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# Caring to Improve Patients' Energy Field in Community Nursing - Effects of Healing Touch Intervention-

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**Abstract:** Healing touch, as a complementary therapy, was provided to 14 patients as a nursing care method in a community setting. The comparison of pre- and post-test outcomes demonstrated statistically significant effects in three of the four domains: "physical," "emotional," and "thinking". The generality of effect was large. There were no negative effects. This healing touch treatment was non-invasive, effective, non-toxic, and economical. Healing touch has a strong potential as an effective and efficient intervention in the setting of community nursing care.

**Keywords: healing touch, community nursing, palliative care, complementary and alternative therapy, holistic, energy, field, Numerical Rating Scales, pre- and post-test, touch care**

## 1. Introduction

In the United States, Japan as well as other developed countries, the use of complementary and alternative medicine is increasingly used by patients often seeking additional comfort or support as they manage their illnesses and promote their own health (Frass, Strassl, & Kaye, 2012). At the USA, National Center for Complementary and Alternative Medicine, complementary and alternative therapies are defined as one of the five domains or categories, and healing touch falls into the 5[h] category: "Energy Therapies." (National Institute of Health, 2003)

The five categories are:
1. Alternative Medical Systems (Ayurveda, traditional Chinese medicine, homeopathy, naturopathy etc.)
2. Mind-Body Interventions (music, prayer, diary therapy, imagery therapy, humor, relaxation, etc.)
3. Biologically-Based Therapies (herbs, aromatherapy, macrobiotic diet, supplements, etc.)
4. Manipulative and Body-Based Methods (massage, tai chi chuan, exercise, etc.)
5. Energy Therapies (qi, therapeutic touch, healing touch, reiki, magnets, acupuncture, shiatsu, reflexology, etc.)

Healing touch is a complementary medicine categorized as an energy therapy. It was created and developed in 1989 by Janet Mentgen, RN, BSN and a team of nurses from the American Holistic Nurses Organization (Hover-Kramer, Mentgen & Scandrett-Hibdon,1996). This complementary energy therapy can be implemented integratively and harmonizes with existing remedies in a wide variety of fields including palliative care, relaxation, pain mitigation, postoperative care, psychiatry, hospice, elder care, *etc* (Wardell & Weymouth, 2004). Among complementary therapies, healing touch has drawn attention especially in the field of community nursing where it is regarded as important in Snyder's (2009a) examination of complementary therapy.

Healing touch is a bio-field therapy in which the practitioner intentional supports the human energy bio-field to achieve balance and harmony (Hover-Kramer, *et al.*, 1996). In nursing practice, healing touch is used as a method for improving a disturbed energy field (Herdman, 2009, p. 163), which is the diagnosis provided in North American Nursing Diagnoses Association NANDA-I Nursing Diagnoses. The American Holistic Nurses Association (AHNA) has endorsed Healing Touch as an approved educational program. According to Snyder (2009ab), AHNA's approved healing touch program has six levels. Nurses must reach Level 5 in order to become healing touch practitioners. In addition to 105 hours of classwork and lessons, healing touch practitioners also produce case studies and receive mentoring. Lessons include ethical standards, patient/practitioner relationships, etc. After nurses have completed Level 6, they must follow a prescribed set of observations and supervised teaching sessions before becoming certified healing touch instructors. In Japan a small number nurses have advanced to Level 5 where their education began as early as 2007 and there are a growing number of practitioners receiving certification from Healing Touch

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今回の調査対象の大学1･2年生は他者を信頼する傾向が強かった。楽観的回答の多さは、ネットと携帯・スマホの普及による社会生活の変化、東日本大震災での若者の意識変化などの他に、高学歴化による影響が含まれていると推定される。教育年数の長い者ほど他者を信頼する傾向が強く[7,9]、日本では大学・短大・専門学校への進学率が53.7%（1990年）から72.7%（2013年）に増加していることから、同様の傾向が同年齢のデジタルネイティブ世代に共通すると予想される。

