therefore, one provider would be listening to a tape through headphones, and one would not. Recipients also were told that, because this was a research study, talking was restricted to before and after the two HT treatments (i.e., HT and sham).

Following the treatment, recipients again filled out two more MPQs and tape recorded their impressions of the session. Providers left the room during the tape recording unless the subject specifically asked them to stay. Each provider wrote a note describing her experiences during the treatment (see Appendix J). The investigator was concerned that providers would just describe assessments of recipients and not relate any of their own experiences. Therefore, all providers were told to write primarily about themselves and their own experiences. All data were put in an envelope in the office where the treatment was provided and mailed to or collected later by the coordinator.

The day after the third intervention, the investigator called each recipient to discuss the overall experience of being in the study and elicit any additional thoughts on the interventions (see Appendix I). Recipients were asked how the three treatments differed for them, if they preferred one over another and why, and how they had felt since the last treatment. They were asked if any of the treatments was especially helpful and how. If the recipient mentioned

that his/her pain had changed after a treatment, the investigator asked how it had changed and how long the change lasted. At the close of the telephone interview, the recipient was asked to fill out the last set of MPQs and send them to the investigator in the envelope provided when admitted to the study.

Interventions.

The thirty minute Healing Touch treatment began with the provider "centering," or entering a meditative or altered state of consciousness. The state is a relaxed one in which the practitioner shuts out external distractions and concentrates on the sensations sensed by hands and mind. The type of concentration required for centering is similar to that required to hear subtle variations in a patient's heart beat when listening to heart sounds.

The Healing Touch intervention was a combination of two standard HT interventions: magnetic unruffling and wound filling and closure, which is also called etheric sealing. Magnetic unruffling is a series of sweeps of the provider's hands longitudinally over the recipient from head to foot. Hands are curved slightly, palms facing the recipient, and fingers held in a raking-like position. The provider made 30 sweeps of about 20 seconds each, which took about fifteen minutes.

Magnetic unruffling is believed to reduce transient electromagnetic disruptions in a recipient's field and to clear toxic substances, such as anaesthesia. Any disruptions the provider senses following magnetic unruffling are assumed to be a chronic, i.e., not transient, state for the subject. Mentgen (1996) teaches that to seal a wound:

> gather energy from the field around the area by moving your hands with the palms toward the client's skin area, back and forth over the identified spot. Then seal this extra energy supply to the skin with the palm of your hand and hold for a minute. (pp. 139-140)

Recipients' responses are the only evidence available to determine if anything happened, other than the providers' hands were waved over and placed upon the subjects.

The sham intervention appeared identical to HT in that it had the same hand movements. However, providers of the sham treatment were audibly distracted and not taught to center or direct energy. In order to distract providers of the sham treatment and interfere with any caring involvement with the subject, providers listened to story tapes during the treatment. Each was supplied with a Walkman-type tape player and earphones. Tapes selected were radio programs, such as "The Lone Ranger", that were close to 30 minutes long. Sham providers clipped the tape player to their belts or wore them in a zippered pouch around their waists.

The third intervention was an interview about the surgery, subsequent pain, and their effects on the recipient's life (see Appendix H). Interviewers were instructed to shake hands with recipients when meeting them. Both recipient and provider were seated during the interview with the provider positioned close enough to touch the recipient occasionally during the interview. The provider was to periodically lean forward toward the recipient as if to hear better and more intensely engage him/her in the conversation. This position and action has been used many times by every nurse during a nursing career and is one with which most patients are comfortable. The provider asked the

recipient about his/her surgery, its results, and his/her experiences following surgery. Information received during these interviews was not collected; the goal was to offer the recipient an attentive and caring nurse who listened to the recipient's story for 30 minutes.

Summary

The Healing Touch intervention contained the three elements believed necessary during HMEH: presence, hand movements, and a centered state. The sham treatment included the same hand and arm movements and the nurse's presence for 30 minutes but the nurse was audibly distracted to reduce the likelihood of centering. The interview involved only the presence of a caring, attentive nurse.

Data Tools and Analysis

The McGill-Melzack Pain Questionnaire

The McGill-Melzack Pain Questionnaire (see Appendix F) was used to obtain data on the dependent variable, chronic non-malignant abdominal pain, because it measures three of the six dimensions of pain--sensory, affective, and cognitive. During development of the tool, subjects classified 102 words culled from clinical literature relating to pain into a few categories that described different aspects of the pain experience. The categories were further condensed into three major classes measuring three of the six dimensions of pain, and 16 subclasses that clarified aspects of those dimensions (Melzack, 1975). Melzack labeled the sensory dimension, "sensory-discriminative"; the affective, "motivational-affective"; and the cognitive, "cognitive-evaluative".

The MPQ provides three major indices of pain level: the pain rating index (PRI), number of words chosen (NWC), and the present pain index (PPI) (Melzack & Katz, 1992). The

pain rating index (PRI) evaluates total pain (PRI-T) and the three dimensions of pain. It has two miscellaneous affective/evaluative and sensory measures. Sensory qualities (PRI-S) are separated into categories such as temporal, spatial, pressure, and thermal. Affective (PRI-A) adjectives describe levels of tension and fear. Evaluation (PRI-E) words describe the subject's impression of the overall intensity of the entire pain experiences.

Seventy eight adjectives are arranged in 20 subclasses and in order of severity. The least severe is ranked 1 and each subsequent word in a group is ranked two, three, four, etc. according to the number of words in a particular group. Ten of the twenty subclasses describe the sensation of pain; for example, pain can be rated by its degree of constriction from pinching (1) to crushing (5).

Five subclasses provide affective choices, such as exhausting, vicious, terrifying. The evaluative subclass has only one set of choices ranging from annoying to unbearable. The last set of subclasses is miscellaneous, which includes the direction of the pain (spreading, penetrating), temperature (cool, freezing), a miscellaneous sensation measure, and a final existential choice (nagging, agonizing, torturing). Subjects are to select only those word groupings that apply to the pain at the moment and to circle the one word per subclass that most closely describes the current pain. Total (PRI-T) and individual affective (PRI-A), evaluative (PRI-E), sensory (PRI-S), and miscellaneous (PRI-M) pain scores can be obtained.

The Present Pain Index (PPI) is a measure of overall pain intensity at the time the subject is filling out the questionnaire. It is a number-word combination and ranges from no pain (0) to excruciating (5).

The MPQ has been given to many types of patients in pain, including cancer patients, women in labor, people with chronic nonmalignant pain, women with acute postepisiotomy pain or chronic dysmenorrhea pain, dental patients, and children. Results indicate that the tool can aid in discriminating types of pain. Patients with the same disease or pain syndrome select remarkably similar words to describe their pain and select different words than patients with other conditions. For example, cancer patients tend to select the most number of words, primarily from the sensory category, and women with dysmenorrhea the least number of words (Abu-Saad & Tesler, 1986). Patients with identifiable causes for pain, labeled organic pain, selected distinctly different words than patients with pain with no detectable cause, labeled functional pain (Melzack & Katz, 1992).

The primary disadvantage of the MPQ is that it is relatively complex and contains words that may be unfamiliar to some subjects (McGuire, 1988; Melzack & Katz, 1992). It requires time and patience to complete, which is especially difficult when one is in pain.

It is reported to have good reliability and validity. Test-retest with cancer patients has resulted in a 75 per cent consistency between administrations. Face validity is suggested by the frequency with which it is selected from the pool of pain rating tools as the tool of choice. Construct validity of the evaluative, sensory, and affective dimensions has been supported in studies of patients with low back pain, dysmenorrhea, chronic nonmalignant pain, arthritis and others. Concurrent and predictive validity has been established in studies with dental pain, dysmenorrhea, laboratory-induced pain, headache, and others (McGuire, 1988; Melzack & Katz, 1992).

Only one study, a 1985 one by Turk et al, has suggested that the dimensions of the MPQ may not be clearly separated and do not provide discriminant validity. They recommended using only the total pain rating score. (McGuire, 1988; Melzack & Katz, 1992). Melzack and Katz (1992) argue that high intercorrelations among psychological variables do not negate differences in nuances within similar variables. Certain characteristics, both biological and psychological, can co-vary and still represent distinct entities.

Qualitative Data

Qualitative data from providers and recipients were examined using semantic content analysis following Wilson's (1989, p. 470) guidelines. Wilson listed three steps in analyzing content. First, one must decide whether to use a complete response or break down responses into separate words, phrases, or sentences. Secondly, one must create categories based on themes that emerge from the data. Thirdly, one must fully define the categories and develop a rationale and illustrations of typical entries.

The investigator used separate words and phrases, such as words indicating sensations of heat, movement, pain, pain relief, or relaxation. "Pain" was differentiated from "ache" and "hurt". Pain was defined as relieved only if the recipient specifically said it was. "Temporary pain relief" was defined as pain that returned soon after the treatment ended, such as while still in the treatment room or later in the day. Recipients who described pain relief in one part of the body but not another were coded as having "partial pain relief". "Total pain relief" was identified only if the recipient stated that all of his/her pain was gone and remained absent until the next visit or telephone call. Providers' unpleasant sensations were coded in two ways,

globally as unpleasant and separated by type, such as diaphoresis, joint aches, back aches, pain.

The investigator took little liberty when coding providers' and recipients' experiences. A sensation such as pain or relaxation was so coded only if the subject specifically used the term. Some interpretation was necessary when comparing providers' and recipients' mutual experiences. For example, if a provider described feeling warmth and a recipient said s/he got hot, the experience was coded as both people experiencing increased heat.

Summary

The study design used to test the safety, effects and elements of HMEH on chronic non-malignant post-operative abdominal pain was a counterbalanced design in which each subject received HT, a sham HT treatment, and an interview. Each treatment was designed to highlight one of the three study elements--presence, hand movements, or the provider's conscious involvement. Recipient subjects were self-selected and had to have been in pain at least four weeks following abdominal surgery. Provider subjects were female nurses. All HT treatments, which included magnetic unruffling and wound sealing, were given by experienced HT practitioners. Sham and interview providers had no energetic training. Training was given by video tape and written instructions.

The McGill-Melzack Pain Questionnaire was chosen as the pain assessment tool because it enables a person to evaluate three of the six dimensions of pain. It has been shown to be reliable and provide valid data on pain perceptions. Qualitative data was obtained by oral reports tape recorded by recipients and notes written by providers.

A study of the safety, elements, and effects of HT will contribute to the existing literature by offering evidence of the safety of HT for both the provider and the recipient experiencing abdominal pain. It may indicate whether a HMEH treatment has any effect on chronic non-malignant post-operative abdominal pain. It may begin to clarify the relative contributions of various aspects of a HMEH treatment, including the role of deliberate attention during the treatment and the importance of the nurses' presence as placebo effect. The qualitative aspect of the study will provide the first report of subjects' and providers' experiences during HT and sham treatments.

Chapter 4

Findings

Research Questions 1 and 2: Are HT and Sham Treatments Safe for Recipients and Providers?

Recipients

The first two research questions concerned the safety of HT and sham treatments for recipients and providers. Of the 69 treatments given (3 each to 23 subjects), one case of nausea, two headaches, and four instances each of drowsiness and dizziness were reported on the post-treatment MPQs (see Table 2). One recipient stated her arthritic pain had increased after HT, a side effect not assessed by the MPQ. Fifteen instances of nausea, headache, dizziness, or drowsiness were relieved.

Table 2

Recipients' Side Effects of HT, Sham, and Interview as Measured by the McGill-Melzack Pain Questionnaire

	Nausea		Headache		Dizziness		Drowsiness	
	Less	More	Less	More	Less	More	Less	More
HT	3	1	3	1	0	2	1	3
Sham	2	0	4	0	1	1	0	1
Inter-view	0	0	1	1	0	1	0	0
Total	5	1	8	2	1	4	1	4

Note: Total Less symptoms after HT, 7; after sham, 7; after interview, 1. Total More symptoms after HT, 7; after sham, 2; after interview, 2.

There were more instances of recipient non-pain effects after HT than after sham or interview. HT recipients reported eight cases of non-pain effects, seven as measured by the MPQ and one reported by the recipient on the audio tape. Sham recipients developed only two non-pain effects, dizziness and drowsiness. Fourteen recipients received relief of pre-treatment non-pain complaints, seven after HT and seven after sham. After the interview, recipients reported one case of dizziness, one headache, and relief of one headache.

Four cases of dizziness followed treatments: two after HT, one after sham, and one after the interview. Two recipients who had headaches unrelieved by HT developed dizziness. One who developed dizziness after the sham treatment had a headache and nausea beforehand; the headache was relieved; the nausea was not. Dizziness did not exist alone; it always accompanied nausea or headache.

Providers

A number of sham providers reported physical changes during treatments. Five felt warmth or became hot. One developed "profuse diaphoresis" (perspiration). Five became tired, one experienced "waves of nausea," one felt her joints stiffen and creak, and five developed backaches. Two who developed back pain were working with recipients whose back pain was relieved during the sham treatment. The other three backaches occurred while providers were working with recipients without backaches. Sham providers tended to experience more pain in treatments that followed HT.

Two sham providers who gave more than one treatment added a self-care technique during the second treatment.

One used self-hypnosis and self-relaxation and the second described herself as calmer during the second treatment. Neither reported aches or pains during the second treatment.

Only five HT providers reported an unpleasant effect of giving the treatment--pain. One described it as "a painful burning that traveled to elbows. Uncomfortable." Another said it exited at her wrists. One HT provider characterized it as a "piercing pain in right thumb." One felt a "sharp tight pain from left fingertips to left shoulder and breast"; the recipient described essentially the same pain. Each report of pain occurred when HT preceded the sham treatment; if HT followed sham, HT providers reported no descriptions of pain or any other unpleasant side effect.

Research Question 3: Do Recipients Perceive That Their Pain Changed from Pre-Treatment States After HT, Sham, and an Interview?

Abdominal Pain

A significance level is the statistical probability that a result is due to chance (i.e., because of sampling error). When the probability is small enough, traditionally below $p<.01$ or .05 (i.e., one or five chances out of one hundred), results are considered significant (Bartz, 1976). A significance level near or below 5% indicates strong evidence of some association between treatment and results, not that the association is strong. Thus, a 5% or lower significance level indicates only that there is strong evidence that reports of changed pain levels following treatments were related to the treatment. A 5% significance level was used as a bench mark of significance but, as suggested by Moore and McCabe (1989), not held to rigidly.

Table 3 shows means and standard deviations of change in perceptions of abdominal pain on each of eight MPQ measures of pain after each of the three treatment conditions. As inspection indicates, there was little difference between HT and sham means, but the lower interview means indicated that the interview was a decidedly different intervention than the HT and sham treatments.

