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# A Pilot Study of Healing Touch and Progressive Relaxation for Chronic Neuropathic Pain in Persons With Spinal Cord Injury

Diane Wind Wardell, PhD, RNC, HNC, CHTP  
*University of Texas*

Diana H. Rintala, PhD  
*Baylor College of Medicine  
Houston Veteran Affairs Medical Center*

Zhigang Duan, MD, MS  
*M. D. Anderson Cancer Institute*

Gabriel Tan, PhD, ABPP  
*Baylor College of Medicine  
Houston Veteran Affairs Medical Center*

This pilot study assessed the role of Healing Touch (HT), an energy-based therapy, in modulating chronic neuropathic pain and the associated psychological distress from post spinal cord injury. Twelve veterans were assigned to either HT or guided progressive relaxation for six weekly home visits. The instruments selected showed sensitivity, although there was a large variation among the groups. There was a significant difference in the composite of interference on the Brief Pain Inventory ( $t = -2.71, p = .035$ ). The mean score of the fatigue subscale of the Profile of Moods decreased ( $ns$ ) in the HT group and in the subscale of confusion yet remained stable in the control group. The Diener Satisfaction With Life Scale showed increased well-being in the HT group and no change in the control group. Participants reported various experiences with HT sessions indicating that it may have benefit in the complex response to chronic pain.

**Keywords:** *healing touch; biofield therapies; integrative medicine; chronic pain; neuropathic pain*

Pain following spinal cord injury (SCI) has been reported in one third to more than 90% of patients, but it mostly occurs in 75% to 85% of those with a SCI (Turner, Cardenas, Warms, & McClellan, 2001). Persons with SCI experience neuropathic, musculoskeletal, and visceral pain (Siddall, Taylor, & Cousins, 1997). The central nervous system undergoes dramatic changes in response to SCI. In a complete SCI, there are no clinical signs of sensory or motor function below the level of injury. A "discomplete" lesion, however, is clinically complete but is accompanied by neurophysiological evidence of residual brain influence on spinal cord function below the level of the lesion (Sherwood, Dimitrijevic, & McKay, 1992). Persons with discomplete SCI often report pain below the level of injury that appears to be neuropathic in nature. Although many researchers have explored the mechanism of action for chronic neuropathic pain

conditions below the level of injury, traditional medical regimes have failed to alleviate this pain.

Many individuals with chronic conditions seek the assistance of alternative therapies in managing their symptoms (Astin, 1998). Alternative approaches may help to complement and support traditional approaches to pain management. One such complementary approach is Healing Touch (HT), which has a nursing foundation with a structured curriculum of study and a certification process (Hover-Kramer, 2001). HT is classified as an energy medicine therapy by the National Institutes of Health, National Center for Complementary and Alternative Medicine (2004).

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The purpose of this study was to determine the feasibility of delivering a healing modality—HT and guided progressive relaxation (GPR)—in a home environment and to determine whether HT and GPR could influence the pain and coping of veterans with a SCI. To maximize understanding of the experience, both quantitative and qualitative methods were used to assess information from both the participants and practitioners.

## Background

The conceptual underpinnings of many complementary therapies (including HT) rely on the belief that individual needs are addressed for the person's highest good (healing), and is not about curing (fixing or alleviating; Rubik & Pavek, 1992; Wardell & Engebretson, 2001a). HT is a nursing-based program of study that incorporates the techniques of a variety of healers, including the founder of HT, Mentgen (2001), a nurse healer; Joy (1979), a physician internist; Bruyere (1994), a sectarian healer; and Brennan (1987), an astrophysicist. There have been more than 50,000 attendees in HT courses (involving both didactic and experiential work) in the United States (Anselme, 2003) and many more individuals worldwide from Australia, Canada, Europe, Africa, and South America. The program of study has five levels and offers certification through a professional review process. These individuals are designated as certified healing touch practitioners (CHTPs).

