What constitutes a demonstration of effectiveness in the use of hands-on healing from the healers' perspective?

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Abstract

As the awareness and use of hands-on healing modalities achieve greater popularity they have slowly edged their way into the sphere of biomedical practices. Proponents of biomedicine, as the gatekeeper of medical interventions in Western societies, have argued that hands-on healing modalities show accountability for effective and safe practice. There is at present no accepted measure that demonstrates effective-based practice for these healing modalities. If hands-on healing is to receive greater acceptance, and possibly integration within biomedical practices, these issues need to be addressed.

Research of this nature is blighted by there being no dedicated science, so although there is an abundance of published research it is dispersed or difficult to access, leading it to be unsuccessful in generating awareness. Historically, research evaluating effectiveness of hands-on healing has focused on predetermined outcomes from biomedical diagnosis. This has placed the focus of hands-on healing on the healee, and neglected aspects of the healer, leading to limited available research detailing the perceptions of healers.

The research enquiry was performed around the charity, the Healing Trust. The Healing Trust training program was completed to acquaint the author in how hands-on healing is performed within the charity. Ten experienced healers, who are members of the Healing Trust, were interviewed regarding their practices of hands-on healing. Discussion was focused on how healers perceived what constituted an effective intervention from performing hands-on healing on a healee. Respondents answered a set of open-ended questions from which they were encouraged to expand on their experience of practicing hands-on healing. Interviews were transcribed and analysed using Grounded Theory to create a generalised theory of perceptions of effectiveness.

Within the thesis a discussion is presented that theorises that effectiveness is perceived as enacting a ‘change’ within the healee that is acknowledged by both the healer and healee as a therapeutic outcome. Therapeutic outcomes of this calibre are not accepted by biomedicine as genuine markers of success, due to their lack of objective measurement. If hands-on healing is to acquire better recognition there needs to be a consensus as to what effectiveness means, and how to measure it.

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Chapter 1

Introduction

Hands-on healing (HoH) modalities are practices that fall within the definition of complementary and alternative medicine (CAM). CAM therapies are procedures that substitute for or aid biomedical practices relating to health matters (Spencer, 2003 p.2). CAM differs from biomedicine in that its procedures tend to emphasise the body's ability to promote its own health, as opposed to biomedicine, which is disease-focused or which treats specific parts of the body (Wersch, Forshaw & Cartwright, 2009 p.3). Biomedicine may be effective at treating acute conditions, but persons afflicted with chronic conditions are becoming discontent and choosing to look towards CAM for additional means of illness management (Graham, 1999 p.11; BMA, 1993 p.9; Cant & Sharma, 1999 p.46).

Whether a therapy is considered complementary or alternative is a political decision (Easthope, 2003; Leckridge, 2004) that centres on how useful a CAM procedure is to biomedicine. Those therapies that have been reallocated from alternative to complementary are now discussed as becoming integrated within biomedical practices. Cant et al. (1999 p.160) define integrated therapies as those which have exceeded the referral process, where CAM and biomedicine are used in conjunction with each other. Contemporary use of HoH moves easily between the three descriptors of alternative, complementary or integrated practice, dependent upon the preference of the parties involved. Considered to be a natural phenomenon by its proponents, HoH defies the need to be categorised, as it can be performed without the recipient having an ailment.

HoH is an arduous subject to the uninitiated. The growth in its popularity and in the available literature sources have only served to disseminate confusion and endless debate over techniques or procedural knowledge. Popularity has not produced objective evidence of effective practice, and so although HoH abounds with anecdotal claims from its supporters, these claims fail to meet the standards of empirical research.

The discussion influencing the present thesis is that if HoH modalities work then there should be an acceptable means of observing what healers are doing and measuring the outcomes of

practice. With no accepted mechanism attributed to HoH, critics of these therapies have dismissed them, attributing any benefits to be no more than a placebo effect (Schwartz & Simon, 2007 p.169). Yet, proponents of HoH argue that the established means of observing medical interventions may not be conducive to HoH (Aldridge, 2000 p.187).

The premise of this argument is that biomedicine has a research protocol that represents its requirements and that CAM therapies are expected to adjust their activities to meet this protocol. Giving rise to contentious debate, because if CAM therapies are claiming to observe and treat the human body differently then why should they be subject to the same research criteria? This perspective argues that research designs should be more pragmatic and not all performed to the same specific formula (Sparker, Crawford & Jones, 2003 p.149), allowing for better representation of practitioners in real life scenarios.

Therefore, to produce a research design that is more pragmatic and appreciative of HoH practices some notion of what healers are purporting to do is of benefit. A significant difficulty with HoH research is that healers have been treated as a constant value, which, like other CAM therapies, has been subjected to research models designed for the pharmaceutical industry. Most prominently, randomised controlled trials (RCT), which usually assert an intervention of fixed value or quantity, are administered to a cohort. The difficulty of implementing such a method with HoH is that there is no means to measure the healing-presence of the healer. Discussing presence is also problematic as it is presented in a variety of manners throughout literature (McKivergin & Daubenmire, 1994), so a brief definition is beneficial.

Jonas & Crawford (2004) describe healing-presence as the special quality of the healer that operates outside of the conventional psychosocial dynamics. The term healing-presence refers, according to McDonough-Means, Kreitzer & Bell (2004) to the complexities of an individual that enable them to provide a beneficial, therapeutic or positive change within another person. Following on from this, McDonough-Means et al. (2004) explain that healing-presence has the dimensions of ‘being with’ (physical), ‘being there’ (psychological) and ‘therapeutic-presence’ (spiritual connection). To achieve this, the healer or caregiver needs qualities of centring, intuitive knowledge, imagery, connecting and intentionality.

Godkin (2001) derives an understanding of healing-presence from nursing literature as a hierarchical achievement obtained from understanding the patterns of human response that go beyond the scientific data. Achieving healing-presence is providing the cumulative effects beyond a psychical, cognitive and spiritual presence. It is knowing what will work and when to act (Godkin, 2001).

Within HoH, the healing-presence is the decisive concern of healers. In essence, it is the healing ability of the healer, yet is dismissed by science as a result of the healee's belief or expectation, and is generally considered to be a placebo-response. Jonas et al. (2004) suggest that failing to acknowledge the healing-presence is the most crucial obstacle to healing research, meaning that realistic measurement becomes awkward as no procedure for identifying the healing-presence of the healer has been devised (Bengston & Murphy, 2008; Jonas et al., 2004).

Aldridge criticises (2004 p.13) research focusing on the healer, claiming it neglects the healing relationship, and that one-sided research has the potential to produce erroneous results. However, there is a problem in that research at present has almost solely observed the healee and neglected the healer. The aim of this thesis is to identify how healers believe they are demonstrating the effectiveness of HoH, and, with the benefit of learning how to observe HoH through scenarios more relevant to real life, to evaluate whether healer values of effectiveness are compatible with biomedical practices. In the following chapter a more descriptive definition will be provided to guide the reader into the aspects of HoH specific to the thesis. However, an understanding of the terminology is of benefit, as HoH gives specific meaning to words from everyday language.

Terminology

HoH is generally referred to as 'healing', and will be referred to as such extensively throughout the thesis. The term healing is the core of healthcare, according to Sayre-Adams & Wright (2001 p.13), and so can be vaguely applied to all means of health. This gives healing as a word several different meanings, claims Levin (2008). It is often referred to as recovery from an illness or disease, or a process that someone undertakes to recover from an illness or disease. It is also the intervention used to aid recovery from an illness or disease, and in this instance healing becomes a therapy.

As a HoH therapy, healing will be referred to as ‘Healing’ when distinguishing it from broader definitions of the word. Healing as a therapy is theorised to come from a source outside of the healer/healee interaction, in what Angelo (1991 p.18) calls the ‘healing triangle’. There are now numerous different modalities purporting to do this. The three most popular Healing modalities practiced in Western cultures are Therapeutic Touch (Nicoll, 1996), Reiki (Miles & True, 2003) and what is commonly known in the UK as spiritual healing.

Healers who participated in this thesis will be referred to as ‘respondents’, to emphasise the statements specific to them. References made to ‘healers’ are of a more generalised nature, referring to the wider healer population. Although claims can only be made about respondents, there are some aspects of Healing that are clearly more universally shared. Obviously, generalised claims are dependent on how representative the population sample is. For this, representativeness is difficult to substantiate, as there are no data against which to evaluate respondents. All the respondents are available to the public through the same means that they were approached for the thesis, and on that basis there is no cogent evidence for representativeness, but equally there is no evidence to refute it either.

The vocabulary of Healing is interchangeable, with healers, observers and recipients sharing descriptors for different aspects of Healing. The term Healing is used to distinguish HoH from medical terminology, through fear of prosecution for practicing medicine without a licence. The description of the healee as a patient is also usually avoided, and in this thesis the patient will be predominantly referred to as the recipient, healee or client. Although an individual as a client in its more strict sense would be a fee-paying recipient, for the benefit of continuity and ease of language recipients may be referred to as clients whether they were fee-paying or not.

Through analysis of the respondents’ descriptions of their performing Healing there are three clearly identifiable aspects to Healing which will be referred to throughout the thesis. These have been labelled as the procedure, the process and the mechanism.

Procedure The procedure is the physical actions of the healer and what s/he is doing to the healee. All HoH modalities have a procedure, as this is in part what distinguishes one modality from another. The procedure will be referred to as the healing-act, as opposed to the

healing performance which is the entire interaction between the healer and the healee. This is not to be confused with the performance of Healing, which is assessing the effectiveness of Healing. The importance of a procedure is difficult to assess, as its value is based on subjective interpretation.

Process The process is what Healing is doing to the recipient, determined from the interaction between the healer, the recipient and the Healing agent. For practitioners the terms 'process' and 'procedure' are often interchangeable, as they are in the literature, yet examination of Healing practices demonstrates there is an identifiable difference. The procedure clearly changes from modality to modality, yet there is no evidence that the process changes. Enactment of the process is done through performing the procedure: how successful a healer is at enacting is down to their healing-presence, to be expanded upon in chapter seven.

Mechanism The mechanism is the action/agent of change, or that which changes the recipient and brings about a transformation that is observable in the recipient. Within academic literature the product of this is referred to as an outcome, but that description causes difficulties for Healing. Healers have a different means of evaluating the client and determining what is to be observed, to be discussed in chapter ten.

Thesis discussion

The aspect of Healing that will be discussed is the healers' perceptions of their effectiveness in producing a therapeutic effect on the recipient. There is no objective examination of their effectiveness; nor does there need to be. How to produce an objective examination is the crux of the debate surrounding Healing, and is likely to continue for the foreseeable future, with proponents on both sides of the debate drawn between accepting or rejecting Healing (Spencer, 2003 p2). The argument in many ways has become the battle line for demonstrating whether Healing is effective.

The discussion put forth in the present thesis is not directly concerned with demonstrating that Healing is effective. The assumption is that respondents believe Healing to be effective, and this enquiry is aimed at determining how effectiveness is perceived by respondents. Effectiveness is understood as different from efficacy, as Cohen (2007 p.91) writes, and it is

important to distinguish between the two. Efficacy is testing whether a therapy works in theory, and is based more on controlled observational research. Testing efficacy, Aldridge argues (2004 p.145), is a misguided policy of establishing Healing within the biomedical domain.

Effectiveness (Cohen, 2007 p.91) is determined through more clinical-based research, and is pragmatic in application. It has more value to real life scenarios, as it observes a therapy in its natural setting. Perceiving effectiveness is within the respondents' aptitude; it is their set of values and judgments which create the concepts of Healing. Therefore, this enquiry is heavily indebted to the respondents' understanding of the world they perceive, and less involved with external sources. A greater discussion of the distinction between efficacy and effectiveness will be provided in chapter three, as the differences have important implications in how therapeutic interventions are assessed.

Thesis structure

The thesis begins with a brief explanation of Healing. The subject area covers a wide arena, so Healing is introduced in a context that is useful to its understanding for this research enquiry. Healing is historically experienced throughout the world (George, 2003 p.3), yet is culturally specific in how it is understood. Therefore, respondents were sourced from one collective organisation, the Healing Trust, which provides identity to its members but does not exercise authority over them. The common Healing practices supported by this collective will be identified in order to present the reader with a succinct understanding of the respondents' landscape within Healing.

The following chapter first discusses the problems that have impinged on Healing research, and then progresses to examining what is needed from Healing research to advance it through the politics of evidence-based medicine/practice (EBM/P). Although most authors write about EBM, it will be referred to in this thesis as EBP, as Healing is not a medicine. There is a substantial amount of literature written about the policy of EBP, which will be discussed, confirming that although EBP is accepted in principle, it is challenged in practice. The chapter will end with a brief introduction as to what research into Healing could achieve.

The literature review is aimed at research similar in aspect to the thesis. Literature regarding Healing is vast, so an appropriate direction is necessary, and therefore literature sourced was limited to qualitative research into the perceptions of healers. Four primary papers are examined regarding healers' perceptions, which illustrate the complexities researchers are finding regarding Healing. Healing, like all CAM modalities, is coming under pressure to substantiate claims and prove the benefits its advocates insist that it provides. Establishing where to place Healing within the healthcare environment is a desired corollary to EBP research. To achieve this, there needs to be an understanding into what healers are attempting to provide for their clients, and this thesis will attempt to enlighten the reader about the healers' perspectives.

The methodology chapter introduces how this research was undertaken. An explanation of what, how and why is provided, to convince the reader that an appropriate research methodology was utilised. Difficulties ensuing from qualitative research allow its critics to devalue it as less robust then quantitative methods. Yet, quantitative methods cannot explore the complexities of Healing, nor allow for theory creation, which is a fundamental aspect of the analysis method. Grounded Theory (GT) is introduced as the method utilised to create theory from the data collated, as GT has prominence in research where little or no data exist (Glaser, 1992 p.32). This makes GT an appropriate method of analysis, as there is a limited amount of research conducted on the healers' perceptions because the focus has historically been on the healee (Sutherland & Ritenbaugh, 2004).

A brief chapter introducing the chosen theory allows the reader to comprehend the 'bigger picture'. The presented theory is derived from three themes. These themes in turn are derived from the respondents' data, and are presented with a brief explanation of their meaning before an expanded explanation is presented in the following chapters.

The first chapter, examining the respondents' narratives, looks at the environs they practice in and how they communicate with their clients. The relationship between the healing environment and the respondents' discourses with their clients is a central motif of the healing performance. Its impact on perceptions is discussed, to provide the reader with insight into the theory presented.

The following chapter discusses the respondents' philosophy. Philosophy within Healing has a guided, individualistic approach, as respondents have a multitude of sources to influence their Healing career. Yet, respondents identify philosophy as their own, and a policy of 'it works for me' is conveyed as authentic in understanding Healing, but not authoritarian in its approach.

The concluding chapter describes the different means by which respondents witnessed effective practice, or, in some cases, non-effective practice. Effective practice could be summarised as a 'change' within the client. The term 'change' is to be expanded upon within the thesis, the clients' experiences of change share little commonality, other than the recipients receiving it. The results of change are witnessed through different facets of experience, and are indifferent to outcomes set out in biomedicine.

In the discussion chapter, the role of Healing within the context of pluralistic healthcare is deliberated. As Healing has not been accredited through the rigors of EBP it is perceived as an inert therapy. As such, Healing is considered a placebogenic treatment within biomedical research. The debate encompassing academic responses to placebo-effect is explained, as these responses hold implications as to where Healing becomes situated within healthcare.

Healing has commonality with psychotherapy, and parallels are drawn between the two. Psychotherapy has developed theories to comprehend 'change' within the client. Prochaska & DiClement's (2010 p.489) transtheoretical model of change is discussed, as it has become dominant within health-behaviour change (Armitage, 1997). The transtheoretical model of change, and how Healing relates to it, is explained. As both psychotherapy and Healing lack pharmacological or physical treatments, they therefore attempt to promote change within their clients through the management of client expectancy.

Chapter 2

Defining Hands-on Healing

Within this chapter a broad overview of the debates surrounding Healing will be presented, providing the reader with an understanding as to why the thesis has been written. Discussing HoH can be problematic, as the majority of people do not have a sufficient grasp of the subject matter to understand the differences and difficulties surrounding it. As Hufford writes (2003 p.294), "what are we talking about?" is the challenge in Healing research: to define what is essentially a diverse range of practices.

Through the course of undertaking the research it became apparent that an expansive perception of Healing prevails which generally inhibits its comprehension. The description provided is presented here to benefit the reader in understanding Healing within the context of the thesis. This is not as a means to discount the description as being of limited generalised value; rather, it is to emphasise the importance of recognising the limit of the research parameters being discussed.

Healing misconceptions

Before delving into what Healing is, it is important to note what Healing is not, as there are many misconceptions of Healing which lead to pejorative ideas. Healing is not, or at least not in the context of this thesis, 'faith healing', which is a term often used incorrectly to describe Healing, and which is occasionally used in academic literature (Levin, 2008). The use of this term often denotes the ignorance of the author, as there are clearly perceivable differences that are cultural in nature. HoH is also often mistaken for evangelical practices or charismatic healing, which are more entwined with faith healing than HoH or spiritual healing. The Healing Trust (2009) is keen to acknowledge the core difference by suggesting that faith healing requires a deity and that that deity is the source of Healing. The key differences lie in the background to Healing, and not necessarily the observable actions.

On a superficial level, these 'other' forms of Healing may appear similar to spiritual healing. The actions performed by the healer are similar in some cases, and share an ancestry with HoH, yet the intentions are often different. Within Healing the intention of the healer

determines the healing performance. Therefore, it is important to introduce the differences within Healing practices to illustrate how perceptions of Healing influence personal attitudes and beliefs.

Defining Hands-on Healing

Laying-of-hands, or hands-on healing (HoH), is one of various Healing modalities that have been historically grouped under the umbrella of spiritual healing in the UK. This umbrella comprises a broad range of practices and beliefs which are either aimed simply at a person's general well-being, or directed more towards a therapeutic intervention. Definitions should result from practice, and not just the dictionary (Aldridge, 2004 p.6); therefore, defining Healing practices becomes complicated as it differs according to the expectations of the practitioner and their recipient.

The esoteric nature of Healing, however, gives it intangible properties that are unique to the individual. This causes problems for Healing as practices may vary considerably. As a consequence, Fulder (1996 p.176) argues that defining Healing becomes difficult to achieve as it encompasses a variety of beliefs held by different populations. Healing becomes awkward to interpret, as analysis reflects the opinion of the commentator as much as the phenomenon itself.

The confusion is aided by the fact that there is no legitimate or legal body to provide a definition or exclusion of practices, and as such there is no requirement for healers to be a member of any existing organisation. Persons involved in Healing practices are also not prevented from creating their own organisation, adapting existing ideas or claiming new techniques. The growth in the many techniques now offered in esoteric and CAM publications gives testament to this.

Literature regarding therapies of a more esoteric nature, like Healing, demonstrates this claim. Literature sources produce a wide variation in concepts and understanding, which illustrates the difficulties in reviewing Healing practices. Authors are left to create their own definitions of Healing that represent the level of their understanding or the limitations of their knowledge of the subject. Aldridge (1993), discussing spiritual healing, was able to reference thirteen different definitions from various authors to highlight the problem. From which he

surmised that the mix in the discourses of differing scientific and religious beliefs is the cause of this difficulty.

So, definitions can be broadly summarised as what the practitioner is doing or what Healing is expected to achieve. The actions of practitioners, as so often discussed by commentators, can be observed, and so can be readily described, by providing a limited interpretation. However, it is practitioners' motivations that are more difficult to qualify, as they often use explanations that are considered pseudo-science (Wersch, Forshaw & Cartwright, 2009 p.34; Davis, 2009 p.49).

This can often be seen in how practitioners describe the processes within Healing. A common example would be so-called 'subtle energy' as the force of change, which is derived from quantum physics, understanding that all things are energy. Yet, the source of the energy is often attributed to a 'universal consciousness', which is aligned to spiritual values, not scientific sources.

Brown (2000) suggests that Healing has more to do with the state of mind of the healer rather than what s/he does. Aldridge (2000 p.152) also mentions the 'state of mind' of the healer, and suggests that it has eluded research, meaning that research has been more physically focused, usually through controlled clinical trials. So, definitions provided by practitioners tend to describe their motivations, not their actions. Techniques used in Healing will vary from practitioner to practitioner, and how marked that variation is depends on the awareness of the observer and what s/he believes they are observing. What Benor (1995) describes as the 'inner awareness', which is clearly perceivable but difficult to describe in words. The motivation of the practitioner, and not necessarily his/her actions, is seen as key to describing events by practitioners (Levin, 2008).

The confusion in defining Healing practices is exacerbated, explains Aldridge (2004 p.6), by the fact that Healing does not have a technical language that is shared amongst its practitioners. This, it could be argued, is particularly true in the UK, where descriptions can become rooted in personal ideology. Benor (2001 p.3), writing on this matter, claims that Healing has become known by various names and descriptions derived from the culture, religion or techniques it is situated in. But whichever culture it is in, it is usually divided

broadly into the three main categories of meditation, prayer and HoH (Benor, 2001 p.3; Aldridge, 2000 p.15).

In summary, meditation and prayer have a wider appeal than their use as a Healing modality, and can be viewed as part of a lifestyle, opposed to a therapy. This can lead to them often being mistakenly classified together, according to Roush (2003 p.19), who, differentiating between the two, suggests that meditation is usually a personal internal experience from which the meditator focuses on issues within themselves. Prayer, in contrast, is aimed at the external or internal sense of God or spirituality; as such, praying is performed on behalf of someone else.

Meditation and prayer in Healing, as they appear to the public who are aware of them, are more commonly used in distant Healing, although they are referred to as absent Healing by respondents, as there is no concept of distance in Healing practices (The Healing Trust pt.1, 2006 p.6:1). Absent Healing could be understood as the practitioner meditating on the healee. This would allow absent Healing to be understood as a form of mediation that is external, as the practitioner's use of 'focused intention' is a meditation guided towards the well-being of the healee, not him/herself.

The Healing interaction can be through any of the three modalities the healee chooses to experience, and is more to do with the preference of the healee than it is to do with any other issue. Benor's (2001, 2004) research into and personal experience of Healing has led him to write about all three different types of practice, as an individual may be drawn to experience just one modality or possibly all three. The result is seen as more important than the method, and as such Benor's interest is in discussing their possibility in achieving wellness, as opposed to being entangled in their differences. Benor (2001 p.4) has provided a succinct definition of Healing as:

> A systematic purposeful intervention by one or more persons aiming to help another living being (person plant or other) by means of focused intention, hand contact or passes to improve their condition.

Benor (2001, 2004) provides an introduction to the broad scope of the different Healing modalities. HoH is researched separately from other methods of Healing due to its uniqueness, in that the healer comes into contact with or in close proximity to the healee,

although it is acknowledged that healers practice both HoH and absent Healing. Most research is specific to one modality, and in that sense the thesis conducts research into Healing as a therapy where one person uses their hands in a healing-act on another person. Healers often perform both HoH and absent Healing with the same approach, and do not share academia's enthusiasm for distinguishing between the two. In Healing, practitioners use either method freely, which leads to the question: what purpose do the healer's hands perform? Most HoH modalities have a procedure that directs the practitioner as to how they perform Healing around the healee's body (Levin, 2008), yet absent Healing would demonstrate that the hands are not a necessity.

An argument could be presented that the performance of using the hands adds complexity to Healing in what is essentially a simple procedure when performed without the use of hands. With these actions the healer's use of 'focused intention' is not diminished, and yet there are no reported results of HoH being more effective than meditation or praying (Benor, 1995). The Healing Trust (pt.1, 2006 p.2:1) avoids suggesting how healers perform Healing with its definition:

> Spiritual healing is a process during which the spiritual awareness of an individual is raised. During and as a consequence of this process, physical and emotional problems become resolved, and individuals may find that their attitude to life alters and their quality of life improves.

Healing is not perceived as a therapy, but instead reflects the notion of Healing as self-healing, and recognises the contribution of the healee over that of the healer. It is presented as more of an achievement of Healing than a definition. The objective (The Healing Trust pt.1, 2006 p.2:1) is to influence the spiritual consciousness of the patient, from which a positive effect on their health and well-being can be achieved. However, explanations of this nature have to be guarded against, argues Aldridge (2000 p.163), as this may hide the true reason behind Healing. The problem of labelling understandings as spiritual is that this may detract from the pragmatic understandings which are necessary for daily life.

Levin (2008) is more incisive in his description of HoH by acknowledging that there are varying disciplines of HoH, and so suggests that whichever method is performed it must possess the three commonalities:

1. The practitioner uses their hands as a therapeutic aid in the performance during the healing-act.
2. The practitioner's hands must have a functional proximity to the healee's body.
3. The engagement of subtle-energies of variant conceptions and descriptions postulated to be the agent of change.

(Levin, 2008)

Levin's (2008) first commonality is easily recognised. Distinguishing HoH from absent Healing is important, as, historically, absent Healing has been seen as a religious performance (Astin, 2003 p.19; Jones, 2005) such as praying. HoH is the variation of Healing that is usually practiced and researched as a complementary therapy (CT), and as such it is becoming more widely accepted in hospitals and doctors' clinics, which in turn has promoted the need for research (Brown, 1995; Hodges & Scofield, 1995; Vaghela, Robinson, Gore, Peace & Lorenc, 2007). Absent Healing has not received the same attention, as there is a much greater problem in establishing cause and effect (Astin, 2003 p.14; Krucoff & Crater, 2009).

Leven's (2008) second and third commonalities are postulates, and present themselves to greater debate. Although Levin uses these commonalities as a means of reducing the research parameters, neither the use of the hands as a therapeutic aid nor the use of subtle-energy as an agent of change can be totally relied upon as a shared philosophical understanding of Healing. The 'agent of change' within the recipient is not fully understood, and therefore claims of what creates the change and how it does so are premature.

The energetic body

Evidence of the energetic body is contentious, and the more pragmatic disciplines of science question theories of this nature (Aldridge, 2004 p.151). As a part of quantum physics theories, they are not within the knowledge base of medical practitioners, who are more concerned with pragmatic solutions to health problems (Anderson, 2003). The term subtle-energy has no agreed-upon definition (Anderson, 2010), yet it is used to distinguish it from measurable energy (Eden, 1998 p.27) and is concerned with emphasising those aspects of reality that defy assessment, description or measurement by mechanical instrument (Hammer, 2005 p.31).

The notion of subtle-energy is endemic within Healing literature. It is known as 'parallelism' (Hanegraaff, 1996 p.69), as it emphasises parallels between modern physics and Asian

philosophies. The correlation between Asian philosophies and modern physics was championed by Fritjof Capra (1975 p.17), who explained that the two observe the same phenomena from different perspectives. Capra (1975 pp.133-134) argued that the basis of this comparison is from our understanding of the unity of all things from subatomic physics, and that the concept is shared with Asian philosophies.

Partridge (2005 p.215) surmises Capra's argument that Asian philosophies understand all manifestations as the same reality, a reality that is conceptualised as energy, and, because everything is energy within quantum physics, it is perceived as agreeing with Asian philosophies. This understanding of existence is difficult to translate into or show to have meaning in everyday life. Although quantum physics is accepted as science, its implications are challenged when used to justify the more tangential aspects of life (Partridge, 2005 p.215).

Wright & Sayre-Adams (2001 p.171) suggest that modern science recognises four forms of measurable energy: gravity, strong and weak nuclear forces, and the electromagnetic spectrum. They are critical of jargon that uses the word energy liberally, claiming it offers no clear definition of what is meant or what it purports to do. They argue that caution should be used around claims of the existence of subtle-energy, as this is not one of the recognised forms of energy, despite how New-Age thinkers like to draw parallels with quantum physics. Discussing the American therapy Therapeutic Touch, Wright et al. (2001 p.171) dismiss theories supporting the existence of subtle-energy, as they place Healing under ridicule, making it difficult to advance our understanding of these approaches within the scientific community; an argument that can be applied to all HoH modalities that describe subtle-energy as the agent for creating therapeutic change.

Biomedicine does not advocate the body as an energy system (Graham, 1999 p.37; Gerber, 2000 p.9) due to its reductionist, mechanistic philosophical underpinning based on Newtonian psychics. By not accepting theories of the body as an energetic system, historically there has been no call for research into developing a means to observe or measure subtle-energy transference, or any other scientific explanations for the understanding of Healing (Ernst, Pittler & Wider, 2006 p.350). Oschman (2000 p.122) claims that sceptics of the energetic-body fail to acknowledge that physics recognises that living organisms comprise dynamic energy systems. The term 'vibrational medicine' is often used to describe

therapies that utilise subtle-energy, which is in reference to their molecular structure and the speed at which they vibrate. Healing is claimed to change or synchronise this molecular vibration. Oschman (2000 p.217) argues that the body as an energetic system cannot be disputed in contemporary science, and the reason this knowledge has not been assimilated into biomedicine is due to the traditional bias against notions of subtle-energy. So, as science has developed this understanding it has failed to be assimilated into medical science.

Practitioners of Healing, regardless of modality, claim that therapeutic results are produced from the channelling or transference of subtle-energy from a source – which source depends on their esoteric beliefs – through themselves, into the recipient. CAM therapies that assert that their mechanisms are derived from energy transference are broadly classified as energy medicine (Eden, 1998 p.2; Jones, 2005) and vibrational medicine (Gerber, 2000), also known as Biofield therapies in the United States (NCCAM, 2011).

The juxtaposition of biomedicine and CAM perspectives is that biomedicine concerns itself with theories of disease, not theories of health (discussed in chapter three), and so foci are on pathology and symptomology (Hammer, 2005 p.35). Biomedicine recognises nerves and blood as the circulatory systems of the body (Reid, 1998 pp.16-18), whereas CAM, particularly those from Asian philosophies, recognise the energetic body as another primary network within the human body, and contend that the alleviation of disease should start there. The two frequently discussed means of working with the energetic-body are the meridians and chakras (Appendix A).

Healers perceive subtle-energy as a postulate and work with this energy on a pragmatic level as well as a philosophical one. The transference of energy is clearly the most popular explanation in contemporary literature regarding Healing. Healers can purport to use subtle-energies, but there is no evidence of a correlation between their understanding of this energy and their effectiveness as healers. The ‘how’ of Healing is a debate between healers, and this will be expanded upon throughout the thesis.

<u>The source of Healing energy</u>

The source from where energy is purported to be transferred is a contentious point within Healing. The two dominate influences on Healing have been the aid of spirit-guides and the

transference of subtle-energy. Fulder (1996 p.177) claims that there are three widely accepted scenarios explaining the source of subtle-energy.

First, it is believed that subtle-energy comes from a universal source or a universal energy (Fulder, 1996 p.177). From this perspective, God is one of the many names given to the essence that is Healing, and God is a label given to universal energy. The philosophy most associated with Reiki and Therapeutic Touch and all contemporary non-academic literature refers to subtle-energy or the energetic body (Hodges et al., 1995).

Second, energy is believed to come from divine light or God (Fulder, 1996 p.177). A religious interpretation, in which healers believe that the essence of Healing is provided by a spirit, and that that spirit is God. From this perspective, God is the universal source of energy, and all other names are simply mistaken for God.

Third, there is the belief that incarnated spirit-guides help in providing energy to the healee (Fulder, 1996 p.177), a philosophy that is usually associated with spiritualism and is better known as spiritualist healing. Belief in spirit-guides does not necessarily label someone a spiritualist, as that leans more towards religion. As to be discussed later in this thesis, healers have differing opinions about spirits and spiritualism which are founded on personal experience and not learned philosophy.

Some respondents were not interested in making a distinction, and it could be argued that there is a fourth opinion as to how energy is transferred: the belief that all three of Fulder's scenarios are correct. It could be perceived that universal consciousness and God are the same, as many esoteric sources suggest, and are merely different ways at looking at the same issue. Spirits or spirit-guides serve under the same God and use the same energy, which has a universal source, to apply Healing to the recipient. Although this is not strictly an option, it is an attitude that was sometimes shared by respondents who were not particular interested in being drawn on conclusions.

An attitude shared by some authors who simply avoid the issue. Jack Angelo (1991 p.1) defines Healing as "the channelling of Healing energy from its spiritual source to the one who is in need of help", a description that allows the reader to decide for themselves what

they want to believe; but Angelo (1991 p.20) does not conceal the notion that he personally believes in spirits, by describing their appearance and how they work.

