

Examining the Impact of a Healing Touch Intervention to Reduce Posttraumatic Stress Disorder Symptoms in Combat Veterans

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Objective: This study examined the use of Healing Touch (HT), a biofield therapy, as an intervention in treating posttraumatic stress disorder (PTSD). It exemplifies the upswing of biofield (energy field) therapies that have been taking place recently for a number of clinical conditions, including cancer, pain, arthritis, movement restriction, and energy psychology. Theoretically, the human body is the physical aspect of an individualized field of energy (biofield) in which electrical activity functions as a complex, organized whole or system. Hypothetically, this system plays a critical role in the effective treatment of PTSD. Trauma-induced congested energy in vital areas of the human body, particularly the chakras and the funnel-shaped crown-to-transpersonal channel, impedes the natural release of unwanted energy of emotions, thereby becoming a major obstacle to treatment. This qualitative and quantitative study examined the use of HT as an effective intervention to break up and clear away congested energy, promote a strong energy flow, and allow the natural release of unwanted energy of emotions to normalize. The test group would average a mean reduction of symptom severity of at least 18 points after 10 treatments, as measured by the psychometrically sound self report measure of PTSD symptom severity for military use. **Method:** In a 2-armed randomized crossover waitlist controlled trial, combat veterans experienced the impact of HT techniques complementing standard care on the severity of their PTSD symptoms. **Results:** The test group's mean reduction of symptom severity was a clinically significant 18.11 points, along with a reliable change of 5.57 points for the control group. Overall, subjects reported a range of positive physical and psychological effects. **Conclusion:** Although continued research using larger samples is needed, it may be concluded that HT is a low-risk, low-cost intervention for PTSD that should be implemented as a treatment option, especially in combination with "gold-standard" therapies.

Clinical Impact Statement

The healing power of touch has its roots in Judeo-Christian traditions borrowed from ancient Middle Eastern civilizations, in the Buddhist background of Reiki, and in the energetic foundations of Chinese medical practices. Janet Mentgen's Healing Touch program is a modern adaptation of ancient methods that is new to the therapeutic scene for posttraumatic stress disorder (PTSD). This study confirms its rightful place alongside psychological interventions and hints of an essential complementary relationship with other therapies that could impact future PTSD treatment practices for military and civilian populations.

Keywords: PTSD, symptom severity, combat veterans, Healing Touch, congested energy

Combat veterans are those individuals who have fought in combat during a war or a skirmish against a declared enemy. Although statistics from the National Center for Veterans Analysis and Statistics indicate that the population of veterans is declining (19,602,313 in 2018 vs. a projected 11,995,108 in 2045), these veterans' psychosocial needs remain a major issue that affect the care and management of veterans today. The population of veterans is aging, with the largest group in their 70s.

The characteristic experiences and field encounters that combat veterans face produce sorrow, physical pain and suffering, stress of combat, extreme exhaustion, and emotional torment. Multiple and extended deployments, new kinds of weaponry (e.g., improvised explosive devices), and the high incidence of traumatic brain injuries as well as other types of injuries contribute to the psychosocial trauma of war. Hassan, one veteran interviewed, explained, "Serving in a combat zone multiple times and engaging the enemy multiple times affects how you see the world. Even for those of us that never shot at the enemy, we return home viewing our environment through a different lens" (Jackson, 2013).

These different lenses often are the result of posttraumatic stress disorder (PTSD), characterized by symptoms such as reexperiencing a past trauma, engaging in cognitive or behavioral avoidance of trauma triggers, and hyperarousal. Past traumas that involved

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death, serious injury, or the threat of these are those incidents most likely to result in PTSD (American Psychiatric Association, 2013). PTSD is a persistent problem for combat veterans and active-duty military personnel. Estimates indicate that 21.8% of recent Iraq and Afghanistan veterans receive a PTSD diagnosis. The incidence of PTSD reportedly increases with combat exposure (Phillips, Leardmann, Gumbs, & Smith, 2010; Smith et al., 2008; Vasterling et al., 2010).