HT employs a gentle laying on of hands either directly over the clothed body or above the person. It facilitates the person's self-healing within a multi-dimensional focus, including the physical, emotional, mental, and spiritual aspects of the person (Hover-Kramer, 2001). The hands are placed in a series of sequential movements and may follow a more individualized pattern depending on patients' needs. The HT practitioner uses a variety of both local (at a specific site/problem area) and full-body techniques (encompassing major points on the body), depending on the assessment of the energy field that surrounds the body. HT and other energy therapies have been used successfully for chronic pain relief (Wardell, 2000), depression (Bradway, 1998), acute pain (Osterlund, Davids, Gima, & Verderber, 1998), mood (Cook, Guerrero, & Slater, 2004), stress (Wardell & Engebretson, 2001b), and various other physical and emotional problems (Wardell & Weymouth, 2004).

GPR in this study was used as the control condition. GPR is a well-established intervention that was

first introduced by Jacobson in 1929. It is used to create a general sense of relaxation and well-being (Lichstein, 1988; Smith, 1990). It requires tensing and then releasing each of the muscle groups, starting with the feet and working toward the head. As a delivered intervention, it served as a control for attention.

## Method

### Design

A mixed-method design was used to facilitate understanding of using an energy-based therapy for those experiencing chronic pain from SCI (Keegan, Guzzetta, & Dossey, 2000). The use of quantitative and qualitative methods allows for greater potential to gather the variety of experiences and determine meaningful outcomes that can serve to more fully explain the phenomena. Participants completed questionnaires to identify their pain experience. Interviews were conducted pre- and postintervention with the participants to further elucidate the experience not captured by the questionnaire data. Focus groups were also conducted with the practitioners to gather insight into providing HT to SCI veterans.

### Sample and Provider Selection

It was felt that a total sample size of 10 could provide meaningful clinical data that would provide a basis for further study from the pilot with consideration for the time and funding constraints of an in-home study with multiple data points. There were 7 participants in the HT group (to allow for attrition in this group, although there were no dropouts in either group) and 5 in the GPR control group during the specified time period. Potential participants were identified from clinic records if they were English speaking, older than age 18, greater than 6 months post-SCI, experiencing chronic (greater than 1 month duration) neurogenic pain, on a stable medication regime for pain for more than 1 month, and had pain greater than 5 on a visual analog scale (range 0-10) at some point during the previous week.

Twenty-nine males who met the inclusion criteria at a SCI unit of a Veteran's Affairs Medical Center during the study time frame were invited to participate. There were no female veterans who met the inclusion criteria during the study period identified. Of these 29 individuals, 12 agreed (for a participation rate of 41%). The reasons for refusal were reported as "didn't have time" ( $n = 7$ ), "don't like research studies"

( $n = 6$ ), “no reason” ( $n = 3$ ), and “don’t believe in holistic medicine” ( $n = 1$ ).

Seven CHTPs were selected from a pool of 12 practitioners to provide the HT intervention based on their geographical proximity to the participants. The practitioners were in practice (full- or part-time) for at least 6 years. In addition to being CHTPs, 3 were nurses, 1 was a doctorally prepared therapist, and 2 were professional businesswomen. All were female, and 5 of the CHTPs were European American and 2 were Hispanic American ranging in age from 51 to 64 years.

The research assistant (RA) was a Hispanic female in her mid-twenties with experience in recruiting and interviewing research participants with SCI. The RA was trained specifically for this study to deliver GPR to the control group. She had no training in HT or any other energy-based therapy prior to this study.

### Approval

The institutional review boards at two universities, one of which provides oversight for the Veterans Affairs Medical Center in the study city, approved the study. Participants supplied informed written consent prior to the therapeutic interventions, and all current standards for the protection of human subjects were followed using HIPPA (Health Insurance Portability and Accountability Act) guidelines. The study was conducted during 2002 and 2003.

### Quantitative Findings

*Measures.* A variety of instruments were used to capture the pain experience in this sample of chronic-pain patients as HT is thought to affect physical, emotional, mental, and spiritual health. A questionnaire was developed to obtain demographic data (date of birth, gender, race/ethnicity, marital status, and education level) and injury-related information (cause of injury, date of injury, and level and completeness of injury).

