Published in final edited form as:

J Altern Complement Med. 2004 ; 10(Suppl 1): S25–S41.

Fostering a Healing Presence and Investigating Its Mediators

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Abstract

The purpose of this paper is the exploration and explication of the complex phenomena of “healing presence” and of appropriately supportive theoretical approaches to integrate emerging models for research design. Healing presence is described as an interpersonal, intrapersonal, and transpersonal to transcendent phenomenon that leads to a beneficial, therapeutic, and/or positive spiritual change within another individual (healee) and also within the healer. An integrated framework merging knowledge from diverse fields of research develops the multiple elements of healing presence, the healer, the healee's capacity for response and the healing effect as an entangled phenomenon. A conceptual systemic model is presented, and questions and dilemmas that emerge are delineated. An integrated qualitative-quantitative research design is proposed. A systemic relationship model, which includes the healer, the healee, and persons within the healee's environment is presented. The challenges are substantial, but the research questions are meaningful and worthwhile. The goal is to foster healing at bio-psycho-social-spiritual levels of the human being.

INTRODUCTION

The term healing presence implies a complex property of an individual (healer) that leads to a beneficial, therapeutic, and/or positive spiritual change. This may then lead to a self-healing transformation in another individual (healee)¹ and also within the healer. Presence has been described by Gilje² as being an elusive interpersonal, intrapersonal, and transpersonal phenomenon. Since the early 1960s, there have been attempts, primarily in the nursing literature, to define and describe presence and its importance to health care. The literature that has emerged has been more conceptual and theoretical than empirical.

In general, two dimensions of presence are described: physical and psychologic, “being there” and “being with.”³ Physical presence involves body-to-body proximity and the requisite skills of seeing, examining, touching, doing, hearing, and hugging or holding. Psychological presence involves mind-to-mind contact. To be psychologically present requires that the caregiver have skills of listening, attending to, caring, empathy, being nonjudgmental, and accepting. A third level, therapeutic presence, entails a spirit-to-spirit connection, and requires that the caregiver have skills of centering, intentionality, intuitive knowing, at-one-ment, imagery and connecting.⁴ Godkin⁵ proposes that acquisition of skills proceeds along a novice to expert continuum. Skills in sensing precede the caregiver's ability to go beyond scientific

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data. Implied in this model is the notion that healing outcomes are related to presence, and that skills of being present can be learned.

The most comprehensive and detailed framework for delineating the concept of presence is offered by Osterman and Schwartz-Barcott⁶ (Table 1; as adapted). This work is based on observations of caregivers in an acute care environment in which all patients were dependent on mechanical ventilation and many required continuous feeding pumps. Four distinctive ways of being present were noted with a discernable range of outcomes.

As explicated in this model, the four levels of presence differ in the quality of being there, the focus of energy, the nature of interaction, and positive and negative outcomes. Presence is “being there” in the context of another, physically present, yet not having any level of interaction or involvement. Partial presence is a way of “being there” in which a caregiver is physically located in the context of another and focuses their energy on a task relevant to but not directly focused on the other. The proliferation of technology in acute care environments may result in caregivers monitoring machines, minimally interacting with patients and patients feeling disconnected and isolated intrapersonally and interpersonally. Full presence, a way of “being with” in the context of another, includes psychologic as well as physical presence and is the embodiment of empathy, caring, and the use of self in face-to-face interaction. Transcendent presence is the fourth and final level. The exchange of energy between the caregiver and patient is transforming and spiritual in quality and moves beyond the interactional to the transpersonal. Presence is felt as peaceful, comforting, and harmonious, truly more than the therapeutic use of self. Transcendent presence has been achieved when a oneness is felt between caregiver and patient. For purposes of this discussion, transcendent presence may be broadened to include the condition of being physically distant and spiritually present within the quality of being there and healing intention within the focus of energy.

Some questions that arise are: What is presence which is healing? How is healing presence characterized, and what are the models necessary for further investigation? As is implied in the term salutogenesis, healing is a dynamic process characterized by individual developmental trajectories moving in a healthy direction, nested within an environmental system. Dynamical, integrated, systemic contextual research models are required,^{7,8} composed of lower order systems existing within higher order systems.

Systemic model

Figure 1 provides a conceptual model to serve as a nidus for heuristic thought in addressing healing presence. Two-dimensional representation is inherently limited in depicting a multidimensional process. The layers in the diagram represent both degree of system complexity (inner to outer or lower to higher) and, in theory, functional relationship with each other. The egg shape or embedding of one within the other reflects the interactive nature of each hierarchy of function and communication; thus, position should not be viewed as fixed. For example, the bioelectromagnetic layer likely functions with close physical proximity to living beings, could have multiple positions and just as easily be placed at the next level after physical/chemical. Similarly, elements of the nonlocal dimension likely impact all less complex layers.

The relationship of bioelectromagnetic forces and of nonlocal and higher order Universal Consciousness or supernatural forces is variably conceptualized within current literature. Structure, function, and system of operation of the bioelectromagnetic layer or field has been proposed to adhere to current physical laws, and likely more physically proximate to living organisms,⁹⁻¹¹ and the biofield.¹⁰ The biomagnetic field functions as a complex information network whose core functional attributes are coherence,¹² entrainment or coupling,¹³ and resonance, the master regulator or communicator of living systems. Others define a broader

construct, the bioinformation field,⁸ as inclusive of the bioelectromagnetic layer and the nonlocal layer and bioinformation as an entropy-reducing (*dis-order-reducing*) signal of biologic origin.¹¹

The nonlocal system, first conceptualized by the early work in “force field” or morphogenetic field,^{14,15} is now seen as a fundamental interaction^{16,17} or informational phenomenon. The nonlocal system is being validated via the effects it creates upon known physiologic and behavioral function, although its network of informational bonds, physical agents, and mechanism of operation are not yet understood.^{8,18} As an example, distant healing or intention, defined as a conscious, dedicated act of mentation attempting to benefit another person's physical or emotional well being at a distance, can alter physiologic function and influence healing.^{19,20} Healing presence is proposed to involve, of necessity, forces at all levels of complexity (Fig. 1) operating within a complex system inclusive of healee and surrounding environment.