Understanding, preventing, and effectively treating PTSD remains a key priority for VA clinicians and researchers. Common treatments include talk therapies (Forbes et al., 2012; Kline, Cooper, Rytwinski, & Feeny, 2018), pharmacotherapy (Institute of Medicine, Board on the Health of Select Populations, 2014; Krystal et al., 2011), complementary and alternative medicine (Church & Feinstein, 2017; Jain et al., 2015), and combined therapies. However, these therapies have limited benefits for combat-related PTSD. For example, pharmacology has been associated with treating symptoms rather than core issues and introduces the risk for addiction and side effects (Friedman, Marmar, Baker, Sikes, & Farfel, 2007; Krystal et al., 2011). Talk therapies can require significant time, thus incurring substantial cost and reporting high dropout rates. One review found that only 2–8% of PTSD patients received an adequate dose (eight sessions or more) of prolonged exposure or cognitive processing therapy, the “gold standard” psychotherapies for PTSD (Najavits, 2015). This is often due to subjects dropping out, declining treatments, or not being a good fit.

Complementary and alternative medicine therapies have been increasingly sought by military personnel to treat various health concerns. Estimates have indicated that 39.3–50.7% of U.S. military personnel report use of such therapies (e.g., acupuncture, energy healing, biofeedback) within the previous year (Jacobson et al., 2009; Kent & Oh, 2010; Smith et al., 2007). Relevant to this study, use of complementary and alternative medicine is particularly prevalent among veterans and military personnel diagnosed with PTSD.

Energy healing has been around for thousands of years. Therapies from Chinese medicine to Native American practices posit that there is an energy field that makes up and surrounds the body (Anderson, Anselme, & Hart, 2017). In the practice of Reiki, an energy therapy from Japan, hand positions are used to affect the field around the body to promote healing (Usui & Petter, 2011). Common purposes of the many modalities are to balance the right and left sides of the field, clear and energize the chakras, break up blockages of congested energy, and clear the field of toxins and debris. Proponents of energy therapies assert that releasing excessive, unneeded, and unwanted energy is key to health and recovery (Brennan, 1993; Chiasson, 2013). Therapeutic intervention can break up and clear away such congestion. This, essentially, is what Healing Touch (HT) techniques accomplish. When trauma-induced congested energy is not dealt with, it remains in one's cells and energy field, becoming denser with time as more related energy of emotions is added (Fuentes, 2007). As this occurs, the potential positive effects of psychotherapy and other interventions can be obstructed, and symptoms of trauma suffering become increasingly severe. The only other known randomized controlled study that looked at HT and PTSD was a trial by Jain et al. (2012). It combined HT with guided imagery as complements to standard care and found a significant reduction in PTSD symptom severity and depression. However, it was difficult to tell which of the two

complementary approaches—HT or guided imagery—was the therapeutic ingredient. This study examined the impact of HT as the only complement to standard care without the confound of guided imagery on PTSD symptom severity.

Method

This two-armed randomized crossover waitlist controlled trial was conducted at the Tibor Ruben VA Medical Center, Long Beach, California.

Sampling

Veterans eligible to participate had to be mental health care outpatients with a current diagnosis of PTSD; age 18 or older; with at least one deployment in a combat zone (as documented in their military file and confirmed verbally); mentally fit to participate, as confirmed by their mental health care providers and the researcher's observation; and physically fit to participate, as confirmed by the researcher. Those interested in the study were self-referred or referred by mental health care providers.

The study was publicized using flyers that announced the date, time, and place for combat veterans to learn about the research trial using HT as a PTSD intervention. The informational meetings presented the consent form in detail and answered questions. In addition, there were investigator presentations to outpatient support groups and groups of mental health care providers. A total of 40 study candidates were enrolled over a period of 5–6 weeks. Those veterans who chose not to participate often had scheduling conflicts or were skeptical of HT. Those who signed up were interested because there would be no medication or talk therapy involved. With enrollment completed, random assignment to the control and treatment groups was performed. The test group consisted of 19 subjects (1 subject dropped over the course of treatment), and the control group consisted of 20 subjects. Average psychometrically sound self report measure of PTSD symptom severity for military use (PCL-5) scores at screening were 58.31 ($SD = 12.57$) for the test group and 62.27 ($SD = 13.7$) for the control group. Average age of subjects was 62.3 ($SD = 10.0$) for the test group and 57.7 ($SD = 15.3$) for the control group. All branches of military were represented in each sample. This study was approved and overseen by the Veterans Affairs (VA) Medical Center Institutional Review Board. Coding was used to protect participants' identities.

Treatment

In Phase 1 of the study, the test group received a weekly series of 10 1-hr HT treatments in addition to standard care, and the control group received only standard care. Standard care was delivered by subjects' regular practitioners and consisted of medication, psychotherapy, and a variety of other interventions, such as relaxation training, meditation, archery, or yoga. In Phase 2 of the study, which commenced immediately upon conclusion of Phase 1, the control group (now the Phase 2 test group) received the weekly series of 10 1-hr HT treatments.

