

2015

# The Effect of Healing Touch Therapy for Youth Diagnosed with Reactive Attachment Disorder

Kelli Stiles  
*Walden University*

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# Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Kelli Stiles

has been found to be complete and satisfactory in all respects,

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Review Committee

Dr. Kelly Davis, Committee Chairperson, Psychology Faculty

Dr. Sandra Mahoney, Committee Member, Psychology Faculty

Dr. Stephen Rice, University Reviewer, Psychology Faculty

Chief Academic Officer

Eric Riedel, Ph.D.

Walden University

2015

Abstract

The Effect of Healing Touch Therapy for Youth Diagnosed with Reactive  
Attachment Disorder

by

Kelli Stiles

ADN, Iowa Central Community College, 1989

BS, Culver-Stockton College, 2005

MSEC, Quincy University, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

General Teaching in Psychology

Walden University

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## Abstract

Reactive attachment disorder (RAD), a disorder marked by a severe disruption in developmental attachment, is most often diagnosed in youth who have received substandard or negligent care from their primary caregiver. Such youth have increased risk of behavioral and emotional issues as well as future relationship problems; they generally do not respond to traditional evidence-based practices of therapy. The present study examined the use of the biofield energy practice of Healing Touch (HT) as a viable therapeutic option for improved quality of life for youth diagnosed with RAD. A quantitative, quasi-experimental research study using secondary data was conducted. Eligible participants were 40 children between the ages of 6 and 21 residing at a residential facility and having the diagnosis of RAD. Half of the participants received HT therapy while the other half did not. Dependent variables of frequencies of seclusion, aggression, self-injury/self-harm, property damage in excess of \$50, and running away from the facility were assessed at set intervals before and after implementation of HT therapy. Findings from a 2 x 2 mixed factorial design using mixed ANOVAs lacked statistical significance; therefore, the alternative hypotheses were not supported. However, the potential remains for positive social change. Clinical importance was evidenced in several variables demonstrating improvement in behaviors for many participants. In addition, while statistical significance was not obtained, the study contributes to the knowledge base regarding the use of HT therapy for future studies.

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## Dedication

This dissertation is dedicated to my family. My children and grandchildren: Lanny, Logan, Cooper, Heather, Alysia, Justin and Grace. My youngest, Grace, has seen me work on my higher education for the majority of her life. I hope by dedicating this to her, it reminds her to always strive for the best and never give up. I would also like to dedicate this to my family by birth as well as my family by marriage and my family by choice. And most specially, the man who has put up with evenings and holidays with me in front of the computer, my husband and best friend, Lanny E. Stiles, DO.

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This dissertation has been birthed through marriages, divorces, births of children, unfortunate deaths of loved ones, hospitalizations, in sickness and in health, lost holidays, graduations, moving children across the nation, and one F-5 tornado. However, each event has reminded me that life goes on and family is so important. For that, I humbly acknowledge my love and respect for my mother-in-law, Avis, who while faced with utter destruction and the loss of nearly everything, continued to ask me about my schooling and encourage me to fulfill my destiny.

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## Chapter 1: Introduction to Study

Attachment with another human being is formed as a means to develop the dynamics of a long-term relationship between two individuals and is often used to explain the relationship between primary caregivers, such as parents and a child. The first years of life are filled with wants and needs of the infant. As infants cannot provide for themselves, they must have wants and needs fulfilled by others. While many individuals have their needs fulfilled, some youth do not receive such care. Thompson-Jinariu (2011) identified that infants and youth who are given adequate care and love are more likely to have the ability to form secure relationships with others in the future. However, if the infant or youth does not receive a secure foundation, the infant/youth is at risk for creating future relationships that are insecure in attachment.

Infants are likely to form secure attachment with a consistent caregiver who is responsive and interactive. While quantity of time spent between the caregiver and infant is important, the quality of the interaction is integral as well. However, when a break in the quality and quantity of time spent with the caregiver occurs, the risk emerges for insecure attachment formation. This may be the result of a nonresponsive or non-interactive caregiver or an abusive/neglectful caregiver. While the biological mother is often the primary caregiver over a period of time, the role of the primary caregiver may be fulfilled by any individual, including a father or grandparent (Bowlby, 1980).

The historic works of John Bowlby and Harry Harlow are reviewed in this chapter. Projecting forward, connections with historic works and the application for childhood trauma are examined. Information regarding key definitions, including but not limited to, Healing Touch (HT) therapy and Reactive attachment disorder (RAD) are

examined as well. The problem statement, purpose, research questions, hypotheses, theoretical considerations, and the potential for social change are also examined. Assumptions, delimitations, and limitations are also addressed. The significance for positive social change is examined to discuss the need for the proposed study.

## **Background**

### **John Bowlby**

John Bowlby (1980) identified that children come into the world hardwired to form attachment to others as a means of survival. Bowlby further identified that the desire to form an attachment to another is instinctual and attachment to another may be considered evolutionary in nature. Infants who stay close to primary caregivers are more likely to survive the first few years of life and such infants are more likely to grow up and have children of their own. The concept of forming attachments may lead to the suggestion that attachment may be considered an evolutionary learned behavior. Bowlby suggested that a child would form a primary attachment with one caregiver, and this caregiver would form a secure base from which to explore the world. In addition, this attachment would serve as a prototype for all future social interactions. Disruptions of this primary attachment could result in severe negative consequences, including but not limited to learned helplessness, injury, and death. While Bowlby primarily discussed the mother, he identified that the primary bond could be with any individual regardless of gender or biological connection.

Bowlby (1980) further identified that care from the primary caregiver should be continuous for approximately the first two to five years of life. Bowlby postulated that if a connection with a primary caregiver is broken during the critical first 2 years of life, the

child will potentially face lifelong consequences with forming future attachments.

Bowlby identified this risk as continuing through the first 5 years of the child's life. With such a break in attachment, the youth may exhibit issues with delinquency, aggression, and affectionless psychopathy (difficulty with or inability to establish relationships and care for others).