Spirit-guides

The role of subtle-energy within Healing is a contentious issue to persons observing Healing. The role of spirit-guides within Healing is a contentious issue to those observing Healing and also to those practicing Healing. The notion of spirit-guides, or spiritual intelligence, is the least accepted explanation for Healing by researchers according to Schwartz & Simon (2007 p.173). And discussing spirit-guides proved to be a difficult issue for many of the respondents. The Healing Trust's official position does not currently support the notion of spirit-guides, although it does not discourage its members from personally believing in them. Harry Edwards, the founding member of the Healing Trust, was a spiritualist (Edwards, 1950 p.14), but the Healing Trust's policy is now to present Healing as a complementary therapy (The Healing Trust, 2009) and veer aware from the spiritualist perception, although Harry Edwards's books are still in publication and make claim to spirit-guides. The Healing Trust now describes the healer as a channel for healing energies (The Healing Trust pt.1, 2006 p.5:1) as opposed to a channel for spirit.

The belief in spirits progresses in two main directions. The most popular perception is mediumship, which is the attempt to communicate with deceased persons (Hanegraaff, 1996 p.23). Spirit-guides have also been historically connected to Healing. A belief which held a much greater acceptance with previous generations, and although still popular today, the main explanatory theory of Healing focuses more directly on the transference of subtle-energy. From the spiritualist perception, Healing is seen as another means of channelling or communicating with a different purpose than receiving messages (Edwards, 1950 p.23).

Spiritualism did gain attention with the public at its conception during the nineteenth century. Popularly recognised as beginning with the Fox sisters, spiritualism was to make bilateral challenges to both science and religion at a time when religion's role in science was debated. The spiritualist challenge to both science and religion was brief, peaking in popularity and then being reduced to a marginal interest within half a century (Garroutte, 1992 pp.57-58).

As a science, psychic research was able, during the last part of the nineteenth century, to gradually organise itself into a branch of science which briefly held the respect of prominent academics of the time (Brown, 1997 p.20). Before this split, psychic research was closely linked with psychology, in which the survival (or not) of the human personality after the body has died was openly debated (Randall, 1982 p.115; Henry, 2005 p.10). As psychology was to turn towards behaviourism in research, psychic phenomena became less of a concern, and were eventually abandoned (Randall, 1982 p.115).

According to Randall (1982 p.142), psychic research in the first half of the twentieth century became critical of mediumship; many of the prominent mediums of the time had been proven to be frauds, and those who had not been were by then suspected of being fraudulent. Consequently, parapsychology, as it had become known, shifted away from mediumship and séances to research into ordinary people and extra sensory perceptions (ESP). Spiritualism as a consequence lost its claim to scientific validity (Garrotte, 1992 pp.70-71; Henry, 2005 p.11), and as a religion moved towards 'proof' to the individual and away from empirical investigation.

The rejuvenation of interest in mediums in the popular media has indicated a broad contemporary acceptance of spirit-guides, but this does not have appeared to have influenced respondents. So, although there are actually no certainties regarding Healing, as there are no popularly accepted scientifically proven theories relating to its mechanism, the notion of spirit-guides remains awkward for respondents to deal with. McEneaney (2010 p.3), in her research, describes a 'detached acceptance' of these experiences across society. She writes about the experiences of the relatives of those who died in the World Trade Centre attack (9/11), discovering that many individuals had experiences of a paranormal nature but were afraid to disclose these experiences publically due to assumed social prejudices.

Despite the decline in the acknowledgement of spirit-guides in Healing, the theory has never been satisfactorily disproved, and is still as valid as any other theory accredited to Healing (Weatherhead, 1955 p.211; Gerber, 2000 p.420). All other theories regarding the source or the agent of change emanates from are also inconclusive. Therefore, attitudes towards spirit-guides are more to do with public perception than reasoning.

The Healing Trust

The Healing Trust is a non-denominational organisation which claims to be the oldest and largest membership organisation in the UK (The Healing Trust, 2009). Its members operate volunteer clinics, usually from community centres, for a few hours each week. These clinics, aptly named 'healing centres', allow the public free access to HoH.

The Healing Trust was founded in 1954 by Harry Edwards to promote spiritual healing (The Healing Trust, 2009) at a time when spiritual healing was receiving a revival in interest (Caradog Jones, 1955 p.4; Edwards, 1950 p.13). The organisation began as, and until recently was known as, The National Federation of Spiritual Healers (NFSH), but this rather long title has become old-fashioned. The term 'spiritual' now has an expanded meaning (Tracy, 2004 p.28) from the one it had at the date of the NFSH's creation. To the Healing Trust, the word spiritual is derived from 'spirit', and is taken from the Latin 'spiritus' meaning 'breath of life' (The Healing Trust, 2009). However, it is also known by respondents to be commonly associated with spirit-guides, which is an unfortunate misnomer for the charity as it has become confusing to the public.

The older respondents claimed they were keen to keep this title; however, they were consciously aware that this was impeding the organisation's ability to expand and attract new members. As an organisation, the Healing Trust is now well established, yet it does not have the public awareness or popularity more recent therapies such as Reiki have attracted. It appears to have the polar opposite problems to most other HoH therapies. The Healing Trust has not given a name to its practice other than the generic label of spiritual healing, yet the Healing Trust has a strong centralised organisational body to regulate and maintain standards. All other non-denominational HoH modalities in the UK have a therapeutic label to distinguish their practice, but have poor centralised organisation or governance, which leaves their practitioners with issues of quality and accountability.

In terms of unification and standardisation the Healing Trust can make some claim to success, as the charity has an internal regulatory system. The Healing Trust maintains its own training courses and examinations to ensure a level of competence is achieved by all its probationary members before they are allowed to become full members. CAM in the UK is

usually taught through small workshops or one-to-one apprenticeships (Cant & Sharma, 1996), and in this respect the Healing Trust is no different.

The Healing Trust training course attended by the author was performed at the home of a regional trainer who was fortunate to have a house large enough to accommodate twelve trainees. The course was divided into four sections. Each section consisted of two one-day workshops where apprentices learned a new section of the Healing Trust training manual (The Healing Trust, 2006) and how to practice the Healing procedure. The course is spread throughout the year, as it is believed that the time between training sessions allows the trainees to practice Healing and adjust from their experiences during the training sessions. Regional workshops offer a cost-efficient means of utilising existing resources, such as community halls, and allow for an easier commute for the public. A level of competence is assured, if rather tenuously, by practitioner insurance provided through membership, which requires members to practice within their code of conduct (The Healing Trust pt.4, 2006 p.9:1).

Standardisation of practice is more difficult to claim. Healing practices appear to becoming more diverse, with newly created therapies developing all the time. This is not to claim that there cannot be consistency amongst them, but this does not seem to be the trend at present. If proponents of Healing are convergent, is has to be asked why new therapies are developing and becoming available. So, for standardisation to happen external regulation would need to be enacted, but at present Healing operates under common law (Cant & Sharma, 1996). The most visible external influence is the insurance policy used by The Healing Trust members. Self-regulation is also currently provided through two umbrella organisations, The Confederation of Healing Organisations (www.confederation-of-healing-organisations.org) and UK Healers (www.ukhealers.info).

Is Healing New-Age or spiritual?

Healing is often referred to as spiritual healing, and the Healing Trust (The Healing Trust, 2009) advocates this term. Spiritual healing appears to be used interchangeably with the term ‘New-Age’ in literature. However, the terms New-Age and spirituality provide a problem for academic writing in that there is no agreed definition for either. New-Age is a difficult phenomenon to describe because of lifestyle preferences, metaphysical preoccupations and

voguish superstitions (Raschke, 1997 p.206). So although they are part of everyday language, when discussing spirituality and 'New-Age' the practices are quite vague, and the terms can be applied indiscriminately to whatever a commentator sees fit (Hanegraaff, 1996 p.1).

Healing, like many CAM therapies, fits into the modern interpretation of New-Age practices, according to Healas (2008 p.64), where the activities of mind-body and spirituality are present; and respondents would fit into this landscape (Healas & Woodhead, 2005 p.78). This is a problem for the Healing Trust, because, although it was formed in 1954 and predates the popular association of New-Age from the 1960s (Healas, 2008 p.61), it can today be seen as being of that movement. Yet Tracy (2004 p.3) draws attention to the notion that the spiritual movement and New-Age are not the same. New-Age is described as the commercialised attachment of the spiritual movement from which spirituality is explored for gain, and not necessarily aid.

Rose (2001) also writes that spirituality has no clear definition, but acts a neat, catch-all phrase that enlightens the reader about something without necessarily revealing much of its content; he claims that spirituality describes the box, when really what we want to know is what is in the box. As spirituality is not subject to objective investigation of verifiable explanation, Whipp (1998 p.139) describes spirituality "as being like jelly, good if you can grasp it but difficult to pin down". He defines spirituality as "the concern for things that matter".

But what does that mean? Healas (1996 pp.21-24) claims that spirituality is achieved through experience. The move towards abandoning traditions is a means of dispersing authority, which is represented as internal voices of ego. The experience of intuition allows the individual to serve as their own source of guidance. A sense of self-responsibility, by moving away from ego and blaming society for what is wrong in one's life. However, Tracey (2004 p.40) suggests that spirituality in this form is susceptible to false prophets and the industries that emerge from it. He claims that it may give independence from culture and tradition, but also as much alienation as liberation.

Superficially this could appear true if it were not for the amount of contemporary literature and other media available for persons perusing spiritual ideals; they may be on their own, but they are clearly not isolated or alienated. There are clearly shared values which are

represented in particular authors. A notion displayed by respondents who held 'self-judgements' as to whether a particular author resonated with them; for those who did not, respondents simply moved on to another author.

Bennett (1964 p.13) describes the actions of spiritual awareness as natural, as opposed to supernatural, and, although occurring throughout nature, are mysterious and unexplainable in terms of the laws of nature. The Healing Trust is keen to describe Healing as a natural process (The Healing Trust, 2009) devoid of psychic or spirit interference. How Healing relates to spirituality is influenced through culture. Healing per the Healing Trust does not fit the consumer model of New-Age. Most respondents did not associate Healing with monetary reward or personal gain, which is a reflection of its charity status and the community setting in which the Healing Trust has placed itself.

Reiki could be argued to fit the New-Age model better. It is prominently promoted through media sources, through which courses and workshops are advertised. CAM fairs consistently have Reiki stands selling 'taster' sessions to the public, as if Reiki is something bought for pleasure. The Healing Trust also advertises its courses, but with a lot less promotion. It also occasionally has stands at CAM fairs and other events, but the charity does not charge a fee because the Healing Trust aims to be more engaged in promoting the training of Healing, as opposed to selling Healing sessions (Cheek, 2008 p.36).

Professionalisation

Bowman (1999) writes that there is growth in accreditation within holistic healing, and suggests this is a reflection of the increasing number of practitioners who now have 'letters' after their names. Healing does not have recognised professional status, although the Healing Trust insists that its members be professional. Professionalisation requires a unification of knowledge, standardisation of practices and external legitimacy (Cant & Sharma, 1996). Yet Levin (2011) argues that claims to professionalisation are not relevant to Healing, and that healers do not have to identify with being a healer, or be labelled as such. Healing can be provided by anyone with compassion and intent.

Levin's (2011) argument can be understood from an American perspective, as the most popular HoH modality in the US is Therapeutic Touch, which was originally, and is still primarily taught to nurses (Gerber, 2000 p.410). Nursing is already considered a profession,

and so nurses do not need to associate Healing with professionalisation. Other therapists practicing Healing as an adjunctive therapy may also already have professional status – a claim that cannot be made about the majority of healers in the UK, who may perform Healing with more esoteric values and come from backgrounds not aligned to medical care.

Chapter 3

Evidence-based Practice

Literature discussing CAM and medical services note that they are divided into those that are supported through government regulation and all others (Vos & Brennan, 2010). But, as Derkatch (2008) explains, when examining therapeutic interventions it is not about a distinction between alternative or conventional, it is about proven or unproven, as that determines whether a therapy is allocated resources or not. Who and what decides a successful therapeutic intervention when examining therapies has been determined by the philosophy and ethics of practice (Anthony & Parsons, 1993 p.49). Historically, this has led to biomedical research practices determining outcomes, and CAM has not been convincingly successful in this arena. As such, the perceived value of CAM therapies has differed: between biomedical practitioners who observe CAM and the public who use CAM.

The central debate of evidence-based CAM (EBCAM) has, according to Richardson (2000), become understanding how the methodologies of differing world views can be transferred to each other. The focus on how to observe therapeutic interventions allows for differing philosophical and professional orientations (Derkatch, 2008), and not detrimental to CAM research, as the methodology serves as the central argument for the function of evidence-base practice (EBP), implying that interventions do not necessarily have to be proven to work within the biomedical domain if the therapy in question is not purported to work within the biomedical model.

Evidence-based practice

EBP defines the measure by which a therapeutic intervention is accepted within medical practices (Niessen, Grijseels & Rutten, 2000). This is both an opportunity and a threat to Healing, which has received research detailing both successes and failures in effectiveness. Current debate now revolves around how to research Healing for EBP.

The difficulty in defining Healing has made it difficult to research. Advocates of Healing, responding to a collection of practices seen as disparate or culturally determined, dispute with each other as much as with persons outside of Healing. As practitioners of different therapies

can be equally distrustful and disapproving of each other, and yet endure a shared experience of dogmatism against their practices from a similar distrust and disapproval from outside influences.

Those outside sources are predominately the public and academia. The public are becoming persuaded to accept Healing through their own values and interests, and academia has now been challenged to accept these values and interests or dispute them (Hodges et al., 1995; HoL, 2000 para 2.2). Historically, science has chosen to ignore Healing and placed barriers to its academic facilities. On account of this, Healing research has not developed an academic infrastructure similar to that of conventional medicine (Hufford, 2003 pp.297-300; Ernst, 2005).

As traditional attitudes fall out of favour within a changing society, Healing, it could be argued, is moving toward academia which is struggling to decide how to confront it. There is an abundance of literature discussing the increase in, and impact of, CAM in healthcare that reflects this (Raschetti, Menniti-Ippolito, Forcella & Bianchi, 2005), from which debates on CAM are far in excess of the number of papers researching it. This is also reflected in the use of CAM, as Ernst (2000) claims, as financial expenditure on CAM far outweighs the amount spent in researching it. So as Healing achieves greater recognition there is a need to provide a measure of effective practice. From which the measure will situate the application of Healing within the biomedical context. If Healing fails to demonstrate effective practice it will be excluded from consideration in medical interventions.

The problem with research

Healing, as with all therapies that purport to engage subtle energies, has struggled to be substantiated through objective scientific enquiry (Hankey & McCrum, 2007). Levin (2008), through his summary of the issues of Healing research, reports five different issues which have consistently been identified by critics, and, although his work is not conclusive, he suggests that science has historically ignored Healing due to these influences:

1. All healers are fakes, frauds, charlatans, hoaxers, quacks etc.
2. There is no empirical evidence supportive of Healing.
3. There are no posited theories of Healing.
4. There is no consensus mechanism for Healing, thus it cannot possibly happen.

5. Features of purported explanatory models for healing either do not exist (bioenergy) or are solely epiphenomena of the functioning of physical structures such as the brain (consciousness).

(Levin 2008)

Reviewing Levin's issues (2008), it is not difficult to find literature contradicting these criticisms. The issues presented are based on what is not known by opponents of Healing, and not directly concerned with academic debate. Exponents of Healing are drawn from different sciences, and as such do not have the collective presence to influence academic opinion.

The first criticism of healers not being genuine has become a difficult argument to sustain with there now being so many practitioners of Healing, many of whom are volunteers and so have nothing to gain by deliberately defrauding the public. This is not to be confused with the practitioner being competent; it is merely suggesting that they are not fraudulent. In addition, the criticism does not address the experiences of the healees receiving Healing, suggesting that these experiences are invalid or the result of a cognitive bias.

Second, there is the belief that there is no empirical evidence supportive of Healing, when there is actually substantial evidence arguing for Healing's effectiveness. Benor (1995) reports that out of 155 controlled studies of all types of Healing published by 1995, more than half demonstrated statistically significant effects. Benor (1995) concludes that if Healing were a medicine it would be available on the market. Unfortunately, a large portion of this research has been published in obscure journals, and is not readily accessible (Benor, 2001 p.11; Jonas, 2001; Levin & Mead, 2008).

Hodges et al. (1995) also state that there is an extensive historical record concerning the effectiveness of spiritual healing; however, they express concerns over the reliability of some of this literature, because almost all records are made up of anecdotal evidence with suspected varying degrees of historical and scientific inaccuracy. In addition, there is the problem that attitudes towards disease and health have changed dramatically through history, so that present-day interpretations may differ. Hodges et al. (1995) are not dismayed, and suggest that, although some individual accounts may be viewed as unreliable, on the whole the number of positive accounts is favourable for the validation of Healing.

Third, the criticism is that there are no posited theories of how Healing works, when in fact Gerber (2000 pp.415-421), Oschman (2000 p.107) and Benor (2005 p.143) all describe theories about how Healing works. This criticism is also unfounded, as it is not a requirement of EBP to understand how an intervention works. Contemporary literature regarding Healing is rich with explanations detailing the transference of subtle-energies within and around the human body. This energy is seen as the critical factor in sickness and health (Hammer, 2005 p.37; Gerber, 2000 p.11), which is regulated by chakras and meridians.

The fourth criticism is that there is no consensus mechanism for Healing, and so it cannot happen. Most books written about Healing provide some sort of mechanism believed to enable the therapeutic change, which are usually focused on subtle-energy (Schwartz et al., 2007 p.167). However, those making statements regarding the mechanism of Healing need to be more cautious in their claims, as this is a contentious matter. Earlier literature regarding Healing often claimed the assistance of sprit-guides as agents of change, such as the books authored by Edwards (1950 p.18, 1953 p.27). There is also no way to be certain that a different explanation may emerge that disputes energy theories in the future (Schwartz et al., 2007 p.167).

The mechanisms of Healing techniques used are not understood, and the evidence of its effectiveness is disputed (Abbot, 2000), and so Healing is still argued to not be a valid therapy by its critics. Healers are not concerned with observing a mechanism. Healing, as described in chapter one, is about 'focused intention'; this is not to be confused with changing the subtle-energy within the recipient, which is what is postulated by healers to happen from the healer's focused intention. Healing can still be performed and experienced without knowledge, or without concern for a mechanism. Healers appear to hold opinions opposed to those of their critics, in that healers accept Healing and then philosophise as to why it works. Their critics refuse to accept that Healing works, because they cannot philosophise as to why it could work.

Fifth, there is the contention that features of purported explanatory models for Healing either do not exist, or are solely the epiphenomena of the functioning physical structures such as the brain. This is a case of science not believing what it cannot see or measure. The explanation for Healing in this context is the placebo effect. Yet the placebo effect is not a concern of

healers, as Healing is considered self-healing. Illness is perceived as having a strong psychosomatic element influencing it, which has a connection to the energetic-body.

Due to lack of a diagnostic system or accepted ways to evaluate energy theories, Healing has remained on the fringe of research (Rubik, 2002). It is difficult for lay people and researchers alike to believe that there can possibly be a link between someone placing their hands near another person's body to influence a medical condition (Fulder, 1996 p.176; Charman, 2000; Hufford, 2003 p.294; Nicoll, 1996). This has not prevented an increase in the popularity of Healing, as the public have not been dissuaded from experiencing it (Aldridge, 1993). The popularity of Healing has in turn prompted health researchers to examine it more seriously, according to Abbot (2000).

Scientific enquiry has also not been helped, according to Jonas & Crawford (2004), by anecdotal stories and myths that accompany most claims of Healing's effectiveness, suggesting that the development of simple real-time objective techniques to measure Healing should be the first proviso in conducting quality research (Jonas et al., 2004). This provokes the debate as to what to observe and how to observe it.

What does EBP imply?

According to Aldridge (2004 pp.63-64), research validity in general is a political process, as it relies on the willingness from a group of individuals to accept the work of another. Healthcare, and the knowledge underpinning it, is regulated by the state. From a scientific standpoint, people are classified and analysed according to their deviance from the norm, whereby disease becomes a category instead of a unique experience of the individual.

Healing, in comparison, is fixed on the unique experience of the recipient, and traditionally has drawn its accreditation from sources other than science, although proponents of Healing have, as with many CAM therapies, attempted to use science to validate its practices as theoretically viable, Healing has still been able to survive without scientific validation. Aldridge (2004 p.75) explains that scientific perception is only one particular means of knowing, and that this perception is usually based on obtaining an objective truth above all other truths. Aldridge suggests that there are many different means of knowing, and that if

clinicians disregard these ways then the idea of an objective-definitive-external truth that is only accessible to select people is promoted.

CAM therapies are reported as receiving increased usage, but it is difficult to estimate accurately the rise of CAM, as it is not known how much they have actually increased in use as opposed to how much they are being reported better (Willis & White, 2004 p.50; Thorne et al., 2002). If CAM is not considered within the scientific domain then there is a clear indicator from the public of which side they are drawn to. The BMA (1993 p.9) recognises this, and claims that it is not a rejection of biomedicine, but simply that patients are choosing to use different therapies if they believe one will work better than another for them in managing their complaint.

Healing has circumvented any gatekeepers of knowledge through direct access to the public (Fønnebø et al., 2007). As its growth gives concern to science, a need to establish it accurately within EBP becomes apparent. Healing is deemed illegitimate due to the fact that it exists without scientific validation, but because it is used by the public it cannot be ignored. Its standing within EBP is weak, not because it has been demonstrated as ineffective, but because the research that has been published is not recognised as evidence that it is effective. So healers have been using their own assessment as a guide to effective practice.

The perceptions of healers cannot be taken in isolation. Respondents were able to provide varying anecdotal statements of their understanding of their effectiveness, but this is not accepted within wider healthcare research. The House of Lords (HoL para 4.25) reports that anecdotal claims are not to be viewed as reliable, as the proponents of such claims may not have epidemiological knowledge. Anecdotes are merely hints that something is happening, and only give cause for research, they do not act as research (Ernst, 2007b p.22), although anecdotal claims are not entirely dismissed, as they provide the basis for clinical practice (Aldridge, 2004 p.133), and respondents claimed they used these to support their own practice. Healing is considered an individual endeavour, and not in need of political persuasion. Therefore, respondents were content in the measure of legitimacy anecdotal statements provide.

The need for research

The rise in CAM and EBP are the two most significant influences of present-day healthcare (Adams, 2000; Stone & Treweek, 2004 p.60). Means that there is a need to research the extent to which Healing can be demonstrated as an effective therapy because, as with all therapeutic interventions, Healing is required to comply with the policy of EBP. According to Derkatch (2008) there is now an often cited definition of EBP which is used as the mission statement for its proponents:

> The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients
>
> (Sackett, Rosenburg, Gray, Haynes & Richardson, 1996)

The aim of EBP, Rosenberg & Donald (1995) claim, is to remove from the medical decision-making process, dangerous, expensive and ineffective treatments. They proclaim its advantage is in integrating medical education with clinical practice. EBP also improves continuity and uniformity of care through promoting similar guidelines (Rosenberg et al., 1995).

EBP now dominates the health services (Niessen et al., 2000; Wilson & Mills, 2002), becoming the principle means of evaluating therapeutic interventions. And so CAM therapies need to be represented within EBP (EBCAM) if they are to gain wider acceptance and be subjected to the same level of scrutiny biomedicine receives (Wilson et al., 2002; Stone et al., 2004 p.60). How successful Healing will integrate into EBP depends on the evidence expected from it.

One of the main concerns that EBP addresses, claim Davidoff, Haynes, Sackett & Smith (1995), is how to halt the problem of deterioration in clinical performance of medical practitioners. It does this by providing readily available, contemporary medical data to keep medical practitioners up to date with modern techniques and procedures. EBP is performed through four stages of accomplishment (Sackett et al., 1995).

First, the best scientific evidence available should be used to determine clinical decisions. Second, the clinical problem, not established protocols or habits, should determine the evidence used. Third, epidemiological and bio-statistical means should be used to perform

evidence collection. The evidence collated must be put into action in making healthcare decisions. Lastly, this process should be constantly evaluated and refined (Sackett et al., 1995).

The actualisation of EBCAM through Sackett et al. (1995) assessment is problematic for Healing. These four proposed stages are situated around the patient's health complaint and fail to define the patient's role. Healing, as a therapy is indifferent to the clinical health concerns of biomedicine, as Healing does not share biomedicines interpretation of outcomes. The client's willingness to experience Healing must also be reflected here, as acceptance of Healing demonstrates a broader concern for health issues beyond that of EBP. Therefore, Healing does not share the needs of EBP, as it is client-led.

However, with Healing receiving greater attention from the public there is greater need for accountability. Wilson & Mills (2002) write that the calls for CAM to become more evidence based is the same argument that was placed before biomedicine when it was opinion based. Wersch, Forshaw & Cartwright (2009 p.80) also suggest that it is a matter of ethics that CAM practitioners show evidence for what they do. The increased need for integrating CAM therapies with biomedicine has highlighted the debate over how to conduct EBCAM, as it is argued that CAM therapies do not have the same rigorous evidence to support their effectiveness compared to biomedicine.

Observing effectiveness or efficacy

The crux of EBP, according to Jonas, Lewith & Walach (2002 p.7), is how evidence is accumulated, as this determines how confident the conclusions reached from research are applied to a therapeutic intervention. The greater the number of different means of evaluation that conclude a therapeutic outcome, the greater the confidence can be placed in a therapeutic intervention that it is working. Confidence in these conclusions is received through accepting the balance between rigor and relevance when determining evidence (Jonas et al., 2002 p.4), which, explained by Kaptchuk (1996), translates into either fastidious efficacy, pragmatic efficacy (effectiveness) or performative efficacy.

A rigorous approach refers to the management of biases that threaten the valid conduct and interpretation of data. There is thus a stronger claim to internal validity, in that the research

question tends to be very specific, allowing conclusions to be attributed to specific outcomes (Walach, Jonas & Lewith, 2002 p.31). Claims about fastidious efficacy are usually produced from performing random controlled trials (RCTs) as the preferred method when looking for these conclusions (Jonas et al., 2002 p.7), with the most rigorous approach being the double-blind RCT, where neither the participant nor the medial practitioner is aware of which participant is receiving the real treatment and who is receiving the sham treatment. Fastidious efficacy research has clearly defined boundaries, and produces direct cause-and-effect evidence, which is better suited to detailing how certain parts of a therapeutic system affect clinical outcomes (Kaptchuk, 1996).

Relevance addresses the usefulness of the information put to specific audiences. There is a greater claim to external validity, as research on one particular population should have more general acceptance with the wider population (Walach et al., 2002 p.30). Conclusions are associated with outcomes rather than attributed to them, and so results are reported as pragmatic efficacy or effectiveness. RCTs can be utilised, but they are rarely blind, as performing effectiveness studies when observing cause-and-effect is impractical, unethical, unreasonable, impossible or misleading. They are best applied when evaluating complex or chronic conditions where narrow selection and treatment criteria are inappropriate (Jonas et al., 2002 p.4). Effectiveness research does not distinguish between specific-effects and non-specific effects, making it more difficult to attribute placebo-response within a therapy (Kaptchuk, 1996).

The issues of relevance are that different values are placed on different types of information (Jonas et al., 2002 p.4). Even when all information is valid, different groups will differ over which type of information is most important for their use. Jonas et al. (2002 p.4) argue that an ethical approach to scientific investigation will seriously consider the population it serves. Failure to consider different group values when designing and conducting research risks ‘methodological tyranny’, in which we become slaves to rigid research hierarchies that serve only a few, rather than using research as a tool for broad services. Long, Mercer & Hughes (2000) claim that the choice of whose outcome criteria is given prevalence and how these criteria are measured may have substantial bearing on how well a therapeutic intervention is determined to have worked or not. They suggest that relevance is determined by what outcomes (effects) have been explored in research studies, and over what timeframe. Further questions are posed: what are the desired outcomes of the key stakeholders, and what match

is there between these outcomes and those of the key stakeholders? And can the research findings be applied to the practitioner's practice and particular patients (Long et al., 2000)?

Performative efficacy is a cultural, anthropological approach that accepts symbols, expectation, persuasion, belief and suggestions, according to Kaptchuk (1996). There is a stronger association with the metaphysical through spirituality and religion. There is no association with objective measurement or neutrality through randomisation. Performative efficacy relies on the users deciding between genuine and sham therapeutic interventions, as the patient's expectation is considered responsible for receiving an active treatment or placebo-response (Kaptchuk, 1996).

Performative efficacy accepts Healing as a ritualistic therapeutic act. The power and function of ritual have been increasingly attracting research from biomedicine, CAM and psychology, according to Kwan (2007), because of ritual's capacity to enact self-healing. Kaptchuk (2002) writes that healing rituals maybe viewed as healthcare systems that rely on placebo-effect. This is a medicine-based interpretation, and Kaptchuk (2002) questions whether the results are more important than the method. Healers look at results; medicine looks at method.

Should a research agenda look at efficacy or effectiveness, and should the differences between the two dictate how a therapy can be researched? The greater the internal validity attributed to a specific outcome, the less externally valuable or relevant it becomes. Biomedicine, influenced by pharmacological research, is drawn towards testing efficaciousness and using rigid inclusion criteria, homogeneous populations and clear-cut endpoints to minimise statistical noise (Derckatch, 2008). And, as consequence, it is more successful at treating the acute, traumatic, infectious, genetic and tropical conditions, according to Fulder (1996 p.5).

Historically, CAM researchers have largely assumed that the same pharmacological research methods can be followed in the evaluation of CAM (Fønnebø et al., 2007). This is possibly due to the understanding that most CAM research has been done by persons not practicing CAM, or possibly, not understanding CAM (Ernest, 2001). However, CAM therapies tend to be more successful at chronic, psychosomatic or non-specific/multi-origin conditions (Fulder, 1996 p.5) which draw towards effectiveness research as they are individual in application. Research tends to be community-focused, with more heterogeneous groups that exchange

methodological fastidiousness for applicability. There are less stringent inclusion criteria and more varied treatment settings and ambiguous endpoints, and results are perceived as less statically reliable due to greater statistical noise (Derckatch, 2008).

The efficacy or effectiveness debate has centred on the use of RCTs, which have been used as the principle means of obtaining reliable assessment of a treatment effect (Richardson, 2000; Earl-Slater, 2001). Derkatch (2008) details the fact that, although EBP literature has endorsed RCT research, in general there are criticisms of its methodology and ideology. Claims of rigour are questioned because biomedical research often does not meet its own standards towards RCTs. Relevance is also often disputed because there is poor association between research evidence and clinical behaviour (Derkatch, 2008).

Issues with RCTs

Willis et al. (2004 p.50) and Small (2003) write that EBP as a methodology for medical decision-making uses a hierarchical system of evaluation, placing RCTs at its apex. The RCT hierarchical position has come under criticism; Bowling (2002 p.226) and Ernst (2005) suggest that, although RCTs have been the accepted method of providing EBP, they have become recognised as not suitable for all therapies. With some therapies there is a problem with randomisation, or with the chance that the client may also use another therapy in conjunction with the researched therapy.

Bowling (2002 p.227) continues by suggesting that it is simply too impractical to conduct a true experiment method with therapies such as Healing using randomisation in real-life settings. She criticises trials that are based on RCTs, as it is known that clinical treatment intervention trials tend to recruit from less affluent social economic populations than those of preventative treatment intervention trials; it is also known that more affluent participants have healthier lifestyles, which has a critical bearing on any outcomes. This claim is supported by Wersch et al. (2009 p.9), who suggest that CAM users are more likely to be better educated and more affluent.

Ernst (2005) is also critical of RCTs in CAM research, and suggests that CAM therapies are too complex for RCTs because treatments are altered to meet the needs of the client and so cannot be standardised. Randomisation is only ethical when a true equilibrium exists between

treatment groups, as patients can hold a strong preference for the use of one therapy over another (Jonas et al., 2002 p.20); this is a situation that can be viewed as particularly relevant for Healing, which still sustains contentious debates from medical practitioners and lay people alike (Abbot, 2000).

Rogers (2002) questions what Sackett et al. (1996) mean by 'best'. If the aim of EBP is to move medicine towards a scientific base, replacing medicine based on tradition and opinion, best practice means deriving evidence from RCTs. The theoretical framework of EBP has the aim of producing the best possible evidence upon which to base decisions, so it needs to be recognised that the production of evidence is a complex process involving methodologically imposed limitations and value-laden decisions (Rogers, 2002).