Two different protocols were used in each session. The first was the HT biofield treatment. First, the HT practitioner would conduct an intake by soliciting verbal input from the client. Second, the HT

Table 1
Descriptive Statistics: Test groups, phase 1 and 2

Variable	Screening	Phase 1 posttest	Phase 2 posttest	Phase 1 delayed post	Phase 2 delayed post
Test group Phase 1	$M = 58.32$ $SD = 12.57$ $n = 19$	$M = 40.21$ $SD = 19.16$ $n = 19$	—	$M = 43.29$ $SD = 14.79$ $n = 17$	—
Test group Phase 2	$M = 62.27$ $SD = 13.68$ $n = 15$	$M = 56.70$ $SD = 12.52$ $n = 20$	$M = 42.30$ $SD = 15.99$ $n = 20$	—	$M = 48.30$ $SD = 16.45$ $n = 20$

Note. In Phase 1, the test group received Healing Touch (HT) plus standard care, and the control group received standard care only. In Phase 2, the control group became a second test group, receiving HT plus standard care.

practitioner would prepare by grounding, centering, and setting the intention of contributing to the highest good of the client. At this time, the practitioner also would practice the art of presence, conveying from the heart unconditional love and limitless compassion. Third, a pretreatment energetic assessment would be conducted wherein the subject would be assessed using a pendulum, a hand scan, and a check of the energy field's edges. The HT practitioner would include the transpersonal in the pendulum assessment and note if there were any leaks of energy from the field or if the field was off-balance in relation to the physical body. Next, four interventions would be conducted: (a) the Hara Alignment Meditation, (b) clearing the client's body using full-body connection with chelation, (c) breaking up energy congestion through ultrasound treatment of chakras, and (d) magnetic clearing to flush the subject of unneeded energy. Finally, the HT practitioner would conduct a posttreatment energetic assessment using the pendulum, hand scan, and check of the field edges and address any needs for field balancing or leak sealing.

The second protocol was the HT amygdala treatment. The procedure began with the HT practitioner standing behind the client, placing his or her fingertips in different positions on the head for the purpose of sending the amygdala healing energy to restore harmony and balance and then to promote energy flow and communications between the amygdala and the (a) brainstem, (b) prefrontal cerebral cortex, (c) adrenal glands, and (d) root chakra. This protocol closes with both the HT practitioners' hands above the client's heart. Finally, the HT practitioner would ground by holding the client's feet, allowing electrical balance to be normalized for the practitioner and the subject (Wardell, Anselme, & Kagel, 2014).

Treatments were delivered by a certified HT practitioner in a private, comfortable exam room at VA Medical Center Long

Beach. Before starting treatment, each subject was educated about what to expect during the therapy, hand positions that would be used, and the process for consent for touch. At the completion of each treatment, subjects were offered water and allowed time for any questions or concerns. Subjects were advised they could discontinue treatment or withdraw from the study at any time. If PTSD symptoms were exacerbated, the research staff would have protected subjects' rights and supported them physically, emotionally, and psychologically. If a higher level of care was needed, the individual would have been referred to the walk-in mental health clinic or emergency department.

Measurements, Data Collection, and Analysis

The PCL-5 was used to assess the severity of military service-related PTSD symptoms experienced by subjects within the previous month. For each symptom, respondents rated their incidence on a scale of *not at all* (0), *a little bit* (1), *moderately* (2), *quite a bit* (3), and *extremely* (4). The scale score was calculated by summing the item scores, yielding scale scores of 0–80. A cutoff score of 33 is needed for a provisional diagnosis of PTSD. A change of 5 points or more indicates response to treatment, whereas a change of 10 points or more indicates clinically meaningful improvement.

All subjects were assessed using the PCL-5 at the time of consent, constituting both groups' screening test and the treatment group's pretreatment test. Both groups also were assessed immediately after Phase 1, which constituted the treatment group's immediate posttest and the control group's pretest. Additionally, the treatment group was assessed 3 months after Phase 1 to produce a delayed posttreatment test. The control group was assessed immediately after receiving the 10-treatment series and 3

Table 2
Comparison of Mean Phase 1 PCL-5 Scores

Variable	Test group	Control group	<i>t</i>	<i>df</i>	Significance
Screening	$M = 58.32$ $SD = 12.57$ $n = 19$	$M = 62.27$ $SD = 13.68$ $n = 15$	.875	32	.388
Phase 1 posttest	$M = 40.21$ $SD = 19.16$ $n = 19$	$M = 56.70$ $SD = 12.52$ $n = 20$	3.164	30.773	.003

Note. In Phase 1, the test group received Healing Touch plus standard care, and the control group received standard care only.