### **Harry Harlow**

Harry Harlow also attempted to examine the significance of attachment and the need for nurturing touch. Harlow (1973) used rhesus monkeys, separating them from their birth mothers shortly after birth. While some of the physical needs were met by laboratory assistants, the infant monkeys were primarily "raised" by surrogate "mothers" made of either a heavy wire mesh frame or a wood frame covered with foam rubber and a soft terry cloth. Both mothers were warmed by an electric light. The wire surrogate had no soft sides while the wood surrogate was considerably softer and more physically inviting. Harlow (1973) provided nutrition to the infants via nipples woven throughout the wire or wood frame. Harlow concluded that regardless of who provided the nourishment, the infant monkey chose to spend the majority of the time with the wood and cloth surrogate. Harlow identified that closeness and perceived affection were more instrumental than mere nutrition and warmth.

Harlow (1973) further purported that the infant monkeys that had been removed from their mother's care, once raised to adulthood, exhibited continued behavioral issues, regardless of whether they were raised with the wire mother or the wood and cloth surrogate. Harlow reported that the monkeys displayed stereotypical behaviors suggesting excessive/misdirected aggression, including but not limited to rocking and self-isolating

behaviors. In addition, the adult male monkeys had difficulty forming and maintaining sexual relations. The adult female monkeys often displayed abusive or negligent behavior. Harlow concluded that deprivation of the emotional bonds at key times in the infant monkeys' development led to difficulty forming secure attachments with their own offspring. While the cloth and wood surrogate was better than the wire surrogate, Harlow concluded that neither was an acceptable replacement for a live caregiver.

### **Childhood Trauma and Attachment**

Connors (2011) identified that attachment theory is a strong theoretical foundation that applies to those at risk of affect dysregulation and attachment with future relationships. Aideuis (2007) discussed the idea of attachment impairment as the result of continual or intensive abuse and neglect. Such abuse and/or neglect threaten the ability to form and then maintain attachment with a caregiver, limiting the youth's capacity to form future relationships. When a caregiver is abusive or neglectful during said pivotal times, the youth may not learn how to self-regulate. The youth is at risk for continuing the pattern of abusive/neglect, as well as continuing the pattern of an emotionally distant, future relationships. Such individuals often do not respond to traditional therapeutic options. Aideuis encouraged the use of a multiple treatment team approach, complementing traditional therapeutic care with alternative treatments such as biofield energy healing and kinesthetic self-awareness.

### **Healing Touch**

HT therapy is a nursing-based intervention (Hover-Kramer, 2011). HT therapy purports to work with a person's personal energy field to create alignment and allow the body to naturally heal. Hover-Kramer (2011) identified that HT is safe to work with all

age groups and is to be used as a complementary component to traditional therapy. The participant lies on a table, fully clothed, and the therapist places his/her hands either lightly on the individual or just above the individual in order to gain connection with the participant's energy field.

HT is considered a biofield therapy which promotes balance and/or restoration of the body's magnetic field. Healing Touch therapist, Marilyn Vincent, RN, BSN, HTCP (2013) identified that HT uses touch in a positive, nurturing manner that is heart-centered and promotes self-healing of the energy centers that control the individual's energy field throughout the physical body. The goal of HT is for the therapist to assist the individual in restoring balance and allow the individual to self-heal (Hover-Kramer, 2011). HT therapy has been used for a variety of conditions, including but not limited to pain management, hypertension management, and Post Traumatic Stress Disorder. HT therapy has been used anecdotally in other medical and mental health conditions but remains lacking in systematic research (Wardell, 2004).

A need exists to bridge the gap for possible therapeutic options for the vulnerable youth population. Traditional evidence-based therapeutic options often do not work to optimal results with youth at risk for attachment impairment (Stinehart, Scott, & Barfield, 2012). A further need exists to examine possible non-traditional therapeutic options and contribute to the gap in the existing knowledge.

### Problem Statement

If the infant or child has not received a positive secure base of attachment, the youth will potentially fail to form a secure attachment with any individual (Bowlby, 1984). Such youth often face additional issues such as psychiatric and behavioral issues

(Thompson-Jinariu, 2011) and future relationships are placed in jeopardy. Unfortunately, youth who have not been able to form an adequate attachment foundation often do not respond to traditional evidence-based practices of therapy for additional psychiatric and/or behavioral issues (Thompson-Jinariu, 2011). A need exists to explore non-traditional means of treatment. With such exploration, possible future evidence-based therapy options may be discovered. The question remains as to what forms of alternative or non-traditional treatments options can be considered viable as therapeutic options for youth at risk for attachment impairment.

Bernard et al. (2012) identified that early intervention may help the individual at risk for attachment impairment to self-heal and form future positive relationships. While the concept of attachment impairment is not a new condition, therapeutic options for this vulnerable population remain limited. If the cycle of attachment impairment can be broken, current therapeutic options may be revised. At present, individuals with attachment impairment often do not respond to traditional therapeutic options of cognitive behavioral and/or medication therapy. Additional therapeutic options need to be explored to help the individual and possibly provide cost effective therapeutic options. As mental health care costs rise, it remains integral to find cost effective methods that can best serve the local and global community. Taking a proactive rather than a reactive approach may help this and future generations. If youth can self-heal and break the cycle of abuse and neglect, then they themselves can serve as higher functioning primary caregivers as adults and future generations will be less likely to face potential attachment impairment.

## Purpose of Study

Bowlby (1984) identified that the bonds that are often formed or not formed with a primary caregiver such as a parent are often repeated throughout the lifespan. The purpose of the proposed study was to quantitatively explore the use of HT therapy with youth diagnosed with (RAD). My study placed focus on the use of biofield energy practices, specifically HT therapy, as a complementary therapeutic option to traditional evidence-based therapeutic options for youth diagnosed with RAD.

Youth who have been diagnosed with RAD or are at risk for attachment impairment often do not respond well to rules and restraints. Suicide, self-injury, and harm to others are common manifestations of a reaction to limitations and restrictions (Stinehart, Scott, & Barfield, 2012). The independent variable in my study is the use of HT therapy. One study group (the control group) received traditional therapeutic options (e.g., talk therapy, medications), while the other study group (the HT group) received traditional therapeutic options plus HT. Dependent variables included the number of episodes of seclusions, physical aggression, suicidality/self-injury, destruction of property in excess of \$50, and running away from the residential facility.

## Research Questions and Hypotheses

1. After treatment, will youth diagnosed with RAD who receive HT therapy have significantly different seclusion frequencies than the control group?
  - a. *H<sub>01</sub>*: After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different seclusion frequencies as compared to the control group.

