

Empathy, Intention, and Attunement in Healing Touch (HT): A Small Phenomenological Study

Jill Alexander, M.A., Energy Medicine, Lesley University

Abstract

Objective: To explore patients' lived experience and process of receiving Healing Touch (HT) biofield therapy during serious illness. The intent was to document the full range of outcomes experienced by the patients; most notably, whether the use of energy healing transformed the patients' self-perceptions, attitudes, thoughts, emotions and behaviors regarding their illnesses and recoveries.

Setting: The setting for this study was The Rothfeld Center, an integrative medical practice located in the Boston metro area.

Subjects/Sample: Four women, ages 25-60, who were current patients of The Rothfeld Center, and presently experiencing or recovering from serious illnesses.

Design: The study was a single trial 6-session qualitative phenomenological study. Face-to-face semi-structured interviews were conducted with participants during their last appointment to elicit information about their lived experience and perceptions of receiving Healing Touch (HT) during chronic illness. All data was subject to content analysis.

Intervention: The treatment consisted of six thirty-minute Healing Touch (HT) sessions provided by a certified Levels 1 and 2 Healing Touch (HT) student. Treatments contained elements common to all sessions, and interventions were tailored to the individual subject based on information gathered during intake. Each session included fifteen minutes of patient intake/uptake in addition to the thirty minutes of treatment/intervention.

Results: All of the subjects experienced notable quantitative shifts in physical symptoms (less pain, reduced medications), significant experiences of patient/practitioner attunement and empathy, and profound transformations in their attitudes and behaviors concerning their illness. A surprising finding of the study was that these experiences and benefits were not realized during subject's previous/other experiences of biofield modalities and holistic therapies. This strongly suggests that the patients' transformational experiences in the study were not due exclusively to the application of the intervention itself, but to other factors within the sessions such as guided intention and/or the HT provided by the therapist.

Conclusion: The findings of the study indicate that the use of directed intention, a conscious decision on the part of the patient to shift their thoughts, feelings, and behaviors, as a possible key factor in facilitating patient/practitioner attunement and empathy, initiating patient empowerment, and making the experience of biofield modalities transformational and effective for the patient.

Keywords: Healing Touch, energy healing, biofield therapy, empathy, intention, consciousness,

Introduction

Energy healing modalities, often referred to as “biofield therapies” (Jain & Mills, 2010) in scientific literature, such as Reiki, Therapeutic Touch (TT), and Healing Touch (HT), are increasingly being used in clinical settings as complementary care designed to invoke the Relaxation Response and reduce symptoms of stress commonly correlated with surgery, illness, and extended hospital convalescence.

Reiki is presently used in 74 hospitals, clinics, and hospices (Hahn et al, 2014). Therapeutic Touch (TT), developed in the early 1970s by New York University nursing professor Dolores Krieger, Ph.D., R.N. and intuitive healer Dora Kunz, has been taught in 80 countries and is currently being integrated into the medical school curriculum at the University of Connecticut, School of Medicine (Hart, 2012). Healing Touch (HT) is presently practiced in 32 countries and has over 100 completed studies, many of which have received support from North American universities and hospitals and the National Institutes of Health (NIH) (Hart, 2012).

There is clinical evidence in randomized studies that notable benefits are seen in critically ill patients. These benefits included reduction of pain intensity (Hammerschlag et al, 2012), significant reductions in total fatigue (Jain et al, 2012), decreases in two different indicators of depressed mood compared to relaxation training (RT) and to usual care (UC) (Lutgendorf et al, 2010), and; significantly, support of positive immune response by demonstrating “positive effects in preserving natural killer cell cytotoxicity (NKCC) over the course of treatment, whereas the NKCC of RT (relaxation training) and UC (usual care) patients declined sharply during chemoradiation” (Lutgendorf et al, 2010, p. 9).

While investigation of biofield modalities thus far has largely centered around quantitative results, there has been limited investigation surrounding the patient’s lived experience and process of using these modalities during illness and recovery. What role, if any, can biofield therapies play in healing during treatment and recovery of serious illness? Can energy healing also transform the patient’s perception and experience of their illness? If so, what are the factors that instigate these shifts of experiences and transform the patient’s perceptions, emotions, awareness, and actions—i.e., their consciousness—in relation to their illness? This small phenomenological study suggests that biofield therapies have the potential to be transformative interventions for the patient, restoring empowerment, self-direction, and self-care in their lives, their recovery, and their treatment decisions. Findings of this study strongly suggest that the use of directed intention is a critical but perhaps overlooked component in a patient’s experience of healing and holistic/integrative care.

Study objective

The study was conceptualized as a qualitative phenomenologic approach to explore the lived experience of individuals who use biofield therapies as significant practices during their treatment and recovery from chronic illness.

Methods

Classified as a biofield or energy therapy by the National Institutes of Health's National Center for Complementary and Alternative Medicine (NCCAM), "Healing Touch (HT) is an energy therapy in which practitioners consciously use their hands in a heart-centered and intentional way to enhance, support, and facilitate physical, emotional, mental, and spiritual health and self-healing" (Mentgen & Bulbrook, 2013, p. 2). Healing Touch (HT) uses touch to influence the human energy system, specifically the energy field that surrounds the body, and the energy centers that regulate the energy flow to the physical body (Mentgen & Bulbrook, 2013).