The Brief Pain Inventory (BPI–short form) was used to determine the interference that pain had on daily living (Daut, Cleeland, & Flanery, 1983). The BPI includes a body map of pain and questions on the intensity and effect of the pain on daily life (interference). The alpha coefficients of the severity and interference subscales on the BPI are reported to be 0.88 and .092, respectively (Frank-Stromborg & Olson, 1997).

The Profile of Moods States (McNair, Lorr, & Droppleman, 1992) is a 65-item questionnaire measuring six states including tension-anxiety, depression-dejection, anger-hostility, vigor-activity, fatigue-inertia,

and confusion-bewilderment. It has been used for more than 20 years and has long-standing reliability and validity when used as a psychological measure. There is a reported moderate to high correlation with symptom measures (McNair et al., 1992)

The Diener Satisfaction with Life Scale (Pavot, Diener, Colvin, & Sandvik, 1991) is a 5-item scale measuring global life satisfaction. It has been found to have a high correlation with the Life Satisfaction Index A ( $r = .81$ ) and with other measures of well-being, lending support to the scale’s validity. Pavot et al. (1991) reported a Cronbach’s alpha of .83.

The Center for Epidemiological Studies–Depression Scale short form (CESD-10) by Andresen, Malmgren, Carter, and Patrick (1994) is a 10-item, self-report scale ranging from 0 to 3 according to how often the person experienced certain feelings during the past week. Scores for positive feelings are reversed. It has been found to have good predictive accuracy (Kappa = .97) compared with the original 20-item CES-D by Radloff (1977). The reliability was found to be moderate ( $r = .71$ ) by Andresen et al.

A Visual Analogue Scale (VAS) was used to determine immediate effects of the treatment sessions. The VAS used was a 10-cm. line. Three questions regarding their “current pain,” “most severe pain,” and “coping” were used. Participants were told to mark across the line at the point representing their experience. The VAS has a long-standing history of reliability and validity (Huskisson, 1983).

*Analysis.* Because of the pilot nature of the study, quantitative data were analyzed using methods varying from descriptive to comparative analysis. Descriptive statistics were obtained for the study sample, and initial differences between the HT and GPR groups were assessed with chi-square and t test analyses. The quantitative analyses were performed using the SPSS for Windows, version 11.5 (Chicago, IL).

### Qualitative Findings

*Measures and data sources.* Both the participants and the CHTPs provided qualitative data. First, to explore the process and the meaning of the session, the participants were asked questions both before and after each session (Denzin & Lincoln, 1998). The CHTP or RA asked structured interview questions about the experience, how the participant felt, whether they noticed any changes, and whether they had anything else they would like to offer the research team. The sessions were audiotaped and then transcribed verbatim. The RA conducted the interview for the GPR group. In the HT group, three of the CHTPs had previous

experience with conducting research interviews and were able to elicit more in-depth responses. The other four CHTPs had no previous experience with research, and one did not capture any information from the interview on tape after the first session.

The second source of data was the CHTPs' individual perspective of the healing sessions performed. The Healing Touch Charting Form used by the CHTP to record the HT treatment was able to capture this. The form provided a place to record both subjective and objective findings; the type, number, and order of techniques used; and postsession evaluation. This form was modified from the Premature Infant Data Form used in another study (S. Kagel & S. McDonough-Means, personal communication, May 2000).

In addition, the CHTPs were asked to review the session forms of random sessions (six total) and one complete series (all six sessions of 1 participant). All personal identifiers were removed prior to the review. They discussed their findings and wrote impressions based on a list of open-ended questions developed by the research team. One written response by a practitioner was also provided after this session.

*Analysis.* The qualitative analysis used an interactive approach identified by Maxwell (1996) focusing on understanding the contextual experience of both the participant and the practitioner and identifying unanticipated phenomena during an HT session. The analysis was conducted in a systematic fashion. First, the researcher verified each of the transcripts by listening to the individually taped sessions. Each of the transcripts was then read for the overall experience in two groups related to either the HT or GPR experience. The transcripts were then reread for specific events that identified a response to the HT or GPR sessions. After this was completed, additional reviews were conducted to determine whether any general themes emerged from the data.