Rogers (2002) writes that as a consequence the range of treatment options becomes narrowed down and predetermined in order to produce manageable and answerable questions when making guidelines for treatment. This gives pharmaceutical interventions an advantage, as they are where most of the evidence is. Non-pharmaceutical interventions that may be of interest to the patient will not rank highly on these guidelines, due to lack of evidence.

Derkatch (2008) and Aldridge (2004 pp.75-77) are also critical of the term best practice, arguing that it appears to become a rationale for disregarding the experience and intuition of practitioners in favour of empirical evidence. Derkatch (2008) claims that the value the RCT is over-estimated due to its hierarchical position within research. Aldridge (2004) describes this as pursuing scientific validity as a form of objective truth. Medicine is not exclusive to science, and the notion that medicine is based on RCTs is a myth. Practitioners use observation, experience and intuition, which are facets of knowledge not exclusive to them.

Wilkinson, Bosanquet, Sailisbury, Hasler & Bosanquet (1999) researched EBP within clinical practice and discovered that EBP is not entirely supported by medical professionals. Their research concluded that most doctors were ambivalent about EBM, as practicing it was believed to conflict with their routines or beliefs. This places doctors in disagreement with EBP, as, according to Sackett et al. (1995), the use of routines and beliefs are what EBP has been developed to address. Doctors also believed that EBP compromised their internal clinical expertise, and harboured suspicions about its political motivation as an external influence.

The issue is discussed by Rogers (2003) and Thorne et al. (2002), who write that there is a conflict in ethics between patient care and population health. The relationship between practitioner and patient involves a high respect for patient autonomy. Yet population health deals with the good of population groups at the expense of individual privacy and confidentiality. Rogers (2003) suggests that the challenge for EBP is to find how it supports the duty of care to the individual.

Healing is about the individual, and so if EBP data are going to be sourced primarily from RCTs then it will be difficult for Healing to receive recognition. Practitioners of intuition-based therapies follow a single-case-study design in understanding their clients; therefore group averages have little significance in their practices. Aldridge (2004 pp.73-74), in acknowledgement of this, suggests clinical research should focus more on identifying changes in the patient as opposed to finding group averages. The problem with RCTs is that they may be relevant to the researcher but randomise away that which is relevant to the practitioner or patient.

The different philosophy of CAM practices

Capra (1982 p.353) describes health as "a multidimensional phenomenon involving interdependent physical, psychological and social aspects". But, as introduced in chapter two, healthcare has become more concerned with disease management than actual health care (Davis, 2009 p.41). The departure from looking at health to looking at disease is influenced by the Cartesian dualism which has come to dominate contemporary medical thinking. CAM practices, by comparison, are not influenced by Cartesian philosophy, and are more adapted to holistic approaches to health and illness.

These differences are quite substantial, as both medical practitioners and CAM practitioners have to address the whole individual. Yet, although medical practitioners practice the art of healing this is not significantly acknowledged within biomedicine, as Cartesian dualism reduces the importance of the mind, body and environment connection (Capra, 1982 p.140). Cartesian thinking is influenced by Newtonian physics in believing that component parts of a mechanism or organism are operating independent of each other (Kaplan, 2006 p.10). Capra (1982 p.42, pp.118-140) argues that in medicine the Cartesian philosophy of scientific method is considered the only valid means of understanding the world. Cartesian thinking has

resulted in the biomedical model, from which research has concentrated on understanding the body by ever-decreasing fragments, referred to as reductionism. The advantage of Cartesian thinking is that it provides a simplified means to understanding complex mechanisms, but in doing so provides little attention to the organism's environment (Kaplan, 2006 p.10).

The Cartesian perception is that living things can be seen as similar to machines, which has resulted in medical practitioners specialising in particular areas of medicine. The split in and specialisation of medicine begins somewhere between the physical and the psychological. Yet, in some instances, like emergency medicine or the treatment of acute illnesses, the reductionist approach has been quite successful. However, reducing health to a mechanical function has removed the humanity from biomedicine, which now struggles to conceive notions of healing and health (Capra, 1982 p.42, pp.118-140).

CAM practitioners also deal with the whole individual, yet their holistic approach resembles the system concepts of health. System concepts look at the whole not the component parts of an organism (Kaplan, 2006 p.11). Capra (1982 p.353) explains that system concepts of health perceive the person as being in continual activity that may change through response to environmental challenges. A person's condition is always dependent to some degree on their environment. An argument forwarded by McKeown (1988 p.2), who writes that population increase and the concomitant transformation of health in technologically advanced countries began hundreds of years before there were effective medical interventions. Rises in health standards are not associated with better medical care, but with higher standards of living, better nutrition and improved hygiene.

Capra (1982 pp.118-120) writes that the holistic approach followed by traditional healers involves greater awareness of the practitioner in the healing role, and of the client in the self-healing role. Illness is seen as a discord within the whole person, and should not be reduced to either a physical or psychological complaint. There is 'intensity' between the healer and their client, which is often interpreted as a supernatural force channelled through the healer (healing-presence). Concepts of this nature cannot be understood within the framework of biomedicine, so these practices are discarded and not perceived as effective. Fulder (1996 p.5) describes the holistic approach as accepting the energy patterns or spiritual person over more material aspects of the person. Although these concepts have received respect within society (Myss, 1998 p.xv), holistic therapies offer concepts not readily accepted within

biomedicine, as mechanisms of action do not lend themselves easily to RCT research methodology (Davis, 2009 p.31).

Gadamer (1996 pp.104-129) argues that the healing arts are always placed on the defensive because there is no visible process of making or doing. The contribution science has made to medicine is understood, yet our society has had to create the phrase 'quality of life' to regain something that has been lost. There is clearly more than the scientific world perspective where persons can receive healing practices and the healing arts, and not just the practice of medicine. Aldridge (2004 p.62) also suggests that there is greater need for the healing aspects of health. Not to deny scientific achievements, but to accept that the tension of understanding both elements means that one has been denied. The problems with chronic illnesses need society to go beyond partisan beliefs. And so it is left to the medical practitioner to mediate between the personal needs of the patient and the health needs of the community, which is the basis of the reductionist argument (performed through the use of RCTs).

What constitutes good health is not an issue generally addressed by biomedicine, as it is perceived as a philosophical issue addressed through spiritual concerns (Capra, 1982 p.144). Aldridge (2004 p.34, p.37) proposes that, although research tends to assume that health and illness are on opposing sides, lay persons might not think or behave in such a way. The notion is constructed by healthcare professionals educated to think in those terms. Health is no longer about not being sick, as persons may choose to become healthy. The change in emphasis from 'being sick' to 'becoming well' is an act of reclaiming personal identity, as opposed to having the identity imposed by another.

Fulder (1996 p.5) also addresses this, suggesting that CAM and biomedicine differ in their approach to health and illness, writing that the philosophies underpinning many CAM therapies do not perceive the patient as being in a state of illness or disease. This leads CAM practitioners to look at aetiology in a different way, with possibly a different set of outcomes. CAM therapists use the patient's symptoms as a guide to the origin of their complaint. Therefore, they work through managing the symptoms as opposed to suppressing them. According to Fulder (1996 p.5) many CAM therapies place the emphasis on restoration of health, and not necessarily the removal of disease.

So, in looking at a client as an integrated human being, CAM therapists treat the patient and their symptoms without Cartesian dualism. Internal validity, as accredited by the use of RCTs, is difficult to obtain, as the patient is not divided into constituent parts (Fulder, 1996 p.5). The greater problem with RCT-derived EBCAM, according to Derkatch (2008), is that the data are often difficult to interpret because CAM methodologies tend not to be straightforward. The RCT creates an ideal scenario that most CAM therapies cannot adhere to. Lack of evidence of fastidious efficacy is perceived as lack of effectiveness, yet RCT standards are often beyond those of biomedical approaches. CAM is more amenable to effectiveness studies as they treat more nebulous population groups (Derckatch, 2008).

Mitchell (2000) suggests that the challenge for EBCAM research is to develop an agenda that works for the persons using CAM, but also rigorous enough to be scientific in its application. She suggests that research agendas should focus more on the patient's desired outcomes, and less on reducing interventions into constituent parts. Sparker, Crawford & Jonas (2003 p.149) support this claim by suggesting that research designs that have a closer resemblance to actual CAM and biomedical practices will prove to be more valuable than clinical trials, due to the complexity of human illness.

The pluralist position (Aldridge, 2004 p.74) allows for orthodox research methods to be integrated with new methods and ways of understanding. Differing studies build on each other, allowing science to accept multiple viewpoints and a greater range of therapeutic options. The issue for present research is that pluralistic healthcare is already happening, with many patients reluctant to inform their doctors that they are visiting CAM practitioners (Cant & Sharma, 1999 p.47).

If Healing research can follow a patient-centred approach, EBP becomes a viable proposal for Healing. Jonas & Crawford (2003 p.xv) ask what clinical impact Healing has on real-life situations, whether these impacts are observed from independently produced research of quality, and how significant are these effects. The key determinants for assessing this are by separating non-specific aspects of Healing with the specific effects of outcome (Mitchell, 2000), or distinguishing the psychosocial from technical aspects, if they exist.

An attitude reflected by the House of Lords (2000 paras. 7.8-10), in a decision that research can be rigorous and still be sympathetic to the CAM methodology being examined,

suggesting that the emphasis of research should focus on the effectiveness and safety of a therapy, and not on its mechanism. Not understanding the mechanism of a therapy does not exclude it from being used, providing that first safety and then effectiveness can be demonstrated (HoL, 2000 para. 4.29). Healing is considered to be iatrogenic, as it does not presently have any known safety issues or contra-indicators, as there is no diagnosis or physical manipulation of the healee (Benor, 2001 p.459).

Categories of evidence

The House of Lords (2000 para. 2.1) categorise Healing into group 2 in their description of CAM disciplines. These are therapies that have limited evidence of benefit and, because they make no claim to diagnose or have a specific effect, they are largely seen as complementary to biomedicine. The House of Lords (2000 para. 4.28) distinguished between evidence of effectiveness and evidence of mechanism. Lack of a recognised mechanism has been problematic for Healing (Benor, 2005 p.143), yet EBP does not require a known mechanism to recognise effectiveness.

According to Willis et al. (2004 p.53), EBCAM in general is usually emphasised in outcomes not explanations, as safety is seen as the primary concern, followed by effectiveness. Still, the direct effects of focused intention and intuition are two of the biggest challenges to EBCAM research and current Western scientific methods (Jonas et al., 2002 p.19). Finding a mechanism is the crux of Healing research. If effectiveness can be demonstrated, but a mechanism cannot be found, Healing could still be considered placebo-effect. This is down to the complex relationship between expectation, awareness and psychological processes connected to outcomes (Jonas et al., 2002 p.19; Tovey, Easthorpe & Adams, 2004 p.5), which are not completely understood, and so are usually represented as placebo-effect (Schwartz et al., 2007 p.167).

Placebo and nocebo

A placebo is generally understood to be an inert substance provided as a substitute for a biological agent (Porto, 2011), and is the only psychological variable that must be accounted for before a new therapeutic intervention can be approved (Kirsch, 2002 p.129). Healing is often dismissed as a placebo, but this is a misnomer: as with all therapeutic interventions

where placebo is suspected, it is either considered to be a placebo-effect from the patient-practitioner interaction or as a placebo-response (Ernst, 2007a).

French (2001 p.39) writes that the mechanisms of placebo-effect are not completely understood, although it is accepted that it derives from the patient's expectation of receiving an intervention. Its influence is not constant, as the expectation of a therapy is achieved through social variables such as novelty, media claims, the therapist-patient relationship (Ernst, 2007a) and the degree to which the patient has preference for biomedical or CAM therapies (French, 2001 p.39). Placebo-response is the degree to which a person or group of individuals receive a therapeutic outcome from a sham treatment.

French (2001 pp.37-38) argues that the development of therapeutic interventions that are demonstrated to be effective in their own right is a recent phenomenon. All societies have historically respected individuals who were responsible for healing, however they practiced medicine, and the notion that these individuals were perceived as having the ability to treat illness is an illustration of placebo-effect. Placebo is still a part of modern medicine, but is not valued as part of the therapeutic intervention. Yet, placebo-effect may actually account for a significant aspect of any medical intervention (Withers, 2001 p.112). So, controlling for placebo-effect is acknowledging that it is important and, as Kirsch (2002 p.129) suggests, it would be more reasonable to accept it as a legitimate part of treatment.

In Hróbjartsson's (2001) summary of placebo-effect, he claims that defining placebo is problematic, and should be varied according to the type of intervention being researched. He is critical of accounts which dismiss therapeutic effects as a placebo if there is no empirically supported theory for their mechanism of action, acknowledging that there are several known therapeutic interventions that have no specific effect, yet are not considered placebo. This begs the question of how to evaluate placebo within Healing. Wright & Sayre-Adams (2001 p.171) define placebo as "any procedure that produces an effect in a patient because of its therapeutic intent and not its specific nature". They suggest that with Healing this is a paradoxical definition, as 'the intent' in itself is a specific outcome in Healing. By this account, Healing becomes an excuse for effectiveness, not the reason, due to client expectation. The specific nature of Healing becomes scientifically undetermined, and therefore cannot be accredited with an outcome.

Helman (2001 p.4) suggests that when looking at placebo (and nocebo) it is important to situate it within the wider context of expectations, assumptions and norms of the culture it occurs in. Meaning, a placebo that is specific to one group or population may not work with another. Placebo-effect is known to be dependent upon expectation (French, 2001 p.39). Yet, within the culture of Healing, respondents reported witnessing effective practice that would be beyond reasonable expectation, particularly so with some spontaneous remissions which could be difficult to dismiss as placebo-effect (Krogsbøll, Hrøbartsson & Gøtzsche, 2009).

Bensing & Verheul (2010) suggest that there are three different categories that are understood to influence placebo-effect. First, they suggest that the conditioning of the patient will affect the outcome of a therapeutic intervention. This is the patient's previous experience with the therapy or the persons administering it. The psychosocial influence, or 'hello goodbye' factor mentioned by Abbot (2000), is often reported as the reason why CAM therapies are successful.

Placebo-effect can also be influenced through the manipulating of the patient's expectation of the intervention (Bensing et al., 2010). Within Healing, respondents negotiate or manage expectancy with their clients, so expectancy is not seen as a placebo-effect by healers. Respondents claimed that achieving a viable recipient expectancy was crucial to initiating successful Healing sessions. Expectancy becomes part of Healing, as it helps define how Healing is evaluated.

The third placebo category is influencing the patient's natural state of stress level. Bensing et al. (2010) claim that decreasing a patient's stress level because of the way they are treated is considered a placebo-effect. In Healing, decreasing stress level is seen as necessary to perform Healing, and is also seen as a result of Healing. Healing, by this account, would have to be a placebo-effect, as, although there is historical reference to Healing in UK culture, it is not recognised by the medical establishment in the form of EBCAM.

Bensing et al. (2010) claim that the common conception of placebo is that it is seen as sham practice, compared with biomedicine, which is seen as making the patient informed about the treatment and alternatives. Yet, the paradox of placebo is that in clinical practice it is administered and supported, but in clinical research it is minimised. This is because the definition of placebo places it outside the scientific arena, and therefore more likely to be

controlled for rather than researched (French, 2001 p.40). It is treated in research as a problem that disguises the effectiveness of a biomedical intervention. RCTs have traditionally been utilised by scientists to control the placebo-effect, while at the same time those scientists avoided dealing with them. So, placebo-effect is generally ignored or considered a nuisance (French, 2001 p.40; Kirsch, 2002 p129; Lewith, 1993 p.38; Bensing et al., 2010).

Aldridge (2000 p.153) explains that Healing is commonly dismissed as placebo-response, yet research with lower organisms indicates there is a direct influence (Benor, 2001 p.335; Gerber, 2000 p.350). Aldridge continues by arguing that spontaneous regression and expectancy effect are allowed as explanations for patient recovery within biomedicine, yet cannot be seen as any less metaphysical than Healing. Therefore, it is not acceptable for conventional explanations within biomedicine to be used as a dismissal of alternative explanations in Healing (Aldridge, 2000 p.153).

Capra (1982 pp.360-363) writes that because placebo refers to aspects of healing that are not based on physical or pharmacological interventions, it often has a pejorative connotation. How confident a patient is in any therapy has influence on its effectiveness. Therefore, positive expectation is a placebo-effect. Self-healing and spontaneous regression are the healing powers of the patient's mental attitude. If illness can be attributed to psychosomatic causes, then the treatment for illness can be too. What is required is for the patient to recognise their involvement in their illness and their involvement in the treatment, as disease is a biological manifestation of illness. Capra (1982 p.396) suggests that the system's concept of health essentially perceives illness as a mental phenomenon, from which effective therapeutic interventions integrate physical and psychological therapies.

What could research achieve?

If Healing is to be reasonably detached from placebo-effect it needs to demonstrate effectiveness. A significant problem with finding an adequate research design for Healing is that researchers are not agreed on how to conduct research (Walber, Kile & Gillespie, 2003 p.83) or what to measure. In addition, a major obstacle challenging the enquiry into Healing is evaluating the difference between how researchers determine effectiveness and what practitioners are claiming to do (Mitchell, 2000; Levin, 2008). The practitioner's perspective appears to be an aspect missing from Healing research. Levin (2008) writes: "the practitioner

is an interpreter of realities and experiences that may be far less familiar to the scientists overseeing the research".

So, what is needed is collaboration between scientists and healers. If a reliable research design is to be tested, then practitioners' input is essential; this will give a better clue as to what a practitioner is trying to achieve, as because this may not necessarily be what Healing research is expecting to observe. A benefit secured, according to Levin (2008), from practitioners knowing the what, where, when, how and why issues relate to their practice. Jonas (2003 p.225) suggests that the use of qualitative research can identify the important outcomes, allowing for more relevant data collection, which is particularly useful in creating effectiveness trials. Mitchell (2000) also suggests this, claiming that if we are to understand the complexities of why people go to healers, what is expected to be achieved from their relationship, and how it should be appropriately measured, then there needs to be more development through the social sciences.

Recognition through EBP would be an external acceptance of Healing practices. Healing as a therapy has survived without the legitimacy that EBP could afford it. Healing will probably survive if it fails to receive EBP legitimacy for the foreseeable future, due to the sheer volume of practitioners. Although it is biomedicine asking Healing to demonstrate effectiveness to be included within its practices, Healing has not sought an external recognition that is evidence-based. So, recognition within EBP is more of an opportunity than a threat to Healing.

However, Levin (2008) suggests that successful evaluation may eventually provide political, legal and financial sanction to Healing. Healers are already permitted to practice Healing under UK law. However, there is no legally enforced qualification or accreditation for Healing (Walber et al., 2003 p.83). Accreditations from organisations may be viewed as weak because of this, although membership in the Healing Trust has more merit than in other organisations. Being a Healing Trust member demonstrates that a healer has some legitimacy, but does not demonstrate their Healing ability in any capacity.

Healing research has the potential to validate Healing and the organisations which support it. This is different from validating healers, and it is argued that different criteria are used to achieve the latter. Research also has the risk of dismissing Healing as ineffective, although

this has to be differentiated from determining individual healers as being ineffective. Understanding the difference between anecdotal claims from recipients, and addressing the difficulty in translating that into positive results in outcome trials, should emphasise these problems.

Research could also illuminate what clients are seeking Healing for (Mitchell, 2000). It could also address the issue of which illnesses Healers believe they have the most effect upon, as enquiries tend to be focused on the preoccupations of researchers. It is generally understood that persons with chronic illness go to healers, yet no literature researching this could be sourced for this thesis. CAM therapies in general are understood to be better at alleviating chronic conditions than biomedicine. Again, there is no drive to research this, as CAM therapies are, in the main, not patentable, and therefore there is no financial incentive in acquiring this knowledge.

The crux to this examination is to enquire as to what healers claim they are actually doing. According to Sutherland et al. (2004), Healing research has neglected the voice of the healer. How healers understand Healing in relation to its outcomes has escaped attention which could clearly lead to a better examination of Healing practices. Healing is person-centred to illness (Healas et al., 2005 p.28), not disease-centred to society, which may require a paradigm shift in research priorities for EBP.

Chapter 4

Literature review

Although there is an extensive amount of literature written on Healing, only a limited amount of it is actually research articles. A review of CAM literature published on Medline (Raschetti et al., 2005) calculated that of the 20,209 articles they reviewed relating to CAM between 1997 and 2002, as much as 59% of them were not research papers. This percentage comprised mainly comments, interviews, historic articles, conferences and meetings proceedings. Jonas & Crawford (2003 p.xv) reviewed published material directly related to Healing, and from the 2200 published articles they collated they determined that nearly 1300 articles were not research papers. As Knudson (2000 p.144) discovered in her research into distance Healing, there is a diverse range of authorship related to Healing, and there needs to be care taken when accepting or rejecting some comments.

Literature sourced for this thesis came from a broad range of authors, many of whom do not have an obvious connection to Healing. Some authors make it clear they are expressing personal opinions, but others make statements that are drawn from less obvious sources or knowledge bases. Healing lacks in technical aspects or professionalisation that would exclude certain individuals and there is no scientific discipline dedicated to Healing. So Healing, in essence, as a genre of research has an open membership policy, allowing debate from anyone who wishes to contribute.

For a therapy that is simple in its application, Healing has a lot of discussion surrounding it. Yet, more discussion does not mean that more is being discussed, and a great deal of debate regarding Healing appears to be regurgitated from one author to another. This may reflect the fact that questions are being asked, but not answered. And there is also the challenge of knowing what to ask (Mitchell, 2000), as the public have taken an interest in Healing that is not directed by academia.

Only four papers were found in a data search that related directly to qualitative analysis of HoH perceptions. On the whole there is limited qualitative research published about the perceptions of practitioners or the people who use Healing (Sutherland et al., 2004). This is

possibly a reflection of the marginalisation of Healing practices in research due to Healing not fitting within the constraints of the biomedical model (Taylor & Chatters, 2011; Levin, 2008; Benor, 1995; Hufford, 2003 p.294).

The literature regarding Healing discusses a vast area, and the increase in CAM usage in general by the public has increased awareness of CAM research and debate. A large segment of this debate has focused on how to conduct research and what actually demonstrates a CAM therapy as effective (Adams, 2000; Wilson & Mills, 2002; Carter, 2003). There are very few original research articles that directly relate to Healing, yet there is recognition of the need to have better understanding of Healing as a therapeutic intervention. For Healing that means understanding the healer (Benor, 2004 p.4) and distinguishing between what the healer is doing and what s/he can be observed to be doing.

Benor (2001 p.11), discussing this problem, describes our understanding of Healing as embryonic, and as such it needs research to expand the current knowledge base to help promote acceptability. Until recently there has been no systematic research performed on Healing, which has fuelled scientific scepticism. Benor (2001 pp.38-75) writes about the personal views of eminent healers drawn from their biographies and personal interviews during the 1970s and 1980s, from which he provides detailed accounts of the healers' actions and perceptions. These interviewees were from differing countries and cultures, which makes systemising their accounts awkward. Many of these healers claimed to have some form of psychic ability, and they practiced outside of mainstream healthcare when Healing was viewed as an alternative therapy.

Benor's (2001) interviewees are what are referred to as 'natural healers', as opposed to those who are 'taught healers' who are the focus of the debate today. Natural healers are those who discovered through their own means that they could perform Healing. All healers could be argued to be natural healers (Bengston & Murphy, 2008), but, with the explosion in interest in Healing practices, plain observation shows that most of the currently practicing healers have been taught. There is no argument suggesting that natural healers are not taught presented here, it is merely to suggest that they probably knew they could perform Healing before they sought training. Bengston et al. (2008) assert that it is incorrect to claim that just because a healer has been taught does not mean s/he did not already possess the ability, and that training maybe nothing more than a means of weeding-out unsuccessful healers.

The contemporary debate revolves around taught healers and their therapies which have developed from the 1970s onwards. When Healing comprised of a small number of individuals claiming to have special or psychic powers it was easy for science to simply ignore them. Theories dismissing Healing, or claiming the effects of Healing as psychosomatic and not responsible for any genuine therapeutic effect, are much easier to substantiate with healers of 'eminence' and the expectancy of their clients which comes with that.

Although this is still a concern, the debate has moved slowly away from the attitude that 'it cannot happen' to 'how can that happen' because of the influence of the public, who have been reported to be eschewing science as the authority over health (Kelner, Boon, Wellman & Welsh, 2002). The growth of Healing and all CAM therapies has become too large to ignore (HoL, 2000 para 1.9), so the problem facing Healing research is to determine what should be accepted as sufficient evidence of effectiveness. The notion that RCTs as the best means to research CAM therapies has been challenged, and the move towards more pragmatic solutions, such as circular as opposed to hierarchical evidence, has prompted the question of what to observe (Walach, Falkenberg, Fønnebø, Lewith & Jonas, 2006).

Published research

Pragmatic research, it is argued, needs to be more therapy-based and less clinical-based, as evaluating Healing in a more natural setting is far more beneficial to gaining understanding of it (Abbot, 2000). At the forefront of understanding this enquiry is understanding what the therapists themselves are claiming to do. Brown (1998) is a UK GP who has trained as a healer and refers patients to a Healing clinic operating from his surgery on a weekly basis. Brown claims that Healing is useful, but acknowledges that there is little research demonstrating its effectiveness, and raised this concern following his own research (Brown, 1995).

Brown (1995) recruited, from his own GP surgery, participants who were known to have persistent chronic conditions and who had not responded to more conventional forms of treatment. This was considered a more pragmatic research design, as patients were invited to receive treatment and not assigned to it. Healing was performed by two volunteer healers at the GP surgery, and a quality-of-life questionnaire was then administered. The population

sample comprised twenty-three patients who completed the twenty-six-week study period, from which mixed results were reported. Overall, Brown (1995) claims there were sustained improvements in participants' complaints reported in six-month follow ups after the twenty-six-week study had been completed.

Although it could be argued that this sample is small, it demonstrates a valid research design that can be replicated to some degree and scaled up in multiple locations to achieve more substantial results. Participants with chronic conditions were chosen, as these types of complaint are where Healing is known to be most beneficial, and where biomedicine is less successful. Moreover, patients were given the choice whether or not to participate, as this is considered an important aspect of receiving Healing and better reflects real-life scenarios (Brown, 1995).

Through his own analysis, Brown (1995) suggested that healers may have different outcome expectancies than researchers. He also acknowledged the limitations of using quality-of-life questionnaires, and reported witnessing many improvements in patient outcomes which were not represented in the T-tests, suggesting that these additional observations were of value to the participants, but not to the research per se.

Brown (2000) later argued that it is important to accept what healers have to say when designing a clinical trial, and when accessing published research that directly enquires into the perspective of healers, suggesting that the effectiveness of Healing may be intuitively perceived, and as such may not be measurable by using currently accepted methodology. The concerns that healers have about clinical research into the effectiveness of Healing are identified, and although it is not a comprehensive review of healers, it serves as an introduction to understanding how healers work.

Brown (2000) separated his findings into four themes: patient selection, methodology, measuring outcomes and the healer's health. Regarding the theme of patient selection, Brown (2000) suggests that understanding the population sample researched is critical to good research design. This is reflected in the research setting and the issue as to whether Healing is being used as either a complementary or an alternative therapy. When the selection of population samples is taking place, it is important that the population selected to receive the therapy is considered. Brown (2000) recognises that participants need to choose to receive

Healing, which is part of the healing process, and suggests that from the healer's perspective that may be considered when the Healing process actually begins. A problem in clinical trials is that the healing process may have already begun before a baseline measurement is taken. Research that randomises participants neglects this principle, from which point Brown (2000) takes the argument further, and claims that people and not diseases should be researched. Healers encounter an undifferentiated group of people, and so a population sample should not be restricted by disease.

Brown (2000) suggests there are also issues with methodologies. Healers claim that postulated Healing energy is not directed by the healer, which makes randomising outcomes problematic as the force of Healing is not controlled. Healers rejected the use of a control group or any trial that requires a 'sham practice'. According to their comments, a possibly due to the healers believing they are creating a Healing environment that should benefit all within the locality. Healers also believe that each client is different, and as such cannot standardise any part of the treatment to make accurate measurements. Brown (2000) suggests that the challenge for Healing research is to develop a methodology that separates the therapeutic relationship from any specific Healing effect.

With Healing this is particularly difficult, as it is considered a non-specific-effect therapy, and as such is reliant on the outcomes suggested by the patient. Outcomes of this nature cause contention as EBM requires objective measurement, not just subjective interpretation. There must be a measurable change in a patient's symptoms to claim effectiveness (Wright et al. 2001 p.166).

Brown (2000) reaches a similar conclusion, claiming that, when observing outcomes, many of the changes observed by healers or their clients are not quantifiable; he suggests that "what is an outcome-measure" is a more pertinent question. Healers do not necessarily view illness as a problem, or, in some cases, they have a philosophy that suggests that illness is part of a lesson in life that helps the spiritual growth of the client. This is a controversial issue, and Aldridge (2000 p.163) guards against such responses, claiming that simply promoting something as spiritual possibly detracts from real explanations. Ernst (2006) is more critical of Healing, and argues that the promotion of a belief in the supernatural healing ability of energy undermines rationality. This did not appear to be the situation with the respondents

interviewed; they demonstrated a pragmatic understanding towards Healing and spirituality, and were not inclined to digress into fanciful ideas.

The last category is the healer's health, regarding which Brown (2000) claims that healers themselves may benefit from channelling energy. Research comparing the health of healers may demonstrate them to be healthier than non-healers who are employed in similar occupations. Such research may show that Healing transference, if to be believed, has a positive benefit on the human body.

The notion that channelling energy is the reason healers are healthier than other people could be difficult to substantiate, even if healers appear to have less illness. People who undergo Healing training may do so through greater spiritual awareness, which may also play a part in their health. So, Healing, to healers, may be seen as a means of practicing spiritual awareness, just like religious practice to religious persons, which may influence well-being. Brown's (2000) suggestion also neglects the lifestyle choices of healers, as it is not known how Healing development impacts on personal choices affecting health, such as diet and exercise.

Brown (2000) also raises the obvious issue that some healers may simply be ineffective, or at least not equally effective, as other healers. An issue not addressed in Healing research (Bengston et al., 2000). There is no recognised means to measure postulated energy transference, so there are no means to adequately test healers in regards to such energy. The success of healers is often attributed to the healing relationship (Aldridge, 2004 p.130), and this is possibly correct, but not in the form of the relationship academics discuss. Beyond the healer/client dyad is the elusive element of healing-presence introduced in the present thesis as the process.

When the process of Healing is understood as the 'action between the healer and the client' this unknown, often misunderstood element of Healing becomes an extension of the healing relationship. The process is not something that is obvious, consciously deliberate or managed by the parties involved, it is formed from the willingness to give Healing, and the acceptance of receiving it. This could be argued to be a polar opposite of the biomedical approach, which insists that patient choice should be independent of a specific outcome.

Brown (2000) defends the autonomous actions and beliefs of healers who claim that Healing is too different from the scientific paradigm to be observed in that spectrum. He suggests that a wider scope of observation be used with Healing research, as it is ultimately the client who decides when they have reached a satisfactory outcome. Brown (2000) recommends that simple descriptive reports of what the healers believe is happening during Healing process is the first step in Healing research.

The issue of Healing as being too different to be examined through EBP was illuminated by Kelner et al. (2002). Their research questioned chiropractic, homeopathic and Reiki practitioners about the perceptions of the need to follow EBP, and its cost-effectiveness. The comparison between these therapies was chosen to be undertaken due their different stages of professionalisation.

Kelner et al. (2002) reported that practitioners of the three therapies were different in their assessment of EBP, but all shared the notion that their particular therapy was cost effective. Chiropractors were the most interested in demonstrating effectiveness; homeopaths had some concerns about EBP; and Reiki practitioners had no concerns about EBP. Reiki practitioners were reported as being uncertain about how to reply to questions about how to demonstrate effectiveness, but had no worries about demonstrating that Reiki works. As with Brown's (2000) suggestion, they were convinced that conventional interpretations of outcome would be inappropriate for Reiki. Their understanding was grounded in the notion that Reiki is perceived as a form of spiritual growth based around the concept of a change in the energetic body, whereas scientific perceptions were considered too mechanistic to fit their paradigm (Kelner et al., 2002).

Kelner et al. (2002) concluded that the obvious differences between established professionalisation and the acceptance of EBP have drawbacks. As therapies become pressurised to establish credibility through EBP, there is a risk of licensing restrictions on practice. Kelner et al. (2002) suggest that groups like chiropractors who are willing to engage in research using conventional methodology may have to surrender some aspects of their therapy that are important and integral to their practice.

