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EFFECTS OF SPECIFIC EDEN ENERGY MEDICINE TECHNIQUES ON PAIN PERCEPTION AND THE HUMAN BIOFIELD: A COMPARATIVE STUDY

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1 Advanced Healing Energetics

Editors Note: This paper is a synopsis of the author's dissertation completed in 2018. This synopsis is a result of the importance of brevity for both publication of the article and the reader's convenience. A link to the complete dissertation is included as well.

Abstract

Purpose

To determine whether patient performed energy medicine techniques can reduce the perception of pain in subjects with chronic low back pain.

Materials

Materials included: the BioWell/GDV camera and software, questionnaires included the VAS Pain Scale and the McGill Pain Scale.

Method

In this pilot study, eleven subjects were recruited and completed the study. Two Eden Method interventions were used on a daily basis: the Daily Energy Routine and Zone Tapping techniques. Questionnaires were administered at baseline and study completion.

Results

All participants verbally reported reduction of pain to varying degrees and all had pain reduction on the McGill Pain Scale from beginning to end of study, with statistical significance of $p = 0.0006$. Significance was not found with either the VAS scale or all BioWell parameters.

Conclusion

Successful reduction of pain by participants utilizing energy medicine techniques suggests a new source of preventive healthcare practice with cost-saving potential. This would require further study with larger groups of subjects.

Keywords

Energy Healing, Energy Medicine, Eden Method and Reiki.

Introduction

In the United States, healthcare is prohibitively expensive, with continued rising costs projected and no real solution on the horizon. Is it time to examine this problem from a different perspective? Should we be looking at some of the ancient healing methods for insight and answers? Is there another little-known potential area of preventative healthcare practice that holds promise and the real possibility of healthcare cost reduction? Can viewing an old problem through a different, critically-specific lens shed new light? These questions have serious merit and should be addressed. Overlooked or unconsidered sources of preventive healthcare may offer possible solutions to the complex problem the United States now faces regarding healthcare utilization, delivery and cost to its citizens.

Healthcare in the United States costs more than in any other developed country, while its health outcomes are some of the poorest. Chronic pain management utilizes a significant portion of healthcare expenditures and currently involves additional expense for patients in terms of travel to other healthcare providers' settings, and costs for visits and/or treatment and pharmaceutical management. Pain, and its treatment, has become the most expensive portion of our healthcare costs. It is currently an estimated $560 – $635 billion, which is larger than the cost of all of the nation's priority health problems put together (Gaskin, 2012). What we are doing to manage the problem is clearly not working. One need only look at the opioid epidemic to realize we need to provide more efficient, cost-effective, safer, and ethical pain management protocols. A new source of patient-performed preventive healthcare practice for chronic pain management is necessary.

Background of the Problem

It is no secret that healthcare costs in the United States are expensive and rising at an alarming rate each year. This is evidenced by the frequency of healthcare cost-related articles appearing in newspapers, on television, online, and in popular journalistic publications. Past governmental legislation regarding possible repeal of the Affordable Care Act versus an overhaul of the system mandates our close attention to this critically important matter. An important concept of cost control and/or reduction that has received little attention is that of an innovative use of an energy medicine modality to help mitigate chronic pain, specifically chronic low back pain. This

paper is an exploration of the background of chronic pain, use of an experimental research study to address this, and limitations, findings, and conclusions. A sobering fact is that the United States spends a larger portion of its Gross Domestic Product (GDP) on healthcare than any other of the major developed and industrialized countries (Squires & Anderson, 2015, p. 1). In fact, the estimated total paid for healthcare received by the civilian, noninstitutionalized population of this country was $1.401 trillion in 2013 (Stagnitti, 2016, p. 1). These authors state the reporting of the expenses represent the various payments to hospitals, physicians and other healthcare providers and were gathered from information collected in the Medical Expenditure Panel Survey (MEPS) Household Component and payment data and Medical Provider Components. In addition, the expense estimates include payments made by individuals, private insurance, Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) (p. 1).