Framework for thought

A framework is required that integrates knowledge from traditional fields of research (psychology, sociology, physical and medical sciences, and spirituality) with that which is emerging from biofield medicine research. Evaluation of healing presence may be approached via two main streams of thought:

- Measurement of physical properties
- Measurement of effects of nonphysical or nonlocal forces

Physical properties include traditional physiologic variables including behavioral responses (facial expression, eye contact, physical proximity, movement), environmental variables (smell, light, color, sound, and touch) and the non-traditional, weak bioelectromagnetic forces within and around the body.

The focus of this paper is a discussion of the nonphysical forces, their properties and measurement, and their potential impact on healing. It may be helpful to view physical properties and nonphysical or nonlocal forces as the ends of a continuum with bioelectromagnetic forces as the “transducer” or regulatory interface. The forces along this continuum may be seen as dynamically, variably, and simultaneously functioning with variability dependent on the unique nature of the healer-healee dyad (personal as well as positional) and the surrounding healing systemic environment.

In considering the elements of healing presence in an integrative manner, a systems theory approach predicts that the whole will be greater than the sum of its parts.⁷ In other words, it is possible to dissect reductionistically the elements of healing presence at an interpersonal and intrapsychic level, but the interaction of all of the elements within an intact healer-healee dyad may lead to emergent properties of that dyadic social system.^{21,22} Emergent properties are those seen in a higher order organizational level within a system, but not predicted from the properties of the lower order organizational levels (parts) that make up the larger system.²³

Theoretically, the multiple factors involved in healing presence, the healer, the healee's capacity for response, and the healing effect, may require separate assessment. As an example, in any encounter, a healer could have a strong “healing presence” leading to high levels of healee satisfaction with the interaction, yet the healee may show effects along a continuum from worsening in clinical status (deterioration) to complete cure and/or spiritual transformation. Thus, in the context of this paper, these factors necessarily evolve as an entangled phenomenon. Presentation of these psychosocial-spiritual attributes moves from those more traditionally aligned with the healer to those of the healee and the surrounding

environment, inclusive of the researcher. Assessment methods and tools for each will also be described.

ATTRIBUTES AND BELIEF SYSTEMS OF PERSON(S) THAT CHARACTERIZE HEALING PRESENCE

Much of the research to date has focused on the individual nature of the healer and the healee, the beliefs they hold and their psycho-social-spiritual traits/states. A search is unfolding for those attributes or forces that contribute to the dyadic relationship and potentially optimize or highly correlate with the process of healing, and those attributes or forces that are the core or sufficient and essential properties of healing presence. A large body of prior research drawn from individual difference psychology, psychotherapy, placebo research, social psychology, psychophysiology, parapsychology and spirituality offers a heuristic starting point for the assessment of healing presence and to integrate emerging models for research design.

Therapeutic relationship

Empirically, the health psychology research literature indicates that good provider-patient communication leads to better patient satisfaction with the provider and improved adherence to treatment,²⁴ but only sometimes to better outcomes.²⁵ Patients' expectancies of treatment effectiveness and the quality of the therapeutic alliance tend to predict clinical improvement, with outcomes mediated by patients' contribution to the alliance.²⁶ The provider's use of everyday rather than technical medical language and a more affective rather than cognitive style of communication, in both verbal and nonverbal behavior, favor higher patient satisfaction and better quality of life.²⁷⁻²⁹ Great value is placed on affective style in discussion of problems.³⁰ The preference is for medical issues to be discussed with affective quality³¹ and unconditional positive regard.³² The "ideal" physician is friendly, easy to talk to and sympathetic.³³ Various rating scales are available to quantify patient satisfaction^{34,35} and doctor-patient communication.³⁶ However, it is not clear how well these will adapt to assessment of nonphysician healers or of healers across different cultural contexts. Development and validation of new measures will likely be necessary. The therapeutic relationship is discussed more fully elsewhere in this Supplement.

At the biopsychosocial level, studies have shown that more effective communication within the therapeutic relationship includes skill at exhibiting empathy and focused attention.³⁷⁻³⁹ A major source of suffering for people is the experience of isolation, a sense of being cut off from connection. In an empathic model of care, the primary role of the caregiver is to bring people back into healing connection where they begin to reconnect with themselves and bring themselves more fully into relationship with others.^{40,41} The focus is on understanding people's patterns of connection and disconnection, one that fits well with the energy healing concept of the healer "being in resonance" and bringing the healee "into resonance or harmony."^{9,42,43}

Empathy

Whether derived from the German (*einfühlung*) or the Greek (*empathia*), empathy means, "to understand things beyond oneself." A developing consensus defines empathy as a phenomenon, which can only be understood within the dyadic or systemic relationship(s),⁴⁴ an interactive experience or state of separateness and sharing. Empathy is the ability to recognize "the other" as similar to self and makes possible the common experience of an action or emotion, embodied simulation, versus simple cognitive recognition and listening without preconception.⁴⁵ Empathy, an essential developmental task in the formation of the self/other identity,^{46,47} serves as a healing force within relationships as it reduces aggression and antisocial behavior,⁴⁸ functions to discriminate abusive from healthy relationships⁴⁹ and correlates positively with forgiveness.⁵⁰