Warber, Cornelio, Straughn & Kile (2004) recognised that there is a lack of published research regarding the perceptions of healers. Their research was performed in the US, and

consisted of interviewing therapists from several different HoH modalities. Respondents were firmly grounded in the subtle-energy transference philosophies that circumscribe Healing practices in the US. These modalities that purport to use subtle-energy transference have been categorised as biofield therapy or biofield medicine (NCCAM, 2011). Warber et al's. (2004) research was influenced by qualitative literature regarding Healing, which, they claim, primarily focuses on the therapeutic effect and not the underlining principles of Healing.

To address this, Warber et al. (2004) used a Grounded Theory approach to elicit themes related to the process of biofield therapy from nineteen participants. Their results revealed how American healers held an energetic view of the world, and that the use of this energy facilitated the Healing process. Their results were summarised into several themes.

According to Warber et al. (2004), all participants acknowledged their belief that all life forms have an energy presence. People in general were described as having a 'human energy anatomy' unique to each individual. Respondents gave differing accounts about how they experienced or perceived the energy anatomy, as perception depended on their ability.

Warber et al.'s (2004) respondents believed that the energy they worked with did not come from within themselves. Respondents 'attuned' to this energy, which was described as coming from a 'universal' source, or from God. The movement of energy was identified as two separate processes. First, energy moves from the 'source' to which the respondent attuned him/herself in the Healing process, through the respondent, into the client. The second identified process is the movement of the client's energy, which may be described as low or out of balance, which the healing process then puts back into balance (Warber et al., 2004).

The experience of energy (Warber et al., 2004) was also a theme. Respondents described their experience with energy as personal, as it comes from the five senses and from extrasensory perception. Accounts from the respondents varied according to their extrasensory abilities; however, these accounts were only about perceiving energy and did not reflect on the Healing-act. How well respondents can transmit energy was also not discussed.

Warber et al. (2004) also identified the action of energy as another major theme. Energy is understood to have its own intelligence, and works on its own accord during the Healing process. As the respondent performs the procedure they report experiencing sensations from their extrasensory perceptions that change throughout the Healing process. These are indicators to the respondents of energy changing, although how the energy changes are not discussed.

Warber et al. (2004) claim that use of the language of physics among their respondents was common to describe their respondents' understanding of energy. Scientific language is reported as being used in the description of the mechanism of Healing, and as a metaphor for the experience of Healing. This perception is recognised as coming from cultural and disciplinary philosophies that are taught, with additional individualised perceptions.

Relating to Healing in energy terms is understandable for research conducted in the US. HoH modalities have avoided language that may confuse them with religious practices (Gerber, 2000 p.410), which has caused controversy in the past. Faith Healing or Healing conducted through evangelical churches is much more prevalent in the US, and CAM therapists are keen to disassociate themselves from those practices.

Warber et al. (2004) came to the conclusion that healers were not charlatans, but, in their experience, were ethical practitioners who worked with perceptions inside and outside of the normal ordinary senses, suggesting that it is not wrong for healers to maintain their beliefs, and that it should be for science to disprove the healers' theories. They suggested the creation of scales to assess the relevant characteristics of healers and clients, as this may yield relevant information to more accurately test the effectiveness of Healing, an argument shared by Bengston et al. (2000) and Brown (2000), mentioned previously, who suggest that healers may have different abilities which need to be addressed.

Warber et al.'s (2004) research paper on the whole appears superficial. Many of the claims made can be read in almost any book on Reiki, esoteric philosophy or metaphysics (admittedly they do acknowledge this, albeit fleetingly). The concern is that their respondents probably learned the replies that they provided from the literature of this nature. If that is the case, then Warber et al. (2004) have merely produced a summary of biotherapy healers' beliefs for academics who might not otherwise access the contemporary literature.

Warber et al. (2004) acknowledge that their research is based solely on the healers' perceptions, and suggest that therefore the perceptions of clients would also be advantageous. This argument is also put forward by commentators Mitchell (2000) and Aldridge (2004 p.13), but the problem arises concerning client perceptions, which will be directly influenced by the HoH modality experienced. To argue that the client perceptions should be observed assumes that all HoH modalities are the same. This is particularly true in research like that of Warber et al. (2004), which was based on several different HoH therapies, meaning that enquiring about the clients' perceptions would be problematic.

An illustration can be shown between Therapeutic Touch and Reiki. Therapeutic Touch is primarily used in nursing (Sayre-Adams, 1993), meaning that 'the client' might have no perception that Healing has taken place, as it is simply offered to them in the hospital environment. Reiki is more client-involved, and as such the client may have made numerous decisions before choosing to experience it. Suggesting there is no reason to assume that the perceptions of the client will be the same in the case of different Healing modalities.

A recent research paper that did look at the perceptions of healers and clients was published by Vaghela, Robinson, Gore, Peace & Lorenc (2007). This paper is of particular interest because it details a pragmatic trial with the Healing Trust members as practitioners in four of their healing centres. Vaghela et al. (2007) claim the aim of their research was to explore the use of Healing in persons with cancer during the Healing Trust routine, with emphasis on the impact of Healing on well-being. They also set out to provide a general assessment of the research tools utilised and the research process.

In brief, Vaghela et al. (2007) utilised a multi-method observational design incorporating qualitative and quantitative analysis. For the quantitative observation, available standardised questionnaires were administered. Participants also completed a Physical, Emotional, Mental and Spiritual evaluation form after each Healing session. For the qualitative element, participants were interviewed about their wider concerns about their health and Healing issues. Focus groups were held at the end of the study at each healing centre, one with the healers and one with the cancer patients.

The population sample was small, with only fifteen participants completing the six Healing sessions. The multi-method design did enable in-depth accounts of participants, and Vaghela

et al. (2007) were able to conclude that the attitudes towards Healing were positive, noting improvements in perception of concerns, well-being and anxiety/depression. This research was not designed to test Healing for effectiveness, and little attention was paid to that, although particular results from participants regarding their aetiology were mentioned. Persons afflicted with a disease tend to want treatment, or at the very least an alleviation of symptoms. If anxiety and depression are to be considered symptoms of cancer then this research can marginally claim to demonstrate that Healing has value, although Vaghela et al. (2007) did acknowledge possible bias from participants in recording these results.

Well-being is a 'soft target' for Healing research due to its subjective means of measurement, and yet Healing should be able to demonstrate more substantial results. However, another paper, also published in 2007, looked at well-being and cancer through Healing from an exploratory perspective (Pohl, Seemann, Zojer, Ochsner, Luhan, Schemper & Ludwin, 2007). Their design was originally an exploratory RCT, with one genuine healer and one sham healer, and the genuine healer withdrew from the research shortly after it commenced. Pohl et al. (2007) continued with only the sham healer, and yet were still able to conclude that Healing was able to provide a significant improvement in well-being and depression symptoms in persons with cancer. Pohl et al. (2007) take HoH at face value, and declare that their results demonstrate that HoH is effective in well-being measurements whether a Healer is used or not.

The use of a sham healer was to provide a placebo-response within the recipient. Therefore, Pohl et al.'s (2007) research only serves to illustrate the problem facing critics and supporters of Healing: that of inconclusiveness. It can be argued, by either party, that the results demonstrate the effectiveness of self-healing, the placebo-effect or even those participants simply welcomed the attention they received (Jonas, 2001). Although the methodology conforms to EBP, well-being is not normally associated with aetiology of disease. Healing is generally understood to aid well-being (Aldridge, 1993), so the need to substantiate it is questionable, and the HoL (2000 para 4.18) have recommended that well-being studies do not need to utilise strict research designs.

The Healing Trust audit

Evidence of well-being is claimed in an audit produced from hospital patients who received Healing (Edwards, 2008), and is reproduced on the Healing Trust website (The Healing Trust, 2011). The audit reports the results of seventy-five patients who completed a questionnaire at a Midlands hospital. It enquires about their experiences before and after receiving Healing at the hospital. Patients were also asked to return a further questionnaire one week later; thirty-two patients responded, reporting general aspects of well-being such as sleep patterns, relaxation and energy levels, and favourably compared them against the 'before' questionnaire.

The audit did not enquire directly about the patients' illnesses, but did allow for additional comments to be provided, which were reproduced in the audit. Perceived improvements in symptoms were reported by respondents here. However, the audit was conducted independently of the hospital, and was limited in only reporting experiences of those patients who were willing to receive Healing and return the questionnaire. Edwards (personal communication) acknowledged that the audit did not claim to be a strict scientific enquiry, yet it was sufficient to assist in securing a £205,000 Lottery grant to research Healing (The Healing Trust, 2011).

In its truest sense, this audit was as much a report on the healer as much as it was on Healing. As to be discussed later, this a problem for Healing research, as there is no recognised means to determine the healing-presence that the healer has on the recipient. Some healers may not have a developed Healing-presence, and some maybe extraordinary, yet research designs have neglected to factor for this.

In Healing, well-being tends to be a claim healthy persons make for experiencing it. Providing Healing to persons who are not ill may be a good means for testing well-being, but through disease the concept becomes more complicated (Jonas, 2001). There is the challenge of defining well-being amongst persons with differing stages of illness. Vaghela et al.'s (2007) paper is disease-centred, but does not research disease; yet a study of well-being does not need to be based around a single pathology. Healers and Healing are not disease-focused, so to research Healing with an emphasis on a particular disease does not translate into a better research design when looking at well-being. An undifferentiated group could illustrate how

well-being is affected for different illnesses, which Brown (1995) demonstrated in his paper by recruiting patients with a multitude of different chronic conditions for his research. The important shared element was that they did not respond to recognised treatments, not that they shared the same complaint.

Vaghela et al. (2007) also claim that their research is "a real life practice for Healing", yet they restricted the research period to six weeks. This appears to be limiting, as persons in these particular situations may go to a healer for many months, and so a set session allocation is less than pragmatic (this is acknowledged in the paper). Brown (1995) also acknowledges this in his research, and utilised a period of fourteen months, which, he suggests, could have been longer.

Discussion

If Healing is to achieve any role in modern healthcare that is recognised by healthcare professionals and not just the public that use it, there needs to be more development in how to conduct research. Abbot's (2000) review of Healing research focuses on clinical trials for specified conditions, and he claims that "no firm conclusions about the efficacy or inefficacy of Healing can be made from the evidence contained in the RCTs currently accessible from the scientific literature" (Abbot, 2000). He expresses difficulty in assessing the accuracy of research findings, due to quality concerns. Sutherland et al. (2004) suggest this is down to different interpretations and descriptors, which need addressing with a common language understood by all concerned. A problem addressed by Jonas & Chez (2004), who have providing definitions of terminology and Healing research practices. They provide an overview of standards for research protocols to help better coordinate future research.

Talking the same language is a start in coordinating research and taking it in a meaningful direction. As Healing slowly moves away from marginalisation within health research, there needs to be a consensus about what Healing can actually achieve and where it can achieve it. Particular symptoms, such as pain, offer an obvious direction, because this is a chronic condition many respondents reported receiving clients for. A better understanding of Healing, beyond descriptions, is required.

Chapter 5

Methodology

Practitioner-based enquires are established within epistemological perspectives that are derived from complex and controversial philosophies (Murray & Lawrence, 2000 p.18). The discussion presented in the previous chapters has revealed that Healing is no exception in terms of complexity or controversy. Much of the contention regarding Healing and EBP is rooted in both behavioural and social sciences, as they share a reciprocating relationship through philosophy (Murray et al., 2000 p.22).

The thesis is grounded in behavioural science, as its enquiry is motivated to enquire into the perceptions of people and their personal behaviour, as opposed to political structures and organisations. The methodology chapter will detail how personal perceptions and behaviours of healers have been learned, and inform the reader that appropriate methods of enquiry have been used. The author's role and reflexivity will be discussed to provide transparency.

Ethnographic-constructionist approach

Research has been approached from an ethnographic-constructionist stance. Not in the traditional ethnographic sense, where the researcher is 'imbedded' within a culture and immersed in the population's lifestyle (Jones, 2010 p.17); rather, influence has been drawn from Silverman's (2000 p.31) depiction, where ethnography is the study and description of human groups or cultures. Research of this nature attempts to show how these groups create everyday social communication from which conceptualised descriptions of these cultures are then produced to explain the researcher's observations.

Hammersley (1992 p.15) states that the purpose of ethnographic observations is to create concepts or models allowing the audience of the research to see events in new ways – not in the conventional scientific sense of prediction and control but as a means of better understanding the persons or culture observed. An approach to ethnography in this form is deemed beneficial as it is the personal perceptions of healers that guide the enquiry to understand how they comprehend their interactions with the recipient.

Although there is a substantial amount of research published about Healing in general (Brown, 1995; Benor, 2000, 2004) there is little research published regarding the actual understanding of healers and yet their understanding may have a significant influence on evaluating outcomes (Brown, 2000). Healing is understood to be influenced by the focused-intention of its practitioners, and so it is the values and preoccupations of respondents that provoke interest. With the foci for the thesis is reliant upon the perceptions of respondents, there is little in the sense of community to be immersed in. There are also no social activities to observe or interact with, as the procedure used in Healing by the respondents is straightforward and mostly routine (Appendix B).

Constructionists observe what their respondents' see as reality, what they assume is real and how they create that assumption. Knowledge is situated in particular positions, perspectives and experiences, according to Charmaz (2006 p.127), from which the researcher pieces together a picture of the respondents' world through an abstract interpretation of their responses. An attractive approach when researching healers, as it is assumed that healers' 'realities' regarding Healing are built up over time from their learned experiences. These individual experiences are collated to create an overall picture.

From an ethnographic-constructionist stance of observing culture, a generalised account of the perspectives and practices of respondents is provided. Respondents' accounts are obtained through the use of interviews, which are treated as conversations focused on the issues that were raised in the interview schedule. Respondents' responses are treated as constructed narratives from which theoretical descriptions can be derived. The value of these theories is to add to the knowledge of the audience, not simply to give an explanation of their actions, through providing a better understanding of the perplexing issues of the respondents' philosophy underpinning those actions.

Research enquiries of this nature rely heavily on the perceptions of the researcher to provide a relevant representation of respondents' reality (Silverman, 2011 p.359). The etic and the emic have a strong relationship here which bears influence on how the researcher's understanding is portrayed from the respondents' vernacular. Therefore, representation will come from a perspective (Hammersley, 1992, pp.51-52) that possibly emphasises some relevancies to the detriment of others.

This influences how valid research findings can claim to be. Validity is claimed if "an account represents accurately those features of the phenomena that it is intended to describe, explain or theorise" (Hammersly, 1992 p.69). With socially constructed realities, validation is through verifying the interpretations of respondents. For Grounded Theory, this is part of the research process and not the end result (Kvale, 2002 p.309). However, Denzin & Lincoln (2000 pp.17-22) argue that validity is not important in interpretive paradigms, and that accurate representation should be presented through trustworthiness, credibility, transferability and confirmability. They claim that the qualitative researcher creates a lived experience within their social text. The researcher's creation is not devoid of the researcher's imprint, and therefore causes representation issues.

Charmaz (2000 pp.523-523), in discussing this, claims that the use of Grounded Theory in ethnographic research is to 'look at slices of life' at that particular moment, and not the entire community. A reality is claimed to be interpreted from the researcher's experience and that of the participants'. Therefore, it is not the participants' reality represented, it is a shared reality which is reliant upon how social science constructs those realities.

Silverman (2011 p.369) argues that validity is always appropriate, whichever theoretical orientation a researcher uses. To produce relevant research that represents and can be generalised to the wider healer population would suggest some means of accounting for the findings reported. The theory to be presented is the conclusion of the findings which has been created through interpretations of the data recorded. Research still has to be sufficiently authentic (Lincoln & Guba, 2003 p.274), so, in using Denzin & Lincoln's (2000 pp.17-22) criteria for representation, a reflexive process becomes important to explain how the researcher understands, interprets and conceptualises data received from their respondents. Part of conducting Grounded Theory analysis is to perform memo writing (Chamaz, 2006 p.72), which helps the researcher engage with the raw data. Its use is in providing a procedure for collecting thoughts, comparisons and connections to help pursue the direction of research. This is by its nature and in its performance a reflexive process.

Reflexivity & Ethics

Ethical approval for the thesis was granted by the University of Derby Psychology ethics committee. Careful consideration was given to comprehending the motivation influencing the

thesis in regards to how and what impact may occur on respondents by divulging their statements, and how these should be presented. Hammersley & Atkinson (1995 p.263) argue that, ethically, ethnography should be the production of knowledge and not the improvement of professional practice or political goals, as the ethnographer should be looking for truthful accounts of the researched phenomena. Yet this cannot be decided by absolute rules (Hammersley et al., 1995 p.285), so researchers should in their pursuit of knowledge act in ways that are ethically sensitive and acceptable to the research in question.

An emphasis on reflexivity is placed here, as Healing research could be seen as politically motivated, and there is certainly a mass of opinionated commentary debating this. The central political argument is whether to accept the scientific validation of metaphysical therapies such as Healing, and commentators are usually drawn to one side of the debate or the other. Hammersley et al. (1995 p.20) describe this as the researcher defending a status quo or challenging it.

The thesis is intended to be a challenge to the status quo, as it examines the perceptions of the healers and is not drawn on the debates of demonstrating Healing effectiveness. So, although the author advocates Healing, the thesis is not strictly politically orientated, as belief in Healing centres on individual aspirations, not communal expectancies. Assumptions are made that respondents believe in the effectuality of their own healing-presence, and so, based on a constructionist stance, 'truth' is accepted as being within the perceptions of the individual.

Hammersley (1992 p.136) claims that ethnographic research is only relevant to practice if it has value to the particular needs of the group it is studying, suggesting that those needs are best served by researchers who specialise in the subject studied, and not necessarily in research per se. Hammersley (1992 p.138) explains that practitioner-research has a stronger claim to validity as it tends to be direct and specific, as opposed to indirect and general. The research method has been influenced by practitioner-researcher ethnography, as Robson (1993 p.447) and Hammersley (1992 p.145) suggest that practitioners of a particular vocation have a better situational awareness or insider-knowledge of the phenomena being studied than persons not of that vocation. They will have experience in the setting being investigated and already have relationships with persons in that setting.

Trained in the practice of Healing, but not a registered practitioner, my epistemological position is that Healing in the correct circumstances can be an effective therapy. This is a stance that has been developed from the author's own experiences of performing Healing on friends and family, from which positive results have been reported but are elusive in their explanation. Macpherson (2008 p.12) labels this the 'both-sider' approach, as it presents challenges to subjective reasoning. Therefore, there is no claim to be autonomous from the research issues of Healing.

The practitioner-researcher approach is not without its difficulties, and Hammersley (1992 p.144) shares several concerns, suggesting that research by these means has to still be guarded from the ill intentions, hidden agendas or politicisation of research designed to prove a view and not examine it. There are also issues regarding how the knowledge held by the practitioner has been obtained, and whether it is suitable for the research arena that s/he has ventured into. Also, the researcher's working relationships may constrain the enquiry, as the influence of their vocation may prevent access to certain information.

A contemporary example is reported by Solfvin, Leskowitz & Benor (2005), who looked at research published by Daniel Wirth on the effectiveness of Healing and complain of a lack of academic integrity. Ernst (2006) writes that Wirth has authored more research articles than any other researcher on Healing, but Solfvin et al. (2005) and Ernst (2006) agree that there are difficulties establishing Wirth's credibility from the lack of information provided about his authored research; this is also indicated by his unwillingness to engage in correspondence to discuss these matters, suggesting that his research lacks scientific validity.

However, the difficulty in producing a research design that tests the effectiveness of Healing remains an issue for practitioners and non-practitioners alike. A significant difficulty for non-practitioners researching Healing is in understanding the connection between a healer's actions and the outcome experienced by the healee. This thesis will help address that issue by enquiring about the healers' perspectives and how they influence their Healing performance.

So, for this thesis, practitioner-researcher knowledge is claimed to be an advantage, as it is the knowledge of what is not known that encourages the enquiry. A greater awareness of what to observe and how to observe it presents a more appropriate approach. Healing has a practitioner base that varies from part-time enthusiast to full-time professional, yet the act of

Healing remains relatively the same regardless of achievement. The practitioner's philosophy, however, evolves and changes through continued practice and development. Therefore, a more open attempt at enquiry is utilised as opposed to a polarised one.

As an enthusiast, the author has a situational awareness of practice to a degree that would surpass that of an outside observer. The enquiry is based on the philosophical development, structured around the 'practice' of Healing, of which there is limited knowledge. The limitation from the healers' perspective is proposed to have come from the lack of literature written concerning healers.

Although the thesis is written through an 'intellectual gaze', there is no claim to be independent from feelings and actions. It is these feelings and actions that provoke intellectual enquiry. From here a distinction can be drawn between personal experience and the enquiry proper, as the thesis outlined researches how 'practicing healers' perceive, and to some extent evaluate, Healing effectiveness. It involves conveying their experiences, and, although the author confesses to believing that Healing is effective, this in itself does not warrant a significant claim for bias: first, as this is not an experiment and so effectiveness is not being tested; and second, it is presumed that the respondents' believe that Healing actually works and that they have had successes performing it, or else there would be little motivation to be a healer. Respondents are not expected to be effective with their therapy, as the enquiry is aimed at merely discussing how respondents 'perceive' their effectiveness.

When does the knowledge of the researcher impede the phenomenon being studied? No working relationship outside of the research with the respondents or the Healing Trust was maintained. A reflective diary was kept throughout the research process and was instrumental in developing the interview schedule. As the interview schedule was the core means for data enquiry, the reflective account became the critical means of checks and balances.

The issue of biased reporting is raised here, according to Hammersley et al. (1995 p.160), by influencing authors when they attempt to predict who their audience is and tailor their statements for the agreement of that audience. The target audience for this research has a broad academic and demographical range, which makes it difficult to present data the audience expect to read. It is aimed at audiences wanting to better understand healers,

because Healing has been, until recently, a social world that has remained a relatively isolated community, not involved with the scientific community in any great detail.

The research enquiry is direct in examining Healing and does not make claim to prove anything. It is assumed that respondents perceive Healing as effective, and no attempt is made to challenge this. As Healing modalities are simple in their procedure, and practitioners do not purport to diagnose, researchers need to be more appreciative in their understanding of Healing and look beyond the obvious. It is acknowledged that claims of 'knowing' about Healing need to be made with caution by all researchers, as this implies they will know what to include and what to exclude: a dangerous assumption, as the more a research agenda is polarised the greater the chance of limiting its achievements.

However, it has been noticed throughout the research process, and in the respondents, that there is a limit to what is deemed believable or acceptable. It is recognised that, although the interview schedule has been designed from literature sources, the process has been influenced by personal experience. No setting can be completely homogeneous (Hammersley et al., 1995 p.50), so even though the Healing Trust has been used to create a member-categorised population, sample difficulties still arose. As Levin (2011) claims, healers do not have identify themselves as healers, as, it is argued, Healing is a natural ability of everyone. So, membership to the Healing Trust provides social inclusion, but, as will be discussed, did not expand into a shared philosophical understanding. Therefore, the possibility of deviant cases within the population sample showed to be significant.

Biased reporting of data reflects on data-gathering. Lincoln et al. (2003 p.278) claim that all voices should appear within a text in order to promote fairness and prevent marginalisation. Yet the tenth interviewee, who has been given the pseudonym Kate, was omitted from the research findings due to inappropriate responses elicited during her interview.

The first hindrance was the request for remuneration for time taken during the interview. No respondent was offered financial reward. So, after issues of ethicality were explained, an interview was performed; however, personal claims were made that suggested an unbalanced relationship with practicing Healing. In one particular statement, Kate claimed she was the fifth best Reiki practitioner in the world. Claims of this nature are inappropriate, as healers tend to be modest about Healing due to issues of ego. There is also no acknowledged means

for calculating such a claim or, in reality, the need to do so, which brought suspicion about Kate's motivations or understanding.

Kate also claimed to be a spiritualist-medium of international recognition. Although claims of this nature are made by many mediums in the UK as a means to elevate their professional status, Kate used this is a pretext for not answering some questions on the basis that her replies could damage her reputation. Kate reluctantly allowed the interview to be recorded after assurances that all responses are anonymous, but such a precaution was not deemed sufficient for some of her replies. As such, concerns about protecting her 'important status' as a known spiritualist medium were put forward to explain her unwillingness to reply to some questions.

The general location and quality of the dwelling inhabited by Kate did not suggest that any claims of success had had a positive financial impact on her life. It is understood that Healing in general does not have a significant financial impact on people's lives, but claims made about her success from her other practices did not tally with her situation. As with the examples provided above and other statements made during the interview, it was considered unacceptable to allow some of Kate's responses and reject others, and on that basis her entire interview has been omitted.

Burns (2000 p.421) writes that deviant cases should be presented to the audience even if they cannot be represented in the analysis, and the existence of deviant cases does not necessarily undermine the theory presented or those that cannot be incorporated into it. Fortunately, there had been nine previous interviews from which themes had already emerged. As the last respondent planned to be interviewed, Kate demonstrated concerns similar to previous respondents. Unlike other respondents, Kate presented considerable resistance towards conveying truthful insight into her Healing practices, and so, although many of her statements were not conducive to demonstrating a grounded relationship with Healing, her motivations for withholding particular information can be understood within the context of the research.

Through the use of constant comparison as part of the reflexive process it is easier to gain notions of what not to expect more than notions of what to expect. An example is respondent discussions on spirit-guides, as the perceptions of other respondents (discussed in chapter eight) present the spiritualist view that it is concealed from the healee. Kate claimed to be a

practicing spiritualist medium, so it was reasonable to expect that her views would lean towards the spiritualist perception of Healing, as described in chapter two. As will be discussed in chapter eight, spiritualism is not openly accepted throughout society, and so guarded opinions are maintained. Theories of energy transference are also not completely accepted or rejected, but they are far more openly discussed, which is more in line with the Healing Trust's approach to explaining Healing. There are now numerous Healing modalities competing for the public's attention, so prudent commentary leans towards more excepted ideas.

Explanations of subtle-energy transference from Kate were expected, as all but one respondent discussed Healing in those terms. However, Kate demonstrated a resistance to discussing the spiritualist perception, which placed her at odds with her claimed professional status. Spiritualism was acknowledged by all respondents, and the respondents with spiritualist perceptions were more forthright in describing their beliefs and demonstrated a far better, more balanced understanding.

Kate claimed to have a professional relationship with the Healing Trust, a claim which was substantiated on the Charity Commission's website. As a non-denominational organisation, spiritualist opinions are not invited to be discussed. There were however, other respondents who held spiritualist views, and other respondents who also held professional relationships with the Healing Trust who were more open in their discussion.

A difference between the emic and the etic becomes apparent here, as Kate maintained views that could be argued to be more politically motivated than forthright, challenging the validity of the research. Misrepresentation by respondents is a concern for all qualitative research (Burns, 2000 p.419; Murray et al., 2000 p.20), which is usually addressed in ethnography by incorporating multiple methods of data collection. That would be challenging for research based around perceptions and not actions, as data are derived purely from the respondents' recollections. For a compensator, respondents were sourced from different geographical areas and a diverse range of Healing practices.

Interview schedule

The interview schedule was initially developed from a need for enquiries suggested by previous research and literature; this was performed to purposely avoid creating questions based solely on personal experience. The use of Grounded Theory as the analysis method was an attempt to help prevent bias, as, although there is a substantial amount of literature regarding the purported process of Healing, it is too convenient to allow this literature to constrain the research process into finding expected conclusions. Therefore, the author is not claiming to be a passive observer of Healing and the epistemological assumptions are not indifferent to the literature that has been evaluated. Healing does not have a technical language (Aldridge, 2004 p.6), nor any uniformly recognised mechanism, so ideas, beliefs and language can vary greatly, giving researchers a need to show caution in interpretation.

Respondents were interviewed face-to-face, and data were gathered from semi-structured interviews (Appendix C), which had been deemed the most suitable method possible for obtaining in-depth answers to complex questions. To aid the reflective process, a more worldly view of Healing was used to avoid the author's preconceptions. Respondents were asked a set of open-ended questions, initially influenced from various literature sources (Aldridge, 2003 p.225; Benor, 2001 p.83; Brown, 2000; Ernst, 2006; Mitchell, 2000), from which those areas lacking understanding in the practice of Healing were identified. The interview schedule acted as a research 'net' from which respondents' perceptions were 'caught' through answering a range of questions. By allowing for the different aspects of Healing to be discussed, respondents' understanding could be substantiated through a constant comparison of their replies alongside consistency evaluation. The interview schedule was then expanded and revised to incorporate respondents' responses in areas of importance identified by them.

Population sample

Purposive sampling has been used, with participation criteria applied to the representativeness of candidates to Healing practices. The charity, the Healing Trust, was selected as a means to locate candidates for this thesis. The use of a healing organisation to find respondents is particularly beneficial due to the difficulty in establishing authenticity among healers. As there is no mandatory registry in the UK for healers that can assure professional accreditation, standards and practices may vary or be difficult to ascertain.

Criteria included full membership of the Healing Trust and to have completed three years minimum Healing practice beyond their probation period as either a paid practitioner or as a volunteer in a clinic. Respondents had to also be currently practicing Healing on members of the public. How active respondents were in providing Healing was not considered a valid prerequisite, as no data could be sourced to indicate how often an average healer worked over a given time span.

One respondent did, however, acknowledge that she had not undergone a training programme when she joined the Healing Trust. All that had been required for her to do at the time was to perform a demonstration of HoH to an appointed Healing Trust examiner. Her membership had extended to twenty years of service, and during that time the Healing Trust had not asked for her to receive training, so it was considered that her Healing experience was sufficient to accept her responses. Although this was by accident and not design, it proved to be beneficial, as will be explained throughout the thesis.

There were no criteria placed on age, sex, race or religion, although individuals have to be eighteen to join the Healing Trust, which suggests that the youngest a respondent could possibly be was twenty-three. All respondents were English Caucasian and lived in the Midlands in the UK. Eleven interviews were conducted, with one interview omitted. From the ten interviews admitted there were six women and four men, with an average age of sixty-eight (Appendix D).

Other than acknowledging that the average member was aged forty and above, the charity was not able to provide demographical information about its members (Edwards, personal communication). This was unfortunate, as the Healing Trust is a charity dedicated to its members and not run to help persons with needs outside of the organisation, other than providing Healing. It is not unreasonable to expect that an organisation might know something about the people it claims to be supporting, particularly since they are fee-paying members.

The organisation's recent move in location, and hints from some respondents that the trust's administration is not particularly well organised or modernised, were suggested as reasons for this lack of accountability. However, individuals within the charity were more accommodating, in particular those who provided Healing to the public or ran Healing

centres. Overall, the respondents were found to be helpful and approachable, and were keen to share information once it was established that I was a genuine researcher – the only exception being the omitted respondent.

Respondent selection

The first respondents were selected from the regional membership directory published in the *Healing Today* magazine. The directory contains the contact details of members who are responsible for running local training courses and administering regional affairs. It had been assumed that individuals listed in the directory had been members for longer than the minimum three-year criterion. As it is not a realistic expectation for a novice healer to become the secretary of a region, nor would s/he have the experience needed to provide training courses. This assumption proved to be correct, with the average length of membership of the Healing Trust in the population sample equalling thirteen years.

Additional respondents were sourced through 'snowballing', which is the process of getting the first respondent to nominate another candidate for research (Denscombe, 2007 p.18). This was performed until data saturation had occurred, in conjunction with the analysis method. Snowballing has the advantage of being successful in locating disseminated populations (Knight, 2002 p.122), and, although slow to organise, its use can yield a more unified response with respondents concerning the issue of effectiveness. The drawback is that its results can be too homogenised, as respondents might only recommend persons who share their understanding (Ritchie, Lewis & Elam, 2003 p.94). This had not shown to be the case, however, as respondents demonstrated a wide and divergent area of belief and understanding.

All respondents were listed on the Healing Trust's healer directory, which is accessible from the Healing Trust website (The Healing Trust, 2009). The directory provides members of the public with a means of finding a healer within a geographical area. It works by allowing members of the public to enter the first section of their post code, and then a list of the closest healers in that region is provided along with their contact details. The directory does not identify how a healer practices, either as a private practitioner or through a healing centre, nor does it distinguish between healers who charge a fee and healers who do not. Ensuring that all candidates for participation were listed in the directory supported a stronger claim that the population sample was representative of real-life scenarios. It was considered important to

locate ‘bread and butter’ healers who practice amongst ordinary persons, as this is where and how it is believed the majority of people experience Healing.