男女の違いでは、女性はテレパシー体験率が高く、かつ他者を信頼する傾向が強かった。女性は男性よりも他者に共感する能力が高いことが知られており[13,14]、本結果は女性の共感能力の高さを反映していると解釈できるだろう。

精神的健康や体験の有無は第六感などの超常現象信奉には関係しないとされている。例えば2000年から2003年にかけて488人の学生（18～27歳、男250人、女238人）の精神健康度と超常現象信奉度との関係を調査した今泉は、神経症、うつなどの軽症精神疾患と超常現象信奉は相関がなかったと報告している（両者の相関係数は0.034）[15]。本調査でも、第六感の信奉と特異体験の有無はほとんど相関しなかった。その代わりに信頼の質問2との間に弱い正相関があったことから、第六感信奉は特異体験よりも他者信頼など他の要因と関連することが示唆される。

## 5. 結　論

デジタルネイティブ世代とされる大学生の信頼と特異体験の調査を行った。特異体験の有無は四半世紀前の調査結果と同様の傾向となり、特異体験の体験起因説が支持された。他者信頼は過去の日本人よりも高い値となった。また、第六感信奉は特異体験よりも他者信頼など他の要因と関連することが示唆された。

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International. In actual nursing practice, only a few institutions and establishments in Japan have incorporated healing touch into their care regimens. However, healing touch, as a complementary therapy, is showing promise for the practice of community nursing in Japan, including at-home palliative care.

Wardell (2008), states in the guidelines for evidence-based nursing interventions that there is a great deal of higher level II and III research from English speaking countries supporting the effects of healing touch. Lower grades of research are typically found as research unfolds in a new field of study. An examples is Hiratsuka and Motomura's (2008) study on the efficacy of healing touch where they found that the treatment was effective in eliminating or mitigating pain, reducing anxiety, improving QOL, reducing stress and improving the symptoms of autoimmune disorders. In Japan, a case study (Naka, Amano, & Ito, 2014) on healing touch administered to a patient with Parkinson's Disease demonstrated that, based on the before and after measurements, the treatment was effective. However, we were unable to find a randomized-control trial or other such evidence-based scientific study on healing touch among a Japanese population.

While this study is not a randomized-control trial, the goal of this study is the measurement of the effectiveness of healing touch based on the comparison of statistical data produced before and after treatment was administered and with a larger sample.

## 2. Purpose

The purpose of this study is to compare patients' statuses before and after the administration of healing touch, and based on the measurements of any results thereof, verify the efficacy of healing touch as a potential method of palliative care in community nursing in Japan.

## 3. Method

**Design study: Factual investigation using medical questionnaires**

This study was a pre-test, post-test design without a control group. A convenience sample was sought.

Before the administration of healing touch, the participants were questioned about their main medical complaint(s) and medical history, and were asked to share their thoughts after receiving treatment. For the pre-test and post-test, the Numerical Rating Scale (NRS; Hirakawa, 2011) was employed in order to quantify their condition in four spheres: physical, emotional, thinking, and spiritual. A 10 indicated the best status and 0 the worst. For the physical subscale, participants were asked to give a numerical value from 10-0 with the instruction: "How would you rate your current physical condition on a scale of 10-0, where 10 equals "I am in excellent, vigorous health" and 0 equals "I am lethargic and cannot move." The other three subscales had similar instructions. For the thinking subscale 10 equals "I can concentrate very well" and 0 equals "My brain is foggy and I can't think clearly." For the emotional subscale 10 equals "I am filled with a sense of well-being" and 0 equals "I am despondent and want to die." For the spirituality subscale, 10 equals "I have found value in living and a purpose in my life" and 0 equals "I have found no purpose in my life." The possible total high score was 40 and total low score was 0.

