

Healing hands reviewing the potential applications of energy therapies to redirect pain during labor and childbirth

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HEALING HANDS: REVIEWING THE POTENTIAL APPLICATIONS OF
ENERGY THERAPIES TO REDIRECT PAIN DURING LABOR AND
CHILDBIRTH

by

CECELIA A. DINH

A Thesis submitted in partial fulfillment of the requirements
for the Honors in the Major Program in Nursing
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Thesis Chair: Ms. Joyce Burr

Abstract

The birth experience is a highly subjective phenomenon that leaves a lasting impression for mothers and their families and friends. Although the passage of a child from the mother's womb into the world is typically joyous, the experience is not always as positive. Negative physical and psychological factors may greatly impact a woman's impression of the childbirth experience. Among childbearing women, the two main concerns of childbirth are pain and safe management. Similarly among healthcare providers, management of labor pain is one of the main goals of maternity care.

Pain is a highly subjective phenomenon that is expected during the birth experience. Pharmacologic interventions have significantly reduced pain perception, but have left many women dissatisfied with the overall birth experience due to their potential adverse effects. Energy therapies have been studied for their role in creating a positive birth experience in relation to pain.

This literature review examines the empirical evidence and makes suggestions for research and practice regarding energy therapies during labor and childbirth published between 1986 and 2012. Energy therapies, specifically Reiki, Therapeutic touch (TT), and Healing touch (HT) were examined in regards to pain perception and the childbirth process. Although pharmacologic interventions have been successful in reducing some childbirth concerns, the addition of complementary therapies such as Reiki, TT, and/or HT provides a holistic approach to pain management during labor and childbirth.

Dedications

To my parents who have always supported my every decision and who have encouraged me to reach for success no matter how small of a task it may have been. Thank you for your unconditional love, wisdom, and guidance throughout my entire life spiritually, emotionally, and academically.

To David, who I love, respect, and adore. Thank you for bringing life and love into my heart.

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Introduction

The dominant image of the birth experience depicts the mother, family, and healthcare team celebrating the passage of a baby into the world from its previous dwelling, the mother's womb. For some, the overriding emotion is not joy but pain, fear, and/or worry. According to the American Pregnancy Association (2011), pregnancy can bring on psychosocial concerns (body image changes and insomnia) and physical discomforts (headaches, heartburn, sciatic nerve pain, and morning sickness), as well as other complications. Aside from the challenges of pregnancy, labor and childbirth open the door to other painful difficulties such as breech presentation, episiotomy, and premature labor (American Pregnancy Association, 2011).

Due to the highly interactive relationship shared with patients, nurses have a chance to intervene and assist the mother in relaxation, anxiety reduction, and alteration of pain perception experienced with labor and childbirth. According to Hidaka and Callister (2012), among the various complications associated with labor and childbirth, pain is the major concern for childbearing women. Reflectively, healthcare providers consider pain management as a top priority during labor and childbirth (Hidaka et al., 2012).

Shute (1997) explains that pain during labor and childbirth is a highly individualized phenomenon that can vary during different times and intensities for each childbearing woman. *Our Bodies Ourselves* (2011) further explains that labor and childbirth pain is different from other types of pain for the following three reasons: (1) the pain experienced during labor and childbirth is self-limiting and will end when the baby is born; (2) pain experienced is usually

intermittent, so the woman has times of rest; (3) the pain intensifies over time and allows the woman time to adapt. The majority of the pain experienced during labor and childbirth can be attributed to the strong, rhythmic contractions of the uterus in addition to the stretching of the cervix. Other common causes of pain and discomfort comes from the passage of the baby's head through the birth canal, back labor, fetal size, and shorter laboring time (Shute, 1997).

Studies indicate complementary therapies have been used to reduce the perception of pain. Kalder, Knoblauch, Hrgovic, and Munstedt (2011) identify complementary energy therapies such as Reiki, Therapeutic touch and Healing touch may be helpful as adjunct therapies during labor and childbirth because they are simple, noninvasive, and are shown to cause no harm.

Background

Pain

According to Lewis, Dirksen, Heitkemper, Bucher, and Camera (2011), pain is a multi-factorial, complex experience that causes suffering and decreased quality of life. Pain is highly subjective and is influenced by the individual's physiologic, behavioral, cognitive, spiritual, socio-cultural, and situational factors (Lewis et al., 2011). In this way, pain is similar to the individual nature of the birth experience.

Lewis et al. (2011), emphasizes the importance of the meaning of pain to the patient. In the context of labor and childbirth, women in labor may be in a great deal of pain but may not perceive the pain as suffering. Instead, they may embrace the pain as part of a joyful event. Conversely, pain may be perceived as uncontrollable and may lead to negative feelings as well as poor patient outcomes (Lewis et al., 2011).

Although pain during labor and childbirth is an expected phenomenon, the pain response is highly individualized and is based on the patient's cultural influences, psychological adaptations, and past experiences. The expression of pain in some cultures may allow the laboring woman to openly verbalize her pain, whereas in other cultures, the laboring woman may be expected to remain stoic and internalize her pain (Ward & Hisley, 2009).

In an effort to control the pain associated with labor and childbirth, medical interventions such as epidural analgesia have become a popular option offered to women as a single-line intervention. The strikingly increased use of medical interventions during the past twenty years

has put into question the safety and efficacy of epidural analgesia, induction, and operative deliveries.

Indraccolo et al. (2010) and Nguyen et al. (2010) suggest that routine medical interventions such as epidural analgesia and chemical inductions are used for pain more often than needed during labor and delivery. They have also suggested that routine epidural analgesia be deferred as much as possible due to the high incidence of birth related complications such as risk of vacuum extractions, labor induction, and operative deliveries. In addition, suggestions to explore other options for pain management were mentioned.

Routine medical interventions seem to be more readily available to the laboring mother than natural methods and interventions. Some natural interventions, specifically complementary therapies, such as herbs, hydrotherapy, homeopathy, and acupuncture have been used during the birth process and have shown to reduce the use of epidural analgesia and produced positive patient experiences (Bayles, 2007; Kalder & Knoblauch, 2011; Nesheim, Kinge, Hrgovic, & Munstedt, 2006).

Indraccolo et al. (2010) evaluated medical interventions such as oxytocin augmentation, induction, amniotomy, and epidural analgesia on the outcome of operative deliveries. Regardless of the woman's pregnancy risk level (low-, medium-, or high-risk), medical intervention use was high and had the potential to increase the risk of operative deliveries (Indraccolo et al., 2010). Nguyen et al. (2010) studied the effects of epidural analgesia on cesarean sections and operative vaginal deliveries (defined as forceps delivery or vacuum extractions) in nulliparous women and multiparous women. They found that nulliparous and multiparous women who received epidural

analgesia had a 19.3% and 16.6%, respectively, higher risk for operative vaginal deliveries as compared with women who did not have an epidural (Nguyen et al., 2010).

