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Towards a Model of Distant Healing

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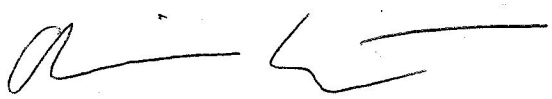
Declaration

I, Alison Easter, declare that this thesis has been composed by me and that the research presented is my own work, except as specified. No portion of the work has been submitted for any other degree or professional qualification.



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Abstract

The studies presented in this dissertation examine distant healing using both quantitative and qualitative methods. Distant healing purportedly works through the mental intention of one living system affecting another at a distance. The literature to date shows mixed results with regards to its efficacy and very little examination of the experience of healers and healees who practice and receive distant healing outside of research settings. This thesis aims to clarify some of the gaps in the literature and to direct future investigations of distant healing through the development of a more comprehensive model of distant healing.

To better understand the components that may contribute to distant healing, the first study presented in this thesis is designed to understand the role that belief and expectancy may have on outcomes in a trial of distant healing. Quantitative approaches to the study of distant healing have yielded mixed results (Astin, Harkness & Ernst, 2000), with some studies showing small positive effects of distant healing and others no effect or a slight negative effect. This clinical trial utilized a partially blind design to measure the impact of awareness of receiving distant healing. Therefore, half of the participants were blind to their allocation condition, while the other half were aware of their assignment to either the healing or no healing condition. While no effect of distant healing was found overall, there was an apparent effect of knowledge of allocation, with those aware they were receiving healing reporting better outcomes than those aware that they were not receiving healing (d = 0.76). This effect was not, however, significant in the analysis of covariance, and thus should be interpreted with caution. In the future, studies with a similar design and larger sample size should be pursued to confirm the effect of expectancy on healing outcome.

The characteristics and perspectives of healers are largely ignored in the available literature, and may aid in understanding the phenomenon of distant healing. The primary goal of the second study was to investigate healer characteristics (N = 130) in the areas of personality, spirituality, exceptional experiences, boundaries and emotional intelligence. This was achieved using questionnaire measures and comparisons with population norms where available. Also included in the study was a series of open-ended questions that asked participants to define and describe spiritual healing and healers. Thematic analysis revealed that healers believed factors such as skill of the healer and healee receptivity

to be especially important to the healing process. It was also recognized that healing might not be appropriate in all situations. For example, healers report that it should not be considered as a primary form of treatment for a broken leg and it may not be as effective if the healee is in a negative and unsupportive environment.

Qualitative investigations of distant healing have been limited, with much of the research focusing more broadly on spiritual healing or other alternative approaches to healing. The third study investigated the experience of distant healing as reported by healees with a strong cultural context of belief or acceptance in the possible efficacy of mental healing. This study took place in Sri Lanka, and the healees were recipients of distant healing from a Buddhist monk and healer, Bhante Seelagawesi. Healees were interviewed about their experiences. Interpretive phenomenological analysis (IPA) of interviewees' accounts revealed participants' attitudes towards traditional and modern approaches to healing, such that while they showed an awareness and acceptance of the latter, they often preferred the former. The experiences were overwhelmingly positive, however a number of factors, in addition to distant healing, appeared to be therapeutic. There was a strong community aspect to healing, and overall a theme of empowerment was evident.

Overall, these studies allow us to build a more complete and holistic model of the distant healing phenomenon, which is presented in the final chapter. The studies also fill in some of the gaps found in the current literature, particularly by utilizing a mixed methods approach and focusing on both efficacy and also healer and healee accounts.

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Chapter 1: Introduction

In 1727, the Jansenist deacon François de Paris died at the age of 37. Almost immediately after his burial in the cemetery of St. Medard, pilgrims began to flock to his grave, where healing miracles were claimed to have been performed, including "the curing of the sick, giving hearing to the deaf, and sight to the blind" (Hume, 1748/2008, p. 92). The Scottish philosopher David Hume, who was living in France at the time, knew well of the affair and devoted a long section to it in his famous refutation of miracles in *An Enquiry Concerning Human Understanding*. Although he had commented rather smugly that it is strange "that such prodigious events never happen in our days" (Hume, 1748/2008, p. 89), implying that the miracle cure is a thing of more barbaric, less enlightened ages, Hume (1748/2008) admits the seeming reality of the Abbé Paris' miracles:

> Many of the miracles were immediately proved upon the spot, before judges of unquestioned integrity, attested by witnesses of credit and distinction, in a learned age, and on the most eminent theatre that is now in the world. Nor is this all: a relation of them was published and dispersed everywhere; nor were the Jesuits, though a learned body, supported by the civil magistrate, and determined enemies of those opinions, in whose favour the miracles were said to have been wrought, ever able distinctly to refute or detect them. Where shall we find such a number of circumstances, agreeing to the corroboration of one fact? (pp. 92-93).

To this overwhelming support for the healing powers of the Abbé Paris, Hume directs his axiom that a miracle is an impossible violation of the laws of nature, and thus, the hundreds of witnesses at St. Medard are simply wrong. Although philosophers like Hume contributed to the rise of modern science, it is clear that scientists today cannot be so dogmatic. A phenomenon such as the healing at St. Medard cannot be rejected in a single stroke but rather constitutes a problem to be investigated.

Around the world individuals are increasingly turning to "unconventional" therapies such as homeopathy, art and music therapies, herbal remedies, laying-on-of-hands, acupuncture and distant healing to treat health problems and improve their well-being (Owen, Lewith & Stephans, 2001; Shmueli & Shuval, 2004). Additionally, alternative healing methods are increasingly regarded as belonging to normal (conventional) health care (Boon, Olatunde & Zick, 2007; Fadlon, Granek-Catarivas, Roziner & Weingarten, 2008; Joos, Musselmann, Miksch, Rosemann & Szecsenvi, 2008). "Medical pluralism" - the use of multiple forms of healthcare - is widespread today (Bodeker, 2001): it has doubled in Europe and North America in the last decade and about half the population of industrialised countries regularly use complementary medicine in addition to their standard health care (Bodeker, 2001; Ernst, 2003; Kaptchuk & Eisenberg, 1998). Of course, these so-called "alternative therapies" have been developed over hundreds, in some cases thousands, of years and are still to this day considered "conventional" in many cultures, while western or allopathic treatment is only sought if traditional therapy fails.

This thesis will focus on distant healing, an example of an alternative therapy. The primary aim of this thesis is to investigate the efficacy of distant healing utilizing an empirical method and to describe and analyze the experience of distant healing from the point of view of healers and recipients of healing (also called healees), with a view to developing a model of distant healing. In this chapter I will define and describe distant healing, present a summary of each chapter, and review the aims and objectives of this thesis.

1.1 What is Distant Healing?

While there is no standardized definition of distant healing, researchers often describe the phenomenon similarly and usually stress the importance of intention. Schlitz, Radin, Malle, Schmidt, Utts and Yount differentiate distant healing intentionality from other healing modalities, explaining, "it postulates that mental intention alone can affect living systems at a distance, unbounded by the usual constraints of both space and time" (2003, p. A31). They go on to describe the role of intention, clearly distinguishing it from desire. Unlike desire, intentions are directed towards achievable goals, often involve some deliberation and decision-making, and generally come with a greater commitment to follow through with the intended action.

The term distant healing is used interchangeably with a number of other terms. Some of these terms are, for our purposes, identical, while others refer to slightly different but classifiably similar phenomena. Transposable terms include distant healing intention, distance healing, non-local healing and psychic healing. Similar phenomena that may be included under the umbrella of paranormal healing include non-directed prayer, directed prayer, intercessory prayer, non-contact therapeutic touch and Reiki (level III). While these lists are not all-inclusive, they do cover the most prevalent terms identified by healers participating in research studies (Astin, Harkness & Ernst, 2000; Astin, 2003).

The working definition of distant healing that was used as a reference for participants in the research presented in Chapter 3 of this thesis reads as follows:

> Distant healing is a hypothesized form of healing intentionality occurring beyond the reach of the physical senses that appears to be unmediated by any demonstrable form of physical signal. It encompasses a broad range of healing practices. Broadly speaking, healers in this study will use forms of meditation where the practitioner holds a compassionate intention to relieve the suffering of another.

The first sentence here is borrowed in large part from the definition of distant healing provided by Jonas and Chez (2004, p. 173), and the following two sentences were added to describe to participants the practices that were utilized in this study.

Distant healing practitioners employ a variety of techniques, some learned, others self-taught. In addition, they often incorporate a number of spiritual or religious influences into their practice. The specific components of self-described healers' practices and beliefs will be discussed further in Chapter 4. The possibility and experience of healing intentionality is the shared quality among these various techniques and approaches to distant healing.

Drawing an analogy to the more familiar concept of prayer might help further elucidate the notion of distant healing. Like distant healing, prayer both refers to the healing potential of an unseen force or intention and is equally susceptible to encompassing a broad range of techniques and approaches. Prayer, however, usually involves communication with some specific spiritual force (God, Bhrama, Allah, Great Spirit, etc.), whereas distant healing may not. Dossey speaks to these differences, noting that teasing apart the possible mechanisms, be they a higher power or a direct mind-to-matter interaction, may be inconceivable, pointing out, "there are no 'God meters' in science" (2008, p. 348).

It should be stressed that intention is a quality shared by both healer and healee. And, if intention is taken to be an influential factor, not only would healers carry the intention to heal, but also the intention of the participants to participate in the healing process would be necessary. Furthermore, in the study of distant healing, the intentions of researchers must also be taken into account. These factors complicate the investigation of distant healing and highlight one major difference of distant healing in comparison to other alternative therapies: there is no visible communication or action made between the healer and healee. This is not to say that

other alternative therapies discount the importance of intention, but rather that intention and mental influence alone are not the defining features of these other therapies. Most of these other therapeutic techniques involve some visibly communicative or physical aspect, offering the potential for a therapeutic benefit in the relationship as well as expectation. Expectancy occurs frequently when individuals begin a certain medication or therapy and is seen in clinical trials as a placebo response. Sceptics often view alternative healing therapies that lack substantial evidence of efficacy as merely placebo (Beyerstein, 1997; Charlton, 1992).

A clinical trial may shed light on the efficacy of distant healing, but it cannot capture the nature of the healer/healee relationship, nor can it account for the history and narrative of a healee's experience. In real world situations, distant healing is rarely set up like the isolated medical intervention that researchers typically study. In particular, distant healing is often a long-term project, one that stretches beyond the bounds of the typical Western ailment-cure timeline. It may involve third parties, or even a community, in a way that is usually not common in the traditional doctor-patient relationship.

Although clinical trials of distant healing intervention studies are largely inconclusive (Astin, Harkness, & Ernst, 2000; Astin, 2003), anecdotal evidence of positive outcomes in distant healing research is prevalent (Benor, 2002). Further investigation of distant healing may reveal replicable components of healees' experiences that will aid in both understanding and eventually utilizing the therapeutic effect of distant healing interventions. Chapter 5 will take a qualitative approach, designed to better understand the healee's experience beyond quantitative measure of success or failure.

1.2 Overview of the Thesis

This thesis consists of a series of three studies that investigate the phenomenon, and the phenomenology, of distant healing from converging and complementary perspectives.

In Chapter 2 the literature concerning distant healing will be reviewed. In addition to recapping the experimental studies of distant healing and related phenomena, this chapter will also explore relevant qualitative approaches to the study of healing. The evaluation of the strengths and weaknesses of previous studies identified in Chapter 2 played a large role in the design of the three original research studies, which constitute the subsequent chapters.

Chapter 3 describes a small-scale randomized controlled clinical trial of distant healing with arthritis sufferers. The primary goal of this study was to determine the efficacy of distant healing while accounting for expectancy and self-reported belief in distant healing. Efficacy was measured through the analysis of self-reported health and well-being measurements taken at baseline and post-intervention. The role of expectancy was observed by utilizing a partially-blind design in which half of the participants were aware of whether or not they were receiving distant healing and the other half were blind to their allocation. In addition to measurements of health and well-being, participants were also asked to complete a questionnaire measuring their belief in the power and effectiveness of distant healing and other paranormal phenomena in order to shed light on the relationship between belief and the efficacy of distant healing.

In Chapter 4, the focus will shift to a closer examination of the healer. This study consisted of a questionnaire survey of self-described distant healers. The aim was to develop a descriptive psychological profile of distant healers in terms of their demographic characteristics, gender differences, boundaries, personality, and

spiritual connectedness. The survey included an open response section that asked healers to describe and define their healing practice in detail. A thematic analysis of these responses was carried out to gain insight into how healers describe and understand their healing practice.

Chapter 5 describes a study that focuses more intently on the healee to develop a phenomenological perspective of the healing process. This study used the qualitative method of Interpretative Phenomenological Analysis (IPA) to build a broader understanding of how healees experience and attribute meaning to their distant healing encounter. This study took place in Sri Lanka, a cultural context in which distant healing is regarded as an orthodox form of treatment for physical and psychological ailments.

Finally, Chapter 6 will review the main findings of each study and, together with the literature discussed in Chapter 2, build a model of distant healing. The goal of the model is to include research outcomes that account for the variety of perspectives held by healers and healees and that are found in the body of empirical research.

While the progression of the thesis reflects the temporal timeline of the research, more notably it suggests a movement from quantitative analysis and focus on efficacy to a more qualitative approach of understanding the experience of distant healing. By utilizing a variety of methods, this thesis is able to address different facets of the healing encounter and connect the different perspectives presented. The goal of taking this mixed approach is not to privilege one method over another but to acknowledge the value of clinical and experimental trials while also recognizing the rich phenomenological underpinning to the process of distant healing. With further development and technological advancements it is likely that the experimental trials of distant healing will be more conclusive, but, at the same time, it is important not

to ignore or move too far from the phenomenon of distant healing as it is experienced in the world. Qualitative accounts may serve to improve the design of and provide rationale for empirical work, but it can also stand on its own as a record of lived experience that science has yet to fully understand.

Chapter 2: Literature Review of Distant Healing Research

2.1 Introduction

Researchers have used a wide range of methodological approaches in their attempts to understand healing. Most frequently the objective of this research is to describe either the experience of healing or the event of healing. While the experience encompasses the whole process of healing, the event is objective and focuses on the outcome. Furthermore, there is a wide range of measurements used to assess the effectiveness and experience of healing, from phenomenologically based variables and scales to physiological tests.

This review will cover the relevant evidence-based, individual differences and qualitative research pertaining to distant healing and related phenomena. The benefits and drawbacks of various methodological approaches will be discussed in addition to the relevant findings of distant healing research to date.

2.2 Evidence-based Research Methodology

2.2.1 Trials of Distant Healing and Prayer

Experimental research designed to evaluate distant healing can give clear measures and controlled accounts of a participant's response to healing. While it is not possible to completely replicate the natural conditions of typical healing situations, well-designed research methods can significantly minimize differences.

Clinical trials are commonly utilized to measure distant healing efficacy (Astin, Harkness & Ernst, 2000). In his discussion of the study of applied research related to psychics and healers, Schouten (1993) asserts that determining the

effectiveness of a treatment corresponds to the difference in the state of health between the start and finish of treatment. He adds that the effect of the method is measured by the difference between the experimental and control groups. This is a standard approach to applied medical and psychological research, and the classical randomized, double blind clinical trial is commonly held to be the "gold standard" among researchers.

This is, of course, not without reason. Clinical trials enable researchers to make claims about the relative efficacy of various treatments, and this approach is widely used in research of both standard medical research and investigations of complementary and alternative therapies. In biofeedback research, for example, Young (1985) offers the following criteria in assessing the therapeutic potential of experimental research: the degree of clinical meaningfulness; the quality of the experimental design used in gathering and reporting data; the extent of follow-up obtained or reported; the proportion of the treated patient sample that improved significantly; the degree of result replicability; and the extent to which results can be applied to the patient's ordinary environment.

A number of reviews assessing the efficacy of distant healing and similar phenomena have been conducted in the last decade. Astin, Harkness, & Ernst (2000) and Astin (2003) provide reviews of various distant healing techniques. Three categories of healing were identified: prayer, non-contact Therapeutic Touch, and other forms of distance healing (Astin, Harkness, & Ernst, 2000). These reviews selected research meeting the following criteria: random assignment, placebo or other sufficient control, publication in peer-reviewed journals, clinical (not experimental) designs, and the use of human participants. The first review covered 23 trials involving 2774 participants, of which 13 trials (57%) generated statistically significant treatment effects, 9 showed no effect over the control measures, and 1

showed a negative effect. Astin's later review (2003) focused exclusively on prayer and other forms of distance healing, but excluded trials of Therapeutic Touch. This analysis included 14 trials with a total of 2448 study participants. Of those reviewed, six (43%) showed a significant, positive treatment effect on at least one outcome in participants assigned to the prayer or healing condition, and eight studies reported effect size where the average or pooled effect was small, Cohen's d = 0.30 (P = 0.003).

These and other studies are summarized in Table 2.1, which I created to provide an overview of the most frequently cited studies to date. They will be discussed in greater detail later in this chapter.

Table 2.1: Trials of distant healing

Author(s) (year)	Design	Participants' Condition(N)	Experimental Treatment	Results	Considerations
Joyce & Welldon (1965)	Double-blind – matched pairs	Chronic or progressively deteriorating psychological or rheumatic disease (N=48)	Prayer, Interdenominational Christian Prayer (5 groups) and Quaker Prayer (1 group), 19 people	No significant differences in clinical outcomes or attitude state	• Result for 16 out of 19 pairs reported. • Heterogeneous patient groups, • No explicit inclusion/exclusion criteria reported.
Collip (1969)	Triple-blind – Two parallel groups	Children with leukemia (N=18)	Daily prayer by 10-families known to the author through their Protestant church	Death rate higher in control at the 90% level of significance	No inclusion criteria: 2 patients in the control group and none in the treatment group, had acute myelogenious leukemia, highly malignant
Miller (1982)	Double-blind – Two parallel groups	Patients with hypertension (N=96)	'Remote mental healing' in Church of Religious Science tradition	Decrease in systolic blood pressure in treatment group	• Results only given for 4/8 healers. • Use of medication was not controlled. • Unclear how many patients received follow-up
Byrd (1988)	Double-blind – Two parallel groups	Adults admitted to the cardiac care (N=393)	Directed daily prayer by "born again" Christians, included members of Protestant and Catholic churches	Treatment group required less ventilatory support, antibiotics or diuretics	Did not use Bonferroni to adjust for multiple comparisons, but did combine outcomes into a "severity score" (lower in treatment group)
Greyson (1996)	Double-blind	Patients with depression (N=40)	Distance healing using the LeShan technique	No treatment effect	Post-hoc analysis suggests lack of statistical power
O'Laoire (1997)	Double-blind	Healthy adult volunteers (N=406)	Non-directed and directed intercessory prayer by 90 "agents recruited through newspapers and churches	No treatment effect	Significant positive correlation b/w amount of prayer "agents" reported and positive outcomes on all 5 objective measures
Walker et al. (1997)	Double-blind – Two	Adults admitted to alcohol abuse	Non-directed prayer by volunteers from	No treatment effect	Lack of statistical power

	parallel groups	treatment (N=40)	Catholic, Protestant and Jewish traditions who reported more than 5 years of regular intercessory prayer and a belief that their prayers were answered		
Sicher et al. (1998)	Double-blind – Two parallel groups	Patients with AIDS (N=40)	Distant healing practiced by 40 healers from different spiritual traditions (each patient treated by 10 healers)	Treatment group had fewer new AIDS defining illnesses, lower illness severity, fewer doctor visits and hospitalizations, and improved mood	• Baseline differences in mood may be responsible for mood changes. • Did not use Bonferroni for multiple comparisons (author indicates post hoc analysis did not alter results; personal correspondence with Targ found in Astin 2000)
Harris et al. (1999)	Double-blind – two parallel groups	Patients admitted to the cardiac care unit (N=990)	Daily directed prayer by 75 intercessors from a variety of Christian traditions	Significant effect for summed and weighted coronary care unit score. No significant difference in length of hospital stay.	• Using Byrd's scoring system there is no significant treatment effect. • Baseline differences may not have been controlled for
Harkness et al. (2000)	Double-blind	Patients with warts (N=84)	Distant healing ('channeling of energy') by 10 healers	No significant treatment effect with regards to the size or number of warts	Baseline differences may not have been controlled for
Matthews et al. (2000)	Partially-blind	Adults with rheumatoid arthritis (N=40)	Prayers by lay volunteers from the Christian Healing Ministries "for the health of the patient." Initial in person prayer as well as 6-months of intercessory prayer daily	No effect from distant prayer; in-person prayer resulted in significant improvements at 1 year follow up on 10-outcome variables ($p<0.0001$)	• Sample size small, not representative of general population in terms of religiosity. • Initial group assignment (in-person prayer) not randomized-based on dates of enrollment and availability to receive prayer; • Belief about receiving distant prayer was highly correlated with improvement in global well-being, pain reduction and physical function
Abbot et al. (2001)	Four-armed randomized double blind controlled	Chronic pain patients (N=105)	Spiritual healing, first face-to-face (eight-weeks) (control received sham healing) and then at a distance (eight-weeks)	No treatment effect	Treatment group did report a more frequent occurrence of 'unusual' subjective experiences during the distant healing treatment period
Aviles et al. (2001)	Double-blind – Parallel groups	Patients admitted to the cardiac care (N=779)	Prayer conducted by 212 self-identified Christians from local organizations,	No treatment effect	• Prayer began after hospital stay – in an attempt to somewhat control for additional prayers out with the study

			organized into groups; 5 per patient		• Authors question outcome measures
Leibovici (2001)	Double-blind – Two parallel groups	Patients with bloodstream infection (N=3,393)	Retroactive directed prayer by someone who prayed for the well-being of the treatment group as a whole	Length of stay in hospital (p=0.01) and duration of fever (p=0.04) were significantly less for treatment group, mortality showed significant difference	Intended as a joke, but interesting (prayer conducted in 2000, patients admitted to hospital 1990-96)
Matthews et al. (2001)	Manipulated sample assignment to distant prayer or distant visualization was reported to patients – 1/3 received what they were told, 1/3 received the opposite intervention, 1/3 received no intervention despite being told assignment	Hemoidialysis patients with end stage renal disease (N=95)	Individual and group intercessory prayer by 6 Catholic women	No treatment effect (of prayer or visualization)	Subjects who expected to receive prayer reported feeling significantly better than did those who expected to receive positive visualization (P <.02)
Palmer et al. (2004)	Double-blind	Individuals who attend a local church (both for religious services and unrelated community events) (N=86)	Daily prayer by 8 members of a church's prayer chain and four retired women living in a Christian retirement home	No significant effect on primary outcomes; Marginally significant reduction in the amount of pain observed in treatment group (p=0.04); when belief was added to the model intervention subjects showed significantly less pain (p=0.01)	• Patients were not told that they were taking part in a study of prayer, but rather the relationship between health and religious behaviors - this brings up some ethical questions; • The role of belief appears to be a factor in positive intervention outcomes despite lack of transparency regarding the purpose of the study
Seskevich et al. (2004)	Double-blind assignment to prayer condition; additional noetic therapy was in-person/not blind	Patients undergoing percutaneous coronary intervention for unstable coronary syndromes (N=150)	Prayers of different types, durations and frequencies by a number of spiritual groups (Christian, Buddhist, Jewish)	Remote prayer had no effect on mood	Stress management, imagery and touch therapy showed decreased levels of worry
Mathai & Bourne (2004)	Triple-blind	Children attending a child and	6-individuals chosen by the PI were asked to	No treatment effect	The follow-up measures were completed by only half of the initial sample

		adolescent mental health service (N=36)	pray once a week		(due to patient discharge or patients failing to return at 3-months) resulting in decreased power
Krucoff et al. (2005)	Double-blind assignment to prayer condition; additional music, imagery, touch (MIT) therapy was in-person/not blind	Patients undergoing percutaneous coronary intervention or elective catheterization (N=748)	By groups described in Krucoff et al. 2001, shifted to tiered prayer strategy and added 12 prayer groups in the final 2 years	No treatment effect (prayer or MIT therapy). Those receiving prayer and MIT therapy had slightly lower mortality than prayer alone (p = 0.04)	64% of those not receiving prayer believed they were receiving prayer, compared with 35% of those who were assigned to prayer
Astin et al. (2006)	Double-blind – three arms	Patients with a history of AIDS category C and at least one AIDS-defining opportunistic infection (N=156)	Distant healing conducted by professional healers (1-arm) or nurses with no experience in distant healing (1-arm); participants received healing from a different healer or nurse every other week – in total receiving prayer from 10 individuals	No treatment effect for primary outcomes. Reduction in CD4+ lymphocyte counts at 6-months in patients treated by nurses compared to controls (p=.02) – however not significant at 12-months	• Incomplete follow-up (data missing for 24% of controls and 40% in nurse and healer groups at 12-months). • Healers expressed concern about rotating between healers as hindering process. • Blinding assessment shows at 6-months 72% in nurses group and 82% in healers group believed they were receiving healing compared with 51% of control group (p=0.02)., no effect at 12-month follow-up
Benson et al. (2006)	Partially blind	Patients undergoing non-emergency coronary artery bypass graft surgery (N=1,802)	Prayer from 3 Christian groups, participants added to prayer list for 14-consecutive days with a directive statement for improved health across groups	No treatment effect of intercessory prayer	Patients aware of placement in prayer condition had higher rate of complications (p=0.025) -knowledge of prayer condition allocation appears to be harmful
Walach, et al. (2008)	Partially blind, 2x2 factorial design	Patients with chronic fatigue syndrome (N=409)	3 healers practiced for each patient (from a pool of 462 healers in 21 European countries with varying healing practices)	No significant effect of healing	Patients who were not blind became worse (p=0.027), expectation of treatment in the blind had positive effect
Tsubono et al. (2009)	Double-blind	People with chronic pain (N=17)	Initial meeting and meditation with Japanese healer by both treatment and control, followed by distant healing for treatment group	Statistically significant results for Present Pain intensity (p=0.0016) and near significant for visual analogue (p=0.056) indexes, not significant for Pain Rating index	Results for 16 subjects - small sample size

I will discuss the studies presented in Table 2.1, with a special focus on the literature that has been particularly influential in the formation of the research that will be discussed in subsequent chapters. Studies will be discussed according to their orientation as either a prayer study or "Other distant healing," the latter referring to methods from diverse traditions that are not identified as prayer. In most cases "Other distant healing" studies do not involve a communication with God, although individual healers may identify a relationship with God or a higher power. Instead, these healers report a meditative practice, transfer of energy or communication with the patient as central to their healing practice. There is undoubtedly a great deal of overlap between the two practices, and this separation is not an attempt to privilege a specific approach. Some reviews present these studies together (Astin, 2003; Cadge, 2009). However, as we will be focused primarily on distant healing practices in Chapters 4, 5 and 6, it is useful to differentiate between the two here.

2.2.1.1 Prayer studies. Distant healing and prayer studies are often grouped together because, although the techniques used may be different, they each suggest the healing potential of an unseen force or intention. One major difference is that prayer involves a communication with some specific spiritual force (God, Shiva, Allah, however named). Jonas and Chez define various forms of healing that will be discussed (2004, p. 173):

> **Prayer:** Communication with an absolute, immanent, or transcendent spiritual force, however named. Such communication may take a variety of forms and may be theistic or nontheistic in nature, as in some forms of Buddhism.
> **Intercessory prayer**: An appeal to such a force in order to influence another person, thing or event.
> **Healing prayer**: An appeal to such a force for the healing and recovery of self or other.
> **Directed prayer**: Prayer that is offered with a specific outcome in mind.
> **Non-directed prayer**: Prayer that is offered with no specific outcome in mind, such as "Thy will be done" or "May the best outcome prevail."

Astin, Harkness, and Ernst's (2000) evaluation of the studies of prayer as a distant healing technique suggest a small positive effect size (0.25), with 2 of 5 studies showing significant, positive results. To understand these results it is necessary to understand the studies' methodological strengths and weaknesses.

Byrd (1988) evaluated the effects of intercessory prayer (IP) in a coronary care unit population in what is perhaps one of the most well known studies that researchers have aimed to replicate. The design involved a randomized double-blind, 10-month study with 393 patients. Volunteers, described as "born again" Christians, were designated to pray outside the hospital daily until the patient was discharged from the hospital. Each "intercessor" was asked to pray for the patient's rapid recovery and prevention of complications and death, in addition to any other prayers they might have deemed beneficial. Each patient had three to seven people praying for them, and it was assumed others outside of the study would pray for patients in both the IP group and the control; this could not be controlled for. Results showed that the IP group had significantly less congestive heart failure, required less diuretic and antibiotic therapy, had fewer episodes of pneumonia, fewer cardiac arrests, and was less frequently intubated and ventilated. There was not a significant difference in 20 other new diagnoses, problems or therapeutic events, including mortality and readmission into the cardiac care unit. This study lacked a standardization of prayer quality and quantity, and there was no measure of possible differences in regards to the number of people praying for each patient (Krippner & Achterberg, 2002). Although methodologically this is one of the stronger studies (Astin, Harkness, & Ernst, 2000), Byrd did not use a Bonferroni correction to adjust for multiple comparisons. Instead, he created a "severity score" by combining the different treatment outcomes; the treatment group's score was significantly lower.

More recent attempts to use Christian prayer to help coronary patients include Harris et al. (1999), Aviles et al. (2001) and Benson et al. (2006). In addition to these trials, a feasibility study was conducted by Dusek et al. (2002) for Benson et al. (2006). Seskevich et al. (2004) and Krucoff et al. (2005) also used a population of coronary patients but had a broader definition of prayer and included interventions by various faith groups where there is overlap with distant healing techniques. While outcome measures and intervention were not consistent across these investigations, overall these studies represent the strongest attempts at replicating effects in prayer research by repeatedly utilizing a population of coronary patients. Only one of these studies demonstrated a positive treatment effect of prayer (Harris et al., 1999). And while this study was relatively well powered, with 990 participants, it is unclear whether baseline differences were adequately controlled. Furthermore, Harris et al. (1999) used a summed and weighted coronary unit score that was different from the scoring system developed by Byrd (1988). When Byrd's scoring system was applied, no differences were observed between the two groups.

2.2.1.2 Other distant healing. In the Astin, Harkness and Ernst (2000) review, seven studies analyzed the effects of other forms of distant healing. They were described as "distance healing or distant healing" (Greyson, 1996; Harkness et al., 2000; Sicher et al.; 1998; Wirth et al., 1996), "paranormal healing" (Beutler et al., 1988), and "remote mental healing" (Miller, 1982). Positive results were found in four of the trials, three showed no significant effect, and the overall effect size was Cohen's d = 0.38.