**Period of data collection**

July 2012 to April 2013

**Participants and setting**

Healing touch research participants were recruited from the local region, through workplaces and acquaintances. Consenting to participate were 14 people (3 men and 11 women) whose main complaints included stiff shoulders, joint pain, lumbago, headaches, nausea, dizziness, depressive symptoms and reduced vision. The treatment was conducted at the participant's home or in a therapy room. The treatment duration was 60 minutes.

**Ethical Considerations**

The participants were presented with a description of the study, the objective of the study, and were told that data from their medical questionnaire would be used as reference material for the study. The participants were told that no personal information would be disclosed during the presentation of the research, that no personal information would be used for purposes outside the scope of the study, and that the participants were participating of their own free will and could discontinue at any time. Signatures were obtained from all participants. The intervention was carried out in accordance with Healing Touch International's standards of practice and ethics , and the study was based on the ethical standards of International Healing Association for Nurses

**Statistical analysis**

In order to note any difference in the participants' statuses after healing touch was administered, calculations were made using data from the four subscales (physical, emotional, thinking, spiritual) and an overall mean was calculated from the aggregate scores. In the aggregate score, the difference in the mean value of the pre- and post-treatment scores for each participant must be zero or a value greater than zero; no minus scores were accepted.

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## 5. Results

The pre and post treatment scores are presented in Table 1. In the general, 11 participants' scores increased, one had no change, and none decreased. In other words 11 of the participants' aggregate scores showed an improvement. Next, we conducted a *t*-test to determine whether or not the difference between the pre- and post-treatment scores was 0.

In the change in scores between the pre-treatment test and post-treatment test, there was a large difference in the overall average: $M = 5.08$, 95% *CI* [1.28, 8.88], $SD = 6.29$ representing a statistically significant increase ($t$ (12) = 2.91, $p = .013$). The effect size was large ($ES = .81$). Of the participants' scores for the overall average of four subscales, 92% showed an improvement.

For the physical subscale, there was a large difference in the overall average score: $M = 1.29$, 95% *CI* [.29, 2.28], $SD = 1.73$ indicating a statistically significant increase ($t$ (13) = 2.783, $p = .016$). The effect size was large ($ES = .75$). Eleven participants' scores increased, three had no change, and 0 decreased; for the physical subscale 79% showed an improvement.

For the emotional subscale, there was a large difference in the overall average score: $M = 1.36$, 95% *CI* [.35, 2.36], $SD = 1.74$; a statistically significant increase ($t$ (13) = 2.924, $p = .012$). The effect size was large ($ES = .79$). Nine participants' scores increased, five had no change, and 0 decreased; Of the participants' scores of the emotional subscale 64% showed an improvement.

For the thinking subscale, there was a large difference in the overall average score: $M = 1.21$, 95% *CI* [.28, 2.15], $SD = 1.63$; a statistically significant increase ($t$ (13) = 2.795, $p = .015$). The effect size was large ($ES = .79$). Nine participants' scores increased, five had no change, and 0 decreased; 64% of the participants' scores of the thinking subscale showed an improvement.

For the spiritual subscale, there was a difference in the overall average: $M = .92$, 95% *CI* [-.11, 1.95], $SD = 1.706$, which was not a statistically significant increase ($t$ (12) = 1.951, $p = .075$). The effect size was medium ($ES = .54$). Five participants' scores increased, eight had no change, and 0 decreased; 38% of the participants' scores of the spiritual subscale showed an improvement.

In the written feedback section, one male participant whose main complaints before treatment were nausea and headaches showed a pronounced positive change after treatment, stating, "I feel like I'm on a bed made of clouds." This showed a remarkable improvement. There were two cases where there was no change in the numerical value in pre- and post-treatment status; however, both participants expressed they felt positive changes, such as, "My body feels refreshed", "My field of vision has become more clear", and "I feel like I am able to venture out of doors."