Gallese⁵¹ puts forth a “shared manifold hypothesis of intersubjectivity” that frames the neuroanatomic and functional underpinnings for the development of empathy as an integration of cognition and emotion. Empathy can be framed as an isopraxic function, the ability to perform or act in like manner tasks of mirror neurons, which is proposed to instantiate a supramodal “intentional share space.” Functional and structural neuroimaging research consistently demonstrates activation in the area of the limbic system, left anterior middle temporal lobe, and specific portions of Broca's area during empathic tasks, as well as integrated tasks whether observed, self-performed, or heard.⁵² Measures of assessment reflect the evolution in the concept of empathy from the individual to the contextual. These include paper-pencil tasks of subjective self-knowledge⁵³ and response⁵⁴⁻⁵⁷ or the experience of felt-empathy by the receiver.^{58,59} Videotaped, blinded rating of real-life interactions^{60,61} is perhaps the measure that is most reflective of the bidirectional nature of empathic behavior.

Compassion

A qualitative study of Buddhist nuns found that their effectiveness as healers derived largely from healees' perceptions of their wisdom, compassion, and ability to inspire confidence in the healees.⁶² Compassion is being open to and moved by the suffering of others within the perspective of a desire to ease their suffering, offering patience, kindness, and nonjudgmental understanding, inclusive of the awareness of human imperfection including oneself.⁶³ Compassion requires empathy and seeks to achieve good in the context of suffering.⁶⁴ When achieved within, a state of equilibrated mental perspective or mindfulness⁶⁵ exists and thus is available to be experienced by others. There is the necessary quality of “mental space”⁶⁶ which allows recognition of the inner state of oneself, without becoming over-identified, and being able to experience that in the context of the broader human experience including the other. A 26-item, 5-point Likert Self-Compassion Scale⁶⁷ has been developed, well-validated, and correlates neutrally with narcissism and negatively with mental health states of depression and anxiety.

Charisma

Charisma of a healer is another interpersonal quality pertinent to healing presence.⁶⁸ A charismatic presence⁶⁹ includes (1) an ability to communicate visionary content with (2) an inspiring, motivational style (e.g., a transcendent healing event via metaphorical interpretation or ceremonial enactment⁶⁸). Prior social psychology research on charisma may help put into context the real-world observation that some healers exhibit a selfless, other-oriented, socialized benevolence, whereas others exert healing effects within an intensely narcissistic personality style.⁷⁰⁻⁷² Inherent in the concept of healing charisma is an imbalance in the relationship between healer and healee.^{73,74} Some such healer-leaders foster the development of the individual healee as an autonomous and evolving being, whereas others expect complete passivity from their healees in following their directives.^{73,75} Individual preferences of healees for different interpersonal styles of charismatic healers (e.g., using a directive versus a shared decision-making approach) could affect the perceived experience and impact of healing presence, just as in provider-patient relationships.^{26,30,76,77}

Spirituality

Spirituality, belief in a power apart from one's own existence, implies a connection with a universal force transcending everyday sense-bound reality. Spirituality defines the search for purpose and meaning.⁷⁸ The impact of the healer's spiritual beliefs on healing presence and on the healee's experience of healing, as well as the interaction of the spiritual beliefs of the healer and healee, are areas of investigation that have received scant attention in the literature. Does a healer's spirituality impact their capacity to be a “healing presence”? In Native American⁷⁹ and ancient cultures and practices (Tibetan^{80,81} and Ayurvedic⁸²), it is common for those who

are physically ill to seek spiritual healing from an identified practitioner, the spiritual sage identified as a healer. Contemporary healing therapeutic disciplines (Healing Touch,^{83,84} *reiki*,⁸⁵ Johrei) have as foundation the belief in healing by a Supernatural Force or God and his/her efficacy as healer.⁸⁶ Osterman and Schwartz-Barcott⁶ describe full presence as being transcendent in nature and quality and identify the healer under these circumstances as possessing metaphysical beliefs, being centered and drawing from universal energy, and being oriented beyond the here and now, thus being capable of transforming reality.⁸⁷ While not yet empirically tested, this model or theory clearly implies that spiritual awareness and development are critical for full or transcendent presence.

Research on spirituality thus far has tended to focus more on the healee than on the healer, on identifying dimensions or domains of spirituality, differentiating spiritual beliefs and practices from religious beliefs and practices and examining ways in which spirituality and religiousness relate to physical and mental health outcomes. The literature on the impact of spirituality/religiousness on health outcomes, summarized by Koenig et al.,⁸⁸ Levin et al.,⁸⁹ and Seeman et al.⁹⁰ has focused predominately on the impact of one's own spiritual, religious beliefs and practices on one's own health and wellness.

Rigorous investigation of the spiritual states of healers as well as healees requires robust instruments that measure spirituality, spiritual beliefs and spiritual states. A widely used and validated standard set of measures is not yet available.⁹¹ Key domains having strong conceptual, theoretical or empirical connection to health outcomes include: daily spiritual experiences, meaning, values, beliefs, forgiveness, private religious practices, religious/spiritual coping, religious support, religious/spiritual history, commitment, organizational religiousness and religious preference. Examples of instruments used to measure these domains include: the Spiritual Well-Being Index,⁹² Intrinsic/Extrinsic Religiosity Scale,⁹³ the Spiritual Involvement and Beliefs Scale,⁹⁴ and the Index of Core Spiritual Experiences.⁹⁵ There are additional domains that one would want to measure including spiritual maturity, mystical experiences, compassion, hope, prayer and spiritual integration. These variables have not been studied in relation to health and lack empirical documentation.