It is recognised that there are also spiritualist churches throughout the country that also provide Healing to the public. Their philosophy has an obvious bias towards their religion, and as such many of the people seeking Healing within a spiritualist church possibly do too. Therefore, those providing or seeking Healing through the Healing Trust can be identified as a different population to those providing or seeking Healing through a spiritualist church. Non-membership in a spiritualist church did not exclude participation in Healing, but in hindsight it could be argued that the Healing Trust offers an alternative to spiritualist values. Spiritualism was a question put to all respondents due its influence upon society regarding Healing matters, and these findings are discussed within the thesis.

Respondent anonymity

Respondents’ names have been replaced with pseudonyms. For simplicity’s sake, respondents have been given names in alphabetical order. Due to the nature of the Healing Trust’s organisation and the regional proximity of some respondents, it was believed that any reference to a respondent’s real name might allow another member of the trust to identify them if they were to access this thesis.

Grounded Theory analysis

A qualitative analysis was performed with the use of Grounded Theory (GT), as described by Glaser (1992). Glaser claims that the goal of GT is not to provide a description or verification, but rather to produce a theory that will account for the observed behaviour relevant to those who are being observed (Glaser, 1992 p.75). As with Hammersly’s (1992 p.145) argument that practitioner-research has a greater scope for relevance, Glaser claims that GT allows the researched population of interest to be discovered from their own perspective (Glaser, 1992 p.5). It requires the researcher to be immersed in the field of enquiry best suited to practitioner-research, which is usually more direct and specific than indirect and general (Hammersly, 1992 p.138).

For this thesis, the results are provided to promote a generalised theory from which to aid the direction of future debate, rather than theorise in the traditional scientific sense of

understanding and predicting. As a pilot study, the population sample was not large enough to substantiate a 'grand theory' or defining body of knowledge. It was, instead, better suited to providing a mid-range theory to provide understanding in areas where knowledge is missing.

The criticisms aimed at qualitative research revolve around the issues of how to focus observation and how to collect data systematically, and GT was developed with these criticisms in mind (Glaser & Strauss, 1967 p.vii). The use of GT provides the advantage of focusing the process of 'how' to conduct research, and supplies a methodological means for compiling its results in a meaningful way, according to Charmaz (2006 p.23). This suggests that GT allows objectivity in analysis, as it stops the researcher from taking the participant's point of view. It also helps the researcher find direction, avoiding unnecessary ventures in the field and collecting superficial random data.

The process of GT produces theory built around a core category derived from the coding process. Coding is the process of identifying and labelling data and comprises three stages. First, these codes are used to categorise data within the transcript. Then, through the coding process, data are reduced as initial categories are amalgamated to create more conceptual categories. Finally, this process helps define what is happening in the data, and provides a better grasp of what the data mean (Charmaz, 2006 p.46).

GT has been developed and refined since its conception. These developments have led to differing opinions between Glaser and Strauss as to what constitutes genuine GT, and the method by which GT is utilised has a decisive impact on how the data are analysed (Strauss & Corbin, 1994 p.277). Glaser's approach is less formulaic and easier to achieve without having to follow complicated rules that can stifle productivity (Charmaz, 2006 p.180), and this method has been followed.

Interviews have been transcribed using NVivo 8 © software. This software has been useful in organising transcribed text into different codes. Using NVivo 8 © has been deemed quicker and easier than coding by a traditional means of cutting transcripts into sections and regrouping them by codes.

The initial coding process, known as open coding, is the dissection and labelling of a transcript into its component parts (Charmaz, 2006 p.46). Open codes are the individual

pieces of data provided by respondents, and for this thesis an individual datum is a specific statement. Open codes look to define the actions identified by the researcher within the transcript through explaining their meaning and significance, as GT is suited to understanding the process of a phenomenon, not the setting it is located in (Glaser, 1992 p.13). These definitions are conceptual, with the emphasis on understanding what the data are suggesting and from whose perspective.

The second coding process is axial coding. Axial codes are the observations of the researcher through grouping open codes together and transforming them into categories. Categories identify the relationships between open codes based around their content or meaning. There is a more focused look at the meaning of the data in this thesis derived from converging data through the means of constant comparison between different interviews. Abstract ideas obtained from categories will be used to create themes which should represent the issues or concerns of participants.

Stages one and two are performed simultaneously. Data received from continuing the interview process are added until the point of saturation. This is when there is no further need to acquire more data on a particular subject providing the same information. The third coding stage is selective coding. This is the process of creating themes from the categories created during axial coding. Selective coding explains the relationships between these themes. The third stage has the aim of verifying the themes discovered in stage two.

Coding reached saturation within ten respondents. Although every respondent reported something different in their interview, there was enough convergence within their replies to integrate a theory from the data. Themes produced from the participants' replies were examined against published journal articles relating to CAM research and Healing, much of which has been presented in the previous chapters.

Conflicting interests

The author has no working relationship with the respondents or participatory bodies that might produce a conflict of interest or limit results. No financial assistance or rewards were provided to respondents or the Healing Trust, nor were any received for the research. The author has undergone the Healing Trust training program to better understand the working process deployed by respondents, but is not a member of the Healing Trust.

Chapter 6

Theory overview

This brief chapter will introduce the theory to be discussed. An explanation is presented as to how the theory relates to the respondents, and the following chapters will go into greater detail in exploring the circumstances influencing respondents' Healing perceptions. Healing has qualities that not effable, yet respondents were able to present a broad range of understanding towards the actionalisation of Healing.

The Healing Trust's procedure is the most commonly accepted element within their practice. From there, respondents differed in their interpretation of this practice, which makes it difficult to establish an overall theory that can easily generalise about perceptions of effectiveness. This means that, although not exclusive to the presented theory, a perception of Healing effectiveness can be defined through the following statement:

Effectiveness is perceived as enacting a 'change' within the healee that is acknowledged by the healer/healee dyad as a therapeutic outcome.

In brief, the measure of effectiveness becomes a perception situated between the desired therapeutic intent and the therapeutic outcome. Such a measure cannot be claimed to be unique to Healing, as all therapeutic interventions provide some causal relation between intent and outcome. However, unlike practitioners of more conventional therapies, respondents suggested that there may be underlying reasons for illness that have no recognised aetiology to specific health complaints. The recipient's complaint maybe a recognised disease in biomedicine, but within the philosophy presented by some respondents it is explained as merely a symptom of illness and not the focus of the therapeutic intent. Therefore, the alleviation of specific health complaints is not necessarily the therapeutic intent of Healing.

Respondents claimed that the expectancy of the recipient was managed or negotiated into realistic outcomes. Effectiveness is a self-assessment by the recipient which is not constrained by expectancy measures. Recipients acknowledge beneficial changes within

themselves that provide the impetus for achieving parity with their health concerns. Meaning that, Healing aids the recipient towards a more balanced outlook of their health complaint. As effective Healing does not have fixed goalposts, it is concerned with leading the recipient towards self-healing. Aimed towards the positive aspects of life, Healing is independent of isms, ologies and prognoses.

Respondents are aware of there being an influenceable process that is enacted by the healer but engaged with the recipient. As previously mentioned, this process is usually accounted for through descriptions of subtle-energy by practitioners which academia challenge. Whatever dynamism powers this process, it is believed by respondents to actually exist, and that Healing is not simply the result of placebo-effect.

The theory suggested is influenced by three distinct themes inferred from the coding process, which demonstrates that there are underlying principles shared by respondents. The themes describe how respondents, as healers, perform a focused intention during their healing performance. Healers are not attached to specific outcomes, and therefore do not attempt to direct Healing to a particular outcome. As a consequence, healers do not find value in diverging from performing Healing (their focused intention) to comprehending what Healing is achieving or how Healing is achieving it. The psychosocial aspects of Healing in relation to the preferred Healing environ of the healer are equally not considered to be significant determinants in producing effective outcomes. Healers, and possibly their clients, have preferred environs in which to experience Healing, yet the differing environs discussed by respondents suggests this has minimal influence on Healing effectiveness. Healing environs have shown to involve personal preferences in experiencing Healing, and not the technical aspects of performing Healing.

Healing is described within this thesis as a three-stage performance. First, a procedure is performed by the healer on the healee. Second, there is a process that happens between the healer and the healee during that procedure. Third, there is a mechanism which creates the therapeutic effect within the healee as a consequence of the process of receiving Healing.

First theme of Healing

The first theme derived from the data may seem a peculiar statement. But, as will be explained, respondents understand their role in the healing performance, which has a direct influence in how they interact with it. The first theme concerns how respondents relate to the process stage of Healing. The first theme is: the belief of respondents in the process of Healing as being more important than what the Healing process actually achieves. It suggests that, although respondents are engaged with Healing, they are not directing the Healing effort. There is no specific outcome understood from or associated with the process of Healing. Therefore, respondents, through performing the procedure, are in a sense inviting the process to initiate a therapeutic effect. In essence, respondents are convinced that there is a 'source' that is guided through its own intelligence to aid the recipient towards better health.

Respondents could not provide a conclusive theory or explanation as to how the process of Healing creates a therapeutic effect. Rather, they discussed the recipient as 'changing', and said that this change within the recipient is the desired achievement, which did not have to be specifically correlated to the recipient's complaint. Change involves the recipient becoming different from how they were before receiving Healing. This is in contrast to biomedicine, which attempts to return the patient to their former state of health and is indifferent to the recipient's desired outcome(s), which is usually pragmatic and revolves around the alleviation of a specific complaint. The outcome of Healing is more complicated, and can be summarised as progressing the recipient towards being better than how they were before receiving Healing. Healing has a non-specific effect, or possibly an unknown specific effect, on the recipient, so their personal perception is seen as important in determining the experienced change and the value given to it.

The change enacted by the process is independent of the consciousness of both the healer and recipient. This is a difficult aspect for 'outsiders' to Healing to comprehend. The healer performs the procedure, the procedure enacts the process and the process enacts the mechanism. The recipient's complaint or their expectancy has no direct correlation to these performances.

Because respondents help facilitate a change, they are not focused on effectiveness from a biomedical stance. The process, which is an elusive 'black-box' of Healing, is a much discussed and misunderstood element of the action of Healing by observers (Sutherland et al., 2004). Respondents recognise that the process is not under their control or direction, and so do not attribute success to their healing performance.

A claim often made of Healing practices is that healers are not attached to specific outcomes. On a superficial level this would appear true. However, respondents did have a specific outcome, but it was different to the recipient's, or to how EBP would interpret an outcome. Respondents asked for 'the highest good', which is a specific outcome but not specific in result. The highest good is accepting what the 'source of Healing' determines the recipient's needs. It is a specific outcome bringing the recipient in the direction they need to go. In that respect everyone is given the same (the highest good), but they do not receive the same (observable outcome).

Second theme of Healing

The second theme derives from how respondents perceive the action of Healing. This is an issue that has been raised in literature yet never satisfactorily answered. Respondents expressed an attitude of focusing on what was important in the healing performance. What is not necessary to achieve as an outcome is marginalised. The second theme is: healers have a focused intention that is embedded within actually achieving Healing, and not in how that Healing is actually achieved.

At a glance this may appear very similar to the first theme, but they are uniquely different. The first theme relates to 'what' respondents perceive the process of Healing to be doing within Healing, its direction and consequences. The second theme refers to the entire performance of Healing, or the 'how' Healing has affect. From the procedure, process and mechanism sequence, respondents were unconcerned about claiming to understand how Healing works.

Respondents did not disassemble Healing, as they were not separating or segregating Healing into consistent parts. There was no attachment to the knowledge of the means of the outcome, in that there is a difference between knowing and understanding. Knowing implies an

intellectual conception of Healing. Understanding Healing is drawn more from an intuitive conception. Respondents' understanding improves, develops and progresses through their personal development or Healing career. Knowing can be perceived as the opposite: respondents acknowledged that the more they understood, the less they realised they knew. This is a paradox that is alleviated by not maintaining rigid philosophical views; as these are considered an obstruction to what all respondents claim that they really have to do, which is, concentrate on performing Healing.

Therapies are not essentially holistic, it is how they are utilised that makes them holistic (Patterson, 1998), and in that respect Healing is holistic. Healing is accepted for what it is and how it is, and no attempt was made to improve the process of Healing by respondents; there was only improvement in the healer. Therefore, there is no examination of the process, because there is no means of understanding how it can be improved. Only the respondents' ability to enact the process can be improved.

Third theme of Healing

All respondents were able to report success in Healing, yet they held a varying array of different beliefs in how to be a healer. The third theme sets out to emphasise that differing perceptions and beliefs are not correlated to healing-presence. That is, the respondents' ability to Heal is not reflected in the environ they practice in. This is not the same as claiming the respondents' healing-presence did not improve. Respondents were aware that their healing-presence improved through practice; it was their perception of their understanding that changed.

The third theme is: healers are able to facilitate change in the recipient regardless of the recipient's personal perceptions of Healing. This theme refers to how respondents create the environ they practice in, as there was no perceived difference in Healing effectuality between these environs. It was more of a reflection of the healing relationship and how respondents choose to practice. These differing Healing styles reflect the philosophy of the respondent, and not the philosophy of Healing. It suggests that respondents had a preference for a particular Healing relationship experience.

Respondents coordinated the parameters of the Healing relationship to sustain what they saw as valuable in Healing. Some values are dependent on the circumstances with the recipient, whereas with others it resembles more of a blanket policy. These values are reflected in the environ itself and respondents' personal philosophy, from which communication and explaining Healing to the recipient were central to the motif of the healing relationship.

All respondents were able to express effective practice, suggesting that their personal perceptions of how to conduct Healing were influential to themselves, but not necessarily a determinate to Healing. The following chapters discuss these influences and how respondents engaged the client within their Healing practices.

Chapter 7

Communication & environ

The themes presented in chapter six are derived from three facets observed through data collection. First, there is how personal philosophy underpins the respondents' actions, which will be discussed in the next chapter. Second, there is the environ in which respondents performed Healing. This has a direct consequence on the third facet: how respondents communicated with their clients.

Grounded Theory (GT) has been used to develop these themes, and is performed through observing the phenomenon that is taking place and not the setting that it is located in (Charmaz, 2006 p.23). Therefore, where respondents practiced Healing was not a criterion considered. As respondents were sourced from the Healing Trust directory (The Healing Trust, 2009) or through snowballing, their preferences within Healing were unknown. Respondents described practicing in different environs, yet still reported observing change within the recipients. So, although environs cannot be discounted as part of a psychosocial influence of the cause and effect that creates benefit to the recipient, there is a healing-presence of the healer that eludes observation but is inclusive to all respondents.

The first two themes involve the 'what' and 'how' of Healing in producing a benefit to the recipient. Respondents said they direct their focus towards creating the achievement or benefit of Healing. What they do not focus on is how Healing achieves a benefit to the client or what that benefit is. What creates the benefit is known as the healing-presence, which may be initiated by the healer but remains outside of their conscious influence. Dismissed in science as a placebo-response (Jonas et al., 2004), healing-presence can be understood as the essence of Healing (Davis, 2009 p.23). Davis describes healing-presence as:

> The experience of crossing over into a shared moment of meaning that is deeply felt and makes it impossible not to experience the impact of one's actions on the patient.

Within this thesis, healing-presence is the ability within the healer to enact the process of Healing. How respondents achieve that may differ according to how they perform Healing. Glaser (1992 p.75) claims that the use of GT is for looking at patterns of behaviour which

have relevance to the problem observed. In this instance the observed is how respondents believe they can best create the healing-presence. If the healing-presence is recognised as making a beneficial change to the recipient, then a therapeutic outcome can be claimed.

The environ influences the pattern of behaviour observed, as HoH requires close proximity of the Healing participants. The differing environs used by respondents provided an interesting assay, as respondents reported no perceived difference in effectiveness from one environ over another. The environs described by respondents presented a mix of situations that represented their preferences in performing Healing, or, in some cases, acted as the only opportunity afforded to the healer practicing Healing.

Respondents who had the option to practice in different environs chose environs that reflected their preference about how to perform Healing. The greatest preference being the degree of dialogue expected to be received during the healing performance. Discourse is seen as an essential aspect of Healing, but not seen as essential in performing Healing. Respondents divulged their preference for communicating with the client, but this was secondary to the client's preference for communicating with the healer.

The optimal healing environment (OHE) could be described as being wherever the respondent/client dyad could meet to provide Healing in a relaxing, secure location. The key concern of the respondents regarding their healing performance was said to be the relaxation of their client. Relaxation is requisite of the healing-act. To achieve relaxation, clients need to feel safe and have trust in the healer, but respondents differed in their means to accomplish this.

Respondents were inclined to place value in actions that promoted the effectiveness of Healing. This determined what actions they took during their healing performance. Respondents demonstrated different Healing styles in how they interacted with the client, and this represented the greatest difference amongst them. Although they all followed the Healing Trust's procedure, they differed in how they interacted with the client. If the client wanted to voice their concerns, all respondents were willing to listen. However, there was a clear divide between respondents who actively sought dialogue with the client and those who did not. How respondents preferred to interact with the client to some extent influenced the environ they chose to work in.

Respondents who practiced in more than one environ changed the way they interacted with the client to suite that environ. And the purpose of communication changed between the different environs. As will be explained throughout this chapter, dialogue with the client had different values in accordance with the healing performance. So, when discussing the third theme, it is understood that regardless of the preferences of respondents the client can still experience change.

Healing environs

Respondents reported working predominantly in three different environs, with the most popular being a Healing Trust healing centre. Some respondents also reported working in NHS hospitals in addition to healing centres. Three respondents offered only private appointments, either due to their location within the UK or for philosophical reasons.

Healing centres are where the majority of respondents volunteered Healing. Eight of the ten respondents were involved or had been involved at some time with a healing centre. Only two respondents claimed to have had no experience in a centre, as they did not live in close proximity to one. Six respondents reported that the healing centres were the places where they practiced Healing during and after completing the training course.

The Healing Trust has fifty healing centres located around the UK (The Healing Trust, 2009). Although the majority of the respondents had had experience in one of these centres, this cannot be expected to be the case for the majority of the Healing Trust members, as many parts of the UK do not have a centre near them. The healing centre visited made apparent that there were several advantages to this environ.

Where these facilities are available they provide a degree of safety to the healer and the healee. Healers who are looking to gain experience can use these facilities to encounter real situations with the public, which would be less daunting than attempting to practice privately. These encounters with the public offer a more rewarding experience for healers than practicing in ‘closed groups’, which are often organised locally by the Healing Trust-appointed trainers and mentors. As Healing is intuitive and not intellectual, understanding apprenticeship training is required. Healers are not taught Healing, they learn it through practical application. Healing centres allow experienced healers to monitor apprentice healers

to ensure, to the best of their ability, that they are genuinely committed to practicing Healing in a manner acceptable to the Healing Trust.

Healing centres also allow healers to depart from these activities when not volunteering in one. Unlike healers who see clients privately, respondents who only volunteered in healing centres were able to keep Healing separate from their everyday lives. Respondents volunteering in healing centres expressed an interest in Healing, not in the sense of a hobby, but as a pragmatic means of demonstrating esoteric philosophy. An aspect not discussed in detail with respondents, as it is far beyond the scope of the thesis. However, the connection between esoteric philosophy and Healing modalities is well reviewed and comprehensive.

The Healing centre visited was in a small community centre rented for three hours on Sunday evenings. The organisation was efficient, with the community centre reception area acting as a waiting room. A secondary room leading into the Healing room was used by healers and clients to brief and debrief the Healing session. Healing was conducted in the main room of the building in which two massage tables and two chairs had been positioned, allowing for a maximum of four persons to receive Healing at the same time. The chairs were rarely used, as most clients chose to lie on a massage table. There were no partitions between massage tables, which were placed about three metres apart. The adequate space between tables and the relative quietness of the Healing sessions did not make the lack of privacy a concern, as healers and clients became absorbed in the healing-act.

There were only four healers volunteering on the night of the visit; the healing centre coordinator claimed that attendance of healers varied, and there could be as many as eight. Low attendance of healers did not appear to be problematic, as the environment was always calm and controlled. Most clients came at appointed times, and this was the preferred means of client interaction, but ‘walk-ins’ were welcome.

Three respondents worked solely by private appointment, of which two charged for the service, claiming Healing as a source of income. A further three were willing to make private appointments for free, and one respondent provided private appointments for a fee to cover costs. Respondents who charged for Healing were in the minority, and some respondents were critical of fee-based Healing services. Fee-charging respondents did not take a commercial approach in that they did not promote Healing in what Healas (2008 p.97)

describes as ‘consumption’ in New Age spirituality. Both of the solely fee-based respondents claimed to have a laissez-faire attitude towards attracting clients. This is practice-guided by the philosophy that accepts that the right client will be attracted to them regardless of their promotional attempts.

All respondents who worked by private appointment did so from their homes with the exception of one respondent, who always visited the client. Of those working from home, three had dedicated rooms in which to perform Healing. The other respondents would use the living room of their house.

Two respondents were volunteering one day a week in a general hospital, and one respondent had been volunteering in a psychiatric hospital. The hospital environ is the most progressive of all different environs. All three respondents who practiced in the hospital environ did so through their own efforts by personally going to the hospital and volunteering their services. Those respondents volunteering in hospitals were the only group where all of the respondents worked in more than one environ.

Respondents had to first persuade sceptical hospital staff to allow them to perform Healing within hospital departments. This was done by performing Healing on staff to demonstrate the benefits of Healing, and the willingness of the hospital staff to receive Healing prompted them to encourage patients to receive it also. Respondents in hospital also received patients who had been offered Healing by the consultant they were visiting. In the psychiatric hospital patient access was more controlled, and only patients who were near a release date were allowed to receive Healing.

Overall, the environ in which respondents practiced Healing reflected a mixture of opportunity and personal preference. Different environs require or allow different approaches in dialogue with the client. Environs reflect the respondents’ perceptions about the purpose of dialogue, financial reward and social aspects, such as community based or private consultation.

They do not reflect in any observable way a hierarchical evaluation of best-practice. Environs represent the value placed by respondents in certain aspects of Healing. The most notable was

how respondents communicated with their clients, and how important this aspect was considered to be within the healing performance.

Explaining healing

Explanations about how Healing works have been standardised to a consensus that is also advocated by other therapies and taught through the Healing Trust training seminars. The 'official' version of how Healing works is supported by all respondents, although, when probed deeper, many suggested having an understanding that was greater than the accepted explanation. This was particularly true for the respondents who claimed to believe in spirits. Respondents expressed an interest in keeping the explanation of Healing simple. As Jack claimed:

"I do keep the explanation simple unless someone asks me a lot of questions then I can go a lot deeper, and it depends on the individual … erm … but most people don't".

Simple explanations are preferred because there is no definitive answer or undisputed scientific evidence of Healing, which could expose the philosophy to ridicule if it could at a later date be disproved. Explanations are also vague as opposed to specific, which allows for some degree of personal interpretation. Ambiguity is particularly favoured when discussing the source of the Healing energy. As Helen explained:

"There is more than one pathway, isn't there? There's lots of different pathways … who's to say what's right and what's wrong … unless they say something like, oh its Satan, then I'm willing to agree, you know what I mean, but … some people believe in the source and some people believe its God, some people believe it's your higher self, but I'm not quite sure about that, I don't 100% know myself so".

Respondents claimed to not talk about the process of Healing as much as possible, but preferred to direct any conversation to the client's complaint. Thinking about the process promotes reasoning about it, and respondents claimed that it did not pay to think about Healing too much, as intellect is seen as getting in the way, because of the need to justify beliefs and make rational judgements. Evan summarised his approach:

"I wouldn't try to browbeat them with any particular way … if they wanted to know more I would tell them more at the end of the day, but I think really that it could undo the healing sometimes".

As explained regarding the second theme, respondents were focused on achieving Healing, which in turn produced a therapeutic outcome. If explaining Healing has no value in aiding a therapeutic outcome, there is little impetus to do so, as not understanding Healing does not impede the Healing process.

Yet, getting clients to accept Healing does require some intellectual engagement. Lack of credibility from the client's perspective could lead to a reduction in Healing effectiveness. Several respondents claimed that they had encountered clients who did not believe in Healing, demonstrating that, possibly, belief in wellness or good health is where thoughts should be directed. Therefore, respondents tended to not discuss philosophy with their clients if possible. As Bob suggested, it is too easy to be prescriptive and make claims that are wrong, or which misguide people. The important aspect of Healing, according to respondents, is to simply get on with it. Thinking of the why, how and where distracts from the core value of what participators are looking for Healing to attempt to achieve.

Discourse with the client

Respondents could be divided by their use of two different approaches to dialogue with their clients. The first approach is a preference for discussing with the client their complaint, and is seen as an integral part of the healer/client relationship. The second approach is not concerned with talking to the client, but is more interested in the Healing-act, or following the procedure seen to have been the actual agent in the healing performance.

The respondents did not claim that they would not discuss the client's complaint; they merely acknowledged that they were less inclined to invite the client into a discussion. Respondents in this category believed that knowing the client's complaint could impede their Healing ability, as the key aspect of performing Healing is to focus on a therapeutic outcome and not on the client's complaint. In these instances, the healing-presence is firmly believed to be enacted within the healer/healee relationship, but outside of their self-awareness.

Discourse with the client has the primary purpose of negotiating and explaining how the Healing session will be performed, so that the client understands their role during the healing-act. This gives the client time to relax and gain trust in the healer. Relaxing is seen as an important step for the client to accept Healing, as tension or apprehension is perceived as

barriers to the Healing process. Relaxation is achieved in the few minutes it takes to settle a client down on the massage table whilst explaining what is going to happen. All respondents were unanimous about this, and recognised that the client's ability to relax is of key importance to the healing-act.

For those respondents who invited discussion during the introduction, discourse became part of the healing performance, a process by which clients could explain their situation and why they sought Healing. It could be argued that this is almost an expectation of the healer/client relationship, although it was not unanimously considered a necessity by respondents. So, respondents determined the need to communicate with their clients on an individual basis.

Influenced by how respondents understand their healing-presence. If the healing-presence is understood as something outside of the person's consciousness and aligned to the process of Healing, then dialogue is of less importance. As explained above (p.8), the process of Healing is seen as enacted through performing the procedure. There is no psychospiritual element to Healing requiring a conscious engagement of self-awareness.

If healing-presence is understood as an integral part of the Healing relationship, then dialogue is preferred. Self-awareness is seen as having a greater importance in the self-healing that Healing produces. Self-awareness is represented by clients discussing their complaint and the changes they have noticed since receiving Healing. The process of Healing in these circumstances may not be the dominant factor during the healing performance.

Respondents who worked by private appointment demonstrated the greatest willingness to discuss issues with their clients. This is understandable given that it could be expected that the healee would want to discuss why they are visiting a healer, particularly if they are paying for the service. These respondents were also more inclined to discuss problems in depth. Ann, Helen and Jack were three respondents who received clients privately. Jack visits his clients at home, and claimed that he did discuss the clients' complaints, and preferred to know what the clients were expecting to gain from Healing:

"I would always ask them why they have requested Healing ... erm ... I don't particularly go deeply into it because generally that's more counselling sort of thing, you know; I will ask them what their expectations are and I will explain to them that there are no guarantees and,

you know, erm … we'll see how it goes sort of thing, but I will always ask them why they've requested healing".

Jack's approach – talking to the client but not talking too much – typifies the respondents' approach. Respondents understood the difference between getting the client to discuss their concerns and the role of counselling. Jack claimed that he had experienced clients who were unwilling to talk in great detail, which was more so with male clients than female. These clients would often become more talkative as the sessions progressed, and Jack suggested that this change in the client mirrored other changes within the person, and so he was content to allow clients to 'open up' at their own pace.

Jack's attitude was more concerned with the actual act of Healing. Possibly to do with his perceptions, as Jack was self-reportedly the most sensitive of all the respondents and was able to assess the client through other means than the five senses. From which he sees Healing-presence as active, without the need for substantial dialogue.

However, the other private practitioners, Ann and Helen, had both taken counselling courses, although they both acknowledged that they did not strictly counsel their clients. Talking about a client's illness in relation to the rest of their life was seen as important. Ann discussed the need to get clients to look at their life to see where events had influenced their own problems. She suggested that there needs to be a lot more communication between the client and the healer; consequently, client participation is an integral part of Ann's healing style. An illustration of Ann's approach in working privately with clients was in her expressing dissatisfaction with healing centres:

"I mean, they're the sort of people that just want to come in, tell you where they're at with their treatment, how they're feeling and their response to the treatment, sit on the chair, get the Healing and out the door, you know that's all they want … and for me that's not what I'm about … and that's why I don't like working in healing centres because you can't work one-one with them".

Ann's preference was to get into the client's life and get them to understand their illness via a psychospiritual connection. Ann continued:

"I know I need to talk to them, there's an awful lot of counselling goes on, there's an awful lot of social work goes on, to help them through their lives and help them adjust to something that's more appropriate for what their body really wants".

Ann perceived Healing to be an incomplete event without these aspects. There is a more active engagement with the client from the philosophical perspective that illness is a physical manifestation of personal problems. So, helping address those problems and their cause will aid the Healing process, she believed. This approach is not limited to private practice; it is simply more available to private appointment healers, who work on an hourly session basis.

The option to talk in detail is curtailed in healing centres do to time constraints. Some respondents in centres shared the same philosophy of illness with appointment-only healers. As Ian, discussing his approach to clients in a healing centre, pointed out:

"Yes, but at the end of the day we're not consultants, we're not counsellors, we're here to offer healing ... erm ... the first thing you always say to someone is how are you today, and that would start the conversation off, then some things will come up and they'll tell you because ... erm ... because nine times out of ten ... erm ... what they tell you is ... the problem isn't why they've come, it's not really the problem that's causing the disease".

Respondents practicing in healing centres claimed that most of their clients had had previous appointments, but as these centres are free to anyone the respondents never know how many people are going to come on any given evening. The time constraints imposed on healers do not permit them to spend too much time with the client beyond the usual twenty minutes the healing session takes.

Any conversation that does occur is usually directed at the client's personal experience of their illness. Allowing the client to talk about their complaint was seen by all respondents as aiding the therapeutic process. The most common approach adopted by respondents was to encourage an open dialogue with the client regarding their complaint. Ian did not talk to clients; he let them talk to him:

"Yeah, you'll find I've got a bit of a reputation as a pebble dropper, I just drop the pebble and watch the ripples and step back. I like to create the atmosphere where they will talk because they haven't come to hear me talk".

All the respondents who worked by appointment were keen to follow this approach, as were most of the respondents who worked in healing centres. Healing is about the client and what wellness means to them. Discussing health complaints was recognised as a form of release by respondents. This is not performed in a counselling sense, but as a means of engaging with the client in a focused manner. Respondents do not have a preference for knowing the client's illness, as there is no diagnostic element to the procedure, and Healing is a non-specific

therapy in its process. Respondents said they were interested in engaging with their client in a dialogue that's benefitted the client. Talking about their circumstances is client-led and is used solely at for the client's benefit.

The second approach by respondents was to not encourage discourse with their client. The two respondents who volunteered in a general hospital, Donna and Fran, believed that talking was not necessary, as healers do not need to know their client's complaint. Donna and Fran stressed that they did not enquire about the client's complaint unless the client wanted to discuss it. The healing-presence can be demonstrated to be independent of the healer/healee dyad; as will be discussed in chapter nine, Donna was able to report cases of spontaneous remission, yet preferred to not develop relationships with the recipient.

The third hospital respondent was Ian, who volunteered in a psychiatric hospital and was not encouraged to discuss the problems of the client by the hospital staff. Ian acknowledged the value in allowing the client to discuss their complaint, and, although constrained in the hospital setting, he did engage in dialogue within other environs. There was clearly value placed on the Healing-act independent of personal Healing preferences. As Ian discussed, his willingness to change his style of performing Healing helped him to demonstrate that Healing is not dependent on respondent preferences.

Donna was currently restricting her Healing practice to one day each week at a local hospital, and claimed the clients had already discussed their complaint with the consultant. Consequently, she did not see a need for the client to discuss it again with her. Donna justified her decision by claiming that her consciousness did not need to know, and she was most ardent concerning this:

"So there's not much need for dialogue with the patient because you haven't got to know what's the matter with them, or which bit is the matter, you're doing the whole body anyway".