Complementary Therapies

The National Center for Complementary and Alternative Medicine [NCCAM] (2012) defines complementary therapies as interventions that are used in combination with conventional medicine to increase positive patient outcomes for a variety of medical conditions. Conventional medicine is also referred to as allopathic or Western medicine, which is practiced by holders of an M.D. (medical doctor); D.O. (doctor of osteopathic medicine); and allied health professionals such as physical therapists, advanced practice nurses, nurses, and psychologists. Complementary therapies consist of natural products, mind and body medicine, manipulative and body based practices, movement therapies, and energy field therapies. The NCCAM further divides complementary therapies into five wide range categories: (1) alternative medical systems such as traditional Chinese medicine; (2) mind-body interventions such as meditation and prayer; (3) biologically based therapies such as herbs, dietary supplements and vitamins; (4) manipulation and body-based methods such as massage, chiropractic, and osteopathy; and (5) energy therapies such as Reiki, Therapeutic touch, and Healing touch (NCCAM, 2012).

Koc, Topatan, and Saglam (2012) explain that complementary therapies have been used in a number of societies in the world of obstetrics. For example, in Germany, complementary therapies used during pregnancy are the most common methods of healing in the field of obstetrics.

Many pregnant and birthing mothers use complementary therapies when available because these therapies are considered to cause little harm, promote patient autonomy, and follow the holistic approach. Women may choose to use complementary therapies due to dissatisfaction with conventional treatment and concerns of medication side-effects (Kalder et al., 2011). Harding and Foureur (2009) identify four main themes appeared in the literature about complimentary therapy and the primary use for them in general obstetric practice, (1) Resistance to avoid medical interventions; (2) Efficacy of complementary medicine being gentle and safe during the birth process; (3) Women's choice in emphasizing that complementary therapy should be an option to autonomous women; and (4) Keeping birth normal to support the normal process of birth and health promotion. These four themes reflect four important aspects of obstetric nursing practice (Harding et al., 2009).

Harding et al. (2009), surveyed midwives on the frequency of complementary therapy use in their practice and the specific types of complementary therapy used. The leading complementary therapies used during the birth process were herbs, homeopathy, aromatherapy and acupuncture. These four methods show up frequently in the literature and are consistently and most often recommended by nurse midwives. The one group of complementary interventions that have not been addressed frequently in the literature were energy therapies which includes Reiki, Therapeutic touch (TT), and Healing touch (HT).

Energy Therapies

According to Fazzino, Griffin, McNulty, and Fitzpatrick (2010), when the holistic harmony of a person's body is disrupted, it may result in illness, disease, weakness, pain, or

psychospiritual issues. The purpose behind energy therapies is to unblock disturbed energy paths within a person's body to maintain harmony. Energy-based Practitioners use direct or indirect contact touch to manipulate the human energy field and affect the physical, mental, and spiritual dimensions of the patient.

Energy therapies are considered a subcategory of one of the five categories of complementary and alternative therapies described by the NCCAM. Within this subcategory are Reiki, TT, and HT (NCCAM, 2012). Coakley and Barron (2012) highlight two particularly important aspects of energy therapies, the nurse's presence and intention. Although the two are difficult to assess, they are significant factors to creating a healing environment (Coakley et al., 2012).

Energy healing can be found throughout the world, across many cultures and religions. Levin (2010) identifies four main groups of energy healing: East Asian traditions (i.e. Reiki), Western professional traditions (i.e. TT and HT), bioenergy traditions, and contemporary metaphysical traditions. Energy therapies are extremely diverse in regard to method, teaching, and tradition. However, three common themes have been identified among energy therapies. The first theme relates to the ability of the healer to focus on the task at hand. The second theme relates to the importance of the healer's compassion for the practice of healing. The third theme relates to the positive intention of the healer. Among energy healers, these three themes have become the hallmark of successful quality care. These same core themes may be reflected into other medical professions such as nursing (Levin, 2010).

Much of what has been written about energy therapies has been strictly descriptive. However, the existing findings are needed to help create a foundation for future research (Levin,

2010). Furthermore, research and practice of energy therapies in the area of labor and birth are minimal. Buenting (1993) supports further research and clinical practice of energy therapies among nurses to move away from the biomedical model of labor and birth and to move towards a truly holistic theoretical framework.

Reiki

Reiki is an ancient energy healing modality that originated in East Asia. It was reintroduced by Dr. Mikao Usui during the early 1900s in Japan. According to Levin (2010), Reiki uses contact and non-contact touch along the patient's meridian system from head-to-toe. The practitioner's hands are placed either above or on the patient's chakras to guide energy flow purposefully through the patient's body.

During the late 1930's, Reiki was introduced to the Western culture and is still being used in many home and health care settings and among many populations (Levin, 2010). With the growing interest among health care providers to promote holistic healing approaches such as energy therapies into their practice, some hospitals have included Reiki as an outpatient service. In an article written by Kryak and Vitale (2011), they explain how Reiki has become an outpatient service in a Pennsylvania hospital that offers an integrative multidisciplinary outpatient facility that provides Reiki, aromatherapy, hypnotherapy, and acupuncture. Nurses are also able to become Reiki masters and perform Reiki within the hospital setting if they have passed a yearly competency. The authors indicate that integrative therapies have shaped some health care institutions into holistic places of healing (Kryak et al., 2011).

Potter (2003) explains that Reiki is passed on from Master to students through a laying on of the hands which is called attunement. There are three levels of attunement that progress from basic to master. The attunements consist of opening the flow of Reiki energy through the student's body in the first level, incorporating symbols (i.e. power and emotion) and distance healing in the second level, and mastery of skills as well as learning to attune others in the third level (Potter, 2003).

Reiki has been used to decrease pain, depression, stress, and anxiety (Coakley et al., 2012). A study by Dressin and Singg (1998) found true Reiki treatment significantly reduced the pain, depression, and anxiety of chronically ill patients when compared to the sham Reiki treatment. A quasi-experimental study by Weze, Leathard, Grange, Tiplady, and Stevens (2005) found significant improvements in both psychological and physical functioning, especially in regards to stress, pain, coping strategies, and overall general health ratings after Reiki treatment. Assefi, Bogart, Goldberg, and Buchwald (2008) performed a randomized, double-blind trial on one-hundred men and women with an average age of 49 years-old who had diagnosed fibromyalgia to test the influence of Reiki therapy on chronic pain as compared to mock Reiki. The results showed no significant difference in outcomes between the four treatment groups.