Healing Touch (HT) is research-based and integrated in over forty hospitals in the U.S. It is the first and only energy healing certification modality. The National Commission for Certifying Agencies (NCCA) granted accreditation to the Healing Touch Program (HTP) in 2014 for demonstrating compliance with the NCCA Standards for the Accreditation of Certification Programs. The Healing Touch Program (HTP) is an accredited provider of continuing nursing education by the American Nurses Credentialing Center (ANCC). ANCC is the world's largest and most prestigious nurse credentialing organization, and a subsidiary of the American Nurses Association (ANA). The Healing Touch Program (HTP) is the first Energy Medicine education provider to achieve this status. The Healing Touch Program (HTP) has been peer-reviewed, and is endorsed by American Holistic Nurses Association (AHNA) as well as the Canadian Holistic Nurses Association (CHNA) (Mentgen & Bulbrook., 2013).

Author's Note: Although the Principal Investigator (PI) was also trained in Reiki she did not use Reiki hand positions or Reiki symbols, which are keys to Reiki interventions, at any time during this study. HT protocol and interventions were strictly adhered to.

Research design

The study was a single trial, six-session qualitative phenomenological study. The study was originally conceptualized as an eight-week study but was modified to a six-session study to facilitate participant recruitment and commitment and to accommodate a mandatory schedule commitment on the part of the Principal Investigator (PI). Selected patients received a thirty-minute Healing Touch (HT) session from the Principal Investigator (PI).

Inclusion criteria: Adults currently suffering from chronic illness. No exclusions or special screening were done regarding age, gender, or specific medical diagnosis other than seeking out participants currently experiencing or recovering from chronic illness. Sessions were scheduled to take place once a week. The first four sessions were done on consecutive weeks. There were no sessions administered on the fifth week due to the Principal Investigator (PI) being unavailable due to a pre-existing commitment. Sessions resumed the following week at each subject's normally scheduled time and the remaining two sessions were done on consecutive weeks with the study commencing on September 6, 2014 and concluding on October 18, 2014.

All of the subjects completed all of the prescribed study sessions with the exception of one patient who was unable to attend one session due to out-of-town travel. Sessions consisted of thirty minutes of application of Healing Touch (HT) therapy with an additional fifteen-twenty minutes total of patient interview prior to beginning the session (known as the Intake or Uptake in Healing Touch (HT) protocol) to inform the Principal Investigator (PI) of the subject's current state of health, medications, goals for the session, and for discussion at the conclusion of the session to record subject/patient observations and questions.

Principal Investigator (PI)

The study employed one Principal Investigator (PI), Jill Alexander. The PI was a master's candidate in Energy Medicine at Lesley University (expected degree conferral, May 2015) and the study was part of the PI's final thesis project. The PI was a certified Levels 1 and 2 Healing Touch (HT) student and had also completed the 100-hour Reiki certification through Brigham & Women's Hospital in Boston.

Subjects

Subjects included four women presently experiencing or recovering from chronic illness. All of the participants had complex medical histories and presented with several serious medical issues/illnesses that they had not been able to resolve through conventional medical care. The spectrum of health conditions included:

Patient A: cell damage resulting from non-specified toxic exposure, and autoimmune illness. The patient cited generalized pain as her primary symptom with severe fatigue and lethargy also being significant enough to regularly preclude normal daily activities such as work and hobbies. She also suffered from PTSD due to early childhood trauma.

Patient B: Autoimmune illnesses; her fatigue and depression were severe enough to disrupt normal daily activities and generalized pain was also cited as a frequent concern. She also suffered from PTSD and frequent depression.

Patient C: Spinal surgery (microdisectomy); multiple ovarian cysts and low levels of estrogen and progesterone; hormonal imbalances that were severe enough to require a medical abortion. Anxiety and panic attacks were the symptoms causing her the most distress at the commencement of the study. She also cited depression as moderately high concern.

Patient D: Severe chronic allergies, thyroid inflammation, and recurrent viral/bacterial infections; fatigue/lethargy and memory problems were the primary areas of concern during the Intake session. The patient also cited depression as an area of significant concern.

Subjects reside in the greater Boston area and are currently patients of The Rothfeld Center, an integrative medical practice based in Waltham, Massachusetts. Nine subjects were approached for inclusion in the study but five had to be omitted due to schedule conflicts or physical limitations which would affect participation or adhering to study parameters, such as limited ability to drive to the location or disability that would make completing full sessions difficult. Subjects ranged in age from 25 to 60.

Subjects were recruited via fliers posted in The Rothfeld Center, thus allowing participants to self-select. Subjects were also referred by staff members at The Rothfeld Center. All subjects were initially interviewed via telephone before being officially admitted to the study to make sure subjects fit study parameters for inclusion and participation. All patient participation was strictly voluntary and patients were informed verbally and in writing that they would be free to withdraw at any time.

Blinding and randomization

Because of the required subject/investigator interaction, and subjects' self-selection into the study it was not possible to blind or randomize the study.

Setting

All sessions took place at The Rothfeld Center in Waltham, MA, an integrative medical practice. Sessions and interviews were conducted on site.

Data collection process

All subjects were required to complete an Intake Form that detailed medical history including medications, lifestyle practices, and goals for the sessions. The Principal Investigator (PI) also

completed an assessment for each participant at the beginning and conclusion of each session known as the Uptake Form which detailed length of session, changes in medications or physical symptoms noted since last session, and any new lifestyle practices or patient goals for that particular session, as well as any general patient comments or questions. Both of these forms are required as documentation of sessions in Healing Touch (HT) protocol.