Evan took the argument further and said that knowing what is wrong can sometimes get in the way. A healer's focused intention should be on the wellness of the client, not their illness:

"*People tell you what's wrong, and I think that can distract you through the Healing a little bit".*

His approach is in stark contrast to Ann's and Helen's, whereby discourse with the client clearly had different values attached to it. Discussing the client's complaint is informative to the respondent, but it is really seen as actually engaging the client with their situation. The client is seen as taking a measure of control in moving towards their own well-being.

The approach of not talking to the client is followed by healers who see more value in the process of Healing. Healing, according to some respondents, is agreed to be something that happens to the client: they receive it, and in return it manifests as a positive change in their well-being. So, a dialogue is performed if it is of benefit to the client, and the respondents need to know about the client's illness is debated. Respondents' attitude was not opposed to talking to the client, it was merely to restrict the healer's activities to what they were practiced at doing. In Healing, the healer is to focus on the well-being of the client, not their complaint. Knowing the nature of complaint can misdirect the healer's focused-intention, it is believed. That is, the thoughts of the healer are towards the wellness of the client, not their complaint.

Ego

The issue of misdirected focused-intention was addressed by respondents through the understanding of the sense of ego. Ann was one of the respondents who did engage in discourse with her clients, and she shared her concerns about respondents delving into the client's complaint, even though her personal approach was to engage in dialogue with the client:

"I try to distance my ego from the process, so I am getting into what I would call a meditative state. I am trying to … erm … stop all the mind chatter".

In essence similar to the argument put forward by respondents who preferred not to engage in dialogue. The issue of conceptualising the respondent's role in the Healing process as something the healer does, but does not create, is reflected in the attitude of not needing to know the client's complaint. As Ian claimed:

"I like to think that when I go to Heal someone, or someone comes here to Heal, that my ego is left outside the room and you concentrate on what is in front of you".

The healer is part of the Healing process, but not the active agent of change within the client, as all Healing is essentially self-healing. The healer's need to know is perceived as an ego

issue. As healers do not diagnose, there is, to some extent, little value in learning about the client's complaint, yet respondents do ask their clients how they believe they have changed. This is different from looking at aetiology or symptomology, as anecdotes from clients represent their values, not objective measurement. As Donna explained:

"It would be lovely for my ego if they came with symptoms and left without it".

Donna's approach was more openly detached from the clients than other respondents were willing to admit. Like Donna, Fran was more persuaded by the Healing process than the healing-presence. However, Fran did not find it necessary to detach from the client:

"I'm happy to talk to people about anything they want to talk about, in respect to Healing; as far as I am concerned, I don't see that I am in anyway egotistical, I am not dealing with an egotistical situation, what I am dealing with is me linking into a socket for universal energy that is all around, that is vibrating at a frequency, and that I'm channelling from A to B through me, and that's what I'm doing".

Without dialogue, the healing relationship becomes difficult to assess. Respondents volunteering in hospitals claimed there is no pronounced healing relationship with their client, so the healing-presence defines the healing relationship. The healing-presence is seen as the process which is 'the event' between the healer and the client, and is understood to be its own authority. Once the process is enacted it works simultaneously and independently of the consciousness of the healer or the client.

The argument is supported by the fact that respondents practicing in all environs acknowledged the risk of clients becoming attached to the healer, and stressed that this should be guarded against. In healing centres, clients were encouraged to see different healers after several sessions. Evan discussed clients returning to his centre:

"They could have such profound experiences at times that they try to attach to the healer and I try to avoid that".

He continued:

"We allow them two or three times, but then we try and persuade them to see somebody else because they can develop an attachment to the healer".

In hospital environs this is not a problem, as respondents rarely see the same client again. Private practitioners acknowledged it as a problem, as a result of which clients are

encouraged to assess what they are getting from Healing and decide if they want to continue. Ann said:

"Let's say after nine months or twelve months – it depends on the problem – I'll sort of like review what they were like before they came in the first place and how they're … erm … feeling now … how their condition has improved or not, as the case may be … and just talk to them, what benefits are they getting from coming here?"

Asking the client to discuss what benefit they are receiving means insisting that clients maintain a self-evaluation. The respondents did not perform Healing as a New-Age activity in what Tracy (2004 p.3) describes as "the commercialised wing of the new spiritual movement". They followed the notion of self-ethic, which promotes individual responsibility (Healas, 1996 p.24).

Discussion

To review the themes presented within the context of this chapter it is important to understand how respondents were active in promoting the process of Healing. They were not concerned directly with specific outcomes of the process, or healing-presence. A therapeutic outcome is an acknowledged benefit to the recipient. Therefore, respondents focused their concern on achieving Healing, which does not translate into having an interest in how that happens.

There is little evidence, at least from the respondents interviewed, to suggest that the intensity of the discourse between the healer and the client has a serious effect on their healing-presence. Respondents were able to describe similar experiences in regard to effective Healing, regardless of approach. Discourse does not affect the Healing process. This is a claim that directly contradicts belief in the 'hello-goodbye' effect suggested by Abbott (2000), who writes that CAM practitioners are better at giving time to and expressing empathy for their clients. Respondents demonstrated Abbott's suggestion to be mistaken. Talking with the client has been shown to be a matter of the respondent's preference. Healing is client-led, so respondents considered their clients' preferences in addition to their own, which is critical to understanding what respondents expressed.

All respondents acknowledged the difference between healing centres and private practice. There are similarities between them, which are in the respondents' performance**.** Health is the

preoccupation of the client, and discussing health is a point of interest during the Healing performance. The healing environ is the concern of the respondent in reference to their own confidence and desire to perform Healing**.** Respondents demonstrated an adaptability to different styles of Healing performance according to which environ they were located in. The willingness to adapt or accept different environs and still able to provide genuine Healing demonstrates that personal preference has little influence on Healing effectiveness.

Chapter 8

Philosophy

Within the philosophy of Healing and how respondents explained it to their clients, the first two themes presented in chapter six become apparent. Respondents had different approaches to understanding Healing, and this is manifested through how respondents tailored their explanations of it. The 'what' and 'how' of Healing are side-lined as issues of less importance, as they distract from the core achievement of performing effective Healing.

The literature and discussion regarding Healing tends to be focused on effectiveness or challenges to the notion of believability. Healers do not challenge Healing, but they do develop a philosophic means to understand it. Their understanding is not based around the need to find Healing effective, it is to find a means of being more effective at performing Healing. So, respondents said they discussed their interactions with their clients in a way that allowed for conversation to promote Healing, and not become a challenge to it. There was no compulsion for respondents to justify Healing, simply the desire to perform it.

Thoughts and efforts regarding Healing are pragmatic, but they are also centred on personal philosophy, which is how respondents developed the reality of their Healing practices. Philosophy becomes important because it defines the differences and similarities between these practices. Respondents agreed that they held differing philosophical accounts of Healing to each other, yet they were all able to provide a healing-presence to their clients.

The third theme is to do with effective practice, i.e. the ability to enact change within the client. Change within the client can be perceived irrespectively of the healer's philosophy towards creating that change. Therefore, the healers' perceptions of how Healing works have a reduced priority in getting Healing to work.

Philosophy

Respondents' understanding of Healing had developed through experience, and their philosophy had changed through that understanding. The greatest change respondents claimed to have achieved within themselves was the concept of 'acceptance'. Acceptance is

simply allowing the Healing process to regulate itself, and to have trust in the body's self-healing ability and in the Healing process from which to enact that ability.

Knowledge of Healing comes from improved intuition as well as learned observation. Respondents said they had learned to follow their own instincts as well as learned to look for changes in the client. The concept of acceptance suggests a degree of accepting that what will happen, will happen. This is a detachment from specific outcomes, not a devolvement from receiving a therapeutic outcome. Healing is for 'the highest good', but neither the respondent nor the client is necessarily aware of what that actually is. So, respondents' attitudes toward effectiveness were said to be less evaluative than therapies that provide a diagnostic system.

The philosophical underpinnings of Healing are a mixture of taught practices and personal beliefs that are incorporated to create an explanation for what is an ineffable phenomenon. Philosophy, to the respondents, is a gradual progression evolving through their changing perceptions of the workings of the Healing process. This progression in understanding develops and changes through the course of their personal development or Healing career.

The taught philosophy consists of a basic introduction to Asian principles of chakras, which relate to the human body as an energetic system. These principles are used to underpin the Healing Trust's taught hand positions around the body. Respondents also claimed to have sourced published books and DVDs from various authors on numerous subjects relating to esoteric philosophy, meta-physics or spiritual awareness.

Healing can be used as a means to develop esoteric beliefs. To some respondents, Healing was the core of their spiritual practices; and to others, Healing represented a pragmatic element of practicing spiritual beliefs. For whatever reason that Healing is practiced, the understanding of philosophy behind Healing is solely for the benefit of the respondent as the development of healing-presence is aligned with personal spiritual development.

Respondents claimed they were keen to explain the recognised philosophy behind Healing to clients who were interested. This is the explanation the Healing Trust adopted, and is not necessarily the philosophy respondents personally accept. However, respondents were not keen to go into detail with the clients about their own Healing philosophy.

Healing was predominantly labelled as spiritual Healing by respondents, which has become a contentious identification. The word 'spiritual' can be confused with spiritualism, an issue respondents were aware of. The recent debate over this problem within the charity had ensued, leading to the charity's name being changed. The word 'spirit', according to the Healing Trust (The Healing Trust, 2009), refers to its Latin meaning, the 'breath of life'. Most respondents identified a spiritual element of their practice, which they understood to be the part that is ineffable in Healing.

Conveyed to clients as a journey by several respondents, the journey is an individual experience, and as such allows for each individual to have their 'own journey'. It negates the need for persons to share experiences or have similar points of view, and perceptions are validated internally by the individual. Having experiences is seen as the important element of development, not what those experiences actually are. There is no right or wrong experience, simply ones that a person can grow from. Ann explained:

"All I can do is open the door; whether people choose to go through it is not my concern. Again, it's their journey at the time and place when it's appropriate for them, or not as the case may be".

The 'journey' persons travel on allowed respondents to not concern themselves with explaining the esoteric meaning of Healing to their clients. Healing has a different meaning for each individual, and each different meaning is connected to the problems and expected outcomes addressed from receiving Healing. Clients were considered by some respondents to be drawn to Healing to address spiritual issues masked by illness. From the psychospiritual perspective, the symptoms of illness were seen as physical manifestations of lessons to be learned. Evan explained this:

"The complaint maybe a very small part, you know … [it is] the reason they come in, but they might not realise it".

This is not necessarily why clients believed they were going to healers, as clients are often more interested in pragmatic health concerns and issues that have created direct problems in the present time and which led to cause for concern. Donna explained the reasoning her clients gave for receiving Healing:

"I'm confident that they've only been drawn to come for a Healing session with me because they are ready for a quantum leap … so that is what I have in my mind, so that there are no limitations".

Esoteric beliefs about health were understood to be not the concern of the client, and so were not discussed with the client by most respondents. Some respondents acknowledged that they addressed belief as little as possible with the client unless the client asked. Respondents emphasised the need for clients to have a balanced expectation of what Healing can achieve. Ian claimed:

"A lot of people who come for spiritual healing are looking for diagnosis ... or they know what's the matter with them and ask, is there any chance you can cure me?"

Not understanding Healing does not prevent it from working, but not believing that it can work is suspected as being detrimental to its effectiveness, in the form of low expectations. Therefore, respondents were inclined to not explain the Healing process, or they provided simplistic versions of it.

It could be argued that the procedure used is not important from a philosophical perspective. The Healing Trust procedure provides total body coverage, which, if adhered to, provides protection for the healer/client from accusations of malpractice. Healing is seen as more than a procedure performed by respondents. The procedure as a performance provides Healing with a structure that can be observed. The value of the procedure has been over-emphasised in some research papers, where sham healers have mimicked Healing in the expectancy of placebo-effect, as in Pohl et al. (2007) and Mansour, Beuche, Laing, Leis & Nurse (1999).

These papers are attempts to research Healing through a reductionist stance, and respondents were keen to express that hands have a value in Healing, but they are not Healing in themselves. However, they did give respondents feedback about changes within the client in some instances. As Ann pointed out:

"That is where the energy comes from, the energy releases through my hands to the individual".

The mechanism is the client's willingness to accept Healing. Understanding the mechanism is not as overtly important as the blocked or stagnant energy theories that are readily provided, but which are not tested or disputed. So, respondents said they focused their concerns on providing Healing and ensuring its effectiveness, and not on how Healing works.

Several respondents held views that differed from the official Healing Trust's explanation. Although the Healing Trust's explanation has changed over time (the founder was a spiritualist), it could be argued that it now has diminished importance. Many respondents had come to this opinion because their philosophy had changed through development, so that perception and understanding were shifting occurrences. Donna's attitude towards discussing Healing with the client was one of indifference, and her personal opinions were not shared with the clients:

"I tell them what they need to know, really, and I could talk to them about the ideas people have about being a channel of ... erm ... Healing energy coming through ... erm ... I don't actually see it that way".

As discussed in the previous chapter, philosophy can be summarised as having value to the person, and not to the process of Healing. Goals and expectations of Healing can be shared, but its beliefs and meanings to the individual are not. Philosophy is accepted if it makes sense or 'strikes a chord' with the person, but this is indifferent to the agent of change. Changing perceptions have not been shown to have a significant influence on effectiveness.

The intent of the respondent with Healing is to achieve 'the highest good'. This is not to say the healer is indifferent to the client's illness; they are simply not directly focused on it. All aspects of Healing other than the focused intention on the highest good are secondary in performing Healing. Therefore, any foci of Healing that detract from achieving the highest good are received in varying ways depending on the preferences of the healer. This means that the recipient may have needs beyond the Healing-act, such as discussing their complaint with the healer.

Subtle-energy

The core of the philosophical understanding of Healing discussed by respondents is the sense of a subtle-energy. An understandable stance, as Healing and CAM literature abounds with references to energy. The 'state' of the postulated subtle-energy within the human body is the basis for a person's condition of health. Subtle-energy can be seen, sensed or both dependent on the respondent's ability.

Faber (1996 p.237) explains that energy is a difficult concept to describe due to its esoteric nature, and is critical of 'energy' language and people that purport to use it, describing energy as:

> A ubiquitous New-Age term which is just vague enough, just imprecise enough, just imponderable enough to serve as a psycho-physicalistic catch-all for pretty much anything and everything the New-Age savant may want to establish about humanity and the universe.

Faber's criticism becomes valid when references to energy are looked upon as metaphors to aspects of health and well-being. To respondents, concepts of subtle-energy have become the life of Healing. All respondents understood Healing as an energy transference from which energy was described as being increased, changed or altered within the client through the aid of the healer. As Ann described:

"Healers don't do Healing, they channel an energy which is universal, and that energy recharges their system so they have an opportunity of helping themselves".

So, energy has become the reason why Healing is succeeding, but not the reason for Healing failing. It is understood to be a transcendent power which is outside and greater than the individual. Respondents expressed a notion that they engaged with energy by channelling it from a source into the client, and that influences the physical/mental state of the client. Respondents are part of that energy process, but they do not perceive themselves as the centre of that energy, merely as a facilitator of the process.

Illness is seen as a physical/emotional manifestation of a problem within the energy of the person. In illness, energy is described as blocked or stuck, and the action of the healer is to facilitate a release of this energy. Therefore, the healer is not directly focused on the illness or complaint, but rather on helping the energy flow more freely through the person. Energy was described as low, or the human aura as flat, if health is poor. It was also described as resonating or vibrating in frequency.

Energy theories are learned through esoteric and Healing literature, although they were argued by respondents to be natural in experience. The word 'energy' was used in explaining Healing by all respondents, with the exception of Gill and Carol. Energy was discussed broadly in a metaphorical sense by most respondents, as they had limited ability to sense energy and so were more inclined to discuss what they thought it did. All respondents were able to describe sensations from changing energy on the client, but these sensations were

limited to part of the client's body. Evan explained how he related to the healee's energetic body:

"I use my hands, not as diagnostic tools as such but as sensory organs. If you imagine, I place my hands around the edge of the patents and the chakras round the body and feel the energy change and you know somehow that you need to stay in that area for a while".

Energy sensing is not unique to Healing, as it is also performed in other therapies. Reiki and Therapeutic Touch both use energy sensing or scanning to determine areas of the body that may need attention (Gerber, 2000 p.427). Energy sensing is used to determine which areas of the body need more attention and not a means of diagnosing the client's illness. To respondents, subtle-energy becomes a tangential experience and not symbolic healing, as reported by Helman (2001).

Healing is its own authority and does not need interpretation by the healer. A lesson suggested by several respondents as they developed their philosophy of Healing. As Jack claimed:

"I tend to work intuitively; where the hands go, it doesn't vary much, but I mean I follow their basic procedure, but if I was suddenly guided to put my hands somewhere else then I would".

The more sensitive the respondent claimed to be; the more they stated how unimportant trying to interpret subtle-energy was. The most sensitive respondent, Jack, was very adept at sensing subtle-energy, and even claimed to sense chakras. Jack had come to the conclusion that sensing subtle-energy did not mean he could interpret its meaning, and so he avoided looking for meaning (*"I can see energy but it doesn't mean neither here nor there"*). Sensing subtle-energy change is not a measure of effectiveness, and so was not actually important to the respondents. It is merely an indication that something has changed.

Sensations not emanating from the client were a different matter. Many respondents received sensations in their hands which they did not associate with the client's energetic body. These were perceived as guiding when to start or stop the Healing procedure. Donna claimed her hands give an indication if she is not finished:

"If I should have done more somewhere, my fingernails will click and sometimes it's loud enough for the person to have heard, and sometimes more than one nail, it's as if it's on the

back of the nail; it started happening some years ago, and also the hands shake sometimes as well, and I have a vibration in the hands".

Subtle-energy acts as the foundation for present esoteric beliefs by many authors. Some respondents, it could be argued, use Healing as a means of practicing their philosophical beliefs, through which they understand that the bulk of our existence is in a meta-physical form. It acts as the basis for a continuous development process for these respondents and in relation to Healing, which could be seen as a practical application of the belief that 'everything is energy'.

The source of the energy

Healing was described by respondents as usually the action of spirits or subtle-energy. These concepts had strong influence on respondents and produced the most obvious divide in opinion regarding subtle-energy. Respondents' philosophy could be surmised as a core belief shared amongst respondents at its basic level. It differs slightly in terms of the more particular aspects of Healing, but the core belief had established healers' way of 'action-ing' what they do. Bob claimed:

"Oh no, they're not all in the same camp, they're all different camps, but it doesn't matter. That's the whole point, it doesn't matter … because it doesn't matter what some beliefs in terms of where the energy is coming from. They can still use it and still have the same effect".

Personal philosophies of Healing are supposition, as no evidence is presented. Little importance is placed in expressing philosophy, as personal understanding did not improve Healing. Respondents were open to accept different interpretations of what is regarded as energy at its very essence. These different interpretations depend on the ability of the healer and varied greatly. Bob suggested:

"It doesn't matter where people think the energy is coming from because they can still use it".

Healing is practiced on a pragmatic level, so simplicity is observed. Evan, like most respondents, expressed the notion being 'true' or 'pure' to the source:

"[It's] just being true to the source really; giving it your highest attention it helps more, I mean it's only … it's all about the pure intent".

The debate concerning the source is secondary as it is a digression away from Healing. A common theme amongst respondents was the belief that there is only one source, and all debates are merely different attitudes toward it. This was a common response from several respondents who shared an understanding of not knowing where the energy came from, but who were not particularly concerned.

Evan did question the source as part of personal development, but really just trusted to the belief that what needs to happen will happen. True to the source is how Healing energy is engaged: not as a force to be controlled but as an intention to be focused:

"I'm not indifferent to it; I find it important to question it and sort of work at, you know? … I would like to actually know the truth, if there's a belief in spirit-guides people like to know the name of it and all sorts of things that aren't important".

There is no need to see the source as more than one different thing if you cannot measure the source to begin with. As Bob claimed:

"What other energies are there to be used … it's not whether you use the same energy, it's whether you use it the same way".

The term subtle-energy is used due to a lack of an acceptable alternative to describe Healing. Respondents were confident of a subtle but as of yet un-measurable energetic force, which provides transformation of the client into wellness. As Donna explained:

"The energy is creating the transformation, I'm presuming … but it's not my … it's involuntary, I've just created a space that Healing can occur in more easily because the person is surrendering to Healing energy … that's what I'm asking people to do by relaxing".

The English language tends to be based around physical observations, and so the lack of descriptive words only makes it harder for respondents to describe what they are doing. Some respondents had better sensations than others, or different sensations than others, and the respondents who believed in spirit-guides had totally different perceptions. This complicates describing and defining Healing practices.

Spirit-guides

Although the core of Healing philosophy has become grounded in the language of subtle-energy, as mentioned in the second chapter, spirit-guides have historically been associated

with Healing (Gerber, 2000 p.420). Belief in spirit-guides does not distract from the belief in energy; spirits merely act as the source of the energy. Historical literature demonstrates that belief in spirits was greater than it is now. A line was clearly drawn between possibly accepting privately and yet dismissing publically a belief in spirit-guides by respondents.

Respondents' acknowledgement of spirits is restricted within the legal system, the charities rules and social perceptions. These possibly had a greater influence on the behaviour of respondents than their esoteric beliefs. This led to the cautious responses given by respondents regarding spirits, who were reluctant to speak until a level of trust could be achieved. Healing is clearly a guarded arena by its practitioners, which could be a result of the fact that there is little definitive evidence recognised as supporting it.

Insurance coverage provided to healers is based around the presumption of subtle-energy transference, and so explanations revolving around spirit-guides or anything else are discouraged. Claims made by respondents suggesting that there are spirit-guides would invalidate their insurance coverage. Ian explained the Healing Trust's position:

"You're insured by the NFSH (The Healing Trust) *for the act of Healing providing it's administered in accordance within the NFSH rule book and training; the minute you deviate from it you've got a problem".*

Variations of this statement were made by many respondents as an 'up-front' attitude on the subject. However, privately, respondents acknowledged that their assessment of 'outside sources' may differ and not comply with the Healing Trust's official recommendation. Those who believed in spirits tended to have personal experiences that influenced these decisions. Other respondents who had some experience in spirit matters accepted them in a theoretical sense but did not feel obliged to become involved with them.

Respondents who could be viewed as having a relationship with spirit-guides can be broadly split into three categories. The first category is the self-declared spiritualist. Gill, Carol and Helen were three respondents who were open about believing in and accepting spirit-guides as helping during the Healing process. Gill and Carol were the two oldest respondents interviewed, and were both in their eighties. They understood themselves to be natural healers; that is, they discovered they had the ability to perform Healing and then joined an organisation, as opposed to most healers today who are trained to be healers through an

organisation. Gill and Carol both acknowledged that they were psychic, that Healing was one of their abilities, and that they had a conviction that Healing is spirit-Healing, in the sense that there are spirit-guides engaging in the process during the healing-act.

Gill was the one respondent interviewed who had not undergone the Healing Trust training. Gill gained membership of the Healing Trust after completing a competency exam, as her membership predated mandatory training. And Carol claimed she had been performing Healing since a child, but had only joined the Healing Trust fourteen years ago as a precaution against legislation. She was unique in the aspect of not describing Healing as a means of subtle-energy; Healing was considered spirit-involved and not energy-involved.

This was even though when the issue of energy was raised at the end of her interview, Gill understood that it was all energy regardless of perception. This served to emphasise how Healing perceptions are changing. A belief in spirit-guides does not inhibit the belief in life as energy; it is simply a different philosophical background for healers who do not believe in spirit-guides.

The second category is those who acknowledged there are spirit-guides but who were not concerned with working with them. Belief in spirit-guides does not necessitate a need to integrate that belief into their practice as solidly as those in the first category. As Ann suggested:

"I believe in spirits; I don't really consciously work with them, but I believe in them … but you don't have to, to be a healer".

Ann claimed she could not see or sense spirit-guides, even though she held the belief in their existence. The belief in spirit-guides is seen as a more personal philosophy and need not be incorporated into Healing directly. Whether these entities are part of the Healing process or not has no connection to believing in them, as respondents who fell into this category had limited direct experience influencing their decision.

Other respondents who had some experience with mediumship or similar experiences were still not inclined to acknowledge spirit-guides openly. Bob simplified his philosophy:

"It's an esoteric … yeah … but I'm not a spiritualist … but I'm not alienated by them".

Bob had personally attempted mediumship for communication, and had self-claimed success, but was still not drawn to it. Bob, like several respondents, did not claim to reject his own experiences with spirit-guides; he simply did not find value in them:

"One of things I did do was go on a mediumship course, and in one of the lectures was … erm … [I] went into trance and had someone come through, but only once".

Jack had also attempted mediumship for communication:

"I've tried to work with guides years and years ago, meditations and meet your spirit guide blah blah blah, and I've had experiences, but I feel the guidance I don't need to give a name or, like, archangel so and so or anything like that; I just feel guided, and I just accept that guidance and it's a feeling, if, you know, something appeared to me then, you know, I would see at the time".

Self-claimed success does not guarantee encouragement of an interest in spirit-guides. The outside influences historically raised by religion and the more contemporary media-driven idea of mediumship also have influence. As Jack claimed:

"At one point I looked into mediumship training because I thought it could be useful for people who had a loss and it may in a healing context if I was able to pass on any messages, but when I got down to it I decided that it wasn't for me because it seemed show business, maybe show business is the wrong word … staged and, you know, dramatical and entertainment, and it just didn't fit with me".

All of the respondents in this category claimed openly or inadvertently to have some mediumship or psychic ability. But their experiences had drawn them away from spirit-guides and towards a more direct focus on Healing. Those in the first category, who were openly drawn to spirit-guides, perceived them as having a much greater role in their lives than just performing Healing.

The third category is those who were not interested in spirit-guides and did not acknowledge them. This is different from denying the existence of spirit-guides, as Ian summed up:

"I'm not at odds with it; each to their own. I'm quite happy to go along with it, the fact that it doesn't make sense it … is of no consequence to me, I quite accept that other people do and that's fine but as far as spirit-guides are concerned, with the sort of Healing that we do it's not part and parcel of it".

Evan's awareness of spirit-guides was one of respect, but of distance from them, as he did not have personal experiences of these entities and as such had no concern for them:

"All sort of things happen in a Healing session, I mean every Healing session is different … erm … I don't ask for guides to come through, I don't turn them down or if they exist".

No respondent was willing to reject the notion of spirit-guides. They would only talk about this matter as in how they related to them, from the perspective of a degree of certainty to uncertainty. Spirit-guides are strongly connected to spiritualism, although you do not have to be a spiritualist to believe in them. This was a contentious issue for all respondents who were not religious, yet clearly had weight in their philosophy. As Evan continued:

"I find spiritualism a little outdated … I know spiritualists, some are friends, I know some healers, but they wouldn't be allowed to work here without learning our process".

Respondents were clearly aware of other healers' different philosophies and accepted them. For respondents, the spiritualist perception was tolerated if the subject was mentioned, and just ignored if it was not. Fran was questioned about the issue of spirit-guides, and acknowledged that she was aware of other healers' perceptions:

"*From my perspective I do hear healers talking about that, I do … amongst other healers they do talk as in … quietly behind closed doors about that to themselves; as far I am concerned I do not talk about that"*.

Attitudes towards acknowledging spirits was one of: I am not for it or against it. If it does not play a part in the respondent's Healing then there is no need to make an issue out of it. Ann summarised her relationship with spirit-guides; although she believed in them, she claimed this differed from the spiritualist perception:

"I know I have guides, but more often than not I often wonder what they think about me … because I don't work with my guides they choose to work with me, and most of the time, ninety-five per cent of the time I am totally unaware of their presence … can you see the difference of a approach?"

Public perception was the key determinate in discussing spirit-guides. The spiritualist Helen claimed:

"I believe in spirit but I don't always use that word on the client because sometimes they are frightened".

Gill discussed how she approached the subject:

"I just say that I give Healing but you just have to trust me and see if it will work because I guarantee nothing. I don't say 'oh I I've got somebody from the spirit world with me' – many people would be terrified, 'oh we're going to see a ghost', so I try to avoid that unless they're spiritualist".

Several respondents were able to claim that the clients reported incidences associated with spirit-guides, as Jack stated:

"I think quite often people say to me they feel other hands apart from yours and I accept that, I wouldn't have a problem thinking there's something else that's there as well".

Fran accepted that Harry Edwards (founder of the Healing Trust) was a spiritualist, but kept her explanation purely in the present circumstances:

"He (Harry Edwards) *did, but I suppose I'm quite purely coming from the NFSH* (The Healing Trust) *background and I'm really coming from the perspective that was laid there; I respect everyone's perspective in terms of religion, in terms of spiritualism, I respect all that, definitely and I certainly wouldn't be unless invited to do so discussing it with anybody".*

Respondents worked around the issue by claiming that they worked with the 'source' of Healing energy. Fran claimed:

"I know people that do workshops and they say, they sort of invoke what they say they call spirit-guides, I certainly don't do any of that, I attune to the universal source".

Ann pointed out the difference between her and a spiritualist:

"A spiritualist would say, oh it's my guides doing the Healing. I don't want to go there … I'm quite happy to have extra assistance, I don't mind that as a concept, I want to work … as clearly with the source".

Respondents questioned the value of pursuing such knowledge. If it did not improve Healing then there was little emphasis to understand it. Evan discussed the value in pursuing such knowledge:

"I'm not indifferent to it; I find it important to question it and sort of work at, you know? … I would like to actually know the truth; if there is a belief in spirit guides people like to know the name of it and all sort of things that aren't important".

Two respondents who could sense spirit-guides but did not actively engage with them were Donna and Jack. When talking about confirming the presence of spirit-guides and who they are Jack stated:

"I think that some people need to put it in the form of a guide, it just makes them feel that they are getting some information almost externally".

Donna, like many respondents, was not interested in psychic awareness or spirit-guides. Donna summarised her position:

"I don't bother with that myself; I'm only interested in the end result of healing".

Many respondents did report experiences beyond the five senses during their interviews, even if they claimed to not be psychic. They admitted that psychic awareness does not have value when discussing the healing-act. Respondents might implement psychic abilities, but there is no advantage in informing their clients. Donna continued by acknowledging having some experiences with spirits:

"I'm confident that all positive forces in the universe are helping in the Healing process, I'm confident of all that ... but they don't need to have names, I don't need to know the identity of any particular force, a guide or whatever, unless they think I need to know, and I have been made aware of two guides in the past".

Donna claimed she did not invite or refuse spirits, but towards the end of her interview acknowledged that she also performed 'Spirit Release', a therapy for removing attached spirits from persons (SRF, 2011). The practice of Spirit Release was performed outside of the Healing Trust activities. Generally, Donna was not concerned with sharing her personal philosophy. If the circumstance arose and she needed to discuss philosophy, Donna adapted her explanation to meet the expectations of her audience.

Helen claimed that up to twenty years ago most practicing healers would have acknowledged spirit-guides. This belief has dissipated as taught healers have joined the charity in greater numbers. Taught healers are influenced by the language used in contemporary Healing, which is synonymous with subtle-energy terminology. Before training within the Healing Trust was mandatory, persons joining the charity would have possibly had more self-awareness of Healing gained from sources outside of the charity. Those sources would have been of a spiritualist persuasion, as Reiki did not make an impact on Western societies until the mid-1990s.

Discussion

Healing as energy transference is a learned philosophy. The energy theories were an easy 'mask' for what some respondents were really thinking. Other respondents were not entirely convinced, but were open to the acceptance of spirit-guides. However, as they did not dwell on it, it was not seen as an important aspect in the Healing arena. Healing explanations are created and devised for the benefit of the healee. The healers' motivations and beliefs are not obvious to the recipient. So, respondents structured their acknowledged philosophy around what works for the client, not what works for them.

Respondents were able to provide an array of different perceptions as to how they relate to Healing. The personal beliefs that respondents adhered to demonstrate differing philosophical values yet respondents shared an understanding of 'acceptance' within Healing. The notion of acceptance steered respondents towards the proposed theory, of enacting a change within the recipient, by employing behaviours that limited influences which do not facilitate change within the recipient. The 'what' and the 'how' of Healing become marginalised as focus is maintained on the recipient's therapeutic outcome.

Chapter 9

How respondents perceived effectiveness

As discussed in the previous chapters, the multitude of different approaches and environs allowed for respondents to demonstrate differentiated practices. The Healing Trust does not purport to be a therapy in its own right, and therefore its members are allowed to be heterogeneous in their values in all but the code of conduct and procedure set out by the charity.