Sicher, Targ, Moore and Smith's (1998) study of the effects of distant healing on patients with advanced AIDS is an interesting example that merits discussion. This study measured belief in distant healing, which is of particular interest in Chapter 3 as well. In this study 40 patients with AIDS were treated over a period of

10 weeks by 40 self-identified healers from different spiritual and healing traditions; each patient was "healed" by 10 healers, each for one week, to minimize any differences in healers. A majority (85%) expressed belief in the benefit of distant healing.

A blind medical chart review was undertaken six-months after the start of the study. It was found that the treatment group acquired significantly fewer new AIDS-defining illnesses, had lower illness severity, and required significantly fewer doctor visits, fewer hospitalizations, and fewer days of hospitalization than controls. There was also a significant improvement in mood compared with the control group, but this finding may be related to an effect of an average lower baseline mood state in the treatment group; and it is possible that hope or expectation related with being in the study contributed to their mood improvement more than patients with higher baseline mood states. This level was approximately equal in both groups, and there was no significant correlation with medical outcomes observed. It is also notable that no statistical adjustments were made for multiple analyses, such as the Bonferroni correction, although Targ (in personal contact with Astin, Harkness, & Ernst, 2000) stated that post hoc analyses with corrections for multiple comparisons did not change their results. Replication of this study would be useful to determine if a consistent effect of distant healing is observed in a larger sample of patients with AIDS. The inclusion of belief in distant healing as a baseline measure is a useful component to this study. The results suggest that belief in distant healing, which one might assume would be a component of expectancy, is not a strong predictor of distant healing efficacy.

More recent studies that would fall into the category of other forms of distant healing are: Abbot et al. (2001), Astin et al. (2006), Walach et al. (2008) and Tsubono

et al. (2009). Of these studies two showed no treatment effect of healing, one had mixed results, and one showed a positive effect of healing.

The more recent studies utilize methodologically advanced approaches. For example, Walach et al. (2008) explored the role of belief and expectancy by conducting a partially blinded trial for patients with chronic fatigue syndrome. By keeping half of the patients blind to their allocation condition, and half of the patients not-blind to their condition, the study is able to tease apart the effect of knowledge of distant healing treatment. This study served as a model for the research presented in Chapter 4 and will be discussed further therein.

Another example of design innovation is found in Abbot et al. (2001). The design involves an initial eight-week period of face-to-face healing (as well as sham healing) followed by an eight-week period of distant healing. Although a strong placebo response was found, there were no significant differences between experimental and control conditions.

Tsubono et al. (2009) designed a study around one particular Japanese healer. Participants were individuals who had chronic pain. Both the treatment and no treatment group met the healer for an initial session in Missouri that included a 20-minute meditation with the group of participants, after which the healer returned to Japan. All participants were asked to meditate for 20-minutes each day throughout the two-month trial, during which half the participants received distant healing. The McGill Pain Questionnaire served as the outcome measure, with individual subscales used to report results. There was marginally significant improvement in the visual analogue scale ($p= 0.056$) and significant improvement in the Present Pain Intensity Scale ($p= 0.0016$). However, the Pain Rating Index, while showing some improvement in the treatment group, was not significantly different between groups ($p= 0.12$). This portion of the scale comprises the bulk of questions in the McGill Pain

Questionnaire (Melzack, 1985). Similar to the Sicher et al. study, belief in distant healing was measured and had no effect on outcomes observed. The positive outcomes in this study, while significant for some measures, should also be treated with caution due to the small sample size (N=16). A larger replication study that incorporated an initial meeting with a well-reputed healer would be worthwhile. It is possible that some initial connection between healer and healee helps to facilitate distant healing as reported in this study.

These examples provide a rich base to support and inform future research. Areas that warrant future investigation are belief and expectancy. It appears, from the literature reviewed, that belief in distant healing is not necessarily important in healing outcomes (Sicher et al., 1998 & Tsubono et al., 2009), while expectancy, as shown by Walach (2008), appears to be a possible mediating variable. Suggestions for future research also include more careful measures of psychological factors that are known to interact with physical health but are absent in the available literature (Astin, Harkness, & Ernst, 2000 & Targ, 1997). Some of the positive results found in previous research may be the result of multiple analyses and possible data selection (e.g. Byrd, 1988); thus pre-specified analyses should be utilized. Further, it is suggested that future studies utilize non-human populations in order to minimize methodological problems such as the difficulty of attaining a pure control group in prayer studies, as well as possible blocked receptivity to healing due to uncertainty in participants of randomized trials (Dossey, 1997). Finally, due to the inconsistency in results it is important to explore other methods of investigation that might be useful to our understanding of distant healing phenomena. Other approaches that maybe useful include purely physiological measures as well as qualitative approaches. These approaches will be reviewed in the following two sections.

2.2.2 Physiological Research and Neuroscience

Although it is important to measure the therapeutic effects of distant healing directly on outcomes, the clinical evidence remains uncertain. Therefore, measurements in controlled laboratory conditions might be more straightforward in assessing the potential for distant healing.

The psychophysiological model has been explored in studies where physiological changes appear to occur and are measured in changes of body temperature and local changes in blood supply. For example, Green and Green (1977) tested an Indian swami under controlled conditions and found that he was able to generate significant differences in skin temperature between the two sides of his palm. While in this case the swami reportedly used his mind to generate changes in his own body, investigations into distant healing ask if it is possible to do this for another living being.

One study examines this possibility by recording the skin conductance of patients while they were receiving distant healing intentionality (Radin et al., 2008). Thirty-six couples participated in the trial. Twenty-two of these were composed of one adult who was healthy and the other undergoing cancer treatment. For twelve of these pairs the healthy person was trained to direct intention to their partner and asked to practice the technique daily for three months prior to the experiment. Another ten couples were tested before the partner was trained (waitlist group). Finally, fourteen healthy couples with no training served as the control group. Although planned between-group differences in skin conductance were not significant, overall the receivers' skin conductance increased during the period of distant healing intention ($z=3.9$; $p=0.00009$, two-tailed). Furthermore, post hoc analysis revealed that the largest and most sustained peak deviations were in the trained group, which is where the observed response in skin conductance continued

to rise progressively for eight seconds on average. In contrast the waitlisted group had an initially strong response that subsided after five seconds, while the control group's response subsided after just four seconds. These differences were not predicted, and the authors caution that replication is necessary to interpret these post hoc findings (Radin et al., 2008). Although this study does not measure the clinical efficacy of distant healing, one major benefit of this design is the ability to measure the response to distant healing by measuring an aspect of the recipients' physiology in real time.

Radin and colleagues' (2008) approach is representative of previous distant intentionality research that focused on measuring biological changes in target systems by self-reported healers, psychics and other self-selected volunteers. Schmidt, Schneider, Utts and Walach (2004) reviewed the effect of Direct Mental Interaction in Living Systems (DMILS) and remote staring. In this meta-analysis DMILS effects were seen ($p=0.001$) in 36 studies; however a best-evidence synthesis of seven studies yielded no significant effects ($p=0.50$).

Previous research has also measured electrical brain activity in an attempt to understand distant communication of individuals (Duane & Behrendt, 1965; Grinberg-Zylberbaum, Delaflor, Attie & Goswami, 1994; Radin, 2004; Standish, Kozak, Johnson & Richards 2004; Wackerman, Seiter, Keibel & Walach, 2003) and blood flow to the brain using fMRI (Achterberg et al., 2005; Richards, Kozak, Johnson, Standish, 2005). Measures of brain activity using EEG yields complicated results, although a number of studies had positive results. The study by Grinberg-Zylberbaum et al. (1994) consisted of seven pairs of participants' simultaneously measured EEG, with one member of each pair being photically stimulated at random intervals. Half of the pairs were complete strangers and did not meet prior to the experiment, whereas the other half were introduced before the trial and asked to sit

together in meditative silence for twenty minutes. Pairs of participants in the latter group showed significant EEG correlations, while the former exhibited no correlation. Other EEG studies cited, with comparable methods, showed similar results, with the exception of Sabell, Clarke and Fenwick (2001) who did not replicate the effect.

The fMRI studies in particular present a number of methodological flaws and warrant further investigation by skilled researchers. In Richards et al.'s study (2005), significant changes in brain activity were reported; but they examined only one pair of participants. In Achterberg et al.'s research (2005), eleven healers were chosen to be the senders; however they were not asked to practice healing but rather to attempt a distant connection with their partner (who was someone chosen by the healer as a person they felt a connection with) who was measured using fMRI. Although significant differences in the metabolic activity of participants' brains were reported during the distant healing periods, this study contains a major flaw in the lack of randomization of the trial epochs, thus leaving space both for unknown artifacts as well as possible leakage of information to other participants in the study.

In determining empirically how psychic healing might function, it is important to address the biological study of the relationship between the mind and body. The study of psychoneuroimmunology has brought forth evidence for the strong connection and overlap of psychological and physical systems. For example, research includes the identification of receptor sites for neuropeptides, which are hypothesized to link emotions and thoughts with bodily processes (Pert, Ruff, Weber, & Herkenham, 1985). Neuropeptides, as described by Rossi (1993), "modulate neural communication in mental and behavioral states of emotion, pleasure, pain, stress, trauma, memory, learning, and behavior that are of central interest in virtually all approaches to mind-body healing" (p. 159).

The placebo effect is the most widely accepted model to account for anomalous healing (Krippner & Achterberg, 2002). Roberts, Kewman, Mercier, and Hovell (1993) demonstrated the strong power of the placebo in their review of studies for treatments that were ultimately shown to be ineffective. Non-specific effects, including factors such as expectancy, belief, and persuasion, were very strong, and Roberts et al. concluded that it would be almost impossible to find differential effects between a placebo treatment and an actual biological treatment when positive expectations are present in both practitioners and patients. He goes on to suggest that the same observation may be present in unconventional treatments. Theories that account for the placebo response include psychoneuroimmunity, Wickramasekera's (1980) Pavlovian conditioning theory, as well as theories of transference and attribution. Transference sees placebo effects as regressive behaviors that are rooted in child-parent interactions, where the patient may unconsciously interact with the physician in such a way that imitates a trusting child-parent relationship. The attribution theory suggests clients are hyper-aware of subtle changes in their internal state during treatment and credit the placebo to these changes (Krippner & Achterberg, 2002).

2.3 Individual Differences

Individual differences, such as personality and beliefs, may moderate the experience and outcome of psychic-healing events. To better understand distant healing it is important to extend this investigation to include the characteristics of healers.

There is very little reported research regarding the individual characteristics of healers or healees involved in distant healing research, as the majority of studies focused instead on outcome measures. It is therefore helpful to look beyond the

research specific to distant healing and consider findings from related areas of interest.

Previous investigations into exceptional recoveries from serious illness (without healing intervention) uncover patterns that reveal several traits associated with recovery. For example, a 10-year follow up study of women with breast cancer examined the association between psychological attitudes and treatment outcome. Women categorized as being in denial and having a fighting spirit were more likely to have a favorable outcome than those categorized as having stoic acceptance and helplessness/hopelessness (Pettingale, Morris, Greer, & Haybittle, 1985).

Although not specific to distant healing, Saher and Lindeman (2005) investigated factors related to belief in complementary and alternative medicine (CAM). This study found participants were more likely to express belief in CAM if they also possessed an intuitive thinking style. The strongest predictors of CAM beliefs were believing in the paranormal and having magical food and health beliefs. The authors note in particular the relation of CAM beliefs to gender, which is initially significant but disappears when thinking style, paranormal beliefs and magical food and health beliefs are controlled for.

A fairly recent investigation of individual differences as they relate to distant healing outcomes was conducted by Lyvers, Barling and Harding-Clark (2006). In a small scale trial of distant healing, twenty participants were allocated randomly to either a healing or control condition. Healing was practiced by a well-known Australian psychic healer and resulted in no observed treatment effect. However, pretreatment questionnaire ratings of belief in psychic healing and related phenomena, such as hypnotherapy and alternative medicines, revealed a significant correlation with improved outcome regardless of treatment allocation. Thus, belief appears to be a significant factor in healing outcomes.

In summary, the social support, hope and encouragement that distant healing or prayer might potentially provide to individuals may increase their healing capacity. Belief in treatment is associated with particular cognitive styles, and this too is associated with positive outcomes. Whether it is the patient's receptivity to distant healing or a placebo effect is not evident at this time. Furthermore, the function of the placebo effect may in fact be an individual tapping into their own healing potential (Walach, 2001). Further investigation of personality factors and coping styles might identify the individual characteristics that make one most receptive to distant healing interventions.

The role of a practitioner's quality and quantity of experience is another area that warrants further investigation. It is important to understand the social context of the healer and the traditional roles or attributes which may be ascribed to them. In this vein, some research has investigated the effect of the healer's mental state. While it was initially presumed that many of the shamanic healers were psychotic with some characteristics paralleling that of schizophrenia, the research does not support this presumption (Boyer, Klopfer, Brawer & Kawai, 1964, Murphy, 1967, Noll, 1983). Characteristics among self-described healers include feelings of grandiosity, self-confidence, and pleasure in being the center of attention (Appelbaum, 1993). However, psychic healing is of a different nature, involving minimal or no actual contact with the healer, which may indicate that these healers have different characteristics.

2.4 Qualitative Research

An experience-based approach to psychological research can be utilized when examining both the patient or participant and the healer. A phenomenological study

is useful when creating a framework for the experience of healing and providing information that might be difficult to extract using quantitative methods.

Giorgi (1970) advocates an existentialist viewpoint of psychology as a "human science." This method seeks to describe and process human life in a context that goes beyond natural science and "objectivity" and avoids cultural assumptions. A dualistic split between mind and body is an example of a cultural premise that dates back to the Age of Enlightenment. This premise sunders the relationship between mental and physical health, and it assumes that one aspect can be treated without consideration for or treatment of the other. The "human science" model that Giorgi describes defines the researcher's role as finding a pattern or meaning based upon the interdependence of the individual and the world. Similarly, Coliazzi (1989) suggests that close reading and analysis of participants' descriptions of their experiences provide an opportunity to look for patterns therein and, as a result, form generalized descriptions that might be agreeable to a majority of the participants.

A good example of qualitative research in the realm of healing is the book *Ritual Healing in Suburban America*, which provides a detailed overview of healing practices throughout the United States (McGuire, 1988). Although this study takes an anthropological approach to research, there is some overlap here with the qualitative methods utilized by psychologists. This study was not specific to healers per se but focused on spiritual groups around the country that engage in healing practices (distant healing or otherwise). In total, 255 group sessions from 31 different groups were observed and recorded in detail. Three hundred and thirteen interviews were conducted with leaders, healers, members, and clients of the various non-medical healing groups. An additional 43 interviews were conducted with a control group that was selected from comparable neighborhoods and matched for gender and age. The groups studied are broadly categorized as Christian, Metaphysical, Eastern

Meditation, and Psychic and Occult. The author reported that most adherents did not join the group as a last resort to heal an illness but rather were attracted to the community by the larger system of belief, of which health- and illness- related beliefs are only a part. The efficacy of a specific healing technique was found not to be particularly relevant to most of these groups; importance was instead placed on a whole system of beliefs and practices that reportedly "work" in several complex ways. The author highlights the distinct intent of the healer in this system; noting that, although financial gain could be a possible motive, most groups did not seem to be fabricating their beliefs and experiences regarding the efficacy of their healing practice.

According to McGuire (1988), healers appeared to utilize their own methods and devoted considerable time and effort to developing and practicing them. Psychic healers reported that they did not themselves do healing for another person but rather that all healing is self-healing. Their role is thus to channel energy or lead the person to self-healing through teaching, counseling, and mentoring. Similarly, Eastern Meditation groups considered the healer as promoting the healing of another individual. To quote one interview, "Healing is…helping people discover in themselves other alternatives….So I see [being a] healer as the same as an educator…to bring a person to a place where they are more conscious about what the problem is, what the ramifications are and what they are getting from it, what it is keeping them from doing" (McGuire, 1988, p. 171). Thus, the expert healer in these groups is usually a role model, teaching and demonstrating self-healing techniques and encouraging others to practice them.

Metaphysical groups similarly emphasized the power of self-healing. Although practitioners were identified as having important healing roles, the main goal of the practitioner is to encourage self-healing. Finally, the Christian groups had

a different emphasis. They primarily reported that the healer was an intermediary between the sick person and the healing God. Individuals with strong faith, humility and commitment to the Lord were said to be particularly suited to be intercessors of God's healing. Overall, McGuire's findings provide a comprehensive account of various healing groups, how adherents and healers practice and participate in the group, and the meaning they attribute to their involvement. The author notes that many of the groups studied were easily located due to advertisements and presence in national associations, telephone directories, etc. Thus, groups and healers who were less-public were likely underrepresented in McGuire's study. For the purpose of this thesis, a concentration on healers with a specific practice of distant healing would have been useful.

In her study of spiritual healers, Grytting (1997) used a grounded theory approach to generate a theory of spiritual healing. Grytting received demographic information and responses to open-ended questions from thirty-five healers. The grounded theory developed from this study is that spiritual healing is influenced by the relationship between the Divine Spirit, the healer, and the client. While the specific results of the open-ended questions will be discussed in greater detail in Chapter 4, the primary finding was that the perception of a strong connection to the Divine Spirit was a principal factor believed to contribute to spiritual healing and was a quality healers felt was important to have in themselves and other healers. Reported obstacles to spiritual healing included the unchecked ego of the healer, the healer not doing his/her own work, and the client's own belief, fear or resistance to getting well.

Interpretive Phenomenological Analysis (IPA) is a method developed by psychologists that is rooted in phenomenology and hermeneutics (Smith, 2007). IPA provides a structure to phenomenological inquiry in the field of psychology and may

be helpful in understanding how distant healing is experienced. There are no previous studies that utilize IPA to study distant healing, but this approach will be introduced in Chapter 5. Here the description and interpretation of healees' experience of distant healing will be explored.

2.5 Conclusion

The literature offers a number of inconclusive outcomes, but as the methodological design of distant healing research evolves it may be possible to tease apart some of the factors involved. In the future, quantitative research that evaluates the expectancy and beliefs of participants may be particularly informative, and Walach et al. (2008) and Lyvers, Barling and Harding-Clark (2006) have paved the way for such work. As technology develops, physiological measures of distant healing may be particularly helpful in identifying the physical systems that could be involved both in healer and healee. Further developments in physics may also be useful in understanding the possibility mechanisms involved if distant healing is efficacious. Applying a scientific approach to healing research represents an attempt to "medicalize" healing practices. As Cadge (2009) points out, this approach can be extended to a variety of religious practices, including prayer and meditation, and although it may not directly influence how such practices are carried out, it will influence how they are received by the larger public.

Overall, the use of qualitative methods in distant healing research has been limited, although some studies that include qualitative approaches can be found in student dissertations, such as Grytting's (1997). These studies, and the work in related fields, offer information that is helpful in understanding the healing process and may be useful in directing future studies. For example, the work of McGuire

(1988) is extremely thorough in observing and recording the differences among different types of healing groups. Her work provides insight into how members of groups practicing healing understand their experience. However, some points may be lost or difficult to control for in qualitative research. Specifically, McGuire notes that for most groups the healer is not responsible for the health of the patient, but rather the healer is there to help encourage self-healing or act as an intercessor with God. More importantly, the notion of whether healing "works" is not considered central, and the healing process is not based on a relationship between patient and healer alone but connected to a larger structure of beliefs. These factors suggest that the healing process for both practitioners and recipients is much more multifaceted than a standard medical treatment that focuses on clinical outcomes.

Chapter 3: A Clinical Trial of Distant Healing

3.1 Introduction

As we have seen from the literature review, many factors could be involved in anecdotal claims of distant healing, including placebo effects, individual expectations, and the strength of faith in a specific healer. At a time when there is a broad, growing interest in alternative medicine (Eisenberg, et al., 1998; Oldendick, et al., 2000; Snyder & Lindquist, 2001; Thomas, Nicholl, & Coleman, 2001; Tindle, Davis, Phillips, & Eisenberg, 2005), these factors and their role in the healing process in general demand investigation. This study aims at piecing together the possible factors involved in the practice of distant healing. Using a partially blind design, some of the participants were informed whether or not they would be receiving healing (the "not blind condition") and some were not (the "blind condition"). This design was employed with the aim of clarifying the role of expectation in the clinical study of distant healing. The juxtaposition of the experiences of blind and not blind participants may highlight the imposition of the experimental setting on the participants' self-reporting.

Healers in this trial were self-referred; after correspondence with them, I chose six experienced healers based upon their self-reported training and background with distant healing. Although the healers employed a variety of techniques and were thus given the freedom to practice healing in the way most suitable to their background and training, all healers practiced "distant mental influencing" or "intentionality" for a minimum of thirty-minutes for each participant each week. Specific differences between healers can be observed in their individual logs, which will be discussed in further detail later in this chapter.

Very few studies have examined the role of belief in healing. According to the literature and research on psychoneuroimmunology and psychophysiology (Pert, Ruff, Weber, & Herkenham, 1985; Rossi, 1993), belief is an undeniably important aspect of the healing process. In a study with a similar design to the present one, Walach, et al. (2008) found a significant effect ($p = 0.027$) on self-reported mental and physical health outcomes of experimentally blind participants with chronic fatigue syndrome. More importantly for the present study is the additional finding that post-hoc analysis of participants' beliefs as to whether or not they were receiving healing appears to be related to mental and physical improvements, with those who believe that they are receiving healing having more positive outcomes.

The current study also accounts for participants' self-reported beliefs about distant healing. One possible explanation of the reported efficacy of distant healing is belief or faith, clearly present in the term "faith healing". This could be manifest as faith in a higher power or in the healer.

3.1.1 Hypotheses and Planned Analyses

Hypothesis 1: Participants who receive distant healing will report greater relief from their illness compared to the control group.

Hypothesis 2: Participants aware of placement in the healing condition will report greater relief from their illness than those participants aware that they are in the no healing condition.

Hypothesis 3: Participants who report a higher belief in the effectiveness of distant healing will report greater relief from their illness than those with low belief.

3.1.1.1 Planned analysis. An analysis of variance will be used to calculate between-group differences of the post-treatment (after 6 weeks of healing) scores for the Short-form McGill Pain Questionnaire and the General Health Questionnaire. The pre-treatment

scores will be included as covariates, using an ANCOVA. The Healing and Paranormal belief scale pre-treatment scores will be included as additional covariates.

3.1.1.2 Exploratory questions. Further analysis using data collected at the baseline measurement including age, gender, severity of illness, personality, spirituality and satisfaction with life will be explored. Additionally, data from each healer will be analyzed separately to uncover any possible differences in healer performance.

3.2 Method

3.2.1 Sampling Procedures

Participants were recruited from the Western General Hospital in the Rheumatology outpatient clinic after NHS ethical approval was obtained. Appropriate prospective participants were screened according to their medical history and then approached in the waiting room. Participants were also recruited by word of mouth and online through Arthritis Care's website, the Koestler Parapsychology website and the Parapsychology blog. Only adults (18 and over) were considered as participants in the study. Patients were excluded if their medical records reported severe mental illnesses that might have interfered with accurate self-reporting. All participants received information about the study in the recruitment phase and subsequently gave consent if they wished to participate.

3.2.2 Participant Characteristics

Participants were primarily British nationals, although due to recruitment online, participants from the USA (n = 11), Austria (n = 1), Australia (n = 1) and Denmark (n = 1) were also included in the study.

There were 46 women and 14 men who participated in this study. These numbers are reflective of the demographic make-up of arthritis sufferers. In a recent study of gender as a predictor of outcomes in rheumatoid arthritis patients, descriptive statistics showed that 79% of those included in this large multinational cross-sectional cohort of 6,004, were female, and that the overall mean age was 57 years (Sokka, et al., 2009). In the present study, approximately 77% of participants were female, and the mean age was 53. In general, then, participants in the current study appear to be comparable to the general population of arthritis sufferers.

3.2.3 Healers Sample

Six healers participated in the study. They were self-referred in response to an article in the Harry Edwards Healing Sanctuary's magazine, *The Healer*. The healers came from a variety of backgrounds and training; four were members of the National Federation of Spiritual Healers (though even amongst them, beliefs and backgrounds varied). The other two healers were certified Reiki masters. Each was chosen based on self-reported experience and training in distant healing.

3.2.4 Sample Size and Power Considerations

The goal of enrolling 60 participants in the study was met. In total, 125 potential participants were recruited and sent an information packet, letter of consent and baseline measures. Of those 63 responded, 60 completed participation in the study and 3 failed to return post-treatment measures. Of the 60 participants who completed the study (i.e., who completed and returned all assessment materials), 40 were recruited from the Western General and 20 were recruited online or by word of mouth. Participants were offered a book token or a charitable donation in recognition of their efforts.

Ideally a larger sample would have been attained, but due to the limitation of

resources available, this was not possible. For a clear picture of the timeline and effort involved in this project, refer to Appendix A. It should also be noted that, unlike most clinical trials, which are frequently conducted by a team of researchers, assistants and support staff, this project was undertaken independently, with all aspects of preparation, recruitment, correspondence, data collection and analysis undertaken by myself (with the guidance and occasional logistical support of my supervisors). It was understood from the outset of the study that a sample size of 60 would most likely not produce statistical significance, but the project was pursued as a pilot-study and learning opportunity. It was initially planned that a second, similarly designed follow-up trial with a similar design would follow, however failure to attain local ethics approval as well as time and funding constraints prevented this. Although previous studies suggest that the healing effect may be small and difficult to detect in a clinical trial, the sample size was determined to be adequate for effect size calculations.

3.2.5 Measures and Covariates

Participants completed the 12-item General Health Questionnaire (D. Goldberg & Williams, 1988), Short Form McGill Pain Questionnaire (Melzack, 1987), Paranormal Belief Scale (Lange, Irwin & Houran, 2000), IPIP personality scale (Goldberg, 2001), Spiritual Connection Scale (Hyland & Wheeler), Satisfaction with Life Scale (Diener, Emmons, Larsen & Griffin, 1985), and a brief index of dietary habits. Participants also answered a four-item questionnaire that was designed to assess their belief in paranormal healing. The GHQ and the McGill Pain Questionnaire were the primary outcome measures, and the Paranormal Belief Scale and the healing belief questionnaire served as a covariate to test Hypothesis 3. All other questionnaire measures were used for exploratory analysis. To see each scale in its entirety, please refer to Appendix B.

General Health Questionnaire. The 12-item GHQ was developed by D. Goldberg and Williams (1988) to assess overall well-being. Items are both positively and negatively worded and scored accordingly. There are 12-items, each scored on a scale of 0 – 3 (for example 0 = much less than usual and 3 = much more than usual). The range of scores for this measure overall is 0 – 36, where higher scores are indicative of less general well-being. This version has been shown to be comparable to the longer, and frequently used, 28-item GHQ (D. Goldberg, et al., 1997). The GHQ is one of the most commonly utilized assessments of mental well-being, developed to detect those likely to have, or be at risk of having common mental health problems such as: anxiety, depression and social withdrawal (Jackson, 2007). Furthermore, this measure was one of the primary outcome measures in a similar study by Walach et al. (2008).

Pain Questionnaire. The Short Form McGill pain questionnaire, developed by Melzack (1987), was chosen as a primary outcome measure to gauge participants' symptoms of pain, specifically as it related to their arthritis. The McGill Pain Questionnaire was developed to measure pain using 15 descriptors, 11 of which are sensory descriptors (i.e. throbbing) and 4 of which are affective (i.e. fearful). These are each rated on a scale of intensity where: 0 = none, 1 = mild, 2 = moderate or 3 = severe. Two additional components of the scale are: a Visual Analogue Scale (VAS) of pain – with a range of "no pain" to "worst possible pain"' and the Present Pain Intensity (PPI) on a scale of 0 – 5 (where 0 = no pain and 5 = excruciating pain). In evaluating this measure the VAS was omitted due to irregularities in the online questionnaire version of this measure. The total score was measured adding the 15 descriptive questions with the PPI; therefore scores can range from a minimum of 0 to a maximum of 50, with higher scores indicate greater self-reported pain.

IPIP Personality Questionnaire. Developed by L. R. Goldberg (2001), this is a freely

available online questionnaire designed to measure the five main personality factors of Neuroticism (10 items), Extraversion (10 items), Openness (10 items), Agreeableness (10 items), and Conscientiousness (10 items). This was chosen as a measure to explore the possibility that particular personality factors might be a moderating variable in distant healing efficacy. This questionnaire was administered once, at the baseline assessment. Responses can range on a five-point scale from 1 = Very Inaccurate to 5 = Very Accurate; thus scores can range from a minimum of 10 to a maximum of 50, with higher scores indicating a greater endorsement of that personality factor.

Life Satisfaction. The Satisfaction with Life Scale (Diener, Emmons, Larsen & Griffin, 1985) was also included as an exploratory measure and administered at each assessment period. The questionnaire consists of 5 items, each scored on a 7-point scale ranging from Strongly Disagree to Strongly Agree. Scores can range from a minimum of 5 to a maximum of 35, with higher scores indicating higher life satisfaction.

Spirituality. The Spiritual Connection Scale (Hyland & Wheeler) consists of 14 items, each answered on a scale from -3 to + 3, then recorded as 1-7 for scoring purposes, with response options ranging from Unlike me (-3) to Like me (+3). Scores can range from a minimum of 14 to a maximum of 98, with higher scores indicating greater spirituality. This measure was taken to explore the possibility that spirituality might moderate distant healing efficacy.

Paranormal Belief. The revised 26-item Paranormal Belief Scale (Tobacyk, 1988) was used to measure seven distinct types of belief: traditional religious belief, psi, witchcraft, superstition, spiritualism, extraordinary life forms, and precognition. Responses are rated on a 7-point scale from Strongly disagree to Strongly agree. Scores can range from a minimum of 26 to a maximum of 182, with higher scores

indicating a greater level of belief. This measure was administered at the baseline assessment to test the hypothesis that belief may moderate healing efficacy; for this analysis, scores were combined with the four-item Healing Belief questionnaire.

Distant healing belief. The four-item Healing Belief Questionnaire was designed by the present author. Responses can range on a 7-point scale from Strongly disagree to Strongly agree; scores can range from a minimum of 4 to a maximum of 28, with lower scores indicating lower belief in distant healing. This measure was used with the Paranormal Belief Scale to get a baseline measure of participants' belief.

