

IDEAS FOR THE USE OF HEALING TOUCH
IN DYSTHYMIC DISORDER AND MAJOR DEPRESSIVE DISORDER

by

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DEDICATION

This report is dedicated to my mother. I was honored to support and help her to transition peacefully through the dying process by giving her energy treatments. That complex, important time not only strengthened me and deepened our bond but I believe it supported her as well. The experience was difficult yet invaluable, a life lesson I will always remember.

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ABSTRACT

Mental health is one of the ten leading indicators of Healthy People 2010. Approximately twenty percent of the United States population is affected by mental illness each year. Dysthymia, which is a subclinical depression, is frequently undiagnosed. Depression is expensive. It increases the cost of care for other chronic problems.

Dysthymia is explored along with healing touch, which is a non-invasive bio-field energy treatment. Healing touch applies the work of nursing theorist Martha Rogers and is consistent with her conceptual model the Science of Unitary Human Beings. It is recommended as an adjunct treatment for depression and dysthymia. Although the research focuses on depression it is applicable to dysthymia.

Chapter One

In this chapter the background, problem and purpose of the project are presented. Current thought in medicine does not incorporate energy work or Martha Rogers' Science of Unitary Human Beings Theory into the treatment of dysthymic disorder (DD).

This report will focus on the Psychiatric Mental Health Nurse Practitioner (PMHNP), an advanced practice nurse, incorporating Healing Touch (HT) treatments as part of a protocol for the treatment of DD, a mental illness categorized in the DSM-IV-TR Manual. A life long dysthymic disorder can develop into a major depressive episode when severe stressors are superimposed on the chronic dysthymia. The author's intent is to explain the importance and effectiveness of HT and to illustrate how this energy modality can complement traditional approaches in the management of dysthymia. In no manner does the author suggest that HT replace conventional methods of treatment. Psychiatry and mental health combined with HT will be presented as a powerful combination.

An anecdotal report is that the author of this manuscript, an HT practitioner who has completed the HT program, has given clients with depression treatments with positive feedback of increased relaxation and decreased anxiety. These treatments were administered for a fifteen to twenty minute period on an in-patient mental health unit and were sanctioned by the attending psychiatrists who noted their patients reported positive results of feelings of relaxation and decreased headaches.

Background

Psychiatric Mental Health Practice. Along with the nursing focus on full care provision ranging from mental health promotion to illness rehabilitation, the Psychiatric Mental Health Nurse Practitioner (PMHNP) role also involves interventions which encompass psychobiologic diagnosis and treatment. In addition, emphasis is placed on psychoeducation for these patients and their families to promote mental health and prevent subsequent mental disorders.

The PMHNP can function in a variety of settings particularly outpatient behavioral managed care centers where short-term therapy is the model. In most settings today psychiatric nursing does not have the luxury of providing long-term therapy to patients whose insurance will cover only a minimal amount of sessions. Many acute care psychiatric inpatient units have an average length of stay of seven days. The advanced practice psychiatric nurse must become cognizant of the major changes in the practice settings of today and adapt programs of psychoeducation to the short-term model. PMHNPs must also combine psychiatric and physical diagnosis skills when caring for patients.

The PMHNP is educationally prepared with a skill set to perform psychotherapy and diagnose diabetes or hypertension in a depressed client. The PMHNP may diagnose somatic delusions or pain associated with tendinitis in a schizophrenic client. Thus the PMHNP offers an important role in advanced practice psychiatric nursing.

Depression

Mental health is one of the ten leading indicators of Healthy People 2010 (Healthy People). Approximately 20 percent of the United States (U.S.) population is affected by mental illness each year. No one is immune; it crosses all barriers of race, religion, economic and educational status. More than 19 million adults in the U.S. suffer from depression, the leading cause of disability and the cause of more than two-thirds of suicides each year.

Depression is a grossly misunderstood illness, not a weakness, and the associated stigmatization often prevents those with it from seeking professional help. Depression is often associated with other medical conditions such as cancer, diabetes, and heart disease as well as anxiety and eating disorders. It increases the cost of care for other chronic problems. In 1996 the total estimated direct and indirect cost of mental illness in the U.S. was \$150 billion.