As also mentioned previously, the theory of effectiveness presented relates perceived effectiveness to a change within the recipient. In Healing, respondents do not promote an expectation of what can occur. Expectation is managed to inform the recipient of what will probably not occur – not so as to disappoint the recipient, but as a means of grounding perceptions of Healing in something more meaningful and less fanciful.

Healing is concerned with the illness of the person, not the disease they are labelled with. An orientation different in focus from that of biomedicine, but is still not exempt from biomedical issues. Hanegraaff (1996 p.42) distinguishes between disease and illness. In biomedicine, disease refers to "abnormalities in the structure and/or function of organs and organ systems from which pathology states whether or not they are culturally recognised". Illness refers to "a person's perceptions and experiences of a certain socially disvalued states including but not limited to disease".

Respondents discussing effectiveness tended not to mention disease. Effectiveness came from understanding or observing differences in the recipient, not observing improvements in the recipient's complaint. Healing, as with many CAM therapies, was used for chronic conditions (Fulder, 1996 p.183) associated with pain or discomfort. Subjective analysis has more value in these circumstances, as these therapies have direct consequences for the recipient's quality of life.

Effectiveness was always expressed as anecdotal, single-case studies of individuals, by respondents in this research. Respondents did not refer to their clients in group averages. Clients were experienced as unique, and referred to in that manner. Anecdotes are not

accepted as objective evidence according to Ernest (2007 p.22), but they did provide evidence to respondents. For respondents this was the preferred means for expressing change in the client. It is easier to perceive changes that have occurred in clients than it is to predict changes that may occur.

To the respondents, remembering individual Healing cases is the backbone of performing Healing. Clients with tales of improvement or change give respondents their validation. Effectiveness is a self-observed phenomenon, in that respondents evaluated Healing from the clients directly. Respondents were not reliant upon objective measurement or independent evaluation. Therefore, their observations and judgements were crucial in evaluating Healing. In essence, clients receive effective practice; healers do not achieve effectiveness practice. Healing is not referred to as 'I am doing'; rather it is referred to in terms of 'receiving'.

Respondents reported four different means to account for effective practice.

1. The respondent's client returned for another Healing session.
2. The client provided feedback supporting a claim of effectiveness.
3. The respondent was able to observe changes in their client's personality which indicated a change had occurred.
4. The client had a spontaneous or near-spontaneous remission that could be observed.

<u>Clients returning</u>

A client revisiting the healer is seen as the first level of success. Clients must appreciate that some benefit has occurred for them to return. Ian spoke about the client returning:

"The biggest feedback is that they come again, because they've obviously took benefit from it the first time or they wouldn't come back the second time. If they come back the third time it isn't a coincidence, they come back because they feel it's helping them".

Ann, one of the fee-charging respondents, discussed returning clients:

"Well, the proof in the pudding is that if they come back for more … it's because they have to pay, they can go to the doctor and not have to pay anything, so the fact is, it must be working because they are coming back".

Respondents who received fee-paying clients discussed more experiences in witnessing effectiveness, which they considered the result of spending more time with their clients. As Ann pointed out, clients would not return if they did not find value in her service. There is also the consideration that fee-charging respondents, or at least those who took private appointments, spend more time with their clients to demonstrate value. Gill only asked for a

small charitable donation, but as a private practitioner working from home she understood the value of time spent with the healer:

"Well, I usually give half an hour because they'll think ten minutes, that's nothing … erm … but sometimes before that time's up I feel I've finished, but no, I will keep on, they expect it so I do".

This gives private-appointment healers an advantage in observing changes in some aspect of Healing. However, with the exception of a few reported experiences, effectiveness was not a determinant made by the respondents. Effectiveness is substantiated by the client through self-reporting or feedback to the respondent, and for that, healing centre volunteers could also observe changes.

Effectiveness is related to how the recipient perceives their complaint, as some complaints are easier to interpret than others, such as physical problems compared to psychological ones. Therefore, respondents could observe effectiveness but did not predict it, evaluate it or claim to have caused it. Evaluation through EBP mechanisms becomes difficult, as there are no base-lines from which to observe effectiveness. Jack discussed this point:

"I can't say I'm totally detached from the result, but I try to be as detached as I can from the outcome as that really helps, whereas at one point, especially when you first start, you know you really want this person to get better or this to happen or get a good result, whether that's ego or you just want to help this person, but like I've moved right away from that now, that's part of how my Healing evolved … erm … I've realised that it actually hinders the process, makes it less effective".

Respondents reported not looking for effectiveness, but did report understanding when they had observed it – not necessarily in the biomedical sense of treatment with the aim of cure, more in a sense of the client self-examining their circumstances with a move towards change. All respondents engaged with helping the client change, and that change is the facilitator of a means towards a cure, if possible. This was particularly true with respondents who worked privately and preferred to discuss their client's complaint in detail. The term 'cure' was treated as a four-letter word by respondents, and was not offered to clients, as Ann explained:

"I never use the 'c' word, ever … but cures do happen, but they don't happen overnight, they happen in my experience over a period of time, depending upon how severe the problem is … erm … and what it's related to, then it's all a time factor, where some people pick up the phone and they think, oh, you know, Healing's going to be the miracle cure, one or two sessions, sorted, I've never had that as an experience".

The term ‘change’ with respondents had an elusive meaning, but which could be understood as the recipient progressing towards a greater state of well-being. Aldridge (2000 p.193) describes change “as where the future meets the past and how that transition is understood”. In that sense, if there is no recognised change then there is no means to recognise Healing, as change is not related directly to the recipient’s complaint, because the desired outcomes for the respondent are not the same as the recipient’s. Effectiveness is a determinant that is often based more around recipient experiences than actual measurable results. This is not the same as the recipient receiving their expected result, and Jack dismissed the notion that the recipient receiving what they want is the same as effectiveness:

“No, I wouldn’t class that as effectiveness, in fact I would say that that’s a big misconception of effectiveness in, you know, the Healing works one-hundred per cent of the time but it doesn’t always produce the results the client wants, and that’s why it’s so difficult in, you know, when there’s research and stuff like that, conventional medicine would see a result in being cured or some effect on it. Like I could have some come (clients) *and they’ve got a knee problem, ten sessions later and they still have their knee problem but they’ve dealt with loads of other stuff and they’re really happy”.*

Respondents described themselves as ‘facilitators’ of a mechanism that is understood more from esoteric philosophy than from pragmatic practice. This makes the Healing process contentious, as respondents did not agree with each other as to what is happening, and at the same account face criticism from parties outside of Healing.

Respondents received clients who had health complaints, but did not engage directly with these actual complaints. This approach can be seen as in direct contrast to biomedicine, as it observes the patient through symptomology and pathology. Respondents looked more towards the holistic approach, and recognised each client as unique. They do not direct, diagnose or suggest what clients should receive in the form of Healing; it is left to the ‘universal consciousness’ to determine a course of action. Respondents are responsible for their actions in performing the procedure and take no responsibility for the results of the process. Evan explained this:

“Some people come for physical conditions, you may get some relief perhaps … erm … sometimes they will come with other presenting conditions … get other benefits that they didn’t expect”.

Helping the recipient to 'change' is perceived as the Healing outcome, and respondents expressed outcomes in terms of change, as Bob described:

"Some of them come for physical change; not all of them come for physical change ... erm ... some of them come because they're having difficulty coping, maybe loss or emotional things, and they seem to be able to cope better ... erm ... all those that come regularly seem to be, what's the term, of a happier or more equable disposition than the average after they have been coming here for some time".

What those changes are, is a mix of observable effects from the respondent's and the client's perspective. 'For the highest good' was the phrase mentioned by respondents, and which acts as a therapeutic outcome. As the respondent is not trying to achieve the recipient's desired outcome, they are surrendering to a source or intelligence outside of the control of the Healing session. This is a reference to the notion that the respondent, and possibly the recipient, do not know what the best outcome is. Jack described the progress of change:

"Well they deal with stuff, they may come with a problem and then they have Healing and their awareness, this is how it seems to me, their awareness of things becomes more, and then like it almost peels layers off them and they become more and more aware, and then they have shifts within themselves; like I said, it's all self-healing ultimately, they have shifts within themselves".

The human body is believed to undergo an energetic change through the Healing process from which it self-heals, and so there are no group averages, Healing provides a unique experience to the individual. Therefore, effectiveness is experienced in variable degrees of success.

Spontaneous remission

The least observed means of perceiving effective Healing is spontaneous or near spontaneous remission. It was reported by four respondents, and was usually described as alleviating physical complaints. Spontaneous remission is not an expected means of change, as change is expected to occur gradually over days or weeks, but it is not refuted if it does happen. Jack summarised the problem:

"There seems to be a mind set when you use the word spiritual healer that you have some mystical power that you are going to, like, sort them out in a very short space of time; some people think, I'm going to see this healer'. There are some fantastic ... even these really fantastic healers have the odd one that's that, but I don't know any healer where every time it's just one session that they get a really remarkable result, because what has changed within that person?"

Spontaneous remission is problematic for Healing because it lacks any serious credibility, not helped by religious evangelistic practices purporting to provide miracle cures or similar effects. Although it is recognised as occurring by biomedicine, its credibility is denied in Healing (Aldridge, 2000 p.153; Benor, 2004 p.16). Aldridge criticises this stance, claiming that it is unacceptable for biomedicine to accept placebo-response, spontaneous remission or expectancy effect within their domain and then use these to reject explanations of recovery attributed to more metaphysical explanations.

Historically, biomedicine has rejected any claim of effectiveness by energy therapies (Benor, 1995). Consequently, why should biomedicine accept spontaneous remission as an effect of Healing? In Healing, unlike biomedicine, spontaneous remission is accounted for as a genuine result and not denounced as an alternative explanation.

This does not mean that respondents had an explanation for spontaneous remission; it was simply 'accepted', as noted in chapter six, as part of the self-healing process. Carol witnessed a spontaneous remission with a client when working in a healing centre. The client reported being diagnosed with scleroderma in her hands, which is an autoimmune disorder leaving her partially disabled. Carol explained:

"I got her hand between my two hands like this, and as the Healing was coming through I felt her fingers straightening, and when I finished she was doing this … and she could just not believe it, neither could I, I was amazed … and the receptionist said when she ran out to her husband and said 'look, look at this' and … erm … she said 'I can't believe it' and she drew a fist and off she went. Well, two weeks later we had another (Healing) *session and she came again, and she wanted to see me and she came in and she could still do this and she said, 'not only can I move my fingers but I can also open the tops of jars and bottles. I can do anything with my hands'".*

Other respondents were also able to report near-spontaneous remission with recipients. This is where recipients have reported their symptoms gone after a few days. Donna discussed the case of a man who had cut the tips of his fingers off in an accident, as a result of which he had been experiencing chronic pain for the nine months after an operation to reconnect the tissue:

"I said, 'well you've got nothing else to do for twenty minutes so let's do a Healing session', which he did, and he noticed immediately in his wrist and he's not had any pain since, and in the Healing sessions he's had subsequently his fingers have come into normal use again, not had the pain, and even the ends of his fingers have resumed their finger-edged shape as opposed to the mashed ends that they were".

Donna's account is the most compelling recorded with what would seem like an impossible or a miraculous achievement as a result of Healing. Jack also provided an account of spontaneous remission:

"Yeah, I've had a few ... erm ... but there not as much as you think, yeah? You know, I've had a few and some surprising ones, you know, some that I thought would definitely need more than a few (Healing sessions)*, but for whatever reason. I had a guy who had a serious back problem for ten years, totally unhealthy life style and abusing himself and I thought, you know, he's going to need some serious Healing work, many sessions. He had one session and his back problem went and it's never come back. I still know of him now in Northampton, and I often think about that, he's probably got a lot of other problems but what he came for is solved".*

Gill recollected a story of a client with dwarfism:

*"He wanted the operation to lengthen his legs; it's very painful and then they turn the screws [he] went up I think it was to London and the doctor said he couldn't do it because the spine is narrowing, it's impossible. D**** brought him to me, so then they went up again and the doctor said, I don't believe this, we have records his spine was definitely narrowing, now it's normal, we can operate".*

No explanation was given for how this occurred. Of the four respondents who reported spontaneous remissions, two were spiritualists with mediumistic abilities and the other two respondents claimed to have psychic abilities. Other respondents discussed being aware of such occurrences but did not report experiencing them. These examples could be argued to be exceptional; however, Donna was confident that most healers were getting similar results in Healing, and that the real problem is that there is no facility or mechanism to report effectiveness of this nature within Healing.

Personality change

Change in personality tended to be a self-observed effect reported by clients to respondents. Clients reflected that they were different in their outlook or calmer in their personality. A change in a client's personality was more commonly described by respondents, as it represented a more subtle and moderate observation. Those respondents who preferred a more discursive approach to Healing were more inclined to discuss this aspect of client change. Jack discussed how clients explain change:

"If they have had a few sessions where they say I can't put my finger on it but something changed, they're not talking about a physical thing really but their ... for me they become

more aware of something, you know, their awareness has changed … erm … some people say their life feels better, they don't use them words, I'm using them words".

As another respondent who preferred to talk with the client, Ann discussed effectiveness as occurring when clients look at their lives. It is difficult to make a specific or a non-specific connection with Healing and wellness, so Ann claimed that there is a connection and yet there is not a connection. This is a contrast between the psychosocial and the psychospiritual aspects of Healing. Ann explained the healing relationship that she preferred to have with the client, as opposed to the non-relationship advocated by other respondents:

"I need to talk to them, there's an awful lot of counselling goes on, there's an awful lot of social work goes on to help them through their lives and help them adjust to something that's more appropriate for what their body really wants. And that takes time with most people. If they don't want to make changes in their life, if they are happy with what they do, but you know, unless they make changes … something has to change in order to get the end result".

Ann had a greater preference for the psychospiritual aspects of Healing, in which there is more commitment to aiding the client to connect with themselves, from which clients become more balanced. Illness is an opportunity to grow in a spiritual dimension, not something that is simply recovered from.

<u>Healee-evaluated feedback</u>

Feedback from the client was said to be the greatest means for respondents to become aware of effectiveness. Respondents claimed that feedback was received both directly and indirectly from clients. Direct feedback was the most common, with respondents simply asking how the client had felt since their previous session. Ann:

"I'm not looking for changes within the client as a result of what I have just done; on the next session I ask for feedback as to how their life has been in the intervening period".

Self-evaluation was seen as critical in determining effectiveness – learning how clients can perceive possible changes that have occurred and discussing these changes with the client is a means of getting them to realise what changes may have occurred. Gill gave an example of a Healing scenario as a gradual process of improvement:

"Sometimes they'll say 'oh I felt wonderful for two days then the pain came back'; I'll say 'I know, that does happen', and what I find is, the next time you come, say it's lasted two days, the next time it will be for four days and then after about a month he'll say 'I don't think I need to come back', you know it works permanently, I say 'why that happens I don't know, I don't understand it', but that often happens".

The gradual change is not a prescriptive process. Jack described how the Healing relationship slowly develops:

"It's really individual because, say, like some people don't want to talk at all, or at least not at first; maybe after a while they start to open up, or, as the layers come off, they may express certain things, so quite often I mean the first session it's a quick routine as they don't know me, I don't know them and they might be a bit nervous, but after a while sometimes I will, well I do generally, get into talking with them after they get to know me".

Indirect feedback was expressed from respondents as being an evaluation of comments made by clients on their return visit. This was a technique practiced more by those respondents who worked privately, as they tended to spend more time talking to their clients. Subtle clues were claimed to be taken from what clients said or how they said it, and questions the clients asked gave clues to their awareness. Fran:

"I don't usually need to ask, they usually tell me ... they're usually very keen to tell me, in fact everybody tells me, normally, I don't go out of my way because really it's always nice to get a bit of feedback, I suppose, but do I need it, I can usually see the difference in the person from when they've started, when they've come in, when they've left the room and when they've come back".

What that difference is was not discussed. Knowing a change has occurred is not the same as knowing what the change is. So, respondents allowed the client to determine the level of change they were experiencing. Not all responses come from discourse; crying, for example, during the Healing session is a sign that something is shifting. Emotional release is seen as a positive event, even if the emotional response is negative. Respondents also reported being aware of their client through facial expressions exhibited during the Healing-act. These were used as indicators of the client's receptiveness to Healing. Tied to emotional responses, facial expressions are used to determine if the client is distressed at the point of receiving Healing, and is used as a guide in continuing the procedure.

Energetic feedback

Most respondents discussed sensations felt through their hands during the Healing procedure. Experiences of this nature are completely individualistic. Bob reported that he received limited feedback through his hands; if he did, it was usually when the client was experiencing pain. Evan claimed his hands were 'sensory organs':

"I use the hands, not as diagnostic tools as such, but essentially organs. If you imagine chakras round the body and feel the energy change and you know somehow that you need to stay in that area for a while".

The importance of the hands when used in Healing was reported by all respondents, even though discounted as a reliable means for evaluating effectiveness, as sensations felt on the recipient's body have no known correlation to change in the person. As Jack explained:

"It's not the most effective way, anyway, for me; well, I don't analyse, if you're talking about now, like I said my Healing has evolved, at one point I would go into the client's energetic body and see all sorts of things, I wouldn't necessarily discuss it with them but I would see things and be doing things but that's not how I work now".

Jack had come to understand the difference between sensing the energetic body and understanding what it means. Sensing differences in the energetic body is not related directly to health concerns, as Jack explained:

"I don't take much notice of that anymore, because that is not how I predominately get feedback, I can scan and feel the cool patches and this that and the other … and the hands go hot or other sensations but I don't really analyse it".

Sensations on the recipient's body are widely discussed in the literature. Therapeutic Touch and Reiki use these sensations to some degree in their Healing procedures. Scanning, as it is known in Reiki and Therapeutic Touch, is used in these therapies to determine differences in the body (Gerber, 2000 p.425). There is no correlation between scanning a person and effective practice. Therefore, scanning is more of an indicator of how sensitive the healer is, not what health issues the recipient has.

Hospital feedback

Donna and Fran volunteered in a hospital in addition to running Healing centres. In hospital, clients were not usually seen again, but the ward staff were aware of the benefits of Healing because they quite often asked the healers to provide Healing to distressed patients, or even themselves. In some ways, this could be argued to demonstrate the value from receiving Healing, even though it does not demonstrate effectiveness in the sense of illness reduction.

In the department where Donna volunteers, patients are offered Healing by the consultant after their consultation, which makes Healing difficult to substantiate as an effective therapy because patients are not seen on a routine basis, as Donna explained:

"You can't ever know which people are going to agree to have a Healing session and which ones aren't, so some time I can be very, very busy and other times I just see one … but then I can always … erm … call on the faculty and give someone on the staff a Healing session".

Donna continued by claiming that Healing sessions for the staff demonstrated to the staff that there is benefit to Healing:

"It's good to give sessions to the staff because they can recommend it whole-heartedly to patients if they've had experience of it themselves".

Donna was aware that although she would invite patients to try the healing centre, very few would attend. The fact that the consultant suggested Healing to patients was seen as giving 'permission', which to some extent validated Healing to the patient. Donna claimed she had seen some patients' symptoms disappear after twenty minutes in the hospital, which was not attributed to any particular reasoning.

Although Jack did not volunteer in a hospital, he did have a doctor as a client:

"I did some healing on a doctor when she lived here, she is a doctor and she has a back problem and she is one that only had one session, she was completely and absolutely gob smacked and she said, like, I can think of, like, ten patients off the top of my head that I would send to you; unfortunately she was emigrating to Australia at this time or I could of done something with her, she was into it and she could do nothing for her patients and she really felt that the Healing would".

Demonstrating Effective Healing to medical staff with their own complaints showed that there was some measure of convergence. As Fran experienced:

"I've been very fortunate, some of the consultants have actually had Healing on a regular basis, end of the day some have fetched me, they've a problem to sort out their patients which I mean I'm not medically trained, but they've been stressed, 'can you sort them out?' or they've been recommended (to the healer) *and come in and actually watched me work, patients or members of staff, to see how it all works, it's been quite good".*

Using Healing to alleviate stress in aggravated patients arguably produces benefit for the patient, staff and other patients on wards. It demonstrates a benefit of Healing by proxy, but cannot be accounted for as effective practice unless stress was the initial complaint. This reduces Healing to simply aiding well-being, yet respondents were confident that more serious concerns can be addressed. Respondents recognised stress as a contributor to many of the complaints clients reported. Healing is known to help alleviate stress as part of its own performance, but that is usually in reference to aiding more serious complaints.

Client expectancy and non-effective practice

Ann's approach to Healing, as a fee-charging healer, allowed her to separate her clients into two broad categories. The first group was persons looking for change in their lives. This was the most populous category, and these persons were considered easier to work with as they were more engaged with wanting change. This group was more likely to succeed in developments in their outlook and report subtle changes.

The second category was described as persons needing change, usually from living with terminal illness, and who viewed Healing as a last resort. Clients looking for change in their lives were understood by respondents as being more likely to receive benefits from Healing. A greater degree of success was expected of clients who choose change over those who need change, as those who choose have more realistic expectations. Ann explained the difference between clients who want change and those who are desperate for change:

"Client expectation, yes … and it's usually the very severe and it's usually sort of, typically cancer, and they've tried everything else so they will try Healing".

As Ann was quoted saying earlier, clients are not cured overnight, so client expectancy is managed or negotiated by respondents. The client's expectation needs to balance with, and appropriate to, the complaint enquired about. Jack also discussed persons desperate for change:

"You get people that are expecting miracles; I have a woman who … erm … [was] in a wheel chair, was disabled and wanted to walk again, I'm not saying that's not possible, she emailed me and I explained to her … you know she basically said to me "can you make me walk again?" And I explained to her nobody can say that for a start, and I said it very early on it's not likely, but Healing will still help you and will probably, as a guess, will help you come to terms with the fact that you're not walking, which is Healing in itself, but she … I knew she wouldn't get back to me".

The experience of receiving clients with unrealistic outcomes was discussed predominantly by respondents who preferred a dialogue with their clients. The notion that healers can perform miracles or spontaneous remission comes from misconceptions of what Healing is, although spontaneous remission was not denied if it occurred. Spontaneous remission is not seen as a serious concern, as Gill pointed out:

"Most are very sensible … you do get those that think, oh, you know, miracles, I'll be up and running about, you know, but most are very sensible about it".

Respondents distinguished themselves from miracle workers. Expectancy issues stem from people who have problems that would be unrealistic to change, such as physical disabilities, and from those with complaints that could be helped if the recipient would only give it sufficient time. As Jack confirmed:

"Someone will come and they're are expecting you to perform miracles in one session, and if you don't they don't come back, that's not happened a lot, but I've had people where I've known like, you know, and it's such a shame because I know if they had just stuck it out they would have got the results they wanted".

A more serious issue for perceptions of effectiveness is anecdotal statements. As mentioned in chapter three, anecdotes form the backbone of Healing perceptions. They are narratives of experiences which construct respondents' reality. The problem with these narratives is that they distort the true effectiveness of Healing as a therapy, because the respondents may neglect to look at non-effective practice to provide a balanced appraisal. A few respondents did mention non-effective Healing when the subject was introduced. Ann discussed non-effective Healing:

"I find it a struggle to work with people who [are] in victim mentality, and so years and years ago I went and ... erm ... worked with somebody who is not a million miles away from here, who is a total victim, you know? Life, everything, life was against her, and so I go along and give her some Healing and she has sort of, like ... she was so miserable that, you know, but you know she would start to bring my energies down from the place that she was in".

Non-effective Healing is not seen as a failure of the respondent. Healers are the facilitators; it is at the client's discretion whether they accept Healing, and that is reflected in their attitude towards it. Helen discussed receiving a client she realised she was not effective in helping:

"Oh, I have had one woman come, I can't remember her name ... she came in here and she went, "I've got blah blah"... can't even remember what it was now, but then I was training, "I've been to the homeopathic hospital, I've been to this hospital, I've been to the osteopath, I've been there and no one's cured me", and I thought, well, this is not going to work because of her frame of mind, you know? And, erm ... I think she gave it a couple of goes and no difference".

Both Ann and Helen considered the client's frame of mind important. Connected to expectation there is a need for clients to assess themselves in a positive manner or attitude. Healing promotes self-awareness within the client and teaches them to look at their own problems, take responsibility for themselves and action a response to help alleviate their problems. Healing is self-healing, and so is reliant on the client wanting, accepting and promoting change within them. Healas & Woodhead (2005 p.27) describe this as 'inner

directed solutions' from which persons heal themselves and come to live in harmony with themselves. Jack discussed this as clients taking self-responsibility:

"I had a girl come to me, I used to give her Healing and then she would go off and, at the weekend, party and take drugs, and then she would come back and have Healing; and she was getting some benefit from the Healing but it was almost like she was using it like … well, that is how it was, and that was not good, and it stopped in the end because there didn't seem any point in it. And I had one woman who just like … erm … we got to the point when I thought she needed take responsibility or … not that she wasn't taking responsibility to stand on her own two feet if you like, not to say that I would not give her Healing again, but we'd dealt with loads of stuff, it being dealt with, you know, she was using me as support in a way that was not healthy for her".

Self-responsibility is different from blaming the client for the circumstances they are in. As Mclean (2005) discusses in his observation of a healing centre practice, responsibility for getting well does not translate into blame for becoming ill. Healing is not the opposite of illness (Aldridge, 2004 p.34; Shostak & Whitehouse, 1999), so becoming healthy is not the eradication of disease. Responsibility is recognising life's challenges and dealing with them. Seen as a psychospiritual phenomenon, Jack described illness:

"It's always in a spiritual context and it's a life lesson, and someone develops a disease that is basically their … erm … spirit is like calling out to say there is something wrong on an energetic spiritual level, and that's all in the physical manifestation of that – is like a feedback system basically".

Ann claimed clients have to take responsibility because it is their journey, not hers. Self-development was mentioned by many respondents, and Healing can be seen as part of someone's own development. In what Healas (1996 pp.24-27) refers to this as the self-ethic, as clients have be ready to hear about the whole before they can accept more spiritual realities. Ann, like many of the respondents, had worked through her own illnesses and issues, and as a healer was happy to help other individuals work through theirs. The non-effective Healing that Ann reported was attributed to her client not willing see illness in this way. As there is need for clients to have a sense of believing in engaging with the actions of Healing, even if they do not choose to practice or belong to it.

Respondents who predominately volunteered in healing centres and hospitals had a less committed relationship with their recipients. As such, they were not as articulate about non-effective practice as fee-paid respondents. Different to being less committed to Healing, as with some respondents a greater belief in the 'healing-presence' meant that they did not need

the personal relationship. As a consequence, respondents of this disposition were less able to be specific in claims of non-effectiveness. Evan claimed that people came for varying numbers of sessions to the healing centre he volunteered in. Client attendance monitoring was performed to the minimum required standard:

"We don't follow it up … no, I don't want to appear to be hounding people for work, so … erm … if we had concerns, if someone left a bit upset we would perhaps give them a phone call and see how they are".

The casual approach to Healing left respondents with no accurate means to record non-effective practice. Clients are more likely to report how they perceive successful rather than non-successful results. If there is no value in receiving Healing, clients simply do not return.

There were alternative perceptions about non-effective Healing. Bob claimed that the bottom line is that we have already decided what is going to happen in our lives, a personal philosophy which influences how he perceives effectiveness, but not in how he practices Healing. Healers do not know what the futures of their clients are. So, although the phrase 'for the highest good' was used, Bob was aware of the limits of Healing:

"My personal belief is that we each have decided what we want to do when we come down into physical, into the body, and that hardship, pain and decease sometimes are things that we have to experience, and we have decided before, and no matter if that's what's been decided then it doesn't matter how much Healing someone gets, if they're supposed to suffer, to experience that pain then they'll do it, and the Healing isn't going to make any difference because the Healing is not working on the physical level".

In Bob's account, self-responsibility or blame have little involvement in illness. This is different from self-development, in which a person can still spiritually develop through experience from illness. Most respondents did not share their philosophic understandings with their clients, and it is understandable that this philosophic approach was not shared with Bob's clients.

As a predestined aetiology of life from esoteric thinking, philosophy of this nature has to be guarded against, as it is not strictly within the arena of Healing. Although such an arena is difficult to define, philosophy of this nature is beyond the practice of Healing. As Aldridge (2000 p.163) criticises, notions that support such claims detract from the pragmatic concerns of life. It is also difficult to accept the ethicality of such practices in Western societies, as,

although respondents are detached from specific outcomes, they are not despondent about there being a therapeutic outcome.

Healers evaluating effectiveness

Examining issues of effectiveness is a valid research enquiry from a sociological perspective. Wersch et al. (2009 p.80) write that it is only ethical that therapies demonstrate some effectuality for they do. But the respondents did not necessarily see Healing as a therapy. Respondents in general were not concerned with effective practice. Effective practice is observed, but not looked for, as Ann explained:

"It's sort of like I know what I do and I trust what I do and its sort of like … I don't know … I don't need to go there … my intention is to do my best; what the client does with that energy is outside my control".

Respondents were not concerned about effectiveness or knowing what is wrong because they were not focused on that aspect within Healing. Donna explained her role as remaining passionate about healing:

"In the giving of Healing is to remain passionate about what you are doing, passionate and taking yourself as positively charged … so there is no idea of limitation … you might see someone who has the most atrocious problem physically, mentally and emotionally and it would be tempting to think that what you did might not have an effect, or it might not be in anyway helpful … so [it means] remaining true to the idea that it is working, even if the person isn't consciously aware that events are benefiting you".

A point emphasised when Healing until death. Several respondents mentioned Healing until death, but Jack was the only respondent who commented on it. Death is not seen as a non-effective Healing, as Healing in these circumstances is about quality of life. Healing until death does not have different values to Healing to health. As Jack discussed, change is still observed within the recipient:

"Yeah, they are more content … things flow, you know? Things flow better … erm … they become more at peace, you know? I've worked on … I've had a client who had … erm … cancer and … erm … that was an amazing experience. She had … erm … lost all her fear of death, totally at peace with, you know it was amazing to me, and she was just totally at peace and relaxed and … erm … that's what the Healing brought about".

Discussion

When looking at the presented theory, the concept of change is promoted as what happens from the Healing process. Effectiveness is centred on the client receiving change after Healing which is represented as the therapeutic outcome. The concept of change is holistic within Healing because it has no expectations, boundaries or limitations. This can be demonstrated in the cases of spontaneous remission that are reported.

Spontaneous remission is something that happens, but defies explanation. The fact that it happens so close to receiving Healing suggests it to be a therapeutic effect of Healing. Like all accounts of change from Healing, it can be seen when it happens but it cannot be predicted to happen. Therefore, respondents did not look for change, but were aware when they had seen it.

Changes in personality and feedback are the core of Healing practices and represent how the respondents generally observed change. The degree of effectiveness is represented in how well the perceived change can be assessed relating to an expected measure by the client, or to an objective measure. This, however, is not seen by respondents as accurate, as they claimed that effective practice is not directly aligned with expectancy. So, a degree of convergence has to take place between what is perceived as achieved from Healing and what is hoped to be achieved.

Chapter 10

Discussion

Healing, without empirical evidence of effectiveness, is perceived as an inert therapy, and from an anthropological perspective referred to as ritual healing or symbolic healing. Respondents were focused on producing a therapeutic outcome, and not concerned with demonstrating effectiveness. They explained therapeutic outcomes as 'changes' within their client. Psychotherapy, like Healing, relies on managing expectation to achieve a change in the client. Respondents, like psychotherapists, demonstrated a diverse array of practices to enact change, but were unable to account for the change process experienced by the recipient.

EBP and Healing

How Healing is evaluated by EBP must be related to what Healing has been employed to achieve. Douglas (1994 pp.25-27) differentiates between the spiritual and the material aspects of medical sovereignty, claiming there needs to be a distinction made between physical needs and physicalist remedies. Douglas recognises that within spiritual therapies physical complaints have a spiritual dimension. Therefore, therapeutic interventions that are spiritual go beyond just the clinic they are practiced in as they embrace the whole person and their existence (Douglas, 1994 pp.25-27).

Symbolic healing, according to Helman (2001 pp.12-13), refers to therapies that are not based on physical or pharmacological treatments. They provide a frame of reference through metaphors that the patient becomes attached to, so patients become self-aware of the healing process. In Healing these usually relate to the state of a person's energy.