Dietary Checklist. This measurement was not included in the analysis.[1]

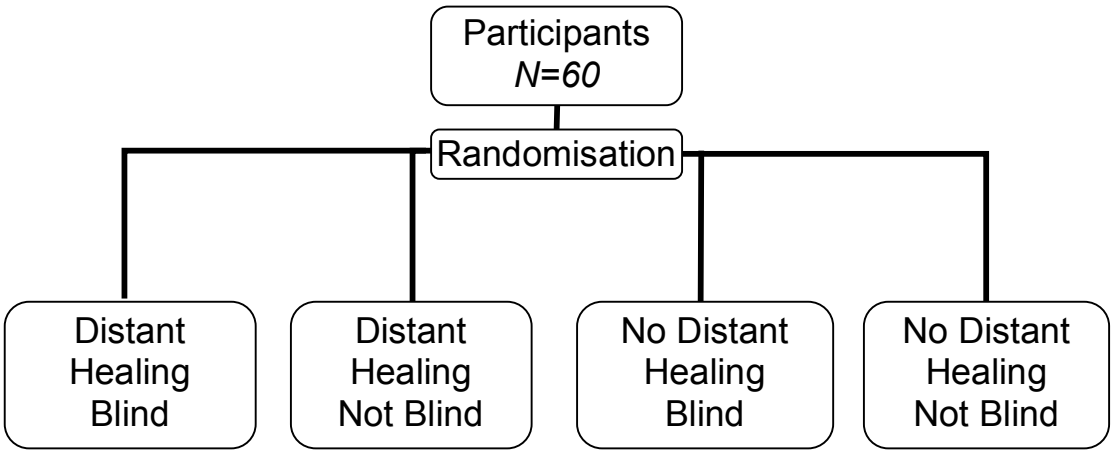
3.2.6 Research Design

Participants were randomly allocated to distant healing treatment versus control (no healing). In order to test for the effect of expectancy, half of the participants were blind to treatment condition and half were made aware of their treatment allocation. There were thus four treatment groups, as shown in Figure 3.1. The four groups were measured at three points (baseline, post-treatment, one month follow-up). The analysis focused on the first two measurement points; the final measurement was taken as an exploratory measure and was not found to be significantly different from the post-treatment measure. This provided a 2x2 factorial design. The study design and procedures were ethically approved by Lothian National Health Service (NHS) ethics board and the University of Edinburgh's Psychology Department ethics

[1]Previous research has suggested that diet may play a role in arthritic symptoms (Kjeldsen-Kragh, et al., 2003; Stamp, James and Cleland, 2005) and dietary suggestions were advertised clearly in the Rheumatology Clinic at Western General Hospital, where much of the recruitment for this study took place. When preparing for this study I met with a distant healer and nutritionist who provided this checklist and suggested its inclusion in the questionnaire pack. The checklist involves a list of foods that are either health promoting, for example: *celery*, *beetroot*, and *eggs (not fried),* or detrimental to health, for example: *cakes*, *chips*, and *coke*. Items were scored as 1 for health promoting and 2 for detrimental, with a maximum possible score of 90 (the minimum, if the participant eats none of the listed items, is 0). Higher scores indicate poorer diets, but, because of the limited scope of this checklist, interpretation of this measure is limited and was not included in the final analysis.

committee.

Figure 3.1: Allocation to experimental conditions.



3.2.7 Randomisation and Security

Random number tables were used to randomly assign participants into one of four treatment conditions and to one of six possible self-identified healers. Dr. Caroline Watt (CW), who conducted the randomisation, did not have contact with the participants in the study apart from informing them of their condition allocation. I subsequently interacted with the participants by sending out and collecting questionnaires and had no information about the participants' condition allocations until all the study data had been collected and entered into SPSS. Records of the condition allocations were kept in a filing cabinet in CW's office, which was locked when unoccupied. Participants allocated to blinded conditions were not made aware of their condition allocation until after their responses to the one-month follow-up had been collected.

3.2.8 Procedure and Participant Flow

Following recruitment, participants were randomly assigned to an experimental or control group. Participants provided their name, age, occupation and basic

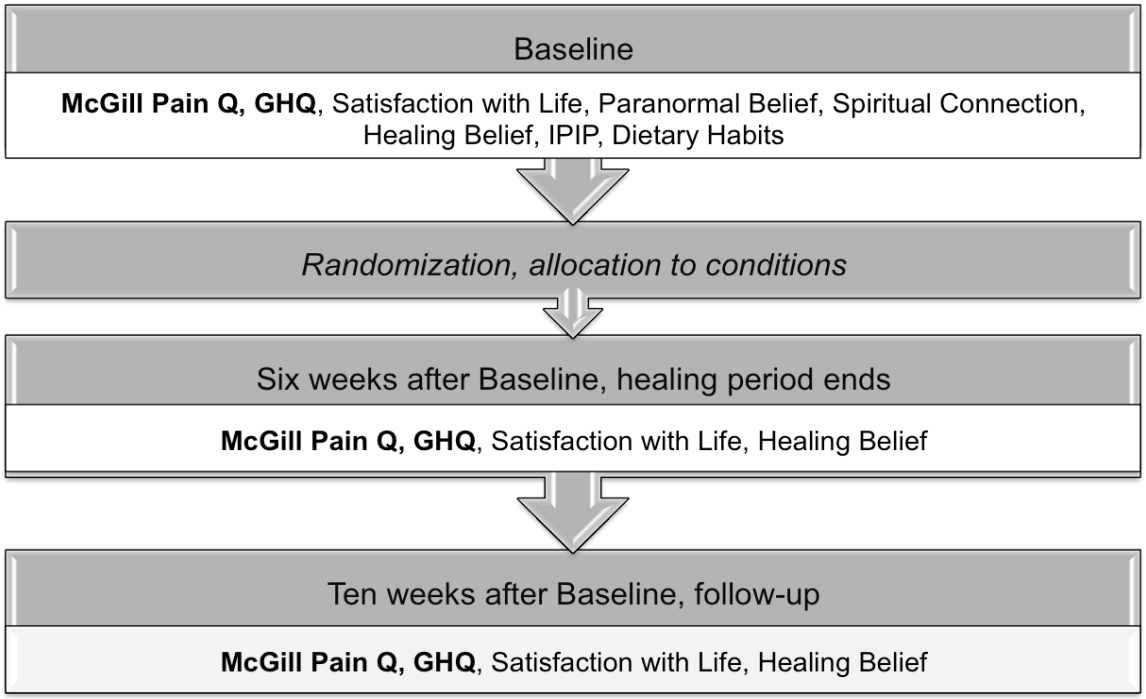
information regarding their physical condition, as well as a photograph for the healers. This information was posted to the healers by CW.

3.2.8.1 Procedure for healers. The healers never met the participants in person. For each patient, the healer was given the participant's name and age, a photograph, and a brief description of the participant's condition at the outset of the study. Healers worked "with" the participants for 6 weeks and were asked to practice distant healing at least once per week. The healers used their normal healing techniques and were asked to record the time, duration and type of distant healing for each patient. Keeping records both provided structure for the healers and held the promise of insight into the effectiveness of different healing regimes and techniques. Logs indicate that some healers chose to practice healing almost daily for shorter durations (1-15 minutes), while other healers practiced healing once or twice a week for longer periods (20-40 minutes). Some healers chose to record the details of specific experiences encountered during the healing sessions; many of these logs resemble conversations between healer and participant. Others' logs are similar to prayer journals, focusing on the act of transmission without much information regarding the nature of its reception.

3.2.8.2 Procedure for participants. Participants were free to continue their current medical treatment or seek additional treatment, as they so desired. At each point of measurement participants were asked to report any significant changes to their treatment, including new medications or lifestyle changes. The control groups received no intervention and completed the same measurements as the treatment groups. As Figure 3.2 shows, after participants completed all questionnaire measures at baseline and returned them to myself, they were randomly allocated to their

condition by CW, who then informed participants of their condition allocation. Healing ended after 6 weeks, at which point the GHQ and McGill Pain Inventory were re-administered. Finally, at follow-up 1 month after the healing period had ended, the GHQ and McGill Pain Inventory were again administered. I posted the questionnaire materials to participants, along with reminder letters or emails to encourage them to return their completed questionnaires in the pre-paid envelopes that had been provided. Following conclusion of the study, those participants who did not receive distant healing were given the opportunity to do so.

Figure 3.2: Administration of measures throughout the study (primary outcome measures are in bold).



3.3 Results

3.3.1 Descriptive Statistics

Due to randomised condition allocation, unequal numbers of participants were allocated to the different conditions. Descriptive statistics showing participant

demographics and mean scores according to responses on the primary baseline measures are shown in Table 3.1. Participants are approximately the same age in each of the four treatment groups (within a range of 10 years). Baseline scores for the GHQ, the McGill Pain Inventory, and the Healing Belief questionnaires appear to be similar across the four treatment groups.

Table 3.1. Demographic, descriptive statistics and standard deviations for the main baseline measures, by condition allocation.

	Blind and Distant Healing n = 18	Not-Blind and Distant Healing n = 15	Blind and no Distant Healing n = 15	Not-blind and no Distant Healing n = 12
GHQ Baseline	26.9 (6.0)	27.5 (7.7)	27.8 (7.2)	22.8 (4.3)
MG Pain Baseline	22.6 (10.5)	20.8 (11.3)	20.9 (12.1)	16.5 (7.1)
Healing Belief Baseline	14.9 (7.0)	17.1 (5.9)	17.3 (7.7)	16.6 (8.1)
Age, years	48.6 (13.3)	52.4 (11.8)	54.3 (14.3)	57.4 (15.0)
Gender	F=11, M=7	F=12, M=3	F=13, M=2	F=10, M=2

Figures 3.3 and 3.4 illustrate the mean change scores on the two primary outcome measures: GHQ and McGill Pain. The change scores were calculated by subtracting the Baseline questionnaire scores from the Post-treatment (after 6 weeks of healing) questionnaire scores. A negative change score represents a self-reported worsening of health and an increase of pain; a positive change score represents a self-reported improvement in health and a decrease of pain. From these initial descriptive statistics, we find many similarities between measures. The largest improvement in health outcomes appears for those participants who knew they were in the healing intervention group, whereas the worst health outcomes occurred for those participants who knew they were *not* receiving healing. We can also see that each of the four groups reported a reduction in pain in the post-treatment measure compared to pre-treatment, as shown in the McGill Pain change scores. These trends are shown graphically in Figures 3.3 and 3.4, where there appears to be an interaction.

Figure 3.3: Mean change in GHQ, by condition.

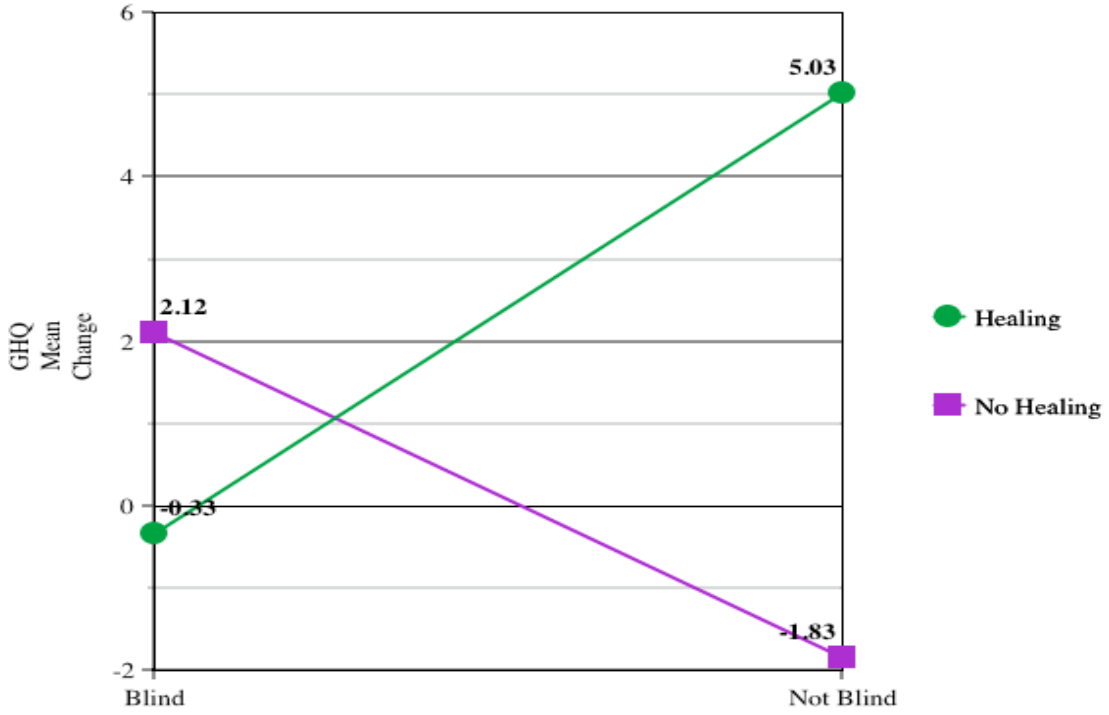
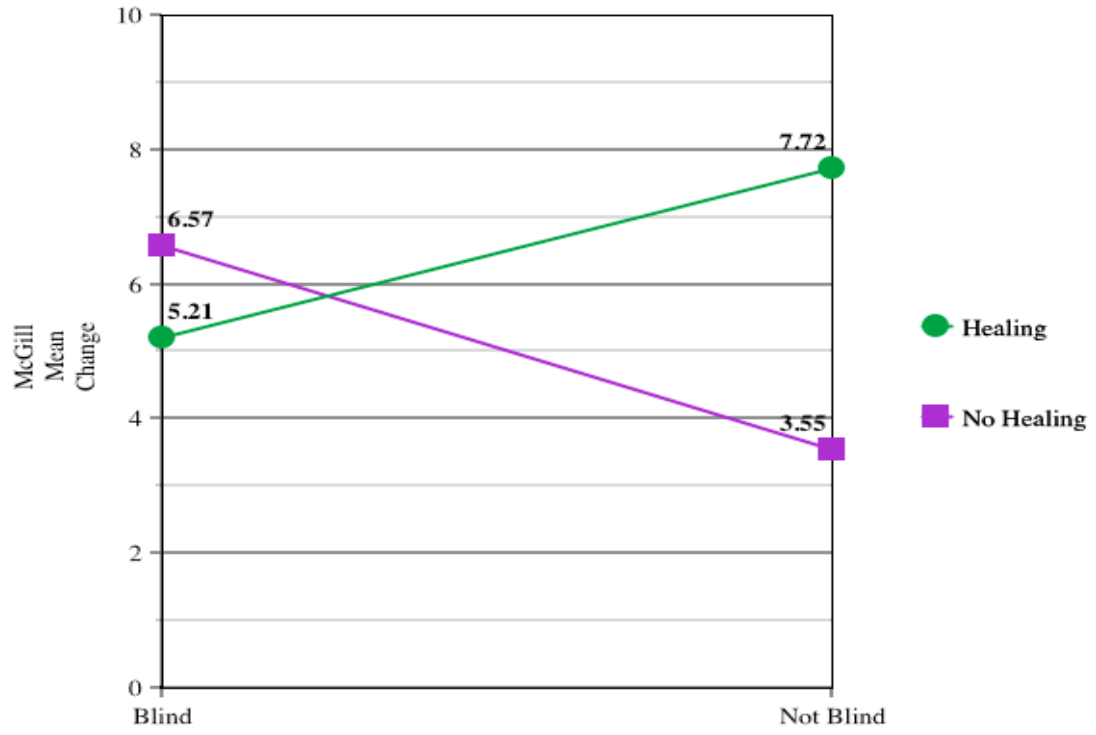


Figure 3.4: Mean change in McGill, by condition



3.3.2 Analysis of the Effects of Healing, and the Effects of Blinding (Hypotheses 1 and 2)

An analysis of covariance was used to calculate between-group differences of the

GHQ change scores and the Short-form McGill Pain Questionnaire change score in order to test the hypotheses concerning the effects of treatment and blinding on well-being and health outcomes. The dependent variables are the change in GHQ and McGill Pain Questionnaire scores, the independent variables are allocation to *healing* or *no healing* and *blind* or *not-blind*, and baseline scores for the respective outcome measure are included in the model as covariates, using an ANCOVA. Hypothesis 1 predicted that participants receiving healing would show better self-reported health and well-being than those not receiving healing. This would appear as a main effect for healing in the ANCOVA. Hypothesis 2 predicted that participants aware that they were receiving healing would report better health than those aware that they were not receiving healing. This would appear as an interaction effect in the ANCOVA.

Outcomes of the ANOVAs are provided in Tables 3.2 (change in GHQ) and 3.3 (change in McGill Pain Questionnaire). Neither analysis shows statistically significant change scores between the groups. The only significant predictor in this model was the pre-treatment scores for the GHQ (R^2: 31.1%) and the McGill Pain Questionnaire (R^2: 27.0%), each explaining most of the variance of their respective models. That is, higher baseline scores predicted higher post-treatment scores. Therefore, there is no significant support for Hypothesis 1.

Table 3.2: Tests of between-subjects effects – GHQ change.

Source	df	F	Sig.	Partial Eta Squared
Corrected Model	4	7.732	.000	.360
Intercept	1	20.961	.000	.276
GHQ Baseline	1	24.808	.000	.311
HealingNoHealing	1	1.243	.270	.022
BlindNotBlind	1	1.008	.320	.018
HealingNoHealing * BlindNotBlind	1	1.907	.173	.034
Error	55			
Total	60			
Corrected Total	59			

Table 3.3: Tests of between-subjects effects – McGill change.

Source	df	F	Sig.	Partial Eta Squared
Corrected Model	4	5.906	.000	.300
Intercept	1	3.369	.072	.058
MGtotal Baseline	1	20.355	.000	.270
HealingNoHealing	1	.047	.829	.001
BlindNotBlind	1	.165	.686	.003
HealingNoHealing * BlindNotBlind	1	1.549	.219	.027
Error	55			
Total	60			
Corrected Total	59			

With regard to Hypothesis 2, although the descriptive statistics (see Figure 3.3) suggested an interaction in the predicted direction for the outcome for GHQ scores, a larger sample is required as differences between groups were not statistically significant. The same trend is seen in the McGill Pain scores (see Figure 3.4), but we will focus on the GHQ scores, where the largest effect is found.

3.3.3 Effect Size

Eta squared values found in the ANCOVA model show null or very small effect from both blind and not blind conditions as well as healing and no healing. Combined, the healing/no healing and blind/not blind factors explain only a small percentage of the model (eta squared values of the combined effect indicate 3.4% for the GHQ change scores and a 2.7% change in physical outcomes).

As planned, Cohen's d effect sizes were also calculated in an effort to capture the magnitude of changes observed in this study. Tables 3.4 and 3.5 give a complete report of Cohen's d effect sizes based on allocation condition and outcome measure. The effect size calculations include comparison of those aware of their allocation condition in the healing and no healing groups, those blind to their allocation in the healing and no healing groups, and an overall comparison of all participants in the healing and no healing groups that does not consider blinding.

Table 3.4: GHQ effect size calculations

	Effect Size	Size interpretation
Not Blind – Healing vs No Healing	*d* = 0.76	Medium large
Blind – Healing vs No Healing	*d* = (-)0.32	Small
Overall - Healing vs No Healing	*d* = 0.40	Small

Table 3.5: McGill effect size calculations

	Effect Size	Size interpretation
Not Blind – Healing vs No Healing	*d* = 0.45	Small - Medium
Blind – Healing vs No Healing	*d* = 0.12	No effect
Overall - Healing vs No Healing	*d* = 0.10	No effect

These calculations did show some effect. Most significantly, when the mean change in GHQ scores is considered in the groups not blind to their conditions, there is a medium-large effect size of d = 0.76. This effect shows that when participants are aware of allocation in the distant healing condition there is an improvement in GHQ scores (due to placebo or otherwise). While it is important to keep in mind that there is no significant interaction in the other planned analyses as previously shown with the ANCOVA results, this effect suggests the need for further testing of Hypothesis 2, that participants who know their treatment allocation in the healing condition will report greater relief than those aware that they are not receiving healing.

3.3.4 Analysis of the Effects of Healing Belief (Hypothesis 3)

Before participants were assigned to their treatment conditions, a baseline questionnaire measure of Healing Belief was administered. Hypothesis 3 predicted that participants who reported a high belief in distant healing would report greater relief from their illness than those with low belief. Tables 3.6 and 3.7 show the results when baseline Healing Belief was added into the ANCOVA as an additional covariate. As seen in these tables, Healing Belief is not a statistically significant predictor of either measure, and although it appears to contribute to the model slightly, the adjusted R squared values are not an improvement on the ANCOVA models that exclude healing belief. Hypothesis 3 can be rejected: based on the

planned analysis, it appears that belief in healing does not moderate the effect of outcomes when taken into account as a covariate in the model with the other reported predictors.

Table 3.6: Tests of between-subjects effects – GHQ change, with Healing Belief.

Source	df	F	Sig.	Partial Eta Squared
Corrected Model	5	6.324	.000	.369
Intercept	1	18.341	.000	.254
GHQtotal	1	25.424	.000	.320
HealingBeliefTotal	1	.801	.375	.015
HealingNoHealing	1	1.037	.313	.019
BlindNotBlind	1	1.004	.321	.018
HealingNoHealing * BlindNotBlind	1	1.380	.245	.025
Error	54			
Total	60			
Corrected Total	59			

a R Squared = .369 (Adjusted R Squared = .311)

Table 3.7: Tests of between-subjects effects – McGill change, with Healing Belief.

Source	df	F	Sig.	Partial Eta Squared
Corrected Model	5	4.664	.001	.302
Intercept	1	2.436	.124	.043
HealingBeliefTotal	1	.088	.768	.002
MGtotalBaseline	1	18.273	.000	.253
HealingNoHealing	1	.038	.847	.001
BlindNotBlind	1	.148	.702	.003
HealingNoHealing * BlindNotBlind	1	1.369	.247	.025
Error	54			
Total	60			
Corrected Total	59			

a R Squared = .302 (Adjusted R Squared = .237)

3.3.5 Exploratory Analyses

3.3.5.1 Covariates. A number of measures were taken at baseline, but few seemed to add to the model or were significant on their own. These measures, including, gender, age, satisfaction with life, individual personality measures and spirituality were all included separately as covariates in the ANCOVA. From these analyses, conscientiousness, as measured in the IPIP, did have a small effect on the model as a

covariate, but this failed to reach significance when correlated with GHQ change in the ANCOVA. This result appears to show a correlation of improved health over time with higher levels of conscientiousness rather than an interaction with allocation condition. As seen in the analysis (Table 3.8) the eta-squared value for conscientiousness indicates that this factor explains 9.3% of the model's variance, but the overall model only slightly improves with this additional covariate.

Table 3.8: Tests of between-subjects effects and Conscientiousness – GHQ change

Source	df	F	Sig.	Partial Eta Squared
Corrected Model	5	7.797	.000	.419
Intercept	1	19.831	.000	.269
GHQtotal	1	27.328	.000	.336
Conscientiousness	**1**	**5.517**	**.023**	**.093**
HealingNoHealing	1	.948	.335	.017
BlindNotBlind	1	2.024	.161	.036
HealingNoHealing * BlindNotBlind	1	2.415	.126	.043
Error	54			
Total	60			
Corrected Total	59			

a. R Squared = .419 (Adjusted R Squared = .366)

3.3.5.2 Outliers. The small sample size means that outliers may have undue effects on results. When testing for outliers the result of blinding on the GHQ scores are significant, and suggest the effect of blinding participants to their allocated condition. Outliers were identified and removed if they were more than 3 standard deviations from the mean. Table 3.9 shows the results of the ANCOVA, excluding outliers, and although the overall adjusted R Squared values are similar to the original model, blinding becomes a significant variable in the updated model.

Table 3.9: Test of between-subjects effects with outliers removed – GHQ change

Source	df	F	Sig.	Partial Eta Squared
Corrected Model	4	8.528	.000	.401
Intercept	1	17.170	.000	.252
GHQtotal	1	21.655	.000	.298
HealingNoHealing	1	2.675	.108	.050
BlindNotBlind	**1**	**5.344**	**.025**	**.095**
HealingNoHealing * MaskedNotMasked	1	1.315	.257	.025
Error	51			
Total	56			
Corrected Total	55			

a. R Squared = .401 (Adjusted R Squared = .354)

3.3.5.3 Effect of healer. To investigate whether the healer to whom participants were randomly assigned had any effect on the outcomes, healers were entered as an additional factor in the ANCOVA. This addition does contribute to the model for GHQ scores, with an increase in the eta squared value of the model as well as a near-significant value of the interaction between the assignment of healing or no healing and blind or not blind (in bold in Table 3.10). However, the healer factor itself was not significant in the model. Although inclusion of healer assignment does make a contribution to the model, it should be noted that the adjusted R squared value is comparable to the R squared value of the original model that excludes healer assignment, which is a reflection of the lack of power in this study. Individual differences in healer efficacy thus demand further investigation.

Table 3.10: Tests of between-subjects effects and healer assignment – GHQ change.

Source	df	F	Sig.	Partial Eta Squared
Corrected Model	23	2.423	.008	.608
Intercept	1	16.736	.000	.317
GHQtotal	1	17.494	.000	.327
HealingNoHealing	1	.043	.836	.001
BlindNotBlind	1	.810	.374	.022
Healer	5	.802	.556	.100
HealingNoHealing * BlindNotBlind	**1**	**3.993**	**.053**	**.100**
HealingNoHealing * Healer	5	1.935	.113	.212
BlindNotBlind * Healer	5	1.308	.282	.154
HealingNoHealing * BlindNotBlind * Healer	4	1.531	.214	.145
Error	36			
Total	60			
Corrected Total	59			

a R Squared = .608 (Adjusted R Squared = .357)

For a more detailed look at the performance of each individual healer, the GHQ mean change scores for participants are shown in Table 3.11. The mean change scores are separated by healer assignment as well as condition allocation, providing a thorough and descriptive view of differences in the GHQ mean change scores of participants. The differences between healers do not follow a clear pattern, and performance for some healers appears to be different when compared with the mean McGill Pain change scores (Table 3.12). For example, participants assigned to Healer 5 report some of the worst outcomes in GHQ change scores – and some of the best in McGill Pain change scores. Although this fact is interesting, overall McGill change scores and GHQ change scores are correlated, in a 1-tailed Persons Correlation test p=.008. This difference in healer performance between measures may instead reflect the more general pattern, that is, the overall improvement of McGill Pain scores across healing and blinding conditions. Tables 3.11 and 3.12 show that Healer 6 has the most consistently positive results. On average, all participants assigned to Healer 6 show improvements in both the GHQ and McGill change scores (a trend seen even in those groups who did not receive healing during the study, but had been assigned to the healer for optional healing after participation was complete). Nonetheless, due to small sample size, this result may be due to chance.

Table 3.11: Mean GHQ change scores considering healer assignment and condition

Healer	Condition	Mean	N	Std. Deviation
1	No healing/Not blind	.2500	4	7.50000
	Healing/Blind	-2.5000	4	7.76745
	No Healing/Blind	1.8033	6	7.28451
	Healing/Not Blind	6.0000	2	8.48528
	Total	.8638	16	7.26588
2	No healing/Not blind	-11.0000	1	.
	Healing/Blind	-2.0000	2	1.41421
	No Healing/Blind	-.3333	3	3.51188
	Healing/Not Blind	7.3000	5	10.34166
	Total	1.8636	11	9.01136
3	No healing/Not blind	3.0000	2	4.24264
	Healing/Blind	7.0000	2	7.07107
	No Healing/Blind	.5000	2	9.19239
	Healing/Not Blind	-1.0000	1	.
	Total	2.8571	7	5.95619
4	No healing/Not blind	-10.0000	2	11.31371
	Healing/Blind	.6000	5	12.11610
	No Healing/Blind	-1.0000	1	.
	Healing/Not Blind	12.0000	2	11.31371
	Total	.6000	10	12.15822
5	No healing/Not blind	-1.0000	1	.
	Healing/Blind	-5.6667	3	5.13160
	Healing/Not Blind	-20.0000	1	.
	Total	-7.6000	5	8.08084
6	No healing/Not blind	1.5000	2	.70711
	Healing/Blind	4.0000	2	7.07107
	No Healing/Blind	7.3333	3	8.62168
	Healing/Not Blind	6.0000	4	4.69042
	Total	5.1818	11	5.58244
Total	No healing/Not blind	-1.8333	12	7.50555
	Healing/Blind	-.3333	18	8.33843
	No Healing/Blind	2.1213	15	6.75242
	Healing/Not Blind	5.0333	15	10.29991
	Total	1.3220	60	8.54720

Table 3.12: Mean McGill change scores considering healer assignment and condition

Healer	Condition	Mean	N	Std. Deviation
1	No healing/Not blind	1.1250	4	5.29741
	Healing/Blind	3.5000	4	7.93725
	No Healing/Blind	7.1667	6	11.32107
	Healing/Not Blind	-2.5000	2	7.77817
	Total	3.5313	16	8.75494
2	No healing/Not blind	.0000	1	.
	Healing/Blind	-1.5000	2	2.12132
	No Healing/Blind	2.6667	3	13.57694
	Healing/Not Blind	12.1600	5	14.94751
	Total	5.9818	11	12.80014
3	No healing/Not blind	2.7000	2	2.40416
	Healing/Blind	7.5000	2	13.43503
	No Healing/Blind	4.5000	2	2.12132
	Healing/Not Blind	10.0000	1	.
	Total	5.6286	7	6.27952
4	No healing/Not blind	8.6000	2	.56569
	Healing/Blind	5.5520	5	16.44994
	No Healing/Blind	1.0000	1	.
	Healing/Not Blind	4.5000	2	16.26346
	Total	5.4960	10	12.42178
5	No healing/Not blind	3.0000	1	.
	Healing/Blind	11.3333	3	20.07694
	Healing/Not Blind	5.0000	1	.
	Total	8.4000	5	14.77075
6	No healing/Not blind	6.2500	2	6.71751
	Healing/Blind	3.0000	2	1.41421
	No Healing/Blind	12.5000	3	7.69740
	Healing/Not Blind	9.0000	4	13.11488
	Total	8.3636	11	8.95011
Total	No healing/Not blind	3.5500	12	4.65998
	Healing/Blind	5.2089	18	12.12591
	No Healing/Blind	6.5667	15	9.73005
	Healing/Not Blind	7.7200	15	12.19503
	Total	5.8443	60	10.31458

3.3.5.4 Healer Logs. All healers provided logs that recorded information about the time and duration of each healing session as well as qualitative information about how each healer approached participation in this study.