Depression affects all ages but adults and older adults have the highest rates of depression, especially those with coexisting medical conditions. There are additional costs of treating common chronic conditions when depression is not recognized. Depression increases the cost of care for other chronic problems. Major depression affects twice as many women as men. Women who are on welfare, unemployed, less educated and from certain ethnic populations are more likely to experience it. Fortunately many treatment options exist for depression.

The fundamental feature of a major depressive episode is a period of at least 2 weeks during which there is either a depressed mood or anhedonia, which is the loss of

interest or pleasure in nearly all activities. In adolescents and children the mood may be irritable rather than sad. The individual must also experience at least four additional symptoms drawn from a list which includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. To count toward a major depressive episode, a symptom must either be newly present or must have clearly worsened compared with the person's pre-episode status. The symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress in social, occupational, or other important areas of functioning (DSM-IV-TR, 2000).

Dysthymia

Dysthymia is generally experienced as a less severe but more chronic form of major depression. Dysthymic disorder is distinguished from major depressive disorder by the longstanding history of a patient's depressed mood, often described as lasting one's entire life. It has been described as a subclinical depression, however many patients with dysthymia go on to develop major depressive episodes. Most cases are of early onset beginning in childhood or adolescence (Kaplan & Sadock, 2003). It is common among the general population, affecting 5 to 6 percent of all persons. The essential feature is a chronically depressed mood that occurs most of the day, more days than not, for at least 2 years. With children, the duration is only one year, and any symptom free interval lasts no longer than two months. During periods of depressed

mood at least two of the following symptoms are present: insomnia or hypersomnia; low energy or fatigue; poor appetite or overeating; poor concentration or difficulty making decisions; and feelings of hopelessness. Individuals may observe the presence of self-criticism and low interest and view themselves as incapable or uninteresting. Since these symptoms become so much a part of their daily experience as in “that’s just how I am” they are often not reported unless directly asked by the interviewer. Those who have a dysthymic disorder describe their mood as sad or ‘down in the dumps’ (DSM-IV-TR).

Healing Touch Practice

A conceptualization of the metaparadigm of health as more than the absence of disease, it is rather a state of optimal well being in all spheres of mind, spirit, and body with each affecting the other. When one or more of the spheres is out of balance it is reflected first in a person’s energy field, then in his or her mental outlook, and lastly it is manifested in physical symptoms. There are ways such as HT to assist someone to restore his or her field to wholeness. HT is based on the belief that all life depends on a universal, nonphysical energy that needs to be balanced within the individual for optimum functioning (Hover-Kramer, 1996). HT is a National Institute of Health biofield therapy that is an energy-based approach to health and healing (National Institute of Mental Health, 2002). It complements conventional health care and is used in collaboration with other approaches to health and healing. HT uses touch to influence the human energy system, specifically the energy field that surrounds the body and the energy centers that control the energy flow from the energy field to the physical body. The techniques, which are non-invasive, utilize the hands to clear, energize, and balance

the human and environmental energy fields, thus affecting physical, emotional, mental, and spiritual health and healing. HT includes and utilizes standard nursing activities of observation, assessment, diagnosis, planning, intervention, and evaluation of outcomes. The HT practitioner promotes a heart-centered, which is unconditional love, compassionate relationship in which the practitioner and client come together energetically to facilitate the client's health and healing.

HT is an intentional, conscious process of directing energy through the hands of the practitioner to the patient to facilitate the healing process. The goal is to re-establish harmony and balance in the energy system, which places the client in a position to self, heal (Mentgen & Bulbrook, 1995). Some of the benefits of HT are: increased relaxation; reduction of anxiety and stress; increased energy; acceleration of wound healing; reduced need for pain medication; support for the dying process; and enrichment of spiritual development. HT complements traditional approaches to health and healing (National Center for Complementary and Alternative Medicine, 2005).

Many conventional practitioners of western medicine do not consider the inclusion of what makes up a human being – the soul, the patient's spiritual beliefs, the complexity of human experience, and the need for personalized treatment (Avila, 1999). However many hospitals nationally and internationally now have policies that allow skilled practitioners to employ an energetic modality when appropriate. Health care consumers are requesting this work before and after surgery, in emergency, intensive care units and other settings.