The characteristics of the healer that contribute to their ability to be fully present are important in understanding the concept of healing presence. As described above, when the healee experiences the healer as having empathy, compassion or charisma that might at some level contribute to their perception that the healer has a "healing presence," it may facilitate the healee "coming into resonance" with those same qualities and thus serve as a fulcrum for self-healing transformation. However, examining presence in this way is limiting and implies that a "relationship" exists to the extent that the healee has experienced these characteristics in the healer. Thus, there is a need to examine attributes or forces that characterize healers and healees being physically distant from one another.

Intention

Intention, "a mental state directed toward achieving a goal,"⁹⁶ of the healer in many healing disciplines, is a crucial component of the healing process,⁹⁷ and the sole component in Distant Healing Intention (DHI), well discussed by Schlitz et al.⁹⁸ Unconditional positive regard and focused attention, "a mode of selecting objects of perception, thinking, and awareness"⁹⁸ or selective focusing of consciousness and receptivity, is well-recognized as an important attribute within the therapeutic relationship. It is a frame of mind rather than an orientation toward an action as in intention. Healing by distant intention may be done by practitioners who may or may not be recognized as spiritual healers or for whom spiritual attributes may or may not be identified. DHI is not limited by space or time, and within research is evaluated by the effects created within the healee. Every research study involves more than one person; thus, outcome measures likely reflect more than one set of intentions or entangled sets of intentions. Further

complicating the impact of intention upon a healee, are expectancies of the healee, especially if what is being measured for expected change is known to the healee. Beliefs and intentions of neither investigator nor study participants remain constant over time. Ways of measuring intention and objective measures of what is going on in the minds of healers are needed.

A suggested study design⁸⁶ is one of interdependent, changing variables including nonlocal correlations, and not the traditional cause-effect or unidirectional⁹⁹ models. Entanglement theory¹⁰⁰ (generalized quantum entanglement), arising from complexity theory and quantum mechanics, may pose a critical paradigm for understanding therapeutic efficacy or lack thereof. Entanglement is proposed as a “physical” mechanism for information transfer between macrolevel and microlevel structures used by living systems in which the defining condition or relationship is complementarity of description. That is, structures or elements behave as a whole, observation or measurement on one part of the system has an effect throughout the system¹⁰¹ and change in one part of the system results in instantaneous change in the other to ensure complementarity. Reality does not exist independent of the observer, and precise, simultaneous measurement of all variables or elements is impossible, the noncommutability of observables. This phenomenon, established within quantum physics (microlevel), is believed to hold for clinical application within complex living systems (macrolevel). Thus, in healing functioning as a complex system, the beliefs and intentions of each part of the system—healer, healee and environment—are variably and uniquely defining, crucial to understanding the whole, the entanglement model of healing.¹⁰²

Transpersonal communication

Donovan has demonstrated in college students that greater levels of empathy and charisma, two social psychology constructs, together predict scores for telepathy, a presumptive parapsychological (psi) construct.¹⁰³ Telepathy is defined as a direct transference of thought from one person to another without using the usual sensory channels of communication (i.e., a manifestation of boundary-free, transpersonal oneness in a metaphysical or psychic sense). Skepticism versus true belief in paranormal phenomena may be assessed using specific scales.^{104,105}

Recent electroencephalographic research has shown that some pairs of people who are separated in terms of all possible sensory means of communication nonetheless can exhibit time-locked changes in brain activity consistent with some form of transpersonal, nonlocal event¹⁰⁶ as referenced in the discussion on empathy and intention. Studies also suggest communication of electrocardiographic signals between persons in a sincere caring relationship, at close distance without physical contact.^{13,107} Thus, a more systemic view of the evidence is that telepathy, related psi events and non-physical communication reflect interactive processes at the higher organizational levels of the system, a nonlocal phenomena and above (Fig. 1). That is consisting of emergent properties that are not predicted from the separate component elements at the lower, social-interpersonal or bioelectromagnetic levels of systemic organization.

Healee psychology and biology

Healing presence may emanate from the healer, but it requires some level of interaction with the healee for its ultimate effects on health and well-being and likely for perception. The implicit positive goal of interaction with healing presence is to mobilize or inspire the healee to initiate self-healing processes.^{1,40,41,89} Empirical evidence from the individual difference psychology literature suggests that the personality trait of absorption may favor greater capacity of the healee to detect and even respond to healing presence and of the previously described healer capacities.

Absorption, a disposition or openness for having episodes of “total” attention that fully engages one's representational resources, leads to a heightened sense of involvement and imperviousness to distracting events (e.g. the ability to lose oneself in an experience such as a sunset or a movie). It is partly a genetically determined trait,¹⁰⁸ and higher levels of absorption correlate with greater hypnotizability, intrinsic religiosity,¹⁰⁹ psychic experiences^{110,111} and complementary medicine utilization¹¹² as well as with better outcomes from meditation,¹¹³ relaxation and guided imagery,¹¹³⁻¹¹⁵ and homeopathic treatment.¹¹⁶ In adults, the Tellegen Absorption Scale is a validated means of quantifying trait absorption.¹¹⁷ Psychophysiologic studies have shown that high versus low absorbers can selectively attend to task-specific stimuli while suppressing brain responses to task-irrelevant stimuli.¹¹⁸ The empirical prediction would be that high absorbers will perceive empathy, charisma and healing presence in healers better than will low absorbers.¹¹⁹ If a mediating element of charisma is the ability of the healer to inspire visionary imagery of self-healing,⁶⁹ then the testable hypothesis would be that higher absorbers would also exhibit greater healing effects in response to a healing presence than would low absorbers.