Therapeutic Touch

Therapeutic touch (TT) is a nursing-developed complementary modality created by Dolores Krieger and Dora Kunz in 1972. It is a technique used for symptoms of pain, physiologic distress, anxiety, and the promotion of healing (Potter, 2003; Fazzino et al., 2010). Therapeutic touch focuses on directing compassionate intention, centering awareness, and

redirecting and modulating human energy (Larden, Palmer, & Janssen, 2004; Ireland, 1998; Buenting, 1993). Therapeutic touch is derived from the ancient practice of laying-on-of-hands, and is based on the premise of the human body, mind, emotion, and intuition as components of the complex dynamic of human energy fields (Fazzino et al., 2010). The intention of TT is theoretically supported by Rogers's Science of the unitary human being (Coakley et al., 2012). During the process, the practitioner uses his/her hands and runs them purposefully two to three inches from the patient's body to search for any subtle tones of interruption in the energy field (Larden et al., 2004; Ireland, 1998). The practice focuses on rechanneling energy in and around the patient's body to facilitate healing without any direct physical contact. Similar to Reiki, TT has been studied for the use of relaxation, pain relief, healing, anxiety, and mental health (Fazzino et al., 2010).

The differences between Reiki and TT are subtle. The philosophies of Reiki and TT concur; anyone is capable of administering the modalities once trained properly. The differences lie in the philosophy behind how practitioners are trained. Reiki attunement involves a more spiritual connection between the Master and student. Many Reiki masters compare Reiki attunement to prayer (Potter, 2003).

The process of TT follows the nursing process: assessment, diagnosis, patient outcome, intervention, implementation and evaluation. Coppa (2008) identified three phases of Therapeutic touch which are, (1) assessment, (2) treatment, which consists of orienting the patient, sending, directing, modulating, and rebalancing energy, and (3) finishing the treatment, which uses disengagement.

Kiernan's (2002) qualitative study on Therapeutic touch in the lives of postpartum women found five common themes: feeling open, relaxed, connected, cared for and skeptical. There were two additional overall themes identified by the researcher, which were mutual trust and intimacy between the participant and the practitioner. These seven themes are inherent to nursing practice; therefore Therapeutic touch should also be inherent to nursing practice. Fisher and Johnson (1999) suggest nurses and patients can benefit from Therapeutic touch because it emphasizes natural processes, is simple, inexpensive, and has not shown to produce harm.

Healing Touch

Healing touch (HT) is an energy-based biofield modality that combines a variety of techniques from multiple disciplines. Healing touch practitioners are trained in diagnosing and treating energy interruptions as well as documenting the patient's response and progress. The various techniques help align and balance energy disruptions, which influences self-healing (Ward et al., 2009; Levin, 2010). The HT practitioner places their hands in a specific sequence either above or directly on the patient's body to facilitate general health and well-being, or treat a particular dysfunction by modifying or unblocking the energy field (Anderson & Taylor, 2011; Coakley et al., 2012). The energy field disruptions are generally experienced by the practitioner as temperature, texture, or vibratory changes (Coakley et al., 2012).

Energy therapies are among the most ancient of practices; Healing touch was based on TT and introduced into nursing practice by the originator, Janet Mentgen in the early 1980s. Healing touch differs from TT by incorporating various methods of energy healing to increase positive patient outcomes. The reported benefits of Healing touch include reduced anxiety,

increased relaxation, decreased pain, diminished depression, and an increased sense of well-being (Anderson et al., 2011).

In a quantitative study by Welcher and Kish (2001), men and women, ages 18-94 years old were given HT sessions which lasted between 10-30 minutes in length. Findings indicate a significant reduction in perception of pain but not anxiety (Welcher et al., 2001).

Levin (2010) reported that Healing touch is the most systematically researched energy healing modality. Yet little is known about its safety and efficacy. Anderson et al. (2011) suggests that limited research has been done to review the efficacy, safety, and methods of practice. In addition, Kramer, Mentgen, and Hibdon (2001) suggest that although healing touch has been used in labor and childbirth, no studies have documented its effectiveness.

Problem

According to Hidaka et al. (2012), the anticipated pain during childbirth is a major concern among childbearing women. With changing social values and medical technological advances, pharmacological pain management interventions have become the dominant choice to redirect pain during childbirth (Hidaka et al., 2012; Indraccolo et al., 2010). Although pharmacological interventions for pain management have been shown to be successful, many risks are associated with the use (Indraccolo et al., 2010; Nguyen et al., 2010). Additionally, the adverse effects of pharmacological pain management have shown to impact the birth experience in a negative way. Women who reported dissatisfaction with their birth experiences and who used pharmacologic pain management as a single-line intervention were usually also misinformed about the various pain management options (Hidaka et al., 2012).

A negative birth experience may impact a woman beyond the childbirth process. It may impact a woman for the rest of her life. The experience is carried throughout the postpartum period and may be reflected in the woman's attitude, and relationships.

Harding and Foureur (2009) explain that although complementary therapies are widely used by midwives, little research has been performed to review the efficacy. There are gaps in research in regard to the efficacy of complementary therapies. Kalder et al. (2011) found that women who used complementary therapies during delivery were satisfied with the methods, but were undecided on efficacy. According to Bayles (2007), although women use complementary therapy more frequently than men, there is very little literature on the topic of complementary medicine used during the pregnancy and postpartum periods. There is lack of support for the

efficacy, safety, and practice of complementary therapies in the literature related to the small number of research studies and questionable outcomes.

There is even less literature on the topic of energy therapies such as Reiki, Therapeutic touch (TT), and Healing touch (HT) during pregnancy and the birth process (Kiernan, 2002; Post-White et al. 2003; Vitale & O'Connor, 2006). A majority of the literature on complementary therapy and energy therapies has focused on qualitative reports of overlying themes. Although the qualitative reports are needed to add to the growing body of knowledge on energy therapies, empirical evidence from quantitative findings may be just as important in supporting the qualitative information. Much less quantitative research has been done on the efficacy of complementary therapy and energy therapies as adjuncts to routine medical interventions, specifically during the birth process. This is significant to nursing because more research needs to be done to find if these interventions can be used effectively in combination with routine medical intervention. In addition, quantitative research can help support and can suggest the integration of complementary therapy and energy therapies into standard nurse education.

Purpose

The purpose of this thesis is to provide a review of research findings about energy therapies specifically Reiki, TT, and HT as complementary therapies for pain management during labor and childbirth. The second purpose of this literature review is to focus on the efficacy of Reiki, TT, and HT in relation to redirecting pain during labor and childbirth. The third purpose of this literature review is a reflection on the value of integration of Reiki, TT, and HT into nursing practice and education.

Method

A synthesis of the current research related to labor and childbirth pain perception was conducted for this thesis. An interdisciplinary review of the research was performed using the following databases: Academic Search Premier, ALT Healthwatch, Cumulative Index of Nursing and Allied Health Plus with Full Text (CINAHL Plus with Full Text), Healthsource: Nursing/Academic Edition, and MEDLINE. Reference lists for the articles selected for this thesis were also cross-referenced to ensure saturation.