A final interview was conducted in person at the conclusion of the last session on October 18, 2014. Interviews lasted between 15-30 minutes. Two subjects were contacted for follow-up interviews via phone within 48 hours of their initial interview, as some questions had not been covered in that interview. All interviews were digitally recorded and transcribed within 72 hours. Subjects were asked prior to the commencement of the interview if their answers could be digitally recorded. Subjects were made aware that digital files of the recordings would be kept on the PI's personal computer and would be kept confidential except to possibly members of the PI's advisory team for the purposes of evaluation. All subjects consented to these parameters before the interviews commenced and the recording device was turned on. The white noise system employed at the location and background noise from other practitioners and patients resulted in occasional missed or unclear words.

Questionnaire

Each subject was asked to respond to the following questions:

- How did receiving HT during your illness/recovery make you feel physically?
- How did it make you feel emotionally?
- How did it make you feel mentally?
- How did you perceive your ability to heal your illness/be healthy before receiving HT?
- How do you perceive your ability to heal your illness/be healthy now? Why?
- How do you see your illness/recovery after having the experience of HT? How is that different than before the sessions?
- Do you see yourself differently now than before the experience of HT? If yes, how so?
- Why do you think the experience of HT/energy healing was effective for you? Why do you think it works?
- What did you find to be the most unique and/or powerful about the treatments?
- How would you compare/contrast this experience of treatment/care versus the experience of conventional medical care?
- How would you compare this experience of HT/energy healing to other experiences you have had other energy healing modalities?

Questions were approved by the Principal Investigator's (PI) advisory team at Lesley University prior to commencement of the study and interviews of the participants. The PI's advisory team consisted of three members: Nancy Waring PhD, Lesley University faculty member and the PI's thesis director; Rick Leskowitz, MD, Director of Integrative Medicine, Spaulding Hospital, Boston, MA.; and, Joan Doody, MS, ANP-BC, CHFNP, Manager, Cardiology Heart Failure Program, Lahey Hospital, Burlington, MA. The team members advised the PI on study design and provided grading and evaluation of the PI's study and final thesis project.

Data Analysis

The main phenomenological data analysis procedures employed were those described by Creswell (1997) and demonstrated in the sample phenomenological study in that same volume. All transcripts of the subject interviews were then read through three times for comprehension and meaning. Selected interviews were reviewed again to check conclusions and cross-references. Significant statements, phrases, words, and descriptions were then highlighted and cross-referenced with the other subjects' interview transcripts to compare and contrast differences and similarities between

subjects' answers. Subjects' statements were then clustered into groups and meanings and themes were analyzed and developed.

Session notes detailed on the Uptake forms and the initial Intake forms were also reviewed and cross-referenced to key statements, phrases, words, and descriptions noted on the final interview transcripts.

Confidentiality

Subjects were made aware prior to interviews that they were being recorded. All subjects were assured of the confidentiality of their answers, any session notes or medical information divulged on the Intake or Uptake forms, and their identity and inclusion in the study except to the Principal Investigator (PI), staff members at The Rothfeld Center, and members of the Principal Investigator's (PI) advisory team at Lesley University for the purposes of grading and evaluation.

Protection of human research subjects

As energy healing is non-invasive there are no known harmful risks or side effects associated with the sessions. Subjects were advised that energy healing, and the modality of Healing Touch (HT) specifically, is not intended to be curative but is designed as supportive and adjunctive to primary care protocols they are presently undergoing.

Participants were also required to sign an Informed Consent form, which outlined the purpose and parameters of the study.

Professor Robyn Cruz, Co-Chair of the Lesley Institutional Review Board, was contacted via email by the PI and thesis director, Professor Nancy Waring, prior to the commencement of the study and assurance was obtained that this study is compliant with IRB guidelines.

Results

From 187 significant statements, five themes emerged uniformly across the spectrum of subjects. While some of the themes were anticipated, based on review of other phenomenological studies surrounding biofield therapies, as well as research done on complementary and alternative medicine in general, feedback that emerged during subject interviews points to some possibly new and surprising findings which are explored and analyzed in the Discussion and analysis section to follow.

Theme 1: A sense of integration

An integration of body, mind and spirit was a theme that emerged uniformly across all subjects. Before participation in the study, several of the subjects spoke of seeing multiple specialists to address the diverse health and emotional issues they were experiencing. However, the process of treating the illness, along with the illness itself, often left them feeling fragmented, as each condition was usually addressed in isolation from underlying emotional issues or other physical issues or treated in a mechanistic way by each respective specialist. There was an impression of very little about the body, mind, emotions, and spirit working collectively; rather, there was sense of the participants seeing each issue—be it physical, mental, psychological, or emotional—as a separate problem to be dealt with. Patient B noted during the first session that, "it is hard to connect with myself" while Patient A also said "I have lost a sense of connection with myself" during the initial Intake.

As the sessions progressed, all of the subjects frequently spoke of feeling an increasing sense of integration. Descriptions of being "grounded," "centered" and "present" were used by all of the participants on several occasions. My impression is that these particular words were used to denote an increased sense of embodiment—an awareness of bodily sensations, thoughts, and

feelings in the present moment. This sense of integration seemed to be a mutually reciprocal phenomenon of feeling more embodied and the feeling of embodiment providing a greater sense of integration, clarity and balance for the participants. In the final interview Patient C described a new sense of being able “to see the timeline of what is going on in my life at that specific moment and that that leads to something else and how my chronic illness and physical issues developed. I see them as intertwined with energy and what is going on with my body at that time.”