Optimism-pessimism

At a simpler level of psychologic traits, prior studies have demonstrated that greater levels of dispositional optimism¹²⁰ and positive affect¹¹² are associated respectively with better coping with chronic illness and increased perceived effectiveness of conventional or complementary medicine treatments. Notably, a distinction in predictions for absorption as opposed to optimism in the effects of healing presence is that absorption might lead to objectively measurable better outcomes (greater healing *per se*), whereas optimism may lead to subjective perceptions of better quality of life, with or without objective change.¹²¹ Measurement of each construct, optimism¹²² and positive affect,^{123,124} is readily accomplished with brief validated scales.

Expectancies and beliefs

Placebo effects and their cognitive mediating mechanisms, especially with regard to the expectancies of the healee and others in the surrounding caring environment in the context of healing presence, requires careful consideration.¹²⁵ Expectancy is contextual, individual, dyadic or intimately systemic and sociocultural,¹²⁶ and is likely governed by experience and relevancy within these levels of interaction.¹²⁷ Expectancies have variable impact upon health outcomes that in some contexts may be significant.^{128,129} Contemporary research on response shifts suggests that placebo responders may change their perceptions or internal anchors/definitions of health. In response shifts over time, the person's internalized standards for evaluating the same symptom or condition and/or the conceptualization of a target construct such as overall health may change.¹³⁰⁻¹³²

When treatment-specific expectancy (E_{TX}) is concordant with the intervention, the degree and direction of change in health outcomes is enhanced and may be the primary determinant.¹³³ Introduction of any degree of discordance, as in the element of uncertainty in double-blind placebo trials, alters the outcomes.¹³⁴ In the research in interventions that impact the whole organism and activate the organism's regulatory and self-healing capacities, expectancy may play a powerful role. Alteration of context, such as double-blind versus naturalistic or outcomes-based research models, may alter expectancy.¹²⁸ Global expectancy (E_G), expected improvement without regard to treatment, may be correlated with treatment-specific expectancy¹³⁵ and is closely associated with the dichotomous trait of optimism-pessimism. Thus, in research design, E_{TX} may include E_G and needs to be compared to the expectancy for any other intervention used, including the control (E_{CX}).

Recent psychophysiological studies have shown that certain types of electroencephalographic patterns of placebo responders differ from those of active medication responders, at least for patients with major depression.^{136,137} Thus, the subjective mood phenomenology may appear indistinguishable, but the objective physical manifestations of placebo versus true active intervention may diverge in the brain. If this work extends to other conditions and other interventions,¹³⁹ it raises the possibility that Benson's conceptualization of placebo-induced effects as "remembered wellness"¹⁴⁰ may have a different biologic substrate than do medication-induced effects. Assessment of brain electro-physiology of the healee during exposure to a healer with healing presence versus a sham control may help delineate different patterns of bio-psycho-social-spiritual responsivity in various individuals.

Experimenter effects

Finally, an assumption inherent in the present paper is that researchers can and should investigate the nature and effects of healing presence. Caveats exist. One example is the Hawthorne effect where human beings change when they are "watched."¹⁴⁰ There is current, growing evidence that putting certain healing phenomena into an experimental context (i.e., creating a closed system for observation), may in itself alter the process.¹⁴²⁻¹⁴⁴ This appears to be especially true for a phenomenon such as healing presence, in which not only local, but also nonlocal or transcendent mediators may play a role, such that the beliefs of the experimenters could influence study outcomes.

In psychology, for example, Rosenthal¹⁴⁴ long ago demonstrated the interpersonal Pygmalion effect, in which the experimenter made a one-time suggestion to teachers that certain, randomly-chosen (the random selection was not known to the teachers) students would blossom. With no further experimenter-teacher or experimenter-student interactions, the one-time suggestion led to measurably greater academic improvements in the identified students than in their peers 1 year later. In parapsychology, Schlitz and Wise-man have shown that the same remote viewing protocol results in positive evidence for nonlocal effects when organized by a believer in psychic phenomena, but in negative evidence for such effects when organized by a skeptic.¹⁴⁵⁻¹⁴⁷ Thus, both lower and higher order levels of system organization may mediate the impact of experimenter behavior and belief on study outcome, thereby necessitating assessment of these potentially relevant factors in studies of healing presence.

Surrounding Physical Environment

Lower levels of system organization such as physical-chemical and the toxic and esthetic, ¹⁴⁸⁻¹⁵² built and natural¹⁵³⁻¹⁵⁵ characteristics of the sensory environment merit evaluation for their impact on healing presence. Human beings may maintain an "ecological unconsciousness" that when exposed to natural surroundings is activated and provides benefits for physical and mental health.¹⁵⁶ Improved recovery from surgery,¹⁵⁷ stress,¹⁵⁸ enhanced attention,¹⁵⁹ and decreased distractibility and enhanced inner calm¹⁶⁰ have all been demonstrated with exposure to natural settings. If subtle energetic interactions contribute to healing, then careful assessment of the background electromagnetic environment during a study is also essential.¹¹

QUESTIONS FOR CONSIDERATION

Attributes of healing presence, as highlighted above, may be not only mutually exclusive or even contradictory, but also variably operative within a specific context. Thus, the following questions are presented for consideration in developing an approach to research.

Relationship

- How do presence and relationship differentially and synergistically contribute to healing?
- Is healing presence intrinsically relationship-based and dependent on the dynamics of the healer-healee dyad rather than on either person in isolation?
- Can healing presence occur in the absence of a relationship?
- Does healing presence, similar to charisma in certain human beings, have both positive and negative elements?
- Are there attributes or forces within healer or healee that are core or sufficient and essential, and others that are correlative or facilitative of healing presence?
- Conceptually, how do the healer and healee function and what does this reveal about terminology?

Healer: sender, conductor, “in resonance with . . .”

Healee: receiver, “coming into resonance with . . .”