A breakdown of the distributions of expenses for services revealed the following facts and relevant figures. Nearly 30% of total healthcare expenses were as a result of inpatient hospitalization, and prescribed medicines accounted for more than 20%. The population composed of those under age 65, the uninsured, and those with any type of private insurance had a larger proportion of their healthcare spending on ambulatory services such as office-based visits, outpatient hospital care and emergency room visits, than did those who were publicly insured. In the elderly population, those with Medicare and private insurance had a larger percentage of their healthcare spending accounted for by ambulatory services than did those covered by Medicare only, or Medicare and other public insurance. Private insurance paid for 40.6% of total expenses, Medicare covered 25.3%, individuals and family members paid for 13.8%, Medicaid/CHIP paid for 12.4 %, and other sources were responsible for 7.9% (p. 2-3). Delving further into an examination of the problem, specific figures add an additional important perspective.

A report from the Centers for Medicare and Medicaid Services provides the following data in its NHE Fact Sheet: National health expenditures grew 4.3% in 2016, to $3.3 trillion. This breaks down to $10,348.00 per person and accounted for 17.9% of the GDP. At this rate of growth, the projected NHE is estimated to grow at an average rate of 5.6% per year for 2016-25, and 4.7% per year on a per capita basis. As a result, health spending is projected to grow 1-2% points faster than the GDP resulting in the health share of the GDP to rise from 17.8% in 2015 to 19.9% in 2025. From the 2016 to 2025 15 projection period, the growth in NHE is driven by projected faster growth in medical prices. These prices were historically low in 2015 at 0.8% but are projected to be 3% by 2025. This faster-expected growth in prices is partially offset by the projected slower growth in use and intensity of medical goods and services (CMS).

Finally, another component related to healthcare costs is the burden posed by chronic disease. According to the CDC's Chronic Disease Overview fact sheet, chronic disease is the leading cause of death and disability in the United States. Indeed, 86% of the nation's $2.7 trillion annual healthcare

expenditures is for people with chronic medical and mental health conditions (CDC). Seven of the top ten leading causes of death in 2014 were chronic diseases; the top two together – heart disease (number one) and cancer (number 2) – account for nearly 46% of all deaths. The fact sheet identifies health risk behaviors that cause chronic disease, which include lack of physical exercise or activity, poor nutrition, use of tobacco, and alcohol abuse. Looking more closely at these risks, in 2015, 50% of adults 18 years of age or older did not meet the recommended guidelines for aerobic exercise, and 79% did not meet recommendations for strength training. In addition, in this same year, more than 37% of adolescents and 22% of adults reported eating less than one serving of fruit and/or vegetables per day. 15% of the population admitted to smoking cigarettes; cigarette smoking accounts for more than 480,000 deaths per year (p. 3). It is certainly a possibility that those with chronic pain face limitations in trying to follow these guidelines.

Chronic Pain

What is chronic pain, exactly? It has been variously described as pain that persists for 3-6 months but, in particular, longer than would be expected for "normal" healing for an injury or surgery, etc. (NIH NCCH "Chronic Pain in Depth, 2017). It can be the result of aging, underlying disease or a specific health condition, an inflammatory problem such as rheumatoid arthritis or carpal tunnel syndrome, or a non-specific "neuropathic" pain in which the cause is not well understood or even known (p. 2). Various professional medical associations, such as the American Family Physician, list specific guidelines for the treatment of chronic pain conditions such as low back pain, for example (Herndon, Zoberi & Gardner, 2015, p. 6-11). Low back pain is a very common problem said to affect at least 80% of individuals at some point during their lives and is the 5th leading cause for all physician visits in the United States (Patrick, Emanski & Knaub, 2014, p.1). A certain percentage of those afflicted go on to develop a chronic problem. Low back pain is a leading cause of activity limitation, creating work absences not only in the United States but throughout much of the world, creating a significant financial impact on individuals as well as their families, communities, affected industry and governments (p. 1).

Osteoarthritis is also a leading cause of chronic pain, often affecting the hands, hips, and knees. The American College of Rheumatology (2012) recommends both nonpharmacological and pharmacological treatment modalities which include assistive devices such as splints, walkers, canes etc., as well as pharmacologic agents (Hochberg, Altman, April, Benkhalti, Guyan. McGowan, Towheed, Welch, Wells, & Tugwell, 2012. p. 469). Lifestyle changes, weight loss as needed, and movement therapies are also specifically recommended for osteoarthritis of the hand, knee and hip. Pharmacologic agents range from topical capsaicin to topical and oral NSAIDs (nonsteroidal anti- inflammatory drugs as well as injectable corticosteroids (p. 471). Hip arthritis can lead to low back pain for some patients. Management of osteoarthritis in this fashion still requires regular clinical follow-up, particularly if any prescription medications are prescribed.