Patient D simply stated that the experience of Healing Touch (HT) during the sessions

integrated my head along with my body. It took my mind to a different place and...I sort of understood in a way I didn't understand before what I needed to get better.

Theme 2: Reorientation of power from external to internal

All of the participants spoke of a shift of orientation in their personal power during the experience of receiving Healing Touch (HT). Many subjects spoke of a greater sense of empowerment and agency in their treatment decisions and recovery process. “Control” was a word that was used by all participants and repeated frequently throughout the weekly sessions and in the final interview. The experience of “control” seemed to denote an expanding sphere of influence in how they felt physically, mentally and emotionally on a day-to-day basis, rather than subjugating negative symptoms and experiences. Prior to the commencement of the study, many of the participants described their illness as something they had little power to affect. Thus, they frequently disassociated themselves from the daily anxiety and discomfort surrounding it. However, as the study progressed, all participants increasingly felt more in control of their physical and emotional states. As Patient C said, succinctly and elegantly, “I have more ability to self-govern.”

Nearly all spoke of experiencing a growing realization that they were “stronger” than they had previously believed prior to the study. As Patient C described,

I had a lot of fear and didn't know what was going to happen next...[but] even if there are certain times when I'm having more issues or things are worse...with my body, it isn't going to overtake me. I can see it as something going on but that at the end of the day I'm okay.

Many participants spoke of reasserting agency in their treatment decisions and reclaiming their power to heal from their doctors, practitioners and the medical establishment. Patient B remarked,

I am getting no help from conventional medicine now. I guess they are helpful in a way but I'm past that. I'm learning that other things help much, much more. I think with medicine you get dependent on them and this way you are starting to take control of your own healing.

When asked how she perceived her ability to be healthy before the experience of Healing Touch (HT), Patient A confessed that during her conventional medical treatment

I felt markedly powerless. I felt like I was just being treated and didn't have a role...like I wouldn't be able to do things that would really change things. It was the doctors and the prescriptions...and I think this has shifted that, that kind of thinking...I'm more empowered now.

When queried what she now thought her role was in her health she replied, “Well, I see that I have a *critical* role. I have a role that is more...that is viable.”

Theme 3: Sense of personalized interaction and empathy

Another significant theme that emerged during the study was the patients' sense of personalized interaction and empathy. Patient D described her experience in the sessions as “feeling very cared

for.” Descriptions of “caring” and “empathy” were also used by all of the other participants. However, what was surprising was that this participant’s described experience of care exceeded that of mere kindness, compassion or competency. Three of the four subjects were emphatic that their experience of care was highly personalized. As Patient A noted, “I felt sensitivity to what was going on with *me* and that made me more sensitive to what was going on with myself.” Patient C said, “This practice is very specific to what is going on with *you* (“you” denoting the subject being treated) at the moment.”

My impression of the emphasis on the word “me” used by so many of the participants indicates that they were expressing “me” as denoting their innermost subjective feelings and thoughts, perhaps even their soul or consciousness. This impression was emergent from the fact that all of the participants described their previous experiences with medical treatment as ones that made them feel like a condition to be treated rather than an unique individual with feelings, perceptions, and life history. However, their experience in the study seemed to provide a sense of being known at a very deep subjective level. While all participants said that the experience was difficult to describe, the adjective “intuitive” was used by patients B, C, and D and patient B expressed the feeling that the healing work undertaken in the sessions and the attuned communication between the subject and practitioner created “...a more connected trust, intimate something” for her.

As was touched on in Theme 2, many participants had previously experienced a sense of depersonalization and fragmentation in their conventional medical treatments. Patients often noted a procedural approach or sense that they were “being done to” or being treated as a set of symptoms or condition. As Patient B described the experience of the sessions, “You are following and seeing *my* energy. It’s more one-on-one.” Thus, the experience of empathy in the context of the participant’s experience seemed to encompass a state of feeling “known” at a very personal level in the moment—and the practitioner responding to that subjective state with their words, actions, presence and treatment.

Interestingly, what seemed to be key factor in the participants’ sense of personalized interaction was a shared sense of relational time and space between the practitioner and participants. Three of the four subjects often used the phrase “in the moment” to describe why the experience felt personal and embodied for them. There seemed to be a sense that the practitioner was present in their moment-to-moment experience of the treatment. “It’s the relationship” said Patient B.

Somewhat paradoxically, this sense of partnership or relational experience seemed to empower the subjects in the subjective singular. As Patient A noted earlier, “I felt sensitivity to what was going on with *me* and that made me more sensitive to what was going on with myself.” “Connection” was another word that was frequently used by the participants—“connection” denoting connection with the practitioner, connection in the moment, and connection with their bodies and subjective experience in the moment. Patient C described feeling very connected to the practitioner and the work they were doing together during the session, “I think I felt very much ‘in it’ while it was happening.” Later, she simply stated, “I think I felt very connected to the HT work we did...you were bringing a lot of focus and attention to...certain parts of the body and so because of that I felt more connected to you...and to my body.”

Theme 4: Practitioner/participant attunement or resonance

Another theme that emerged in the weekly Uptakes and the final interviews was an experience of attunement or resonance with the practitioner for the subjects. Three of the four subjects used the phrase “in tune” to describe how they perceived the experience of receiving Healing Touch (HT) during the sessions. As discussed in Theme 3, some of that was due to a sense of relational time and space—i.e., the PI having a sense of what the subjects were going through, or what their issues were physically or emotionally, in the moment it happened.