Table 3

Posttraumatic Stress Disorder Symptom Severity Over Time: Phase 1 (Test) Group

Variable	Paired differences					<i>t</i>	<i>df</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>SE</i> mean	95% CI of the difference				
				Lower	Upper			
Screening vs. Phase 1 post	18.11	18.13	4.16	9.37	26.85	4.352	18	.000
Screening vs. Phase 1 delayed post	15.71	8.52	2.07	11.33	20.09	7.600	16	.000
Phase 1 post vs. Phase 1 delayed post	−4.65	14.77	3.58	−12.24	2.94	−1.298	16	.213

months after Phase 2 to produce its posttest and delayed posttest scores. Open-ended qualitative data were additionally gathered during the immediate and delayed posttreatment tests using a single question: "How have you been helped by participating in this research trial? Please explain in as much detail as you'd like."

Subjects completed the assessments in a private room without others present. Analysis of PCL-5 data used descriptive statistics and independent samples *t* test to detect differences between the treatment and control groups. Paired *t* tests were used to identify significant differences in PCL-5 scores over time.

Results

Descriptive statistics were calculated for both arms and for the sample overall (see Table 1). At screening, both groups exhibited moderate PTSD symptom severity, with the test group reporting a mean of 58.32 (*SD* = 12.57) and the control group reporting a mean of 62.27 (*SD* = 13.68). At the end of Phase 1, the test group's symptom severity decreased to 40.21 (*SD* = 19.16), while the control group exhibited only a slight decline (*M* = 56.70, *SD* = 12.52). The control group showed less severity at the end of Phase 2 (*M* = 42.30, *SD* = 15.99). Both groups showed a sustained lowering of symptom severity at the 3-month follow-up assessment, with the test group reporting a mean of 43.29 (*SD* = 14.79) and the control group reporting a mean of 48.30 (*SD* = 16.45).

Independent samples *t* tests revealed that the test and control groups exhibited similar symptom severity on the pretest but that the test group reported significantly lower symptom severity on the Phase 1 posttest (see Table 2): $t(30.773) = 3.164$, $p < .01$, suggesting that the HT plus standard care was more effective at reducing PTSD symptom severity than standard care alone.

Paired *t* tests were calculated for the Phase 1 test group to determine whether the PTSD symptom severity was significantly different over time (see Table 3). Results indicate that, compared to the symptom severity at screening, a significant decrease in symptoms was reported at the posttest, $t(18) = 4.352$, $p < .001$, and delayed posttest, $t(16) = 7.600$, $p < .001$, but that no significant change was noted from the posttest to the delayed posttest: $t(16) = -1.298$, $p > .05$. These results suggest that the Phase 1 (test) group experienced a decline in symptom severity during the period in which they received HT plus standard care and that these results were sustained 3 months after the treatment period.

Paired *t* tests also were calculated for the Phase 2 (control) group (see Table 4). Results indicate that, compared to the symptom severity at screening, a significant decrease in symptoms was reported at all subsequent points in time, $p < .05$. Moreover, significant declines in symptom severity were noted from the Phase 1 posttest to the Phase 2 posttest and to the delayed posttest, $p < .05$. These results suggest that the Phase 2 (control) group experienced a decline in symptom severity during the period in which they received standard care only and the period in which they received HT plus standard care. These results were sustained 3 months after the treatment period.

Qualitative Result

Qualitative analysis focused on open-ended question responses that identified common effects experienced by subjects covering PTSD symptoms, pain, and general health and well-being. Such responses revealed that 18 Phase 1 (test) subjects and all 19 Phase 2 (control) subjects reported positive effects (see Table 5). The

Table 4

Posttraumatic Stress Disorder Symptom Severity Over Time: Phase 2 (Control) Group

Variable	Paired differences					<i>t</i>	<i>df</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>SE</i> mean	95% CI of the difference				
				Lower	Upper			
Screening vs. Phase 1 post ^a	5.000	6.782	1.751	1.244	8.756	2.855	14	.013
Screening vs. Phase 2 post ^a	18.467	9.538	2.463	13.184	23.749	7.498	14	.000
Screening vs. Phase 2 delayed ^a post	11.600	12.426	3.208	4.719	18.481	3.616	14	.003
Phase 1 post vs. Phase 2 post ^b	14.400	12.343	2.760	8.623	20.177	5.217	19	.000
Phase 1 post vs. Phase 2 delayed post ^b	8.400	14.039	3.139	1.830	14.970	2.676	19	.015
Phase 2 post vs. Phase 2 delayed post ^b	−6.000	8.724	1.951	−10.083	−1.917	−3.076	19	.006

Note. ^a *n* = 15. ^b *n* = 20.