In terms of disability, the chronic pain of arthritis is the most common

cause of disability, with a high percentage of those diagnosed stating that they have trouble with activities of daily living as a result of their arthritis (CDC, 2018). According to the CDC's statement, "Cost Statistics: The Cost of Arthritis in U.S. Adults" (2018), the cost of arthritis in U.S. adults is two-pronged. Medical costs, which include prescriptions and ambulatory care visits, were $140,000 billion in 2013. Earnings losses, due to arthritis-attributable lost wages, were $164,000 billion in 2013 as well (p. 1). In 2008, about 100 million adults in the United States were affected by chronic pain, to include joint pain or arthritis, according to MEPS (Gaskin 2012, p.1). Pain, then, is another significant factor impacting the cost of healthcare in the United States.

It can be seen, then, that a significantly high contributor to the cost of healthcare in the United States stems from chronic diseases and disability, many of which appear to have a strong foundation in lifestyle choices. While an overview of the problem has been provided, what are some solutions? It could be argued that preventative health practices could, or should, have a significant impact on reducing these rates. How well do current preventative screenings work? How well are they utilized, recommended or followed? While a specific examination of these concepts is beyond the scope of this paper, according to the CDC these chronic diseases can be largely preventable or detected early enough to make a difference, through appropriate screenings ("CDC: Preventive Healthcare," 2018). However, many Americans go without preventive care due to a number of reasons, most often financial. Frequently, high co-payments and deductibles deter people and their families from obtaining recommended screenings and/or immunizations. While the ACA has made many of these preventative services covered without cost-sharing, under-utilization persists (p. 1).

Concept of Preventative Care

A concept of preventative care that deserves careful consideration is a modality that does not involve ambulatory care visits, injections, or invasive-type screenings. And that is the field of energy healing. Similar to the recommendations of getting regular exercise and improving dietary choices, another preventative care modality could be based on the body's innate ability to heal, given the right support. In addition, the modality should be easy, painless, cost-effective, able to be done at home and also accessible to those with disabilities such as low back pain and osteoarthritis. It would also be something that could be done in a short period of time that could show an overall improvement in energy, vitality, quality of life and possible reduction of pain. So much of the current healthcare system in the United States involves patients following the recommendations of others, placing their power in the hands of healthcare professionals. In other words, the locus of control is externally driven. Is it possible that self-care techniques performed by patients, that result in improvement in their symptomatology – things like increased energy and pain reduction, for example – might be a motivational force for health that deserves further examination? Is there a relationship factor here between mind, body and spirit as well?

The nursing profession, and in particular holistic nursing, has long recognized the importance of the

connection between body, mind and spirit in healing. In looking at the issue of pain, for example, at its most basic level, it is a signal from the body that something is amiss and needs to be addressed. However, today's modern advertising bombards society with any number of medications to control pain; in other words, treating the symptom, but not necessarily the root cause. The foundations of the nursing profession began with the efforts of Florence Nightingale, who was responsible for fundamental changes in how patients were cared for. Therapeutic communication and touch, using the hands, was a foundational piece of this. Caring for the whole person, then, involves the physical care of the body as well as appropriate mental, emotional, and spiritual support as needed.

Short History of Key Energy Practices in Nursing

A nursing paradigm pioneer, Martha Rogers, (1914-1994), promulgated her theory of the Science of the Unitary Human Being. To her, a person was not a singular entity but rather a "unitary human being" which she defined as an "irreducible, indivisible, pan-dimensional energy field identified by pattern and manifesting characteristics that are specific to the whole and which cannot be predicted from knowledge of the parts" (Dossey & Keegan, 2016, p. 467). She further defined this energy field as "the fundamental unit of the living and non-living. Field is a unifying concept. Energy signifies the dynamic nature of the field; a field is in continuous motion and is infinite." (p. 467). Rogers further described the person and environment as "open systems", believing that there is a constant interaction and exchange of energy and matter within these systems, with the implication that all of who we are – everything, to include our behavior, thoughts, emotions, consciousness and the unconscious parts of us are continuously interacting with everything and everyone in that environment (p. 467).