Table 3

Reduction in Perception of Abdominal Pain Measured as MPQ Score before Treatment minus MPQ Score After Treatment

	HT		Sham		Interview	
Score	Mean	SD	Mean	SD	Mean	SD
PRI-Total	**8.30**	8.76	**9.39**	11.00	**1.22**	4.73
PRI-Sensory	**5.00**	5.43	**5.91**	7.03	**0.48**	3.16
PRI-Affective	**0.70**	1.15	**1.09**	1.41	**0.00**	0.67
PRI-Evaluative	**0.95**	1.22	**0.44**	1.31	**0.22**	1.13
PRI-Misc Sensory	**1.17**	1.92	**1.17**	1.90	**0.26**	1.32
PRI-Misc Affective/ Evaluative	**0.48**	0.99	**0.78**	1.35	**0.30**	0.93
Number words chosen (NWC)	**3.22**	3.59	**3.74**	4.18	**0.48**	1.95
Present Pain Index (PPI)	**0.86**	0.96	**0.90**	0.79	**0.26**	0.56

Data on changes in pain perception were analyzed as a one-within-subjects repeated measures ANOVA design for each of the eight MPQ scores. Significant F-values for treatment effects were found for each except for the PRI-Miscellaneous Affective/ Evaluative measure (see Table 4), indicating that there were significant differences in pain perception due to treatment type. Post hoc contrasts compared estimates of reduction in perception of abdominal pain of each treatment to every other treatment. The estimate of average reduction after HT was compared to the average reduction after sham

Table 4

Changes in Perception of Abdominal Pain (F-Values) As Measured by the McGill-Melzack Pain Questionnaire

Score	Probability
PRI-Total	.0002
PRI-Sensory	.0003
PRI-Affective	.0003
PRI-Evaluative	.0227
PRI-Misc Sensory	.0483
PRI-Misc Affective/ Evaluative	.1864
Number of words chosen (NWC)	.0001
Present Pain Index (PPI)	.0359

and interview, and the average reduction after Healing Touch and sham was compared to the change after interview. Estimates were tested for significance, as shown in Table 5.

HT was found to give greater reduction in abdominal pain than interview on each of the scales except the PRI-Miscellaneous Affective/Evaluative measure (nagging, nauseating, agonizing, dreadful, torturing), and sham gave greater reduction than interview on every measure except the Evaluative and Miscellaneous Affective/Evaluative scale. The latter was close to significant ($p=.0717$). The Miscellaneous Affective/Evaluative scale measures an aspect of pain that blends both the affective and evaluative dimensions, but is not clearly either.

HT approached being different from sham only on the PRI-Evaluative dimension ($p=.0547$). The direction of the difference was a greater reduction under sham than under HT.

Comparing the combined HT and sham scores to the interview shows significance on all dimensions except PRI-Miscellaneous Affective/Evaluative, but comparing HT to the combination of sham and interview shows significance only on PRI-Evaluative. The results suggest that the outcome is due to the large difference between HT and interview.

The Number of Words Chosen (NWC) scale scores closely reflected the same pattern as the PRI-T and PRI-S; all were nonsignificant for HT versus sham but indicated that there was a significant difference in pain perception between the three treatments. The NWC scores probably are due to the MPQ's structure. The PRI-S score is the total of responses on 10 of the 20 blocks of adjectival choices. Additional sensory input is obtained from the Miscellaneous-Sensory

Table 5

Estimates of Differences in Pain Reduction/Treatment Effects on Abdominal Pain as Measured by the McGill-Melzack Pain Questionnaire

MPQ Score	HTvsS	HTvsI	SvsI	Hvs(S&I)	(H&S)vsI
PRI*-Total	1.09[m]/ 0.5774[p]	7.09/ 0.0007	8.17/ 0.0001	3.00/ 0.0805	7.63/ 0.0001
PRI-Sensory	0.91/ 0.4855	4.52/ 0.0011	5.43/ 0.0001	1.80/ 0.1156	4.98/ 0.0001
PRI-Affective	0.39/ 0.1233	0.70/ 0.0077	1.09/ 0.0001	0.15/ 0.4842	0.89/ 0.0002
PRI-Evaluative	-0.52/ 0.0547	0.74/ 0.0076	0.22/ 0.4153	0.63/ 0.0085	0.48/ 0.0425
PRI-Misc Sensory	0.00/ 1.000	0.91/ 0.0325	0.91/ 0.0325	0.46/ 0.2091	0.91/ 0.0144
PRI-Misc Affective/ Evaluative	0.30/ 0.2465	0.17/ 0.5056	0.48/ 0.0717	0.07/ 0.7727	0.33/ 0.1533
Number words chosen (NWC)	0.52/ 0.4885	2.74/ 0.0007	3.26/ 0.0001	1.11/ 0.0935	3.00 0.0001
Present Pain Index (PPI)	0.07/ 0.7911	0.59/ 0.0305	0.66/ 0.0187	0.26/ 0.2481	0.62/ 0.0106

Note: HT = Healing Touch; S = Sham; I = Interview

* PRI= Pain Rating Index

[m] The first number of each set is the mean pain reduction score.

[p] The second number of each set is the p value of the mean pain reduction score.

scale, which includes 3 blocks of choices. The result is that of the 20 blocks of adjectives on the MPQ, 13 of them reflect the respondent's sensory experience. The PRI-T and NWC scores, therefore, are strongly influenced by the total score on the sensory scales. The NWC scale's value was questionable.

Two conclusions present themselves from the quantitative data. First, there were no real differences between effects of HT and sham on chronic non-malignant postoperative abdominal pain sensations, but both HT and sham differ from the interview. Second, recipients evaluated the sham treatment quantitatively as providing greater cognitive-evaluative changes in pain responses, but not greater changes in pain sensations or affect. Results may indicate that the MPQ successfully discriminates between dimensions of pain.

Other Pain

As with abdominal pain, there was no significant difference between HT and sham on any of the eight measures of Other Pain, but there were significant changes in PRI-T, PRI-S, and NWC following HT and sham treatments as compared to interview (see Tables 7 and 8). Mean scores and standard deviations are presented in Table 6. Scores on affective and evaluative dimensions (PRI-A, PRI-E, and PRI-M) were consistently nonsignificant for Other Pain. Scores for Total and Sensory pain were higher for HT and sham than for interview, but all other means were similar for the three treatments.

Table 6

Means and Standard Deviations of Recipients' Changes in Perception of Other Pain

Score	HT Mean	HT SD	Sham Mean	Sham SD	Interview Mean	Interview SD
PRI*-Total	5.04	6.70	4.61	7.33	0.61	4.24
PRI-Sensory	3.00	4.08	2.74	4.45	-0.61	3.30
PRI-Affective	0.35	0.93	0.48	0.85	0.17	1.47
PRI-Evaluative	0.48	1.24	0.43	0.84	0.22	1.44
PRI-Misc Sensory	0.74	1.45	0.83	1.59	0.52	0.99
PRI-Misc Affective/ Evaluative	0.26	0.75	0.13	0.55	0.30	0.76
Number words chosen (NWC)	2.00	2.78	1.57	3.45	0.00	1.76
Present Pain Index (PPI)	0.81	0.87	0.37	1.30	0.14	0.65

* PRI= Pain Rating Index

Table 7

Changes in Perception in Other Pain (F-Values) as Measured by the McGill-Melzack Pain Questionnaire

Score	Probability
PRI*-Total	.0051
PRI-Sensory	.0013
PRI-Affective	.4798
PRI-Evaluative	.7175
PRI-Misc Sensory	.7083
PRI-Misc Affective/ Evaluative	.6385
Number of Words Chosen (NWC)	.0047
Present Pain Index (PPI)	.1356

* PRI= Pain Rating Index

Quantitative results for Other Pain may have been influenced by different pre-treatment patterns of pain. Eight of the twenty-three subjects reported no Other Pain prior to at least one of the three treatments. Four experienced no Other Pain before all three treatments, two reported no Other Pain prior to the sham treatment, but had pain prior to HT and the interview. Two other subjects indicated they had no Other Pain before two treatments, sham/control and sham/HT. All eight had no Other Pain prior to the sham treatment. No subject without Other Pain prior to a treatment reported having Other Pain after it.

As shown in Table 8, the Present Pain Index (PPI) (no pain---excruciating) approached statistical significance

Table 8

Estimates of Differences in Pain Reduction/Treatment Effects on Other Pain as Measured by the McGill-Melzack Pain Questionnaire

Score	HTvsS	HTvsI	SvsI	Hvs(S&I)	(H&S)vsI
PRI*-Total	-0.43[m]/ 0.7602[p]	4.43/ 0.0031	4.00/ 0.0071	2.43/ 0.0533	4.22/ 0.0013
PRI-Sensory	-0.26/ 0.8003	3.61/ 0.0010	3.35/ 0.0021	1.93/ 0.0347	3.48/ 0.0003
PRI-Affective	0.13/ 0.6043	0.17/ 0.4901	0.30/ 0.2297	0.02/ 0.9204	0.24/ 0.2752
PRI-Evaluative	-.04/ 0.8993	0.26/ 0.4494	0.22/ 0.5280	0.15/ 0.6097	0.24/ 0.4235
PRI-Misc Sensory	0.09/ 0.8182	0.22/ 0.5661	0.30/ 0.4226	0.07/ 0.8422	0.26/ 0.4274
PRI-Misc Affective/ Evaluative	-0.13/ 0.4963	-0.04/ 0.8202	-0.17/ 0.3653	0.04 0.7930	-0.11 0.5126
Number Words Chosen	-0.43/ 0.4752	2.00/ 0.0019	1.57/ 0.0129	1.22/ 0.0246	1.78/ 0.0014
Present Pain Index (PPI)	-0.42/ 0.1440	0.54/ 0.0574	0.12/ 0.6690	0.48/ 0.0531	0.33/ 0.1767

* PRI= Pain Rating Index

[m] The first number of each set is the mean pain reduction score.

[p] The second number of each set is the p value of the mean pain reduction score.

(p=.0547) for HT versus interview and for HT versus sham combined with interview (p=.0531) but not for any other comparison, including HT versus sham. The F-value for changes in PPI scores between the three treatments was nonsignificant. There was a greater change, although not a significant one, in PPI following sham than after HT (estimate = -.42, p=.1440).

Research Questions 4 and 5: Providers' States of Consciousness and Providers' and Recipients' Experiences

Quantitative data indicated that differences in providers' state of consciousness were noncontributory to recipients' pain relief, as there were few statistically significant differences between HT and the sham treatment. However, qualitative data revealed differences in the subjective experiences of providers and recipients (see Tables 9, 10, 11, and 12 and Appendices O, P, and Q). Mutual experiences reported in Tables 10 and 11 do not include all reported experiences. Some providers neglected to ask recipients to tape record impressions, so matching data was not available. Also, some sham providers gave terse and uninformative comments, such as "Better today" preventing matching of recipient data. The narrative descriptions in Appendices O and P include all comments, not just those incorporated in Tables 10 and 11.

HT Providers' and Recipients' Experiences

Fourteen recipients of HT experienced some pain relief. Four described total pain relief, one temporary pain relief, and nine partial pain relief. Two reported no pain relief.

Table 9

Pain Relationships between HT Provider and Recipient Experiences

HT Provider Experience	Recipients Experiences: Total pain relief	Partial pain relief	Temporary pain relief*	No pain relief	Relaxation
Ran energy	-	2	1	2	5
Felt recipient was pulling in energy	-	2	-	-	1
Heat	2	7	-	-	1
Tingling	1	-	-	-	1
Congestion heaviness disappear	-	2	-	-	-
Pain	1	4	1	-	2
Other:					
Soft columns	-	-	-	-	1
Electricity	-	-	-	-	4
Pulsations	-	3	-	-	-
Draining	-	1	-	-	-

Note: A single recipient may have reported several sensations; some reported none. The numbers in the table do not represent 100% of the recipients, only those who reported pain relief or relaxation. Fourteen of the twenty-three recipients reported some pain relief.

*Temporary pain relief refers to pain that was relieved during the treatment but returned immediately thereafter.

Five of the ten HT providers reported "sending energy"; all five recipients described the treatments as "relaxing", "peaceful", "warm", "soothing" and pain relieving. Fourteen recipients reported some relief of pain. Eight provider-recipient pairs described similar activity or sensations, such as pulsations, energy transfer, moving pain, draining pain, or warmth. In every case of such mutual experiences, the recipient reported reduced pain. One recipient described an unpleasant sensation of her abdomen being massaged internally, but had pain relief following the treatment. The provider did not touch the recipient.

Three of the ten HT providers felt they were being pulled into the recipient's field or that the recipient was taking in energy, rather than the provider sending energy. Recipients described their experiences as "something emanating from the scar like steam", "energy transfer", and "pressure change, like sounds changing from side to side inmy ears". A fourth provider described a flow of energy through her from her feet to the recipient. Her recipient reported feeling energized and experienced total pain relief at the end of the treatment.

In the four cases, recipients gave graphic descriptions of changes. One said that she had a sense of "overall lightness" and "stomach tissue softened and melted into [her] stomach". One reported that her constant pain of many years had totally disappeared. She pressed on her stomach to see if it would come back but it did not return during the rest of the time she was with the provider, another fifteen minutes. (Unfortunately, the subject could not be reached for follow-up or for her other two appointments.)

Table 10

Non-Pain Relationships between HT Provider and Recipient Experiences[m]

Provider Experiences	Recipients Experiences: Wonderful/ Hypnotic	Less stress	Sensations*	Pressure/ Muscle spasms	Lightness	Heat
Temp Cold	1/1	1	-	-	-	-
Warm	1/1	1	2	-	-	-
Sensed Pulses	1/1	1	3	-	1	1
Static			2	-	-	-
Tingling	1/1	1	1	1/1	-	-
Peristalsis	-	-	-	1/1	-	-
Congestion	-	-	4	-	1	1
Traveling pain	-	-	-	0/2	-	-
Energy Sent	1/1	1	-	-	-	-
Pulled in	-	-	3	1/0	1	-
Refreshed	1/1	1	-	-	-	-

[m]Table 10 reflects only provider-recipient mutual experiences, not all reported experiences. See Appendices O and P for a complete account of all experiences.

*Sensations included pain draining out from wound, pain being pulled away, movement, pulsing, emanation.

In all cases in which the provider reported energy being pulled into the subject, rather than sending it, recipients described a specific change in sensation. Recipients whose providers sensed they were sending energy described their treatments more globally, usually as relaxing with pain relief.

Recipients and providers reported numerous sensations. One recipient who was not touched described feeling a weight on her abdomen. Two stated they could tell the difference in sensations when the providers removed their hands. Two recipients felt their pain was being pulled out or drawn away; another said the pain was released and described her pain after the treatment as "a pain memory."

Most recipients described feeling warmth, but one described a cooling sensation all over her body. One felt heat transfer between herself and the provider, but could not tell from whom it originated. One recipient's primary pain eased after the provider's hands got very hot. Once it eased, the provider moved her hands slightly to cover an area in which pain had intensified. It, too, diminished.

One subject began fine undulating motions from head to foot that continued at least half of the thirty minute treatment but ended before the timer went off. This subject was unable to schedule her sham treatment until seven weeks after the HT treatment. Sometime during that seven weeks, the pulling pain that she had had since her appendectomy thirty-two years earlier disappeared. It had not returned at the time of the sham treatment.

Two providers felt heaviness or thickness that disappeared prior to the end of the treatment. Several

described congestion and static. One sensed soft bands of energy from her hands into the recipient's abdomen. Another felt electricity that got smoother and sensed a "buildup on her fingers of unseen matter that was easily released". A provider described a "big cold hole sucking in energy". Three providers described becoming unpleasantly hot, a state that resolved before the treatment was over.

The presence of unseen "guides" during the treatment were reported by two HT providers. One guide was described vaguely and no behavior was recorded. The second guide was perceived by the provider as the subject's deceased husband. During that treatment, the provider, who knew the recipient, understood messages intended for the recipient, including "husband is with you". She also sensed that surgery was being performed on the subject, with "clipping and dissolving in the right lower quadrant". This was the recipient in whom the provider sensed a "big, cold hole sucking in energy". The recipient recounted getting very cold about the time the provider sensed the "surgical" activity. Following the treatment, the recipient reported total relief of abdominal and side pain, but her joint and back pain became severe and she was "stiff from head to toe" after the treatment.