Table 5
Positive Effects of Healing Touch Reported by Subjects

Positive effect	Phase 1 (test) group (n = 18)	Phase 2 (control) group (n = 19)	Total (n = 37)
Improved mood and relaxation	14	14	28
Reduced pain	10	9	19
Overall improvement	5	8	13
Gained self-care awareness and tools	1	7	8
Reduced PTSD, sensitivity to triggers	1	6	7
Increased energy and mobility	1	5	6
Reduced blood pressure (self-reported)	2	1	3

Note. PTSD = posttraumatic stress disorder.

most commonly reported effect was improved mood and relaxation (n = 28). Participants shared the following:

This is very good. I can relax when I am here. I only sleep 3 to 4 hr a day. It helps me to be calm. I get stressed out with life and family. (69-year-old Army veteran, Phase 1 [test] group)

I looked forward to each session and always felt great after. . . . Yes, as I left the Sessions I felt more relaxed. (74-year-old Army veteran, Phase 1 [test] group)

My stress level has gone down. . . . I was coming out of my depression, not easily startled, calm, and getting back to "my normal self." My sleep was getting better. (53-year-old USMC veteran, Phase 2 [control] group)

Helped me control my temper. . . . It helped me by being more relaxed and less aggressive. (69-year-old Army veteran, Phase 2 [control] group)

Nineteen of the 37 subjects reporting positive effects disclosed reduced pain, as described by these participants:

Pain levels went down in periods of time. Normal pain levels 5 to 10. Not too much now. I still have chronic pain under 5. . . . Pain in my right hand is not as severe. (63-year-old Navy veteran, Phase 1 [test] group)

My knee has not had a flare-up; is no longer bothering me. (53-year-old Army veteran, Phase 1 [test] group)

Helped reduce pain in my back and joints. (69-year-old Army veteran, Phase 2 [control] group)

The 10 treatments helped prevent my back muscle spasms from reoccurring. (67-year-old Navy veteran, Phase 2 [control] group)

Thirteen of the 37 subjects reported general overall improvement. Comments included the following:

These sessions have made quite a bit of difference in my overall condition. (69-year-old Army veteran, Phase 1 [test] group)

I feel I'm a better person. . . . I think . . . no, I know . . . that Healing Touch has helped me! (67-year-old USMC veteran, Phase 1 [test] group)

I always left feeling better physically and mentally about myself. (71-year-old Army veteran, Phase 2 [control] group)

After therapy, I always left feeling better than when I arrived. (66-year-old Army veteran, Phase 2 [control] group)

Note: 39 of the 40 Phase 1/Phase 2 test group subjects completed the trial. The single dropout was uncomfortable being treated by a male practitioner.

Eleven of the 38 total subjects noted some limits to the effects they experienced (see Table 6). Ten of these subjects stated that the effects of their experiences were temporary. Sample quotes include the following:

When I leave, I feel, for the most part, without pain and at general peace with the world. However, the duration of these feelings lasts only between 3 hr to 3 days. I wish there was a more permanent effect of the treatment. (56-year-old USAF veteran, Phase 1 [test] group)

During the sessions, I felt that things were a little better, but only for that 1-hr session. After leaving, it seems that I would go back to the way things were prior. I believe that my external environment must change before I can experience the changes needed to go forward and truly heal. Thank you. (44-year-old USAF veteran, Phase 1 [test] group) *Note:* This veteran was on an overseas civilian assignment during the post + 3-month period and could not be reached for further assessment.

After the treatments, I've been slipping back into something dark. I've been constantly cranky and irritable, along with uncontrolled outbursts. My sleeping pattern has gotten worse, and I have days when I

Table 6
Limited Effects of Healing Touch Reported by Subjects

Limit on effect of Healing Touch	Phase 1 (test) group (n = 5)	Phase 2 (control) group (n = 5)	Total (n = 11)
Temporary improvement only	5	5	10
No or uncertain impact on PTSD	1	1	2
Not as effective as standard care	1	0	1

Note. PTSD = posttraumatic stress disorder.