Modern nursing today has developed a nursing diagnosis of "imbalanced energy field" as well, which was approved by NANDA (North American Nursing Diagnosis Association) in February of 2017 (Press Release, AHNA, 2017). The energy field balancing technique of Healing Touch, for example, is a popular and widely used form of energy healing and used frequently by nurses with their patients in hospitals and other healthcare settings in the United States (Healing Touch International website, 2018). Indeed, the American Holistic Nurses Association (AHNA website, 2018) embraces a model of whole person wellness based on the concept of a "partnership" between nurse and client. This partnership arises from a recognition of the reciprocal importance of nurturing self and client. The AHNA was founded in the 1970s by Charlotte "Charlie" McGuire as a result of her concern over the current healthcare paradigm valuing profit over healthcare quality or working conditions for nurses. She and other like-minded nurses saw the need for the "nurturers to be nurtured." The system was broken, resulting in a sick healthcare system, with sick healthcare providers (AHNA.org, 2018). Sadly, it is not difficult to see parallels with today's healthcare system.

Eden Method

Other forms of energy healing involve Reiki, Pranic Healing,

Therapeutic Touch, Body Talk and Eden Energy Medicine, to name a few. Donna Eden, pioneer of Eden Energy Medicine, is a clairvoyant, teacher and author (Eden, 2018, p. 7). As a result of significant health problems that she suffered in her early thirties, she relocated to Fiji for a time in order to try to heal. A lifestyle that was supportive to healing included a locally-sourced diet free of chemicals and other residue of industrialization, daily ocean swims, no exposure to electronic media or devices and adequate quiet and restorative time. While dealing with a severely compromised immune system, she received successful treatment for a poisonous insect bite from the local village's shamans, which had an impact on her eventual desire to help others (p. 7). Upon returning to the United States, she was introduced to Touch for Health. Finding that the training awoke a familiar knowing in her, she found that the program gave her a structure that allowed her to balance her intuitive nature for working with the subtle energies that she could not only see but intuit. She relates that she went on to be trained in massage therapy in order to have a license to touch other people and thus opened a practice. Using her own experiences blended with the training from Touch for Health, she was able to help her clients balance their own energies in order to heal their ailments (p. 9).

As a result of this, she developed a series of simple, yet profound exercises that are designed to bring balance to the body's energy field, or biofield. Titled: "The Five Minute Daily Energy Routine," it is a series of movements designed to help build positive habits into the person's energy field (pp. 72, 73). Part of the movement techniques involve tapping on various areas of the body. The significance of the tapping is that they involve tapping on acupuncture meridian points. Church (2007) brings an important perspective with his work in Emotional Freedom Tapping to this concept. Piezoelectricity, involved in tapping, is an important and fascinating concept that is critical to the understanding of healing with subtle energy. When tissue has pressure applied to it, it causes a phenomenon called piezoelectricity; in other words, it can polarize into positive and negative electrical poles and generate electrical fields [22]--??? (Oschman, 2016, p. 162). This has profound relevance to working with the subtle energies of the biofield to promote healing.

In the article, "Six Pillars of Energy Medicine: Clinical Strengths of a Complementary Paradigm" (Feinstein & Eden, 2008), provide a convincing argument supportive of the six properties of energy medicine that could augment the current biochemical model that is the dominant structural foundation of conventional medicine (p. 44). These six strengths are: 1) reach, 2) efficiency, 3) practicality, 4) patient empowerment, 5) quantum compatibility, and 6) holistic orientation. The authors discuss the various ways that energy medicine supports these strengths in the following descriptions:

"Energy medicine can: 1) address biological processes at their energetic foundations (reach), 2) regulate biological processes at their energetic foundations (efficiency), 3) foster health and prevent illness with interventions that can be readily, economically, and noninvasively applied (practicality), 4) include methods that can be used on an at-home, self-help basis, fostering a stronger patient-practitioner partnership

in the healing process (patient empowerment), 5) adopts non-linear concepts consistent with distant healing, the healing impact of prayer, and the role of intention in healing (quantum compatibility) and strengthen the integration of body, mind, and spirit, leading not only to a focus on healing, but to achieving greater well-being, peace, and passion for life" (holistic orientation) (p. 44).