Dr. Valerie Hunt (1995), a physiology researcher, states that there are two primary electrical systems in the physical body. One is the well-known alternating electric current of the nervous system, the brain, the neurons, and the nerves, which causes muscle contraction, nerve transmission, glandular secretion, and sensation. The other is a newly discovered electromagnetic system most likely originating from cells and atoms. The pool of electromagnetic energy around a person or object allows energy exchange. An interesting finding of Hunt's studies was that the energy field expanded when the person was near the mountains or the sea. She feels this phenomenon was possibly due to the increased negative ions present in those environments. If a person's field was exceptionally small, Dr. Hunt would send him to the pool to swim or to a cold shower or to walk barefoot on the grass at the university campus. She observed that these exercises increased the field and improved the person's mood, which she felt was probably due to the increase of negative ions.

Hunt recounts the results of a study when the electromagnetism in a room was manipulated. A change in the field transaction strongly affected sensory-motor capacities of the subjects in the room. The whole process of coordination and movement seemed to be related to interaction with the environmental electromagnetic field, not only to gravity. This caused Hunt and her colleagues to reflect on the likelihood of training athletes and rehabilitating those with muscular disabilities in a strong magnetic energy field. Hunt notes that the literature states that external electromagnetic energy penetrates the body through acupuncture points and flows through the meridians into the whole field. She discovered that it also flows through the connective tissues and therefore concluded that

the electromagnetic environment is a milieu in which life and physiological happenings occur so for all systems to function optimally, a rich field must be present.

Hover-Kramer explains that lowered energy in the field is often the precursor of physical pathology. This state may be experienced by the client as irritability or fatigue. Often field assessment with the practitioner's hands can detect dysfunction before it actually becomes physical illness or more severe exhaustion.

Dossey, Keegan, Guzzetta and Kolkmeier (1995) offer that the framework of client nursing research has shifted from an illness to a wellness model of health care. They state that nursing needs to ask sophisticated questions related to complementary interventions: under what conditions is the complementary therapy the treatment of choice, for which particular client, and with what type of problem? The interventions need to be evaluated for their effectiveness not only in treating various illnesses, but also in promoting high-level wellness and prevention programs. Early evaluation studies often focused on discovering whether such interventions worked and employed an experimental group and a control group. Comparative outcome studies are needed to determine the usefulness, indications, and contraindications of complementary therapies.

McEwen and Wills (2002) feel that it is imperative that nursing research respond to important questions and issues from nursing practice, administration and management, and education. Lo Biondo-Wood and Haber (2002) observe that the health care environment is changing at an unprecedented pace which challenges nurses to expand their comfort zone and areas of practice by offering creative approaches to old and new health problems. One approach that this can be accomplished is through the inclusion of

integrative health promotion strategies. The nursing profession is further challenged to design new and innovative programs that improve everyone's health status.

History of Healing Touch

HT grew out of the nursing practice of Janet Mentgen RN, BSN. It began in the early 1980s as a nursing continuing education program. In 1989 a pilot program was introduced at the University of Tennessee and the University of Florida, Gainesville. The following year the HT program was sponsored by the American Holistic Nurses Association (AHNA). From 1993 to 1996 it became a certification program from the AHNA. In 1994 energy field disturbance was approved by the North American Nursing Diagnosis Association as a nursing diagnosis. In 1996 Healing Touch International (HTI) was established and became the certifying body for the HT program for practitioners.

HTI developed international standards of practice and code of ethics. It also provides a certification program, continuing education, research, and health care integration assistance. HT is endorsed by the AHNA. Classes exist nationwide and worldwide and many are hospital sponsored programs. HT is heart-centered caring. HT practitioners work in South Africa with traditional healers and native people. HT Romania has trained nearly 400 people from a variety of medical groups to work with the children of Romania. In South America HT practitioners work with religious and lay volunteers who offer services to the poor. HT instructors teach culturally diverse populations.

The principle of the work is that the body is a complex energy system that can be affected by another to promote well being (Mentgen & Bullbrook). It includes the use of intention and the placement of hands in specific sequences either above or on the body. HT is taught as a multilevel program with a 1-year mentorship that leads to certification. The increased use of HT in health care has been largely accomplished by the enthusiasm of its practitioners and patients' responses. In the United States alone over 75,000 people have taken at least the first-level course, and it is also taught in countries around the world. Practitioners use this technique in such diverse areas as outpatient pain centers, private practices, and operating rooms.

Healing Touch Energy Theory

The human body is made up of a physical body, a subtle energy body, and layers of fields of energy. The three distinct parts of the human energy system, which work interchangeably, are an energy field often known as the aura, energy centers which are called chakras, and energy tracts of meridians. Potential illness appears in the energy system before physical symptoms appear. A person's health and quality of life are affected by the health and quality of the energy system. Energy fields are the fundamental unit of the living and environmental, such as plants.