However, all the subjects described an even deeper state of relational resonance that often seemed to occur at levels that were different than ordinary sense perception or empathetic and compassionate care. Many of the subjects admitted that they didn't always know to describe the experiences but the words/phrases "intuitive" and "in tune" were used frequently. Patient D exclaimed,

I could actually feel the fields of energy over my body when you worked on me! I could tell where your hands were even though you weren't touching me and I couldn't see because I had my eyes closed, but I could feel energy moving. I could feel where you were and if a calming or energizing effect was happening.

Subjects repeatedly described this feeling of attunement as the most powerful, unique, and surprising part of their experience. Moreover, what was most impacting for the patients was that these experiences of resonance or attunement were often attained without the use of dialogue between the PI and participant, or the participant informing the practitioner as the treatment was being done where they felt pain, constriction or blocked energy. However, nearly all of the participants frequently recounted episodes of practitioner/participant attunement in the weekly Uptakes and post-session discussions. They recounted the Principal Investigator (PI) saying things during sessions such as, "I feel some congested energy in your back...[or] "There was just a release in your solar plexus area" and the patient confirming after the session had concluded that they had indeed been feeling discomfort at that specific area of their back or that they had experienced a release of tension in their solar plexus only a moment or two before the practitioner told them of it. As Patient B described,

When you said, 'You are really holding stuff here' I knew you were right, but I couldn't figure out how you knew that. But right where you were at that very moment...was right where I needed what you were doing. It amazed me! It was pretty impressive.

Theme 5: Conscious intention of thoughts, feelings, and behaviors

The use of intention is a key part of Healing Touch (HT) protocol and was employed during the sessions. Per the HT protocol, every session commenced with the subjects verbalizing their stated intention or goal for that particular session. Examples of such intentions frequently included objectives such as "feeling less anxious," "pain relief," or "strengthening my immune system." This practice of intention and goal-setting is also reinforced by the HT practice of giving the patient/client self-care assignments and homework designed to support the benefits of pain relief, relaxation, or other physical/emotional relief obtained from the actual session.

The practice of intention seemed to be critical component of realizing benefits, sustaining the subjects' commitment to regular attendance in the study and work done in the sessions, and also their commitment to getting well. Moreover, the practice of intention seemed to grow for each of the participants during the progression of the study and, most notably, seemed to contribute to beneficial shifts of thoughts, feelings, and behaviors. Surprisingly, these shifts occurred in ways that often didn't seem to directly correlate to or that superseded the original stated intentions or goals.

However, as the sessions progressed, the subjects began to see their thoughts, emotions, and even their energy as something they could consciously direct. Moreover, by doing so they had the power to exercise agency with their day-to-day health, emotional states and their lived experience at large. Patient B replied after being queried how she saw her illness/recovery/physical condition after having the experience of Healing Touch, "Well, I still don't like it but I see that I can develop patterns of thought that are going to help it from dragging me down instead of me dealing with it." Indeed, it seemed that by the end of the study all of the participants had internalized the process of intention and consciously adjusting their thoughts, feelings, and actions. Patient D remarked,

You know that sometimes you know what the best thing is for you but you don't do it? This just made me get more in line with knowing the best thing for me and getting on the path to doing it.

Another of the surprising experiences for three of the subjects was that the practice of intention and consciously directing their behaviors and thoughts to a more productive place developed despite their initial resistance to it. Patient B recounted the following story of half-heartedly doing the self-care homework that she had been assigned. At the conclusion of one particular session, the PI had queried what the subject did for a creative outlet, as the patient seemed to be very artistic. The subject wistfully recounted how she had loved to do arts and crafts but didn't anymore and that time and money precluded picking it back up. The PI suggested buying a coloring book and working in it a bit each night for stress relief and as an artistic activity. However, the participant recounted with laughter and amazement how, despite her ambivalence, the coloring book became a kind of cue for remembering the intention of relaxation. As she explains,

I thought, 'Oh, I don't like to color'...but when I saw the coloring book on my dresser this week when I was going through a stressful time it just brought me back to that calmed-down state, so it was kind of a tool for me.

Patient D came into the concluding session in a very excited mood. Despite weeks of gritting her teeth through her daily self-care assignment of meditation and deep breathing exercises intended to support her goal of calming anxiety and creating more mental clarity, she had discovered in the last week "that I actually found myself looking forward to the daily meditation" and "it made me feel happy when I did it."

Discussion and analysis

In this study, the practice of positive/healing intention emerged as a critical component in the subject's experience of healing, transformation, and reorientation of power from external means and persons (i.e., doctors, medications, procedures) to their own internal, autonomous decisions and behaviors. Moreover, the use of employing intention relationally between the PI and the subject during the study sessions seemed to be a key factor in facilitating a state of attunement and transpersonal exchange. All subjects spoke of feelings of care, compassion, and deep relaxation present during the sessions. These findings were anticipated, given results reported in other qualitative studies of energy healing, including those by Kieman (2002), Sneed, Olson, and Bonadonna (1997) and the mixed quantitative/qualitative study by Richeson, Spross, Lutz, and Peng (2010).

However, somewhat surprisingly, all subjects strongly asserted during the concluding interview that their experience during the sessions was deeper and more emotion-laden than simply a generalized feeling of care, compassion, or deep relaxation. Rather, their comments spoke of a profoundly relational and personalized experience that touched their subjective inner world. Comments that spoke to this included Patient B's statement, "You are following and seeing *with me my* energy;" while Patient C said, "I think it was effective...because I was willing to let go...[and] entrust into someone else...and how they were working with *me*."