Finally, energy medicine requires no special tools or ambulatory visits to healthcare providers. These are important as well as intriguing concepts to consider when examining realistic methods to rein in spiraling medical costs, particularly in the area of chronic pain. Eden and Feinstein ("Energy Medicine: Balancing Your Body's Energies for Optimal Health, Joy and Vitality," 2008) define the term "energy medicine" in the following manner: "In energy medicine, energy is the medicine. Medicine is an agent that is used to heal or prevent disease. Your body's energies know how to mobilize themselves to respond to all manner of illness and threat, bringing the purest and most natural elixir that exists to care for your maladies. Energy gives life to the body. (p. 4). In energy medicine, troubled energies are the patient. The energy systems that attempt to adapt to a world of stresses, pollutants, and information overload unknown to your ancestors become overwhelmed and confounded, settling for imperfect compromises, and requiring significant re-patterning if you are to fully thrive. Energy medicine is able to bring about such repatterning" (p. 4).

Human Studies Ethics Approval

Approval from National Foundation for Energy Healing Human Studies Ethics Board receive April 22, 2018. Project #04-22-18-02.

Purpose

The purpose of this study is to determine whether patient performed energy medicine techniques can reduce the perception of pain in subjects with chronic low back pain.

Materials

Materials included, the BioWell/GDV camera and software, questionnaires included the VAS Pain Scale and the McGill Pain Scale.

Methods

In this pilot study, eleven subjects were recruited and completed the study. Two Eden Method interventions were used on a daily basis: the Daily Energy Routine and Zone Tapping techniques. Questionnaires were administered at baseline and study completion.

Statistical Analysis

All outcome measures (VAS, McGill Pain and BioWell) were summarized in terms of means, standard errors and 95% confidence intervals. A linear
mixed effects model with subject-specific random effects was used to evaluate changes from pre- to post-assessments and to conduct comparisons between the initial and end of study assessments. Changes from pre- to post-intervention assessment were quantified by calculating Cohen's effect size *d*. Effect sizes *d* are interpreted as follows: $d < 0.2$ no change, *d* between 0.2 and 0.5 indicates small change, *d* between 0.5 and 0.8 indicates a moderate change and $d > 0.8$ indicates a large change. All reported *p*-values are two-sided and P <

0.05 was used to define statistical significance.

Results

All participants verbally reported reduction of pain to varying degrees and all had pain reduction on the McGill Pain Scale from beginning to end of study, with statistical significance of $p = 0.0006$. Significance was not found with either the VAS scale or all BioWell parameters.

Discussion

Our current preventive or preventative screening guidelines are failing to actually address the issue of prevention. There can be many reasons: lack of access or financial means to obtain preventive care; lack of knowledge of preventive services available, and finally a "one size fits all" list of these screenings. Screening must be tailored to the individual, taking into consideration the individual's actual specific risk factors and actual desire and/or understanding of the necessity of obtaining these screenings. An example of a pitfall of a "one size fits all" approach to preventative services is the following.

The U.S. Preventive Services Task Force (USPSTF), Center for Disease Control (CDC), and the American Heart Association (AHA) have recommended that clinicians screen their clients for heart disease risk factors since 2009 using the Framingham risk calculator, as well as consideration of screening for nontraditional risk factors such as coronary artery calcium, homocysteine levels, etc. The recommendations at that time found no benefit in adding these other screenings to the current considerations of age, family history, smoking history, activity, weight, etc. (USPSTF Final Recommendations, p. 1). In 2016, the USPSTF recommended the addition of statin therapy as a preventive medication for adults ages 40-75 with no history of CVD (cardiovascular disease), 1 or more risk factors for it, and a calculated 10-year risk of a CVD event of 10% or greater in addition to dyslipidemia screening (p. 2). Statins are believed to confer protective effects against coronary events due to their ability to reduce the biosynthesis of cholesterol (Stancu, 2001, p. 379). However, their use is not without risk; indeed, statin use has been linked to myopathy, rhabdomyolysis, hepatotoxicity, nephrotoxicity, diabetes mellitus, neurologic manifestations, release of proinflammatory markers, ophthalmological manifestations such as diplopia, etc., increased prostate cancer risk and erectile dysfunction in men, dry mouth, oral pruritus and cough (Grover, Luthra & Maroo, 2014, p. 894).