Definition of HT Terms

Aura. The aura or human energy field is a field of energy, which surrounds and penetrates the body. The aura underlies and supports the functioning of the body. Contained within the aura are the energetic aspects of every structure and function of the

body, as well as all that we experience, i.e. physical sensations, thoughts, feelings, and states of consciousness.

Centering. This is accomplished by becoming fully present, clearing the mind of all unrelated and irrelevant thoughts, breathing deeply, releasing tension, and turning attention inward.

Chakra. The word chakra is Sanskrit for wheel or disk and signifies one of seven basic energy centers in the body. Each of these centers correlates to major nerve ganglia branching forth from the spinal column. In addition the chakras also correlate to levels of consciousness, archetypal elements, developmental stages of life, colors, and sounds.

Meridians. According to acupuncture, these are the invisible channels through which qi or energy circulates throughout the body.

Summary

This chapter reviewed the background of HT, the role of the PMHNP and a definition of depression and dysthymia. The next chapter will include three areas. The first will be the theory developed by Martha Rogers, Science of Unitary Human Beings. Secondly, the framework of this theory as it applies to PMHNP practice, followed by a review of the literature of HT as it relates to depression. There is no literature specific to dysthymia.

Chapter Two

This chapter presents Martha Rogers theoretical framework and its application to PMHNP practice. It also includes a summary of the literature review about HT and depression.

Theory Description of Rogers Science of Unitary Human Beings

Martha Rogers was a pioneer who blazed a trail at a time when the discipline of nursing was deep in the positivist era in the 1960s. She first described her Theory of Unitary Man in 1961 and sparked widespread debate and controversy among nursing scholars. Her theory, *An Introduction to the Theoretical Basis of Nursing*, published in 1970, did not easily fit into the contemporary paradigm of nursing at that time and was rejected by many in favor of the post-positivist school of thought.

McEwen and Wills note that prior to Rogers, it was rare that anyone in nursing viewed human beings as anything other than the receivers of care by nurses and physicians. The health care system was organized by specialization in which providers focused on separate areas of functions such as medication, health teaching, administration, or dressing change. Caregivers were not aware of the whole person. In 1970 Rogers insisted that the person was a unitary energy system in continuous mutual interaction with the universal energy system. This concept has significantly influenced nursing by encouraging nurses to consider the person as a whole entity or unity when planning and delivering care.

Influences on the Development of the Theory

The Science of Unitary Human Beings started as an abstract theory created from theories of numerous sciences, hence it was deductively derived. Rogers was influenced by: von Bertalanffy's theory on general systems with the concepts of entropy and negentropy and open systems in constant interaction with the environment; Rapoport's work on open systems; and the work of Herrick, who added to the principle of the evolution of human nature. Rogers blend of the works of these scientists shaped the basis of her proposition that human systems are open systems within larger, open environmental systems. She included the idea that living systems have organization and pattern, that time is unidirectional, that human beings are responsive, aware and capable of choosing and feeling. Shortly before her death in 1994 she retitled her theory the Science of Unitary and Irreducible Human Beings.

Concepts

In Rogers' work the unitary human being and the environment are the focus of nursing practice. The purpose of nursing for her is to help human beings achieve well-being within the potential of each individual, family, or group. Rogers related that nursing is a learned profession, a synthesis of science and art. It is the study of unitary, irreducible human beings and their respective environments (Rogers, 1990). The goal of nursing according to Rogers' Science of Unitary Human Beings is to promote human-environment field patterning (Barrett, 2000).

The concepts addressed in this broad, grand theory are: energy fields, openness, pattern, and pandimensionality. The principles of homeodynamics include: resonancy, helicy, and integrality.

Energy fields. A continuous, irreducible, fundamental unit of all living and nonliving things. Neither humans nor environment have an energy field rather both are integral energy fields.

Openness. Open systems extend to infinity and are integral with each other. They exhibit negentropy, the opposite of entropy. They do not run down but display increasing diversity and complexity of organization.

Pattern. An abstraction, a single wave that identifies the given energy field. Wave patterns are unique and ever-changing.

Pandimensionality. A nonlinear domain without spatial or temporal attributes from which innovative change continuously emerges.