The CHTP recommendations were reviewed from observational notes and from their written comments. This information was shared with the CHTPs during the focus group, and general consensus was obtained about these observations.

## Procedure

The RA contacted potential participants verbally either in the clinic or by phone to determine whether they wished to participate. If they agreed, she identified whether their place of residence was close to the

residence of one of the participating CHTPs. If so, that participant was assigned to the HT group and the RA contacted the CHTP, who then telephoned the participant to arrange for the first session. Otherwise, the participant was assigned to the GPR group. For persons assigned to the GPR group, the RA scheduled their first appointment based on her availability.

The CHTP or RA explained the study and obtained written consent in the participant's home or another setting designated by the participant (one elected to have the sessions at his workplace) before receiving the first treatment. The participant was asked to complete questionnaires before the first session and again after the second and sixth sessions. A VAS was also used before and after each session for the level of current pain. Participants were audiotaped while describing their experiences after the first session and before and after each subsequent session. A total of six sessions were conducted approximately 1 week apart. The CHTP remained the same for a given participant in the HT group for all six sessions. HT sessions were individualized for the participant based on the energy assessment and HT techniques used determined by the CHTP. The RA delivered the GPR treatment to all participants in this group.

After the second visit, the CHTP or RA specifically asked whether the participant wished to continue in the study to reinforce the volunteer nature of the study. At the fourth session, participants in the HT group were given the option to have their primary caregiver instructed in HT techniques. These caregivers were encouraged to participate in the fifth and sixth sessions. This occurred for 4 of the 7 participants in the HT group. In one case, the CHTP was called back to the home after study completion to perform this service. This option was provided to allow for continued application if the participants deemed the treatments to be beneficial.

Practitioners completed the Healing Touch Charting Form for each session. Three meetings were also held with the practitioners. The first was held prior to the beginning of the study to discuss the techniques and sequencing recommended from other practitioners who had experience with clients with SCI. The second meeting was conducted approximately halfway through the study period to allow for discussion of findings and suggestions from experience gained, and the third was at the end of the study to analyze the session data and to make recommendations for future studies and treatment approaches.

**Table 1**  
**Demographic Variables**

Distributions of categorical variables	Group		Pearson Chi-Square Test (two-sided)			
	HT	GPR	Chi-Square	<i>p</i> Value		
Race						
White	4 (57.1%)	3 (60.0%)	2.204	.531		
Black	2 (28.6%)	1 (20.0%)				
Other	1 (14.3%)	0 (0.0%)				
White and Hispanic	0 (0.0%)	1 (20.0%)				
Injury						
Complete	4 (57.1%)	2 (50.0%)	0.52	.819		
Partial	3 (42.9%)	2 (50.0%)				
Education						
High school	0 (0.0%)	3 (60.0%)	7.063	.029		
Some college	3 (42.9%)	2 (40.0%)				
College	4 (57.1%)	0 (0.0%)				
<i>t</i> Test (two-sided)						
Continuous variables	Group	<i>N</i>	Mean	<i>SD</i>	<i>t</i>	<i>p</i> Value
Age	HT	7	56.1429	7.28991	0.759	.466
	GPR	5	52.6000	8.90505		
Months since injury	HT	7	202.8571	111.77720	-1.390	.195
	GPR	5	311.6000	160.79894		

Note: HT = healing touch; GPR = guided progressive relaxation.

## Results

### Sample

The categorical background characteristics (race, education level, and type of injury) were analyzed using a two-sided chi-square test, and continuous characteristics (age, months since injury) were analyzed using *t* tests to determine whether the groups were similar (see Table 1). There was a significant difference only between groups with respect to education; the HT group was more educated.