- b.  $H_{A1}$ : After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different seclusion frequencies as compared to the control group.
2. After treatment, will youth diagnosed with RAD who receive HT therapy have significantly different physical aggression frequencies than the control group?
  - a.  $H_{02}$ : After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different physical aggression frequencies as compare to the control group.
  - b.  $H_{A2}$ : After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different physical aggression frequencies as compared to the control group.
3. After treatment, will youth diagnosed with RAD who receive HT therapy have significantly different suicidality/self-injury frequencies than the control group?
  - a.  $H_{03}$ : After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different suicidality/self-injury frequencies as compared to the control group.
  - b.  $H_{A3}$ : After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different suicidality/self-injury frequencies as compared to the control group.



4. After treatment, will youth diagnosed with RAD who receive HT therapy have significantly different property damage frequencies than the control group?
  - a.  $H_{04}$ : After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different property damage frequencies as compared to the control group.
  - b.  $H_{A4}$ : After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different property damage frequencies as compared to the control group.
5. After treatment, will youth diagnosed with RAD who receive HT therapy have significantly different running away from the residential facility frequencies than the control group?
  - a.  $H_{05}$ : After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different running away frequencies as compared to the control group.
  - b.  $H_{A5}$ : After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different running away frequencies as compared to the control group.

#### Theoretical Considerations

Attachment theory is the concept set forth by John Bowlby (1984). Bowlby theorized that the behaviors of attachment are instinctive in nature as a means of survival. Bowlby postulated that babies are instinctually born with behaviors that will ensure contact with a caregiver such as crying, smiling, or crawling. Bowlby stated that a child's

initial chance for attachment will serve as a base for all future social relationships.

Bowlby further postulated that when the attachment process is considered to be positive in nature, the child is more likely to perpetuate positive attachment to the next generation. However, if the attachment process is considered disruptive or negative, the child has the potential for dire consequences, including but not limited to the inability to form attachment with their own future children.

Bowlby's theory of attachment (1984) proposed that children have an innate need to form an attachment to a primary caregiver. While Bowlby identified that an infant could form an attachment with others, he postulated that the primary bond should be with a primary caregiver (most likely a mother). Failure to form the primary attachment could result in affectionless behavior and psychopathy. Secondly, the theory of attachment postulated that the youth should receive continuous and consistent care from this primary caregiver for approximately the first two years of life. If the attachment is broken or disrupted for an extended period of time during the first two years of life, attachment impairment is also at risk. If impairment occurs, there is the potential for long term cognitive, social, and emotional difficulties including but not limited to increased aggression, delinquency, and impaired future relationships. Bowlby identified the primary caregiver relationship as a prototype for all future relationships.

Field (2002) and Harlow (1973) espoused the fundamental need for children to receive positive, nurturing touch while the youth is developing into an adult. Such touch should include touch for reasons beyond basic needs. Youth at risk for attachment impairment often have experienced inappropriate or a lack of positive touch (Stinehart, Scott, & Barfield, 2012, p. 356). All identified that positive, nurturing touch is integral

during formative years to allow the youth to learn that touch promotes self-healing and a sense of connection with another individual.

#### Nature of Study

The secondary data information obtained for the study was obtained from Chaddock, an internationally recognized long term residential facility. Chaddock works with youth with various behavioral and psychological concerns, including but not limited to youth at risk for attachment impairment. Based on the needs and desires of the agency (Chaddock), this study applied quantitative reasoning to secondary archival data collected by the agency for other purposes creating a quasi-experimental status (Creswell, 2014). Quantitative reasoning was best suited to understand the relationship between the variable of HT therapy and the effect it has on outcomes of harm to self and others, including seclusions, physical aggression, suicidality/self-injury, property damage in excess of \$50, and running away from the residential facility.

The study used quantitative secondary data that was ex post facto quasi-experimental in nature. Participants were a convenience sample of youth residing at a nationally recognized long-term residential facility for youth facing attachment impairment. Because participants were not assigned to groups via random assignment, the study was quasi-experimental in nature (Creswell, 2014).

The study involved youth who reside at a long-term residential facility and are receiving treatment for behavioral and emotional issues. The between-subjects variable in this study is the receipt of HT. One-half of the participants received HT, while the other half did not receive HT. At this facility, youth are assigned to receive HT based on prior behaviors; they are not randomly assigned to receive HT. Because participants were not

randomly assigned to the HT group or the control group, this study was quasi-experimental (Creswell, 2014).

The within-subjects variable in this study is the timing of the dependent variables assessment. Dependent variables (e.g., seclusion frequencies) were assessed both pretreatment and posttreatment for all participants. Mixed analysis of variance tests ANOVAs with one between-subject variable (HT therapy group vs. control group) and one within-subject variable (pretreatment vs. posttreatment assessment timing) was intended to be used to test the hypothesis but a Mann-Whitney U was ultimately conducted to meet the needs of the assumptions..

#### Operational Definitions

*Biofield therapy:* Biofield therapeutic options follow the concept of using an individual's own subtle energy flow, often used in Eastern Medicine. While the name for the energy flow varies according to the practice being used (Chi, Qi, Prana), all identify a subtle energy flow from within the body that affect the body and mind (Jain & Mills, 2010), For the purpose of this study, the biofield therapeutic option of HT therapy were examined, although the existence of Chi was not addressed.

*Chi:* Chi is a Chinese term identifying a purported life force or energy flow (Liao, 2009). Ancient cultures identified ancient people identified an invisible force within all of life and nature. Chi may also be identified as *qi*, *ki*, or *chee*, depending on from which country the term is originating. Liao (2009) identified that ancient Chinese believed Chi permeated everything and linked their surrounding together. Ancient Chinese sought to understand Chi believing they could increase the purported life flow in an effort to provide stability and longevity to life (Liao, 2009).

*Healing touch therapy:* HT therapy is defined as biofield energy based on complementary and alternative medicine. Considered a nursing based intervention designed by Janet Mentgen, HT is often administered to the fully clothed individual using light touch or near-body touching (Hover-Kramer, 2011). The reported purpose of HT is to clear and balance the human's energy fields. Furthermore, HT therapy purports to provide support to the body's natural energy field or Chi. It is purported that Chi allows the individual to self-heal the mind, body, and spirit. Under the concept of HT therapy, negative life events result in congestion and stagnation in the life energy fields. HT is intended to unblock any congestion/stagnation and allow the individual to self-heal and recover to a state of harmony (Hover-Kramer, 2011).