Two providers felt that treatments were incomplete and forced themselves to stop when the timer went off. In three HT provider/recipient pairs, there were no clear relationships between reports of experiences.

Two of the three recipients who reported total pain relief were treated by the most experienced HT provider, who gave graphic and detailed descriptions of her experiences.

The following is her written report following the HT treatment of a recipient who had total pain relief, did not return for the sham treatment and interview, and could not be reached for follow-up.

> At first, I felt a nothingness, an absence in her field (in her) during the first magnetic unruffling sweeps. Gradually, with my etheric fingers reaching deep inside her, a tingling began, especially from her diaphragm to her upper thighs. Gradually this tingling changed to a stronger rhythmic vibration. I saw clouds (white) of energy swirling softly in and around her body. With each magnetic unruffling sweep, the energy emanating from me reached deeper into her. This reaching was more accurately described as a pulling sensation of my energy into her depths. I noticed (felt) a thickness or denseness in and over abdomen and pelvis which became lighter and clearer. During the etheric gathering in of energy over the wound, I felt a heaviness over groin and pubic area that graduated to less heaviness or dense. During the filling (etheric wound healing), with my hands directly over and on the abdominal wound, I felt intense heat, localized at the wound. This heat began to spread out into her body (in ever widening circles) and changing to a warm glow. After about five minutes, I felt a shift under my hands; a strong drum-like vibration began, continuing while the

heat (that was a faster, lighter, clearer quality) began spreading further out.

(During the magnetic unruffling, she had been audibly wheezing. The audible wheeze stopped during wound closure.)

Then I sensed the healing energy move deep into the wound and surround it as a cocoon. The vibration became fainter and fainter. I moved my hands and stepped away from her. I had a strong urge to move my hands over her energy field to "seal" and strengthen the new energetic pattern. I did not do this (because this is a study).

With the treatment completed, the subject sat up and started to fill out the post-treatment MPQ. After 30-45 seconds, she said, "I'm sitting waiting for the pain to return and it's not. I feel no pain. This is the first time in 1 1/2 years that I've not been in pain."

Sham Providers' and Recipients' Experiences

Twelve recipients of the sham treatment reported some degree of pain relief. One experienced total pain relief and eleven described partial pain relief. No one noted that their pain relief was temporary, i.e., lasting only during the treatment session or for a short time thereafter.

Sham providers and recipients reported a narrower range of experiences than did HT providers and recipients (see Table 11). Three of the twelve sham providers became warm, one perceived warmth in the recipient, and one sensed warmth coming from her own hands. One experienced waves of nausea, one developed profuse diaphoresis, and another felt her

Table 11

Relationships between Sham Provider and Recipient Experiences

Sham Provider	Recipients Experiences: Pain Relief		Panic	Temp diff	Relaxing	Wonderful	Felt sensations*
	Total	Partial					
Was warm (2)	-	2	-	1	1	1	-
Felt Warmth (2)	1	-	-	1	1	1	-
Discomfort** (8)	-	4	1	1	3	1	1
Uninvolved (4)	1	2	-	-	4	2	-
Felt movement (2)	1	1	-	1	1	1	-
Self-Hypnosis (1)	-	1	-	-	1	-	-
Interesting (1)	-	-	-	1	-	-	-

* Felt sensations include feeling tingling or movement and feeling that pain was being pulled out.

** Provider discomfort included diaphoresis, nausea, arms aching, joints stiffening, back hurting, and tiredness.

Note: A single provider or recipient may have reported several sensations and some reported none. The numbers in the table do not represent 100% of the providers and recipients, only those who reported mutual experiences. Twelve recipients reported some degree of pain relief.

joints stiffen and creak. Three had aching arms and shoulders, one described her hands as aching.

Several described sensations HT providers routinely relate. One said energy was moving. Two felt something moving in the recipient's abdomen while their hands were resting over the area of pain. One felt heaviness over the recipient's head and chest and tension from her abdomen. Two perceived that moving their hands above the recipient from head to foot (the magnetic unruffling movements) got easier as they progressed, and one noticed that she felt less the higher her hands were above the recipient's body.

Descriptions of nine sham providers indicated they were essentially uninvolved in the treatment; they were putting in the time. Six became tired and one found it hard to concentrate. One reported she had many distracting thoughts and another worried about her personal chores for the day. Two thought the tape helped the time pass. Despite providers' distraction or boredom, three recipients reported feeling pain relief, four felt relaxed, and one described the treatment as wonderful. Two recipients of uninvolved sham providers reported neither pain relief nor relaxation.

Nine of the twenty-three recipients reported feeling less pain or being more relaxed after a treatment in which the providers had experienced pain or other side effects, such as diaphoresis or joint pains. Seven of the nine experienced pain relief, two reported feeling more relaxed, and two stated they had pain relief and were more relaxed.

In only two provider/recipient pairs were there no apparent relationships. In both cases the recipients reported feeling only a cooling sensation.

Interviewers' and Recipients' Experiences

Neither interviewers or recipients reported many impressions following the interview (see Table 12). Interviewers were specifically asked to described their own sensations but seven described recipients' presentation of themselves and four discussed the conversation. Eight commented on the process but not on their impressions of the recipients or of themselves. Five recounted their reaction to the recipient. Several felt sorry for the recipient, others were impressed by the courage displayed.

Two were concerned about their techniques. A psychiatric nurse was uncomfortable not collecting data and another interviewer was concerned that her technique was being evaluated. The latter interviewer was acquainted with the recipient, who was a nurse. There were no reports of physical changes within providers or that they sensed anything out of the ordinary in the recipient.

Recipients had little to say about the interview. Six indicated they enjoyed it; two disliked it because it made them remember their pain and what they had experienced. One specifically said it did not relieve her pain, but five reported that it lessened it. One had a headache that increased in intensity during the interview. One said she enjoyed the interview but her pain did not change. One recipient realized that she scored the MPQ sensory measure exactly the same following the interview as before it, but evaluated her post-treatment pain as less. She stated that the experience made her realize she had some control over her response to her pain. Another said it helped her mental state but not her pain.

Table 12

Relationships between Interview Provider and Recipient Experiences

Provider Experiences	Recipients Experiences: Less Pain	More Pain	Useful Comfortable	No Change	No Comment
Reported about client (n=7)	1	1	2	0	2
Reported about self (n=5)	2	1	4	0	0
No impressions noted (n=11)	3	0	2	4	6

Note: A single provider or recipient may have reported about both self and the recipient. Some providers commented on the process, rather than the people involved. The numbers in the table do not represent 100% of the providers and recipients.

Several noted that the interview was useful. One said it was "good to have someone listen to me," another that "talking helps the pain. You don't concentrate on it. It makes a sharp pain go to a dull pain." One felt "strangely cared for" even though her headache got worse during the interview. One commented on the interviewer's voice. She described it as "soothing", as taking the pain away. Another noted that "talking is a stress release. Thanks for the opportunity to talk."

Recipients' Final Report On Their Experiences

During the final telephone interview, the researcher asked all subjects to compare the three treatments (see Appendix H). One preferred the interview because she had not been able to talk about her surgery in the two months since it occurred. One favored the sham provider because the recipient felt the provider was paying less attention to her than the HT provider or interviewer. Despite that, she liked the HT treatment better. Six stated they preferred the HT treatment and four could not tell a difference between the two.

When asked why they had a preference, answers were often vague. Usually the recipient mentioned more pain relief, more relaxation, or just that s/he liked a treatment better. A few gave specific reasons. One said it had relieved 50% of her pain and she appreciated that. Another, who had surgery just six weeks before, said HT was stress relieving. "I had a wonderful time last night. I went to dinner and made love for the first time since surgery. I feel like I have been on a vacation." No similar reports followed sham treatments.

Summary

Data indicated that HT and sham treatments were safe for providers and recipients, but sham treatments were more uncomfortable for providers and HT for recipients. There were no quantitative differences between HT and sham in recipients' perceptions of sensory or affective changes of either abdominal or other pain, but there were differences in cognitive-evaluative ratings of changes in abdominal pain. The response may be due to chance or may represent

the ability of the MPQ to discriminate between pain dimensions. Recipient's quantitative and qualitative reports indicated that the interview is followed by fewer changes in recipient's pain perception than HT and sham.

Healing Touch providers gave rich descriptions of activity they sensed. They perceived heat, cold, tingling, vibrations, a build up on their fingers of unseen matter, congestion, prickling pressure, a big cold hole, absence, clearing, heaviness, and lightness. They reported various types of movement: filling, draining, sending energy, energy being pulled in, spasms of heat released, throbbing pulsations, a rhythmic rapid shaking up, and a chaotic flow.

Sham providers reported fewer sensations with less vividness than HT providers and often discounted their impressions. One said she felt silly. Their most frequently reported experiences were feeling warmth within themselves or the recipient and unpleasant side effects. Nine of the twelve sham providers (75%) were distracted and largely uninvolved in the treatment.

With two exceptions, the interviewers enjoyed the interview. No one had physical experiences similar to those of the HT and sham providers.

Recipients experienced movement, increased and decreased pain, pain draining and being pulled away, and relaxation during HT and sham treatments. Qualitative reports indicated that recipients tended to prefer HT, but only slightly. Some could not tell the difference between HT and the sham treatment. Two disliked the interview.

Chapter 5

Conclusions, Implications, and Recommendations

Conclusions

Research Question 1: Is Healing Touch Safe for Recipients and Providers?

Healing Touch appears to be safe for both recipient and skilled provider. Of the eight side effects experienced by recipients following HT, there was one case each of nausea, headache, and increased arthritic pain and two instances of dizziness. Each case of dizziness accompanied a headache. One more non-pain effect developed after HT than was relieved.

Drowsiness was reported after HT by three recipients. It is a common effect of being relaxed, and relaxation was reported more often than pain relief after HT (five reports of relaxation, three of pain relief). Drowsiness may be a positive side effect, rather than a detrimental one.

Relaxation is accompanied by prickly and tingling feelings in the extremities, increased awareness of pain, and mild to extreme anxiety (McCaffery & Beebe, 1989), all of which were reported by sham and HT recipients. If some uncomfortable experiences were due to increased relaxation, positive effects of HT may be offset by the side effects of relaxation. Recipients may have to choose between increased pain and/or anxiety and increased relaxation.

Of the eight non-pain effects reported, five were uncomfortable and at least three were related to relaxation. The uncomfortable side effects occurred in 21.73% of treatments. While uncomfortable, they were not detrimental

to the sufferer. Therefore, data from this study did not indicate that HT was unsafe for recipients.

HT providers reported only one side effect--pain, which disappeared for all but one provider by the end of the treatment. This suggests that HT is safe for providers.

Research Question 2: Is the Sham Treatment Safe for Recipient and Provider?

Sham recipients reported fewer non-pain related side effects following sham treatments than following HT. No one developed nausea or a headache. Nausea was relieved in two people and headaches in four. One person's dizziness disappeared. Another, who had a preexisting headache, developed dizziness and nausea.

Only one person developed drowsiness following the sham treatment. There were only two reports of relaxation but three of pain relief, as opposed to more relaxation than pain relief following HT. If drowsiness is related to a sense of relaxation, perhaps the lower incidence was due to fewer reports of relaxation following the sham treatment. Based on data from the small sample of twenty three treatments, the sham treatment may be considered safe for recipients and more comfortable than HT.

The experience of sham providers is less positive. There were five reports of aching during the sham treatment, a rate of 21.73%. Two sham providers stated they were uncomfortable and did not enjoy the session. Two developed successful approaches to reduce unpleasant side effects when they gave their second treatments. It appears that one can learn to protect him/herself from recipients' pain and that the two sham providers and skilled HT providers did so.

Without that learned ability, nurses not trained in any HMEH modality are uncomfortable giving sham treatments, but there is no indication that such treatments were unsafe.

Research Question 3: Do Recipients Perceive That Their Pain Changed From Pre-Treatment States After HT, Sham, and an Interview?

Quantitative data indicated that recipients evaluated changes in their abdominal and other pain differently after the interview than after HT and sham treatments. There was little change after the interview, although several subjects reported feeling better because, they said, talking helped reduce stress and the pain became less severe.

Changes in the quantitative measures of pain perception after HT and sham indicated that recipients evaluated (PRI-E) the sham as being following by more significant abdominal pain reduction than after HT. On none of the other MPQ scales was there a significant difference between sham and HT. None of the MPQ scales indicated significant differences between sham and HT effects on Other Pain, yet six of the eight measures indicated that sham was followed by a greater reduction in pain than HT, although these changes were not statistically significant.

The one difference found between pain perception after sham and HT may have been due to chance or may have reflected the different pain dimensions measured by the MPQ. The latter conclusion is supported by the report of one recipient who noted that she rated her pain sensations the same after the interview, but rated her responses to pain differently. The MPQ was designed to provide subjects an opportunity to differentiate between sensations of pain and

responses to pain. The small sample size does not provide enough evidence to determine if the results were spurious or if they reflected the ability of the MPQ to separate the different dimensions of pain.

The goal of the study was to test HT against a standard nursing behavior that represented the attention and presence of a caring nurse. While planning the study, the investigator recognized two problems with the selection of the placebo control. First, a standard nurse/client action was to be compared to a non-standard nurse-client action, supine HT and sham treatments. The most standard nurse-client action is a seated conversation. Because nurses believe that listening to someone relieves pain, the investigator chose to compare a standard seated interview to the non-standard supine HT and sham treatments. She believed that interviewing a relatively healthy subject who was supine was not a normal nurse-client interaction for a relatively healthy client. Second, recipients were touched only briefly during the interview but continuously touched for fifteen minutes during the other two treatments.

Contact Healing Touch/Sham was selected rather than non-contact to increase sham providers' comfort. The investigator was concerned that sham providers would be excessively uncomfortable if asked to hold their hands still and in one position slightly above the recipient's body for fifteen minutes as would be required in a noncontact treatment.

The striking statistical differences between the changes in pain descriptors following HT/Sham treatments and the interview indicated that the effects of the two touch

treatments differed significantly from the effects of getting to tell your story to a caring nurse. It was clear that, for this population, a supine touch treatment produced more pain relief than interacting with a caring nurse. From the quantitative data, it was not possible to determine whether the differences were due to the treatments, resting for thirty minutes in the middle of the day, being touched, the combination of resting and being touched, or other variables yet to be identified and explored.

Qualitative data suggested that recipients' responses to HT and sham may have been related to more than just resting. Providers and recipients related similar experiences, such as heat, pain, and pulsations. Recipients identified specific responses, such as relaxation of the abdominal scar, stomach tissue softening and melting into the recipient's stomach, a sense of something emanating from the scar, something leaving like steam, and pain being pulled away or drawn out. One recipient's pain of thirty-two years disappeared several weeks after HT. Such sensations and experiences are not normally associated merely with resting in the middle of the day.

Results may be related to touch. All providers were female nurses accustomed to intimately touching patients. Few people experience continuing touch at a surgical site at any time, especially not weeks and years after the surgery. The effect of a simple, intimate touch may have influenced the results.

Provider and recipient expectations may have contributed to the results. HT providers thought they were doing something, but several sham providers stated they felt

silly. Their differing expectations and emotions may have influenced the treatments. Recipients' expectations may also have influenced the outcome; they cared enough to attend three sessions. Several recipients were disappointed and slightly upset when they arrived for the interview; they had forgotten it was one of the treatments. Expectations of all concerned may have contributed to an active placebo or nonspecific effect.