After an initial literature search, it was decided since there was little research on energy therapies and the birth process, to expand inclusion criteria and minimize exclusion criteria. Studies focusing on Reiki, TT, and/or HT used as interventions related to women were included to the review. The inclusion criteria for this review of research consisted of research focused on but was not limited to Reiki, TT, and HT in relation to pain, labor, and childbirth. Also, inclusion of peer reviewed, any date, full text, U.S. publication, international publications but had to be translated to English, and .edu, .org, and .gov websites.

Exclusion criteria for this review of research included articles that did not focus on pain, labor and childbirth, or women; newspaper articles; magazines; abstracts; those written in non-English language; articles which used animals as their source of study; and .com websites.

Key words used were nurs*, preg*, nursing, nurse, midwifery, nurse midwifery, midwif*, TT, Therapeutic Touch, therapeutic touch, healing touch, Reiki, childbirth, complementary therapy, complementary therapies, energy therapies, energy therapy, energy healing, CAM,

complementary and alternative medicine, birth process, labor and delivery, labor and deliv*,
birth*, efficacy, and intervention.

Multiple studies were used to provide introductory and background information regarding Reiki, TT, and HT as complementary treatments for redirecting pain during labor and childbirth. Seven total studies were used under findings to review the efficacy of Reiki, TT, and HT in the clinical setting for various symptoms and populations.

Results

There are limited studies that have been conducted to determine the effectiveness of energy-based therapies to reduce the perception of pain during labor and childbirth. There were no studies found that actually addressed Reiki, TT, or HT for redirecting pain during labor and childbirth. Many of the studies found did not directly associate an energy-based therapy with labor and/or childbirth pain. However, they addressed energy-based therapies in association to either pain or labor and childbirth. The interventions included in these findings are Reiki, TT, and HT. A total of seven studies were used to investigate the clinical significance of energy-based therapies to reduce the perception of pain or to facilitate labor and childbirth.

Reiki

Two studies focused on the use of Reiki therapy as a treatment for pain in the female population. The first study focused on Reiki's influence on pre- and post- surgical pain in women scheduled for abdominal surgeries. The second study focused on Reiki's influence on post-Cesarean surgery pain.

Vitale and O'Connor (2006) performed a study on twenty-two women with a mean age of 47.5 years-old who were scheduled to have abdominal hysterectomies to see if Reiki therapy before and after surgery would have a significant impact on pain and anxiety. The control group (n=12) received traditional pre- and post-operative nursing care. The experimental group (n=10) received three 30-minute Reiki sessions in addition to traditional nursing care. The first Reiki session was performed thirty minutes before surgery. The second Reiki session was performed

24-hour post surgery. The third Reiki session was performed 48-hour post surgery. The Reiki sessions were administered by registered nurses who were certified as Level III Reiki experts. The first of two instruments used in the study was the State-Trait Anxiety Inventory (STAI). The STAI is a tool used to differentiate between state (situational) anxiety and trait anxiety found in study participants. The State Anxiety scale measures feelings of apprehension, tension, nervousness, and worry in response to physical danger and psychological stress at the time of the event (Vitale et al., 2006). The STAI was administered and timed for ten minutes; it consisted of twenty questions with a four-point Likert style format. The STAI was given to the patients on the day discharge to identify the patient's level of stress post-surgery and prior to discharge. The second instrument used in the study was the Visual Analog Scale (VAS), a scale of 0-10 used to measure pain. The STAI and the VAS both have adequate validity and reliability. At the 72-hour mark post surgery, the experimental group reported significantly less anxiety than the control group ($P=0.005$). Average pain scores for the experimental and control groups were 3.8 and 5.4 respectively on a scale of 0-10 ($P=0.04$) after the 24-hour mark after surgery. However, there was no significant difference in average pain scores at the 48-hour and 72-hour marks after surgery. A secondary finding of the study revealed that with an average surgery time of fifty to ninety minutes, the average surgical time for the experimental group ($M=29$) was significantly less than the control group ($M=72$; $P=0.004$) (Vitale et al., 2006).

Vandervaart, Berger, Tam, Goh, Gijzen, Wildt, Taddio, and Koren (2011) performed a randomized double-blind control trial to determine the effectiveness of distant Reiki on pain in 80 women post Cesarean section. The women were ages 19-44 years of age, had scheduled elective Cesarean sections, and were recruited during a routine prenatal visit. The participants

were randomly assigned to one of two groups, either the control (n=40) or intervention (n=40) group. The participants in the control group received traditional nursing care after Cesarean section while the intervention group received traditional nursing care in addition to three distant Reiki sessions. The distant Reiki was performed at 100km away from the subjects for twenty minutes per session by a Reiki master who had ten years of experience in Usui Reiki. Pain was assessed on a scale of 0-10 using the VAS. Secondary outcome measures included dosages of opioid medication consumed, rate of healing, vital signs, and the time of first activity (hunger, voiding, eating solid foods, walk, etc.) via the Milestone Questionnaire. Since Reiki is used for more than just pain, the Milestone Questionnaire was chosen to capture the various healing aspects of Reiki therapy even beyond pain. Overall pain scores between both groups for days 1-3 showed no significant difference ($p=0.96$). There was no significant difference in opioid consumption between the two groups. However, post surgery heart rate in the interventional group (74.37 bpm) was significantly lower than the control group (79.87 bpm; $p=0.003$). In addition, post-surgery blood pressure in the interventional group (106.47mmHg) was significantly lower than the control group (111.96mmHg; $p=0.02$) (Vandervaart et al., 2011).

Therapeutic Touch

Two studies were reviewed to investigate the efficacy of Therapeutic touch (TT) in relation to pain, discomfort, and client well-being. The two studies used TT as an intervention for obstetric patients in relation to enhancing the effectiveness of labor as an adjunct to Lamaze and during the postpartum period.

Krieger (1987) studied forty middle class, nulliparous couples who were enrolled in Lamaze classes to evaluate the effectiveness of TT in addition to the Lamaze training. It was hypothesized that couples who engaged in Lamaze and used TT would have greater marital satisfaction than those who used Lamaze alone. A second hypothesis stated that couples who used TT with Lamaze would have less anxiety compared to the Lamaze-only couples. The couples were randomly assigned to either the Lamaze-only group or the TT and Lamaze group. During the 24th-36th week period of pregnancy, Krieger taught TT to the couples in the Lamaze with TT group. Pre- and post-delivery data was collected for each couple using the Interpersonal Conflict Scale (ICS) and the STAI. The results supported the first hypothesis with TT used in adjunct to Lamaze classes increasing marital satisfaction. However, there was no significant difference between groups in regards to decreasing anxiety (Krieger, 1987).