- Who exudes healing presence? Is it a native ability or learned or both?

Context and system

- Is healing presence universal or social/cultural context-dependent?
- In a practical sense, to what extent do individual caregivers and/or members of a social support network with different degrees of healing presence contribute to the net outcome of a healee or healing presence?
- What influence does observation of the healing process exert on healing? Can an experimenter, who is a believer, versus a skeptic, of the healing potential of a healer, a healee, and/or an intervention, influence the outcome in a research setting?
- Are there levels or degrees of inter-relatedness among the components within the healing environment or system? What is the relationship between the physical properties of healing presence (including the biofield or bioelectro-magnetic energy) and the nonphysical or nonlocal forces (measured via their effects)?
- In the various healing traditions and therapies (prayer, Therapeutic Touch™, shamanism), is healing presence unique or characteristic for each, universal or both?

Spirituality

- Does spirituality contribute to healing presence, the capacity of the healer to “be present” or the healee to perceive/receive, and if so how?
- Is there an interaction between a healer and healee's spiritual beliefs and does this have an impact on the health outcomes of either?
- Is healing possible in the absence of spiritual beliefs on the part of the healer and/or healee?
- What does knowledge about healing presence reveal about or how does it relate to Universal Consciousness or Ultimate Creative Force?
- Are the belief systems and attributes of person(s) that characterize healing presence, as discussed in this paper, the determiners of healing or is it the Ultimate Healing Presence and/or coming into resonance with or being open to that Presence?

Intention

- Does healing occur without conscious awareness of being a healer or healee? If so, how do we conduct that research (as informed consent necessitates awareness) and what does that tell us about the nature of healing?
- Is healing intent necessary for healing presence? Does neutral-intentioned physical presence, “the superficial act of being there,” function in some circumstances or at some level as sufficient for healing presence? And if so, for whom and under what conditions?
- In research design, how do we deal with negative intention? Does ill or mal-intent create dis-ease or illness or nonhealing?¹⁶¹

Dilemmas encountered in research

Given the nature of healing presence, as discussed above, naturalistic settings are required within research design. This poses a myriad of challenges, which include the following:

- “Too much else going on”: Health care professionals, healers, and healees and those within their significant systems are actively engaged in their routines of care and living, are often overloaded and overworked, and see something unknown as of lower priority to divert time and energy away from “necessary” therapies or tasks, in order to consider an unfamiliar intervention or to deal with potential risks or unknowns.
- Complexity of outcome measures: The impact of the non-physical forces and those therapies that focus upon their use for healing, is whole-person and often more gradual and incrementally subtle. Thus change in outcomes may be more broadly effected and more difficult to measure than the dramatic or immediate changes expected by more focused interventions (e.g., pharmaceuticals or surgery).
- “Catch 22”: The acknowledgement of any efficacy for a dimension of function (expectancy, intention, prayer) that is not honored nor rewarded within a health care system (e.g., nurses within a busy intensive care environment) can be seen as threatening both personally and professionally. The separation of mind, body, and spirit by our health care system has had powerful and at times subtle impact. Health care personnel may truly believe that what they think about a particular therapy, “is it going to work or not,” has nothing to do with their work or the progress of a patient whether the intervention be a new drug, an energy healing modality or harp music during recovery from surgery.¹⁶² Data abounds to show the potential power of intention to affect the outcomes of research studies^{163,164}—whether the subjects be inanimate entities,¹⁶⁵ animals^{166,167} or human beings.¹⁶⁸
- Personal challenge: To acknowledge that our personal state of being, our whole being or our healing presence has an impact within a healthcare setting is much more demanding than the view that the tasks completed are the real medicine.
- Research team demands: Study within naturalistic settings must begin “where the system is.” This requires a great deal of acceptance, respect, flexibility and compassion for those within the system. The process of conducting the research study needs to alter as little as possible the system as a whole, and learn about healing within a system before trying to actively change the system. The very act of introducing an experience of healing (the healer-healee dyad) within a system (family, medical office or hospital unit) induces change. A helpful point of view for communication is use of the healing experience to accomplish traditional medical goals for the subjects/patients, often goals that can be shared.

- Cost in time and money: To address the dilemmas that arise adequately, may indeed require more resources than more traditional or simplistic designs.

Proposed research methods and design

An integrated qualitative-quantitative research model is an appropriate and/or necessary beginning. Focus groups and content analysis are particularly important as communication tools in design: formulation of the healing procedure; conceptualizing the pertinent nonphysical forces to be assessed; and planning implementation.

Choose a population and a system that are in an “ill” or unstable state, or in need of healing, to demonstrate efficacy of healing presence. Some degree of instability provides a more sensitive target for measuring effects of the subtle or nonlocal forces¹⁶⁸ (e.g., healing intention, expectancy), that are operative as part of healing presence. The selection of subjects within the continuum between inflexibility (death or total order) and chaos, rather than those who are at the extremes of “no place to change.”

A systemic relationship model evolves within the process of design. It serves to focus upon the important aspects for assessment from each element within the healing environment. A systemic relationship model includes the healer and healee and those persons within the healee's environment who may or may not lend a healing presence. A theoretical framework for the healee's environment includes:

- Persons who are intimately related, genetically or by marriage, and are influential intentionally
- The most physically close persons in their living or in their healing space
- Persons who are influential intentionally but distant physically
- Persons who are distant physically but intentionally influential for the intimate person (s)
- The investigator(s).

The model in Figure 2 depicts a system for a research study of an energy healing therapy in a pediatric inpatient setting.* Those relationships that are operational at all levels (physical, intentional, caretaking or intimate) are depicted by solid lines, and those that are operational at one or two levels, by a variety of uniquely significant noncontinuous lines.