One possible explanation for HT and sham being followed by perceptions of reduced pain is that they may have provided unknown nonspecific or placebo effects over and above the presence of a caring nurse. Guzzetta (1995) includes "a medically inert . . . ritual" in the definition of placebo (p. 198). While the recipients experienced a normal interaction during the interview, they were cared for in a novel way during both sham and HT treatments. They were positioned comfortably, covered, asked if they would like a pillow under their knees, and hands were rhythmically moved over them. One person was completely focused on them in an unusual way for thirty minutes. Even when the sham providers were seen to be distracted, they were still present and making rhythmic hand movements. The entire procedure may have been perceived as a healing ritual and thus produced a placebo or nonspecific effect.

As Krieger (Krieger, Peper, & Ancoli, 1979) pointed out, if responses to HMEH are due only to the placebo effect "[learning] to systematically maximize this process . . . would in itself be a significant contributor to nursing (p. 296). Out of twenty-three subjects who had experienced weeks and years of chronic abdominal pain since having

surgery, twelve had some degree of pain relief following the sham treatment, fourteen following HT. One person experienced total pain relief following sham and four following HT, pain relief that continued several hours, days, or weeks after the sessions. These recipients had not received similar results from standard medical or nursing treatments.

Research Question 4: Is the Provider's State of Consciousness Significant or Are Hand Motions Alone Sufficient for Perceived Results?

HT providers centered themselves prior to beginning treatments; sham providers put on earphones and listened to story tapes. The aim of giving sham providers something to listen to was to keep them from inadvertently centering or concentrating on what they were doing.

Quantitative results indicated the recipients' perceptions of their pain sensations (PRI-S) did not differ following HT and sham treatments, but, as discussed on page 73, recipients may have evaluated the sham as more soothing than HT (PRI-E). Moreover, recipients experienced fewer uncomfortable side effects following the sham treatment than after HT. Three explanations presented themselves. First, the seeming differences between HT and sham were spurious. Second, hand motions alone were sufficient for HT and sham treatments to be followed by both qualitatively described changes in pain sensations and evidence of quantitative changes in evaluative and affective responses to pain, providing that effects were due to a factor other than resting and/or being touched. The HT providers' presumed

altered states of consciousness may have had no effect on recipients' evaluations of changes in pain experiences.

Third, sham providers may have entered an altered state of consciousness while listening to the audio tape. If so, their altered state of consciousness may have differed from that of the HT provider, but the effect on recipients' pain perception did not. HT practitioners believed they were actively involved in the treatment and sham practitioners did not think they were. The results were virtually indistinguishable.

The greater number of non-pain related side effects and reports of perceived pain relief following HT than sham may be an effect of the HT providers' state of consciousness, or at least state of mind. HT providers had more than a casual interest in the results of the study, and they also wanted to help the recipient. They had only one chance to do so. The HT providers are taught both to "run energy" and to "allow energy to flow". Running energy can be described as creating an internal state in which one senses that one is actively sending energy to the recipient; allowing energy to flow is the perception that something that feels like energy is allowed to flow through the provider without disruption, which is a passive action.

Most of the HT providers routinely gave one hour treatments during their private practices and all worked intuitively, called "following the energy". Because they had less time than usual and were restricted by the study protocol in the techniques they could use, HT providers may have tried to "push" energy. They may have provided a more aggressive HT treatment than the sham providers. If so,

perhaps an aggressive, rather than a passive, treatment resulted in more unpleasant side effects following HT than after sham and, at the same time, more qualitative reports of total pain relief. However, neither quantitative nor qualitative data helped determine whether the reported differences in pain relief, relaxation, and side effects between HT and sham treatments were due to HT and sham providers' different states of consciousness or some other unidentified factor inherent in the providers' treatments.

Research Question 5: What Are the Experiences of HT and Sham Providers and Recipients During Treatments?

Qualitative data indicated that both HT and sham providers experienced sensations that are not routine in normal nurse-client interactions. Both reported feeling movement within the recipient, both became hot and/or felt warmth within the recipient, both experienced some type of physical pain during the treatments. Sham providers experienced a greater number of personally uncomfortable sensations than did HT providers.

Two sham providers learned to protect themselves from discomfort, a skill routinely taught in HT classes. One sham provider described herself as calmer during the second treatment she gave; the second used self-hypnosis and self-relaxation. These are types of centered or altered states of consciousness. Learning to protect yourself from pain during HT may have something to do with the provider being in a calm, centered, or altered state of consciousness and may reflect a type of self-referencing biofeedback.

Sham providers reported a narrower range of sensations within recipients than did HT providers, who have learned to

look for them. One sham provider reported feeling less the higher her hands were above the recipient. Practitioners of HMEH expect this sensation. Feeling less further away from the recipient is interpreted as sensing a more external energetic body such as is described by Brennan (1987) and others, or sensing an area of less electromagnetic field density.

Another noticed that magnetic unruffling movement became easier toward the end. This, too, is expected by HT providers, who use the sense of increased ease as a sign that the field is clearing of "energetic debris". The technique, usually, is continued until the provider senses no differences in the field from head to toe, or until it becomes apparent that a sensation is no longer changing. At that time, a HT provider will begin another technique, often running energy, at the area in which s/he feels or intuits an unchanging or undesirable sensation.

Sham providers' experiences of sensing changes in the space above a recipient suggested that the sensations may reflect normal human phenomena of some type, possibly electromagnetic field characteristics. Only two of the twelve sham providers experienced these external sensations, which implies that experiencing subtle sensations around another person's body may be either imagined, a function of some unknown personality characteristic of the provider and/or recipient, or due to some other factor. The data from this study did not support any conclusion other than two sham providers noticed phenomena that are consistent with electromagnetic field density characteristics and expected by HT practitioners.

Some sham and HT providers and recipients reported feeling something moving that felt like energy. Several pairs of provider-recipients had related experiences, such as pain in shoulders. Sham providers developed aches, especially backaches. HT providers described pain moving up their arms; one said it exited at her wrists. One described a sense of energy coming into her feet, moving up her body, and entering the recipient. Each of these descriptions depicted sensations one might experience if a low amplitude, low voltage electrical current were flowing through, and possibly between, the provider and recipient. If so, it would not be surprising if each person in a pair experienced similar sensations because the current would be carrying specific information, such as pain or heat or backache.

The possible existence of an electrical-like current may provide one explanation as to why sham providers experienced more aches, pain, and other unpleasant side effects than HT providers did. Both HT and sham providers reported feeling pain, but HT providers described releasing it. Learning how to release such pain is a standard part of the HT curriculum. If information about pain, such as backaches, is transferred from recipient to provider on a current of some sort, perhaps the sham providers received the recipient's back pain and HT providers sent the information-laden current elsewhere.

Another possible explanation for the differences in provider side effects may be the unusual positions providers had to assume during the two phases of the treatment. Both sham and HT providers used awkward hand and body movements during the magnetic unruffling process. During wound

sealing, they stood next to and gently touched the recipient's abdomen for fifteen minutes. Uncomfortable movements and the unaccustomed position may have contributed to the sham providers' backaches. HT providers may have not experienced, or reported, similar discomfort because they have learned to compensate for it, rather than having learned to release pain. They may have learned to do both.

Two HT providers described sensing non-corporeal guides during the treatment. Such guides are often reported by HT providers. One provider vaguely sensed a presence; the second gave specific details about the presence, specifically that it was the recipient's deceased husband bringing messages. The sparsity of the reports prohibited any conclusion other than that the providers reported the experiences.

The fact that the HT provider who reported specific details of the guide was acquainted with the recipient and her situation undermines the credibility of the report. It does not negate it, but it brings up questions as to the possible role the provider's subconscious has in creating details about sensed non-physical beings.

Two of the three recipients who reported total pain relief were treated by the same HT provider, who had the most and broadest HMEH training of all of the HT providers. Her results and her descriptions of what she sensed, including the breathing patterns of the recipient, suggests that a broad HMEH experience provides one with more or different abilities and perceptions.

Summary of Conclusions

Nine conclusions were reached following analysis of the quantitative and qualitative data.

1. HT and sham treatments were safe for providers and recipients. As noted in Chapter 4, HT was more uncomfortable for the recipient, and sham for the provider.

2. Recipients' evaluated their chronic non-malignant pain as less grievous after HT and sham than beforehand.

3. Amount of pain relief was greater after sham than after HT, but not to a statistically significant degree except for the cognitive-evaluative (PRI-E) scale. In qualitative reports, recipients reported more pain relief following HT than after sham. Abdominal pain may have been evaluated cognitively as more tolerable after sham than after HT, despite the lack of a significant difference in sensory changes.

4. Recipients perceived that their pain changed from pre-treatment states after HT and sham treatments, but not after an interview. It was concluded that HT and sham effects were due to more than the simple placebo effect of interacting with a caring nurse, but that results could have been influenced by a complex placebo, or nonspecific, effect involving ritual and expectations.

5. All effects attributed by the recipient to HT did not occur immediately. One subject noticed her unrelenting "pulling" pain of 30 years disappeared several weeks after the interview and HT but before receiving the sham treatment. The recipient specifically gave credit to the change in her pain to HT, which was the only unusual incident in her life at the time.

6. HT and Sham providers both may have provided treatments while in some type of altered states of consciousness. Amount of recipients' non-pain related side effects and more qualitative reports of total pain relief following HT may be due to aggressive treatments given by HT providers. More partial pain relief following sham may be due to a gentler, more passive treatment.

7. Some type of self-referencing biofeedback may have protected HT and two sham providers from pain and other side effects while giving treatments.

8. Recipients' and providers' reports of their experiences depicted a sensation similar to a moving electrical current. If such a current exists, it may explain why providers and recipients experience similar pain or describe similar sensations during a treatment.

9. The results neither support nor negate the thesis that consciousness interacts with electromagnetic and bioelectromagnetic physical phenomena for healing.

Strengths of the Study

Several characteristics of the study enhanced the reliability and validity of the data.

1. The use of multiple providers prevented undue influence of just one or only a few providers.

2. Multiple sites reduced the possibility that an idiosyncratic characteristic of an area of the country may have influenced recipients and/or providers in ways that would not have occurred elsewhere.

3. The researcher and local site coordinators did not give treatments, which helped separate the research and management roles from the provider roles.

4. Training was standardized through training videos and written instructions. Individual differences in training because of providers' questions or provider/investigator interaction did not occur.

5. Instructions to subjects were standardized through written instructions to the coordinator. Because multiple coordinators recruited and admitted subjects to the study, individual adaptation in admission instructions was diluted.

6. Subjects acted as their own controls and received the three treatments in random order. There was no risk of statistically different populations receiving different treatments.

7. The McGill-Melzack Pain Questionnaire's measurement of three dimensions of pain gave more information than would a tool measuring a single or blended dimensions, such as a visual analog scale.

Limitations

Limitations of the study were:

1. The results are valid only for the type of recipients who participated in the study, that is, people with chronic nonmalignant pain associated with abdominal surgery. Participants had uninfected wounds or other infections and were amenable to receiving three different treatments administered by nurses on three different days.

2. Results are valid only for the types of HT interventions tested: magnetic unruffling and wound healing/closure as taught in the American Holistic Nurses' Association's program, Healing Touch for Health Care Professionals.

3. Qualitative descriptions of providers' and recipients' experiences reflect only their experiences with the interventions given or received. They are valid for the providers and recipients but not generalizable.

Implications

This study has a number of implications for research, standard nursing and HT practice, and theory building.

Research

1. Sham providers experienced aching and pain despite the researcher's attempt to minimize their physical discomfort. HT providers did not have a similar experience. It appears that HT training effectively prepares providers to minimize their own discomfort. Nurses unfamiliar with energetic healing are not equally prepared and should not be used to provide sham treatments during research studies.

2. Several sham providers gave one treatment and withdrew from the study. Each study site had to recruit and train several sham providers in order to complete treatments on just a few subjects. One site trained as many sham providers as they tested recipients; the HT provider and interviewer continued unchanged. In addition to their physical discomfort, a few sham providers indicated they felt silly or awkward doing the treatments. Physical and psychological discomfort may have influenced the exodus of sham providers. Continually recruiting and training sham providers increased the time and cost of the study.

Professional Practice

1. Any nurse, or care giver of any type, can experience discomfort while touching a patient for a lengthy time. If the nurse is prepared or relaxed, there is less

likelihood of discomfort. Bed baths, back rubs, dressing changes and other touching activities may result in discomfort for the caregiver.

2. Sham providers, largely, were distracted, not deliberately involved in the treatments, and took no responsibility for any effects of the treatment. Many of them didn't expect any responses. HT providers had a vested interest in the study and in its results; they were not as neutral as sham providers. Recipients' greater statistical pain relief from the sham treatment may have been due, partially, to the fact that sham providers were neutral. HT providers need to learn to be similarly neutral.

Theory Building

The data neither support nor negate the implication that information, perhaps bioinformation, is carried from one person to another on a current of some sort. Providers' and recipients' experiences offer slight support to the proposition that such a current exists. The existence, nature of such a current, and information that it might carry needs to be studied.

Nursing is primarily based on biology, chemistry, and physiology. Few nurses are exposed to more than the rudiments of Newtonian physics and are seldom taught concepts of electromagnetic physics. If HMEH modalities utilize physical, rather than biological or chemical, properties, nurses need to understand applicable physical and biophysical concepts, such as electromagnetics and biophoton emissions.

Recommendations

Nine recommendations resulted from data analysis.

Research

1. Sham providers in research studies should be protected from the side effects of giving treatments. At the least, they should be taught the body mechanics HT providers learn to use during treatments to diminish back pain and fatigue. The most ethical approach is to design studies in which untrained providers are not used.

2. Research should be done comparing seated HT to supine HT, and comparing supine HT to resting states.

3. Studies should be done comparing results when HT providers are constrained by a research protocol and/or time and when they are allowed to give an intuitive treatment without protocol or time constraints.

4. The longitudinal effects of HT should be studied. Such studies might include how long after HT a recipient feels any effect and time of peak effect.

5. A questionnaire should be designed to study side effects of HT. The questionnaire should include sensations in addition to those normally associated with pain. Arthritic pain, stiffness, muscle cramps and twitching might be included on such a questionnaire, as might emotional feelings during the treatment.

6. The MPQ should not be used as the sole quantitative tool to study HMEH effects on pain. Use of a visual analogue scale would complement the MPQ.

Practice

1. Nurse-client relationships and interactions should be examined from the perspective of energy transfer.

Touching activities such as bed baths, back rubs, and dressing changes may provide opportunities for energy to transfer between nurse and patient, possibly relieving pain in one and resulting in pain in the other.

2. HT recipients should be protected after HT treatments. Dizziness and drowsiness after a treatment could contribute to an unsteady person falling.

3. Nurses interested in pursuing HT should study a variety of modalities. The most profound effects from any of the 69 treatments occurred when the HT provider with the most and broadest experience gave treatments.

Validity and Reliability

The validity of the study results was limited to the types of treatments provided for people with chronic nonmalignant post-operative abdominal pain. External validity was enhanced by data being collected by numerous providers in eight cities. Internal validity was controlled by each recipient acting as his/her own control and by the required time separation of treatments, which reduced the effects of a previous treatment from influencing a later one. To reduce threats to reliability of content analysis, recipients' and providers' verbatim reports were analyzed using a three step process recommended by Wilson (1989).