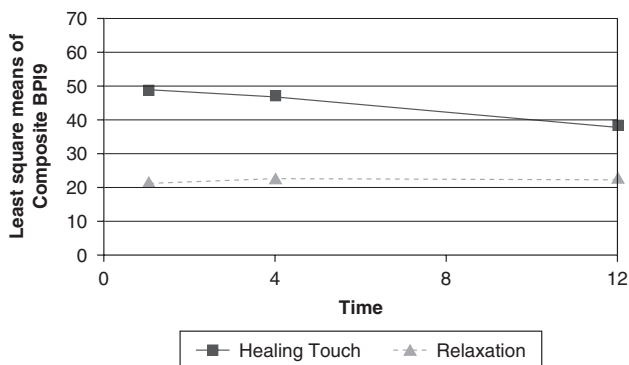
### Quantitative Findings

As a pilot study, it was important to determine whether the instruments selected would be sensitive to changes that might occur with an HT session. The instruments selected were those that could potentially identify multifaceted aspects of chronic pain management. All showed some level of change, although no conclusions can be drawn because of the high variation and small sample size.

**BPI.** There was no change across the study period for the composite score ( $F = 1.59$ ,  $df = 2, 13$ ,  $p = .24$ ) of the BPI. There was a significant difference found between the groups in the Composite of Interference scale ( $t = -2.71$ ,  $p = .035$ ), with the HT group reporting less interference. Another scale, The Interference of Pain Over the Last 24 Hours scale (BP19), showed a decrease in the HT group (see Figure 1), although it was not significant ( $F = 2.82$ ,  $df = 1, 7$ ,  $p = .14$ ). On the question about "least pain in the past 24 hours," the HT group's mean decreased from 5.57 to 4.29, and the GPR group increased from 4.2 to 4.4 from pretreatment to postcompletion of the treatment series. On the question, "average pain over 24 hours," the HT group's mean at pretest was 6.79 and decreased to 5.35 at the end of the study, whereas the GPR group's pretest mean was 4.56 but 6.20 at the end of the study. The variation was large for both of these questions, and the findings were not significant.

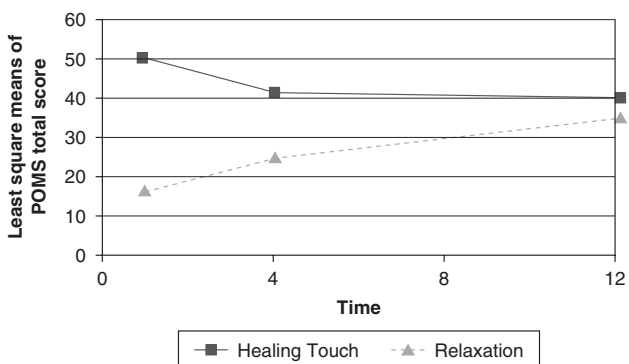
**Profile of Moods Scale (POMS).** There was no difference in the POMS total score between groups in the trend of change ( $F = 0.69$ ,  $df = 2, 19$ ,  $p = .51$ ) across the study period (see Figure 2). In the fatigue scale, the

**Figure 1**  
**Interference of Pain in the Past 24 Hours**  
**on the Brief Pain Inventory**



Note: Time 0 = pretreatment; Time 4 = after the second session; Time 12 = posttreatment.

**Figure 2**  
**Profile of Moods Scale Total Score:**  
**The Amount of Disturbance**

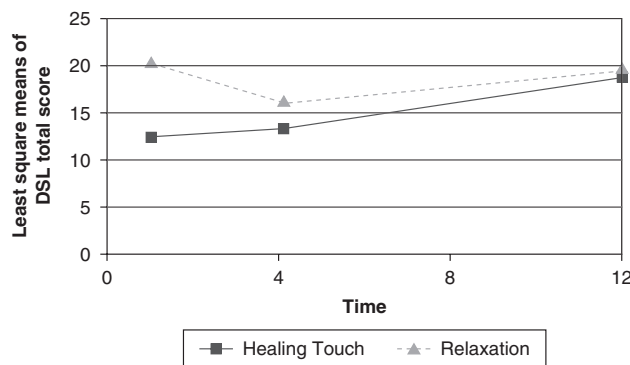


Note: Time 0 = pretreatment; Time 4 = after the second session; Time 12 = posttreatment.