Kiernan (2002) explored the lives of five postpartum women who received TT one month before delivery and two months postpartum. The women were all married, Caucasian, pregnant for the first time, and ages 28-38 years old. Four of the five women had a vaginal birth and one woman had a cesarean section. Five women who had no prior experience with TT were recruited during the last month of their pregnancy and were followed in their homes during that time before delivery and then followed at home two months postpartum. During the home visits, the women received TT two to three times per week. The visits were recorded with a voice recorder used by the practitioner. In addition, each individual woman was given a journal to keep a running entry of the experience. The practitioner was also asked to keep a running journal of her experience of the sessions. A researcher analyzed the data for recurrent themes found throughout the study. Five themes emerged which included: (1) feeling relaxed; (2) feeling open; (3) feeling

cared for; (4) feeling connected; and (5) feeling skeptical. The practitioner documented a feeling of intimacy and mutual involvement with the women (Kiernan, 2002).

Healing Touch

Three studies were identified that explore the relationship of HT on pain and/or women's health. Welcher and Kish (2001) performed an experimental study with one hundred and thirty-eight inpatients, both men and women, ages 18-94 years old who were admitted for a variety of medical issues. The purpose of the study was to evaluate the use HT as an adjunct therapy to reduce symptoms of pain and anxiety experienced by the study participants. The patients were given ten to thirty minute HT sessions by an HT provider at the bedside. Questionnaires were administered to assess each patient's level of pain and anxiety before treatment and after treatment using a scale of 1 to 10 (with 1 being no pain/anxiety; and 10 being the worst pain/anxiety). Research found that the HT sessions significantly reduced the perception of pain but did not reduce anxiety (Welcher et al., 2001).

Although the findings of case studies may have limited application, the following were included due to the relevance of the outcomes in relation to HT. Wetzel (1993) followed one woman who had a cesarean section wound infection for over twenty weeks to explore the efficacy of HT on wound healing. The wound size at the beginning of the case study was 7cm long, 4cm wide and 3cm deep. Routine medical protocol was followed to heal the wound. The wound was opened, debrided, irrigated, packed, and then left to heal with secondary intention. Healing touch was used as adjunct to the routine medical interventions. After 11 days of administering HT to the patient, the wound closed completely except for a small corner and the

deepest part of the wound was 5cm long, 3cm wide, and 2cm deep. After thirty-one days the wound was closed. Three weeks later the wound scar was 3cm long as compared to the initial measurement of 7cm in length. Five other women who had healing cesarean wounds and did not receive HT in addition to routine medical protocol were compared to the study participant. The comparison cesarean wounds took nine to sixteen weeks to heal. The HT subject's wound took six weeks to heal (Wetzel, 1993).

Kissinger and Kaczmarek (2006) followed a forty year old woman who wanted to use Healing touch to induce fertility after being unable to conceive. Healing touch (HT) was performed on the patient once a month for nine months. The types of techniques used were chakra spread, chakra connection, and energy field clearing and balancing. Then the frequency of HT sessions was increased to once per week. In addition to the techniques used, the practitioner administered full body connection. A full year after therapy had started; the patient conceived and delivered a healthy baby boy. HT was used throughout the entire pregnancy and during labor. Narratives from the practitioner and the patient were used to describe the process of HT for pre-conception, pregnancy, and labor. The patient and her husband reported feelings of joy throughout the experience (Kissinger et al., 2006).

Discussion

The purpose of this literature review was to examine the past and current findings related to energy therapies used for pain management during labor and childbirth in addition to many other uses. The interventions of Reiki, TT, and HT have been examined for their effectiveness in altering the perception of pain in an effort to establish their use and incorporate them into standard nursing care. The findings of this review were consistent with previous research in that no single energy therapy has been shown to successfully manage pain alone. In addition, energy therapies have not been tested as a technique to manage pain in women during labor and childbirth. However, energy therapies may be considered as an adjunct therapy to other forms of pain management with additional research.

Reiki

Anecdotal comments in the literature indicate that Reiki therapy may be used to for morning sickness, aches, pains, stress, and fears (Rakestraw, 2009; Nielsen 2006). Based on the results found in the literature, Reiki during labor may reduce the use of pain medications, shorten labor, and help reduce complications. The special population of childbearing women may benefit from complementary Reiki therapy with the ongoing support of a nurse. Through the use of Reiki, nurses can help redirect pain experienced the birthing mother by directing the mother into a deeper state of relaxation.

Distant Reiki showed no clinical significance in pain management for women three days after elective Cesarean section (Vandervaart et al., 2011). Reiki as a primary method of pain

relief for women who have undergone Cesarean section may not be appropriate due to the lack of evidence supported in the literature reviewed. Implications to further research on Reiki as an adjunct therapy for pain manage after Cesarean section is suggested. From the results and quality of the study, further research is needed to find if distant Reiki is beneficial to use as a healing modality for women experiencing any type of pain during the ante partum or postpartum periods. Furthermore, the significance of the study in relation to nursing may be beneficial to understanding the impact of distant Reiki during various stages of the healing process.

Reiki has shown to reduce pain and anxiety in women who have undergone obstetric surgeries. Vitale et al. (2006) found Reiki as an effective therapy for reducing pain in women undergoing abdominal hysterectomies. The significance of Reiki's influence on pain is connected to the idea that the energy produced during a therapy session can increase the energy flow in a patient and assists in redirecting pain (Vitale et al., 2006).

Vitale et al. (2006) had three limitations that were specific to their study including confounding results related to administration of pain medications, small sample sizes, and length and frequency of Reiki sessions administered. The first limitation related to medication administration to participants for pain after their scheduled abdominal hysterectomies. The therapeutic effects of the pain medication may have altered the true effects of the Reiki therapy. The second limitation related to the small sample size of participants. The third limitation related to the length and frequency of the Reiki sessions. The length and frequency of a standard Reiki session has been unidentified in formal teaching. The length and frequency of the Reiki sessions administered in this study may have been too short in duration and frequency for Reiki to take full effect. Based on the limitations identified, the study may still be adequate enough to support

Reiki as an adjunct therapy for pain management during labor and childbirth with adjustments to the limitations identified by the researchers. Although pharmacologic pain medication was used during the study, participants reported needing less medication after the administration of Reiki therapy. The interventions and methods of this experiment may be further studied in the rest of the obstetric world in regard to vaginal childbirth and the pain that comes with it. Reiki has been shown to help manage pain from the physical, mental, and spiritual aspect; and bring obstetric nursing to a more holistic perspective.

Vandervaart et al. (2011) had two limitations that were specific to their study. First, significant differences between treatment groups and control groups were not detected because the small size of the sample. Second, they reported that the generalizability of their study was limited due to the fact that only one Reiki Master was performing all of the distant Reiki treatments, which could have caused a bias and/or a limitation on the method and intensity of therapy given to each patient. Based on the limitations, Reiki as a single-line therapy for pain management during labor and childbirth may be inadequate because Reiki did not have a significant influence on surgical pain from Cesarean section. However, Reiki has shown to have some influence on the physiological and psychological aspects related to pain. Reiki did show significant decreases in heart rate and blood pressure three days post Cesarean section. The findings were consistent with three previous studies, two of which specifically focused on the physiological changes related to Reiki (Vandervaart et al., 2011).