*Reactive attachment disorder:* RAD is a disorder marked by a severe disruption to developmental attachment (American Psychiatric Association, 2013). According to the *Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> edition (DSM-5;* American Psychiatric Association [APA], 2013), RAD is usually is a result of gross pathological care before the age of 5. There is also a presumption that the inadequate or absent care is the cause for disturbed behavior. The individual with RAD will demonstrate inappropriate formation of attachment with caregivers. Youth with RAD are believed to have the capacity to form selective attachments when benefitting them. However, due to limited opportunity to form secure attachments during early development, the emotional regulation capacity is compromised. A youth should not be diagnosed with RAD if the youth was developmentally or intellectually unable to form attachment. According to the *DSM-5* (2013), the prevalence of RAD is unknown but considered rare. It is identified

that even in populations of severely neglected/abused children that the disorder is uncommon (p. 266).

*Complementary health approaches:* Complementary health approaches include health care options that are used together with conventional medical approaches. The National Center for Complementary and Alternative Medicine (NCCAM; 2013) identified nearly 40% of Americans use some form of a health care approach outside the confines of traditional Western medicine. HT therapy may be used in conjunction with traditional Western medical options. Such use would be considered complementary integrative health in approach rather than alternative which would be in place of traditional Western medicine.

*Running away:* For the purpose of this study, a youth was determined to have run away if the person had left the residential facility without the permission of a care provider. The individual must have left the property for a period of at least 15 minutes. In addition, the youth must have left the property without consent or knowledge from the provider at Chaddock. Records were maintained by Chaddock and/or the police department, depending on the severity and time being away from campus.

*Seclusions:* For the purpose of the study, seclusion was defined as the act of physically removing the participant from a potentially harmful situation to their self and/or others. The person was placed in a secluded or locked facility until the person could regain enough physical/emotional control to no longer be considered at risk of injury to self and/or others. Seclusion must accompany a physician order or documentation justifying the behaviors as a means of protecting the individual and/or others. If a youth is required to remain in seclusion beyond a 2 hour period, a renew order

from the physician needs to be in place. During the entirety of the seclusion, the youth is monitored for safety, often via a one-way mirror and/or video camera display (M. Vincent, personal communication, June 24, 2014).

*Physical aggression:* For the purpose of this study, physical aggression is defined as any behavior causing or threatening physical harm to another individual. Episodes of physical aggression are documented by caregivers in the residential facility via medical records, and depending on the severity of the aggression, police records. Episodes of physical aggression may include but are not limited to threatening others, throwing objects, attempting to choke another individual, or striking another person (M. Vincent, personal communication, June 24, 2014).

*Suicidality/Self-Injury:* For the purpose of this study, a youth was determined to be suicidal or self-injurious if he/she reports intent and/or suicide by action. The severity of the suicidal intent was evaluated by the staff regarding plan, intent, and availability of suicidal means. Self-injury, for the purpose of the study, is defined as injury or bodily harm to the self that requires medical attention. Coded data from Chaddock employees combine the concept of suicide attempts and self-injury that requires medical attention. Only self-injurious behaviors that move beyond the superficial level are included in the data (M. Vincent, personal communication, June 24, 2014).

All episodes of suicidality/self-injury are documented by caregivers in the residential facility. Each episode of suicidality/self-injury was defined to need medical and/or psychiatric assistance, so cutting that does not require medical attention is not included in this category. Episodes of suicidality/self-injury may include but not limited to cutting on arms, placing belts/shoelaces around neck, or attempting to stand in front of

a moving car. Episodes of suicidality/self-injury are documented by Chaddock medical records, and depending on the severity, police records (Personal communication, Marilyn Vincent, HT provider, June, 24, 2015).

*Destruction of property:* Destruction of property is defined as the participant damaging or destroying property of others or themselves. The episode of destruction needed to have an estimated cost of at least \$50 or more in monetary value. Episodes of destruction of property may include, but are not limited to vandalism, putting holes in walls, or stealing a car. Documentation of destruction of property is maintained by Chaddock medical records and, depending on the severity, police records (Personal communication, Marilyn Vincent, HT provider, June 24, 2015).

## Variables

### **Independent Variable**

The independent variable in the proposed study is intervention type (HT therapy vs. control). While all participants have the diagnosis of RAD and resided in a long-term residential facility, only those in the intervention group were introduced to the variable of HT therapy. For inclusion into the HT program, the participant had to be referred by the primary clinical therapist and recommended by the HT practitioner, medical director, and core treatment team. Both the treatment group and the control group were available for current evidence-based therapeutic options, including but not limited to medication therapy, cognitive behavioral therapy, and traditional talk therapy.

Using secondary data, frequencies of the dependent measures was assessed for 3 months prior to the addition of the HT therapy and then for 3 months following the



beginning of the HT therapy. The control group was also monitored for a similar time frame, although they did not receive HT therapy.

At the time of the study, Chaddock only employed one HT certified therapist, so all interventions were by the same individual. The HT therapy sessions were completed by HT therapist, Marilyn Vincent. Only secondary data was examined. The data was de-identified by employees of the guardian of record (Chaddock, n.d.).

### **Dependent Variables**

There are five dependent variables for the study. The first dependent variable was seclusion frequency. For the purpose of the study, seclusion is defined as the act of physically removing the participant from a potentially harmful situation to self and/or others. The person was placed in a secluded or locked facility until which time the person could regain enough physical/emotional control to no longer be considered at risk of injury to self and/or others. Seclusion must accompany a physician order or documentation justifying the behaviors as a means of protecting the individual and/or others.

If a youth was required to remain in seclusion beyond a 2 hour period, a renew order from the physician needed to be in place. During the time of seclusion, the youth was monitored, often via a one-way window or video camera. The need for seclusion identified that the person required the need for isolation in a locked room or secluded area that he/she was unable to leave until determined safe by an independent provider.

The second dependent variable was physical aggression frequencies. All episodes of physical aggression were documented by caregivers in the residential facility via medical records, and depending on the severity of the aggression, police records.

Episodes of physical aggression included but were not limited to threatening others, throwing objects, attempting to choke another individual, or striking another person.

The third dependent variable was suicidality/self-injury. All episodes of suicidality/self-injury were documented by caregivers in the residential facility. Each episode of suicidality/self-injury was defined to need medical and/or psychiatric assistance. Episodes of suicidality/self-injury included but not limited to cutting on arms, placing belts/shoelaces around neck, or attempting to stand in front of a moving car. Episodes of suicidality/self-injury were documented by Chaddock medical records, and depending on the severity, police records.