HT group decreased (pretreatment  $M = 17$ , posttreatment  $M = 11.29$ ), but the variation was large. Four of the HT participants decreased at the end of treatment. In the fatigue scale, the HT group decreased (pretreatment  $M = 17$ , posttreatment  $M = 11.29$ ), but the variation was large (4 of the HT participants had decreased scores). For both of these subscales, the GPR group remained stable ( $M = 8.0$  and  $M = 3.1$ , respectively).

*Diener Satisfaction With Life Scale.* The HT group showed an increase in satisfaction, but it did not reach significance ( $F = 1.41$ ,  $df = 2, 20$ ,  $p = .27$ ). Please see Figure 3.

**Figure 3**  
**Diener Satisfaction With Life Scale Pre- and**  
**Posttreatment Sessions**



*CESD-10.* The measure of depression with the CESD-10 showed no significant change pre- and posttreatment in the two groups ( $t = -1.12$ ,  $p = .29$ ), with a large variance within groups, although the mean decreased from 5.71 to 1.23 in the HT group and from 2.6 to .02 in the GPR group.

*VAS.* The weekly before- and after-VAS scores to the questions on current pain, most severe pain, and coping showed significant decrease after each treatment using the  $t$  test, but the pain intensity returned to pretreatment level before the next treatment. The means of current pain and coping decreased in both groups after the study but did not reach significance. The GPR group's perceived most severe pain decreased after the study but not significantly, although there was a slight increase in the HT group. The variation was large.

*Other.* Different practitioners were used for each of the participants. Thus, there was no way to determine whether there was a practitioner effect as has been reported in other studies (Wilkinson et al., 2002).

### Qualitative Findings

There was significant variation in the experiences of the study participants. More variation occurred in the HT group than in the GPR group.

*GPR group.* All of the GPR participants reported a general sense of overall benefit in the ability to relax. Some said that they felt more comfortable answering questions after the second session and attributed this to not knowing what to expect during the sessions. A few participants reported that they started using the GPR techniques to help them with muscle tension

outside of the study time, and one said he used it to help him go to sleep. One of the participants gained the following insight:

Not focusing on the pain is how I have gotten rid of the pain. So, if I was to do this, I probably will keep on doing this—what you showed me to do—except I won't do the lower part, my legs, because that is what hurts so, by focusing on them. It has taught me how to deal with the pain . . . not [to] think of the feet and everything where the pain is.

*HT group.* In reviewing the responses of the participants in the HT group, the following statements are reflective of the individual experience. Pseudonyms are used to refer to the participants. For the first participant, Carl, the experience focused on the feeling that his “medication really kicked in.” Carl did not attribute any effect to the HT session, even though in one session he felt pain relief past his usual medication-peak period.

For the second participant, Nick, the effect was the most dramatic, as he experienced “almost no pain—it's amazing. I feel like a whole new person.” The third participant, Sam, could not discern any effect other than “feeling heat on one of my hands,” which is where he experienced most of his pain.

One unanticipated report came from the fourth participant, Mike. Mike had an initial response of “decreased spasms” and “moved my mind to a state of silence” in the first session. In the third session, he reported that “the spasms and stuff ceased,” although he said that “tomorrow, if not before, they will be back again.” During the last two sessions, there was overt hostility directed toward the practitioner about her being paid to do the sessions even if he was not having pain relief.

Charles, the fifth participant, noted that the pain was “practically gone. It is unbelievable.” The sixth participant, Mark, felt that the treatment was relaxing but did not notice any other effects on his pain or ability to cope. His caregiver, however, did report improvement in his symptoms. The final participant, Bruce, had “a little bit” of response, but no further data were available after the first session as his practitioner failed to record the interviews for the remaining sessions.

One of the interesting findings occurred with the first participant, Carl. First, he felt a shift in how the pain felt in that it moved from one place to another in his back during the HT session. A few days after the next HT session, he had total pain relief for 6 hours

following use of a vibrator on his back. This had never happened previously. He went from having a nonoperable pain condition to being a candidate for surgery. These events cannot be attributed solely, if at all, to the HT session.