These concepts form the basis of an abstract conceptual system defining nursing and health. From this system Rogers developed the principles of homeodynamics that suggest the nature and the direction of human beings' evolution.

Principles of Homeodynamics

The principles of homeodynamics have undergone several evolutions since 1970 when they included resonancy, helicy, reciprocity, and synchrony. The following definitions have been accepted since 1983.

Resonancy. The continuous change from lower frequency to higher frequency wave patterns in human and environmental fields.

Helicy. The continuous, innovative increasing diversity of human and environmental field patterns.

Integrality. The continuous mutual human field and environmental field process.

Nursing Metaparadigms

Person. The unitary human being, an irreducible, indivisible, pandimensional energy field identified by pattern and manifesting characteristics different from those of the parts and cannot be predicted from knowledge of the parts.

Environment. An individual pandimensional energy field identified by pattern and integral with the human field.

Nursing. A science and an art. It is the study of unitary, irreducible, indivisible human and environmental fields in a creative, imaginative way.

Health. The least well defined metaparadigm, it is a value term defined by individuals and cultures. Health and illness are manifestations of pattern.

Theory Analysis

The concepts are theoretically defined. McEwen & Wills note that a theoretical definition gives meaning to a term in context of a theory and permits the reader to assess the validity of the definition. Tomey and Alligood, (1998) state that although all the metaparadigm concepts are explored, the emphasis is on the integrality of human-environment field phenomena. Nursing is conceptualized as the professional practice in nursing which seeks to promote symphonic interaction between human and environmental fields, to strengthen the integrity of the field, and to direct and redirect patterning of the human and environmental fields for realization of maximum health

potential (Tomey & Alligood). There is consistency between the worldview, values and beliefs and the definitions of the major concepts. With the unitary perspective Rogers differentiates fields, not boundaries, and argues that the whole cannot be understood by examining its separate parts. The human field pattern is valued through demonstrations of the whole pattern in ways of perception, experience, and expressions.

The major value of Rogers' work has been extending nursing science by challenging traditional ways of thinking about nursing and the world. To understand her concepts necessitates a willingness to let go of the traditional and possess a capability of seeing the world in a creative, new way (Joseph, 1990). Her theory supports complementary treatments such as HT and provides a distinctive frame of reference for viewing human beings through the human-environment process that manifests compassion. She looked at how the life process unfolds using imagination and intuition. Therapeutic modalities are increasingly emphasizing the noninvasive. Martha Rogers was a visionary who demonstrated a creative, innovative approach to nursing. According to McEwen and Wills the more simple, elegant, and universal a theory, the more global it is in contributing to the science of nursing.

In pattern appraisal it is through observation and participation that the nurse focuses on human expressions of experience, reflection, and perception. Mutual exploration of emergent patterns allows identification of unitary themes predominant in pandimensional human-environment fields. Evaluation centers on the perceptions emerging during mutual patterning. The appraisal process is continuous with intuitive emphasis on emergent patterns. Human beings and the environment are energy fields.

Literature Review

After an extensive search the author has concluded that there is minimal research into the area of depression and HT. There was not any research found relating to dysthymic disorder and HT. Due to the paucity of research only four studies were found, two on stress, one about posttraumatic stress disorder (PTSD), and one on anxiety. They were preliminary in nature and showed a variety of outcomes. Adequate conclusions cannot be drawn because of the small sample sizes, inadequate controls, and potential study biases.

In a quasi-experimental study, Bradway (1998) evaluated depression in 30 participants recruited from psychotherapists' offices who measured in the moderate or severe range of depression on the Beck depression inventory. The participants were divided into two groups, 15 members of the treatment group received biweekly HT sessions for 3 weeks while the 15 members of the control did not receive any treatment. In addition a hand scan, a pendulum assessment, and vital signs were taken for comparison between the two groups. The HT techniques chosen for the treatment group were centering, chakra spread to open the field, magnetic unruffling to clear any debris, modified mind clearing. The same treatment was given to the treatment group in the same order at every session. The HT group had significantly less depression than did the standard group as measured with the Beck Depression Inventory, and 1 month later they continued to be less depressed than they were at the beginning of the study. The vital signs changes were not significantly different between the control and treatment group.