Summary

Quantitative data indicate that supine HT and sham treatments were safe and were followed by essentially the same degree of perceived changes in pain sensations. The cognitive-evaluative quantitative data (PRI-E) suggested that sham may have been evaluated as being followed by greater pain relief than HT, despite the lack of other

significant differences between the two treatments. Qualitative data revealed that recipients experienced more unpleasant side effects and had more total pain relief after HT than after sham or the interview. Sham providers had more unpleasant side effects than did HT providers.

Supine HT and sham treatments were followed by statistically significant greater changes in pain perception on all scales than a seated interview. If the interview were an adequate test of the placebo effect of having a nurse pay attention to a recipient for thirty minutes, then HT and sham were more than placebo. However, quantitative data does not indicate whether the perceived effects were due to the treatment or to just resting, touch, or the novel experience of the treatment. Qualitative data indicated the effects may have been due to more than just resting; recipients and providers reported a number of non-ordinary sensations, some of which were followed by a recipient's sense of reduced pain.

Data do not support any conclusion about the effect of providers' states of consciousness. The development of more non-pain side effects and more pain relief after HT than after sham may or may not be related to the providers' state of mind, state of consciousness, training, and/or desire to assist the recipient. Research suggestions were proposed.

The study contributed to the growing body of nursing literature on pain management and HMEH because it was the first study of HT, the first to study effects of any HMEH modality on chronic non-malignant post-operative abdominal pain, and the first to use naive providers to give sham treatments. The two most important questions arising from

the study were due to the sham treatments. Because the sham treatments were, largely, evaluated by recipients as being followed by as much or more pain relief than HT, the questions of conscious involvement and training in HMEH must be addressed more thoroughly. Second, sham providers experienced discomfort during treatments. Research must be conducted to determine if this is a natural phenomenon experienced, but not recognized, by nurses in everyday non-HMEH interventions. The study raised more questions than it answered and the new questions were, in the long run, the study's greatest contribution to nursing.

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APPENDICES

Appendix A

Introductory Information

You are invited to participate in a research study conducted by Vicki Slater, a Registered Nurse and a Ph.D. candidate at the University of Tennessee, Knoxville. It is entirely your choice whether or not to be in the study. The time commitment and other details are described on the "Consent to Participate" form which I will be asking you to read and sign. If you agree to participate in the study of postoperative nursing interventions, you will need to meet with the nurses giving the interventions every other day for six days. That is, tomorrow or the next day you would see the nurse giving your first treatment, two days later meet with the second nurse, and two more days later, meet with the third nurse.

For example, if today is Monday and you cannot meet with the first nurse until Wednesday, your second treatment will be Friday and your third Sunday or Monday. I will call you one to two days after you meet with the third nurse, in this case Wednesday of next week, to find out what you thought about the experiences and to ask you to fill out a questionnaire, which you can mail back to me in this envelope. (Hand the subject a stamped self-addressed envelope).

Two of the interventions will involve you lying down on a bed or massage table with the nurse lightly touching you in the area on or above your surgical site, but you will not be asked to remove or rearrange any clothing. The third intervention is an interview in which the nurse may reach over to lightly touch you on your hand or arm. Do you mind being touched? (If so, will that make it difficult for you to participate in the study?)

The two treatments in which you will be touched over the surgical site look similar. In those treatments, the nurse will be moving her hands above your body, lightly touching the area above the surgical incision through your clothing, and concentrating while listening to tapes I have given them. Therefore, please don't talk while you are on the massage tables or beds unless the practitioner speaks to you. Just relax and rest for the thirty minutes.

Before and after the treatments, you will be asked to complete the McGill Pain Questionnaire, which I will teach you to do in just a moment. Also, after the treatment, the nurse will ask you to describe

your experience. Are you willing to have that conversation tape recorded, knowing that I will be the only one to hear and transcribe the tape? Also, following the last treatment, I will call you to interview you about your experience with the study and with the individual treatments.

I cannot tell you what order in which you will have the three interventions or with which one you will start. That will be decided randomly. I will be telling the nurses to assume that they are giving you the first of the three treatments.

After I leave here, I will contact the three people who will be working with you. They will call to schedule an appointment. Depending on the type of treatment, they may ask you to meet them at their office or offer to come to your home. You can expect the first appointment to be as early as tomorrow, if that is convenient, or as late as two days from now.

Do you have any questions about your part in the study? Please give me the telephone number where I can reach you after your last intervention.

Appendix B

Consent to Participate

I understand that I am being asked to participate in a research study conducted by Vicki Slater, a Registered Nurse and doctoral candidate at the University of Tennessee, Knoxville. The study is to test three ways nurses try to make people comfortable. The experimental interventions are relatively new to nursing and are increasingly being used by nurses in hospitals, homes, and offices. While nurses believe that the three approaches help people, none of them has been scientifically proven to do so. The purpose of the study is to learn if any or all of them accomplish what nurses think they do.

Two of the methods will involve my lying down on a bed or massage table and being touched lightly over the surgical site; the third is an interview about how I have felt since my surgery. I will be seated during that interview. Each of the three sessions will last 30 minutes plus the time it takes before and after the treatment to fill out a short questionnaire about how I feel at that moment. After each treatment, I also will be asked to answer a few questions about my experience with the treatment I just received. My answers to these questions will be tape recorded. The total time involved for the three individual treatments is about one hour each. The sessions will take place on alternate days, such as Monday, Wednesday, and Friday, at a time mutually convenient to me and to the nurses giving the treatments. Within two days after I have had all three treatments, I will be called and asked to fill out another copy of the questionnaire and discuss my feelings and impressions about the three interventions. Thus, my total time commitment will be approximately four hours.

Each of the three treatments will be given by a different Registered Nurse and the final interview by Vicki Slater. None of the nurses giving the interventions will ask me to remove any clothing. Ms. Slater, however, has permission to inspect my surgical incision today to see if it is healed or is healing. I understand that the treatment will cause no pain, although I might feel subtle changes inside me. There is no risk associated with the methods other than that normally expected from a light touch or conversation about my surgery and my pain. I can withdraw from the study at any time.

Any information collected about me, such as the date and type of surgery and extent of post-operative pain, will be coded. All information identifying me will be kept in a locked cabinet at the Slater home and only Vicki Slater will have access to it. The audiotapes will be heard and transcribed only by Vicki Slater and my name will not be on them. They, also, will be kept in the locked cabinet in the Slater home and will be destroyed following the completion of the study. If I have questions about the study or my part in it, I can reach Vicki Slater through Linda at the University of Tennessee College of Nursing Center for Nursing Research, 1200 Volunteer Boulevard, Knoxville, TN 37996 or at (615) 974-0591.

Participant's signature _____ Date_____

Researcher's signature _____ Date_____

Appendix C

Consent to Participate as a Provider

I understand that I am being asked to participate in a research study conducted by Vicki Slater, a Registered Nurse and doctoral candidate at the University of Tennessee, Knoxville. Part of the study is to begin to discover what practitioners perceive during interactions with patients. I understand that I am being asked to carry out a thirty minute nursing intervention which I will be taught or to interview several subjects for thirty minutes. After each interaction, I will write down my impressions. There is no risk involved in my participation beyond that ordinarily associated with patient contact. My responses will be coded and only Vicki Slater will have access to identifying information, which will be stored in a locked cabinet in her home. I can reach her through Linda at the University of Tennessee College of Nursing Center for Nursing Research, 1200 Volunteer Blvd, Knoxville, TN 37996 or at (615) 974-0591. My total involvement will depend on the number of subjects I volunteer to treat or interview. I can withdraw at any time.

_____

Practitioner's signature_____Date_____

Researcher's signature_____

Appendix D

Record of Practitioners' Energetic Training

Practitioner #_____

HT:

Level I: Date_____

Most Advanced HT Level: Date _____

Reiki:

First Degree: Date _____

Second Degree: Date _____

Third Degree, Therapist: Date _____

Other (give type and date completed.)

Appendix E

Admission Data

Patient's Code Number_____ Date_____

Age_____ Gender F M

Race_____ Temperature_____

Years of formal education _____

Date of Surgery _____

Type of Surgery _____

Type of anesthesia: general_____ other_____

Reason for surgery_____

Condition of operative site_____

a. Closed, no redness, healed

b. Closed, red.

c. Weeping, open, bandaged.

Statement of health status:

Now:

Prior to surgery:

Statement of pain level at operative site:

Now:

Prior to surgery:

Statement of additional pain:

Now:

Prior to surgery:

Appendix F

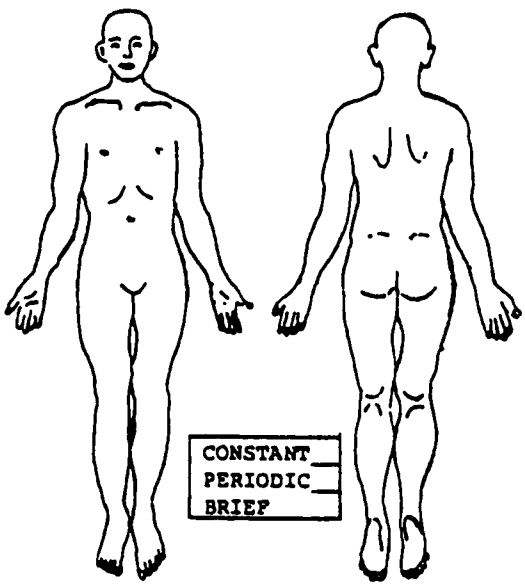
McGill-Melzack Pain Questionnaire

Patient's Name_____ Date_____ Time_____ am/pm
Analgesic(s) _____ Dosage_____ Time Given _____ am/pm
_____ Dosage_____ Time Given_____ am/pm

Analgesic Time Difference (hours): +4 +1 +2 +3
PRI: S_____ A_____ E_____ M(S)_____ M(AE)_____ M(T)_____ PRI(T)____
(1-10) (11-15) (16) (17-19) (20) (17-20) (1-20)

1 FLICKERING	11 TIRING	
QUIVERING	EXHAUSTING	
PULSING	12 SICKENING	
THROBBING	SUFFOCATING	
BEATING	13 FEARFUL	
POUNDING	FRIGHTFUL	
2 JUMPING	TERRIFYING	
FLASHING	14 PUNISHING	
SHOOTING	GRUELLING	
3 PRICKING	CRUEL	
BORING	VICIOUS	
DRILLING	KILLING	
STABBING	15 WRETCHED	
LANCINATING	BLINDING	
4 SHARP	16 ANNOYING	
CUTTING	TROUBLESOME	
LACERATING	MISERABLE	
5 PINCHING	INTENSE	
PRESSING	UNBEARABLE	
GNAWING	17 SPREADING	
CRAMPING	RADIATING	
CRUSHING	PENETRATING	
6 TUGGING	PIERCING	
PULLING	18 TIGHT	
WRENCHING	NUMB	
7 HOT	DRAWING	
BURNING	SQUEEZING	
SCALDING	TEARING	
SEARING	19 COOL	
8 TINGLING	COLD	
ITCHY	FREEZING	
SMARTING	20 NAGGING	
STINGING	NAUSEATING	
9 DULL	AGONIZING	
SORE	DREADFUL	
HURTING	TORTURING	
ACHING	PPI	
HEAVY	0 No pain	
10 TENDER	1 MILD	
TAUT	2 DISCOMFORTING	
RASPING	3 DISTRESSING	
SPLITTING	4 HORRIBLE	
	5 EXCRUCIATING	

PPI_____ COMMENTS:



CONSTANT
PERIODIC
BRIEF

ACCOMPANYING SYMPTOMS:	SLEEP:	FOOD INTAKE:
NAUSEA	GOOD	GOOD
HEADACHE	FITFUL	SOME
DIZZINESS	CAN'T SLEEP	LITTLE
DROWSINESS	COMMENTS:	NONE
CONSTIPATION		COMMENTS:
DIARRHEA		
COMMENTS:	ACTIVITY:	COMMENTS:
	GOOD	
	SOME	
	LITTLE	
	NONE	

Appendix G

Pre-Treatment Observations

Subject's Code #_____ Practitioner's Code #_____

Date of Intervention_____

Number of days after surgery_____

(If necessary, date of surgery_____)

Subject's verbal statement of status of wound closure

a. Closed, no redness, healed

b. Closed, red

c. Weeping, open, bandaged.

Time of last pain medication:_____

Name and dosage of last pain medication:_____

Have subject complete McGill Pain Questionnaire now.

Appendix H

Guideline for Interview Questions

Subject Code #_____ Date_____

Practitioner Code #_____

1. Tell me about your surgery.
2. Why did you have surgery?
3. Did you have pain that led to your having surgery?
4. How did it change after surgery?
5. Can you describe the pain you have had since then?
6. How has it changed since your surgery?
7. Specifically, first tell me about the pain you have at your surgical site.
8. Tell me about what relieves it or makes it better?
9. What doesn't work?
10. How does it affect your daily activity?
11. Do you have pain elsewhere?
12. Do you know what causes it?
13. What relieves it or makes it better?
14. What doesn't work?
15. How does it affect your daily activity?

Appendix I

Final Interview Questions

Client #_____ Date:_____

1. What was it like for you to be a part of this study?

2. What was your first treatment like for you. How did you feel afterwards. (If s/he describes anything specific, ask about it and how long it lasted.)

3. What was your second treatment like? How did you feel afterward?

4. What was your third treatment like? How did you feel afterwards? How do you feel now?

5. Was there a difference between the two treatments in which the practitioners moved their hands over your body? If so, describe that difference?

6. Was there a difference in how you felt between the treatments in which the practitioners moved their hands over your body and the interview? If so, described that difference?

7. Did you dislike or find any of the treatments disagreeable? If so, which one(s) and why?

8. Did you prefer a treatment? Which one and why?

9. Do you have any questions? Would you like to add anything?

10. Please fill out the MPQ now and send it to me in the stamped, addressed envelope you were given by (coordinator's name).

Appendix J

Practitioner Notes

Practitioner Code #_____ Date_____

Subject Code #_____

Appendix K

HT Providers' Instructions

1. Prior to greeting the subject, have available:
   a. Folder with
      Pre-assessment Checklist
      4 McGill-Melzack Pain Questionnaires (MPQ)
      Practitioner notes
   b. Pencils or pens
   c. Timer
   d. Water and cups
   e. Blank audiotape and tape recorder
   f. Bed/massage table
   g. sheet/blanket
   h. 2 pillows
2. Greet subject
   a. You complete Pre-assessment Checklist
   b. Have him/her complete a MPQ for abdominal pain and second MPQ for any additional pain. Note at the top of each MPQ which part of the body is being described. If there is no additional pain, write "No pain" at the top of the second MPQ.
   c. Remind him/her that this is a research study, so there will be no talking once the intervention begins.
3. Place subject on massage table or bed offering pillow under his/her knees and a sheet or blanket cover. Identify area of pain.
4. Start the timer, set for 30 minutes.
5. Center
6. 30 magnetic unrufflings, about 20 seconds a piece. Change sides regularly, if needed.

7. When magnetic unrufflings are finished, place hands on area of surgical site and begin running energy into the abdomen.
8. Continue until the timer goes off.
9. Tell subject that the treatment is over, that you are going to write your notes. S/he may continue resting and complete the MPQ(s) shortly or move to a chair and complete the MPQ(s) now.
10. Help the subject off the massage table and show him/her to a chair, where s/he will complete the MPQ(s). (Steps 10 and 11 may be reversed.)
11. Write your notes.
12. Start the tape recorder and ask him/her to describe his/her experiences with the intervention. Leave the room.
13. Thank him/her for coming and remind him/her that another practitioner or Vicki will call him/her within a day or two.