The logs were reviewed primarily to access the duration and frequency of healing sessions among the healers and as a way for the researcher to confirm that they were practicing healing regularly as agreed. Healer reports reveal that each healer had a unique practice and worked for varying durations and frequency. All healers reportedly practiced at least once per week, utilizing their own approach and technique.

Because of the vast difference in healing logs amongst the group of healers, no theoretical framework was adopted for a detailed analysis. I will offer some examples of healer reports to illustrate the most common approaches of healers in this study. Chapter 4 will address the characteristics and self-perceived role of the healer in further detail.

Healing was typically reported in the logs as a type of communication between healer and healee, an energetic exchange; in some cases, very little of the session was described, though the state of the healer during the session was indicated. One healer approached the healing logs as an imaginary "conversation" with participants (as per this study's requirements, no actual verbal or physical communication between healer and healee occurred). In this particular healer's reports, he detailed the patients' "feedback." For instance, he writes:

> Me: I'm holding on to both of your hands to send you the Reiki energy. Participant: Yes, I need the energy sent to my hands so my fingers can be flexible to hold a pen so I can write down my stories. I would like to be a world famous writer. My life's challenges have made my inner life strong. What I mean by that is my mind is stronger than how my physical body appears. I am a survivor.

This healer reportedly began each session by first "asking" for the

participant's permission to communicate with their subconscious before trawling the subconscious itself for messages for the conscious mind.

Another healer reported a synopsis of each session. After providing the date, time and duration of a session, she writes about movement of "energy," often using the language of "heat" and "pulsing" as reported here:

> Today I started with the whole body to try and get the contact that I feel has not been made in other sessions. I had been working 15 minutes with very little happening. Then I felt intense heat in the abdomen area, with a slight pulsing in my hands when covering the head and heart areas. In the last 10 minutes I felt pulsing in the left hip working its way down to the left foot. Not strong but a slight pulsing.

Others went into far less detail, reporting only the time, duration and context of each session (for example "end of yoga session" or "healing meditation"). Any additional commentary was limited to personal events that might have interfered with healing (illness, travel, etc.).

The healer whose patients exhibited the greatest improvements in both physical and mental health (Healer 6) generally practiced healing for 10-20 minutes per healee, two or three times a week, and recorded sessions in terms of the communication with the participant's state and the ease with which a connection with the participant could be made.

3.4 Discussion

This study investigated the effects of distant healing and expectancy on self-reported physical and psychological well-being. The primary outcome measures were change in General Health Questionnaire scores from baseline to post-treatment (after 6 weeks of healing) and change in McGill Pain Questionnaire scores (from baseline to post-treatment).

It was hypothesised that (1) participants who received distant healing would report greater relief from their illness compared to the control group, (2) participants

aware of placement in the healing condition would report greater relief from their illness than those aware that they were not receiving distant healing, and (3) participants who expressed a belief in distant healing and were aware of the allocation in a healing condition would report greater relief from their illness than those with low belief. There were no significant main effects of healing or knowledge of condition placement, and no significant interactions between the two. Thus, Hypotheses 1 and 2 were not formally supported. Nonetheless, the GHQ effect sizes appeared to indicate there was some therapeutic effect due to not-blinding those allocated to the healing condition. This suggests that knowledge that one is being healed (or not) has a part to play in apparent distant healing effects, providing partial support for Hypothesis 2. This trend was not statistically significant, and this may be due, at least in part, to low statistical power. But the effect measured between the two un-blind conditions did obtain a medium sized effect and, blinding was found to be a significant factor of the ANCOVA when outliers were removed. Follow-up research with a larger number of participants would be needed to confirm the trend seen in the present study.

The results of the present study, as well as the previous similar findings of Walach et al. (2008), do not necessarily support the notion that distant healing effects are due solely to the participants' expectancy of healing. It is possible that participants are more receptive to paranormal healing if they have a positive expectancy. It is also true, however, that the present findings are entirely consistent with the hypothesis that remote healing effects are simply due to expectancy. Further research would be needed in order to reach definitive conclusions; for the moment, Occam's razor dictates that we opt for an explanation based on expectancy alone, given that there is no evidence of healing in the blind conditions.

The possible effect of expectancy is further complicated when results are

compared with those of the Benson et al. (2006) prayer study that was reviewed in Chapter 2. This study looked at intercessory prayer rather than distant healing intentionality and had a slightly different design: although there was a group aware of their allocation to the prayer condition, there was no opposing condition aware of not receiving prayer. In their study the un-blind group had the highest rate of medical complications, a conclusion that was statistically significant. A number of questions regarding these results are discussed in the literature review, and the two that may help to clarify the differences between their study and the present one include: (1) reporting bias, experimenter effect, differences in "healing" and "intercessory prayer"; and (2) the motivation of those praying/healing (including a self-selection bias amongst prayer groups who agreed to participate). Although mortality rate was not included in the discussion of the STEP prayer, it does appear that the group that knew that they were receiving prayer had the lowest mortality rate in the study, a trend consistent with the current study. It should also be noted that only the first name and first initial of the last name were provided on prayer lists, and not full names and photographs as provided in the present study. It was specifically suggested in the design phase by a number of healers (as well as in the protocol for previous prayer and healing studies) that the full first and last name be provided; photographs were also requested, but it was generally implied they would be helpful and not necessarily essential.

Furthermore, the picture becomes more complex when we look at the individual effects of the different healers. Adding the healer assignment into the model appears to increase the fixed factor interaction of healing and blinding condition (suggesting that some healers might have had a bigger influence on participants' well-being than others). Participants had no information about their healer assignment and no contact with the healer to whom they were assigned. This

suggests some support for the idea of a paranormal healing effect, which would undermine or complicate the "pure expectancy" hypothesis. It is important to remember that this effect was not significant ($p = 0.053$), is post hoc analysis and that the sample size is too small to draw any firm conclusions. It is suggested, therefore, that analysis of the individual healers' effect on the participant outcome be explored further in future studies.

Finally, and perhaps surprisingly to some, belief in healing appeared to have no effect on participants' self-reported well-being, and thus Hypothesis 3 was not supported. This finding supports those of Sicher et al. (1998) and Tsubono et al. (2009) but is at odds with the results of Lyvers et al. (2006), in which belief in healing was correlated with positive outcomes. The Lyvers et al. (2006) study used a smaller sample size than the current study and Sicher et al. (1998) and approximately the same as Tsubono et al. (2009); thus, tentatively, we can accept the findings of the current study that indicate belief is not related to positive healing outcomes. This is particularly interesting considering expectancy at some level seems to have an effect but is not contingent on one's belief in the possibility or efficacy of distant healing. This suggests that expectancy itself, or the awareness that someone is practicing distant healing for you, may have a therapeutic component regardless of self-reported belief in the phenomenon.

3.5 Summary

Distant healing is an increasingly common form of alternative medicine, the potential benefits of which bear implications for the practice of healing in general. By examining the psychological factors (such as the role of belief and expectancy) present in the experience of healing, research outcomes will more closely approximate real world practice. The present study focused on quantitative analysis

and found a possible therapeutic effect of receiving and being aware of the receipt of distant healing. Factors from the current study that emerged most saliently will be included in the proposed model of distant healing presented in Chapter 6. These factors include: an awareness that healing is happening or expectancy; tentatively, the impact that individual healers may have on outcomes; larger effect sizes resulting from measures of general-well being in comparison to physical measures of symptoms; and in general the factors present in a research study will be highlighted in comparison to "real world" settings (e.g. in the current clinical trial participants are randomly allocated to condition, blinded and have no relationship or communication with healers).

Studies in Chapters 4 and 5 use both quantitative *and* qualitative approaches in the hopes of providing a more holistic understanding of distant healing. Chapter 4 will focus on the beliefs and characteristics of healers, and Chapter 5 examines the experiences and interpretations that individuals provide regarding their encounters with distant healing.

Chapter 4: Profiling Distant Healers' Psychological Characteristics: A Questionnaire Study

4.1 Introduction

Over the years, research has increasingly alleviated many negative beliefs about healers in general, though not specifically distant healers. For instance, previously held stereotypes that healers are psychotic or schizophrenic have been disproved (Boyer, Klopfer, Brawer & Kawai, 1964; Murphy, 1967, Noll, 1983). An exception to these examples includes one report that found the self-described characteristics of healers to include feelings of grandiosity, self-confidence, and pleasure in being the center of attention (Appelbaum, 1993). Although some of these characteristics may be applicable to the participants of the present study, an evaluation of the characteristics particular to distant healers, as opposed to healers in general, is called for given the idiosyncrasy of the distant healing relationship, wherein little to no contact need be made between healer and healee.

It has been noted in other studies that healing research should investigate the techniques, background and training of healers (Dossey, 2008) and that all of these factors should be considered when designing studies of prayer and distant healing (Targ, 2002). By illuminating these characteristics, we can gain a better grasp on and give voice to the figure of the distant healer.

This study aims to address the present gap in distant healing literature by recruiting a sample of distant healers and asking them to complete a battery of questionnaire measures. More specifically, this study seeks to develop a psychological profile of distant healers by examining a variety of personality measures including openness to experience, emotional intelligence, spirituality, and

by investigating gender differences in these variables. The questionnaire also invites healers to report their perceived efficacy as healers and to define and describe their healing practice in a series of open response questions.

Questionnaires were chosen based upon their perceived relevance to the healer population; for example, spirituality and exceptional experiences were both of interest with this particular population (Palmer & Braud, 2002). The measurement of boundary "thinness" or "thickness" was also measured, with previous literature suggesting healers may have a propensity toward boundary "thinness" (Hartmann, 2000; Rock, Wilson, Johnston & Levesque, 2008). With limited information available regarding the characteristics of distant healers, a personality measurement was included to compare results with population norms. It has been suggested that healers may possess certain qualities that foster a "healing presence" (McDonough-Means, Kreitzer & Bell, 2004). These qualities are hypothesized to include empathy, compassion, charisma and spirituality (McDonough-Means, Kreitzer & Bell, 2004). This study addresses that hypothesis by measuring levels of spirituality, emotional intelligence and exceptional or anomalous experiences. The open-ended response section was modeled after Grytting's study of spiritual healers (1997) discussed in Chapter 2.

4.1.1 Hypothesis and Planned Analysis

4.1.1.1 Hypotheses. The primary hypothesis of this study is that healers will report distinct characteristics in comparison with the general population.

4.1.1.2 Hypothesis building. A central purpose of this study is to describe the characteristics of healers and to acquire their descriptions and definitions of healing. Therefore, this study aims at generating additional hypotheses for future research.

4.1.1.3 Analyses. Where possible, comparisons will be made with questionnaire norms, to allow some inference to be drawn about the differences between a healer population and a less specialized population sample using t-tests. In addition, the descriptive data collected will be presented to the reader and will be used to build an understanding of healers in general.

For the open-ended questions, software will be used to identify the concepts most frequently used in response to each question. The dominant concepts will be identified and described in terms of their frequency; this will be followed by a thematic analysis of responses to provide additional insight into healer responses. For this analysis, responses for each question will be coded individually, breaking down responses into emergent themes. Finally, these responses will be organized, reported, and then interpreted in a concise and comprehensive review.

4.2 Method

4.2.1 Participant Characteristics

The sample for this study is comprised of self-identified healers who responded to calls to participate in a study of distant healers in publications, via email and as advertised on websites. Participants were offered compensation in one of two forms: either an online gift certificate equal to five pounds or a five pound donation to charity. Of those recruited, 101 were members of the International Natural Healers Association (INHA), 26 were from the National Federation of Spiritual Healers (NFSH), and 3 were recruited through websites. As detailing the demographics of a sample of healers is a partial aim of this study, demographic data will be included in the Results.

4.2.2 Sampling Procedures

A call for participants was included in the supplement of *Healing Today*, a NFSH publication distributed to its approximately 5000 members. Unfortunately, the contact information was misprinted in the publication; it is thus presumed that participation was limited to the highly-motivated, who sought to initiate contact on their own by post or by finding the correct contact information on the Internet.

The other primary source of participants was the website for the INHA (http://www.internationalhealers.com), which provides a directory of its members from around the world. This site was used to recruit individuals identified as practicing distant healing. Emails were distributed to 469 INHA members in the UK, USA, Canada, Australia, South Africa and Ireland. In addition to the recruitment initiated through these organizations, a call for participants was placed on the parapsychology blog (http://publicparapsychology.blogspot.com) and the KPU website (http://www.koestler-parapsychology.psy.ed.ac.uk).

Most participants visited the study's website to complete and submit their questionnaires; five participants completed their questionnaire by post. Eleven participants did not complete the questionnaire. Responses to many items were optional, and thus there are many questions that were either purposely or accidentally skipped by respondents. All of the data that was gathered from participants was included in the final analysis. The length of the questionnaire may have been a factor in participants dropping out before completion.

4.2.3 Measures

The questionnaire can be divided into three principal sections. The first section includes questions related to demographics: age, sex, number of years of experience as a healer, ethnicity, highest level of education, spiritual tradition, healer qualifications and perceived success as a healer. These questions were open-ended,

so healers were not limited by specific options. For the perceived success questions, healers were asked to report the percentage of positive healing outcomes they observe in their patients in terms of physical, emotional and spiritual well-being.

The second section investigates different aspects of healers' personality and psychological characteristics, specifically: personality, life satisfaction, spirituality, belief in distant healing, exceptional experiences, "thinness" of mental boundaries, and emotional intelligence. The measures administered are available in Appendix C.

The IPIP Personality Questionnaire (Golberg, 2001), Satisfaction with Life Scale (Diener, Emmons, Larsen & Griffin, 1985), Spiritual Connection Scale (Hyland & Wheeler) and Healing Belief Scale (Easter) have already been described in Chapter 4 (pp. 26-28). The following measures were also administered:

Exceptional Experiences. Devised by Kohls and Walach (2006), this measure consists of two parts: the first contains 25 items designed to catalogue the frequency of exceptional experiences (EE's) in four categories: Positive EE's (7 items, e.g., "Spiritual powers inspire me at work"); Deconstruction and ego-loss (7 items, e.g., "Some of my thoughts seem strange to me, as if they were not mine"); Psychopathological (7 items, e.g., "I am cursed"); and Dream type experience (4 items, e.g., "I dream so vividly that my dreams reverberate while I am awake.") Responses range on a five-point scale from *never* to *very often*, with higher scores indicating more frequent experiences. Scores for Positive EEs, Ego-loss EEs, and Psychopathological EEs can therefore range from a minimum of 7 to a maximum of 35, whereas scores for the Dream EEs can range from 4 to 20. The second part of this measure contains the same items. If participants have had any of these experiences, they are asked to evaluate whether it was a positive or negative experience. This evaluation is done on a five-point scale, with options ranging from 1 = *very negative* to 5 = *very positive* and higher scores indicating a more positive experience.

Boundary Questionnaire. Hartmann's Boundary Questionnaire measures individual differences in "thinness" of mental boundaries presumed to separate the contents of consciousness (Hartmann, 1991; Rawlings, 2001). In other words, the "thinner" the boundary, the more likely the person is affected by outer stimuli and inner thoughts, feeling and images. While, the "thicker" the boundary, the more resilient one is to stimuli coming from both outside and within (Funkhouser, et. al., 2001). It consists of items measuring six categories: Unusual Experiences (12 items), Need for order (12 items), Perceived Competence (9 items), Childlikeness (5 items), Sensitivity (2 items), and Trust (6 items). Respondents are instructed to rate statements on a 5-point scale ranging from *not true of me* to *very true of me*. Trust is not included in the total score, which can range from a minimum of 40 to a maximum of 200. Higher scores indicate "thinner" boundaries.

Emotional Intelligence. Emotional intelligence has attracted attention in recent years (e.g., Goleman, 1995, Mayer & Salovey, 1997) and is frequently utilized as a measure of temperament and social intelligence. Schutte et al. (1998) developed the Emotional Intelligence questionnaire to measure self-reported aspects of emotional intelligence including appraisal and expression of emotion, regulation of emotion, and utilisation of emotion. Responses are made on a 5-point scale ranging from *strongly disagree* to *strongly agree*. Scores can range from a minimum of 33 to a maximum of 165, with higher scores indicating more emotional intelligence.

The third and final section includes four open-ended questions designed to allow healers to speak about their beliefs in and experience of healing. These questions are: *How do you define spiritual healing? What do you believe are the characteristics of spiritual healers? What factors contribute to spiritual healing?* and *What are some obstacles to spiritual healing?* These questions are taken from Grytting's research (1997), and her work will provide a source of comparison for responses.

4.3 Results of Demographic and Psychometric Questionnaire

4.3.1 Descriptive Demographic Statistics

One hundred and thirty healers participated in this study: 89 females (68.5%) and 41 males (31.5%). This is very close to the ratio of female to male members of the National Federation of Spiritual Healers, which has been described as "approximately" 7:3 (Millett, 2009). Participants' mean age was 48 years (range 20 – 78 years). Respondents had an average of 12 years' experience as healers, and of that experience, on average 10 years' experience specifically as distant healers (see Table 4.1 for details).

Table 4.1: Years of experience as healer and distant healer specifically.

	N	Minimum	Maximum	Mean	Std. Deviation
Years of healing experience	102	1.00	49.00	12.314	9.81
Years of distant healing experience	103	1.00	49.00	10.32	8.97

The descriptive statistics for the questionnaire measures are detailed in Tables 4.1-4.17. Data from participants who did not complete the questionnaire in its entirety is included in the following demographic items. Some participants completed the demographic section online and dropped out before completing the subsequent questionnaire items; therefore, N is sometimes less than 130. To provide a general comparison to healers, population norms are included where available.

4.3.1.1 Ethnicity. The majority of respondents were white (86%). Table 4.2 shows that other ethnic groups were rarely represented in the sample.

Table 4.2: Ethnicity.

Ethnicity	Frequency	Percent
White	111	86.0
Other/no answer	10	7.0
Indian	2	.02
Hispanic	2	.02
African	2	.02
Native American	1	.01
Iranian	1	.01
Asian	1	.01
Total	130	

4.3.1.2 Education. As Table 4.3 shows, over 25% of respondents had an undergraduate degree as their highest level of educational attainment, and over 20% had a graduate degree such as a masters degree or a PhD.

Table 4.3: Education.

Education	Frequency	Percent
Secondary School/High School	12	9.2
Some undergrad	12	9.2
Undergrad degree	3	26.1
Masters	14	10.8
PhD	15	11.5
Some graduate school	9	7.0
Other	31	23.8
Did not specify	3	2.3
Total	130	

Compared with the general population, this sample of healers appears to be well educated. The 2003 US Census reports that 27.2% of the US population has a bachelor's degree, 8.9% a master's degree and 3% a doctorate or professional degree. Numbers in the UK are lower, with just under 20% of people in England and Wales holding an undergraduate or higher degree according to the 2001 Census. The category of "other" was inclusive of a range of responses, including: some vocational training (examples include massage and forestry); vague responses such as: "too much to list" and "yes"; and continuing education. However, these responses show a

lesser amount of higher education than found in Grytting's sample (1997), in which 34% of participants held a Doctorate degree and 31% a Masters degree.

4.3.1.3 Spiritual tradition. The sample represents a diverse and eclectic range of spiritual traditions (see Table 4.4). In terms of conventional religions, 15.3% of respondents described themselves as Christian, followed by Spiritualist (12.3%) and Catholic (7.7%). 17% of respondents indicated that they had no spiritual tradition or did not answer the question.

Table 4.4: Spiritual tradition.

Spiritual tradition	Frequency	Percent
Christian	23	15.3
Spiritualist	16	12.3
No answer	12	9.2
Catholic	10	7.7
None	10	7.7
Interfaith	8	6.2
Other	8	6.2
Buddhist	8	6.2
Not religious - believe in god	6	4.6
Church of England	5	3.8
Eclectic	4	3.1
Open to all	3	2.3
Wiccan	3	2.3
Reiki	2	1.5
Shamanism and Sufi	2	1.5
Pagan	2	1.5
Rosicrucian	1	.01
Unitarian	1	.01
Ananda	1	.01
Evolving	1	.01
Jewish	1	.01
Hindu	1	.01
Atheist	1	.01
Quaker	1	.01
Total	130	

According to the Pew Research Center Survey (2007) 76.85% of United States citizens are Christians (with Protestantism reportedly practiced by 51.3% of the

population and Roman Catholicism practiced by 23.9%). Following Christianity is the category of Unaffiliated, including atheism and agnosticism (16.1%), Judaism (1.7%), Mormonism (1.7%), Buddhism (0.7%), Islam (0.6%), Hinduism (0.4%) and Other (1.2%). There has been some disparity in polls in the UK and the 2001 Census which found that Christians made up 71.6% of the population followed by "No religion" (15.5%), Muslim (2.7%), Hindu (1.0%), Sikh (0.6%), Jewish (0.5%), Buddhist (0.3%), Other Religion (0.3%); the question went unanswered by 7.3% of respondents. However, it has been noted that these statistics are reflective of the tradition in which individuals were raised, rather than of active practice. The Tearfund Study in 2007 found that 53% of the population in the UK identified as Christian and only 7% as practicing Christians. The Tearfund Study also found that two-thirds of respondents had not gone to church in the past year. Similar to the general population, the largest reported religion is Christianity (30.8% when including Unitarian, Quaker, Church of England and Catholic into the "Christian" category). Although Christianity was the most common tradition reported, a larger percentage of healers report a very diverse list of religious affiliations. The most common responses following Christian are Spiritualist, No Answer, None, Interfaith, Other and Buddhist. Overall, there is a very eclectic variety of religions represented, and it can be observed that traditions such as Spiritualist and Buddhist make up a greater percentage of the population of healers than seen in the general population.

4.3.1.4 Healer qualifications. Healers reported their primary training or qualification. The majority of the sample is comprised of Reiki Masters (33%) or Reiki Practitioners (7.7%), followed by those who had become qualified through their membership of the NFSH (20%). However, as seen in Table 4.5, a wide variety of different types of healer qualifications are represented. NFSH, Reiki and Therapeutic Touch

practitioners all went through institutionalized training. The intensity and type of training were not specified.

Table 4.5: Healer Qualifications.

Healer qualifications	Frequency	Percent
Reiki Master	43	33.1
NFSH	26	20.0
Other	24	18.5
Various Healing Arts	16	11.8
Reiki Practitioner	10	7.7
Mentored with healer	4	3.1
Intuitive - self trained/self study	4	3.1
Therapeutic Touch	3	2.3
Total	130	

4.3.1.5 Healer success. Participants were asked to report their success with healees on three levels: in terms of healees' physical, emotional and spiritual health. Many participants chose not to answer this question or to answer only one part of this question, as seen in the population values in Table 4.6.

Table 4.6: Success estimated by healer (0-100%).

	N	Minimum	Maximum	Mean	Std. Deviation
Success - Health	85	25.00	100.00	79.7294	19.30235
Success - Emotional	64	35.00	100.00	85.9219	16.15039
Success - Spiritual	58	1.00	100.00	77.6897	23.98626

Some healers used the space, instead, to explain their reasons for not answering; others simply left it blank. Common reasons cited for not answering include: the difficulty in quantifying success, not actively seeking feedback, or not having practiced long enough to say for sure. Participants who responded to this question reported a relatively high success rate in their healing practice as seen in Table 4.6. More interesting are differences in success across the different domains of health, emotional and spiritual well-being. The highest self-rated success rate (86%) was for emotional well-being, and the self-rated success-rate was similar but lower for health (80%) and spiritual well-being (78%).

4.3.2 Psychometric Questionnaire Results

4.3.2.1 Exceptional experiences: frequency and valency. Tables 4.7 and 4.8 show the responses to the questions about exceptional and possibly paranormal experiences that healers may have had in their lifetime. Answers were grouped into four different types of experiences: positive, ego loss, psychopathological, and dream-like. The vast majority of participants reported having one or more EE. Table 4.7 shows responses to the questions about the frequency of EEs. Again, higher scores indicate more frequent experience of the EE. On average, respondents reported that they had had Positive EEs often. The Ego-loss and Psychopathological EEs, though reportedly experienced by most participants, were seldom experienced on average. Responses for the Dream-type experiences fell around the middle of the scale, indicating that these experiences were on average experienced occasionally.

Table 4.7: Frequency of exceptional experience.

	N	Minimum	Maximum	Mean total	Std. Deviation
EE – Positive	116	1.00	5.00	3.81	5.53
EE – Ego-loss	118	1.00	5.00	2.08	4.23
EE – Psychopathological	118	1.00	5.00	1.51	2.53
EE – Dream	118	1.00	5.00	3.06	3.70

Table 4.8 shows healers' evaluations of their exceptional experiences in terms of their valence – whether it was deemed to be a positive or a negative experience. Fewer participants responded to these items compared to the numbers who responded to the frequency questions. The table presents mean ratings with responses ranging from 1 – *very negative*, to 5 – *very positive*. Not surprisingly, the mean score for Positive EEs was 4.4, indicating that participants did indeed rate these as positive experiences. The experiences reported as least positive were those that were categorised as psychopathological, with mean rating of 2.2.

Table 4.8: Evaluation of exceptional experience (mean valency ratings per sub-scale).

	Minimum	Maximum	Mean rating	Std. Deviation
EE – Positive	1.36	1.89	4.43	.21
EE – Ego-loss	2.36	3.56	2.94	.44
EE – Psychopathological	2.85	4.42	2.21	.65
EE – Dream	1.87	2.68	3.66	.39

4.3.2.2 Personality. Participants' responses on the IPIP five-factor personality questionnaire are shown in Table 4.9. For purposes of comparison, norms are provided in Table 4.10. Norms are based on an internet sample of a self-selected group of users who found the IPIP online by searching for 'online test' or 'personality test' through a search engine and were motivated to complete the test. This norm sample is unlikely to differ significantly from a random sample of internet users (Buchanan, Johnson & Goldberg, 2005). The most dramatic difference observed in the healer population compared to the norm is substantially higher scores for Agreeableness and Openness.

Table 4.9: Healers' IPIP scores.

	Men, N = 41	Women, N = 89	Total, N = 130
Extroversion	32.56 (SD = 7.08)	32.44 (SD = 7.16)	32.48 (SD = 7.11)
Agreeableness	43.37 (SD =4.61)	45.01 (SD = 4.16)	44.49 (SD = 4.35)
Conscientiousness	37.10 (SD = 6.50)	38.61 (SD = 6.52)	38.14 (SD = 6.53)
Neuroticism	24.71 (SD = 7.87)	24.44 (SD = 7.69)	24.52 (SD = 7.72)
Openness	40.44 (SD = 4.72)	40.60 (SD = 5.40)	40.55 (SD = 5.17)

Table 4.10: IPIP population norms.

	Men, N = 991	Women, N = 1457	Total, N=2448
Extroversion	28.21 (SD = 7.67)	29.66 (SD = 7.59)	29.07
Agreeableness	25.23 (SD = 4.81)	26.84 (SD = 4.60)	26.19
Conscientiousness	32.53 (SD = 7.47)	33.84 (SD = 7.25)	33.31
Neuroticism	21.57 (SD = 6.76)	22.95 (SD = 6.68)	22.39
Openness	25.52 (SD = 5.52)	26.90 (SD = 4.90)	26.34

Differences measured by one sample t-tests are illustrated in Table 4.11. Note that all differences are significant at a level of $p < 0.01$. In the present sample males scored slightly higher than females on neuroticism. This is contrary to the pattern

found in the general population, where females tend to have higher neuroticism scores than males. Thus, it appears that male healers are more neurotic than a general sample of males.

Table 4.11: T-test, Healers vs. IPIP norms

	df	t	p-value
Extroversion	129	5.47	< 0.01
Agreeableness	129	47.92	< 0.01
Conscientiousness	129	8.44	< 0.01
Neuroticism	129	3.15	< 0.01
Openness	129	31.31	< 0.01

4.3.2.3 Healing belief and spirituality. Table 4.12 shows an unsurprisingly high mean level of belief in healing (the maximum possible score was 28, and the mean score was 27.4). We can also see that respondents give extremely high mean scores on the Spiritual Connectedness Questionnaire (the maximum possible score was 98, the mean score was 91.2).

Table 4.12: Healing belief and spirituality.

	N	Minimum	Maximum	Mean	Std. Deviation
Healing Belief	125	21.00	28.00	27.4400	1.42
Spiritual Connection	130	51.00	98.00	91.2154	8.75

4.3.2.4 Boundary questionnaire. Table 4.13 shows descriptive statistics for total Boundary Questionnaire scores, as well as for each of the six sub-scales. For purposes of comparison, Table 4.14 shows the norms for the Boundary Questionnaire based on a general sample of undergraduates. The norm sample was comprised of 79 males and 221 females with a mean age of 18.95 (SD = 3.74) and age range of 17 – 56 (Rawlings, 2001). For each sub-scale, scores are notably higher for the sample of healers than the comparison group of undergraduate students. This is most evident for the Unusual Experiences (items are concerned with unusual sensory or cognitive experiences and often involve sleep, dream or fantasy) and Perceived Competence (the major theme of these items are personal competence in areas such as general neatness, cleanliness

and punctuality as well as items related to ability to understand or empathize with others) subscales.

Table 4.13: Healers' Boundary Questionnaire scores.

	N	Mean Total	Std. Deviation
Unusual Experiences	113	27.8053	8.58
Need For Order	113	29.6549	6.60
Trust	113	19.4248	3.93
Perceived Competence	113	29.8319	4.67
Childlikeness	113	19.0000	3.93
Sensitivity	113	7.1504	1.99
Boundary Q Total	113	120.4690	14.51

Table 4.14: Boundary Questionnaire norms.

	N	Mean Total	Std. Deviation
Unusual Experiences	300	17.09	8.68
Need For Order	300	26.19	7.16
Trust	300	13.15	4.50
Perceived Competence	300	16.98	5.33
Childlikeness	300	12.71	3.29
Sensitivity	300	5.54	1.82
Boundary Q Total	300	78.50	15.40

A one-sample t-test revealed that the difference between the healer sample and norms was significant for each subscale and the total score; the detailed results can be found in Table 4.15. It is important to note that the norm sample was primarily comprised of college undergraduates, a sample that may differ in many ways from the population of self-described healers in terms of age, level of education, life experience and so on.