The fourth dependent variable was assessing destruction of property. The episode of destruction needed to have an estimated cost of at least \$50 or more in monetary value. Episodes of destruction of property included, but were not limited to, vandalism, putting holes in walls, or stealing a car. Documentation of destruction of property will be maintained by Chaddock medical records and, depending on the severity, police records.

The fifth and final dependent variable was running away from the residential facility. To be determined to have run away, the youth must have left the physical premise of Chaddock without the knowledge or consent of providers of Chaddock for a period of at least 15 minutes. Documentation of running away from the residential facility was and is maintained by Chaddock medical records and, depending on the severity, police records.

Frequencies of the dependent measures were assessed for 3 months prior to the addition of the HT therapy and then for 3 months following the beginning of the HT therapy. The control group was monitored for a similar time frame and frequencies,

although they did not receive HT therapy. Each DV was measured independently of the others to assess changes in the dependent measure mean score from pretest to posttest (Creswell, 2014). While each of the dependent measures is a common manifestation of RAD, these behaviors are not necessarily expected to correlate with one another; therefore, each dependent measure was examined independently.

### **Assumptions**

As with any research, there were various assumptions, limitations, and delimitations that were addressed. It is assumed that all participants in the study were accurately diagnosed as having the diagnosis of RAD by Chaddock's Medical Director or been previously accurately diagnosed by a qualified clinician. Participation in the HT program was determined by documentation and family/participant records in Chaddock medical records. It was assumed that all family and participant history as well as any documentation were accurate and truthful. It is also assumed that the HT provider provided quality services and the residential facility was competent as well. Chaddock is a nationally recognized long term facility providing quality care for at-risk youth and the primary HT provider, Marilyn Vincent, is a certified HT therapist.

### **Scope**

Specific aspects of the research problem that were addressed in the study included assessing negative social behaviors such as destruction of property and physical aggression. While HT therapy places an emphasis of an individual's Chi, focus was not be placed on the existence of Chi. The scope of this study placed emphasis not on whether Chi exists, but whether HT therapy could help some negative societal behaviors. Focusing on quantifiable behaviors has the potential to assist the individual and family

form more positive relationships and diminish financial and emotional costs, including but not limited to legal costs, missing work, and legal incarceration.

### **Delimitations**

Only those participants who were engaged in the HT therapy for a minimum of four sessions were assessed. One delimitation of the study was individuals who receive fewer than four HT sessions. Four sessions was the minimum number of sessions necessary for providing HT therapy per Chaddock policy. After four sessions, the participant was encouraged to use HT sessions on an “as needed” basis and often at the request of the participant (M. Vincent, personal communication, June 24, 2014). Only individuals who have the diagnosis of RAD were included in the study. While Chaddock works with a wide variety of individuals, Chaddock is nationally recognized for work with individuals with RAD, creating a larger sample pool and individuals from a wide variety of walks of life and circumstances (Chaddock. n.d.).

The participants all resided at Chaddock, a nationally recognized long- term residential facility for at-risk youth. While Chaddock does work with individuals on an outpatient status as well, such individuals were not considered for this study in an effort to equalize residency status and level of care received across participants. All participants were between the ages of 8 and 21. Participants younger and older than the intended age were not considered due to the parameters set forth by the admission team for residential living at Chaddock (Chaddock,n.d.).

### **Limitations**

One limitation of this study was that currently only one facility (Chaddock) is using the HT program as a therapeutic option. In addition, there is currently only one HT

provider is employed by Chaddock; therefore, all data was at the mercy of the quality of the provider and the facility. While Marilyn Vincent is a certified HT therapist, she is the sole HT provider at the facility. Both factors limit generalizability.

Another potential limitation was that Chaddock receives funding from various insurance agencies for the HT program. While such funding is not dependent upon the findings of the study, the potential of financial gain/loss did exist. However, because this funding is not Chaddock's only or primary source of income and was not in any way dependent on the findings of this study, the limitation of charting for positive results was minimalized.

Another limitation was the size of the sample pool. Although power analyses indicate that this study was sufficiently powered to detect a medium effect size, future studies may strive to engage larger samples in order to detect smaller effects of HT on measures of interest. Another limitation was that for referral to the HT program, a treatment team must demonstrate that traditional methods are not effective at controlling or improving the child's behavior. It is more likely that youth referred to the HT program may represent more extreme cases of RAD than their control counterparts. Participants in the HT program are chosen by the treatment team rather than random assignment, suggesting those not responsive to traditional evidence-based therapeutic options may be more likely to have been chosen. While all individuals participating had the diagnosis of RAD, a limitation was that a variety of comorbid diagnosis may exist.

The likelihood of improvement was also a potential limitation. Regardless of whether the youth was in the HT program or in the control group, all participants have received therapy and care (including but not limited to psychotherapy, medication

therapy, and Cognitive Behavioral Therapy) at a nationally recognized residential facility. It was likely that both groups would experience some degree of improvement as conventional treatment is being provided for all. Those in the HT group were often recommended for HT after not responding well to the traditional therapeutic options. Degrees of improvement might have been a result of severity (or lack of) of the RAD diagnosis rather than solely based on the addition of the HT program.

Another potential limitation was the utilization of an ex post facto quasi-experimental design. Because participants are not randomly assigned to conditions, causal conclusions about the relationships between the variables cannot be established. However, the use of ex post facto quasi-experimental design is often utilized when individuals cannot be truly randomly assigned or variables cannot be physically or ethically controlled (Creswell, 2014).

Another potential limitation was the potential of a placebo effect (Creswell, 2014). Because of using secondary data, the baseline group did not control for this possibility (i.e., the baseline group knew they did *not* receive HT and the HT group knew they did receive HT), any possible effects of HT may be due to this knowledge rather than the treatment itself. While both groups knew whether they received HT or not, no two individuals at Chaddock received identical overall treatments because treatment plans are tailored to the needs of each patient. Because of this individualized approach to treatment, an individual receiving HT would not necessarily have questions or concerns regarding the specific use of HT over another program. Future studies could examine the use of HT therapy using double blind study procedures in order to reduce the risk of placebo effects. All participants in the study had exhibited behaviors that have justified

admittance to a long term residential facility. A limitation existed that such participants may exhibit higher than average rates of dependent variables of behaviors.