Nearly all of the study subjects placed verbal emphasis on the singular pronouns of "me" and "my" during their answers. They were declarative that the experience of receiving HT during the study sessions gave them a sense of recognition and empathy that they had not experienced in their previous medical care. As Patient B explained her positive experience in the study:

A very big part of it is that *you* are in tune with *my* issues. Doctors, nurses, the conventional medicine...they can't be. That's not what they do. And when you have someone who knows that

you are feeling an issue right there you feel exonerated, vindicated. You kind of feel like you have a partner helping you get better. It's the relationship.

Initially, it was my speculation and that of my advisory teams that the subjects' sense of deep relational attunement and recognition by the investigator at a deep subjective level might be emergent from the experience of *any* holistic/integrative modality. According to Deng et al (2009), the orientation and application of integrative medicine is intended to be a "multi-modality, whole-system intervention, [including] practitioner-patient relationship and partnership, patient goals and priorities...[and] personalization of diagnostic and therapeutic measures to individual patients" (p. 2). This was an important factor to explore, given that the study subjects were all patients of The Rothfeld Center, a noted holistic/integrative medical practice in the Boston area as well as the fact that all of subjects had broad and fairly deep experience of other holistic modalities, including but not limited to, acupuncture, yoga, meditation, massage/reflexology and chiropractic care.

However, a surprising finding of this study is that this sense of depersonalization was also experienced by the study subjects in holistic therapies and, most unexpectedly, other experiences of energy healing. This suggested that subjects' transformational experiences in the study were due, at least partially, to other factors.

When Patient B was queried if she noticed experiences of "they just don't get me" even in a holistic medical practice, she confirmed that this had been her experience, explaining,

Yes...because they are giving me treatments. I've had acupuncture. This [HT] seems to be different and I think it is just because you're in my energy and you're following *my* energy. It's not just like treating a condition. Like acupuncture...they know where to put their needles but they're not following *my* energy.

Surprisingly, this experience of rote, depersonalized or uncaring action was present and, based on patient stories, even more amplified during other experiences of energy healing. Every participant had experienced Reiki at least once, and for some of the patients, a handful of times. Two of the participants had experienced other forms of energy healing, including Polarity therapy and what was described by one of the subjects as a generalized spiritual healing that employed chakra balancing. None of the participants had experienced Healing Touch (HT) prior to the study. When asked how (and if) their other experiences of energy healing compared to those in the study, Patient B recounted her experience of Reiki.

It may have been my distrust [for why she had an ineffective experience]. Because with Reiki they follow some symbols that they see and that's not following me. I know they see symbols and they just have this 'magical' kind of stuff that they follow. They didn't come to me and perceive that there was something going on here or here (patient indicated parts of her body).

Patient C recounted her experiences with spiritual healing and also with receiving Reiki at Brigham & Women's Hospital in Boston after surgery. Describing the experience of receiving spiritual healing

I didn't feel ... very connected to the energy work. In comparison to the energy work that I did with you I think I felt very much 'in it while it was happening.' You were bringing a lot of focus and attention to certain chakras or parts of my body and so I think because of that I felt more connected...to you as a practitioner and to my body. I didn't really understand the work that was being done with the other practitioner. At the end she'd say, 'You're balanced now' but I wouldn't notice it felt differently.

The emphasis on the word “I” in the previous statement about her spiritual healing experiences is notable as it is my impression that it conveys a sense on the subject’s part that the experience was not about her process or understanding in the experience, but rather that of the practitioner’s contributions to the interactions. The experience of spiritual healing wasn’t relational or attuned, but rather that of “being done to.” As Bailey (2011) notes such “actions are operationalized (Rieman, 1986) (p. 56) and “instrumental behavior” (p. 57). In comparison, she described HT as something that provided an experience where she felt “very much ‘in it while it was happening” and left her feeling “more connected...to you as a practitioner and to my body.” Thus, there was much more of a sense of practitioner/patient partnership and attunement within the HT exchange.

The subject’s recollection of her experience with Reiki at Brigham & Women’s Hospital presented similar themes, though she was careful to qualify that receiving the Reiki while being in pain and medicated post-spinal surgery may have affected her perception of that particular experience. As she explains,

It sort of felt like something that was happening around me but I didn’t know, wasn’t really sure if it was affecting my body at all. The HT work...sort of connected my mind, and my body and emotions at the same time. And I think that was the first modality that I’ve done with any sort of energy healing where I really felt all of the parts coming together.

While Patient A did qualify her responses about other energy healing experiences by saying “she didn’t have enough experience with Reiki to really say” a very powerful statement emerged in the post-interview discussion as the subject asked about the Principal Investigator’s (PI) experience as a Reiki volunteer at Brigham & Women’s Hospital in Boston. In briefly explaining the approach and the fact that hand placements were standardized to facilitate shortened time with the patient, limited access to parts of the body due to wounds, IV’s, medical equipment, etc., and possible staff/patient apprehension about certain hand positions in a clinical setting, the subject became very agitated and said emphatically,

Conventional medicine can not standardize for intention! It is a critical component to why this works. If the treatments are the same for everyone how well can it truly work?!