Table 4.15: T-test values, Healers vs. Boundary Questionnaire norms

	df	t	p-value
Unusual Experiences	112	13.27	< 0.01
Need For Order	112	5.58	< 0.01
Trust	112	16.97	< 0.01
Perceived Competence	112	29.24	< 0.01
Childlikeness	112	17.00	< 0.01
Sensitivity	112	8.61	< 0.01
Boundary Q Total	112	30.76	< 0.01

4.3.2.5 Emotional intelligence. Respondents' scores on the self-reported Emotional Intelligence questionnaire are shown in Table 4.16. Participants show levels of

emotional intelligence slightly higher than those for the norms reported by Schutte et al. (1998) (see Table 4.17). The norm sample consisted of participants recruited from a variety of settings in a metropolitan area in the southeastern United States. Participants included both university students and individuals from diverse community settings. A one sample t-test showed that the difference was significant for females, $t(80)= 2.38$, $p = 0.02$; and for males $t(36)= 2.03$, $p = 0.05$. Overall, including both females and males in the t-test calculation, there was a significant difference in scores, $t(117)= 3.05$, $p = 0.003$. Thus, a significant difference in emotional intelligence is observed in the sample healer group when compared with the norm group.

Table 4.16: Healers' Emotional Intelligence scores.

	Females (N = 81)	Males (N = 37)	Total (N=118)
Emotional Intelligence Total	134.90 (SD = 15.61)	129.03 (SD = 12.71)	133.06

Table 4.17: Emotional Intelligence norms.

	Females (N = 218)	Males (N = 111)	Total (N=329)
Emotional Intelligence Total	130.94 (SD = 15.09)	124.78 (SD = 16.52)	128.86

4.4 Results of Open-Ended Questions

4.4.1 Frequency and Thematic Analyses.

Free online word counting software was used to count the number of times different words were used by participants when responding to the open-ended questions (*questions 14, 24, 26 and 27 in* Appendix C). The most commonly used words were identified. The numbers in parentheses will refer to the number of times a particular word was used to answer the question.

The frequency analysis is informative and provides some insight into responses; a more intensive thematic analysis, however, will help to decipher the context and meaning conveyed in the healers' responses. I performed the thematic analysis of each question using the guidelines set out by Braun and Clarke (2006). The analysis took more of an inductive, or "bottom up," approach, allowing themes from the data to emerge (Patton, 1990) without a preconceived theoretical framework from which to work.

Braun and Clarke (2006) describe the process of thematic analysis in six distinct phases:

1. Familiarizing yourself with the data, in other words, reading or re-reading for initial ideas.

2. Generating initial codes. This is done by coding the data in a systematic fashion (codes identify a feature of the data that appears interesting to the analyst).

3. Searching for themes involves sorting the codes into possible themes and re-focusing the data at a broader level.

4. Reviewing themes. This may involve breaking a theme down into two separate themes, combining themes that are similar, or disregarding themes that do not have adequate supporting data.

5. Defining and naming themes. This step involves identifying sub-themes that may be present within the theme and developing an appropriate description of how the theme relates to the data.

6. Producing the report. The final step involves describing the data by using the themes analyzed with supporting evidence.

I first compiled the answers of all participants to a particular question into one document and analyzed each of the open-ended questions individually. I chose this approach because responses were very brief and focused on the specific question

at hand. For each question I will first report the most commonly used words participants chose in responding to the question and then move on to the themes that emerged upon analysis of each question.

4.4.1.1 Question 1: How do you define spiritual healing? Aside from the term *healing*, the most common terms used to define spiritual healing were: *energy* (54), *spiritual* (23), *body* (19), *physical* (19), and *Universal* (16). Thus, the views presented by healers are predominantly centered around the concept of energy.

The thematic analysis of healers' responses provides a more complete interpretation of their responses. Although many responses were similar, there was a great deal of variation in the language used to define spiritual healing, as well as the elements that participants chose to focus on.

The primary themes identified are: *Movement of energy*; *Restoring balance*; and, *Levels of healing: mind, body, spirit*.

Movement of energy. A majority of the responses from healers focus on how spiritual healing happened and on what levels it worked. Healing is often described as a transfer, channeling, transmission or transformation of energy. Some healers give multiple descriptions of energy, others choose just one. Energy is described most commonly as "universal," "divine" and "source" energy. Reference to a God, higher power or consciousness was also made by a number of healers. These were often presented in a way that would be interchangeable with energy. For example, "channeling God" and "channeling universal energy" are both common responses. In general spiritual healing is seen as some sort of transfer of energy or the divine; some describe it as a passive channeling and others as more active and intentional.

Restoring Balance. Healers also define spiritual healing as a promotion of balance and well-being in the lives of healees. The healer and act of healing promote harmony,

and the healees are then able to heal themselves with the help of this harmony. One theme that emerged is the idea that healees go through a "remembering" or a "return to wholeness." Many healers suggest that the healing capacity is therefore not theirs but belongs to the universe or the divine; their job is to connect the healee with this energy and to promote self-healing.

Levels of Healing. With regard to what spiritual healing does, a very common response was to explain the multiple levels that healing addresses, i.e. "healing the mind, body and spirit." These levels include the physical, emotional and spiritual health of individuals. Spiritual healing may not always result in a "cure" physically, but healers maintain that healing spiritually and emotionally can be beneficial in transforming one's attitude and relationship with sickness and death.

Similar themes are reported by the healers in Grytting's study (1997), in which analysis revealed the following items: wholeness, love and acceptance, channeling energy, divine source, and uncovering/reframing/releasing old fears, patterns/pains and wounds. Wholeness was the most commonly observed item in Grytting's work; if, however, divine source and channeling energy are combined, as they were in the present study, these items are found at a similar frequency. Grytting's theme of love and acceptance is found within the theme that I identified as restoring balance, though love and acceptance may also be included in the path to wholeness or balance. The theme that I identified as levels of healing includes some of the aspects that Grytting identified as uncovering/reframing /releasing. It appears that these types of responses were more prevalent in her sample and warranted greater emphasis.

4.4.1.2 Question 2: What do you believe are the characteristics of spiritual healers? Many different terms came to the fore in the analysis of this question, suggesting a rich

variety of different understandings of the characteristics of spiritual healers. Commonly used terms included: *help* (24), *others* (22), *love* (18), *compassion* or *compassionate* (18), *spiritual* (17), *open* (16), *ability* (15), *belief* (10), and *desire* (11). These different concepts all suggest that healers have a compassionate desire to help others.

Two overarching themes emerged in the analysis of responses to this question. First, many responses related to the way of being, spirituality and/or personality of a healer. Second, responses focused on their ability, either natural or trained. I identified these themes as: *Healer traits* and *Healer ability*. Within each theme a number of sub-themes were recognized.

Healer Traits. Characteristics related to the personality of healers include six sub themes: *honesty*, *love* (also described as compassion, empathy, heart), *listening*, *openness* or *non-judgmental attitude*, *egolessness* and *self-care*. For example, one healer touches on many of these, listing the ideal characteristics of a healer as, " having a relationship with the divine, loving, having done one's inner work, unattached to outcome, authentic, intentional, skillful, self aware."

These qualities are certainly admirable, and most would be sought and appreciated in relationships with health professionals and therapists. A survey of physicians rated compassion and empathy as the most important quality of "a good physician" (Carmel & Glick, 1996). Egolessness is a concept not foreign to nursing, medical and psychotherapy literature. Quinn (2000) presents the idea of being able to maintain a state of egolessness for the benefit of the patient, allowing for a self-less opening up to the service of others. In the context of the responses given, egolessness also refers to healers not being attached to outcome; thus, although healers take on some form of responsibility, they consider it beneficial to remain open to whatever outcome unfolds.

Self-care is frequently identified as integral to spiritual healers. One healer writes, "we are our own healer firstly." I include in this sub-theme regular spiritual practice, meditation, prayer, cultivation of self-awareness and overall maintenance of emotional and physical health. Responses reference different aspects of self-care; for example, one healer notes the possible physical limitations involved, responding that healers should recognize the importance of "self caring and taking care of themselves, especially with regards to their own health and wellness." Others refer to the spiritual work needed, emphasizing the importance of having "done one's inner work" and maintaining "spiritual discipline."

Healer Ability. The second category identified relates specifically to the healer's ability, either trained or intuitive. Many responses highlight the importance of training and knowledge with regards to specific healing techniques and of being continually open and willing to learn. Examples of these types of responses include being "well researched and trained" and having "the ability to gather spiritual energies and focus them." Healers also suggest that some abilities are intuitive or due to special sensory ability or natural sensitivity; for example, one healer responds that healers "often see, feel, know or hear things on a different level." "Intention," "intentionality," and "positive intent" are frequently noted as important components of healing, regardless of training or natural ability. This is sometimes explained as a "wish" or "desire" to help others.

These results are similar to Grytting's (1997), where the characteristics identified included a connection to the Divine Source, loving, doing one's own inner work, skillfulness, humility, unattachment to outcome, openness, reliance on the Divine Source, service orientation, authenticity, intentionality, careful listening and self-awareness. Although "Divine Source" was not prevalently employed by the healers in the current study, the similar idea of connection with a higher power or

energy is conveyed. Each characteristic identified by Grytting is also found in the current study, although I have organized them in terms of either trait or ability.

4.4.1.3 Question 3: What factors contribute to spiritual healing? The concepts most frequently used to describe factors contributing to spiritual healing, aside from the obvious term of *healing*, include: *willingness* (23), *open* or *openness* (33), *energy* (17), *love* (11), and *help* (9). A relatively small number of terms seem to dominate the concepts used by healers to describe their characteristics.

The thematic analysis revealed that healers report certain qualities as being important in the healer and healee, in addition to situational conditions that factor into the process. Thus, the themes were identified as: *Healer qualities*, *Healee qualitites*, and *Situational Factors*.

Healer Qualities. This theme brings us back to the previous question relating to the characteristics of healers; here, healers' embodiment of these characteristics are reported as contributing to positive healing experiences. Sub-themes include *intention*, *connection* and *openness*. Healers should be clear with their intention, or "focused intent of healing" and trust in a higher or other worldly power. One healer described the importance of a "deeper faith in a higher being." The "divine light" and "source energy" are also identified as indicating reliance on a higher power/being or energy. Illustrating both the importance of intention and alluding to an energetic source of healing, one healer responds that healers should have "the desire to help and to heal another in a knowledgeable and consciously directed way with help and guidance from the universal energy source."

It was also reported that healers should not be attached to a rigid outcome for their patients. One healer reports that "healing outcomes are not always what you or the patient expected or necessarily wanted" and goes on to say that healing is not

only about "maintaining physical well-being or existence" but also involves a spiritual or emotional transformation, thus on one level healing may take place, but physically there may still be a decline or even death.

Healee qualities. This theme addresses the traits in healees that healers believe facilitate the healing process. Two sub-themes exemplify the qualities important in healees: *unattached to outcome* and *willingness*. Just as the idea of not being attached to a particular outcome was identified as an important quality in healers, so too is it recognized as a positive trait in healees. Healers report that healees should either have or be able to develop a willingness to be healed, not only physically, but to be transformed on other levels, emotionally and spiritually. One healer describes this as a "willingness to look at one's patterns," including those "that may have caused or played into the disease in the first place;" this willingness seems to produce the best longterm results for healees.

Situational Factors. Finally, the theme of Situational factors was identified and contains three sub-themes: *relationships*, *circumstance* and *environment*. Relationships encapsulates the ability of the healer and healee to maintain an open and trusting relationship. One healer describes this by saying that it is helpful if "the energy vibration of the healer and recipient of the healing are similar." Others state the need for "trust," "authenticity," and "honesty" in the relationship. Circumstance, which involves both the type of illness and the timeliness of the healing relationship, was also found to be a recurrent sub-theme. Some illnesses may not be well suited for spiritual healing; as one participant asserts, "a broken leg is a broken leg." While some illnesses may be best resolved by medical treatment, healers report that patients who cannot be helped by western medicine are often most suited for spiritual healing and more likely to commit to the process. Finally, there is the sub-theme of Environment: healers report that a comfortable and quiet setting is

conducive to healing, without which, sustained healing may be particularly challenging.

Grytting (1997) identified similar categories, including items related to healers, clients, the healing process and "other factors." The factors related to the healer include connection with the Divine Source, love, and doing one's own work. These themes are related to those identified in the current study. Both studies emphasize connection, although the current study did not find frequent use of "Divine Source" as Grytting's did. Love in Grytting's study is similar to intention in the current study. The term love implies a pure and positive feeling, and it is with a loving intention that healers reportedly work. Finally, openness might be considered a quality of having done "one's own work." If one is attached to outcome and concerned only with appearing to be a successful healer, the healing process risks being ego-driven and the healer not being open to alternative outcomes.

The factors that Grytting (1997) associates with the client, or healee, differ somewhat from the sub-themes identified in the current study. Grytting found that the most commonly reported factors that contribute to healing are being open, beliefs, connection with Divine Source, courage, letting go, and releasing feeling. The two sub-themes identified in this study were willingness and being unattached to outcome.

Cooperation is a factor that Grytting (1997) identifies as being "other" and is a central component of the situational factors identified by the sample of healers in the current study.

4.4.1.4 Question 4: What are some obstacles to spiritual healing? The frequency analysis for this question was the least successful in identifying central concepts when compared with the previous three questions. It is likely that more complex language is needed

to elaborate upon the obstacles to healing and a simple frequency analysis is less adequate at capturing the meaning of the responses. Again setting aside the expected frequent use of *healing, healer*, and *patient*, words commonly used in the description of obstacles include *lack* or *lacking* (23), *negative* (12, including *negativity*, *negatively*, *negativeness*), *fear* (9), *ego* (8), and *trust* (7). However, we will need to return to the text in order to gain a clearer understanding of the obstacles that healers report.

Three primary themes were identified, again relating to *Healer qualities*, *Healee qualities*, and *Situational Factors*.

Healer qualities. The most frequently mentioned obstructive qualities of healers are captured in the following sub-themes: *big ego*, *poor-judgment*, *lack of skill/training*, *not feeling physically or emotionally well*, *lack of intention*, and *under developed personally/spiritually*. One healer touches on many of these traits, responding that healing is obstructed by "poor training, lack of guidance, lack of self-development spiritually and emotionally, [and] allowing the ego to come in the way." These traits represent the opposite of many of the reported characteristics of spiritual healers.

Healee Qualities. Healers report that the healee should enter into the relationship with willingness and take an active part in the healing process. Patients who are resigned to their illness are difficult to work with, and healers report this as a very common obstacle. Alternatively, having unrealistic expectations and wanting a "quick and easy cure" is not generally conducive to healing. Although belief and trust in the possibility of healing and the healer is important, a few healers were clear that healing is possible even for people who do not believe in it.

Situational Factors. Finally, the Situational factor reported to obstruct healing was a negative, noisy and generally unpleasant environment, which includes poor relationships healees might have with family and friends. For example, if they are surrounded by skeptical, unsupportive or abusive people, healers suggest this gets in

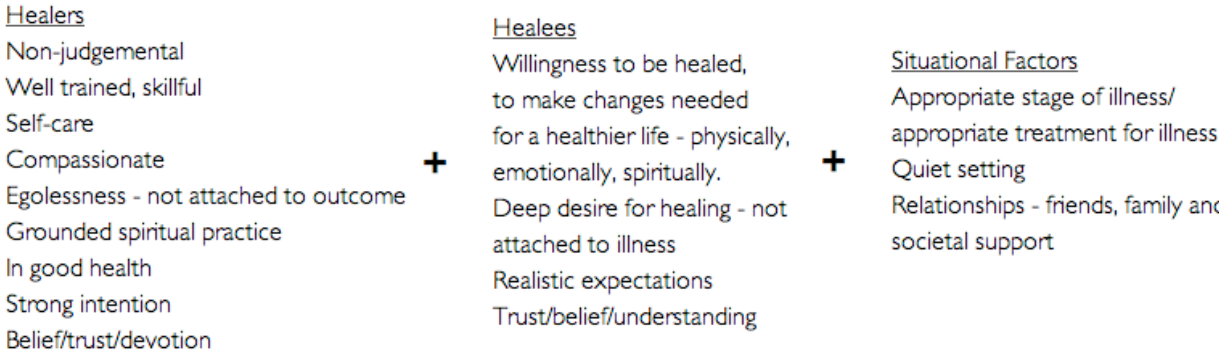
the way of healing. Healers describe the importance of the people that healees surround themselves with, noting that "peer pressures" can be a hindrance and citing the need to "make time for yourself around positive people." On a more subtle level, one healer reports the negative effect of a healee returning "to an unbalanced energetic environment."

Grytting (1997) also categorized factors according to their relationship with the healer, the client, or the process. The primary obstacles relating to the healer were identified by Grytting as unchecked ego, not having done his/her own work, and attachment. These themes were also touched upon in the current study, with a number of related variables reported. Obstacles that related to the client, or healee, were reported by healers in Grytting's study (1997) as beliefs, not wanting to get better, and fear. These results appear to have been replicated in the current study; belief was reported here, however, as being both beneficial and not primary.

Healers in Grytting's study (1997) did not identify the situational factors reported in the current one. Instead, Grytting found that factors related to the healer and client were sometimes presented as specific to neither and therefore not categorized as such.

Most of these themes overlap with those already identified in the previous questions. Figure 4.1 provides a summary of the conclusions of the thematic analysis obtained from questions 1 – 4.

Figure 4.1: Themes conducive to positive healing outcomes – healers, healees and the situation



4.5 Discussion

This study administered a battery of demographic questions, psychological measures, and open-ended questions about healing to a sample of 130 distant healers. The goal was to build a psychological profile of healers and, where possible, to compare this with general population norms. Female healers outnumber male healers about 7:3, both in the UK healer population as reported by the NFSH and in our study sample. The sample was comprised of experienced healers, averaging over ten years of experience as distant healers. A clear majority of participants were caucasian and were quite highly educated, with over 20% reporting a graduate degree such as a Masters degree or a PhD, overall exceeding norms in the population of the United Kingdom and United States. The participants acknowledged a wide variety of different spiritual traditions, predominantly Christian, Spiritualist, and Catholic, though many also said they had no particular spiritual belief. The most common form of training was Reiki, and many were members of the NFSH.

Not surprisingly, when asked to rate their success as healers, relatively high success rates were reported. However, many respondents said they found it difficult to give an accurate answer to this question. A more objective measure of healing success could be obtained by evaluating results from patients, as was done in Chapter 3 with the trial of distant healing for arthritis sufferers. That study did indicate a greater effect in relation to general well-being, as measured by the GHQ (Goldberg, 1988) when compared to the other primary outcome, the Short-form McGill Pain Questionnaire (Melzack, 1987). The largest effect was observed for knowledge of treatment allocation; this effect was stronger in the GHQ measure of psychological well-being, as opposed to the pain questionnaire. This result is

somewhat reflected in the self-reported healer success outcomes, in which healers report the most success with emotional healing, with physical and spiritual healing occurring at lower levels.

As a group, healers reported that they often had positive exceptional experiences, reported extremely high levels of belief in distant healing, and scored extremely high on the measure of spiritual connectedness (mean scores 91.2, maximum possible score 98). Clearly, a dominant feature of our sample of healers is that exceptional experiences are, for them, unexceptional (in that they are fairly common), and belief in healing and feelings of spiritual connectedness are very strong. It is possible that these qualities, experiences and beliefs contribute to an interest in healing. It is unclear, however, if these qualities contribute to healing outcomes. Future research might seek to correlate the self-reported exceptional experiences and degree of spiritual connectedness found in healers to healing outcome. In other words, we ought to examine if high levels of exceptional experiences and spirituality mediate healing. This type of study would require a very large sample in order to obtain a sufficient spread of scores and avoid ceiling effects on the questionnaire measures.

When asked to define spiritual healing in their own words, healers most commonly used the term 'energy'. Being a representation of the divine, God and universal energy, it is something that they feel they can channel and direct towards healees.

Research has shown that boundary 'thinness' and exceptional experiences are highly correlated (Thalbourne & Maltby, 2008). One could argue, then, that exceptional experiences can arise out of having 'thin' boundaries, where material such as preconscious cognition or extrasensory information can cross easily into consciousness. Supporting this point, the current study found that the sample of

healers had substantially higher scores on the Boundary Questionnaire, compared to population norms (healers' mean total score = 120.5, norm mean total = 78.5). 'Thinness' of mental boundaries may also be connected to the alleged ability of healers to channel energy, as reported in the open-ended questions. Future research might investigate this connection between 'thinness' of mental boundaries, high levels of exception experience and self-reported ability to channel energy. Of course, further work could also be directed towards defining and refining this ambiguous concept of energy described by healers.

One factor from the Boundary Questionnaire, Perceived Competence, has some overlap with other areas of the study. This subscale measures competence, not only in maintaining a physically neat and clean space, but also maintaining empathetic relationships. This subscale marked the largest difference between the healer sample and the questionnaire's norms. Higher than usual self-reported levels of empathy are also supported by the results of the Emotional Intelligence questionnaire. It is, however, important to note the norm samples for both the Boundary and Emotional Intelligence Questionnaires were primarily comprised of university students, who may well differ in many respects to the healer populations.

The open-ended portion of the questionnaire continues to emphasize self-perceived compassion and empathy as a crucial characteristic of spiritual healers. These qualities would also be considered important in typical doctor-patient relationships, though often made secondary by practical demands on doctors. Thus, although empathy is considered an important characteristic for doctors to develop (Haslam, 2007), it is possible that the pressures of work may hinder this quality. Carmel and Glick (1996) found that compassion and empathy were identified as being the most important qualities of being 'a good physician,' though the same study identified compassion and empathy as the least important factor for being

promoted in a hospital. Age was also identified as a factor, as compassionate-empathetic identified physicians were generally younger with fewer years of practice. This finding led the authors to suggest that either doctors change their professional pattern with time and age, or they leave their profession earlier than other doctors. Thus, the current medical system, in not rewarding these qualities, does not foster the cultivation of empathy and compassion. In contrast, healers appear to rely heavily on compassion and empathy; these qualities are highlighted both in response to the qualities of healers and to factors that contribute to spiritual healing. Healers are thus self-conscious of and interested foremost in their own level of compassion and empathy, and thus in bearing the most important trait of a 'good physician' unlike many physicians themselves. Furthermore, many of the healers do not accept reimbursement for their healing, and there is not the same pressure for promotion and career mobility; therefore, it appears that compassion is central to the practice of healing.

When compared with population norms, the sample of healers reports significantly higher levels of agreeableness and openness ($p < 0.01$) for the five-factor personality measure. Supporting this finding, themes that emerged from open-ended questions about the characteristics of healers and successful healing suggested that *a compassionate desire to help others* was very important to healers. Having an open and non-judgmental attitude was also considered a helpful attribute for the healer to have. While previous research has shown that the characteristics of self-described healers include feelings of grandiosity, self-confidence, and pleasure in being the center of attention (Appelbaum, 1993), distant healing is of a different nature, involving minimal or no actual contact with the healer, which may suit healers with differing characteristics. Egolessness is, in contrast, an important quality of healers in the current study.

Overall, the thematic analysis brought to light the factors that healers find important in healers, healees and the healing process. Although I was the only rater in this study, comparisons can be made to Grytting's (1997) study, where the responses of thirty-five healers to these same questions are analyzed. One primary difference in our results is that healers who responded in this study did not report primacy of the relationship to the "Divine Spirit," which was central in Grytting's findings. Although prior to the analysis phase I had familiarized myself with Grytting's dissertation as a guide to formulating questions for the healers in the study (summer 2008), I avoided returning to her work again until I had completed my own analysis of responses for healers in the current study (summer 2010). Thus, the direct influence of Grytting's results on my own interpretations was limited.

Contrary to the norm, male healers scored slightly higher than females on neuroticism. This suggests that male healers are slightly more neurotic than a more general sample of males (norm male neuroticism = 21.6, healer male neuroticism = 24.7). However, overall levels of neuroticism were only slightly higher for healers compared to a normal population. Deary, Agius and Sadler (1996) reported higher levels of neuroticism amongst psychiatrists compared with a sample of physicians and surgeons ($p = .009$). Similar to the healer sample, psychiatrists also scored higher on openness ($p = .003$) and agreeableness ($p = .002$). There may be personality similarities between healers and psychiatrists, and these may be related to the need of both groups to communicate and connect with their patients.

One primary limitation of this study is that it is based on the self-reports of healers. It was possible to compare many of the measurements with population norms, thus telling us something distinctive about the healer population, but these results may also be related to other characteristics of the healer sample that are distinctive from the norm samples (some of which are comprised mainly of

undergraduates). So, it would have been better to recruit a more closely-matched sample for comparison purposes. Furthermore, the open ended questions were limited, and a more in depth qualitative analysis may have yielded richer data. These questions were also rated only by myself, and thus the ratings may have lacked reliability.

4.6 Summary

Healers' description of distant healing is helpful in creating a model of distant healing. Factors brought for in the current study that will be introduced into the proposed model include: characteristics of distant healers (extremely high levels of spiritual connectedness, extremely permeable boundaries, frequent experience of exceptional phenomena and high levels of agreeableness and openness); the report of 'energy,' sometimes described as divine and often in the context of transferring or channeling; intention of the healer; the multiple levels of healing - spiritual, emotional, physical; healing as a return to balance or wholeness; and environmental support (e.g. friends and family who support the healee).

We now move on to look at the other side of the healer-healee interaction: Chapter 5 seeks to develop an understanding of what the experience of healing means to the healee.

Chapter 5: The Experience of Distant Healing in a Culturally Supportive Context: An Investigation Using Interpretive Phenomenological Analysis

5.1 Introduction

The aim of this study is to provide a perspective on distant healing that is complementary to the psychological profile of the healers, and to the question of the actual efficacy of remote healing. Here, we focus on what the experience of healing means to the healees. Because we are seeking an in-depth understanding of the phenomenology of healing, the data for this study consists of an analysis of interviews with individuals at various stages in the healing process.

By gaining insight into the lived experience of individuals, this study facilitates building a model of distant healing and helps to put together some of the pieces from the previous two studies. Obtaining access to individuals' stories was achieved through the use of face-to-face, semi-structured interviews.

This study used a qualitative, phenomenological approach to data collection and analysis known as Interpretative Phenomenological Analysis (IPA) in order to obtain an in-depth analysis of, and engagement with, individuals' accounts of distant healing. IPA is an approach to research that is theoretically rooted in phenomenology, hermeneutics and idiography (Smith, Flowers & Larkin 2009). The purpose of IPA is to understand and explore the lived experience of research participants. Rather than asking the question, "Does distant healing work?" the focus of this study is "How do people receiving distant healing make sense of their

experience?" Thus, this study makes no attempt at proving or disproving the existence of distant healing but rather explores how participants understand the phenomenon of healing.

The present study took place in Sri Lanka, a cultural context in which complementary medicine and distant healing are widely accepted as a means of treating physical and psychological ailments. I previously conducted fieldwork in Sri Lanka as an undergraduate in 2002, when I first met Bhante Seelagawesi[1], a Buddhist monk and healer. Though distant healing was not the focus of my research at that time, I found the setting to be conducive to investigation of the topic, as healing took place in the context of a larger community and many positive results were reported. I will now provide the reader with an introduction to the cultural context of healing both in Sri Lanka in general and specifically with Bhante Seelagawesi, who is the healer for each of the participants in this study.

5.1.1 Healing in Sri Lanka

There are many ways in which modern day Sri Lankans approach resolving illness. The way in which they do so reflects their attitude towards illness, and in this predominantly Buddhist country, Buddhist thought or ritual plays a large role in shaping their attitudes and their lives. Despite the wide availability and utilization of western medicine, more traditional forms of healing are still employed. Sri Lankan Indigenous medicine, or Sinhala Vedakama, which parallels Indian Ayurvedic medicine, is a common practice, especially in cases of minor illness (Dharmasiri, 1997). Exorcisms or Bali ceremonies are also still performed in some areas, though generally speaking they are typically limited to villages (Gombrich & Obeyesekere, 1988). Additionally, there are individuals who are believed to possess healing

[1] Bhante has given permission for his real name to be used.

powers and to be able to heal using the capacities of their mind from a distance and/or using and moving "energy". One such healer, Bhante Seelagawesi, a Sri Lankan monk residing in Kandy, and his healing community are the subject of the present study.

In Sri Lanka there has been a spread of what is known as Protestant Buddhism, a term coined by Obeyesekere (1970) referring to the integration of Protestant Christian characteristics into Buddhist practice as a means of Buddhist revival and protest against the privilege and domination of the British (it was also a necessity, at that time, to be Christian in order to participate in government). The movement began in the latter half of the nineteenth century and is characterized by increased lay access to Buddhist practices that were previously thought to be suited primarily for monastics (Gombrich & Obeyesekere, 1988). As a result of the success of this movement, the Sri Lankan lay community possesses both the interest and the access to investigate the Buddha's teachings.

In the Pali Canon, the standard collection of Buddhist scriptures, the Buddha is often represented as a healer, the *dharma* (the teachings of the Buddha) as the medicine and the *sangha* (the community of monks and nuns) as medical attendants. The Buddha is commonly portrayed as healing through his teaching. If listeners had a fatal illness, he instructed them to meditate on impermanence, while those who could be cured were encouraged to meditate on the seven factors of enlightenment. There are, however, also many stories where the Buddha is portrayed as healing by psychic or miraculous means. Some stories relate the healing powers of previous incarnations of the Buddha. For instance, in the *Mahakarmavibhanga*, the Buddha, incarnated as Sarvausadhi, cures those with plague all over the world with whatever he gives them, whatever he touches becoming their medicine (Granoff, 1998).

Many of the Buddhists in the healee community surrounding Bhante Seelagawesi believe that the best way to heal a physical problem is to first heal your own mind from "mental defilements." The idea that one's mental state reflects one's physical state is quite common and reflective of the long tradition of healing that manifests itself in a variety of forms and approaches in Sri Lanka today.

5.1.1.1 The role of karma and misfortune. Disease is often explained as an effect of one's past negative *karma* or in Pali *kamma* (action). Negative *kamma* is believed to create periods of misfortune or in Sinhalese, *apale* (Gombrich, 1991), which can be predicted by astrologers. Sometimes individuals attempt to avoid or cut short the duration of an *apale* through the practice of "white magic". It is not uncommon for an *apale* to last for years; in one example from Gombrich's *Buddhist Precept and Practice* (1991), a young villager's horoscope predicted an *apale* that would last fifteen years. While this particular young man accepted his *apale* in stride, many seek out experts to perform "white magic" to avoid or to get rid of the *apale*. If a man falls ill, and both western medicine and traditional medicine fail, he may attribute the disease to "black magic" and counteract it through the use of "white magic". An illness that is difficult to overcome might also be ascribed to demons of disease or the influence of an *apale*. If each attempted remedy fails, then it may be understood that the man's *kamma* is bad, and thus determined that he will continue suffering (Gombrich, 1991).