Finally, the present study only examined individuals diagnosed with RAD; therefore, findings may or may not generalize to other psychiatric illnesses. Limited data exists for the potential use of HT for psychiatric disorders beyond anxiety and depression (Shore, 2004). Future studies may expand on the use of HT with attachment impairment and other psychiatric and/or behavioral issues.

This study used an ex post facto quasi-experimental design. For the purpose of this study, a random assignment of participants was not possible due to the use of secondary data. Because participants were not be randomly assigned to groups, it was not possible to make conclusions about causal relationships between the variables. To mitigate this limitation and strengthen the study's internal validity, both the HT and control groups were similar in that both groups resided at Chaddock and had other similarities (e.g., diagnosis, age, caregivers).

### **Significance**

This project was unique as it addressed a severely under researched area of study. The results of the study had the potential to provide evidence for possible therapeutic options for a population that does not respond to traditional evidence-based therapy. Results of the study also had the potential to offer therapeutic options that are non-invasive in nature. The need for non-invasive treatment options remains integral, particularly for vulnerable populations.

HT therapy should be considered as a possible non-traditional therapeutic option for a population that does not typically respond to traditional therapeutic interventions.

Potential future studies may provide support for an evidence-based therapeutic intervention for a population that has limited therapeutic options. By breaking the cycle of negative attachment, the potential for positive social change may be far reaching from the individual to future children as well.

The research had the potential to contribute to psychology and society. First, the research may be able to further the knowledge of therapeutic options for a vulnerable population (at-risk youth). At present time, evidence-based therapeutic options for this population are limited. Thompson-Jinariu (2011) identified that youth at risk for attachment impairment often do not respond to traditional therapeutic options such as cognitive behavioral therapy or traditional talk therapy. Future research may be able to provide information beyond the anecdotal level regarding possible complementary treatment options.

The research also had the potential to demonstrate whether HT may be used to help preserve the family unit. Many youth at risk for attachment impairment are part of the foster/adoptive program, and introducing new family members can be disruptive in the best of situations. By reducing the number of self-injurious or destructive behaviors, this treatment could reduce disruptions in the family dynamic, ultimately improving family relations.

In addition, reducing physical aggression episodes may improve safety of all, including but not limited to the client and staff. The treatment offers a possible reduction in other impulsive and potentially dangerous behaviors, including but not limited to legal issues, sexual promiscuity, marital discord, and partner/child abuse. Finally, providing



evidence-based cost effective techniques may assist society as a whole, reducing short term and long term costs to an overtaxed system.

### **Summary**

Forming an attachment with another human being is considered integral for all future relationships. A break in attachment during formative years runs the risk of developing attachment impairment for all relationships. Individuals with attachment impairment concerns traditionally do not respond favorably to traditional evidence-based therapeutic options (Steinhart, Scott, & Barfield, 2012). Complementary and alternative medicine (CAM) such as biofield therapeutic options has been used for many years for a variety of medical and mental issues. Future research may be able to explore future possible applications to CAM usage.

In Chapter 2, I will examine the use of the CAM based therapy of HT, prior studies of issues related to attachment, HT, psychiatric costs, and related conditions. Historical studies regarding biofield therapeutic options and attachment will be discussed. In addition, current issues such as costs of psychiatric care and therapeutic options will be addressed. In Chapter 2, I will also discuss current gaps in the literature regarding the use of HT for attachment-related disorders.

## Chapter 2: Literature Review

When an infant or child has not received a positive secure base of attachment, a youth will potentially fail to form a secure attachment with any individual. Such youth often face additional issues such as psychiatric and behavioral issues. Future relationships are potentially placed in jeopardy. However, youth who have not been able to form an adequate attachment foundation often do not respond to traditional evidence-based practices of therapy for additional psychiatric and/or behavioral issues creating a need to explore non-traditional means of treatment (Steinhart, Scott, & Barfield, 2012).

The purpose of the study was to examine the use of biofield energy practices, specifically HT therapy, as a complementary therapeutic option to traditional evidence-based therapeutic options for youth diagnosed with RAD. Youth who either have been diagnosed with RAD or are at risk for attachment impairment often do not respond well to rules and restraints. Suicide, self-harm, and harm to others are common manifestations of a reaction to limitations and restrictions (Steinhart et al., 2012). Seclusion is implemented when the individual is at imminent risk of harm to self and others. For many, self-injury and suicide attempts are a manifestation of expressing emotions. Both may be useful indicators whether HT may be beneficial in helping the individual express emotions in more healthy manners.

Current literature for the use of HT therapy is focused on using HT in treating medical and psychiatric conditions other than RAD, including but not limited to post traumatic stress disorder (PTSD) and pain management. In addition, current literature suggests that traditional evidence-based therapeutic options such as cognitive behavioral therapy do not work as well with youth diagnosed with RAD (Steinhart et al., 2012). The

focus of this chapter is on examining trauma and attachment issues, RAD, and the importance of touch, particularly HT therapy.

In addition, I explore attachment theory, as set forth by John Bowlby (1984). Theoretical foundations from Bowlby (1984) and problems with attachment (Conners, 2011) are addressed to discuss the needs of those diagnosed with RAD. Trauma and loss (Aideuis, 2007; Myers, 2000; Prather, 2009) are discussed regarding how issues can affect outcomes of behaviors. Focus is placed on individuals placed in foster care and orphanages and those at risk for developing RAD (Bruskas, 2010; Nelson et al. 2009; Smyke et al. 2010). Current treatment options and gaps in literature addressing current needs of youth diagnosed with RAD are discussed to explain the need for the study (Hover-Kramer, 2011; Schnepfner, 2010; Stubenbort et al. 2010).

### **Literature Search Strategy**

For the purposes of this study, a variety of library databases and search engines were used. The following key terms were utilized: *reactive attachment disorder*, *attachment theory*, *psychiatric costs*, *touch therapy*, *Healing Touch*, *biofield therapy*, and *John Bowlby*. Databases included ProQuest, PsychArticles, and the search engine, Google Scholar. Hard copy books and print paper journals regarding HT therapy and RAD were also obtained. The primary years reviewed were from 2009 to present. The review was extended to 2000 and prior if historical years were discovered, such as first-hand accounts by John Bowlby in 1984.