Table 7
Subjects' Perceptions of Healing Touch

Perception	Phase 1 (test) group (<i>n</i> = 9)	Phase 2 (control) group (<i>n</i> = 10)	Total (<i>n</i> = 25)
Appreciated and enjoyed the experience	3	8	11
Practitioner presence was integral to the treatment	4	5	9
Want to receive more HT	3	6	9
Recommended HT for other veterans	4	4	8
Complemented other treatments		1	1

Note. The practitioner became a Healing Touch (HT) student in 2008, began giving treatments at this Veterans Affairs medical center in 2011, received formal certification in 2016, and gives about 100 treatments per month for a variety of conditions.

do not want to do anything . . . so I stay in my room for days while not eating anything. (53-year-old USMC veteran, Phase 2 [control] group)

It helped during the sessions, and afterward things went back as before the sessions started. Relief of pain was only temporary. (71-year-old Army veteran, Phase 2 [control] group)

Twenty-five subjects (9 Phase 1 subjects, 16 Phase two subjects) also offered their perceptions of HT (see Table 7). Eleven subjects expressed that they appreciated and enjoyed the experience. These subjects commonly stated they “enjoyed it,” were “thankful,” “looked forward to it,” and that it was a “very positive experience.” One 70-year-old Army veteran expressed, “I can’t thank you enough, and will forever be grateful for giving me the opportunity to be part of this wonderful research program.”

Nine subjects voiced their desire to receive more HT treatments. While some voiced a request for HT to be a regular offering or to be included in future HT research or treatments at the VA, others had already continued their HT treatments on their own initiative by the time of the follow-up survey. Another 74-year-old Navy veteran shared, “I’ve missed the contact and find myself wondering what sort of follow-up I can structure in my life. I’m currently getting some physical therapy and am considering getting a trainer.” Based on their positive experiences, eight subjects also expressed their desire for other veterans to receive HT. One 34-year-old Army veteran in the Phase 2 group stated, “I wish to use the knowledge to help fellow veterans.” Another 69-year-old Army veteran in the Phase 1 group explained,

Healing Touch would be a blessing to anyone suffering from chronic pain, a tremendous asset to the VA’s program, and a huge benefit to all vets suffering from chronic pain. I have highly recommended these treatments to all my veteran brothers.

Another notable finding was subjects’ emphasis that the practitioner was central to the positive nature of their experience (*n* = 9). Many of these subjects stated that the practitioner was “fantastic,” “a blessing,” “wonderful,” and “patient.” They also described specific aspects of his approach that enhanced their experience. Such comments included the following:

At first it was a little weird, but coming to know Kirk and trusting him, I felt at ease. He put me in a place of calm. He has a way of making you feel safe and relaxed. (50-year-old Army veteran, Phase 1 [test] group)

All the providers involved conveyed a genuine sense of care and concern for me and my well-being . . . much greater than most if not

all of interactions with other VA Medical Center Long Beach staff/providers. . . . I very much enjoyed, appreciated, and felt positive benefit from the one-on-one contact on a reoccurring basis with the Healing Touch provider. I’ve missed the contact. (74-year-old Navy veteran, Phase 2 [control] group)

Discussion

Subjects in both arms of the study showed sustained significant decreases in PTSD symptoms when receiving HT and standard care. Moreover, subjects reported a range of positive physical and psychological effects, although some subjects stated these effects were temporary. Nearly one third of subjects reported they appreciated and enjoyed the experience, and nearly one quarter expressed a desire to receive more HT and recommend it to other veterans. These findings are consistent with past studies that associated HT with reduction in PTSD symptoms (Jain et., 2012). Additionally, the present study added to literature because it did not combine HT with other complementary and alternative treatments (e.g., Jain et al., 2012) and also included a follow-up assessment.

Although continued research is advised, especially with larger sample sizes, it may be concluded based on these findings that HT is a low-risk, low-cost treatment for PTSD that should be implemented as a treatment option for PTSD, especially in combination with standard or alternative care.

HT energy therapy remains a relatively new intervention for PTSD. This study confirms its significance alongside psychological interventions—not necessarily as an alternative but rather as a complementary partner for trauma-focused therapy to calm, relax, and ensure optimal energy system functioning during the weeks of therapy. This may indeed signal a future impact on PTSD treatment for combat veterans.

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