## 6. Discussion

### Summary of the results

In this study, using a pre-test and post-test one group design an improvement in the participants' physical, emotional, and thinking aspects was demonstrated by employing a 10-point evaluation scale. Except for the spirituality subscale the over-all effect was large, which suggests the efficacy of healing touch. Also, no participants reported negative results, which imply that healing touch is non-invasive, so this study was able to support the non-invasive nature of healing touch (Hover Kramer et al. 1996). The participants of this study received treatment either at their home or in a therapy room, suggesting similar results could be achieved with chronically ill homebound patients. As the participants of this study come from a diverse range of backgrounds, this demonstrates that healing touch can be effective for a variety of patients. The participants of this study had a wide range of main complaints, yet by and large they showed positive results.

### Limitations and strength

The results should be interpreted cautiously because of the nature of the design that had no control group for comparison and was a convenience sample. In addition the numerical rating scales while generally considered a reliable measurement may lack robust validity depending on the scale. In this case physical, emotional, thinking, and spiritual states are complex. One-dimensional measurements may not capture the complexity of these states. However previous research indicates that healing touch is frequently effective although difficult to study because of the nature of subtle energy (Wardell & Weymouth, 2004). The strength of the study is the use of the NRS in a consistent manner and the obvious positive results. These results are consistent with other more complex research studies (Wardell & Weymouth, 2004).

### Four benefits of healing touch for visiting nurses

If visiting nurses were to practice healing touch, considering the benefits, we can infer the following positive features (Hover-Kramer et al. 1996):

First, as healing touch is non-invasive, it can be offered as a very reliable, safe treatment option that can be incorporated into at-home care regimens for patients with pronounced physical weakness, pediatric patients, late-stage cancer patients and others who are receiving terminal care.

Next, regarding efficacy, all of the 14 participants who received healing touch therapy reported some sort of positive result. Overseas, studies of the effectiveness of healing touch are already being conducted, and as

reported by Hiratsuka, & Motomura (2008), it has been shown to be an effective treatment option for cancer, heart disease, terminal care, immune function, endocrine function, pain management, improvement of patient satisfaction, psychological changes, post-operative recovery, and stress. In the areas of internal medicine, surgery, psychiatry, terminal care, etc., healing touch is a therapy that is capable of producing a positive effect. The results of this study suggest that healing touch is a very promising option for at-home care plans and intervention methods.

On the third point which shows there is no toxicity or side effects, healing touch appeals to the human body's inborn healing power, and emphasizes balance and harmony. As such, it is a holistic approach with none of the risks of side effects that are common to medication.

In prior research, there has been an unpublished study of 14 elderly residents of a long-term care facility who received nine sessions per resident with improvement in functional ability and decreased pain. Unfortunately the healing touch practitioners had to abruptly stop the treatment resulting in a return of symptoms (Wardell, 2008). These results much also be interpreted cautiously as there was no control group and no follow-up. So long as the practitioner heeds the correct methods of terminating the treatment, it is thought that healing touch is a nursing intervention that can be recommended to patients and families without concern over side effects.

Finally, healing touch is economical, as it requires no special facilities or equipment. This is an extremely strong merit for community nursing. As for at-home nursing, since healing touch is a therapy that can be practiced without the use of implements, practitioners can save time on preparation, and since practitioners don't need to purchase expendable supplies it is cost-effective as well. Since the only costs to the patient are medical expenses and labor costs, it is believed that healing touch therapy can be readily recommended to those patients who are unable to take on extra financial burdens. At present, treatment is billed as a charge for home care, but upon future establishment of a certification system for this specialty, it is believed that a fee structure commensurate with services rendered will be created.

Considering these four characteristics, healing touch is a very promising care method in community nursing that is beneficial to patients, families and even to nurses themselves, and could be implemented as a way to improve the overall quality of nursing care.

## 7. Conclusion

With more patients receiving at-home care, topics including the improvement of the quality of nursing, patients' quality of life, palliative care, pain management, relaxation and the pursuit of comfort are becoming more of a concern for community nursing. It is hoped that we will see an increase in the number of nurses who have acquired skills through proper training in order to preserve patient safety, and will use healing touch as a nursing intervention in their communities.

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