The literature suggests that practitioners should defer the use of medical interventions as much as possible, revisit natural birth processes and/or less invasive interventions, consider the increased risks in regards to pain management, and offer several options in regard to pain

management during the labor and childbirth process (Couper, Jones, & Smythe, 2010; Indraccolo et al., 2010; Nguyen et al., 2010; Ward et al., 2009; Hidaka et al., 2012).

Although the studies found on Reiki did not directly relate to pain management during labor and childbirth, the same principles and techniques can be applied to the obstetric world as an adjunct therapy to other methods of pain management.

Therapeutic Touch

Therapeutic touch has been shown to reduce pain in a variety of clinical situations. Unlike pharmacologic interventions, TT incorporates the components of empathy and the intentions to heal which contribute to the favorable outcomes (Keller et al., 1986). With such favorable outcomes, the placebo effect through the intention of the healer can be suspected.

Krieger (1987) had outcomes that were able to support the hypothesis of Therapeutic touch used as an adjunct to Lamaze classes for increasing marital satisfaction. However, there was no significant difference between groups in regards to decreasing anxiety. The researchers did not include how the birth experience was for each couple and the study did not specify if Therapeutic touch was used during labor and childbirth. Additionally, it was not described if the couples continued using Therapeutic touch during the postpartum period. Based on the limitations outlined from this study, Therapeutic touch and other energy therapies may have applications as adjunct therapies in the obstetric population. However, limited results were found if Therapeutic touch and other energy therapies are applicable during labor and childbirth.

Kiernan (2002) identified mutual trust and intimacy as the two overall themes of her study on five postpartum women. As the practitioner continued to visit each patient, the intimate

relationship and the feeling of mutual trust grew between the patient and the provider creating the sense of tranquility and peace. The clients reported feeling good, safe, and they enjoyed the attention they received (Kiernan, 2002). The practices demonstrated in Kiernan's study can be generalized to all obstetric patients at any stage of labor and childbirth. Nursing values are reflective of the themes identified by Kiernan's study. These qualities are strongly associated with quality nursing care and can facilitate a trusting nurse-patient relationship between nurses and their patients.

Healing Touch

There was no literature found that used HT as an intervention for pain during labor and childbirth. Welcher et al. (2001) found that HT sessions significantly reduced the perception of pain but did not reduce anxiety among a variety of hospitalized patients. This study was performed on patients at a general hospital who were admitted for various medical issues. This study showed that HT may be effective in reducing the perception of pain among various groups of people and may be generalized to other populations. The methods of HT from this study may be applied to the population of obstetrics in labor and delivery where pain is experienced in the lower back, abdomen, and pelvic area.

Two case studies used HT as an intervention for fertility and for wound healing after Cesarean section. It is difficult to conclude significant evidence of HT therapy success for single-person case studies (Kissinger et al., 2006; Wetzell, 1993). It was decided to include case study information in this literature review which adds to the findings of HT exclusively for women.

For the case studies, the influence on findings was attributed to the time and intention put into each HT session (Kissinger et al., 2006; Wetzel, 1993).

In Wetzel's (1993) case study, HT was found to decrease healing time of a Cesarean section wound in the patient by three to ten weeks faster than five other women who had similar Cesarean section wounds who received routine medical interventions without the HT therapy. Decreased healing time was demonstrated and it was suggested by the researcher that HT may be considered a safe, effective, and noninvasive form of healing when added to routine healing protocols (Wetzel, 1993). Healing touch can be easily incorporated into care for women with gynecological or obstetric concerns.

Kissinger et al. found that HT was useful to increase reproductive health, which is parallel with Wetzel's (1993) findings. The increased fertility and healthy pregnancy was also attributed to the increased one-on-one time with the provider, confidence, and relaxation facilitated by HT. Deep relaxation can increase oxygenation and blood flow to the organs, which could have positively influenced the chances of conception (Kissinger 2006). Relaxation as an outcome of HT has been highlighted as a key factor in decreased overall pain (Post-White et al., 2003). The use of HT by nurses is supported by the literature in this review as an adjunct to pain management during labor and delivery to create the effects of relaxation and pain reduction in their patients.

Limitations

Limitations of this literature review included limited research findings based on Reiki, TT, and HT use in the population of childbearing women during labor and childbirth. Although there were numerous studies focusing on the efficacy of Reiki, TT, or HT on a variety of other clinical conditions, there were only few studies focusing on the potential applications of Reiki, TT, or HT used in the obstetric population. Furthermore, there were no studies found that focused on Reiki, TT, or HT as therapies to redirect pain during labor and/or childbirth. Among the studies found and cited throughout this review, the potential applications of Reiki, TT, or HT varied with each study. Limitations for clinical practice include the lack of identified standardized time and frequency of Reiki therapy, the lack of training and education on energy therapies, and the lack of identified stages of labor and childbirth in which energy therapies may most effective. The case studies and qualitative works were not generalizable to the entire obstetric population. Smaller sample sizes in the quantitative works may have not had high enough quality to have recommendations for practice. None of the studies were able to identify energy therapies as single-line agents for redirecting pain. There are currently no evidence-based guidelines for the use of energy therapies in the clinical setting in regard to the obstetric population. The studies reviewed provide for a starting point, but further research is needed to determine if energy therapies are safe and effective during labor and childbirth.

Nursing Implications

Research

Based on the limitations and quality of the studies, additional research on Reiki, TT, and HT in redirecting pain during labor and childbirth is needed to better understand the mechanisms in which energy therapies can influence the perception of pain during labor and delivery. Although energy-based therapies have been used for thousands of years, their use is still young in the modern day healthcare system. As there has been limited research done on the various types of energy-based therapies, it is essential to include all types of studies as a foundation for this growing body of knowledge (Coakley et al., 2012).

Limited research on energy healing and their effectiveness in pain relief has been done in the childbearing population. From the literature reviewed, future studies designed to identify the potential applications of energy therapies on pain during labor and childbirth should increase the length of intervention time, increase sample size, control for the placebo effect, and consider standardization of practitioner backgrounds. The limitations of duration suggest the need for longer time spent with patients during the labor and childbirth process. Standardizing the duration for an energy-based therapy session may be inappropriate because each woman has a subjective perception of pain and healing. Many contemporary healers are hybrids and use various healing and touch modalities from various bodies of practice for one single treatment (Potter, 2003). From the literature reviewed, the variation in practitioner backgrounds added a challenge to some study designs. Nurses should consider each patient and their individual needs for pain management intervention.

Based on the findings of the literature reviewed, implications for quantitative studies to validate the existing anecdotal qualitative data on energy-based therapies are suggested to support their application into care of obstetric patients. In addition, research by nurses is needed to identify the specific energy patterns most beneficial to the maternal clients. Descriptive research focusing on the obstetric population may further understand the energy-flow patterns specific to childbearing women. Increased research may provide evidence needed to incorporate therapy options into standardized care.