Guervara, Mendias, and Silva (2002) designed a protocol for decreasing PTSD for abused women living in Mexico. Thirty-five women with PTSD received 10 HT sessions and completed Speilberger's State-Trait Anxiety Scale and the Horowitz Impact of Events Scale before and after sessions at three intervals. The results indicated that PTSD symptom scores were statistically decreased ($p < .01$) at all three measurement intervals. Clinical personnel and participants were all receptive to HT.

In a study by Rexilius, Mundt, Megel, and Agrawal (2002) HT and massage therapy (MT) were used for caregivers of patients undergoing stem-cell transplants. Thirty-six caregivers, 13 in the control group, 13 in the MT group and 10 in the HT group received biweekly treatments for 3 weeks. The control group received usual care with a 10-minute supportive visit. Data from the Beck Anxiety Inventory, the Center for Epidemiologic Studies Depression Scale, the Subjective Burden Scale, and the Multidimensional Fatigue Inventory showed statistical significance only for MT in anxiety scores, depression, and fatigue. The fatigue scores in the HT group increased. The post study survey of 9 of the 10 participants in the HT group indicated that most reported a time for self-focus and decreased worry; two reported a decrease in pain symptoms. The authors' discussion included recognition of the limitations of the small sample size, non-randomization, unequal numbers of men and women, and changes in care giving expectations at the hospital in the middle of the study.

Taylor (2001), using mixed methods, reviewed the effect of providing HT to 51 undergraduate students. Participants were randomly assigned to the experimental or control group. The experimental group received one HT session with music weekly for 4

weeks, and the control group listened to music. Pre- and posttest measures included Lazarus Coping Scale, Rosenberg's Self Esteem Scale, and Goldberg's General Health Questionnaire, along with a semi-structured interview. HT had no effect on the coping ability, self-esteem, and general health of 1st-year students, but significant effects were found for the 3rd-year students who reported less transient stress ($p=.05$), less chronic stress ($p=.05$), and coping by putting more effort ($p=.05$) than among those in the control group. The qualitative findings showed that all participants in the HT group found the experience positive and reported feeling relaxed, more open-minded, and better able to study and think; and they noticed positive changes in sleeping patterns and being in less of a hurry.

Although these reports were generally positive, they were too limited in internal and external validity to permit robust conclusions. The preliminary work with clients diagnosed with PTSD showed promise and should be explored further. The question of HT as an intervention in mental health care has had only exploratory study. The lack of analysis for HT is due in part to the relative newness of this technique, the clinical emphasis of the program, and the lack of detailed findings in many of the studies to date (Wind Wardell, 2005).

Participants generally reported improved quality of life physically, emotionally, relationally, and spiritually. Wind, Wardell, & Weymouth, (2004) report that if these results continue to be found, another discovery might be reduced medical costs for fewer pharmaceuticals, hospital stays, and clinic time. HT might also be another treatment option for nurses to provide safe, noninvasive care to promote healing.

Simpson's (1998) exploratory paper provides counselors with information about how energy work is being used with counseling to meet therapeutic goals. Qualitative analysis was done with seven informants who are nurse practitioners or social workers. The data describe the effects of the healing work in creating a connection with the client and how it assists clients to access their emotional material faster, which is often revealed when working on the presenting physical symptoms. It explores how it helps clients more readily integrate the work of a talk therapy session. The healers describe how they use the healing work to open sessions and teach clients and their supporters how to continue the support in their lives.

Van Aken's (2002) study aimed to explore and analyze the experiential process of HT for people with moderate depression. The study provides information about the experience of participants in addition to providing a middle range theory about the process. Participants (n=17) were self-referred with moderate depression being verified using the Beck Depression Inventory. Five weekly sessions of HT were scheduled which included pre-session check in, energy evaluation, HT session, energy assessment and post session check in. The Healing Energy and Life Through Holism (HEALTH) tool was used to collect data. On the sixth week an unstructured interview took place and a further Beck Depression Inventory was completed. Written, verbal and energetic information gathered during the sessions was placed on a trajectory for each person. This was the case study aspect of the research. Use of the case study approach has allowed the author to maintain the integrity of each individual's perspective and at the same time discover common variables between cases that will contribute to building theory. Although the

purpose of the research was not to prove that there would be a reduction in depressive symptoms, all of the participants demonstrated a reduced score in the Beck Depression Inventory at the completion of the research.