The power and function of ritual and symbolic healing are increasingly attracting the attention of scholars from other fields of study, such as mainstream medicine, CAM, psychotherapy and theology (Kwan, 2007). Yet symbolism is capable of self-regulation (Healas, 1996 p.67) as it has to make sense to the individual, not to an external authority. Faber (1996 p.155) describes effectiveness through self-regulation as whatever the patient claims it is, as Healing is not a communal need and therefore does not need researching, analysing or externally validating. It could be argued that to the respondents, the value of

symbolism was not seen as important, as recipients were not encouraged to understand the workings of Healing in any way.

For Healing to become more than symbolism or ritual healing to academia, there must be some correlation between subjective experience and objective measurement. Effective practice is finding where the interpretation of subjective experience has met the client's expectation of an objective measurement. The client can then evaluate Healing by assessing from where they began to where they have come to.

So, an understanding of pluralistic healthcare and patient expectation needs to be achieved (Wersch et al., 2009 p.3). Aldridge (2004 p.73) and Cant et al. (1999 p.175) suggest that pluralism in healthcare allows for orthodox clinical trials with an emphasis on new methods and understandings. Different types of research can inform each other, providing that science can accept a multitude of viewpoints on a wider range of therapeutic interventions.

However, there is a strong subculture of spiritualised medicine that does not readily lend itself to the use of quantitative examination (Douglas, 1994 p.40; Graham, 1999 p.10). If this spiritualised medicine is to have a greater share of healthcare, then the definitions of healthcare within Western medicine will need to adapt. A self-regulation by the patient that is not dependent on objective measurement will have more prominence (Aldridge, 2004 p.72).

A preference for the spiritual over the material is not an isolated decision, and each choice has its value (Healas et al., 2005 p.27). If patients are looking for spiritual medicine, then evidence has to come from a different spectrum than the material. EBP has to be set within the context of what the public are looking for. If more spiritual values are pursued by the public, these values will have a greater influence within medical hierarchies (Douglas, 1994 pp.27-35).

The use of RCTs is claimed as being methodologically superior to other research methods because of its ability to prevent bias by randomising participants into statistically equivalent treatment groups at baseline (Jonas et al., 2002 p.29). Tests of an intervention have a stronger claim to differences in treatment over differences in the groups. Aldridge (2004 pp.73-74) claims that RCTs offer solutions to the clinical researcher, but this may randomise away what is relevant to the practitioner and their client, as it is the patient who is randomised, not the

treatment. So what are needed are research methods that observe the individual more, rather than group averages. This leans towards a single-case research design where each patient is treated more according to their needs than a group average. The advantage of single-case design is that it is a more flexible approach with greater ethical considerations for individual cases (Aldridge, 2004 p.82).

Ernst (2001 p.18) claims that the problem of measuring outcomes in single-case research designs are that they are difficult to distinguish from placebo-effect. The patient either experiences improvement or does not. With Healing this is particularly difficult, as it is a non-specific-effect therapy and, as such, is reliant on the therapeutic outcome suggested by the patient; and in the wider sense it is also difficult to establish a general validity for a treatment (Aldridge, 2004 p.82). Wersch et al. (2009 p.90) suggest that to overcome this problem different groups of participating researchers could collect data in a common format, to be analysed as group data.

Another problem with single-case study designs that does not receive much attention is assessing the healer's ability to perform Healing. Bengston et al. (2008) claim that the percentage of people able to perform Healing naturally is unknown, nor do we know whether Healing can actually be taught. Natural healers have always been recognised, and it was believed until recently by many that Healing could not be taught. Dr Dolores Kreiger disputed this, believing that Healing was an innate ability in everyone, with some people having a stronger ability than others. And to demonstrate her claim, Krieger recruited a local psychic to teach Healing and developed the therapy called Therapeutic Touch in which she trained nurses in the 1970s (Gerber, 2000 p.410).

Bengston et al. (2008) claim that just because a healer has been taught does not mean they did not already possess the ability. Training to be a healer could be nothing more than a means of selecting people with actual ability by weeding out those who do not show any ability. Brown (2000) also urges caution about the ability of healers, claiming that some healers may be better than others, and that this cannot be easily accounted for in research designs.

Levin (2008) writes that this concern is overlooked by treating healers as a constant value in research. The consequence is nothing more than simple ignorance of Healing, which in turn challenges the value of producing meta-analysis (Sutherland et al., 2004). Healers may adapt

their Healing style to compensate for the degree of ability they know they have. Differing Healing styles described by the respondents could possibly be linked to ability.

Some of the respondents who did not advocate discourse with their clients were still able to report successes – notably Donna and Jack, who suggested that psychic abilities gave them perceptions beyond their clients' feedback. The term 'subtle-energy', its concept and use, could also be an indicator of ability, as respondents reported using different means to detect and respond to the energetic-body. Respondents who preferred more discourse with their clients might not have had the ability, psychic or otherwise, to detect the energetic-body. This is a concern that is of value to researchers, but may have little importance to healers; as respondents stressed, Healing is not about the healer evaluating Healing, it is about the healee evaluating themselves.

Healers were not looking for effectiveness: an observation made by Kelner et al. (2002), who reported that Reiki practitioners were uneasy about describing effectiveness as they did not believe it would fit within biomedicine requirements, an observation also borne out in the respondent interviews, as they described themselves as better at perceiving effectiveness than accounting for it. We can interpret this to mean that they could see when it had happened, but they could not predict beforehand what or how it would happen.

Therefore, respondents were not focused directly on observing effectiveness; they were focused on performing the Healing procedure. Descriptions of 'becoming a pure channel' or 'connecting with the universal consensuses' were used to describe how that was achieved by respondents. Respondents could not provide a conclusive theory or explanation of how the process of Healing creates a therapeutic effect. Rather, they discussed the recipient as 'changing', and this change within the recipient is the aimed-for achievement, which does not have to be specifically correlated to the recipient's complaint.

Change within psychotherapy

Healing and psychotherapy differ at the societal level in that psychotherapy has a better relationship with science and academia than Healing, and, as a consequence, psychotherapy has greater acceptance among medical authorities than Healing. However, there are similarities (Benor, 2004 p.46), and Rowan (2005 pp.3-4) describes psychotherapy as a

bridge between psychology and spirituality, because a breakthrough in psychotherapy can be a spiritual achievement. Many of the aspects of promoting change discussed within psychotherapy are shared in Healing.

Shared aspects of change between Healing and psychotherapy:

1. Both therapies have different approaches within their disciplines, and there is contention between their disciplines, yet they can still account for change.
2. Both therapies rely on the therapeutic relationship or healing-presence of the practitioner to accommodate their client.
3. Both therapies rely heavily on subjective experiences of their clients.
4. Both therapies are intuitive in application.
5. Both therapies can see improvements in the clients' lives, yet have difficulty substantiating empirical evidence to support these observations.
6. Both therapies manage the expectancy of their clients.
7. Both therapies recognise the clients' self-healing capacity.

Historically, psychotherapy techniques have been based on complex abstract personality theories, and the interpersonal relationship between therapist and client has been seen as the instrument of change (Kanfer & Goldstein, 1980 p.4). Tallman & Bohart (1999 pp.94-96) explain that, historically, the therapist has been thought to provide 70% of interventions and interactions, with the other 30% coming from the client. They argue that the client is actually the primary agent in change, and therefore the ratio should be 70% coming from the client and 30% coming from the therapist. If the therapist were the primary agent of change, then increased experience and training should make a difference. Yet, overall, the therapist's experience has not been found to improve therapeutic results (Tallman et al., 1999 pp.94-96).

Porchaska (1999 p.227) also argues against the historical perception of psychotherapy, claiming that what is important is understanding how people change in general, and not how people change in therapy. Individuals spend less than 1% of their waking lives in therapy; therefore change has to happen outside of the therapy session. Individuals have their own innate self-healing processes that are responsible for change, according to Tallman et al. (1999 p.120), which at times may need assistance from an outside source.

Neimeyer (1995 p.124) introduces change as an aspect of being human, and that being human also necessitates resisting change, if the extent of change is a threat to the consistency and continuity of the core aspects of the self. Readiness of the client to change is known to be the product of substantial psychological activity, yet no particular theory or model can account

for the complexities of behaviour change within the client (Manson & Butler, 2010 pp.20-26), or how the therapist helps to enact that change (Tallman et al., 1999 p.105; Hunt, 2002). Yet, change in the client is discussed extensively throughout psychotherapy literature, as it is known to be connected to the therapeutic relationship.

Psychotherapists recognise the influence that socially valued qualities such as thinking, feeling and behaviour gained from the therapeutic relationship have on the client to promote therapeutic change (Bachelor & Horvth, 1999 p.134). The therapeutic relationship is, however, not the principle means driving the therapeutic change-process, according to Tallman et al. (1999 pp.102-105). Therapists are seen as facilitators who focus the client's self-healing efforts. Therefore, the client has an investment in their role to change, from which clients who are motivated to change are known to have a greater expectation that a therapy will help, and in turn receive greater benefit from it.

Manson et al. (2010 p.19) write that all models of change suggest that there is knowledge of the importance of change, or 'why', and the confidence to change, or 'how', aiding the explanation of motivation and readiness of the client for therapeutic change. Yet, in the differing systems of psychotherapy the 'how' to change is usually agreed, it is 'what' to change that is in dispute; a dispute created from change models based around personality theories, and not the change-processes (Prochaska & Norcross, 2010 p.490).

Transtheoretical model of change

Prochaska & DiClemente's (2010 p.489) transtheoretical model of change was developed by examining the different major therapy models, from which they concluded, Prochaska (1999 pp.227-228) claims, that most theories relating to change are about why people do not change, and they emphasis the content of therapies, such as feelings, thoughts or overt behaviours, rather than the change-process. Yet there are similarities between all the different therapy models, suggesting that there are common pathways to change regardless of the therapy people undertake (Prochaska, 1999 pp.227-228).

In brief, the transtheoretical model uses sequential stages to integrate processes and principles of change from different theories of intervention. The processes of change are narrowed down to ten processes from a systematic integration of the hundreds of theories in

psychotherapy (Prochaska et al., 2010 p.10; Prochaska & Velicer, 1997). The transtheoretical model of change has become dominant within health-behaviour change, and has received substantial research attention and criticism (Armitage, 2009).

In his review, Armitage (2009) describes the transtheoretical model as a framework for understanding change by providing valuable indicators towards a better understanding of successful health behaviour changes, through the model's ability to help identify common flaws and strengths. This makes it a good model to discuss within Healing, as change within the client from Healing should fit with the transtheoretical model. The transtheoretical model consists of three core dimensions: processes of change; stages of change; and levels of change, which will be discussed in turn.

The processes of change represent the 'what' to change, and represent the mid-level abstraction between global theories and specific techniques. They form the basis from which psychotherapists formulate their treatment plan, according to Prochaska (2010 pp.10-11), who describes the processes as "covert and overt activities that people use to alter emotions, thoughts, behaviours or relationships related to problems or more general patterns of living". There are ten core processes of change that have received the most research support and have been successful predictors for therapy changers and self-changers (Prochaska et al., 1992). They are considered the independent variables that individuals apply to progress through the stages of change (Prochaska et al., 1997).

Definitions and representative interventions of the processes of change:

1. Consciousness raising: increasing information about self and problem, observations, confrontations and interpretations.
2. Dramatic relief: experiencing and expressing feelings about one's problems and solutions, grieving loss, role playing.
3. Environmental re-evaluation: assessing one's problem affects physical environment: empathy training, documentaries.
4. Self-re-evaluation: assessing how one feels and thinks about oneself with respect to a problem, value clarification, imagery and corrective emotional experience.
5. Self-liberation: choosing and commitment to act or belief in ability to change, decision-making therapy, New Year resolutions, commitment enhancing techniques.
6. Social liberation: increasing alternatives for non-problem behaviours available in society: advocating rights of repressed, empowering policy interventions.
7. Counter-conditioning: substitute alternatives for problem behaviours, relaxation, assertion, positive self-statements.
8. Stimulus-control: avoid or countering stimuli that elicit problem behaviours: restructuring one's environment (removing alcohol of fatty food).

9. consciousness management: reward one's self for being rewarded by others or making change, contingency contracts, overt/covert reinforcement
10. Helping relationships: being open and trusting about problems with someone who cares: therapeutic alliance, social support, self-help groups.

(Prochaska et al., 1992; Prochaska et al., 2010 p.490)

Prochaska et al. (1997) claim that change implies a phenomenon occurring over time. Yet none of the leading theories of therapy contain a core construct representing time. Change, particularly in behaviour, is constructed as an event. The stages of change relate to the attitudes, intention and behaviours within the change-cycle of the person attempting to change. They describe where an individual is in terms of readiness to commit to particular tasks from the processes of change over time (Prochaska et al., 2010 p.492).

Stages of change:

1. Precontemplation: a problem exists but is not recognised by the individual. Particularly so with behaviours such as drug taking or smoking, individuals may not recognise they have a problem and are possibly seeking help through family or peer pressure, or from legal requirements.
2. Contemplation: the individual recognises a problem exists but has yet to commit to resolving their problem.
3. Preparation: an individual's intention is becoming serious and small behavioural changes may be made.
4. Action: individuals become engaged in addressing the issues that led to the problem, modifying their behaviour, experiences or environment. This is the most visible stage and receives the greatest recognition in therapy.
5. Maintenance: individuals work to prevent relapse, which could last for the rest of their lives.
6. Recycling: a possibility that individuals may have a relapse to pre-behaviour change and have to resort to treatment again.
7. Termination: the individual has recovered from their problem and no longer needs treatment or no longer has to actively seek help from relapses.

(Prochaska et al., 2010 pp.492-496)

At different stages of change individuals apply different processes. Individuals experiencing the first stages of change, precontemplation and contemplation, will need to engage in consciousness raising, dramatic relief and environmental re-evaluation before they are expected to progress further along the stages of change. Individuals who have successfully reached the maintenance stage of change will be engaged in contingency management, helping relationships and stimulus control (Prochaska, 1999 p.241).

The levels of change represent a hierarchy of five distinct yet interrelated levels of psychological problems. The further down the scale, the more unconscious and historical the determinants of the problems are; in turn, the longer a person can expect to be in the change-cycle, the greater resistance they are likely to experience at changing those determinants (Prochaska et al., 2010 pp.502-503).

Psychological problems representing levels of change:

1. Symptom/situational problems
2. Maladaptive cognitions
3. Current interpersonal conflicts
4. Family/systems conflicts
5. Intrapersonal conflicts

(Prochaska et al., 2010 p.502)

Prochaska et al. (2010 pp.502-503) claim that psychotherapy systems tend to attribute psychological problems to one or two levels of change. They describe effective behaviour change as reliant on doing the right things (processes) at the right time (stages) for what (levels) is needed to change. Different approaches in psychotherapy can be perceived as utilising the correct 'processes of change' at different 'stages of change' determined by which 'level of change' an individual is concerned with. Prochaska provides an example of an individual with symptom/situational problems who might benefit from Motivational Interviewing at the precontemplation stage of change. Yet, if they reach the action/maintenance stage they would benefit more from Behaviour Therapy (Prochaska et al., 2010 pp.502-503).

Armitage (2009) writes that the transtheoretical model is not without criticism, which has focused around contested interpretations of various stages of change components within the model. He is critical of research which uses the processes of change as dependent variables in place of their intended use as independent variables, and suggests that this is possibly due to difficulty in coding the intentions of people changing. Intention is different for every individual, as their situations are usually personal and specific to them. Armitage (2009) does not discredit criticism of the transtheoretical model, but does suggest that aspects in how the model is researched need to be addressed.

Manson et al. (2010 pp.20-24) also warn against over-simplifying the judgements of readiness. Stages can distract from the real therapeutic needs of the client if the focus is on reaching those stages and not dealing with concerns. If change is important to the individual, and they have the confidence to achieve it, they will feel more ready to attempt change, and are more likely to be successful (Manson et al., 2010 pp.20-24).

The transtheoretical model was developed to encompass the many different psychotherapy theories of change (Prochaska et al., 2010 p.489), providing a template of how individuals progress through change, and not a theory of change in itself. It covers a varying range of conditions that would not necessarily be seen by healers, particularly those individuals with addiction or serious mental health concerns. However, Healing as a therapy, or those seeking it, are represented within the transtheoretical model because persons seeking Healing will have experienced similar psychological processes as those engaged in psychotherapy, or have possibly chosen to experience Healing in place of psychotherapy.

Change

Healers share the same concerns as psychotherapists, in that they have to persuade their clients of their authenticity. The degree to which a therapist can influence their client's thinking, feelings and behaviour in order to promote a therapeutic change derives from the socially valued qualities of the therapeutic relationship, according to Bachelor et al. (1999 p.134). Healers will receive clients who are actively engaged in seeking change, usually in the form of symptom alleviation. Clients will have passed the pre-compilation stage of change and the associated earlier process of stage of the transtheoretical model. As Ann discussed (p.122), clients either want change or need change, and those clients wanting change are reported to have experienced better success rates than those needing change.

Tallman et al. (1999 p.109) describe individuals, either in or out of therapy, as proactive directors of their change process. Individuals are active agents in their lives, and are continually learning and adapting. They define the change process as:

> The ultimate change process, inside and outside of therapy, is one wherein clients actively explore their worlds, both in thought and behaviour, try out new ways of being and behaving, engage in creative variations on old learning, and solve problems as they come up.
>
> (Tallman et al., 1999 p.110)

Tallman et al. (1999 p.111) write that therapists are engaged in using the naturally occurring client change processes. Therapy is seen as an exemplar of real everyday life, where contexts, experiences and events can be synthesised to facilitate the self-healing process. Tallman et al. (1999 pp.112-114) argue that an individual's capacity for generative thinking is ignored in psychotherapy theories. Generative thinking is the means for an individual to think about their own problems, providing the experience that allows them to be the active agent in change. Change comes through a normal process of thinking, exploring and experimenting, and from the resultant environmental feedback the individual develops new perspectives and bodily shifts.

Tallman et al. (1999 pp.117-120) are critical of therapies that have come under the influence of managed care, as these are adopting a biomedical approach to healthcare. The therapist becomes responsible for diagnosing the client's problem and prescribing their treatment. The notion of collaboration, where the therapist listens to client, and then they think together to facilitate the client's generative capacity, is diminished. In its place, the client's collaboration is reduced to participation and compliance.

Yet, clients have an inherent self-healing process that is responsible for change, and therapists are there to help to facilitate that process. What is important in psychotherapy is the client's ability to bring their own frame of reference to dialogue. Through their own narrative, clients learn to adjust their frame of reference, and they begin to experience change. The therapist is not treating the client; they are there to help facilitate the change process through dialogue with the client (Tallman et al., 1999 pp.120-121).

Clients provide narratives that describe who they are, by recounting what happens in time, the real events that are happening now and what expectations there are for the future. The narrator is the active agent of change, and change is concerned with the transition of where the future meets the past (Aldridge, 2000 p.193). Psychotherapy that promotes the client's self-healing process is a more spontaneous and natural means to adjust the client's frame of reference (Tallman et al., 1999 p.121). It is holistic in approach as it allows the client to stay with their experiences (Healas, 2008 p.100). As Zohar & Marshall (2000 p.60) explain, it is the ability to grasp a situation or respond to it, that provides an individual with their understanding. And understanding the overall context that links the component parts is holistic in application.

Patterson (1998) describes holism as a set of individualistic principles that define the 'whole'. It is the way in which a therapy is performed that makes it holistic. So, holism can be seen in the respondents' practice of Healing in that they are asking for the 'highest good', although there is no decision as to what the highest good is, or how that should help.

Respondents provide Healing as a holistic practice, as there are no isolated factors in Healing. As the themes discussed revealed, respondents perform a 'focused intention' to enact a change within the recipient; unlike in psychotherapy, the 'what' and 'how' to achieve change are mitigated to a less relevant status. Respondents enact the Healing Process, which proceeds under its own direction.

Respondents prevented critical evaluation of Healing by promoting 'acceptance', which negates the need for recipients to focus on the 'how' or the 'what' of Healing. Being critical of Healing is seen as a preventive action to Healing, so acceptance is a concept that asks the parties involved not to judge or have rooted expectations, but simply to allow change to happen.

Inert Healing

Healing lacks an accepted mechanism to account for its therapeutic effect. Healers philosophise about and determine what that mechanism is, usually through the influence of different concepts of energy. The greater debate confronting Healing is from biomedical research, which, failing to observe a mechanism of Healing, will refuse to consider Healing as anything more than a placebo-effect. There are two arguments presented here. One supports the notion that the whole encounter is a therapeutic intervention, because that is how it is performed within society (Rankin-Box, 2008). The other argument agrees that it is known that the whole therapeutic encounter has an effect, but stresses that what is needed to know is what is actually treating the patient: is there a real medical intervention, or is it a psychosomatic effect (Ernst, 2007a)? Both arguments are concerned about placebo. The first argument is content to develop placebo within the therapeutic encounter; it acknowledges placebo is there, and looks to understand placebo better in order to promote it, not prevent it (Hunt, 2007). The second argument wants to contain, control or limit therapies where placebo is strong (Power & Hopayian, 2011).

Rankin-Box (2008) argues that individualised patient care, integrated medicine and the therapeutic encounter form the basis of healthcare. She suggests that we should attempt to observe both the therapeutic encounter and its impact on treatment, rather than try to control outcome. Rankin-Box (2008) claims that the arguments critical of integrated medicine practices which have not passed RCT approval are a methodological concern for all medical research and not only for CAM. The problem with RCT research designs is that they usually include a placebo arm which is compared against an experimental arm, from which placebos are considered constant and inert (Rankin-Box, 2008).

Power et al. (2011) acknowledge that medicine recognises the importance of expectation, communication and the therapeutic relationship, but the integrated approach to care is not unique to CAM. They are critical of CAM therapies that are claimed unsuitable for double-blinded RCTs. This is a claim put forward when the package of the therapy is claimed to be more important than its component parts. Power et al. (2011) argue that concentrating on therapies as a package is misleading and unscientific, as it suggests that if the intervention has any specific-effects then research should not be concerned with observing what those effects are; an approach that can be used to justify any bogus medicine.

Power et al. (2011) argue that focusing on nonspecific-effects does not solve the integrated medicine evidence gap. The term nonspecific-effect is used instead of placebo-effect because placebo-effect has negative connotations. Placebo-effect cannot be the result of placebo because placebos have no effect, and nonspecific-effect can be specific in outcome but arise from unspecified causes. They suggest:

> The true placebo-effect is the clinical effect of the package of care that is not due to the specific intervention. The nonspecific-effect (or perceived placebo-effect) is the observed effect of the package of care in the placebo group of a clinical trial, it is the net result of the true placebo-effect plus systematic measurements (biases).
>
> (Power et al., 2011)

The specific-effects of an intervention are what are important, as the nonspecific-effects are considered contextual and the processes of delivery of an intervention from how outcomes are measured (Power et al., 2011).

Scovern (1999 p.260) writes that medical interventions that are proven to be ineffective in RCTs, or treatments with purported mechanisms that have no plausibility, can, for a certain

period of time, have a curative effect. It is the psychological and psychophysiological qualities present within the individual that strongly influence recovery to health, and these factors are responsible for the initial success of treatments that are later refuted as not having a therapeutic benefit. Moreover, all medical treatments are suspected of benefiting from these factors, including those with proven medical effectiveness and known specific-effects (Scovern, 1999 p.260).

Placebo-effects are referred to as nonspecific-effects because they are believed to derive from the psychological and psychophysiological factors, or common factors, present in a medical treatment. Contemporary research has yielded insight into the psychosomatic effects of attitude, behaviour and cognition on health concerns. The common factors in clinical procedures are known to exert a stronger influence on outcome than has been previously recognised (Scovern, 1999 pp.260-261).

Hunt (2002) suggests that placebo should be defined by, first, the process involving the placebo and, second, the phenomenon of the complaint relief associated with that process, in place of defining placebo as a thing and its suspected effects. Hunt (2007) argues that the process of using placebo is a treatment, and that positive expectations can be linked to the curative response of placebo. There are no psychophysical laws that allow physicalist explanations of psychological experiences, so psychological factors are inextricably linked to the curative effects of placebo (Hunt, 2002):

> Processes of placebo use are psychological treatments which consist of (1) consulting someone perceived as an effective healer who (2) provides *inert* health care, which (3) the patient believes is efficacious healthcare, which (4) the patient *experiences*. The deliberate provision of inert healthcare is a very specific modification of what health-care treatment usually entails.

Hunt (2002) explains that the relationship between placebo and a response to placebo is that of reason and effect. Placebo-responses are from the expectations and beliefs which are held as reasons, and which function as reasons. Hunt (2002) states that the paradox of placebo-effect is that of 'exciting' the phenomenon of self-healing.

Hunt (2002) suggests that the difference between a medical consultation and therapy is no more than the order of psychological, physical and emotional responses that both

interventions can induce. In a consultation, a patient may have expectations and beliefs that lead to physical improvement and which in turn impact on their emotional well-being. In therapy, a client may have expectations and beliefs that improve their emotional well-being, and in turn improve a psychical condition (Hunt, 2002).

Hunt (2002) argues that when there is a formal encounter with someone perceived as a specialised healer, therapy becomes just another ritual that can be observed through medical anthropology. It allows therapy to be seen in terms of performative efficacy, as therapy produces the same psychologically induced benefits of other healing rituals. Attempting to attribute fastidious efficacy to the characteristics of ritual healing is misguided, because although a healing ritual needs defining characteristics to become established in culture, self-healing occurs despite those characteristics and not because of them. Research into performative efficacy should be client-led, and focus upon why some individuals have success with self-healing and what aids that effect (Hunt, 2002).

Kaptchuk (2002) agrees that the healing ritual can have clinical significance, and can be used as a healthcare system that relies on placebo-effect. He asks: what is legitimate healing? Is the measure the patient's own base-line, or should it be compared against placebo? What is required is for the client to recognise their own involvement with their health concern and their involvement with their health recovery (Capra, 1982 p.396).

A key element is expectation. Prochaska et al. (2010 p.6) claim that the expectation of the client has been extensively investigated and debated, from which it is now accepted as impacting on a therapy's success. A nonspecific variable, it relates to faith in the institution, therapist or treatment. Expectation has always had a role in therapeutic encounters, and may have more benefit than the effects of the treatment being administered (Coe, 1980 p.423). This could be particularly true for Healing when observed from a symbolic or ritual perspective.

Kwan (2007), like Hunt (2002), argues that expectation is misunderstood, and claims that it is the human capacity to self-heal and not their expectations and beliefs that heal. The experience of having belief and expectation helps to facilitate that which triggers self-healing. Kwan's argument is derived from spirituality and ritual healing, in which he claims that

effective healing lies in its performance, and not in its meaning being decoded from the ritual performer or encoded through the professional observation (Kwan, 2007).

Respondents would not consider themselves as performing healing rituals or symbolic healing. To respondents, Healing has tangential experiences that defy scientific measurement. How Healing works was of minimal concern for the respondents, and they were not concerned if researchers did not believe that it works. The crux of this discussion is that within Healing it does not matter what respondents believe or think is happening. They are able to report that they are producing a therapeutic outcome that could be a psychosomatic or psychosocial in influence.

Difficulty in perceiving effectiveness suggests that respondents are able to initiate a healing-presence that performs beyond their conscious direction. Therefore, respondents might perceive Healing better than how they might account for it. Respondents' individual Healing styles provide them with the 'how' to Heal. It is the 'what' will happen or outcome that is unknown.

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Appendix A

Healing Trust chakra philosophy

The Healing Trust now teaches the role of chakras within their philosophy (The Healing Trust, 2006 pt.1 7:1). The chakras come from Indian Ayurvedic medicine and consist of seven energy centres within the body that form the main chakras and many smaller ones (Gerber, 2000 p.18). Most references to the chakras limit their discussion to the main seven. They are located from coccyx up the torso to the crown of the head (Davis, 2009 p.348) but are invisible to mechanical detection (Reid, 1998 p.147). Chakras, it is claimed, look like spinning wheels of colour and light (Gerber, 2000 p.18) from which, it is postulated, they redistribute subtle energy absorbed from the environment through the human body. Each chakra is associated with a different part of the body, and illness can be attributed to blocked energy, known as prana, within each chakra.

Appendix B

The Healing Trust's Healing procedure

The first action in the Healing procedure is for the practitioner and the recipient to prepare for the Healing session. In the physical aspect of the Healing performance the recipient is asked to lie on their back on a massage bench, or, if that is not possible, to sit upright in a chair. The psychological preparation for the healing-act is to get the practitioner into a state of focusing their intention, and for the recipient to relax and accept the benefits of the Healing- act. This is described as linking the higher conscious of the practitioner to the higher conscious of the recipient (The Healing Trust pt.2, 2006 p.2:8).

Known as an attunement, which means 'bring to harmony' (The Healing Trust pt.1, 2006 p.5:1), its purpose is to enhance the healer's and recipient's ability to receive the Healing energy. For the healer, attunement is performed as a means of raising their consciousness, which enables them to become a better channel for the source of the Healing energy. The healer enacts their own attunement by performing a combination of various techniques according to their discretion or preference. These generally include the healer allowing themselves to become relaxed through awareness of their breathing and then confirming their intent to perform Healing through prayers, mantras, visualisation or meditation.

The healer needs to be attuned to both the source and to the recipient. Attunement for the recipient revolves around being placed in a comfortable position, usually lying on their back, from which the healer will explain to them how the Healing-act is performed. This short time is also used to allow the recipient to settle down and relax, and then a mental link is made between the two. The healer themself asks for the recipient's higher consciousness to accept the Healing energy.

Attunement links the healer consciously to the recipient's higher self and the Healing energy. This is known as an altered state of consciousness, but not in the traditional sense often referred to in some meditations. The healer is always aware of their actions and performance in the room. The Healing procedure may then begin.

The Healing-act is simple in procedure. The actual Healing performance first revolves around the chakras of the human body (The Healing Trust pt.2 2006 p.7:1), starting with the crown chakra above the head and then working down to the root chakra at the pelvis. The healer spends a couple of minutes placing their hands in the appropriate position over each chakra.

Following the chakra positions, the healer then works the body of the recipient. Starting with a few minutes on the shoulders, the healer gradually moves to one of the arms in a rhythmic motion. From a position of both hands on the shoulders one hand is moved to the healee's elbow, and then after a few minutes the other hand is moved to the same elbow and the first hand is moved to the wrist. Both hands are then placed over the wrist to give them proximity over the healee's hand.

This procedure is then repeated with the recipient's legs, from whichever side the healer is on. When one side of the body is complete, the healer simply repeats the procedure on the other side. The last step is to place both hands over the healee's feet to ground the recipient.

Appendix C

Opening questions/information
Is the participant male/female?
What age bracket is the participant? 20-29 30-39 40-49 50-59 over 60
How long have you been a member of the NFSH?
Do you remember when you first became interested in HOH?
What influenced that interest?
Do you practice other therapies?
Is HoH practiced alone or as an adjunctive therapy?
Are you psychic or have medium abilities?

Main research questions
In a critical case study
So, if we were to discuss your experiences with a client:

Please explain to me your procedure for treating the client.
(How do you prepare your client for the session?)

During this procedure, what do you believe is happening during the Healing process with the client?

When you are using your hands, is this part of a performance or part of the mechanism of the treatment? (Do you really need to?)

Are there any other actions you perform that you would consider to be a technique?

If your presence as a healer is an option then how does that presence contribute to the Healing process? (As opposed to performing absent healing)

Did you notice a change in the client; if so, when did you notice?
(How did you notice? Visual, behavioural, or did your client tell you?)

Are you as a NFSH healer concerned with observing effectiveness?
If so, how do you measure effectiveness?

When you notice changes in your clients, do you consider some of them (changes) to be a measurable outcome, and how do you see that measurement as reliable?

Do you have any thoughts or observations about whose criteria should be used to evaluate healing?
(Client's/health service's/healer's)?

How do you relate your healing practice/ability to your everyday health concerns and personal illness?

Exit questions
Is there anything you think I should have asked?
Is there anything you would like to add?

Appendix D

Participant	Gender	Multi-therapist	Psychic	Spirit guides	Age
Ann	female	yes (many)	no	Accepts guides	63
Bob	male	no	yes	Accepts guides	63
Carol	female	no	yes	Uses guides	83
Donna	female	yes (2)	yes	Accepts guides	53
Evan	male	no	no	Accepts guides	55
Fran	female	no	yes	Accepts guides	64
Gill	female	yes (2)	yes	Uses guides	80
Helen	female	no	yes	Uses guides	59
Ian	male	no	yes	Accepts guides	64
Jack	male	no	yes	Accepts guides	44