Bhante Seelagawesi maintained that although *apale* is a commonly held belief, "the mind is the forerunner" (personal communication, October 12, 2008). He explained his view while that astrology and *kamma* have their place, most obstacles

can be overcome by strengthening the mind, an idea he supports with the first two verses of the *Dhammapada*[2]:

> Phenomena are preceded by the heart, ruled by the heart, made of the heart. If you speak or act with a corrupted heart, then suffering follows you — as the wheel of the cart, the track of the ox that pulls it. Phenomena are preceded by the heart, ruled by the heart, made of the heart. If you speak or act with a calm, bright heart, then happiness follows you, like a shadow that never leaves.[3]
>
> *Translated by Thanissaro Bhikku*

5.1.1.2 Indigenous medicine. The strong connection between Buddhism and medicine in Sri Lanka is evident in the isomorphism of the Buddha's first and central teaching, the Four Noble Truths, and the four questions that formed the core methodology of Ayurvedic medicine in India (considered the root of Sri Lankan indigenous medicine) during the Buddha's time:

1. Is there a disease, if so what is it?
2. What is the cause of the disease?
3. Is there a cure for the disease?
4. If the disease is curable, what is the proper treatment?

According to myth, the magician emperor Ravana, who lived in pre-historic times, brought this Ayurvedic knowledge to Sri Lanka. He also was said to have invented an airplane shaped like a peacock that he used to fly to India for a celebrated medical conference in the Himalayas. On his way back to Sri Lanka, he abducted Seetha, Rama's wife (the story of the Ramayana is Rama's fight to get her back). Ravana is credited for having written four medical classics in Sanskrit, and some of the medicinal recipes contained in them are still used in Sri Lanka today (Dharmasiri, 1997).

[2] The Dhammapada is a collection of Buddhist verses contained in the Pali Canon and traditionally ascribed to the words of the Buddha.
[3] This translation by Thanissaro Bhikku uses the word "heart," though previous translations use the word "mind".

Although Sri Lankan indigenous medicine is based to a large extent on Indian Ayurveda, its practitioners emphasize the importance of its use in the context of Buddhist moral and spiritual teachings (Dharmasiri, 1997). For most traditional native physicians, medicine is practiced as a hobby or type of charity. Money is usually not mentioned in treatment, and it is not a consideration for either physician or patient (Dharmasiri, 1997). Traditional physicians are still found in many villages in Sri Lanka, but they are utilized today primarily in cases of rare disorders, as most villagers know the basic medicines (Dharmasiri, 1997).

5.1.1.3 Bali ceremonies – other alternative approaches to healing. The practice of exorcism and magic generally takes place in outlying areas and villages rather than cities in Sri Lanka. Bali ceremonies - or exorcisms - are usually employed to treat diseases of a psychological nature or physical diseases that are considered incurable, such as cancer. Disorders of emotional origin are usually thought to be a product of sorcery; a Bali ceremony is therefore considered more appropriate than medicine (Gombrich & Obeyesekere, 1988). Traditionally the ritual is performed in the village of the patient, where family members and the larger community can extend support to the patient during the ceremony (Gombrich & Obeyesekere, 1988). Spirits, *bhutas* (ghosts) or *pretas* ("hungry ghosts") are often held responsible for the affliction. This displacement of blame away from the patient in conjunction with support from the community contributes to the effect of psychological healing. These ceremonies are generally "Buddhacized" with Buddhist *Paritta* (protection chants), which are very common in Sri Lanka and used in a variety of circumstances (Gombrich & Obeyesekere, 1988).

5.1.2 Context of Healing for this Study

Bhante Seelagawesi is a Sri Lankan Buddhist monk and has been practicing healing for about 17 years. He was not formally trained in any particular healing art but came to practice healing on his own. Over the years he has explored different methods and has trained others in various techniques. It is not common in Sri Lanka for monks to practice healing. In Bhante Seelagawesi's case, he kept his healing practice secret for many years. Although he felt compelled to heal and was happy that he could help others, he always asked that they keep his activities private. Nonetheless, word of his healing practice began to spread, and the number of people coming to him for healing increased steadily.

The Buddha prohibited monks from practicing medicine outside of the monastic order and specifically prohibited them from earning a livelihood as healers (Dharmasiri, 1997). Certain monks, however, who, "seeing others ill, and having the knowledge and means to cure those illnesses," have taken on the practice of aiding laymen (Dharmasiri, 1997, p. 242). Providing for those in need is an expression, in these cases, of the monks' compassion for others.

Bhante Seelagawesi's own path to healing is rather unconventional, even for healers: he claims to have simply discovered a power in him that had been cultivated in previous lives. Bhante explains that he is constantly experimenting with his healing techniques and making changes as he explores different approaches. When conducting distant healing, he "visualizes the patient's neural structure" and tries to connect with that center and promote the person's "psychoneuroimmunity." On days when members in the community and healees join for group healing, he tells healees that he is going to try to "reach their telepathic centre" and promote their own immunity. Bhante presupposes, however, that most individuals may not grasp

his meaning and will instead believe what they want about the healing process, regardless of what he tells them.

The healing sessions took place in a "temple" built for the purpose of healing in the garden of area of a community member's home (a photograph is provided in Appendix D), and most of the interviews conducted for this study took place in a private room adjoining the temple. There are three healing sessions per healing day: each start with Bhante taking a roll call of attendance for those who have come to receive healing, followed by a period of lecture and discussion, and then group chanting. Bhante explains at this time that he will practice healing for the individuals in attendance in this initial chanting period and will also be relating to their particular illnesses and how best to approach their healing process. Following the group chanting, individuals are called one by one for healing and/or counseling. During this time Bhante often closes his eyes for a few moments, sometimes as long as a minute or two. After this meditative preparation, Bhante will recommend a specific treatment plan, usually including herbal remedies and a particular *Paritta* or "*pirit*" in Sinhalese. In some cases, Bhante will suggest going to a specific doctor, visiting a temple (or, in cases where the healee has a Christain background, a church), or spending time at a specific Bodhi[4] tree.

5.1.2.1 Chanting in relation to healing. The tradition of *Paritta*, or protection chanting, began very early on in Buddhist history. The Buddha himself had *Parritta* recited to him when he was sick, and he requested that others recite it for his followers when they became ill (AN[5] 10.60, transl. 1997, SN[6] 46.14 – 46.16, transl. 2009). It is believed

[4] A Bodhi tree refers to the species of tree that the Buddha sat under when Enlightenment was attained. Sapplings of the original tree can be found around the world, and most Buddhist temples in Sri Lanka have at least one Bodhi tree on the premises.

[5] The Anguttar Nikaya, known as the "Numerical Discourses" of the Buddha, contains the Girminanada Sutta (where the elder monk Girimananda is ill, and the Buddha instructs the monk Ananda to recite teachings of the 10 Perceptions).

that if one listens wholeheartedly to the truth of the sayings, it will "bring into being wholesome states of mind which conduce to health, material progress and spiritual progress" (Piyadassa Thera, 1975, p. 8). The teachings of the Buddha were passed along orally, both during the lifetime of the Buddha and following his death. Because of this, the *suttas* are repetitive in nature and are composed with a rhythmic quality when recited in Pali, the language the Buddha taught in. The vibratory sounds of chanting are considered to be soothing to the nerves and said to bring about harmony in one's system (Piyadassa Thera, 1975). Thus, both the context and the actual auditory effect of the chanting are considered important.

Bhante Seelagawesi often chants the *Bhojjanga Suttas* during healing or healing days. There are three *Bhojjanga's*: each is similar in form and tells of an elder monk suffering from illness. The Buddha suggests that he recite the seven factors of enlightenment to bring relief from the illness. The seven factors include: mindfulness, investigation of truth, persistence, rapture, serenity, concentration and equanimity. In each of the versions, after hearing the seven factors of enlightenment, the monk's health is restored[7]. These factors are traditionally seen as a way of "overcoming the interior poisons", specifically lust, anger and delusion, as they are believed to contribute to imbalance and disease (Birnbaum, 1979, p. 11).

The seven factors are still widely referenced in this manner today. In the book, *In This Very Life*, Sayadaw U Pandita, a respected Buddhist monk, meditator and teacher from Myanmar, states that the seven factors are "comparable to strong, effective medicine" (1992, p. 163). He goes on to give examples of students he has known who, through meditation, have overcome diseases such as tuberculosis and high blood pressure (1992). In such cases, rather than being a difficult manifestation

[6] The Samyutta Nikaya, known as the "Connected Discourses" of the Buddha, contains the Gilana Sutta Ill, where the elder monk Maha Kassapa, Maha Moggallano and the Buddha are ill – the Buddha asks that the seven factors of enlightenment be recited in each case.
[7] In one of the *Bhojjanga Suttas,* it is the Buddha who is ill.

of negative karma, the disease can serve "as a catalytic factor leading to new insight – in some cases – to liberation" (Birnbaum, 1979, p. 12).

In addition to the *Bhojjanga's*, other *suttas* commonly recited include: the Buddha's teaching on love and compassion; reflections on the qualities of the Buddha, *dharma* and *sangha*; sayings of the Buddha from verses of the *Dhammapada*; and chants created by monks for protection and blessing.

5.2 Method

5.2.1 Design

All participants were patients of the same healer, Bhante Seelagawesi (referred to in interviews as Swamingwahanse, Sadu or simply, Bhante – all general terms referring to a monk). Interviewees at different stages of the healing process were sought out: those who are new to healing treatment, those who are currently experiencing healing treatment, and those who are in a post-healing treatment phase. For the current analysis participants were selected based upon the depth and quality of the interview. In total 16 interviews were conducted, transcribed and analyzed, two of which were chosen for phenomenological analysis. The two interviews included in the analysis are with participants in the Post group, who, given their experience with and comfort in discussing distant healing, were particularly capable of clearly communicating their experiences.

5.2.2 Participants

In IPA the researcher deliberately selects participants who have direct experience with the research issue being addressed. Sample size is an ongoing subject of discussion and development in the IPA literature. Smith, Flowers and Larkin

propose four to eight interviews for PhD dissertations (2009). Smith and Osborne suggest that sample sizes for IPA studies can range from a single case study to fifteen or more (2003). Both of these references point to the idea that too much data can be overwhelming, thereby inhibiting the depth that the researcher is able to bring to analysis. It is stressed, however, that the specific needs of the research project should be put before any particular rigid formula. Although sixteen interviews were conducted in total, for the purposes of this analysis, we will focus only on two of those. The interviews that provided the most content for analysis were chosen. In addition, one of these participants, Mr Ut, had a more extensive command of the English language, making translation less of a hindrance. Both of these participants had been receiving healing treatment for a number of years. They also demonstrated a marked openness to sharing their experiences. Finally, they had both been introduced to me on prior visits to Sri Lanka, and were thus quite comfortable discussing their experiences.

Bhante Seelagawesi assisted in the recruitment of participants by announcing the research study to healees on his "healing days" in Katugostota. Pseudonyms have been used to ensure anonymity. Table 5.1 will present in further details characteristics of each participant.

Table 5.1. Participant characteristics.

Group	Name	Sex	Age	English comprehension	Translator used?	Health Problem
Post	Ms Sa	F	45	A little	Was present, and utilized on occasion	IBS/Stomach problems
Post	Mr. Ut	M	37	Fluent	Not present, not needed	Cancer/splenic lymphoma

5.2.3 Interview Procedure

Both participants were interviewed in their homes at their homes in Sri Lanka at their convenience for approximately one hour. A semi-structured interview schedule was prepared, containing a list of the main topics to be covered. This sheet contained the following subjects to cover:

1. How did you come to meet Bhante Seelagawesi?
2. What were your first impressions upon meeting him?
3. What were your impressions and belief about the type of healing he was doing?
4. What has your experience of receiving distant healing been like/how would you describe it?
5. Before meeting Bhante Seelagawesi had you experienced or heard of similar types of healing?
6. Did your belief or opinions about healing change since meeting him?
7. How do you think distant healing works?

The main advantage of the semi-structured interview in IPA research is that it allows for the researcher to follow up on important issues that arise during the interview (Smith, 2004). To this end, interviews were able to progress as naturally as possible and participants were encouraged to explore ideas and experiences that went beyond the interview schedule.

At the first meeting with each prospective participant, they were asked to read and review an acknowledgement of consent that had been translated into Sinhalese. It was also explained verbally to each participant that the interview was part of academic research, and that the content of the interview would be shared

accordingly. All prospective participants granted their consent to participate in the study.

I conducted all sixteen interviews, though an interpreter was present to translate between Sinhalese and English when needed. Oftentimes, the interviewee would answer in English when possible, and the translator would provide clarification when needed. I also speak basic Sinhalese and would inquire about responses if they seemed to be inadequately or incompletely translated.

Each interview was digitally recorded and fully transcribed. Following each interview, I would record my initial impressions, specifically taking note of anything that might not be evident in the recording and transcript (facial expressions, emotions expressed and other forms of non-verbal communication).

5.2.4 Data Analysis

As mentioned previously, IPA is not a prescriptive method and allows for flexibility in analysis (Smith, Jarman & Osborn, 1999; Smith & Osborn, 2003; Smith, Flowers & Larkin 2009). This study had specific components that are relatively uncommon in IPA research, such as: the use of a translator, research outside of the interviewer's native culture, participants already familiar to the researcher, and so on. This unique research situation contains both benefits and drawbacks. The overarching goal of this analysis nonetheless remains true to other IPA studies: to explore the lived experience of the participants, and to investigate how meaning occurs and is made sense of in social interaction (Smith, Jarman & Osborn, 1999).

I analyzed data using the conventions set out in Smith & Osborn (2003) and Smith, Flowers and Larkin (2009). Smith, Flowers and Larkin (2009) discuss the use of larger samples and maintain that "what makes the analysis IPA is the fact that the

group level themes are still illustrated with particular examples taken from individuals" (p. 106).

My analysis proceeded in steps: after reading and re-reading individual transcripts, I began to identify emergent themes (using a transcript with one margin devoted to exploring these initial themes). I then went on to explore relationships between themes (in a second margin), establishing my own interpretations while keeping them rooted in the text. As I moved from one interview to the next, I took notice of recurring themes as well as areas of divergence between participants' experiences. I read the interviews by group in the following order: New, Current, Post. During the initial reading and development of themes, I took each group on its own, not looking to compare and contrast individuals from one group with those in another.

A reflexive approach to analysis was achieved by re-reading the interviews with a focus on myself as the interviewer. Smith, Flowers and Larkin (2009) suggest that reflexivity is an important aspect of analysis but warn researchers not to get excessively carried away in the process. Due to the cross-cultural nature of the present study, reflexivity is perhaps even more crucial to analysis. As a western researcher, my own background differs markedly from those of the research participants; additionally, a language barrier may have inhibited ease of interaction. Thus, when relevant to this study and the understanding of distant healing, these reflexive observations were included in the analysis.

5.2.5 Reliability and Validity

Quantitative and qualitative research paradigms use different methods to achieve and judge reliability and validity due to their differing epistemological bases, aims and objectives (Smith, 1996). Yardley (2000) presents four broad principles to assess

the quality of qualitative research, which include: sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance.

A number of procedures were adopted in the present study to uphold these principles. First, an independent rater (Benjamin Fong) read the transcribed interviews, identified themes and engaged in the interpretive process described previously. Themes and interpretations were regularly compared with my own in order to provide a check on the reliability of my analysis. The aim of this process is to ensure the credibility of the analysis rather than to produce an analysis that is objectively "true" (Yardley, 2008).

Similar to Yardley's guidelines, Smith asserts that internal validity and reliability in qualitative research are achieved through internal coherence and presentation of evidence (Smith, 1996). Internal coherence refers to whether the argument presented within a study is internally consistent and supported by the data. Presentation of evidence refers to the sufficiency of data from participants' discourse within a report to enable readers to evaluate the interpretation. Emergent themes are therefore presented alongside participants' actual discourse, in order that the reader be able to assess the reliability and validity of the interpretations. Finally, transparency in analysis is achieved by providing readers with references to the text throughout the analysis.

5.3 Results

The participants expressed their own experiences with distant healing as something attributed to, not only the healer, but also their own practice and the involvement of the community. Both interviewees had experiences practicing healing for themselves and others, so the discussion included these experiences in addition to their

experience as a healee. Kindness and compassion were mentioned frequently as important to the healing process, findings consistent with reports from healees in the Chapter 5.

Relevant interview extracts are provided in support of each emergent theme. Often extracts include more than one speaker, and individuals will be identified as such: Ms/Mr…. = Respondent speaking; I = Interviewer speaking; T = Translator speaking.

Before discussing these primary thematic results, however, I will first address a troubling but interesting obstacle to this research: the difficulty of translating the concept of "distant healing" into Sinhalese.

5.3.1 Putting Distant Healing in to Words: Translating the Concept

The term "distant healing" was proven problematic for a number of reasons. To start with, when participants in this study talked about distant healing, they tended to exhibit some confusion and had a difficult time explaining the concept. In my first interview, with Ms Sa, a woman in the Post group who has known Bhante for several years, I learned of a surprising obstacle to my research: namely that, according to Ms Sa's account, no word for distant healing exists in Sinhalese. When I first questioned Ms Sa about her experience with distant healing, she described her experience with healing at a close proximity, of the kind that Bhante practices on healing days:

> I: What do you think about distant healing?
> T for Ms Sa: She says…eh that the whole body get warm when she is receiving.
> Ms Sa: Sometimes it's getting…
> T for Ms Sa: Stroke…eh will be continuing in her body.
> I: So she feels frozen?
> T for Ms Sa: She feels it.

When I attempted to clarify her response by asking if she was describing healing at a distance or healing at a close proximity, Ms Sa voiced some confusion:

> I: When you are receiving distant healing, like...close, or also when some is healing from far away, from Kandy?
> Ms Sa: No, close... Distance means long?
> T: Distance means long, yes.
> Ms Sa: Ah, then not the, ah its, ah for me… I can…

Recognizing that the term "distant healing" was clearly an obstacle in our conversation, I asked what the appropriate term might be to utilize in future interviews, so as to prevent further confusion. I found that the English term "telepathic healing" was more frequently used than "distant healing," and furthermore that there was difficulty matching either term with an equivalent in Sinhalese:

> I: In Sinhalese is there a word for healing?
> Ms Sa: *Kirina alenewa*.
> I: And for distant healing?
> Ms Sa: Telepathic healing.
> I: Same as in English. So would you say together with the Sinhalese word for healing, or with the English?
> Ms Sa: No, you don't say with the Sinhalese word.

Ms Sa was able to translate the word "healing" into Sinhalese, but she could not similarly translate "distant healing," and moreover asserted the linguistic difference between the "healing" of telepathic healing and *kirena alenewa*.

As the interview with Ms Sa progressed, there was further discussion of the definition/translation of distant healing in Sinhalese. Ms Sa was pleased with the term "spiritual healing" as a translation for *kirena alenewa* but was adamant about differentiating it from "telepathic healing," and refused altogether to map the western term "distant healing" onto Sinhalese concepts:

> I: So would you use the same word when talking about getting well with the help of a doctor, or only for sort of spiritual healing.
> T for Ms Sa: Spiritual healing!
> I: Spiritual healing is a good way to define that?
> T for Ms Sa: Yes.
> I: Okay. And for distant healing, would you say distant spiritual healing, or you would say telepathic healing in English.
> Ms Sa: Yes telepathic healing.
> I: And for the person in the street who has not met Bhante, will they know what it is?

> Ms Sa: They don't know about that.
> I: They don't know. They know the word?
> Ms Sa: No, they don't know anything. If someone say *kirena alenewa*, it means blessing then they can understand. That they would understand. The street people and all that, they can't understand healing and all that and telepathic healing, these words they can't understand.
> I: And there's no words that they can understand. So if you are speaking to them you would use blessing?
> Ms Sa: Blessing, if somebody says like this, it means Bhante is blessing like this.

Continuing on this topic, Ms Sa explained how "blessing" could be the most commonly used and understood term available, although that too doesn't match the concept of "telepathic healing" for her:

> Ms Sa: Yes, blessings is common
> I: But do you think it is different from healing?
> Ms Sa: Yes, very different.
> I: How? Can you explain?
> Ms Sa: Yes, blessing is some body is telling, no. From the mouth and telling. The healing is coming from the body no. Every Swamingwahanse can bless. Even some people in the street can also say, oh many merits to you, or like this telling. This is blessing, this is different kind. The healing is coming from heart and body, from everywhere, not only from mouth.

The statement, "every Swamingwahanse can bless," alludes to the idea that telepathic healing is not something that would be practiced ordinarily and that such healing goes beyond the common gesture of offering blessings. Extending blessings is a common practice in Sri Lanka. Rather than judging other monks as inferior, I feel that this passage relates instead the lack of fit between the words "blessing" and "distant healing." "Blessing" nonetheless emerged as one of the few approximations of healing available in the Sinhalese language.

With a new awareness of terminology, I adopted the term "telepathic healing" for subsequent interviews, though this still proved inadequate for a majority of participants. Some of the more experienced healees in the Current and Post groups, who had longer relationships with Bhante, were familiar with the term, but it remained challenging to encourage the interviewees to speak about their

experiences with telepathic healing. Only one interviewee used the term without prompting. Mr Ut, who had begun to himself practice telepathic healing for others (with the support and guidance of Bhante Seelagawesi), explained:

> Mr. Ut: And ah, so we are doing some telepathic kind of healing. And ahh, it ahh, actually especially for the people that are not in the vicinity. So we are concentrating, or either we take the photograph or either we take the imagination of the person and do chanting and then actually most of the time they phoned us and told that so I am okay, I got cured or kind of thing. And ahh, especially the occasions where the people who are treating, who are getting healed from us, when they are having the same, when they are having chemo at the hospital, so we are doing the, they have operation at the hospital, so at the same time we are chanting *pirit* and doing telepathic healing.

In brief, Mr Ut defined telepathic healing as healing practiced for someone not in the immediate vicinity by using a picture or mental image of that person and chanting for them. He had a clear description of what telepathic healing was and how it could be practiced, and the term was clearly very familiar to him. The other participants in this study reported less experience practicing telepathic healing as described by Mr Ut, and although the term was understood, it was elsewhere not defined so clearly or mentioned with such ease.

In summary, the interviews conducted pointed to differences in terminology and vagueness concerning the term "distant healing." It was clear from these interviews that something resembling distant healing was being practiced and experienced by the interviewees, yet a special distinction for this type of healing did not seem to be available in the Sinhalese language. Interviewees suggested other terms similar to distant or telepathic healing, but none of these conveyed with specificity the healing they viewed Bhante Seelagawesi as practicing. Although this created a challenge as an interviewer, the practice was usually easily clarified with the participant, as interviewees frequently decided that although "distant healing" or "telepathic healing" was not a term they could translate, it was a subject they had experience with.

5.3.2 Thematic Analysis

Two super-ordinate themes were identified. I will first discuss the Perception of Healing, of which the major themes were Compassion and Kindness. I will then move on to the super-ordinate theme of Empowerment, of which the major theme was Community Participation. These themes will be discussed in more detail and are summarized in Table 5.2.

Table 5.2. Master Theme Table.

Super-Ordinate Theme	Perception of Healing	Empowerment
Major Theme	Compassion Kindness	Community Participation
Sub-Categories	Quality of healer & healing Personal practice	Healing for Self Healing for others

5.3.2.1 Perception of Healing. Bhante Seelagawesi reported that he explains to all healees the mechanism of healing in the same way (2009). Still, healees' accounts of the experience of distant healing have been marked with some ambiguity. The variety of participants' descriptions of what it feels like to experience distant healing is another theme explored in this analysis. Participants most prevalently described their experiences in terms of kindness and compassion. Mr Ut, for example, described his impressions of the healer as follows:

> Mr Ut: But the only thing I saw with him is this unlimited kindness. So whatever is said or done he's quite kind to everybody…. So I came to know that Bhante is ahh, he is very kind, he is very helpful, he is doing all for others and not for him. So then there are enough evidence to believe him, so then I believe in that way.

Here Mr Ut is discussing his belief in the efficacy of healing and relating this belief to the kindness he observes, which facilitated his trust and belief in healing from the outset. Because he doesn't observe selfish behaviour he feels from his first meeting

with Bhante that healing may be possible, even though he hasn't experienced it before.

Not only is this kindness a quality that Mr Ut recognized in the healer, it is reported as an important factor of healing itself:

> Mr Ut: Because only thing is that, the amount of kindness that you are having in the mind and the body is the only thing, the other things are immaterial. So, then ahh, Once I started healing to someone, I automatically got activated these palms, so I can feel these rays kind of thing are releasing, and the person also feels the same thing.

Here Mr Ut, in describing his practice of telepathic healing for others, places emphasis on the "kindness that you are having in the mind," suggesting that this kindness can be shared between the healer and healee, and that this kindness in the mind is central to the efficacy of healing, everything else being "immaterial". It is should be noted here that Mr Ut describes kindness as both a quality of the mind and of the body. This extension of kindness to the body might indicate the relationship between kind actions in contrast to the intention of kindness that might be limited to the "mind". This relates to Mr Ut's observation of Bhante's kindness, as observable in his actions towards others. Another way to interpret Mr. Ut's remarks on the "kindness of the body" could be to see it as operating on an energetic level. Mr Ut goes onto describe the feeling of rays releasing from his hands. Although the connection between the "rays" Mr Ut experiences coming from his hands and the experience of kindness in mind and body is not explicit, they are no doubt related, given the association offered by Mr. Ut.

Mr Ut also suggests that healing should be shared freely with others out of a sense of kindness. When asked if he had visited other healers in Sri Lanka, Mr Ut responds:

> Mr Ut: Ahh, no. No, actually the first one I heart about is Bhangte Seelagawesi, and I am quite sure of him. And there are some popular healers in the country as well, and, but, I think most of them are charging money. And it's quite a thing that you should do full of your

> kindness and your devotion, devote to this certain subject, it's not something to consider money. So, then I don't believe that money will give anything to you in terms of healing. It has to be free with money and free with other intentions sort of thing. Only the matter of supporting another person and kindness towards the person.

It is clear here, for Mr Ut, that healing is based on the support offered, that this support can not be bought or sold, and that it should not be given with any expectations of personal gain. For Mr Ut, "it's quite a thing" that healing is practiced with "kindness" and "devotion" and this generosity, according to Mr Ut, is not readily offered by other healers.

Ms Sa pointed to the periods in which she receives healing as experiences of communication and in terms of feelings:

> T for Ms Sa: She said that she remembers that person…
> Ms Sa: If some person is doing distance healing for me feeling like he is thinking about good things about me and I feel good for that person also.

This excerpt suggests that Ms Sa consciously feels the effects of distant healing and responds by reciprocating with a good feeling for the healer. This generation of good feelings towards others seems to be central to Ms Sa's experience, and this passing along of "thinking good things" does not end with her but is returned to the healer.

Ms Sa also suggests that *maiytre* or compassion has been an important factor in her healing. When asked about the connection between reported bouts of anger and the stomach problems for which she received healing, Ms Sa responds:

> Ms Sa: Yes, Swamingwahanse told me it is connected with my stomach.
> I: And did you feel that?
> Ms Sa: Swamingwahanse told me I have not maiytre, that's why. That's why now I practice maiytre, then I know how to do maiytre, now I am alright.

This passage imparts how Ms Sa, after being counselled by Bhante about a lack of compassion, made an effort to practice, and this she directly attributes to being "alright". Earlier in the interview Ms Sa mentions that she had previously been very

quick to get angry with others and that the practice of compassion, by which she means both meditative practice and kindness towards others, alleviated this anger, thus aiding the healing process.

That kindness and compassion are integral to healing is consistent with reports from healers in Chapter 4. For the participants here, compassion was not only recognized to be part of the healing practice, directly relating to "the amount of kindness that you are having in the mind", as suggested by Mr Ut, but also asserted to be a quality in the healer. In addition, healees are encourages to develop their compassion, which is seen as central to the practice of distant healing.

5.3.2.2 Empowerment. The second theme relates to the importance of community. As already mentioned, the responsibility of healing is shared, lying both with healer and healee but also with the larger community. As noted in the introduction, a wide array of traditional Buddhist and Buddhist influenced healing practices are utilized in Sri Lanka today. Many of these practices, including meditation, talks on the Buddha's teaching, and chanting, involve group participation. In this study it was observed that these traditional practices were often combined with healing practices, seamlessly incorporating community building into the healing practice. Healees were often also healers and were sometimes asked to assist Bhante or take responsibility for a particular patient. At other times, they were simply present to participate in chanting for someone who was ill. Healing is done for everybody; it is something that flows within the spiritual community.

Interviews suggested that people often bear the responsibility for their own cure and do not hesitate to heal for others. Mr Ut, who now practices healing for others, described how Bhante had given him the responsibility to cure himself with

the help of his wife, saying that he could explain the path but that it would be up to them to put it into practice:

> Mr Ut: I would live only 8 months, because of this disease is that much worst. So subsequently he told it's up to you that ahh, to get it cured, I will tell you the path, if you adhere to that, you and your wife so you'll be getting cured.

Both Mr Ut and his wife bear the responsibility to follow a path of healing. Bhante's role as the "healer" is thus minimized to that of an advisor; the adherence to the treatment is up to Mr Ut and his wife.

This advice is a direct reflection of the Buddha's teachings to his followers in the Dhammapada, which states that "Purity and impurity are one's own doing. No one purifies another. No other purifies one" (Thanissaro, v. *165*). This communal responsibility is important and part of the healing process. It is evident in Mr Ut's experience as well as Bhante's counseling. Thus, while healing is very much a community effort, there is also an emphasis on self-reliance.

The experience of healing made a big impact on Mr Ut, and he has decided to devote much of his time and energy to practicing healing for others, he explains:

> Mr Ut: So then I, what I believe was, by the time, so life has given me the opportunity to escape from the death. So it's a lifetime opportunity. Only thing is life will sometimes not give the second opportunity for me. So, only thing is I have to keep this with me. So only, what I have to do is to, by helping others and devoting my, this, life for others, helping the others. So I will give my life, the rest of my life, for the, especially for the patients. The other people, while doing the other, my normal job and family commitments. So, I committed to do other things. So, actually that will be a relief for me as well for my body, because I am continuing to radiate into the principles of Buddhism.