Appendix L

Sham Provider Instructions

1. Prior to greeting the subject, have available:
   a. Folder with:
      Pre-assessment Checklist
      4 McGill-Melzack Pain Questionnaires (MPQ)
      Practitioner notes
   b. Pencils or pens
   c. Timer
   d. Water and glasses
   e. Story audiotape and tape player with earphones
   f. Bed/massage table
   g. sheet/blanket
   h. 2 pillows
   i. Blank audio tape
2. Greet subject
   a. You complete Pre-assessment Checklist
   b. Have him/her complete a MPQ for abdominal pain and a second MPQ for any additional pain. Note at the top of each MPQ which part of the body is being described. If there is no additional pain, write "No pain" on top of the second MPQ.
   c. Remind him/her that this is a research study, so there will be no talking once the intervention begins.
3. Place subject on massage table or bed offering pillow under his/her knees and a sheet or blanket cover. Identify area of pain.
4. Put earphones on and start story tape.
5. Start the timer, set for 30 minutes.

6. 30 magnetic unrufflings, about 20 seconds a piece. Change sides regularly, if needed.
7. When magnetic unrufflings are finished, place hands on area of pain and hold that position until the timer goes off.
8. When the timer goes off, tell the subject that the treatment is over, that you are going to make your notes. S/he may continue resting and complete the MPQ shortly or move to a chair and complete the MPQ(s) now.
9. Help the subject off the massage table and show him/her to a chair, where s/he will complete the MPQ(s).
10. Write your notes. (Steps 9 and 10 may be reversed.)
11. Start the tape recorder and ask him/her to describe her experience with the intervention. Leave the room.
12. Thank him/her for coming and remind him/her that another practitioner or Vicki will call him/her within a day or two.

Appendix M

Interview Providers' Instructions

1. Prior to greeting the subject, have available:
   a. Folder with:
      Pre-assessment Checklist
      4 McGill-Melzack Pain Questionnaires (MPQ)
      Practitioner notes
   b. Pencils or pens
   c. Timer
   d. Water and glasses
   e. Blank audiotape and tape recorder
2. Greet subject
   a. You complete Pre-Assessment Checklist
   b. Have him/her complete a MPQ for abdominal pain and a second MPQ for any additional pain. Note at the top of each MPQ which part of the body is being described. If there is no additional pain, write "No pain" on the top of the second MPQ.
3. Set timer for 30 minutes and start it.
4. Begin the interview. During the interview, be "with" the subject. Lean your body forward occasionally and touch him/her at least twice. Maintain eye contact as much as possible. You are not making notes or taping the conversation because the goal is not to get the information but to be very present to the subject.
5. When the timer goes off:
   a. Make your notes
   b. Have subject complete the post-interview MPQs.

c. Start the recorder and ask him/her to describe his/her experiences with the intervention. Leave the room.

6. Thank the subject for coming and remind him/her that another practitioner or Vicki will be contacting him/her within the next day or two.

Appendix N

Coordinators' Instructions

A. Recruit subjects

18 years of age or older; has pain remaining after abdominal surgery; reads English. Place ads in papers; personal contacts.

B. Interview subjects

1. Explain study

3 one hour sessions, each a different treatment given by different practitioners. Two sessions will be on a massage table, but subject will not get a massage. Table is used to make subject comfortable and help practitioners' backs. One session will be sitting in a chair being interviewed about how the pain has affected his/her life.

2. If subject is still interested:

a. Have subject read and fill out consent form in duplicate. Keep one to send to Vicki; give the other to subject.

b. Interview about pain history using admission questionnaire.

c. Teach and have subject fill out 2 McGill-Melzack Pain Questionnaires (MPQ)--one for abdominal pain and a second for additional pain. If subject has pain only at the abdominal surgery site, write "No pain" at top of second MPQ.

d. Give subjects

-the envelope addressed to Vicki and 2 MPQs

-3x5 card with treatment order, e.g., massage table, interview, massage table.

-Practitioners names for each treatment if known.

e. Give subject a telephone number to reach you.

f. If subject is under immediate care of a health care practitioner, send that person a letter informing him/her of subject's participation in the study.

C. Contact practitioners in order listed on file folder.

1. Give first practitioner subject's name and telephone number so practitioner can call to make appointment. Practitioner is to call you to let you know date and time of appointment, especially if you have to coordinate office space.

2. Once you know the date of the first appointment, call the second practitioner. Appointments can be no closer than 24 hours apart.

3. Once you know the date of the second appointment, call the third practitioner.

4. After the third treatment, call Vicki to let her know the treatments are over. Give her the subject's name and telephone number and the subject's study number. She will call the subject to do the final interview.

5. Mail all paperwork and audio tape to Vicki:

Admission packet, 3 practitioner packets, audio tape.

Names of practitioners for payment.

Time you spent.

Appendix O

PROVIDERS' EXPERIENCES BY TREATMENT ORDER

Interview, Sham, HT

Subject #	Interview	Sham	Healing Touch
P-1	Subject ill at ease at first. Face pale, eyes dull, few smiles. Relaxed as interview progressed.	Warm, especially when hands on abdomen. Profuse diaphoresis.	MU Cold energy tingling, warmth WS Drawing and pulsing of energy. Sent energy. It stopped. Hands warm. Subject relaxed at 4-5 MU. I felt refreshed.
A-1	I was anxious. concerned with self and how subject would view her. Felt rushed.	Hard to concentrate with tape playing. Felt increased warmth over abdomen.	MU Static electricity on my palms at head, chest, knees. WS Soft columns extending from my hand into abdomen.
B-10	Subject open, sharing, and revealing. Felt sorry for her.	Tape helped.	MU Entire field congested/static. Field pulled my hands in. Asked internally for assistance. WS Static full arms reach above site and to sides. Pulse alternating sensation of still vs. pull-pull-pull. Throbbing. Constant pull toward end.

Sub #	Interview	Sham	Healing Touch
D-22	Worried about what we were going to talk about but 30 minutes too short. Subject said she was glad to have someone to talk to.	Tired and yawning.	MU Tingling at incision area x2. Tingling over right side cleared at 8 sweeps; left side became finer, subtler. WS Activity under both hands-tingling to full pulsations to fine subtle energy or feeling on left side. Abdominal twitching 2-3x.

Provider Experiences by Treatment Order

HT, Sham, Interview

Subject #	Healing Touch	Sham	Interview
P-2	MU 0 WS Painful burning in both hands. Pain traveled to elbows. Uncomfortable. Subject swallowed a lot during this stage. Last 10 minutes pleasant, no pain. Noted peristalses and muscle spasms.	I was calmer.	Client at ease. Provider felt relaxed and close to subject. Described conversation. Enjoyed experience.
A-4	MU Congestion over abdomen and knees, left greater than right. WS Slow pulsations center out; 2-3 were stronger and more chaotic. Subject drew left knee to chest at that time and said pain got worse and shot down leg. Provider felt pain in hands and lifted to hands without losing contact with subject. (Wanted to continue treatment until it was finished, but didn't because of time constraint of 30 minutes.)	MU Provider's shoulders ached from position; rested them on waist and got relief. WS Felt heat coming from subject to provider, wondered if subject's pain were transferring to provider.	Easy. She was totally responsive. I was at ease with her but a little uneasy with the procedure. It feels fake in a timed and set up situation.

Sub #	Healing Touch	Sham	Interview
B-11	MU Felt I was entering the field deeper on each pass. Each side felt distinctly different. Right side undulating, an even pulse of bumps. Left side more static and heavy feeling/ congestion. Sides equaled out and began to clear. When finished, still a remaining congestion over waist to knees. WS Very hot at first and was very hot all over. The alternating sides felt like they were taking energy. Cooled off as time passed. Less pull of energy by end. Felt like there were more layers to be cleared if allowed more time.	Tired, relaxed.	0
D-23	MU Thickness, static, tingling, congestion. WS Intense, profuse heat. Shifted, heat decreased, I felt pain in right shoulder. Shifted, her respirations changed, she jerked. Finer energy until end.	MU Lost count. WS Energy or warmth came from hands.	Talking about her pain didn't seem to help it. She has accepted it and is getting on with her life.

Sub #	Healing Touch	Sham	Interview
E-29	MU Neck to waist vacant/empty to fully blocked and cement like. Waist to feet, extreme block/ static/ congestion. Like a cement wall. Evened out, not clear. WS Two layered pulse, pulse within a longer pulse. Spasms of heat released. Steady, faster pulse. Blocks that did not clear. Clearing and draining of field; no replenishing.	Tired, hot, back hurts, calm.	0

Provider Experiences by Treatment Order

Interview, HT, Sham

Subject #	Interview	Healing Touch	Sham
P-3	Subject said she felt better just being still. Back pain completely gone, only aching after interview.	MU 0 WS Pain in right hand that ran to elbow. Had sensation of feeling viscera.	Back hurt, less relaxed than previous treat-ment.
B-7	Subject very pleasant. Informative. Could have talked longer.	MU Three thick bands of congestion-chest, diaphragm, abdominal scar. Dissolved. Congestion from knees down. Ripples of energy and congestion across jaw. WS Piercing pain in right thumb. Subject jerked as if shocked. Hands hot. (Subject got headache and backache. Believed they were from uneven table.)	MU Became smoother and easier as I worked. Back hurt. Watched wind chimes.

Sub #	Interview	Healing Touch	Sham
D-21	Described conversation; concluded subject was very angry.	MU Etheric energy from fingers sliced through tight thicknesses from solar plexus to feet. Sharp tight pain shoot from left fingertips to back of left shoulder and left breast. That changed to pins and needles, and then lighter. WS Pain above solar plexus as gathered energy. Modulating-soft vibration, then blended state with subject began. Softening, fluidity moving through us. Felt my hands were enmeshed in her and had to be extracted.	Made me very tired. Kept yawning. Tape helps.
E-25	Gave her the opportunity to share her pain and frustration. Gave verbal support for her feelings. I do not feel I helped her feel better.	MU Tingling WS Energy running the entire time.	Felt silly, back hurt, hands ached, didn't enjoy it much.

Provider Experiences by Treatment Order

HT, Interview, Sham

Subject #	Healing Touch	Interview	Sham
P-4	MU 0 WS Warmth followed by increasing pain that exited at wrists. Pain climaxed and subsided. Feel this person is a victim of sexual abuse or incest.	Subject slightly nervous at first. Both subject and provider relaxed as interview progressed.	Provider worried about personal chores.
A-2	MU Electricity static at head; elsewhere smooth. Subject began shaking, unwinding motions down entire body.	Awed by subject's strength and courage. Fascinated by her story.	MU Wished I had centered before beginning. Relaxed after raked her aura 3-4 times. She relaxed at same time I reached a rhythm. Felt heaviness over head and chest. WS Felt tension from her when put hands on her abdomen. Did tantric breathing to get her to relax. Worked. Got stiff.

Sub #	Healing Touch	Interview	Sham
D-20	MU Felt an absence in her field. Etheric fingers reached deeply inside her and a tingling began. changed to stronger, rhythmic vibration. Saw clouds of white energy swirling around in and around her body. Pulling sensation of my energy into her depths. Thickness, denseness in and over abdomen and pelvis. Got lighter and clearer. WS Intense heat localized at wound that spread out into body in ever widening circles. Changed to warm glow. Drum-like vibration. Energy cocooned the wound. Vibrations became fainter.	0	0

Provider Experiences by Treatment Order

Sham, HT, Interview

Subject #	Sham	Healing Touch	Interview
P-5	Waves of nausea. Feet and shoulders became tired.	MU Warmth and congested energy. tingling. WS Energy ran almost the entire time. Hand pulsated. Colors red and green flashed in mind.	Pleasant and upbeat conversation.
A-3	Time crawled. Felt my joints stiffen and creak.	MU Electricity at head, shoulders, elbows, knees; got smoother. Felt a built up on my fingers of unseen matter that easily released when I shook my hands and fingers. WS Ran energy. Never touched subject, though subject felt pressure as provider started sealing the wound.	Enjoyable. Spoke mostly about subject's military history. Briefly discussed experiences leading up to surgery. Amazed at subject's strength of character and resilience.
B-8	MU Arms tired only a little. The farther away I lifted my arms from the subject's body, the less I felt I was doing. WS Felt very warm. Back started to hurt.	MU Thick congestion. Electrostatic shocks. WS Felt energy entering my feet and a tingling feeling leaving my hands into her left abdominal area. Strength of the sensation came and went. Body got hot, hands got hot with perspiration.	Very easy to talk with. Friendly. Has control over this aspect of life. Very positive attitude. Seemed like subject enjoyed talking about herself.

Sub #	Sham	Healing Touch	Interview
C-13	Hands, which had been ice cold all day, became very hot. Felt something moving in her abdomen. Made me feel silly.	MU Tingling. congestion. Smelled cigarette odor, fecal odor. WS Dreamed I was talking to a channeled being, trying to communicate something to me. Increasing, then decreasing heat in hands. Hands felt numb, not a part of me. Felt like made a deep energetic connection with subject.	Described conversation.
E-26.	Didn't feel much. Arms ached when hands on abdomen because of hand position over pubic area.	MU More congestion over midline. WS Felt very little when started, felt empty. As treatment progressed, felt prickling pressure in right palm. Then pulsation and area felt fuller. Got very warm.	Enjoyed meeting subject. Tried to draw out as much information as possible but she was closed and nervous. Asked open ended questions; answers very short.

Provider Experiences by Treatment Order

Sham, Interview, HT

Subject #	Sham	Interview	Healing Touch
P-6	Many distracting thoughts.	Provider physically and emotionally hurting. Could feel subject's deep sadness.	When first saw subject, felt she was "full of rage." MU Hands cold. Big cold hole over entire torso (heart and lower abdomen) sucking in energy. WS Energy sucked into abdomen. Left hand at lower right quadrant got especially warm. Energy pulsing into the area. Felt we were in a pink cloud, subject was out of body and many guides were performing surgery. I felt clipping and dissolving being done in right lower quadrant. Felt subject's deceased husband present most of the time. Messages for subject.: "Give up martyr", "Husband is helping you." "For by grace you have been saved through faith." Energy ran entire time.
A-6	Interesting.	0	0

Sub #	Sham	Interview	Healing Touch
B-12	Very relaxed. Used self-hypnosis, self relaxation on self. No aches or pains tonight.	0	MU Field was "airy". Static. Congested. Layers of heat cleared. WS Layers of heat cleared. Flow was unsteady, chaos to stable.
E-28	Loved the tape. Focused on the tape and what I had to do today.	Subject has got such a good attitude. Has accepted pain and gone on with life. Takes it one day at a time. Expects to have pain rest of her life. Not a complainer.	MU Heaviness, congestion, thickness in her field, over head, lower abdomen, pelvis, right ankle. About sweep 10-11, energy between us blended and there was an increased warmth and a fine rhythmic shaking up movement-rapid. After 5-6 more MU sweeps, field became light, soft, cloud like. By sweep 30, the heavy, thick sensations, were completely gone. WS 0

Appendix P

SUBJECTS' EXPERIENCES BY TREATMENT ORDER

Interview, Sham, HT

# Interview	Sham	Healing Touch	Final
P-1 0	In the first part, felt wonderfully comfortable. When she placed hands on my abdomen began to be in pain and to panic. Pain was radiating through abdomen. Was surprised. Feel shaky after treatment over (haven't had lunch).	Wonderful and relaxing. Peaceful. Let your mind drift. Today's touch very different from first (sham); a light, light touch. It was very soothing. Went to sleep, out like a light, feel like I had a nap, ready to go the rest of day.	3 treatments were relaxing, unusual, reminded her of being under hypnotism (the rhythmic hypnotic motion) Hands passing over, OK; hands pressing, not hard but a weight, panicked. Second treatment (HT) was stress relieving. Had a wonderful time last night. Went to dinner, made love first time since surgery (6 weeks). Felt like I had been on a vacation.
A-1 Com- fort- able	Felt pretty good. Relaxed. No pain after treatment. Start of second part (WS), area felt cool, then warmed up. Thought it was great.	Very good. Very relaxing. Wish I could have had this in the hospital.	0

Sub # Inter-view	Sham	HT	Final
B-10 Good to have someone listen to me.	More relaxed. Tingling in back of thighs and buttocks, relaxation of abdominal scar. Warmth, pulsing radiating upwards. Pleasurable and pleasant. Have a little less pain now. Felt currents, could sort of see lines or something. Saw red, green, blue.	Mild sensation of movement in the field above my scar. Relaxation. Stomach tissue softened and melted into my stomach. Pulsing. Something emanating from the bottom of the scar. General overall lightness.	Liked both HT treatments. Relaxation. Pain, softening in tummy area. Had some diarrhea didn't know about while on table, release. The 3 treatments were complementary-interview useful. Combination of being able to talk and be on the table good.