Education

From the literature reviewed, recommendations incorporating Reiki education for nursing and other health care professionals may enhance the ability to create more diverse treatment plans for various patient populations. Therapeutic touch is the most prominent of the nursing-originated systems of energy healing. The healing modality has been taught to more than 100,000 people, most of who are nurses, and has been included as part of the curriculum for over ninety nursing schools (Levin, 2010). More research would be needed before energy therapies are a part of nursing education, but may be offered as elective course. Knowledge of the risks and benefits of various energy healing modalities such as Reiki, TT, and HT will enable nurses to have the confidence to support and promote broader decision making in childbearing women (Hidaka et al., 2012).

Practice

Based on the literature, suggestions include incorporating energy therapies into bedside practice, using energy therapies as adjunct therapies to pharmacologic pain management, and using energy therapies in obstetric care. Incorporating energy therapies into nursing practice nurtures the idea of holistic nursing care and adds depth, spiritually, and intimacy to healing. In addition, deep relaxation from interventions may reduce anxiety and decrease pain in pregnancy and childbirth (Buenting, 1993; Kissinger et al., 2006). Clinical practices around labor and childbirth may be altered with the knowledge and practice of energy therapies. Energy therapies have great flexibility in adapting to each individual patient. This finding is beneficial to the field of nursing because the treatments may be adjusted at the bedside for an individual's specific needs.

Energy therapies are appropriate nursing interventions because they do not require the supervision of a physician and it enhances the nurse-patient relationship (Keller et al., 1986). Nurses should consider each patient and their individual needs for pain management intervention.

Summary

The themes of focus, compassion, and intention found among energy-based therapies have a deep connection to the main concept of holistic obstetric nursing which is “being with woman”. Nurses take into account the highly subjective experience of women in labor and provide the high-touch qualities of nurturance, intuitive awareness, sensitivity, attention, and knowledge for helping women during a vulnerable period in their lifetime (Hunter, 2009).

This literature review provided an introduction to Reiki, TT, and HT and their potential applications to labor and childbirth. Based on the literature reviewed and cited, energy therapies used for redirecting pain may be beneficial to the obstetric population. Few studies were found that focused on Reiki, TT, or HT as pain management interventions during labor and childbirth. In addition, some quantitative studies did not show statistically significant data to support energy therapies as a valid intervention and qualitative studies do not have generalizability to larger populations of obstetric patients. However, energy therapies were not shown to be harmful in any of the studies reviewed. Reiki, TT, and HT have been shown to be effective adjunct treatments for pain in addition to increasing relaxation, decreasing anxiety, and decreasing the fear. Further research on the efficacy of Reiki, TT, and HT for pain management during labor and childbirth is needed to support their potential applications.

Nurses are encouraged to educate their patients during the prenatal period about pain expectations and the various options for pain management. Nurses should advocate for comfort during labor and childbirth as well as providing a positive birth experience. Using energy-based

healing therapies may be found to be the ideal adjunct therapy to pharmacologic pain management during labor and childbirth.

Appendix: Table 1

Appendix: Table1

Exclusion Criteria: Exclusion criteria for this review of research included articles that did not focus on pain, labor and childbirth, or women; news paper articles; magazines; abstracts; those written in non-English language; articles which used animals as their source of study; and .com websites.

Inclusion Criteria: The inclusion criteria for this review of research consisted of research focused on but was not limited to Reiki, TT, and HT in relation to pain, labor, and childbirth. Inclusion criteria consisted of peer reviewed, any date, full text, U.S. publication, international publications but had to be translated to English, and .edu, .org, and .gov websites. In addition, studies focusing on Reiki, TT, and/or HT used as an interventions related to women were included to the review.

Articles	Participants and Study Design	Intervention Details	Outcome Measures	Results (or Key Findings)	Nursing Implications
Vitale, A.T. and O'Connor, P.C. (2006). The effect of Reiki on pain and anxiety in women with abdominal hysterectomies: A quasi-experimental pilot study. <i>Holistic Nursing Practice</i> , 20 (6), 263-272.	22 women, with a mean age of 47.5 years, who had scheduled abdominal hysterectomies. Quasi-experimental Pilot study.	The participants were randomly assigned to either the experimental group or the control group. The experimental group (n=10) received three 30-minute Reiki sessions in addition to	The participants were evaluated for pain and anxiety. Pain was measured using a 0-10 scale and anxiety was measured with the State-Trait Anxiety Inventory (STAI).	The experimental group reported overall less pain and requested fewer analgesics postoperatively than the control group. Reiki influenced pain up to 24 hours postoperatively but did not show	Reiki has shown to reduce pain and anxiety in women who have undergone obstetric surgeries. This experiment may be further expanded to the rest of the obstetric world in regard to vaginal

		<p>traditional nursing care. The first 30-minute session was 30 minutes before surgery, the second 30-minute session was 24-hours after surgery, and the third 30-minute session was 48-hours after surgery. The Reiki sessions were administered by registered nurses who were certified as Level III Reiki experts. The control group (n=12) received traditional nursing care.</p>		<p>significance during the 48-72hour mark postoperatively. The experimental group reported less anxiety 72 hours postoperatively. The control group had longer surgery time than the experimental group. Some of the patients who received Reiki reported “feeling calm: and having a “floating feelings”.</p> <p>Limitations: The small sample size of the experiment does not represent the entire population of women undergoing abdominal hysterectomies.</p>	<p>childbirth and the pain that comes with it. Reiki can reduce the amount of pharmacological pain interventions needed and bring obstetric nursing to a more holistic perspective.</p>
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<p>Krieger, D. (1987). <i>Living the therapeutic touch</i> (1st ed.). New York: Dodd, Mead.</p>	<p>40 middle class, nulliparous couples who were enrolled in Lamaze classes.</p> <p>Randomized, longitudinal study.</p>	<p>It was hypothesized that couples who engaged in Therapeutic touch in addition to Lamaze would have greater marital satisfaction than those who used Lamaze alone. A second hypothesis stated that couples who used Therapeutic touch with Lamaze would have less anxiety compared to the Lamaze-only couples. The couples were randomly assigned to either the Lamaze-only group or the Therapeutic touch and Lamaze group. In addition, Krieger taught</p>	<p>Pre- and post-delivery data were collected for each couple using the Interpersonal Conflict Scale (ICS) and the State-Trait Anxiety Inventory (STAI).</p>	<p>The results supported the first hypothesis with Therapeutic touch used in adjunct to Lamaze classes increasing marital satisfaction. However, there was no significant difference between groups in regards to decreasing anxiety.</p> <p>Limitations: The authors did not include how the birth experience was for each couple and the study did not specify if Therapeutic touch was used during labor and childbirth. Additionally, it was</p>	<p>Although the study had some limitations, the study did lend some support to using Therapeutic touch as adjunct therapy to traditional labor and childbirth interventions.</p>
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		Therapeutic touch to the couples during the 24 th -36 th weeks of pregnancy.		not described if the couples continued using Therapeutic touch during the postpartum period.	
Kiernan, J. (2002). The experience of therapeutic touch in the lives of five postpartum women. <i>The American Journal of Maternal/Child Nursing</i> , 27(1), 47-53.	5 women who were married, Caucasian, pregnant for the first time, ages 28-38 years. 4 of the 5 women had vaginal births and one woman had a cesarean section. They did not have experience with Therapeutic touch before the study. Qualitative study.	Women were recruited during the last month of their pregnancy and were followed in their homes before delivery and two months postpartum. During the home visits, the women received Therapeutic touch 2-3 times per week, and kept a running journal of the experience. The Therapeutic touch Practitioner also kept a running journal of their	Journal entries from each participant, journal entries from the Practitioner, and a voice recorder of each session were used for the results. A professional translator was also used to depict recurrent themes found among the participants.	Five themes emerged from the study: Feeling relaxed, feeling open, feeling cared for, feeling connected, and feeling skeptical. The Practitioner also mentioned intimacy and the mutual involvement between the practitioner and the patient.	Therapeutic touch may have importance in nursing, where the nurse and the patient can make a special bond formed by trust. Mutual involvement can quicken healing time and provide a positive experience for the patient.