Mr Ut expresses the importance of practicing for others and sees it both as a duty, given his second chance at life, but also as something that will benefit him. He says this devotion of his life to others will be of benefit for "me as well as for my body", and he attributes this to his "radiation into" Buddhist principles. Again, we find that

Buddhist ideas have merged with the practice of healing. By devoting himself to Buddhist practice, Mr Ut finds some "relief" both physical and mental. It is clear, then, that the relationships within the community are perceived as being mutually beneficial.

Ms Sa, who also practices healing for others, explained her confidence in her own good health and her willingness to practice healing and spend time with others who are sick:

> Ms Sa:..Now when I come here, they have virus flu and all that, I never get those sickness. Not coming to me. Because I believe that I am doing self-healing for me.
> I: And you think that's also why you don't get sick.
> Ms S: If some sick peoples, somebody don't like to go to sick peoples, no? But I am not scared of that sickness. But I am going and I am treating them. I am sleeping next to them. I am not scared. But I have never come…from them anything, no virus flu and all that.

Ms Sa believes that her "self-healing" practice has not only led to her improved stomach condition (the original reason for seeking healing treatment) but also has contributed to a sustained health and protection from illness. The idea that one can be protected from illness is actually one communicated directly in many of the chants that Ms Sa would participate in both with others in the community and on a daily basis with her family. For Ms Sa the connection is very clear: her good health is directly related to this self-healing practice, and because of this, she is able to be with and practice healing for others.

Ms Sa also weighed in on the role of her own healing and practice in relation to the influence of Bhante's healing practice. When I asked what she felt was more influential to her own recovery, her own practice or the healing from Bhante, Ms Sa responds:

> Ms Sa: If both is coming it's getting better soon. If only myself I am doing, it's very slowly coming goodness. If Swamingwahanse is giving like this, also it is coming very slowly. If both are going same way it's coming soon better.

Thus, for Ms Sa the combination of self-healing and the influence of Bhante's healing practice work together, expediting the healing process. Participation in treatment is

often required of patients in various health care modalities; adherence to medication for example is often a necessary aspect of a treatment plan. However here the "treatment" given to participants includes developing a sense of responsibility and encouraging individuals to engage in spiritual practice without complete dependence. For Ms Sa this was adopting the Buddhist practice of *maitrye* meditation. Mr Ut likewise was advised on particular exercises and chants that would be beneficial and was asked to integrate these practices into his daily life. It seems that for both Ms Sa and Mr Ut, this integration of self-healing has lead to better health and increased participation within the community.

5.4 Discussion

The goal of this study was to generate a phenomenological perspective of what distant healing meant and how it is experienced based upon accounts of those who have received it. Although the research is situated in a Buddhist cultural context, distant healing was often practiced alongside more Westernized medical forms of treatment. Benjamin Fong (the other rater) and I agreed on the primary themes that emerged from this analysis.

First, it emerged that the very concept of "distant healing" seemed problematic for healees interviewed. Participants had great difficulty finding words to identify the Sinhala equivalent of distant healing or telepathic healing. When pressed, they offered phrases such as "blessing" and "spiritual healing" but insisted that these concepts were not equal to telepathic healing. This may be the manifestation of a cultural difference between Western and Sri Lankan ideas of remote healing. Clearly, one limitation of this study was my lack of cultural awareness in this regard. Had I considered this when developing research questions, I might have asked generally about healing, and how it happens a distance, rather

than imposing the terms "distant healing" and "telepathic healing" on the conversation. Still, respondents were able to grasp the idea of distant healing, either with the English term "telepathic healing" or through examples of distant healing in practice. Furthermore, Bhante Seelagawesi did seem to have a clear picture of what he was doing when healing: mentally promoting the psychoneuroimmunology of healees and helping them to heal themselves (personal communication, October 14, 2008). These differences, both between the healer's and the healees' ideas of healing, and also between the Sri Lankan and Western ideas of healing, would benefit from further study. This could be achieved by focusing on distant healing as a concept across cultures, rather than distant healing as an experience, which was the primary aim of the current study.

The first theme relates to the super-ordinate theme of the perception of healing. The theme identified the importance of kindness and compassion to the experience of distant healing. The importance of generating kindness and compassion was emphasized in slightly different ways by the participants. Mr Ut spoke about the necessity of kindness in healing practice, indicating this should be one's primary intention and motivation, rather than any monetary or other gain. Ms Sa spoke of the practice of compassion, the effort she made to develop compassion and the importance this had on her healing process. These ideas were also presented by healers in Chapter 4, who reported that love and compassion were important qualities of the healer and healing process.

Participants reported very positive feelings towards the healer, Bhante Seelagawesi, as well as towards their experiences in healing with him. Though this could be due to a reticence to express negative feelings and response bias amongst the participants, this is fairly unlikely, since participants were informed both verbally

and in writing that interviews would remain anonymous, and that the research was based in the UK.

The second super-ordinate theme identified is empowerment. This theme concerns the extension of responsibility from the healer to the community and the individual. Healees often feel that they can practice healing for others, and thus that healing itself is an accessible ability. Members of the community and family would often chant for the healee, suggesting a communal process, rather than one administered by a single authority figure. Though the purpose of this study was not to evaluate the success of the healing treatment, it seems likely that the positive attitude of the participants and their faith in Bhante, as well as the shared view that healing is a communal process (hence family and friends are actively involved and supportive, and healees take responsibility for healing themselves and others), would maximize the chances of a positive outcome for those aspects of the disease that may be influenced by psychological factors.

The role of personal responsibility in the healing process was emphasized as well. Participants reported that they were encouraged to take an active role in their healing and lauded the benefits of such an approach. It is clear from these accounts that the healees did not rely completely on Bhante but rather accepted their own responsibility to care for themselves. This type of responsibility is common in other types of treatment where adherence to a certain regimen may be called for, but here the prescribed treatment is often meditation or spiritual practice of some sort. Rather than burderning healees, the sense of responsibility served to empower the participants in their own healing journey.

Although this is the first use of IPA in the study of distant healing, Cartwritght and Torr (2005) used IPA to explore the experiences of users of complementary and alternative medicine. One core theme of their study related to

how participants constructed a framework of their experience. They similarly noted that some respondents placed emphasis on their body's capacity to heal itself, identified as "mind over matter" (p. 12), noting that this was an empowering experience for participants.

Drawing from psychoneuroimmunology literature that relates the health benefits of stress reduction (e.g., Herbert & Cohen, 1993), with one of the greatest stressors being the loss of a sense of control (e.g, Henry, 2005), one may argue for a strong link between the positive outcomes of interviewees and the psychological relief, counseling and community support provided by Bhante Seelagawesi and the healing community that surrounds him. If we were to take a systems theory approach (Whitchurch & Constantine, 1993) to the experience of healing in Sri Lanka, we could argue based on what has emerged from this IPA analysis that a much wider system is involved than in Western cultures. 'Ordinary' individuals can heal themselves and others; family and friends are involved in chanting to aid in healing; at the same time the healer may be regarded as having some special divine powers that are shared with the healees through their religious beliefs. One might conclude that these features 'empower' the individual seeking healing, and such empowerment, in providing a sense of control, may well reduce stress and provide genuine health benefits.

Methodologically, this study brings forth a number of issues. Interview data is structured by the researcher's agenda, and thus data can be contaminated and biased based on the interviewers own assumptions (Hepburn & Potter, 2003). There is also an issue of my own cultural competency in the interview process and the issue of language. Of primary consideration is the fact that I, a native English speaker, interviewed all non-native English speakers. As an interviewer, this was often a challenge, adding a dimension to the study that would have not been present if

relating with native English speakers. Jentsch discusses some issues with the use of interpreters, many of which are found in the current study, including, possible bias due to interpreters background, the difficulties in using lay interpreters and the possible lack of control in the interview process (1998).

There is also a lack of consistency across interviews: one of the interviews selected for analysis was in English only (Mr Ut), and the other was conducted with a translator present (Ms Sa). Even with the translator present, Ms Sa chose to answer most of the questions herself in English, despite her lack of fluency. The translator in this study was not a professional, and at times was overwhelmed by the terminology utilized in the interview. Regardless, one issue with the process of translation is the inevitable choice of words and meanings that a translator must make (Venuti, 1998).

5.5 Summary

This IPA study gives a detailed and rich account of the varieties of healing experiences in Sri Lanka. Unlike Chapter 3, this study does not attempt to measure the efficacy of distant healing but rather meets healees at their experience and may therefore be considered subjective. It was observed that there were issues with language, particularly around the terminology of distant healing. The major themes developed related to the experience of kindness and compassion and the concept empowerment. The super-ordinate theme of empowerment was suggested in the combination of communal and personal participation in healing.

The observations and ideas brought forth in this chapter will contribute to the development of a model of distant healing in Chapter 6. Specific factors that will be included in the proposed model of distant healing include: kindness and compassion

in the distant healing encounter; and a supportive community and environment for healing, also described in Chapter 4.

Chapter 6: A Model of Distant Healing: Discussion and Conclusions

The studies presented in this thesis aim at developing insight into the phenomenon of distant healing. Both quantitative and qualitative methods were used to provide a holistic picture of distant healing. Multiple perspectives were taken into account: healers were asked to define and describe their practice, and interviews with healees brought forth the lived experience of distant healing. In this chapter I will summarize the main findings of the studies presented, build a proposed model of distant healing based on these findings, discuss methodological issues raised here, review the contributions this thesis makes to the field and suggest future directions for distant healing research.

6.1 Summary of Main Findings

This thesis is comprised of three independent yet complementary studies. The first reviews the efficacy of distant healing in its relation to belief and expectancy. The second compares healers' self-described characteristics with norms and attempts to capture how healing works from their perspective. The third and final study uses IPA to analyze the experience of healees in Sri Lanka, a culture more accepting of the possible efficacy of distant healing, and thus more likely to offer a contextualized understanding. As I review the primary findings of this thesis, I will make a note of what will be included in the proposed model of distant healing that will be introduced later in the chapter.

In the clinical trial presented in Chapter 3, I sought to understand the role of belief in distant healing and expectancy and how these factors might interact with healing efficacy. I also explored the possibility that self-reported personality factors influence the effectiveness of distant healing. Belief was found to have no impact on healing efficacy, in contrast to Lyvers et al. (2006), who found that participants' belief in distant healing correlated with positive outcomes. The clinical trial presented in Chapter 3 utilizes a sample three times the size of the Lyvers et al. (2006) study and suggests that these earlier findings may not be replicable. Furthermore, findings of Sicher et al. (1998) and Tsubono et al. (2009) suggest that belief in healing is not correlated with positive healing outcomes. Awareness of being a recipient of distant healing, however, did indicate a possible therapeutic benefit. Participants aware of their allocation in the healing condition appeared to have more positive General Health Questionnaire results at the end of the healing period when compared with participants aware that they were not receiving distant healing (d = 0.76). This effect was not found to be significant in the analysis of covariance, likely due to the study's low statistical power.

The results of the clinical trial are consistent with those of Walach et al. (2008). These findings indicate that an awareness of distant healing can be therapeutic and suggest that distant healing effects are due to participants' expectancy. Such results were not found in the population of cardiac patients receiving prayer in the Benson et al. study (2006). It is therefore necessary to continue to replicate studies using this design to determine if awareness of allocation to healing or prayer has an effect on participants. However, since the Benson et al. (2006) study differed both methodologically and in terms of its object of study (prayer), awareness of receipt of distant healing will be included in the distant healing model as a variable observed in Chapter 3 and by Walach et al. (2008).

The clinical trial reported in Chapter 3 also suggests that some healers may be more skilled than others. Although the sample size is too small to clearly determine the effect, post hoc analysis reveals that when healer assignment was included as a covariate, participants of certain healers reported more consistently positive or negative outcomes. Healers who participated in the research presented in Chapter 4 reported the importance of an awareness of their own development, of being firm with their intention, and of practicing healing without an inflated ego. The relative skill of a healer will be tentatively added to the proposed model, though its influence is an area that warrants further inquiry.

The self-description and practice of healers themselves, a topic largely absent in the available literature, is the focus of the study presented in Chapter 4. The healers that participated in this study came from a variety of traditions, but each practiced some form of distant healing. Healers' demographic and personality data was collected and compared with norms when possible.

The participating healers frequently had "exceptional experiences," and as a group they reported "thinner" boundaries compared with norms. Research has shown that these two factors are highly correlated (Thalbourne & Maltby, 2008). As expected, healers reported high levels of spirituality and belief in distant healing; in addition, compared with population norms, they reported significantly higher levels of agreeableness and openness based on the five-factor personality measure and high levels of empathy reported in the Emotional Intelligence questionnaire. These findings were supported in the open-ended portion of the questionnaire, where healers underlined the importance of openness and a compassionate desire to help others. These factors will be considered in the model as characteristics of distant healers.

Thematic analysis in Chapter 4 revealed the importance of the idea of energy to healers. It would be useful in the future to clarify this concept, which was frequently used by healers in their description and definition of healing. Many described this energy as a representation of the divine, and as something that could be channeled or directed towards healees, though its exact nature was not consistently agreed upon. This may be a central component of the healing practice and will included in the model as an aspect of the practice of distant healing.

The intention of the healer was reported as being primary to positive healing outcomes in healers' responses in Chapter 4, and intention has been reported in the literature as a primary aspect of distant healing (Schlitz, Radin, Malle, Schmidt, Utts & Yount, 2003). Intention will also be included in the model as an element of distant healing practice.

Healers participating in Chapter 4 reported that healing was not necessarily equivalent to curing, which suggests that healing happens on many levels and that physical healing may not always be part of the process. Rather, the goal of spiritual healing is to come to, or return to, balance and wholeness, and healers note that this may occur on spiritual and emotional levels. These various levels will be included in the model. This idea is supported by the results in Chapter 3, where a greater effect of healing on those aware of their allocated condition was found in the GHQ results compared to the McGill Pain Questionnaire results, indicating an improvement of general well-being on an emotional level rather than the alleviation of physical symptoms.

Healers frequently cited environmental factors that might inhibit or be conducive to positive healing outcomes. Healers suggested the importance of positive and supportive relationships and quiet and peaceful environments to the healing process. These factors will be discussed further in relation to findings in

Chapter 5, where environment and community appeared to be central to the healing process.

The experiences of healees who had sought healing from a Buddhist monk and healer in Sri Lanka were the focus of Chapter 5. Unlike the trial of distant healing in Chapter 3, healing in this study takes place in a culturally accepting environment without the impositions of a clinical trial (healers in Chapter 4 stress the importance of supportive environments as a factor in positive healing outcomes). Participants visited a healer who employed distant healing, while also offering occasional energetic healings (with hands held above the body), counseling, herbal treatments, dietary recommendations and other healing modalities. Because of these concurrent treatments it is not possible to make a direct causal link of distant healing to positive outcomes, although Bhante Seelagawesi, the healer in this study, stressed that distant or telepathic healing was primary to his healing process. The goal of this study was not, however, to determine the efficacy of distant healing but rather to illuminate the experience of distant healing in a culturally supportive context.

Interpretive phenomenological analysis (IPA) was used to analyze qualitative interviews with healees. Kindness and compassion and empowerment were identified as two overarching ideas presented by the participants. Healees were not only made to feel like an active part of the process, but the healee's community was often involved along with the healer to provide emotional support. Although the themes presented in Chapter 5 help to summarize the participants' experiences, some are more specific to this particular context than others, and thus will not be included in the model; those that are less culturally specific will be included.

Prior to embarking on the thematic analysis it was observed that there was some difficulty in translating the concept of distant healing. Interviewees revealed that there was no direct translation available that matched what the healer called

"telepathic healing" in the Sinhala language. Other terms approached this concept (in English the terms suggested translate as 'spiritual healing' and 'blessing), but none matched perfectly, and participants recognized this. Still, it is notable that participants understood "telepathic healing" in their own way, as similar but distinct from the other terms available such as prayer, blessing and spiritual healing. Although this theme was noted throughout the interviews, it is situated in the context of the Sinhala language and is thus not appropriate to include in the model.

The first super-ordinate theme related to the perception of healing as an expression of kindness and compassion. This reflects findings in Chapter 4 where healers reported high levels of empathy on the Emotional Intelligence scale. Furthermore, the compassionate desire to help others was reported as an important factor of positive healing outcomes. While this seems an obvious aspect of healing to be emphasized by healers in Chapter 4, it is noteworthy that this was also recognized and valued by healees.

The second super-ordinate theme identified was empowerment, specifically the role of community and the importance of individual responsibility. Here, rather than relying completely on the healer, participants reported their own healing capacity, both for themselves and for others. This theme suggests that the connection with a distant healer is not comparable to the traditional doctor-patient relationship, but rather to something that flows through the spiritual community. While the primary healer, Bhante Seelagawesi, typically advised a course of action, many of the suggestions shifted responsibility to the healee and other members of the community.

This sense of community and shared responsibility lends to the super-ordinate theme of empowerment, since healees and other members of the community are asked to be active in the healing process. This may take the form of

practicing distant healing for a particular person or by practicing a particular meditation technique with the aim at healing oneself or another.

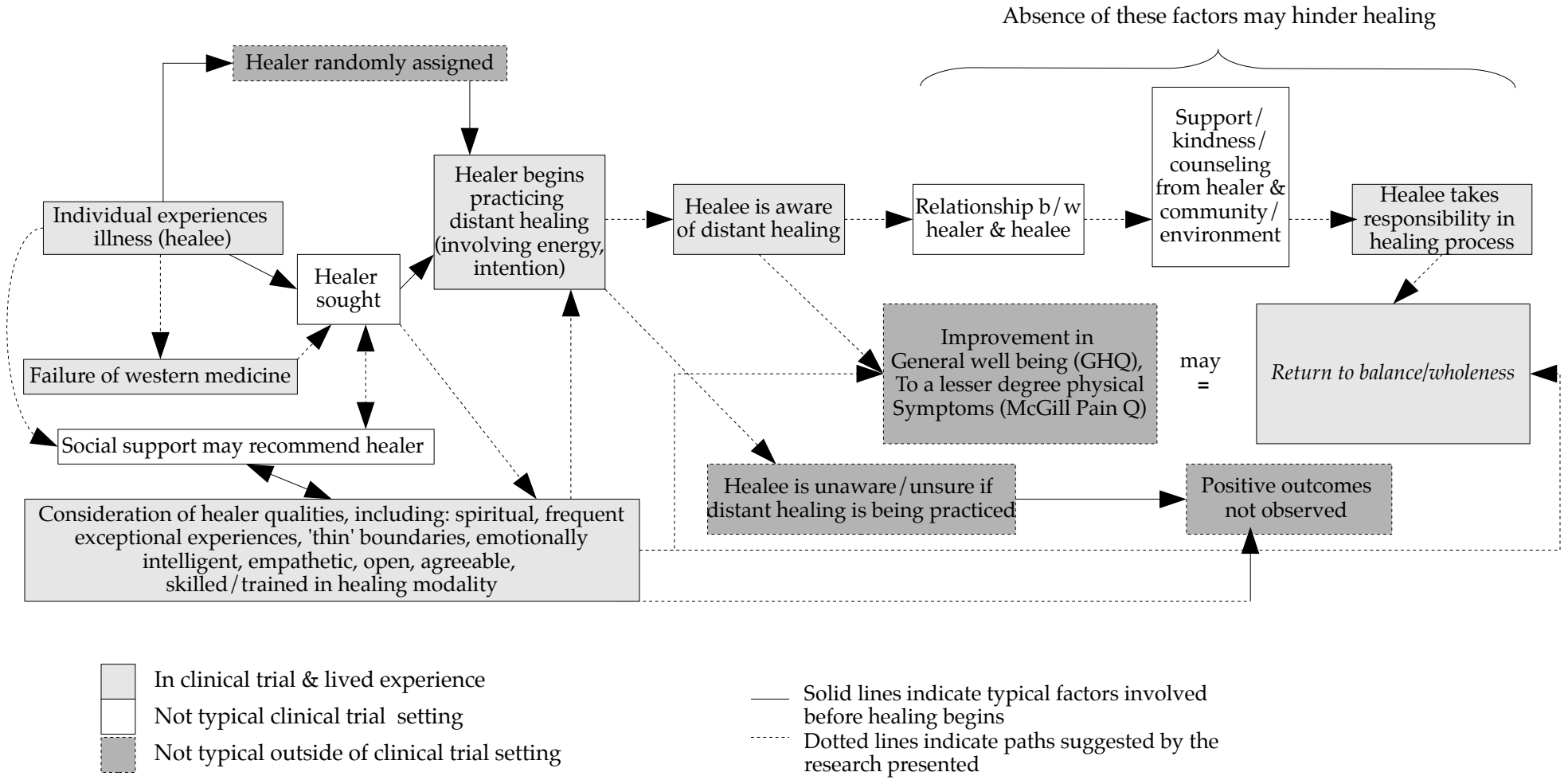
This idea mirrors what healers reported in Chapter 4: the need for supportive environments and people in healees' lives. Healers participating in the study presented in Chapter 4 also suggested that healees must take responsibility for their own healing process and should be willing to make changes in their lives, which also relates to the idea brought forth in Chapter 5 that healees are partially responsible for their healing. Thus, this factor should be included in the proposed model of distant healing.

While each study taken individually has something to offer, as a group they identify areas of interest in the study of distant healing, and the overlap in findings between studies is one benefit of employing multiple methods. These areas of overlap will be emphasized in the proposed model of distant healing.

6.2 Creating a Model of Distant Healing

The research presented in this thesis offers explanations and descriptions of distant healing from the perspectives of healees and healers. By adopting different methodologies I was able to investigate and evaluate these perspectives. Glaser suggests that "different kinds of data give the analyst different views or vantage points from which to understand a category and to develop its properties," calling these views, "slices of data" (1978, p. 151). I will now develop a model using the "slices of data" identified in this thesis and by considering relevant literature in the field.

Figure 6.1: A Proposed Model of Distant Healing



The model, shown in Figure 6.1, guides the reader through the healing process as it is observed both in the clinical trial presented in Chapter 3 and as it is described in research presented in Chapters 4 and 5. The process begins with the healee's experience of illness, without which no healer or healing would be necessary. It is typical to find that medical approaches to healing have failed, both for those who take part in research and those who do not. In clinical trials, such as the one described in Chapter 3, healees are randomly assigned to healers; however, this is not typical of how healees and healers are introduced outside of research settings. The study in Chapter 5 reported that friends and relatives often refer healees to the healer. Healees reported being impressed by the healer's qualities, many of which were consistent with findings in Chapter 4. There is also a connection implied between healer qualities and healing outcome. This is a tentative suggestion based on post hoc findings in Chapter 3, healer accounts in Chapter 4 and healee experiences in Chapter 5. The connection between healer ability/qualities and healing outcome is an area that requires further investigation; however, due to the consistent findings suggesting their relation, this link is proposed in the model.

Once the healer is identified, either by random assignment or after being sought out by the healee, distant healing practice begins. In Chapter 4 healers report that healing involves the channelling or transfer of spiritual energy, which is sometimes in referenced as divine. Intention is also recognized as central to the healing process according to healers in Chapter 4.

In research settings the healee may be unaware that healing is happening. This lack of awareness and uncertainty typically leads to insignificant changes in well-being as observed in Chapter 3 and frequently reported in the literature discussed in Chapter 2 (e.g. Astin, Harkness, & Ernst, 2000). When the healee is aware that healing is happening, as in the non-blind group receiving healing in

Chapter 3 (suggested by medium effect sizes) and in non-research settings, healees move towards positive healing outcomes. Chapter 3 found improvements in general well-being as reported in the GHQ, and to a lesser extent in physical symptoms as reported in the McGill Pain Questionnaire. Although these changes were not found to be significant in the analysis of covariance, effect sizes indicate that there is some interaction, and the model reflects this.

Outside of the research setting there are a number of other supporting factors that appear to be involved. First of all, a relationship may form between the healee and healer. The two may meet physically, speak over the phone, or be in contact through friends, but typically some interaction is present. The healer may offer some emotional support in the form of counselling or simply by being a source of compassion during a difficult time (as reported in Chapter 4 and observed in Chapter 5). It was also reported Chapters 4 and 5 that the environment of the healee should be conducive to healing, which involves supportive friends and family and in Chapter 5 took the form of a spiritual community.

With support in place, healees take on greater responsibility in the healing process and reportedly adopt new ways of caring for themselves. This was reported by healers as factor contributing to positive healing outcomes and was demonstrated by participants in Chapter 5 who engaged in a range of alternative therapies and spiritual practices suggested by the healer in addition to distant healing. Chapter 5 suggests this empowers the healee as an active participant in the healing process.

The support of the healer, both as healer and as caring friend, of the community, and of the healee him or herself all contribute to the healing process. In Chapter 5 healees viewed compassion and kindness as central to their experience. Healers who participated in the study presented in Chapter 4 did not describe healing in terms of curing, but rather a return to balance or wholeness. These

reported outcomes of healing suggested in the research presented in Chapters 4 and 5 may be reflected to some degree in the questionnaire measures such as the GHQ and the McGill Pain Questionnaire that were administered in Chapter 3. Just as the study presented in Chapter 3 showed the largest effect for outcomes of the GHQ, which measures well-being, healers participating in the research presented in Chapter 4 suggested that they had the most success working on the emotional level (when compared with physical and spiritual healing).

The proposed model presumes that the reports of healers in Chapter 4 and the experiences described in Chapter 5 can be understood as typical paths to healing with a distant healer. This model leaves out a number of possible scenarios: for example, many people are likely to receive distant healing outside of research settings without knowing it. Perhaps they are unconscious, or a friend or relative asks a known distant healer to practice for them without their knowledge. The outcomes of distant healing in these situations were not addressed in this thesis but might be of interest in future research. This group is different than the blind condition presented in Chapter 3 because healees in these situations are completely unaware of the possibility of receiving distant healing, whereas those participating in research and blind to their allocated condition are aware of the possibility, though unsure. Dossey (2008) suggests this not knowing and sense of uncertainty might be disconcerting to someone who is ill and suggests this may account for the mixed results found in the healing literature. Without the consent of these individuals, however, the research faces scrutiny on ethical grounds. This model does not account for each and every finding of the research in this thesis; it does, however, encapsulate the most prevalent patterns reported.

6.3 Methodological Issues

This thesis utilized both qualitative and quantitative approaches to the study of distant healing. Rossman and Wilson (1985) provide three incentives for mixed methodology. First, the combined approaches can corroborate results through triangulation. Second, the combined analysis can provide richer data than found with only one approach. Finally, paradoxes rooted in two sources of data provide areas of interest and new modes of thinking. This thesis benefited from the mixed methods approach, and the model presented in this chapter aims at bringing together the results from each study. Frequently, results were corroborated in more than one study.

The clinical trial in Chapter 3 was underpowered, and, although small to medium effect sizes were obtained, this study would benefit from replication with a larger sample to confirm the observed effects and to possibly observe effects unseen due to the small sample size. Other drawbacks of this study include the use of self-reported measures rather than clinical outcome measures, as well as a population with a chronic condition in which changes in well-being and pain may be sporadic and difficult to detect. In the future, intervention studies and clinical trials with greater statistical power as well as trials with non-human subjects may prove beneficial.

Chapter 4's investigation of distant healers brought to the forefront the characteristics and perspective of healers, areas largely absent from the available literature. It was found that healers had similar levels of openness and agreeableness compared with psychiatrists and as opposed to the general population; they also exhibited higher levels of neuroticism amongst males (Deary, Agius, & Sadler, 1996). A direct comparison with psychiatrists might help to locate some of the unique attributes of healers, and also the similarities they may share with those in other

vocations that involve physical or mental health provision. Comparison with population norms is somewhat useful, though many of the norms are taken from samples of young adults and undergraduate students whose questionnaire results may differ greatly from the population of healers for reasons related to age, education and life experience.

Finally, the phenomonelogical analysis presented in Chapter 5 also poses methodological issues. The use of interview data, cross-cultural considerations and the use of a translator in data collection are each topics of methodological interest. Although interview data has not been frequently collected in the study of distant healing, I believe that understanding distant healing as healees experience it is an important way of developing our understanding of the phenomenon and is an approach that may help to develop new theories in the field. The cross-cultural nature of Chapter 5 bears many challenges but also many benefits. For example, while being an outsider may produce some level of unease, it may also facilitate more robust responses from participants, who will go into greater detail describing their practices to someone for whom they are more unfamiliar.

Participants in Chapter 5 were chosen based upon their experience with distant healing: some were new to it, some had received healing for 6 weeks or more, and others had previously received distant healing. All participants were either suggested by the healer or volunteered to participate when coming in for healing. It can be assumed that those who did not had success with healing in the past would no longer participate in the healing programs, and thus were not available to interview. Furthermore, both volunteers and those referred by the healer are likely to have had positive experiences with healing that they deem worth sharing, though there was one participant, referred by the healer, who had been receiving healing but had not noticed any significant physical improvement. Finally, for the thematic

analysis only two interviews were chosen, both with experienced healees who had positive healing outcomes. These were chosen primarily due to the comparatively scarce material available in other interviews where little was shared about the experience of distant healing (likely due to a lack of familiarity in speaking on the topic as well as issues with translation and language). A long term, ethnographic study of distant healing with this community might be able to capture the experience of healees who do not experience positive outcomes. Also of interest would be the results of those who primarily receive distant healing in comparison to those who are directed to other alternative therapies by the healer.

A final issue with this study involves generalizability. The experiences of participants were situated in a specific community with one primary healer. They are likely not representative of other healees in vastly different circumstances. The effort to understand a specific community can nonetheless expand our knowledge of the concepts involved in a practice and provide roots for future research. Strauss and Glaser (1998) suggest that qualitative research works to build theory rather than maintain the canon of generalizability.

Unlike some mixed methods research, each study was independent of the other. This is sometimes referred to as multimethods research (Johnson, Onwuegbuzie & Turner, 2007). It may be beneficial to utilize these methods in a single study; for example, when conducting interviews with healees in a clinical trial and investigating the characteristics of healers in the study to see if these characteristics impact healing outcomes. Alternatively, a qualitative study, such as the one presented in Chapter 5, might benefit from a long-term quantitative analysis to supplement healee reports, using self-report questionnaires or clinical reports.