Sub # Inter-view	Sham	HT	Final
D-22 I answered the attitude questions differently after the interview than before. Not so horrible. Realize I have some control over my response to the pain.	More relaxed. Right-sided pain gone. Left-sided pain same if I concentrate on it but being relaxed makes it seem less. Felt the energy. Feel better.	Relaxed. Hands moving in circular motion woke me up-could feel it in my abdomen. Like being massaged in my abdomen even though she was not touching me. Unpleasant. Overall I have less pain than before. Feel relaxed and fine.	All 3 treatments good. Impressed by both HT treatments. Could feel where their hands were; could feel an intensity. After each treatment, lessening pain but it returned later the same day. One without earphones more intense than one with, helped more immediately.

Subjects' Experiences by Treatment Order

HT, Sham, Interview

#	Healing Touch	Sham	Interview	Final
	P-2 First felt pressure. Not uncomfortable or painful. Noticed little muscle spasms in different areas--left leg, right arm, end of nose. Hands seemed to take the pain to a lower level. When she took her hands off, pain returned. Relaxing.	Felt pretty much the same as with first treatment. Sort of like a gentle pressure, kind of like when you are pregnant. Breathing got quicker.	Pain may be less. This was fun.	Pain probably less. Don't feel the tugging that was pretty constant at the incisional site.

Sub # Healing Touch	Sham	Inter-view	Final
A-4 From head to toe, I was becoming more relaxed, drowsier. Pain still intense on that side. Uncomfortable to lay on back. When hands on abdomen, they were very, very hot, became a lot hotter as it went along. The area in my left lower quadrant eased up some but the ovarian site continued to really hurt and intensify. Moved her hands toward the ovary area and it intensified then relaxed. It was off and on, intensity and relaxation. After, pain is not as bad as before coming. I still feel a dull ache, not a throbbing, more just a fullness in that area. Developed a headache during the process.	Today has been a pretty good day. During the therapy, became more relaxed. One real searing, sharp pain in my left ovary. Upper arms began to hurt down into my hands. It did continue to get worse.	Com-fort-able. Felt fine during and after-wards.	First treatment (HT) helped a little; was in a lot of pain then. I tried to relax. Combination helped. Provider's hands got hot. Lot of pain on left side during treatment, intensified, then released. Second treatment (sham) helped a little, less than first. (In less pain day of 2nd treatment). Provider's hands got hot. Shoulders started hurting during sweeps and that pain lasted through and after treatment. Abdominal pain relief lasted 2 days. Interview: didn't have much pain then.

Sub # Healing Touch	Sham	Inter-view	Final
B-11 0	After treatment felt much, much better. Headache behind eyes is gone; abdomen, did hurt, now don't notice anything particular at all. Back much, much better and I feel much more energized and ready to deal with the rest of the day.	0	Enjoyed the study. Helped the abdomen and back pain. First treatment wonderful, felt long. Pain relief lasted a long time, several hours. Entered the alpha state (know this because I meditate). Felt warmth, energy transfer. Second treatment shorter, pain went away while on table, returned when got to car. (Normal for me.) Had a lot on my mind and was more aware of the treatment. Relaxed but did not go into alpha state. Pain went away but no physical sensations. Didn't feel anything. After interview, pain went away because I bonded with the interviewer.

Sub # Healing Touch	Sham	Inter-view	Final
D-23 Interesting. Relaxing. Fell asleep. Seems my abdomen is not quite as tight as it was, as sore.	Relaxing. No difference in pain right now.	Helped my mental state, not my pain.	Not successful. I do not notice any difference. With first treatment (HT), mentally I was more relaxed, maybe. When she got closer to my stomach, I could feel it, sort of. Didn't feel anything with second treatment. Interview, nice touch. Mentally relaxing.
E-29 Relaxation. Warmth, tingling especially where I was having greatest pain. Sense of drawing the pain away.	0	0	No perceptible difference between first and second treatments. Relaxing, calming, lessening of pain in surgical area that lasted several hours. Interview, lessening of the pain.

Subjects' Experiences by Treatment Order

Interview, HT, Sham

# Interview	Healing Touch	Sham	Final
P-3 Talking helps the pain-you don't concentrate on it. It makes a sharp pain go to a dull pain.	Relaxing. A warm feeling. Whenever she put pressure on where the pain was, it radiated in that one spot and then relaxed.	Relaxing. Cool breeze.	Helped back, not stomach. Back has not hurt for the last 2 days. Maybe it picks out the worse hurt--stomach wasn't hurting as much as back. Wasn't miserable the rest of the day after the last treatment. Relaxed real good after first treatment, no difference in hurting.

Sub # Interview	Healing Touch	Sham	Final
B-7 Headache more intense. Feel strangely cared for.	Pressure in front part of my head, in face. Maybe due to unlevel massage table. Pain in abdomen absent. Like a pain memory. Some places in my spine relaxed. Feel better. More rested.	Mild warmth when rested hands on abdomen. Easing of tension in back. Feeling of general comfort. Spine feels remarkably relieved.	Second HT provider (sham) more attuned to her than first provider (HT). More change at surgical site with first than second. First provider more powerful, Preferred her. Felt energy in abdomen. Wonderful. Both providers felt like energy was being released out of incision like steam. Feels like inflammation now; felt like the heat of it was leaving. Abuse survivor-hardest part was anticipating being in room with stranger with door closed. Felt spine relax with the first part.

Sub # Interview	Healing Touch	Sham	Final
D-21 0	Piercing pain between shoulder blades changed to a mild pinch. Right side incision still sore, tender, not the sharp, cutting pain I had. Dull, not as tender, not as penetrating. When I got on the couch after the treatment, I kept twisting and turning trying to find the pain that was in my shoulder blade . . . and I couldn't find it. No piercing, cutting feeling as before.	Second treatment (sham) did not change the pain; but the effects of first treatment (HT) has continued- 50% less pain and it hasn't changed. (Subject thought second provider had done the treatment wrong, but she described variations between providers, not radically different tech-niques.)	Felt heat from first treatment (HT), not second (sham). Felt absolutely zero from second provider. 1/2 pain left during first treatment. Arthritis came back in fingers but 1/2 still gone. When got off table, pain in back gone. I was in shock. Kept rubbing back, twisting back and forth trying to find the pain. It hasn't returned. Gall bladder pain hasn't come back. She didn't even touch me where I hurt. No pain change during interview.

Sub # Interview	Healing Touch	Sham	Final
E-25 Pain feels a little softer. Belly feels a little more relaxed. Back, area hurting is smaller and warmer. Don't like being labeled as someone having a lot of pain. I sort of just kind of deal with it.	I'm cold, room is cold but my tummy feels warm, belly warm, her hands felt warm when they were on me. Feel a little nauseated. A lot of relaxation in my abdomen. Back hurts- maybe because I didn't move for 30 minutes and didn't have a pillow under my knees. Thought about personal problems; abdominal pain at that moment reminds me of how I used to feel when my parents would fight.	Belly was really warm when she was finishing; sensation of a heating pad on or something. Slept, dreamed Back didn't hurt. Warm room.	When she did the air thing (MU), she moved from one side to the other. That seemed important to me for some reason. Fear I might find another treatment that works that is not reimbursable by insurance. First treatment (HT): interested, watched. Second treatment (sham): slept. Felt heat coming from her hands. Relieved pain for a while. Interview: distressing.

Subjects' Experiences by Treatment Order

HT, Interview, Sham

# Healing Touch	Interview	Sham	Final
P-4 Feel good on right side-no pain. It drifted off to left side but it is better. left side and middle still painful. Shoulders, head, and back still ache. Comfortable, I was warm. It was like her hands pulled out heat from my body.	More comfort-able than when first came in.	0	I can't really explain how good I feel. I can't believe it. I am really shocked. Only pain left now is a twinge on the scar.

Sub # Healing Touch	Interview	Sham	Final
A-2 Felt a smoothing, calming on my left side. Then on right side. Relaxed, sleepy, tingly in my hands and feet. Tingling side to side motion I felt myself shifting from side to side, back and forth, back and forth. And that continued for a short time, in an undulating motion. Then it stopped. Then I felt a warm sensation in the middle of me that continued. The person treating me was not touching me. When she left to turn off the timer, I still felt something like pressing in the middle of me. Relaxed all over. Pain diminished.	Pain more intense after inter-view. The pulling pain has increas-ed.	Very relaxed. Very calming, like first treatment (HT), but I did not have the unwinding. Pain is less. Didn't feel as intense or connected with this person but still totally relaxed me. Didn't get as completely relaxed as first time.	The first treatment was great. Talk about the pain going away. It was really strange. All of a sudden I realized I didn't have the pain anymore. I've had the pain for years, since I was 12. Disappeared sometime in the 7 weeks between first (HT) and second (sham) table treatments. Couple of days after the second treatment, thought the pain was coming back but it went away. Interview-too objective. Better when someone touches you.

Sub # Healing Touch	Interview	Sham	Final
C-14 I became aware of just how tense I am. There were different waves of relaxation, attempts at it anyway. I felt initially like a tickling sensation. I wanted to close my eyes and sleep but was very curious and I wanted to find out just what the person was doing. I realized her hands were very high above me so there was no touching at that point. It was an interesting feeling, a feeling of movement. Felt I needed to know what the whole process was, what was really happening. Couldn't relax as much because I didn't know this. It was an interesting experience; I started becoming aware of my body more.	(Subject could not be contacted for remaining treat-ments)	0	0

Sub # Healing Touch	Interview	Sham	Final
D-20 Relaxation. Slept. I felt a pressure change, like sounds changing from side to side in my ears. Pain was gone when treatment was over. Still waiting for it to come back. Don't feel any different, relaxed, calm but no pain. The usual tightness and feeling like I am coming apart is not there. I'm pushing on my belly, still a little sore but nothing like it was. The heat seems to be gone. Very nice experience.	(Subject could not be contacted for remaining treat-ments.		

Subjects' Experiences by Treatment Order

Sham, HT, Interview

#	Sham	Healing Touch	Interview	Final
P-5	Relaxing. I have a hard time relaxing so that was wonderful. Felt a difference when you removed your hands. When your hands were there, it was relaxing. My entire body relaxed including the area of pain. Pain changed from oppressive to throbbing.	Soothing. Made the pain subside substantially but when the treatment was over, pain came right back.	Interviewer's voice is soothing. It took away the pain.	0
A-3	Relaxing. An air movement or circulation of some sort as her hands moved around.	Relaxing. Felt like taking a nap. No change in pain. At one time felt like there was a weight pressing down on my stomach; it disappeared. Light pressure and gone again. Like taking a nap.	0	It was a loafing time for me. Just laid there and enjoyed things. No difference between first (sham) and second (HT) treatments. Could have taken a nap. I enjoyed it.

Sub # Sham	Healing Touch	Interview	Final
B-8 Did not feel heat or energy going in when you were touching my incision, only felt the pressure of the hands being there. No sensation during MU. pain is slightly less, dull ache in back and little bit of tenderness under incision.	Still felt your hands on abdomen after you were writing your notes. Had flashes of color in my brain several times. Mostly purple. Felt like I was being energized. Legs restless, wanted to shake, wiggle, and jump off the table. Some kind of energy moving in my legs. Felt like my body extended beyond my skin, about 2 feet out. Liked that sensation. No pain right now, even when I press on it.	Enjoyable. Pain level did not really change.	Second treatment (HT) was more powerful than first (sham). Felt I received some healing work-like things are right in the world, balanced. First treatment (sham) and interview were nice but not energetic experiences. (I do TT and polarity.) Body did not feel any different afterwards.

Sub # Sham	Healing Touch	Interview	Final
C-13 Could have fallen asleep. Made me very aware of my body and all the different sensations I was feeling. Pain not as intense now, is very dull.	Asleep during 1st half; woke for second. Felt the break between the two. Very relaxing.	0	0
E-26 Only thing I felt was a cooling sensation.	Cooling sensation over entire body.	Went fine.	During first (sham) and second (HT) treatment had a cooling sensation. When over, felt better. (What do you mean by that?) My nerves are real bad. After all 3 treatments, my nerves settled down. Really liked interviewer. The two on the table were about the same

Subjects' Experiences by Treatment Order

Sham, Interview, HT

# Sham	Interview	Healing Touch	Final
P-6 Pain is better than when started. Cannot say if due to resting for 30 minutes and how much due to session.	Pain diminished slightly. Talking is a stress release. Thanks for the opportun-ity to talk.	Interesting. Felt the energy field passes this time (as opposed to first treatment). Could tell with my eyes closed what part of the body her hands were over at the time. First treatment felt like warmth or heat; this felt like movement but no heat. In and out of sleep. Metabolism shifted-got cold half way through. Abdominal and side pain had stopped completely and started again when I sat up-but less. Now a prickly annoyance. Arms and leg joints and my back pain increased. I'm extremely stiff head to toe. Maybe because I got so cold.	Last treatment (HT) stopped the pain except for a twinge and it didn't get worse. Don't understand the joint pain; as if the last treatment froze me. After first treatment (sham), joints numb, felt like heating pad, warmth radiant heat. After last treatment (HT), not heat but motion. Interview: pain reduced but not as much as after last treatment (HT). UTI between 1st and 2nd tx. Antibiotic between 2nd and 3rd.

Sub # Sham	Interview	Healing Touch	Final
A-6 More relaxed. You could tell when she was over different parts of body even with eyes closed. Could feel warmth.	Very mild headache but less than it was.	0	0

Sub # Sham	Interview	Healing Touch	Final
B-12 Relaxed. Abdominal pain about the same but the rest of my pain feels better. Felt, like, energy, tingling.	Forgot I wasn't going to get treated today and was looking forward to that. About the same as when I came in.	Pain level is less than prior to treatment (HT). Felt heat, not energy or tingling like first treatment. Could tell where she was from the heat that was transferring between us. The direct wound contact really helped a lot. Like I could feel it penetrating. This session, more than the others, I've seen the most dramatic difference.	Very relaxing. Last treatment (HT) felt a lot of heat. Heat radiating; didn't know if coming from her or me. Could feel where her hands were by the heat. Got more out of last treatment (HT) than first (sham). Enjoyed it. Glad I participated in the study.
E-28 Strange. Felt like she was pulling the pain out of me.	Had a good talk. It felt good. The first session was better.	Very good session. Felt like she was pulling the pain up, like the first time.	During first (sham) and third treatments (HT), felt the pain was being drawn out. They did help me. Had a sensation in there where they put their hands. Felt like they were drawing out the pain. The interview didn't help.