		experience.			
Vandervaart, S., Berger, H. Tam, C., Goh, Y.I., Gijzen, V.M., Wildt, S.N., Taddio, A., and Koren, G. (2011). The effect of distant Reiki on pain in women after elective Caesarean section: A double-blind randomized controlled trial. <i>BMJ Open</i> , 1, 1-9.	80 women who had scheduled elective C-sections were recruited during a routine prenatal visit. Ages ranged from 19-44 years old. Double-blind, randomized, clinical trial.	The study participants were randomly assigned to either the control group (n=40) who received traditional nursing care after C-section or the intervention group (n=40) who received 3 distant Reiki sessions in addition to traditional nursing. A single Reiki master who had 10 years experience with Usui Reiki performed distance Reiki from 100km away for 20 minutes per session.	Baseline pain and vital signs were taken prior to surgery and prior to the initial Reiki session. The VAS and the Milestone Questionnaire was used for measuring pain. The participants were asked to report pain using the VAS at rest, when moving, and pain at night. Opioid consumption was measured between both groups and vital signs were compared between both groups as well.	Distance Reiki did not have a significant effect on reducing pain after Caesarean section. There were no significant differences in opioid consumption between the two groups. However, heart rate in the interventional group was significantly lower than the control group (74.37 bpm vs. 79.87 bpm) and blood pressure in the interventional group was significantly lower than the control group (106.47mmHg vs. 111.96mmHg) post	This was the first randomized clinical trial that studied distance-Reiki. Lack of knowledge about the intervention from the participants could have been a limitation to this study. Further research and knowledge is needed among the general population about Reiki and other energy therapies to provide foundational support to the practice of Reiki.

				surgery.	
Wetzel, W.S. (1993). Healing touch as a nursing intervention: Wound infection following a cesarean birth—An anecdotal case study. <i>Journal of Holistic Nursing</i> , 11(3), 277-285.	One woman who had a cesarean wound infection. Anecdotal case study.	The patient was given routine medical protocol: the wound was opened, debrided, irrigated, packed, and then left to heal with secondary intention. Healing touch (HT) was used as adjunct therapy to the routine medical protocol.	The size of the wound was noted as a measure of wound healing. The wound was 7cm long, 4cm wide, and 3cm deep at the beginning of the case study.	After 11 days of giving HT to the patient, the wound closed completely except for a small corner and the deepest part of the wound was 5cm long, 3cm wide, and 2cm deep. After 31 days the wound was closed. Three weeks later the wound incision was 3cm long as compared to the initial measurement of 7cm in length. Five other women who had cesarean wounds were compared to the study participant. The five other women did not	Healing touch can be easily incorporated into office or home care for women with gynecological or obstetric concerns. The researchers suggest that HT is a safe and non-invasive form of healing that can be added to routine healing protocols.

				receive HT in addition to routine medical protocol. For the five other women, their cesarean wounds took 9-16 weeks to heal. The subject for this study only took 6 weeks to heal.	
Welcher, B. and Kish, J. (2001) Reducing pain and anxiety through healing touch. <i>Healing Touch Newsletter</i> , 1(3), 19.	138 inpatients, men and women, ages 18-94 years old who were admitted for various medical issues. Quantitative experimental study.	The patients were given HT sessions that lasted between 10-30 minutes in length.	Questionnaires were administered to assess each patient's level of pain and anxiety before treatment and then their level of pain and anxiety after treatment using a scale of 1 to 10 (with 1 being no pain/anxiety; and 10 being the worst pain/anxiety).	The HT sessions significantly reduced the perception of pain but did not reduce anxiety.	This study was performed on patients at a general hospital who were admitted for various medical issues. This study showed that HT may be effective in reducing the perception of pain among various groups of people. This finding can be further expanded to the realm of obstetrics. Many

					women in labor and delivery experience pain in the lower back, abdomen, and pelvic area. This study shows that HT may be effective in the hospital setting among a wide variety of patients.
Kissinger, J. & Kaczmarek, L. (2006). Healing touch and fertility: A case report. <i>The Journal of Perinatal Education</i> , 15(2), 13-20.	A forty-year old woman who wanted to use Healing touch to induce fertility after being unsuccessful on her own. Descriptive case study.	Healing touch (HT) was performed on the patient once a month for nine months. The types of techniques used were chakra spread, chakra connection, and energy field clearing and balancing. After nine months of unsuccessful conception, the frequency of HT sessions was	Narratives from the practitioner and the patient were used to describe the process of HT for pre-conception, pregnancy, and labor.	After 15 months of HT therapy, the patient had conceived. The patient was able to get pregnant and delivered a healthy baby boy. Use of the core star therapy helped the patient address some concerns she had. The patient and her husband reported feelings of joy throughout the	Although there may have been multiple factors in addition to HT to facilitate the success of fertility and a healthy pregnancy, the authors suggest that energy therapies can be incorporated into care for patients who have a difficult time conceiving. The effects of energy based

		<p>increased to once per week. In addition to the techniques used, the practitioner administered full body connection. After a full year after therapy had started, core star therapy was added to the regimen. HT was used throughout the entire pregnancy and during labor.</p>		<p>experience.</p> <p>Limitations: When there is only one participant, it is difficult to scientifically document a precise reason for the success story. Other factors could have contributed to the successful outcomes such as time, increased time and relaxation.</p>	<p>therapies increase relaxation and reduce stress. As a result, increased circulation to a woman's organs can positively influence the outcome of pregnancy and childbirth.</p>
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