6.4 Contributions and Implications

The contributions of this thesis are found both in the results of each individual study individually and in their conclusions as a whole, as each study offers complementary data. The clinical trial suggests the importance of being aware that healing is happening on positive healing outcomes. The simplest explanation for this observation would be that healee's positive outcomes are due to a placebo effect. The placebo effect itself is an area of interest (Walach, 2004) and deserves attention and further investigation. By utilizing a partially blinded design, it was possible to study the role of awareness of receiving healing. The findings suggest that distant healing may be a placebo response. And yet, while this response appears to be heightened for those involved in distant healing research (Chapter 3 and Walach, et al. 2006), it was absent from a similar study of prayer (Benson, et al., 2006). Healers suggest the importance of some connection with a healer, which has shown to be beneficial even if limited to only one meeting (Tsubono, et al., 2009).

It is interesting to note that while awareness of distant healing may be a therapeutic factor, self-reported belief observed in Chapter 3 was not a significant covariate. Healers who participated in the study presented in Chapter 4 reported openness as an important factor that is conducive to healing. Although this variable was not a significant covariate as measured in the IPIP for participants in Chapter 3's clinical trial of distant healing, perhaps other measures of openness could be measured in the future and with larger samples to investigate this claim.

The study of healers brought forth the characteristics of healers and reported how they describe the healing process. As a group, healers scored highly on self-reported levels of empathy. Empathy has been identified as an important quality of a doctor by patients in previous research (Haslam, 2007). It is possible that the lack of

time and resources to develop this quality in physicians (Carmel & Glick, 1996) is what attracts individuals to alternative healers. Indeed use of alternative and complementary therapies are of growing interest (Tindle, Davis & Eisenberg, 2005).

The accounts provided by healers regarding their perspectives on healing and outcomes were similar to Grytting (1997), though it brought forth a wider range of perspectives due to the larger sample. Future studies of distant healing should investigate healers further, specifically the effect of their relative skill (as tentatively suggested in Chapter 3).

Finally, the phenomonelogical analysis of healee's experience provides accounts of how healing is described by those receiving it. These explanations come from a population that accepts of the possibility of distant healing (despite the fact that terminological boundaries were admittedly loose). The data reported in this study supported some of the responses from healers who participated in Chapter 4's study. Furthermore, this is the first application of IPA to a population of healees. Future utilizations of this approach to other healees, perhaps from Western cultures, could provide interesting comparisons with the data collected in Chapter 5.

Together, the studies presented in this thesis were utilized to propose a working model of distant healing, both as it is observed in a clinical research setting and as healees outside a clinical research environment reportedly experience it. The model offers areas of further investigation: for example, future research might investigate the role of social support in relation to distant healing. Literature suggests that social support is associated with health and immune function (Uchino, 2006), and the extent to which this is present in healer and healee relationships (Tsubono, et al., 2009) as well as scenarios involving a spiritual community is in need of further investigation.

The findings of this thesis provide new perspectives relating to the phenomenon of distant healing and introduce the need for further elucidation and validation in future work.

6.5 Conclusion

This thesis is the first attempt to combine a clinical trial, a study of healers, and phenomenological analysis to create a comprehensive model of distant healing. In this study I have presented the many factors reportedly involved in the experience of distant healing, including those not frequently accounted for. By adopting multiple methods, a working model of distant healing was proposed and is supported by the results provided in numerous accounts of distant healing.

My research makes a number of contributions to the study of distant healing. Chapter 3 demonstrates the primacy of awareness of receipt of distance healing on the part of the healee. In addition, by investigating the phenomenon of distant healing outside of the clinical research setting, a number of variables were incorporated into the working model of distant healing as it is experienced and practiced. These suggest areas of study both within the field of distant healing and parapsychology, and without. For example, the presence of energy as described both by healers and healees in Chapters 4 and 5 is an area of interest to parapsychologists and physicists and requires further investigation. Of greater interest to health psychologists are the reports from healees and healers that social support and a positive environment are important to the healing process. Also of interest is the suggestion that healees or patients may benefit from developing a sense of responsibility and empowerment regarding their own health. These aspects of the distant healing experience are presumably present in other therapeutic practices, and

perhaps greater effort should be taken to integrate these beneficial aspects of care into the healthcare system.

In conclusion, it is unclear to what extent researchers will be able to understand and explain distant healing intentionality. However, given the widespread growth of complementary therapies as well as a body of anecdotal evidence, including a US Gallup Poll (2001) that reports that 27% of respondents have experienced "a remarkable healing" most frequently attributed to a 'higher power' or prayer, it is important that continued and varied approaches of research in this field be pursued to explore the psychological and possible non-local factors that may be involved.

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Appendices

Timeline

9/06-12/06: Literature Review, project planning. Coursework in Statistics, Research Methods and Health Psychology.

Chapter 3: Clinical trial of distant healing

1/07-3/07: Correspondence with organizations who work with Chronic Pain Groups (British Pain Society, Pain Association Scotland, Arthritis Care). Initial hope was to recruit through organizations to avoid NHS protocol.
4/07: Because of the limited response of Pain groups, commenced the NHS application process. Supported by Anne Langston and Dr. Stuart Ralston
5/07: Submitted NHS ethics application
6/07: Meeting with NHS ethics committee - obtained study approval
7/07: Disclosure Scotland and Site-specific approval obtained
8/07: Disclosure Scotland and Site-specific approval obtained
9/07-2/08: Recruitment at Western General Hospital, approaching eligible patients in the Rheumatology clinic 3-5 days/week depending on clinic schedule. Continued online recruitment. Posted materials (questionnaire, consent form and an information letter) to all perspective participants. Data collection commenced, also involved regular communication with healers assigned to the participants.
3/08-8/08: Continued accepting participants from online recruitment methods. Bulk of participants enrolled in the study competed participation during this period. Data entry. (Presented project at the Parapyschology Association Convention, Winchester, August)
9/08-10/08: Last few participants from the Arthritis Trial completed follow-up measurement.

Chapter 4: Questionnaire study with healers

1/07-1/08: Previously planned a second clinical trial. Ethics committee did not approve project due to lack of clinical suppervision and would have required getting NHS Ethics approval had supervision been obtained (was to be with a population with agoraphobia with the same design as the clincial trial with arthritis patients).
2/08-9/08: Recruitment for the project - Healer Association advertiesement.
10/08-12/08: To increase sample size, began sending personal emails to healers registered in the International Natural Healers Association (and were self-described distant healers).

Chapter 5: Distant Healing in Sri Lanka, IPA study

1/08-4/08: Correspondence with contacts in Sri Lanka, beginning to plan research.
5/08-9/08: Background research and preparation for qualitative interviews. Translation of information sheet and consent forms into Sinhala.
9/08-10/08: Qualitative Study in Sri Lanka underway.
11/08-03/08: Regularly attended the IPA Scotand group to get practice and guidance with utilizing the technique, began writing up results for Bial Foundation report. Attended the course, "Reflexivity in Qualitative Research"

11/08-03/09: Data analysis and write-up of Bial Report
04/09-12/10: Writing-up

IPIP Five Factor Personality Inventory

Instructions

On the following pages, there are phrases describing people's behaviours. Please use the rating scale below to describe how accurately each statement describes *you*. Describe yourself as you generally are now, not as you wish to be in the future. Describe yourself as you honestly see yourself, in relation to other people you know of the same sex as you are, and roughly your same age. So that you can describe yourself in an honest manner, your responses will be kept in absolute confidence. Please read each statement carefully, and then put a tick in the box that corresponds to your reply. **You should put one tick in each row.**

HOW ACCURATELY DO THESE PHRASES DESCRIBE YOU?

No		Very Inaccurate	Moderately Inaccurate	Neither Inaccurate nor Accurate	Moderately Accurate	Very Accurate
1.	I am the life of the party.					
2.	I feel little concern for others.					
3.	I am always prepared.					
4.	I get stressed out easily.					
5.	I have a rich vocabulary.					
6.	I don't talk a lot.					
7.	I am interested in people.					
8.	I leave my belongings around.					
9.	I am relaxed most of the time.					
10.	I have difficulty understanding abstract ideas.					
11.	I feel comfortable around people.					
12.	I insult people.					
13.	I pay attention to details.					
14.	I worry about things.					
15.	I have a vivid imagination.					
16.	I keep in the background.					
17.	I sympathise with others' feelings.					
18.	I make a mess of things.					
19.	I seldom feel blue.					
20.	I am not interested in abstract ideas.					
21.	I start conversations.					

HOW ACCURATELY DO THESE PHRASES DESCRIBE YOU?

No		Very Inaccurate	Moderately Inaccurate	Neither Inaccurate nor Accurate	Moderately Accurate	Very Accurate
22.	I am not interested in other people's problems.					
23.	I get chores done right away.					
24.	I am easily disturbed.					
25.	I have excellent ideas.					
26.	I have little to say.					
27.	I have a soft heart.					
28.	I often forget to put things back in their proper place.					
29.	I get upset easily.					
30.	I do not have a good imagination.					
31.	I talk to a lot of different people at parties.					
32.	I am not really interested in others.					
33.	I like order.					
34.	I change my mood a lot.					
35.	I am quick to understand things.					
36.	I don't like to draw attention to myself.					
37.	I take time out for others.					
38.	I shirk my duties.					
39.	I have frequent mood swings.					
40.	I use difficult words.					
41.	I don't mind being the centre of attention.					
42.	I feel others' emotions.					
43.	I follow a schedule.					
44.	I get irritated easily.					
45.	I spend time reflecting on things.					
46.	I am quiet around strangers.					
47.	I make people feel at ease.					
48.	I am exacting in my work.					
49.	I often feel blue.					
50.	I am full of ideas.					

Please check you have completed all the questions

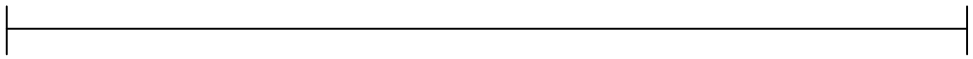
Short-Form McGill Pain Questionnaire

I. Pain Rating Index:

The words below describe average pain. Place a check mark (✓) in the column that represents the degree to which you feel that type of pain. Please limit yourself to a description of the pain related to your arthritis symptoms only:

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

II. Present Pain Intensity – Tick along the scale below for arthritis symptoms.



No Pain Worst Possible

III. Evaluate the overall intensity of total pain experience. Please limit yourself to a description of the pain related to your arthritis symptoms only. Place a check mark (✓) in the appropriate column.

No Pain	
Mild	
Discomforting	
Distressing	
Horrible	
Excruciating	

Satisfaction with Life Scale

Instructions: Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 7 - Strongly agree
- 6 - Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

____ In most ways my life is close to my ideal.

____ The conditions of my life are excellent.

____ I am satisfied with my life.

____ So far I have gotten the important things I want in life.

____ If I could live my life over, I would change almost nothing.

Spiritual Connection Questionnaire

Instructions: Below is a list of statements about the experience of spirituality. Please show to what extent these statements describe you by circling the number which best correspond to your experience. For example, if the statement is *very like you*, then circle *3*. If it is only *slightly* like you, then circle *1*. Do not spend to long over any statement. Just give the first answer that comes into your head. There are no right or wrong answers.

1. My spirituality makes life good for me.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

2. I feel no spiritual connection to the world around me.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

3. I sometimes experience other people 'shining with an inner light'.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

4. I have never had a spiritual experience that has changed my life.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

5. There is a larger plan to life.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

6. I do not feel that there is a form of energy that binds people together.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

7. I feel I have an inner spiritual strength.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

8. I do not have a personal relationship with some power greater than myself.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

9. I feel an inner strength from a spiritual connection with others.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

10. Spirituality is not important to me.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

11. I feel that I am always protected by an ultimate principle, force or being.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

12. I will never have a spiritual bond with another person.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

13. My connection to something spiritual makes me happy.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

14. I do not feel connected to the universe in any spiritual way.

Unlike me -3 -2 -1 0 1 2 3 *Like me*

Which statement best describes you?

I am a religious and spiritual person O

I am a religious person but I do not consider myself particularly spiritual O *(tick **one** only)*

I am a spiritual person but I do not consider myself particularly religious O

I am neither a religious or spiritual person O

Do you attend religious services with other people? Yes O

Infrequently O *(tick **one** only)*

No O

OPTIONAL If you are religious, please write the faith you identify with (e.g., Christian faiths: Anglican, Catholic, Baptist, Methodist etc. Judaism and Orthodox, Muslim and Sunni (if relevant Suffi), Buddhism and Zen etc):

The General Health Questionnaire

Please read this carefully.

We should like to know if you have had any medical complaints and how your health has been in general, *over the last few weeks*. Please answer ALL the questions simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past.

It is important that you answer ALL of the questions. Thank you very much for you're co-operation.

HAVE YOU RECENTLY:

1. been able to concentrate on whatever you're doing?
Better than usual Same as usual Less than usual Much less than usual

2. **lost much sleep over worry?**
Not at all No more than usual Rather more than usual Much more than usual

3. **felt that you are playing a useful part in things?**
More so than usual Same as usual Less useful than usual Much less useful

4. **felt capable about making decisions about things?**
More so than usual Same as usual Less so than usual Much less capable

5. **felt constantly under strain?**
Not at all No more than usual Rather more than usual Much more than usual

6. **felt you couldn't overcome your difficulties?**
Not at all No more than usual Rather more than usual Much more than usual

7. **been able to enjoy your normal day-to-day activities?**
More so than usual Same as usual Less so than usual Much less than usual

8. **been able to face up to your problems?**
More so than usual Same as usual Less so than usual Much less able

9. **been feeling unhappy and depressed?**
Not at all No more than usual Rather more than usual Much more than usual

10. **been losing confidence in yourself?**
Not at all No more than usual Rather more than usual Much more than usual

11. **been thinking of yourself as a worthless person?**
Not at all No more than usual Rather more than usual Much more than usual

12. **been feeling reasonably happy, all things considered?**
More so than usual About same as usual Less so than usual Much less than usual

Distance Healing and Paranormal Belief Scale

Instructions: Please circle one number between 1 and 7 for each question that best describes your level of agreement.

In every case '1' represents 'strongly disagree' and '7' represents 'strongly agree'.

1. Healing someone from a distance is possible

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

2. Distance Healing can improve a person's physical, emotional, mental and/or spiritual well-being

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

3. I have personally experienced or witnessed an unusual healing event of body or mind

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

4. I believe there is an energy or vital force available that can be utilized by healers and/or through prayer to improve the health of an individual, despite physical distance

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

5. The soul continues to exist though the body may die

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

6. Some individuals are able to levitate (lift) objects through mental forces

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

7. Black magic really exists

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

8. Black cats can bring bad luck

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

9. Your mind or soul can leave your body and travel (astral projection)

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

10. The abominable snowman of Tibet exists

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

11. Astrology is a way to accurately predict the future

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

12. There is a devil

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

13. Psychokinesis, the movement of objects through psychic powers, does exist

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

14. Witches do exist

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

15. If you break a mirror, you will have bad luck

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

16. During altered states, such as sleep or trances, the spirit can leave the body

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

17. The Lock Ness monster of Scotland exists

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

18. The horoscope accurately tells a person's future

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

19. I believe in God

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

20. A person's thoughts can influence the movement of a physical object

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

21. Through the use of formulas and incantations, it is possible to cast spells on persons

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

22. The number '13' is unlucky

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

23. Reincarnation does occur

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

24. There is life on other planets

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

25. Some psychics can accurately predict the future

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

26. There is a heaven and a hell

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

27. Mind reading is not possible

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

28. There are actual cases of witchcraft

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

29. It is possible to communicate with the dead

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

30. Some people have an unexplained ability to predict the future

Strongly disagree 1 2 3 4 5 6 7 *Strongly agree*

Please tick the foods you have eaten during the last two weeks.

Porridge	Cocoa
Beetroot	Cheese
Carrots	Cereals like sugar puffs
Brown Rice	Cream
Citrus fruit	Tinned Fruit in syrup
Green peppers	Custard
Eggs (not fried)	Eggs (fried)
Dandelion coffee	White Bread
Green beans	Pasta
Herb teas	Cakes
Broccoli	Biscuits
Bananas	Sweets
Apples	Pizza
Fresh tropical fruits	Pies
Celery	Coke
Baked Potatoes	Chips
Almonds	Sugar
Brazil nuts	Honey
Yoghurt	Salt
Cucumber	Foods with added salt
Fish	Food containing preservatives
Chicken	Chocolate
Sesame seeds	Coffee
Sunflower seeds	Tea
Lentils	Alcohol
Onions	Milk
Garlic	Beef
Watercress	Pork
Fruit juice	Lamb
Cottage cheese	Sausages

A Study of Individual Differences Amongst Healers

Thank you for participating in this study. There are a number of questionnaires to follow. Please follow the directions carefully.

Thank you for your interest in this research project. Before agreeing to participate please read the following information regarding the study. If you choose to participate please complete the statement of consent that follows.

Key Facts: We invite you to participate in a study of distance healers. You will be asked to complete questionnaires aimed at identifying healers' personality characteristics, exceptional experiences, spirituality and well-being. Participation is voluntary and you are free to withdraw at any point if you are uncomfortable with the questions being asked. Please continue reading the details of the study if you are interested in taking part.

Part 1: General Information

Purpose of Research: This study is being conducted to explore the characteristics of individuals practicing distance healing. While there has been a good deal of research into distance healing, relatively little has focused on the healers.

Researchers: This study is being conducted by Alison Easter, a research PhD student, under the supervision of Dr Caroline Watt of the Psychology Department at the University of Edinburgh.

Responsibilities of Participants: Participation in this study requires about 45 minutes of your time.

Your participation is voluntary and you are free to withdraw from the study at any time and discontinue completion of the questionnaires.

You should be aware that some of the questionnaires may ask sensitive or personal questions regarding your spirituality, beliefs and well-being. These questionnaires have been validated in previous research, they have not been found to be disturbing or disruptive to people's well-being, but you may find them somewhat intrusive.

Part 2: Details of Participation

Compensation: You will be compensated for your participation in the form of £5 book tokens/gift certificates upon the completion of the study. You will also have the option to donate this £5 to charity.

Identity protection and Data storage: The data, with identifying information removed (i.e. your questionnaire answers will be assigned a number rather than your name), will be kept for a period of 3 years and will be securely stored in a locked office in the Department of Psychology. Information obtained will be used in the PhD thesis of Alison Easter as well as possible publication in scholarly journals. Identifying information of participants will not be used in any publication or scholarly works.

1) Consent	
I confirm that I have read and understand the information above. I understand that my participation is voluntary and that I am free to withdraw at any time (by simply not completing the questionnaire).	
I agree to take part in the above study.	

2) Please respond to the following biographical information. This will be important in surveying the diversity of the population of healers who respond to this questionnaire. Thank you.	
Today	
Gender	
Age	
Ethnic Background	
Spiritual Tradition	
Education	
Occupation	
Qualifications as a Spiritual Healer	

3) Instructions: On this page there are phrases describing people's behaviours. Please use the rating scale below to describe how accurately each statement describes you. Describe yourself as you generally are now, not as you wish to be in the future. Describe yourself as you honestly see yourself, in relation to other people you know of the same sex as you are, and roughly your same age. So that you can describe yourself in an honest manner, your responses will be kept in absolute confidence. Please read each statement carefully, and then mark a selection that corresponds to your reply. You should put one tick in each row.

HOW ACCURATELY DO THESE PHRASES DESCRIBE YOU?

I am not really interested in others.					
I like order.					
I change my mood a lot.					
I am quick to understand things.					
I donít like to draw attention to myself.					
I take time out for others.					
I shirk my duties.					
I have frequent mood swings.					
I use difficult words.					
I donít mind being the centre of attention.					
I feel othersí emotions.					
I follow a schedule.					
I get irritated easily.					
I spend time reflecting on things.					
I am quiet around strangers.					
I make people feel at ease.					
I am exacting in my work.					
I often feel down.					
I am full of ideas.					

4) ***Instructions*** Below are five statements that you may agree or disagree with. Using the choices below, indicate your level of agreement with each statement by marking the appropriate choice. Please be open and honest in your responding.

	Strongly disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly agree
In most ways my life is close to my ideal.							
The conditions of my life are excellent.							
I am satisfied with my life.							
So far I have obtained the important things I want in life.							
If I could live my life over, I would change almost nothing.							

5) **Instructions** Below is a list of statements about the experience of spirituality. Please show to what extent these statements describe you by marking the number which best corresponds to your experience. For example, if the statement is very like you, then mark 3. If it is only slightly like you, then mark 1. Do not spend too long over any statement. Just give the first answer that comes into your head. There are no right or wrong answers.

	Unlike me -3	-2	-1	0	1	2	3 Like me
There is a larger plan to life.							
I do not feel that there is a form of energy that binds people together.							
I feel I have an inner spiritual strength.							

I have never had a spiritual experience that has changed my life.							
There is a larger plan to life.							
I do not feel that there is a form of energy that binds people together.							
I feel I have an inner spiritual strength.							
I do not have a personal relationship with some power greater than myself.							
I feel an inner strength from a spiritual connection with others.							
Spirituality is not important to me.							
I feel that I am always protected by an ultimate principle, force or being.							
I will never have a spiritual bond with another person.							
My connection to something spiritual makes me happy.							
I do not feel connected to the universe in any spiritual way.							

6) Which statement best describes you?	
I am a religious and spiritual person	
I am a religious person but I do not consider myself particularly spiritual	
I am a spiritual person but I do not consider myself particularly religious	
I am neither a religious or spiritual person	

7) Do you attend religious services with other people?	
Yes	
Infrequently	
No	

8) OPTIONAL: If you are religious, please write the faith you identify with (e.g., Christian faiths: Anglican, Catholic, Baptist, Methodist etc. Judaism and Orthodox, Muslim and Sunni (if relevant Suffi), Buddhism and Zen etc):

9) ***Instructions*** For each statement please mark one number between 1 and 7 to best describe your level of agreement.

In every case '1' represents 'strongly disagree' and '7' represents 'strongly agree'.

	Strongly disagree 1	2	3	4	5	6	Strongly agree 7

I believe there is an energy or vital force available that can be utilized by healers and/or through prayer to improve the health of an individual, despite physical distance							

10) Please rate each of the statements from 0 to 4 (0 indicates "not at all true of me"; 4 indicates "very true of me"). Try to respond to all of the statements as quickly as you can.

	0 not true of me	1	2	3	4 very true of me
In my dreams, people sometimes merge into each other or become other people.					
I trust people easily.					
The movies and TV shows I like best are the ones where there are good guys and bad guys and you always know who they are.					
I am a very open person.					
There are no sharp dividing lines between normal people, people with problems, and people who are considered psychotic or crazy.					
I am always at least a bit on my guard.					
I am a down-to-earth, no-nonsense kind of person.					
I have daymares.					
I wake from one dream into another.					
Sometimes I meet someone and trust him or her so completely that I can share just about everything about myself at the first meeting.					
My dreams are so vivid that even later I canít tell them from waking reality.					
I have often had the experience of different senses coming together. For example, I have felt that I could smell a color, or see a sound, or hear an odor.					
A man is a man and a woman is a woman; it is very important to maintain that distinction.					
I know exactly what parts of town are safe and what parts of town are unsafe.					
I have had the experience of not knowing whether I was imagining something or it was actually happening.					
I have had the experience of someone calling me or speaking my name and not being sure whether it was really happening or I was imagining it.					
I like clear and precise borders.					
I have a clear and distinct sense of time.					
I like houses where rooms have definite walls and each room has a definite function.					

East is East and West is West, and never the twain shall meet. (Kipling)					
In my dreams, people sometimes merge into each other or become other people.					
I trust people easily.					
The movies and TV shows I like best are the ones where there are good guys and bad guys and you always know who they are.					
I am a very open person.					
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In the following two questionnaires (11&12), a number of statements are listed which describe exceptional experiences.

The wording of some statements might seem inappropriate for you. In these cases, please respond according to what best describes your point of view.

11) FREQUENCY OF EXPERIENCE

How often have you personally experienced this phenomenon?

	never	seldom	sometimes	often	very often
Some of my thoughts seem strange to me, as if they were not mine					

Benign light surrounds me					
Some of my thoughts seem strange to me, as if they were not mine					
I am controlled by strange and alien forces					
Spiritual powers inspire me at work					
A strong, sinister power takes possession of my body					
I am in touch with everything					
Other people read my mind					
My consciousness separates from my body					
My environment seems somewhat blurred or illusory to me					
I know my calling					
I dream so vividly that my dreams reverberate while I am awake					
My world-view is falling apart					
I have meaningful dreams					
I am illuminated by divine light and divine strength					
I have strange and peculiar dreams					
I mentally send harm to my enemies					
I feel the presence of spiritual/extraterrestrial beings					
I clearly hear voices, which scold me and make fun of me, without any physical causation					
The world around me seems absurd or exaggeratedly distorted to me					
A higher being protects or helps me					
My thinking slows down					
A feeling of ignorance or not knowing overwhelms me					
I am cursed					

12) Evaluation - POSITIVE OR NEGATIVE EXPERIENCE?

Note: If you had the same experience several times or even very often, but always experienced it in different ways, please respond according to your present point of view. If you are not familiar with a particular experience, you need not evaluate it.

I have had this experience and evaluate it as follows:

	very positive	positive	neutral	negative	very negative
I am in touch with everything					
Other people read my mind					
My consciousness separates from my body					
My environment seems somewhat blurred or illusory to me					
I know my calling					
I dream so vividly that my dreams reverberate while I am awake					
My world-view is falling apart					

A strong, sinister power takes possession of my body					
I am in touch with everything					
Other people read my mind					
My consciousness separates from my body					
My environment seems somewhat blurred or illusory to me					
I know my calling					
I dream so vividly that my dreams reverberate while I am awake					
My world-view is falling apart					
I have meaningful dreams					
I am illumined by divine light and divine strength					
I have strange and peculiar dreams					
I mentally send harm to my enemies					
I feel the presence of spiritual/extraterrestrial beings					
I clearly hear voices, which scold me and make fun of me, without any physical causation					
The world around me seems absurd or exaggeratedly distorted to me					
A higher being protects or helps me					
My thinking slows down					
A feeling of ignorance or not knowing overwhelms me					
I am cursed					

13) Instructions: Indicate the extent to which each item applies to you using the following scale:

1 = strongly disagree
2 = disagree
3 = neither disagree nor agree
4 = agree
5 = strongly agree

	1 strongly disagree	2 disagree	3 neither disagree nor	4 agree	5 strongly agree
I like to share my emotions with others.					
When I experience a positive emotion, I know how to make it last.					
I arrange events others enjoy.					
I seek out activities that make me happy.					
I am aware of the nonverbal messages I send to others.					
I present myself in a way that makes a good impression on others.					
When I am in a positive mood, solving problems is easy for me.					
By looking at their facial expressions, I recognize the emotions people are experiencing.					
I know why my emotions change.					
When I am in a positive mood, I am able to come up with new					

I expect good things to happen.					
I like to share my emotions with others.					
When I experience a positive emotion, I know how to make it last.					
I arrange events others enjoy.					
I seek out activities that make me happy.					
I am aware of the nonverbal messages I send to others.					
I present myself in a way that makes a good impression on others.					
When I am in a positive mood, solving problems is easy for me.					
By looking at their facial expressions, I recognize the emotions people are experiencing.					
I know why my emotions change.					
When I am in a positive mood, I am able to come up with new ideas.					
I have control over my emotions.					
I easily recognize my emotions as I experience them.					
I motivate myself by imagining a good outcome to tasks I take on.					
I compliment others when they have done something well.					
I am aware of the nonverbal messages other people send.					
When another person tells me about an important event in his or her life, I almost feel as though I have experienced this event myself.					
When I feel a change in emotions, I tend to come up with new ideas.					
When I am faced with a challenge, I give up because I believe I will fail.					
I know what other people are feeling just by looking at them.					
I help other people feel better when they are down.					
I use good moods to help myself keep trying in the face of obstacles.					
I can tell how people are feeling by listening to the tone of their voice.					
It is difficult for me to understand why people feel the way they do.					

Please use the following definitions for questions 14 and 15:

healing = spiritual, energetic or paranormal healing (i.e. laying on of hands, reiki, therapeutic touch)

distance healing = performed when the patient is not present

14) How do you define spiritual healing?

15) For approximately how many years have you practiced as a healer?

16) For approximately how many years have you practiced distance healing?

17) Please briefly describe your training and background in healing:

18) Please estimate the percentage of time that your practice of distance healing leads to a positive health outcome for your patients (anywhere between1%=never and 100%=always):

19) Please estimate the percentage of time that your practice of distance healing leads to an increase in emotional and psychological well-being for your patients (anywhere between1%=never and 100%=always):

20) Please estimate the percentage of time that your practice of distance healing leads to an increase in spiritual well-being for your patients (anywhere between1%=never and 100%=always):

21) On average, for how many weeks, months or years do you spend working with someone? *I understand that this will vary greatly case to case–but if you can, please limit your answer to a generalization for this question and explain in further detail in the next if you wish.*

22) What is the range of time you spend healing different patients (average short-term treatment to average long-term treatment)?

23) Considering all of your prospective patients, what percentage do you recommend seek alternative treatment and choose not to treat (perhaps suggesting another course of treatment or referring them to other healers, complementary practitioners or conventional medical doctors)? Please indicate a percentage, again 1% = never and 100% always.

24) What factors contribute to spiritual healing?

25) Please order the following variables from most to least conducive to a successful healing outcome. 1 indicates most important; 6 indicates least important:	
relationship between patient and healer	
healer's level of experience and expertise	
openness of the patient	
technique utilized by the healer	
frequency of healing practice	
spirituality of the healer	

26) What are some obstacles to spiritual healing?

27) What do you believe are the characteristics of spiritual healers?

28) Thank you for participating - I am no longer able to offer compensation for new participants as I reached the 100 participants that I have budgeted for. Thanks to the generosity of participants I was able to donate about £450 to charity.	
Please disregard this question	

29) If you would like information about this study when results become available please indicate below:	
Yes, please send me information about results.	
No thanks.	

30) Please provide your email address if you have chosen a gift certificate for compensation and/or you would like information about this study when results are available.

Thank you for your participation!

Bhante Seelagawesi reads through a list of names of healee's present. After a roll call chanting, meditation and a talk are typical. Followed by counseling and healing consultation.

Many of the interviews were conducted in the home adjoining this household temple that was built to host healing sessions and other spiritual programs.