Appendix Q

ENERGETIC EXPERIENCES BY TREATMENT TYPE

Subject # Tx type	Provider	Recipient	Relationships
P-1 Sham	Warm, Profuse diaphoresis.	Sweeps comfortable. When she placed hands on abdomen, began to be in pain and to panic. Shaky.	Provider felt warmth and diaphoresis. Recipient felt increased pain.
HT	MU: Cold, tingling, then warmth. WS: Sent energy, drawing and pulsing. It stopped. Hands warm.	Wonderful, relaxing, peaceful. Different from first treatment. This was soothing. Felt like I had a nap.	Provider sensed sending energy. Recipient felt treatment was relaxing, peaceful, soothing.

Sub # Tx type	Provider	Recipient	Relationships
A-1 Sham	Hard to concentrate with tape playing. Felt warmth over abdomen.	Relaxed. Abdomen warmed up during treatment. No pain after treatment. Felt good. Thought it was great.	Provider could not concentrate on treatment but felt warmth. Recipient felt abdomen warm up. Relaxed. No pain.
HT	Static electricity on hands; soft columns extending from my hand into abdomen.	Very relaxing.	No clear relationships. Dramatic description by provider of unusual sensations.

Sub # Tx type	Provider	Recipient	Relationships
B-10 Sham	Tape helped	Relaxation of abdominal scar. Tingling in back of thighs and buttocks. Warmth, pulsating radiating upwards. Felt currents. Less pain now.	Provider listened to tape. Recipient had pain relief.
HT	Field pulled my hands in. Pulse alternating sensation of still vs. pull-pull-pull. Throbbing. Constant pull toward the end.	Mild sense of movement in the field above my scar. Stomach tissue softened and melted into my stomach. Pulsing. Something emanating from the bottom of the scar. General overall lightness.	Both provider and recipient felt pulsations. Provider described being pulled into the recipient's field. Recipient described sensing something emanating from the bottom of the scar. Final result--sense of overall lightness and softer stomach tissue.

Sub # Tx type	Provider	Recipient	Relationships
D-22 Sham	Tired and yawning	More relaxed after treatment. Felt the energy	Provider uninvolved in treatment. Recipient felt energy and relaxed.
HT	Activity under hands. Tingling, full pulsations, fine subtle energy.	Relaxed and fine. Felt like being massaged in my abdomen even through she was not touching me. Unpleasant. Less pain.	Provider sensed activity. Recipient felt like being massaged. End result relaxed with less pain.

Sub # Tx type	Provider	Recipient	Relationships
P-5 Sham	Waves of nausea. Feet and shoulders tired.	Relaxed entire body including area of pain. Pain changed from oppressive to throbbing. Could tell a difference when removed hands from abdomen.	Provider experienced side effects. Recipient relaxed with pain reduction.
HT	Energy ran most of the time. Pulsations. Colors flashed in mind.	Soothing. Pain subsided substantially until treatment over.	Provider felt energy run most of time. Recipient's pain subsided.

Sub # Tx type	Provider	Recipient	Relationships
A-3 Sham	Time crawled. Felt my joints stiffen and creak.	Felt air movement or circulation as her hands moved. Relaxing	Provider uninvolved and experienced side effects. Recipient relaxed. Felt air movement.
HT	Felt electricity that got smoother. Had a build up on fingers of unseen matter that easily released. Ran energy; never touched subject.	Relaxing. No change in pain. At one time a weight, light pressure, on abdomen. It disappeared. Like taking a nap.	Provider did not touch subject. Recipient felt a weight.

Sub # Tx type	Provider	Recipient	Relationships
B-8 Sham	Arms tired. Felt less the farther away from the subject's body. Back hurt.	Felt pressure of hands, no heat or energy. Dull ache in back. Pain slightly less.	Both provider and recipient experienced back pain.
HT	Felt energy entering feet and tingling leaving hands into her abdomen. Got hot.	Felt energized. Some kind of energy moving in legs. No pain now, even when press on abdomen.	Provider felt energy entering her and going into recipient. Recipient felt energized. End result no pain.

Sub # Tx type	Provider	Recipient	Relationships
C-13 Sham	Hands became very hot. Felt something moving in her abdomen.	Could have fallen asleep. Pain not as intense now, very dull.	Provider's hands became hot and she sensed movement in recipient. Recipient had pain relief.
HT	Tingling, congestion, hands felt numb. Felt made a deep energetic connection with recipient.	Asleep. Relaxing.	No apparent relationships

Sub # Tx type	Provider	Recipient	Relationships
E-26 Sham	Didn't feel much. Arms ached during modulation.	Cooling sensation	No apparent relationships
HT	Got warm. Prickling pressure and pulsations. Area felt fuller.	Cooling sensation over entire body.	No apparent relationships

Sub # Tx type	Provider	Recipient	Relationships
P-6 Sham	Many distracting thoughts.	Joints numb after. Felt like heating pad, warmth, radiant heat. Pain is better.	Provider not involved in treatment. Recipient felt heat and had pain relief.
HT	Big cold hole sucking in energy. Hand got warm. Energy pulsing into abdomen. Felt guides performing surgery, clipping and dissolving in right lower quadrant. Energy ran entire time.	Got cold half way through. Abdominal and side pain stopped entirely. Started again when I sat up, but less than before. Joint and back pain increased. Stiff from head to toe.	Provider felt guides providing surgery about the time the recipient got cold. Pain relief but joint and back pain with overall stiffness.

Sub # Tx type	Provider	Recipient	Relationships
B-12 Sham	Used self-hypnosis, self relaxation during treatment. No aches or pains this time. Very relaxed.	Relaxed. Felt something like energy tingling. Abdominal pain same but other pain better.	Provider relaxed without side effects. Recipient relaxed. Felt energy and pain relief.
HT	Felt static, congestion, layers of heat that cleared. Flow was unsteady, from chaos to stable.	Felt heat transferring between us or radiating. Couldn't tell if coming from me or her. Penetrating.	Both felt heat. Overall pain level less after both treatments.

Sub # Tx type	Provider	Recipient	Relationships
E-28 Sham	Loved the tape. Focused on it and what I had to do today.	Felt she was pulling the pain out of me.	Provider uninvolved in the treatment. Recipient felt pain being pulled out.
HT	During magnetic unruffling, increased warmth and fine rhythmic rapid shaking up movement at sweep 10-11. Then field became light. Heavy thick sensations completely gone by end.	Felt like she was pulling the pain up, drawing out the pain.	Provider felt heaviness in field disappeared by end of treatment. Recipient felt pain relief.

Sub # Tx type	Provider	Recipient	Relationships
P-2 HT	Painful burning, pain traveled to elbows. Uncomfortable.	Hands seemed to take the pain to a lower level, but it returned when hands removed. Relaxing.	Provider experienced side effects. Recipient had temporary pain relief and was relaxed.
Sham	I was calmer than previous treatment.	Gentle pressure. Same as first treatment.	No apparent relationships

Sub # Tx type	Provider	Recipient	Relationships
A-4 HT	Slow pulsations from center out. Felt pain in hands. Felt treatment was incomplete at end of 30 minutes.	Head to toe relaxed, drowsier. Provider's hands were hot and got hotter. When pain eased in one area, provider moved her hands to area of intensified pain. It relaxed.	Provider felt pulsations, pain in hands, and that treatment was incomplete. Recipient felt provider's hands got increasing hot. Overall relaxation and pain relief.
Sham	Shoulders ached. Felt heat coming from recipient to provider and wondered if recipient's pain were transferring to provider.	Shoulders and upper arms hurt. Relaxed. Pain relief.	Both experienced aches in upper arms and shoulders. Overall result, pain relief and relaxation.

Sub # Tx type	Provider	Recipient	Relationships
B-11 HT	Right and left sides different but equaled out. Congestion began to clear. Got very hot; cooled off with time. Right and left sides felt like they were taking energy. Felt there were more layers to clear but time did not permit.	Pain relief lasted several hours, a long time. Entered alpha state. Felt warmth, energy transfer.	Provider experienced clearing of congestion, equaling of sides, heat. Felt recipient was taking in energy. Recipient felt warmth, energy transfer. Pain relief.
Sham	Tired, relaxed	No physical sensations. Headache behind eyes gone. Abdomen and back hurt before treatment, not after. Feel energized.	Provider uninvolved in treatment. Recipient had pain relief in abdomen and back. Felt energized.

Sub # Tx type	Provider	Recipient	Relationships
D-23 HT	Intense, profuse heat that decreased. Fine energy until end.	Relaxing. Fell asleep. Abdomen not as sore or tight as before treatment.	Provider felt heat. Recipient felt relaxed. Less pain.
Sham	Energy or warmth came from hands.	Relaxing. Didn't feel anything. No difference in pain.	Provider felt energy or warmth. Recipient felt relaxed but no change in pain.

Sub # Tx type	Provider	Recipient	Relationships
E-29 HT	Like a cement wall that evened out but did not clear. Pulsations of energy, spasms of heat released. Clearing and draining of field. No replenishing.	Warmth, tingling especially where had greatest pain. Sense of drawing the pain away. Relaxation.	Provider sensed heat and a draining of the field. Recipient felt warmth and a sense of the pain being drawn away.
Sham	Tired, hot, back hurts, calm.	Relaxing, calming, lessening of pain. No difference between this and other treatment.	Provider had side effects. Recipient had lessening of pain.

Sub # Tx type	Provider	Recipient	Relationships
P-3 HT	Pain in hand that ran to elbow.	Pain radiated then relaxed when she put pressure on the area of pain. A warm feeling. Relaxing.	Both sensed pain that moved.
Sham	Back hurt, less relaxed than previous treatment.	Relaxing, cool breeze.	Provider had unpleasant side effects. Recipient felt cool breeze, relaxed.

Sub # Tx type	Provider	Recipient	Relationships
B-7 HT	Bands of congestion over chest, diaphragm, abdomen dissolved Ripples of energy. Hands hot. Piercing pain in right thumb. Recipient jerked as if shocked.	Felt like energy was being released out of incision like steam, heat. Pain in abdomen absent, like a pain memory. Spine relaxed. Feel better, more relaxed.	Provider felt bands of congestions dissolve, piercing pain, and heat. Recipient jerked. Recipient felt energy being released. Pain relief, spine relaxed.
Sham	Magnetic unruffling became smoother as continued. Back hurt. Watched wind chimes.	Easing of tension in back. Felt mild warmth when hands on abdomen. General comfort.	Provider had unpleasant side effects; uninvolved in treatment. Recipient had pain relief, especially in back.

Sub # Tx type	Provider	Recipient	Relationships
D-21 HT	Sharp tight pain from left fingertips to left shoulder and breast. Changed to pins and needles and lighter. Soft vibrations, fluid movement.	Piercing pain between shoulder blades that changed to a mild pinch. Right side incisions sore, but not the sharp cutting pain as before treatment. Half of the pain left.	Both experienced sharp pain in shoulder that eased. Provider felt energetic movements. Recipient had pain relief.
Sham	Made me very tired, kept yawning. Tape helps.	No change in pain. (Did not think sham provider did a good job.)	Provider uninvolved. Recipient had no pain change.

Sub # Tx type	Provider	Recipient	Relationships
E-25 HT	Tingling. Energy running entire time.	Hand felt warm when on me. Relaxation in abdomen.	Provider described energy running. Recipient described warmth and relaxation.
Sham	Back hurt, hands ached. Didn't enjoy it.	Belly warm when finished, like a heating pad on it. Slept. Pain relief.	Provider had unpleasant side effects. Uninvolved in treatment. Recipient felt warmth from provider's hands, pain relief.

Sub # Tx type	Provider	Recipient	Relationships
P-4 HT	Warmth, increasing pain that exited at wrists. Pain climaxed and subsided.	It was like her hands pulled out heat from my body. I was warm. Pain drifted off to left side but got better. Still hurt.	Provider experienced warmth and moving pain that subsided. Recipient felt warmth being pulled from body. Pain moved and got better.
Sham	Worried about personal chores.	0	0

Sub # Tx type	Provider	Recipient	Relationships
A-2 HT	Began shaking, unwinding motions down entire body that lasted most of treatment.	Calming, smoothing. Tingling side to side motion, undulating. Relaxed all over, pain diminished	Provider saw undulating motions; recipient described them. Pain relief.
Sham	Felt heaviness over head and chest, tension from abdomen. Matched breathing to get her to relax. Got stiff.	Relaxed, calming. Pain less.	Provider added a non-study relaxation modality of matching breathing. Recipient described treatment as relaxing.

Sub # Tx type	Provider	Recipient	Relationships
C-14 HT	I did MU for 5 minutes in upper field--it felt very warm; 5 minutes in middle field--I felt lots of prickles; 5 minutes in close field. Client slept, snored as the field began to smooth. I laid hands on the site of pain, not directly over the incision. Much energy moved at first, then less. Patient became a little fidgety toward the end. My mind was busy, busy, busy. I was aware of the energy flow but I kept having to bat the thoughts away. I decided not to chide myself, to accept whatever happened as OK. Afterward, I felt refreshed and enlivened.	I became aware of how tense I am. Different waves of relaxation, attempts at it anyway. I felt initially a tickling sensation. I wanted to close my eyes and sleep but I was very curious and I wanted to find out just what the person was doing. Her hands were very high above me so there was no touching at that point. It was an interesting feeling of movement. Couldn't relax as much because I didn't know what was happening, what the whole process was. It was an interesting experience because I started becoming aware of my body more.	Provider felt prickles and energy moving. Recipient felt tickling and movement.
Sham	0	0	0

Sub # Tx type	Provider	Recipient	Relationships
D-20 HT	Felt an absence in her field. Etheric fingers reached deeply inside her and a tingling changed to a stronger rhythmic vibration. Felt my energy being pulled into her depths. Thick, dense energy over abdomen and pelvis got lighter and clearer. Intense heat spread out. Vibrations became fainter.	Felt a pressure change, like sounds changing from side to side in my ears. Pain and heat gone. Don't feel the usual tightness and feeling like I am coming apart.	Provider described intricate process, including energy being pulled from her into an absent field that had thick and dense energy over abdomen. Recipient described a pressure change, like sounds. Pain and heat gone.
Sham	0	0	0

Vita

Victoria Slater obtained her Bachelor's of Science Degree in Nursing from the University of Texas in 1968 and her Master's of Science Degree in Nursing from the University of Michigan in 1971. She was Oncology-Hematology Clinical Nursing Specialist and Assistant Director of Nurses at the University of Utah Health Sciences Center before transferring to the College of Nursing to teach in the Continuing Education and Undergraduate nursing programs. While at the University of Utah College of Nursing, she co-founded the Hospice of Salt Lake in 1977 and became its first Executive Director. When she moved to Dover, Delaware with her husband, she taught in the BSN for RN program at Wesley College and assisted in the formation of the Central Delaware Hospice. In 1989, she moved to Clarksville, Tennessee and was introduced to Healing Touch. In 1990, she entered the Doctoral Program at the University of Tennessee, Knoxville, College of Nursing in part to learn how to research the Healing Touch phenomenon and put it into theoretical format. The doctoral degree was received May, 1996.

She is presently continuing research and theory development around energetic healing and anticipates retiring from the Air Force Reserves Nurse Corps in 1997 after twenty-nine years of service.