### **Theoretical Foundations**

Attachment theory was originated by John Bowlby (1984). Postulating that all human infants are born with instinctual behaviors, Bowlby identified that babies display

behaviors that will hopefully ensure contact with a caregiver such as crying, smiling, or crawling. Such behaviors are intended to facilitate and ensure survival. Bowlby further theorized that a child's initial chance for attachment serves as a base for all future social relationships. When the attachment process is positive in nature, the child is more likely to perpetuate positive attachment to the next generation. However, if the attachment process is disruptive or negative, the child has the potential for dire consequences, including but not limited to the inability to form attachment with their own future children.

Bowlby's theory of attachment (1984) proposed that children have an innate need to form an attachment to a primary caregiver. While Bowlby identified that others could form an attachment, the author postulated that the primary bond should be with a primary caregiver (most likely a mother). However, connection with any primary caregiver such as a father or grandparents can also ensure the bonding process. Failure to form the primary attachment could potentially result in affectionless behavior and psychopathy.

The theory of attachment also postulated that the youth should receive continuous and consistent care from this primary caregiver for approximately the first two years of life. If the attachment is broken or disrupted for an extended period of time during the first two years of life, there is the potential for long term cognitive, social, and emotional difficulties including but not limited to increased aggression, delinquency, and impaired future relationships. Bowlby (1984) postulated the primary caregiver relationship serves as a prototype for all future relationships.

### **Problems with Attachment**

While Bowlby identified that positive emotional bonding with a primary caregiver can lead to positive attachments with further relationships, problems may occur when the bonds of attachment are either interrupted or never occurred. Harry Harlow (1973) furthered research set forth by Bowlby by examining consequences when the attachment process was interrupted. Harlow raised Rhesus monkeys away from their mothers' immediately after their birth and examined the process of attachment. Harlow (1973) discovered that the monkeys that had not been nurtured by a primary caregiver developed negative psychological outcomes. When the monkeys grew and had children of their own, the test monkeys were more likely to reject their offspring and demonstrated fewer parenting skills than their counterparts. In addition, the monkeys deprived of a primary caregiver were more likely to display behaviors antisocial to a monkey social group,

More recently, Aideuis (2007) expanded upon the idea of attachment impairment, examining the effects of continual or intensive abuse and neglect. Such abuse and/or neglect threaten the youth's ability to form and then maintain attachment with a caregiver, limiting the youth's ability to form future relationships. When a caregiver is abusive or neglectful during said pivotal times, the youth may not learn how to self-regulate behaviors, such as acts of physical aggression and suicidality. Connors (2011) identified that attachment theory is a strong theoretical foundation that applies to those at risk of affect dysregulation and attachment with future relationships, including but not limited to RAD. Research demonstrated when problems with attachment are severe, the youth is at risk for major impairment that will likely inhibit or impair the child throughout the lifespan (Aideuis, 2007; APA, 2013; van den Dries, Juffer, van

IJzendoorn , & Bakermans-Kranenburg, 2009). Perhaps one of the most severe consequences that can occur with gross pathological care is RAD.

### **Reactive Attachment Disorder**

RAD is identified as a traumatic and stressor-related disorder (APA, 2013). The *DSM-5* identifies that, for a formal diagnosis, the disturbance must be evident before age 5 and there must be the existence of a pattern of extreme insufficient care, including but not limited to social neglect and repetitive changes of primary caregivers (2013, p. 265). An essential feature of RAD is absent or grossly underdeveloped attachment with a caregiver. According to the *DSM-5* (2013), the prevalence of RAD is unknown, but considered rare (p. 266). Without treatment, RAD has the potential to significantly impair the young child's ability to form future attachments and relate with others (Stinehart et al. 2012).

### **Trauma and Loss**

Youth who have experienced attachment impairment such as those with RAD often have faced various forms of trauma and loss, including but not limited to parental separation and abuse. Without treatment, this unresolved trauma and loss has the potential for long reaching outcomes. Myers (2000) researched the impact of unresolved loss on adolescents. Unresolved loss, such as disruptions in the caregiver/youth roles, can severely negatively affect an adolescent. While not all adolescents who experience unresolved loss act out, most identify feelings of anger and desires for defiance. In addition, many adolescents respond to such loss with emotional detachment or distancing (APA, 2013; Myers, 2000).

Aideuis (2007) added to the concept of complex trauma and the promotion of attachment regulation. The author identified complex trauma as the result of repeated or chronic traumatic experiences in childhood. Aideuis (2007) researched traumatic events that threaten the youth's ability to form secure attachments that include, but are not limited to physical, sexual, and emotional abuse as well as neglect. The author further identified that such experiences have a pervasive impact on the youth, limiting the youth's ability to form positive bonds with caregivers, and potentially limiting the youth's ability to self-regulate. Aideuis (2007) further examined various evidence-based treatment options for individuals who have faced complex and sometimes prolonged traumatic events such as war and parental abandonment. Aideuis (2007) encouraged the addition of complex trauma to the *DSM-5*, but identified that RAD could sufficiently serve as well if the child was young enough to meet criteria. Aideuis (2007) recommended the use of initiatives such as trauma-based cognitive behavioral therapy (TF-CBT) and eye movement desensitization and reprocessing (EMDR).

Identifying childhood trauma and attachment issues from the perspective of behavioral analysis, Prather (2009) attempted to provide a theoretical basis for possible treatment models for previously abused children and their foster or adoptive parents. Focusing on cognitive emotive behavioral therapy (CBT) and trauma-based psychotherapy, the author identified that both methods base themselves on the integration of attachment theory. The author identified a lack of research into theoretical implications and treatment for maltreated children who live apart from their families of origin. While Prather (2009) exclusively examined theoretical considerations, the author encouraged further studies to examine research options as well, including but not limited to CBT.

There currently are no specific treatment options for individuals diagnosed with RAD (Mayo Clinic, 2014), however, treatment options such as CBT and individual treatment focused on moving beyond the trauma inflicted often are positive additions to the treatment options available for individuals diagnosed with RAD.

### **Foster Care and Orphanages**

Bruskas (2010) supported Bowlby's concept of attachment theory (1984) in regards to youth residing within the foster care system. Bruskas (2010) maintained childhood as a pivotal time in development that can influence all future relationships. Bruskas (2010) further maintained that the current model of the foster care system is inadequate for assuring the attachment needs for individuals at risk. At present, few programs are geared towards healing past attachments, much less forming and maintaining current potential attachments. Bruskas (2010) examined children in foster care programs using the Bronfenbrenner human health ecology model as well as Bowlby's model of attachment.