A framework for assessment of nonlocal/nonphysical forces (belief systems and psycho-spiritual attributes) of those within the healing environment, the healer, the healee and others within the healing environment (including the experimenter), may then be constructed. Factors to consider include:

1. Relationships of the persons within the system being studied govern the prioritization of measures obtained and upon whom. For example:
  - The use of prayer (or other related distant healing intervention) by a child's mother may have a more powerful effect on the healing of that child than the use of prayer by the nurses caring for the child.
  - The use of a nonconventional energy healing therapy as the intervention may be unfamiliar to or outside the worldview of some and thereby influence expectancy. This may suggest measurement of Openness,¹⁶⁹ the personality factor most correlated with the willingness to try nonconventional therapies,

*McDonough-Means S. Efficacy of healing touch in stressed neonates. NIH R21 AT000734-02. Data collection in process.

and Absorption¹⁷⁰ in the healee or those who are influential within the healee's system.

- When healees and healers are physically present with each other, assessment of empathy and charisma may be more germane than spirituality and parapsychological attributes when healing across distance.
  - It is important that those who are operative within like levels in relationship to the healee be assessed along similar dimensions and with identical scaling methods to allow for comparisons.
2. Whole system change is important if healees are being studied over time. For example, belief in the efficacy of a particular healing intervention by those in the environment may shift dramatically throughout the period of a study, and thus exert a differential effect upon the outcome measures via expectancies. Obtaining pre-post length-of-study measures of belief systems from those in the healing environment would be helpful.

The following is an example of such a framework:

Attitudes, general: World-view or disposition and psycho-spiritual traits and states; attitudes toward the specific (or related) intervention being studied.

Attitudes, specific: Toward both the therapeutic intervention and the standard of care (SOC) or control for the condition being treated/studied.

Prior Experience: With SOC, with the specific (or related) therapeutic intervention being studied and with the condition being treated/studied.

Belief in Efficacy, general: Of SOC or control and of the therapeutic intervention. Relative efficacy of therapy may be expressed as $E_{TX}-E_{CX}$ or as $\% = E_{TX}/E_{TX}+E_{CX}$.

Belief in Efficacy, specific: As above, but for each subject's condition paired with assessment of illness severity. Global belief in efficacy (E_G) specific to each subject, that is expected improvement without regard to treatment (which may reflect rater's optimism), may be embedded within treatment specific expectancy E_{TX} . Thus subject specific expectancy (E_S) = $E_{TX}-E_G$.

Assessment of benefit: Perceived clinical progress of the condition being studied and the whole-person at the end of the study and attribution of cause and risks. If raters are blinded to group assignment, obtain rater's group assignment guess with confidence rating, to assess bias of this rating.

The questionnaire is the most common method of assessment for intra-personal, non-physical attributes or forces. The format and scaling methods need to match the state of the rater and the overall purpose of the content. The 100 mm¹⁷¹ visual analogue scale (VAS) has been widely used and is well suited for capturing subjective ratings.¹⁷²⁻¹⁷⁴ In the ongoing study,* energy healers were asked to choose the scaling method for their clinical assessment of the subject and for rating energy field descriptors. They chose the 100 mm VAS over a Likert or numeric analog scale as more compatible with their "altered state" (i.e., meditative, intuitive, and simultaneous versus linear and quantitative). For similar reasons, the wording of questions was changed from "How ill is . . . now" and "How much stress does . . . have now" to "What is your overall sense of . . . illness now" and "What is your overall sense of . . . response to stress now." Questions which provide more holistic and positive ratings of subjects are desirable (e.g., how "well" versus how "ill" is . . . or a rating of "overall sense of well-being over . . . [time period])."¹⁷⁵

Focused outcome measures, both behavioral and physiologic, are traditionally chosen to reflect the effects of healing presence upon the healee or system. They need to reflect both immediate (phasic) and accumulative or long-term (tonic) change. Behavioral change or interaction during the healing process may be obtained by videotaping with later blind rating utilizing a standard observational rating system. This may serve to reduce the complexity of the entangled intentional expectancy environment. Not only do behavioral parameters have a relationship to chosen biomarkers (physiology), but they also reflect regulatory capacity and have a response to healing presence.¹⁷⁶

Physiologic variables or biomarkers that reflect regulatory capacity are excellent choices and particularly critical to research in healing in view of the proposed model of the biofield functioning as the master regulator. Regulatory capacity, reflected by a gamut of behavioral and neuroendocrinologic responses to stimulation, has species-specific as well as individual characteristics to an expected developmental sequence.¹⁷⁷⁻¹⁷⁹ This may be affected over the long-term by separation and loss, that is the absence of presence.¹⁸⁰ Data analysis then needs to include measurement of individual trajectories^{181,182} in addition to single or averaged group values. Some examples to consider are:

- Electroencephalography (EEG) can be used to spot enhanced coherence and balance or frequencies that reflect “altered or healing state” (low alpha waves, 7.8-8.0 cycles per second)¹⁸³⁻¹⁸⁵; and as a measure of dyadic transpersonal, nonlocal information transfer or force (as above).
- Electrocardiograph(ECG)-EEG can be used to show enhanced intrapersonal coherence with heart-centered attention or mindfulness,¹⁸⁶ possibly reflective of healing, increased capacity to heal or the mindful state in a healer.
- Use ECG-EKG to reflect interpersonal, nonlocal communication (as above)
- Cardiac vagal tone, expressed as an index (Vna)¹⁸⁷⁻¹⁸⁹ and controlled by the myelinated vagus, reflects the capacity for heart rate variability. Within normal parameters, the greater the amplitude of oscillation, the healthier the individual and the greater the capacity to respond to stress or other stimuli. The myelinated vagus is directly linked to the cranial nerves that support affective response and is proposed as foundational to the emergence of love and intimacy.¹⁹⁰ Cardiac vagal tone index has been recommended as a uniquely applicable outcome measure in touch research.¹⁹¹
- A battery of measures to gauge allostatic load, “long-term effect of physiologic response to stress,”¹⁹² may be used to profile recovery or healing and includes: blood pressure; overnight urinary cortisol; waist-to-hip ratio; high-density lipoprotein (HDL) to total serum cholesterol ratio and dehydroepiandrosterone (DHEA) sulfate.
- Neuro-immune-endocrinologic measures have striking differences in and interactions with psychosocial factors relative to vulnerability and resilience in health.^{176, 193-195} Positive personality traits and coping styles engender positive emotions, which act directly via neuroimmunoendocrine pathways and indirectly via health behaviors to positively impact health outcomes and healing. Attendance at religious services is associated with lower levels of interleukin-6 (IL-6), the primary proinflammatory cytokine.¹⁹⁶ Positive social relationships and disclosure of stressful events to another^{197,198} have been shown to positively impact immune function. The limbic-hypothalamic-pituitary axis (L-HPA) has an expected developmental sequence and characterizing individual trajectory.¹⁹⁹ In infants and children younger than 5 years of age, the cortisol response system is powerfully buffered by the presence of “mother,” a secure relationship with an attachment figure, a healing presence.²⁰⁰

- Intracellular Ca^{++} may be used. Bioenergy from a healer's hands has been shown to upregulate intracellular Ca^{++} and reduce the cellular response to stress.²⁰¹

Whole-person outcome measures

When the focus of research outcomes of healing presence is the healee as a whole person, the reliance on disease-specific or organ-specific outcome measures constitutes valuable, but incomplete, assessment.⁸⁵ The healer and the treatment may catalyze a continuum of changes that are multifactorial and multidimensional and often subtle and accumulative or progressive. Measurement of multivariate, global outcomes with appropriate statistical analytic tools becomes necessary.¹⁷⁵ Multidimensional scales such as the Functional Assessment of Chronic Illness Therapy (FACIT), which can assess bio-psycho-social-spiritual status in a coordinated set of modules, may be useful.^{202,203} One item, often visual analogue, global rating scales of health²⁰⁴ and well-being¹⁷⁵ can capture the integrated overall outcomes that separate dimension-specific questionnaires may miss. Measurement of the degree of positive well-being, in addition to the reduction of negative conditions (e.g., diseases), is possible with some available instruments for mood and positive states of mind.^{126,205,206} This may also be reflected by traditional measures such as disease incidence and complications, medications, utilization of health care resources including length of stay, growth, and participation in ordinary life functions. These data, although broad, are seen as acting as interactive variables and avoid the bias of premature focus upon predetermined, more focused outcomes: "The key is not found under the lamp simply because that is where the light is."

CONCLUSIONS

In summary, proper study design within a systems theory context requires comprehensive consideration of possible mediating and/or confounding factors at all levels of organization from the universal consciousness to the physical plane. For example, the possible implications of a transcendent model for healing presence together with the believer-skeptic divergence in experimental outcomes are that researchers must assess the beliefs of not only the healee, but also of his/her entire provider and personal social network. All participants' levels of spiritual beliefs and experience are also relevant. The impact of the nonphysical forces within any environment (e.g., expectancy, intention and attention) pose significant methodological issues for the design, not only of healing research but also of all allopathic empirical research studies.²⁰⁷ Failure to be comprehensive in study design and selection of independent and dependent variables for investigation of healing presence is likely to produce conflicting and confusing data from one study to the next. The challenges are substantial, but the research questions are meaningful and worthwhile toward the goal of fostering healing at bio- psycho-social-spiritual levels of the human being.²⁰⁸

Acknowledgments

Supported by National Institutes of Health R21 AT00734, K24 AT00057, and P20 AT00774

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FIG. 1. Conceptual systemic model. _____, traditional forces and lower levels of complexity; -----, nonphysical forces and higher levels of complexity; - • - • - •, likely to be physical forces and regulatory interface; intermediate levels of complexity.

FIG. 2. Healing presence contextual relationships diagram. _____, physically present, predominately traditional lower level forces (the darker the line, the more influential the force is); - - - - - , influential at least physically and likely to be also bioelectromagnetically; may also be influential nonlocally (the darker the line, the more influential the force is); ..... , primarily influential nonlocally, may at times be physically present (the darker the line, the more influential the force is).

Table 1**Osterman and Schwartz-Barcott Presence Framework**

<i>Characteristics of presence</i>	<i>Presence</i>	<i>Partial presence</i>	<i>Full presence</i>	<i>Transcendent presence</i>
Quality of being there	Physically present in context of another	Physically present in context of another	Physically present (there) - physically attending behavior, eye contact, leaning toward Psychologically present (with) - attentive listening behavior	Physically present Psychologically present (metaphysical beliefs) Holistic
Focus of energy	Self-absorbed	Objects or tasks in environment which are relevant to the other individual but none of the energy is directed at the other	Self/Other (focusing on another influences a reciprocal response)	Centered-(drawing from universal energy)
	Personal, subjective reality	Mechanical/technical reality	Present oriented (here and now) anchoring in present reality	Subject/subject leads to oneness Transcending and oriented beyond here and now; sustaining while at the same time transforming reality
Nature of interaction	No interaction; self-absorbed, intrapersonal encounter	Interaction with part of the other encounter	Interactive; essential communication; boundaries-role constraints; professional relationship dyad; caring	Relationship; high degree of skilled communication; role free; human intimacy/love; humanistic caring, no boundaries; monad relationship