The findings of the study support the use of intention as possibly a key factor in what makes the experience of energy healing powerful, transformational, and effective—at least from the patient’s perspective. It is my hypothesis that the use of intention functioned like a toggle switch for making the experience of the subjects relational, attuned, and personalized rather than rote or standardized, or cultivating a perception of “being done to.” Rather, it facilitated an experience of the sessions being about and for the patients—their singular needs, intentions, and goals—while still preserving a deeply relational and intertwined dynamic with the practitioner.

While the intention to treat or provide an intervention was present in the subjects’ other experiences of medical care, what did not seem to be present, based on their descriptions of such care, was a relational experience of the practitioner witnessing and supporting the patients’ specific goals for their health. The intention was unidirectional—the practitioner having an objective of resolving a symptom or condition and administering the intervention. By contrast, the subjects’ experience in the study was that of relationally attuned intention with their practitioner. Moreover, it was they, rather than the practitioner, who established the objective or goal for the session. As noted earlier, examples of such intentions included, “to feel less anxious,” “to reduce pain,” and “to strengthen my immune system.” The practitioner then administered an intervention and self-care assignments that were specifically tailored to that goal. This practice seemed to facilitate a deep empathy and connectedness between the patient and practitioner during the session. Patient B explained, “It is like you have a partner helping you get better.”

Implications for future studies

Studies by Samarel (1992), Sneed et al (1997) as well as several others indicate that patients' experience of biofield modalities are not limited only to symptom abatement; but rather, hold the potential to be "a fulfilling multidimensional experience that facilitated personal growth" (Samarel, 1992, p. 651).

In examining this question of attunement and empathy, I considered the subjects' answers about their prior experiences with energy healing/biofield modalities as well as other integrative medicine and conventional medicine practices. All were emphatic that a mechanized, rote approach employed by other practitioners diminished their sense of agency and self-worth not only with experiences of Reiki and other forms of energy healing, but with *all* forms of healthcare—conventional, alternative and integrative. Thus, it is my conclusion that attuned empathy between patient and practitioner is fundamental to the healing process at large, not exclusively biofield modalities.

This conclusion is not without its challenges—and numerous practical and ethical considerations. The most important of the former being the question of how a practitioner creates and sustains an attuned, empathetic relationship with their patient without compromising personal boundaries? How does a practitioner maintain detachment and discernment within the treatment process? Perhaps most importantly, given that we are considering the patient's perspective in this particular study, how does a practitioner ensure that "patient goals and priorities" (Deng et al., 2009, p. 2) are sustained in the exchange?

To the last question, I would assert that practitioners need to give the patient definable agency in their healing process. As was noted earlier, a key finding of this study is that directed intention seemed to be a critical factor in realizing relational attunement and empathy between the subject and practitioner while simultaneously creating a subjective and autonomous experience for the subject. Intentional practice and goal-setting created self-determination for the subjects within the exchange; however, it also provided them with a validating sense of support and attunement as the practitioner witnessed their intention and was able to guide them (via recommended homework and self-care exercises) in how they might they might achieve and sustain their goals and objectives for healing and recovery.

While intention is most commonly defined as holding the space for a specific goal or outcome to occur, the results of this study suggest that the practice of intention encompasses a much larger dynamic. Intention in healing is a relational rather than a singular, autonomous exercise. It was my experience in this study that intention involved a blending of practitioner/patient energy fields. For the duration of the session, their intention also became my intention. I allowed my heart and mind to singularly resonate and hold space for their healing objectives within that moment. This attuned empathy enabled me to intuitively perceive areas of pain or blockage within the field and administer a proper intervention within the moment, making the experience effective and powerful for the patient. The fact that the intention/goal used was initiated by the patient preserved a sense of practitioner/patient autonomy within the exchange.

Though inclusion of integrative services and biofield therapies such as the Reiki Volunteer Program at Brigham & Women's Hospital in Boston "has been embraced by hospital leadership and is recognized as a valuable component of a caring and healing environment" (Hahn et al., 2014, p. 18), I believe greater benefits could be realized with inclusion of attuned empathy and intention-based exercises, when possible, during the use of biofield therapies like Reiki, Therapeutic Touch (TT), and Healing Touch (HT). This can be accomplished by simply asking the patient a reflective question such as, "If you could realize a benefit/s from today's treatment, what would that be?" or "How would you like to

feel at the conclusion of today's work?" When the patient responds, "To feel less stressed," or "To diminish pain," the practitioner can simply respond in kind to the patient's stated goal, "Wonderful, we'll make stress [(or pain)] relief the intention of today's work." The practitioner can then integrate the HT interventions of grounding, centering, and attuning to the patient, which aligns the patient and practitioner on a heart-to-heart level.

The practices of setting an intention and grounding, centering, and attuning to the client/patient are a standard part of the Healing Touch (HT) Intake protocol. Moreover, they are brief practices that can easily be integrated with current Reiki or Therapeutic Touch (TT) services, even in busy hospital and acute care settings where time with the patient is often limited.

It must be noted that this is a small, pilot study, so the findings and any conclusions can only be viewed as exploratory. In this regard, one must also acknowledge that the person who is providing the healing interventions invariably shapes the interventions and therefore has to be considered as a factor in assessing the outcomes. It is possible that other, unidentified factors related to myself as a person and/or healer could have played some part(s) in the observed outcomes. It remains to be seen whether the inclusion of the factors of the HT interventions of grounding, centering, and attuning to the patient, which aligns the patient and practitioner on a heart-to-heart level, or other factors in the HT healing protocol are keys to the patient responses observed in this study and whether these can be replicated by others.