A curious consideration here, however, is that while most myocardial infarctions are believed to be caused by blocked coronary arteries due to plaque rupture or coronary embolism, recent acknowledgment of a medical condition theorized to be triggered by extreme physical or emotional stress has been identified which bears further examination. Known as "Broken Heart Syndrome", or Takotsubo cardiomyopathy, it appears to affect primarily postmenopausal women though has been documented in men and younger women. The name is derived from changes seen on cardiac imaging wherein there is a reversible "ballooning" of the left ventricle that is similar in appearance to Japanese octopus pots called "TakoTsubo" pots; hence the name. (Roshzamir &

Showkathali, 2013, p. 193). Found to be a unique form of reversible cardiomyopathy or enlarged heart, it is believed to be activated by a neurogenic stunning of the myocardial muscle tissue (Therkelson & Stronach, 2015, p.345). These authors state in their article "Broken Heart Syndrome: A Typical Case" that upon investigation, both ECG and cardiac markers show minimal change as well as no myocardial arterial blockage (p. 345). Since significant emotional or physical stress is an apparent trigger, and heart disease is the leading cause of death in women, preventive treatment with a statin is likely to be of little benefit to this group. This poses the question as to whether preventive recommendation guidelines for heart disease need to be augmented or revised to include stress identification and reduction modalities as a preventive approach, rather than treating all people with the current one-size-fits-all approach. Perhaps all preventative guidelines should be examined from this same perspective.

Modalities using magnetic fields, electrical currents, voltages or potentials; those using vibration/sound; mechanical and physical interactions such as acupuncture or acupressure; and modalities based upon human intention continue to offer intriguing insights into new methods of pain management and healing based on promising research studies in these areas and their effects on the human biofield. Indeed, several contemporary energy healing techniques such as Energy Medicine, Healing Touch, or Reiki, for example, are believed to employ a combination of these ways of working with the biofield and have shown positive results in terms of management of chronic pain, reduced fatigue, improved mental clarity and other health improvements, all without the frequently associated side effects and cost seen with the use of pharmaceutical and other contemporary interventions

In terms of chronic disease cost, as stated earlier, the treatment of pain is the most expensive facet of US healthcare expense. The opioid crisis is unfortunate evidence that our management of pain, both acute and chronic, is not sufficient. The small pilot study findings in this dissertation were successful with nearly all participants showing significance in terms of pain reduction using the simple technique of zone tapping. Zone tapping, as taught by Donna Eden in the Eden Method, is another effective and easy to use technique to help with chronic pain (Eden Energy Medicine Certification Program; www.innersource.net).

An important consideration to remember during this time of paradigm change is that a lack of understanding, and a focus on differences rather than similarities, often contributes to an inability by some to accept a new model or a new way of doing or thinking about something. A key point to keep in mind would be to emphasize the commonalities between biomedicine and the biofield, rather than the differences. Kuhn, in "The Structure of Scientific Revolutions," says we must remember the following conceptual background framework to consider when bringing forth change:

> "Examining the record of past research from the vantage of contemporary historiography, the historian of science may be tempted to exclaim that when paradigms change, the world itself

> changes with them. Led by a new paradigm, scientists adopt new instruments and look in new places. Even more important, during revolutions scientists see new and different things when looking with familiar instruments in places they have looked before. It is rather as if the professional community had been suddenly transported to another planet where familiar objects are seen in a different light and are joined by unfamiliar ones as well (Kuhn, 2012, p. 111)."

Kuhn's words definitely have applicable and important merit. Science continues to evolve and should never be considered to be settled on anything.

Conclusion

Successful reduction of pain by participants utilizing energy medicine techniques suggests a new source of preventive healthcare practice with cost-saving potential. This would require further study with larger groups of subjects. All participants verbally reported reduction of pain to varying degrees and all had pain reduction on the McGill Pain Scale from beginning to end of study, with statistical significance of $p = 0.0006$. Finally, measurement of the biofield using the research proven BioWell (Korotkov) GDV imaging camera and software, has the potential to yield useful information that also can direct further research. Thus, this study has shown merit and significance. Additional and larger studies emphasizing the role of client performed techniques are both warranted and necessary.

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