Summary

This chapter presented the theory of Unitary Human Beings and the theory of Healing Touch. The minimal literature that is available about HT and depression was reviewed. Although the results were generally positive it is evident that further research should be conducted to examine the use of HT with depression.

Chapter Three

This chapter begins with a discussion of the expected challenges that may be encountered when incorporating HT into a mental health practice. It concludes with a description of the standard management of dysthymia and an HT sequence.

Depression diminishes the entire energy field that surrounds the body. Hover-Kramer notes that the energy field responds more slowly to energetic interventions especially if the depression is of more than a few weeks duration.

Standard Management of Dysthymia

The combination of pharmacotherapy and either cognitive or behavior therapy may be the most effective treatment for this disorder. Reports indicate that the serotonin-specific reuptake inhibitors (SSRIs) may be the drug of choice for pharmacotherapy and should be continued for at least six months. Similarly bupropion also may be an effective medication for patients with dysthymic disorder (Kaplan & Sadock). Unfortunately the possible side effects of some SSRIs contribute to non-compliance. Early onset side-effects may be responsible for rapid withdrawals from treatment, but some of the most troubling of these such as nausea, diarrhea, headache, and agitation will remit in 2-3 weeks.

Sexual dysfunctions are among the most distressing SSRI side effects. Decreased libido and delayed or absent orgasm are the best known. Sleep problems often require concurrent medication; 22%-34% of patients taking SSRIs also are prescribed sedatives

or hypnotics. Also particularly troubling is the side-effect of weight gain, that may not develop until late in treatment (Kaplan & Sadock).

McIntyre and O'Donovan (2004) discovered that patients who fail to achieve a full remission have a more recurrent and chronic course, increased medical and psychiatric comorbidities, greater functional burden, and increased social and economic costs. They did not distinguish between depression and dysthymia. Depression is among one of the most disabling illnesses in the world. As many as 76% of patients suffering from depression were found to report pain symptoms, including headache, stomach pain, vague and poorly localized pain, and back pain. Depression is associated with a substantial functional burden. Employees with depression are absent from work about twice as much as other employees. Workers with persistent depression are 7 times more likely to be less effective on the job. Depression has a significant economic impact on employers, in terms of disability, recidivism, and medical plan costs.

Healing Touch Treatment

Whether in a mental health or primary care setting clients diagnosed with dysthymia may benefit from HT. Initially the HT practitioner would assess the energy field and energy centers to determine needs. The energy field may be assessed by a hand scan or a pendulum or both. A pendulum is a hand held device that detects the direction and the degree of energy flow in the energy centers or chakras. It is a physical, measurable tool. The energy system may be identified through the senses – visual, auditory, kinesthetic and intuitive while energy itself can be experienced as differences in temperature, movement and/or density. An energy system is affected by thought,

emotions, actions, intentionality, and the environment. Requirements for performing HT are: openness of heart as in unconditional love; motivation to help another; openness of mind; intentionality for the highest good of the healee, the person receiving treatment; and letting go of expectations of the outcome.

Thus a basic HT sequence consists of: intake; healer preparation of being centered and grounded; pre treatment energetic assessment; HT interventions such as magnetic passes with hands in motion or hands still; post treatment energetic assessment; ground and release; and lastly evaluation and feedback.

The HT practitioner believes that health and disease are ways through which the patient's body speaks to them, telling them what's right and wrong in their lives, what's good and should be preserved and strengthened, and what's bad and needs to be reevaluated and adjusted. Through self-reflection one can continue to examine how one understands his or her world and then attempt to make changes for what best suits them in their professional and personal life.

Combination Therapy

A blend of HT and traditional treatment for dysthymia could be achieved in a 30-minute consultation. A one-hour appointment with a 45-minute HT treatment with the client relaxing fully clothed on a massage table would be ideal but in this area of managed care that would not be feasible, yet in a private clinic it would be.

During a half hour appointment a client could receive a psychiatric assessment and a 10 to 15 minute HT treatment. That is adequate time for the practitioner after centering to perform a hand scan several inches over the client's body. That would be

followed by one of the HT interventions such as the chakra spread, magnetic unruffling, modified mind clearing, or 7th chakra clearing. Mentgen & Bulbrook describe the techniques. The chakra spread opens the chakras allowing repressed material to surface and deep blocks to be released. The mind clearing technique alters the energy flow inside the head and can be used to adjust the mental and emotional state. Brennan (1987) has observed that the seventh chakra, which connects people to their divine source and their spirit, was often functioning poorly in depression.