*Practitioners.* The charting style of the CHTPs varied from simple identification of the state of the seven chakras to writing on both the front and back part of the forms about what they saw, felt, or intuited. On the human outline, some used color or shading to depict the energy field and others recorded only the condition of the chakras. See Figure 4 for one of the more descriptive recordings.

The CHTPs reported in all cases that there was an improvement in the field of energy surrounding the person as the series progressed. The field is usually perceived to surround the body at about 3 feet in an egg-shaped fashion; it is believed to provide a boundary and reflects a degree of balance or stability. Many of the fields were absent or severely altered in the early sessions. These changes, however, could have reflected a personal bias in recording by the practitioner. All the practitioners who delivered the sessions felt that 6 sessions were not enough to obtain adequate results and suggested a minimum of 10 sessions.

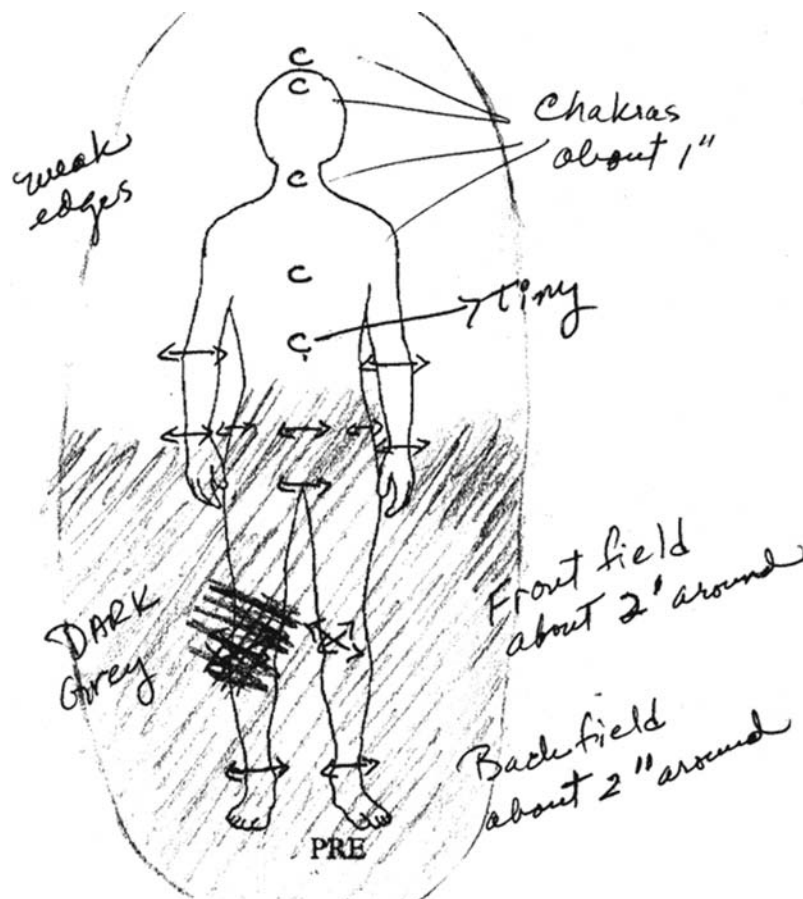
In the case of Mike, the practitioner reported being uncomfortable with the participant after he made suggestive comments to her. She noted that Mike had a gunshot injury and felt as though it had affected his energy field. She wrote the following about her experience:

After consulting with another practitioner, I was able to see that the field had exploded on impact and that his field was in fact scattered and fragmented—some of it maybe not even attached. I was aware of the violence in the field. It was a feeling of “being done violence to.” I was uncomfortable with that feeling, and it took awhile and some processing to identify that the feeling was in the field. As I entered his house, I entered his field that was filled with violence. It was as if a part of the perpetrator of the violence or an imprint of the perpetrator of the violence was there. Also, the patient had a loaded gun that he kept at his bedside. I did not feel threatened by the patient. He was open in his communication and was never threatening.

She reflected that perhaps his lack of a physical boundary to his energy field created this miscommunication. It was interesting to note that the participant



**Figure 4**  
**Compromised Energy System**



also referred to his pain as “murdering him,” a phrase none of the others used to describe their pain.