The field of energy medicine is still nascent in research and clinical practice and research must determine whether the quantitative benefits suggested by other studies are causal or correlative to other factors in the experience and delivery of these modalities. However, I believe this study substantiates Potter's (2013) assertion that "evidence-informed practice includes the modality's meaning for patients" (p. 140). Within this study, intention emerged as the most meaningful variable in obtaining healing, transformation, and agency within the experience. This finding has strong implications for future inquiry and study. It is my position that future research should address and explore the dimension of intention as a critical factor in healing, recovery, and treatment.

Acknowledgements:

It is with deep gratitude that I thank Dr. Rick Leskowitz, Joan Doody, R.N., and Prof. Nancy Waring for their steadfast mentoring and support. I also wish to acknowledge Dr. Glenn Rothfeld, Beth Galan, R.N. and Sara Raimundo of The Rothfeld Center. This study would not have been possible without their gracious assistance and belief in my work. Most importantly, I thank the patients who allowed me the honor of working with them. I am forever humbled you entrusted me with your stories. This work rests on your shoulders.

References

Bailey, Denise, Framing client care using Halldorsdottir's theory of caring and uncaring behaviors within nursing and healthcare, *International Journal of Human Caring*, 2011, 15(4), 54-66.

Creswell, John, *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*, Thousand Oaks, CA: Sage Publications. 2007.

Deng, Gary; Weber, Wendy; Sood, Amit; et al, Integrative medicine research: context and priorities, *Commissioned for the IOM Summit on Integrative Medicine and the Health of the Public*. 2009.

Hahn, Julie; Reilly, Patricia; Buchanan, Teresa, Development of a reiki training program: training volunteers to provide reiki to patients, families, and staff in the acute care setting, *Dimensions of Critical Care Nursing*, 2014, 33(1), 15-21. doi: 10.1097/DCC.0000000000000009

Hammerschlag, Richard; Jain, Shamini; Baldwin, Ann; et al, Biofield research: a roundtable discussion of scientific and methodological issues., *The Journal of Alternative and Complementary Medicine*, 2012, 18(12), 1081-1086. doi: 10.1089/acm.2012.1502

Hart, Jane, Healing touch, therapeutic touch, and reiki: energy medicine advances in the medical community. *Alternative and Complementary Therapies*, 2012, 18(6), 309-313. doi: 10.1089./act.2012.18609

Jain, Shamini; Mills, Paul, Biofield therapies: helpful or full of hype? a best evidence synthesis, *International Journal of Behavioral Medicine*, 2010, 17(1), 1-16. doi: 10.1007/s12529-009-9062-4

Jain, Shamini; Pavlik, Desiree; Distefan, Janet; et al, Complementary medicine for fatigue and cortisol variability in breast cancer survivors, *Cancer*, 2012, 18(3), 777-87. doi: 10.1002/cncr.26345

Kieman, Jane, The experience of therapeutic touch in the lives of five postpartum women. *The American Journal of Maternal Child Nursing*, 2002, 27(1), 47-53.

Lutgendorf, Susan; Mullen-Houser, Elizabeth; Russell, Daniel; et al, Preservation of immune function in cervical cancer patients during chemoradiation using a novel integrative approach, *Brain, Behavior, and Immunity*, 2010, 24(8), 1231-1240. doi: 10.1016/j.bbi.2010.06.014

Mentgen, Janet; Bulbrook, Mary Jo, *Healing touch program notebook, level 1: Official notebook for the healing touch certification program, 7th edition*. San Antonio, TX: Healing Touch Program, Sept 2013.

Potter, Pamela, Energy therapies in advanced practice oncology: An evidence-informed practice approach, *Journal of the Advanced Practitioner in Oncology*, 2013, 4(3), 139-151.

Richeson, Nancy; Spross, Judith; Lutz, Katherine; et al, Effects of reiki on anxiety, depression, pain, and physiological factors in community-dwelling older adults. *Research in Gerontological Nursing*, 2010, (3)3, 187-199.

Samarel, Nelda, The experience of receiving therapeutic touch, *Journal of Advanced Nursing*, 1992, 17(6), 651-657.

Sneed, Nancee; Olson, Melodie; Bonadonna, Ramita, The experience of therapeutic touch for novice recipients. *Journal of Holistic Nursing*, 1997, 15(3), 243-253.

Jill Alexander, MA in Energy Medicine, Lesley University. Jill has practiced energy healing in hospitals, doctor's offices, and in private practice. She holds a 100-hour Reiki practicum certificate from Brigham & Women's Hospital in Boston and has spoken at Spaulding Hospital in Boston on the subject of energy medicine. She is certified to Level 2 in Healing Touch and pursuing her full certification. Her practice, Whole Energy Wellness of New England (www.energywellnessne.com) is located in the Boston metro area.



Contact:

Jill Alexander jill@energywellnessne.com

TERMS OF USE

The International Journal of Healing and Caring On Line is distributed electronically as an open access journal, available at no charge. You may choose to print your downloaded copy of this article or any other article for relaxed reading.

We encourage you to share this article with friends and colleagues.

The International Journal of Healing and Caring
P.O. Box 76, Bellmawr, NJ 08099
Phone (609) 714-1885 Fax (519) 265-0746
Email: center@ijhc.org Website: <http://www.ijhc.org>
Copyright © 2015 IJHC. All rights reserved.
DISCLAIMER: <http://www.wholistichealingresearch.com/disclaimer.html>