After receiving a treatment the energy field would be reassessed using the hand scan technique and feedback elicited from the client. After each treatment a practitioner would assess for decreased depression through subjective and objective reporting while monitoring mood, affect, sleep, appetite, level of energy and concentration, libido, and presence or absence of suicidal ideation passive or active. In addition to assessment skills and expertise the practitioner would ask the client to complete the Beck Depression Inventory. The number of treatments would depend on: the level of depression, the commitment from the client, and the financial status of the client if the treatments were offered in a private practice.

Summary

This chapter has reviewed the standard management of dysthymia and some of the various HT techniques available. It was demonstrated that it is possible to combine conventional and the complementary treatment of HT for dysthymia.

Chapter Four

This chapter will include a discussion on the benefits of using HT for dysthymia, then the strengths and limitations in combining treatments. Lastly the significance for the future will be addressed.

The non-invasive, non-pharmacologic treatment of using HT for dysthymia is a creative, artistic approach for nursing. It is cost effective in a world of spiraling health care costs. It holds social relevance in that it has possibilities to expand both a PMHNP and client's worldview to include inventive strategies for health. An energy field in Rogers' system is the fundamental unit of all that exists in the world and could be applicable across cultures.

To understand her concepts necessitates a willingness to let go of the traditional and possess a capability of seeing the world in a creative, new way. Rogers' theory supports complementary treatments such as healing touch and provides a distinctive frame of reference for viewing human beings through the human-environment process that manifests compassion. She looked at how the life process unfolds using imagination and intuition.

Why is it difficult for conventional medicine and science to accept energy healing such as HT as a valid treatment? Action through intent, that may be effective even from great distances, is considered strange within conventional understandings of the world. Therefore the evidence on HT could be ignored or rejected by some. It is easier to do this than to reassess one's basic beliefs about the world.

Opportunities and Barriers

Barriers for a proposed program to incorporate HT with traditional treatments for dysthymia are that presently for the medically underserved complementary medicine is not a viable option. For those with insurance not all insurance companies will pay for energy work. Just as there is a stigma about depression so there is one regarding energy treatments. This is evident among some health care professionals who cling to traditional methods and are reluctant to examine other forms of treatment. An education program would begin to address this issue. A PMHNP could educate colleagues, clients, and their families through discussions and demonstrations of healing touch. The outcome of disseminating knowledge is improved patient care (Robinson & Kish). Empowering clients is key.

Lodge (2001) conducted a cost-effectiveness study to assess the overall impact of the inclusion of HT on utilization of benefits and medical costs for employees at a manufacturing company. At the end of the study the company decided to include HT in its benefit plan with a co-pay after receiving demands for the continuation of this service from the study participants (Wind Wardell).

In the January 2003 journal of the Nurse Practitioner, Pearson described the legislative update and how each state stands on issues affecting advanced nursing practice. She reports that countless studies have demonstrated that advanced practice nurses provide safe, cost-effective, patient-popular health care. Yet organized physician groups remain resistive in relinquishing control over the health care dollar. This is being

addressed in the Medicaid Nursing Incentive Act to APNs advantage but a barrier still remains with other insurance companies.

Another barrier to practice for PMHNPs is the variation in state-by-state requirements for scope of practice, credentialing, and again third party reimbursement. Requirements need to be standardized within all states. The National Council of State Boards of Nursing is proposing an Advanced Practice Interstate Compact that would standardize advanced practice requirements (Haber, Hamera, Hillyer, Limandri, Pagel, Staten, & Zimmerman, 2003). This would enhance consumer protection and increase public recognition of PMHNPs.

Conclusion

Hover-Kramer summarizes HT when she states that there seems to be a transfer of energy from the more centered intent of the practitioner to the less organized or depleted energy field of the client with the result that the client's field begins to resonate to the higher harmony of the practitioner's more intentional field. This could hold hope for positive implications in the treatment of dysthymic and major depressive disorder. If insurance companies paid for HT sessions as part of the treatment for depression then HT would become available to more people.

However it is evident from the scarcity of available research that further research into the effects of the use of HT is needed. This would be useful to gain wider acceptance for HT in the health care community. Recommended research would be the need for the development of instruments to study depression and dysthymia. Three

suggested areas of study are just HT treatments, a combination of HT and medication, or only medication.

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