### Discussion and Recommendations

Although limited, this pilot study was able to identify a need for further research and highlights the need for more complex designs with complementary therapies. The ability to conduct an in-home study was shown to be feasible because all practitioners were able to make their six weekly visits and no participants withdrew from the study. There was a large variation between the participants in each of the groups and at times also between the groups. Overall, the HT group showed improvement on all of the measures pre- and postintervention, although they did not reach significance, which indicates that they may be

sensitive to detecting changes in a larger study. The findings also suggest that a variety of instruments may be beneficial in capturing the effects of HT. HT may be beneficial in the areas of coping, pain management, decreasing fatigue, decreasing confusion, increasing life satisfaction, and decreasing depression, but it can only be speculative at this time. A holistic approach seems to be the best way to determine the nature of energy-based therapies.

The qualitative findings help to explain some of the variation of the quantitative findings and indicate that receiving HT may be an individualized experience. All of the participants felt some benefit from the GPR intervention, but none had any decrease in pain over time. Two participants in the HT group reported significant benefits in pain relief and 1 an initial relief with return. However, this pain relief did not last between sessions. This did not follow the pattern established

in the chronic pain study by Wardell (2000); however, different techniques were used.

Using a variety of complementary methods for pain relief for those with chronic pain may be more helpful than relying on a single approach. This multipronged approach might provide a more positive experience of complementary therapies by identifying a combination or select benefits from various therapies that might provide a more acceptable degree of pain relief. Using a multipronged approach also may help decrease the disappointment that some of the participants had that HT or GPR was not helping their pain. In usual practice, one would suggest that the HT sessions might help in a variety of ways and not focus singularly on the pain experience, as was stipulated in the consenting process, thus possibly suggesting that if pain relief was not achieved, then the HT or GPR had "failed."

This study supports the work of Weymouth and Sandburg-Lewis (2000), whose study of chronic back pain used chiropractic and HT interventions, in that pain relief can occur along with other coping measures. Because it is not known how many sessions are needed for pain relief or other changes to occur, it is interesting to note that for those who experienced pain relief, the relief occurred during their first session. Having more frequent sessions might have made for a greater improvement. For participants experiencing other, more subtle changes, it often took a number of sessions for such changes to occur.

Some limitations of this study were the small sample size and the large variation in the results, which make it difficult to interpret the findings. Another limitation is the potential study bias that could have resulted from the RA providing all of the GPR sessions. Also, the use of the practitioners to collect the data pre- and postsession could have also biased the results, as participants may have wanted to give positive reports of someone taking time to be with them and attempt to help with their pain. In future studies, it might be of benefit to have an individual not involved in providing the interventions to collect this data.

The reported experiences and findings (although not statistically significant, for the most part) lend support to the need for further research on HT and/or other energy-based techniques in managing chronic pain. Furthermore, it is important to recognize that the experience of chronic pain is complex and that the use of complementary therapies may benefit the individual in a variety of ways yet to be fully understood and documented. This study only reflects a beginning understanding of this complexity.

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**Diane Wind Wardell**, PhD, RNC, HNA, CHTP, is an associate professor of nursing at the University of Texas Houston Health Science Center, where she teaches graduate students. She is also the research director for Healing Touch International, Inc., and a holistic nurse.

**Diana H. Rintala**, PhD, is an associate professor in the Department of Physical Medicine and Rehabilitation at Baylor College of Medicine. She is a veterans affairs rehabilitation career scientist involved in evaluating interventions for chronic neuropathic pain in persons with spinal cord injury.

**Zhigang Duan**, MD, MS, is a statistical analyst in M.D. Anderson Cancer Center in Houston, Texas. He has an MS in biometry and an MS in environmental health and is currently working toward a PhD in biostatistics.

**Gabriel Tan**, PhD, ABPP, is a staff psychologist for the Pain Section, Department of Anesthesiology at the Michael E. DeBakey VA Medical Center and assistant clinical professor, Department of Anesthesiology, at Baylor College of Medicine. He is a clinician-researcher with a special interest in alternative interventions for pain.