The Bronfenbrenner (1979) model examined the ecological system of the child and the child's environment to influence growth and development. Using the Bronfenbrenner model, emphasis is placed on the microsystem or immediate environment the child lives in, including immediate family and caregivers interact. Bronfenbrenner (1979) also identified that the more nurturing and encouraging the relationship, the better the emotional growth of the youth and vice versa. Bruskas (2010) suggested that a multidimensional theory and treatment models need to be in place for at-risk children who often do not respond to traditional therapeutic options.



Several recent potential issues regarding attachment came to light following the collapse of a Romanian dictator, Ceausescu (Nelson, Furtado, Fox, and Zeanah, 2009). Maintaining control for 24 years, Ceausescu followed the concept of increasing the population in order to build a formidable army. The authors identified, due to the prodding of Ceausescu, many parents reproduced more children than they could feasibly maintain, thereby creating real and social orphans. Nelson et al. (2009) identified a social orphan as a youth whose parents are alive but gave up custodial rights and who were raised in the orphanage alongside those that did not have living parents.

Citing historical work by Harlow and Bowlby, the authors identified that the Romanian orphans received fundamental care such as their physical needs being met, but lacked in nurturing needs such as being held for emotional support. The results of the longitudinal qualitative study indicated that youths raised in the Romanian orphanage were significantly more likely to form attachment impairment concerns than their geographical counterparts (Nelson et al., 2009) The authors' preliminary studies suggested those who were removed from the orphanages were possibly at the advantage of learning to form attachment-based relationships.

Follow up studies from Nelson et al (2009) were conducted by Smyke, Zeanah, Fox, Nelson, and Guthrie (2010), which examined attachment for 169 youths (42 months in age) residing in a Romanian orphanage. Institutionalized in the orphanage since birth, the youth were randomly assigned to a care option: care as usual for the orphanage (CAU) or to foster care. The youth were later compared to traditionally family reared children. The results of the longitudinal quasi-experimental design were that youth placed in foster care before 24 months of age were more likely to form attachments than those

remaining in CAU. However, youth placed in foster care later were more likely to develop attachment impairment than their earlier placed counterparts. It was suggested that traditionally reared youth in a secure home is an optimal solution. However, whenever considered not an option for a variety of reasons, foster care was suggested to be considered a more viable solution than orphanage care.

Youth that have been in need of institutional or foster care often are at risk of attachment impairment. Studies suggest that the ideal situation would be with a physically and emotionally nurturing environment (Almas et al., 2012; Breidenstine et al., 2011; Smyke et al., 2010). However, when such an environment did not exist at pivotal times in the youth's life, Almas et al. (2012) and Breidensteine et al. (2011) encouraged, whenever possible, to be able to have the youth be able to either return to or become emotionally ready to enter such an environment. In order for this to occur, the youth must be able to learn to accept such an environment as favorable over what is familiar.

### **Current Attachment Focused Treatment Options**

At present, there are no specific treatment options for individuals diagnosed with RAD. The Mayo Clinic (2014) identified that while no specific treatment options are currently identified for individuals with RAD, a treatment that focuses on a positive stable environment which supports the child and caregiver appears to improve outcomes. The goal is to encourage family connections while allowing the individual in question to feel safe and secure. It is acknowledged that while no specific treatments are currently endorsed as evidenced-based, several, including biofield therapies, are currently under review and seeking evidence for support.

Stubenbort, Cohen, and Trybalski (2010) examined the effectiveness of attachment focused care for youth who have been abused. The authors assessed a group of 53 children who had been formally identified as being abused and were seeking education from a therapeutic preschool setting. Eligibility included being enrolled in the therapeutic preschool setting for a period of at least 12 weeks and being formally identified as being abused or maltreated. Information regarding developmental gains was examined using the Battelle Developmental Inventory, assessing a variety of possible developmental gains and chronological age. The authors identified that early intervention, particularly focusing on attachment-based therapeutic play was positively correlated with developmental gains (Stubenbort et al., 2010). As attachment increased with a caregiver, overall developmental gains and personal-social and adaptive development increased as well (Stubenbort et al., 2010).

Focus was directed on examining youth that had experienced an early traumatic event and were considered at risk for developing an attachment disorder (Bernard, Dozier, Bick, Lewis-Morrarty, Lindhiem, and Carlson, 2012). The authors used the Attachment and BioBehavioral Catch-up (ABC) intervention, targeting nurturance and care among parents and youth identified as at risk for neglect. Attachment quality was assessed for 120 children between the ages of 11.7 and 31.9 months of age. Bernard et al. (2012) suggested that children who engaged in the ABC intervention demonstrated significantly lower rates of disorganized attachment and higher rates of secure attachment as compared to a control. The results suggest that ABC intervention may promote attachment quality before a child is diagnosed with attachment impairment. The question remained whether such treatments may be useful when the neglect and abuse are well

established or whether there is an optimal window of treatment to potentially reduce attachment impairment.

### **The Importance of Touch**

Field (2002) and Harlow (1973) espoused the fundamental need for positive nurturing touch and its importance to attachment development. Field (2002) supported previous work by Harlow that a need exists for human contact beyond fulfilling basic needs. For example, a youth would flourish with positive touch such as massage and light stroking in addition to the basic touch involved in changing diapers or feeding. Harlow further identified that positive, nurturing touch is integral during formative years to allow the youth to learn that touch promotes self-healing and a sense of connection with another individual. Notably, youth at risk for attachment impairment often have experienced inappropriate touch (e.g., sexual and/or physical abuse) or a lack of positive (e.g., neglect) touch (Thompson-Jinariu, 2011).

When a youth is neglected or maltreated by primary caregivers, especially at pivotal times of development, the youth is at risk of experiencing caregivers as an unstable or inadequate form of security (Prather & Golden, 2009). Abuse and neglect will be seen as the norm for such a youth, and the youth will learn to consider touch as either something that is to be endured or is painful in nature. The youth will not learn how touch can be positive or nurturing in nature. Alternative therapeutic means may be needed for such youth to learn the ability and benefits of positive touch (Prather & Golden, 2009).

### **Treatment Issues Related to Touch**

Developmental delays are common manifestations for youths deprived of typical sensory stimuli such as being held and nurtured (Ardiel and Rankin, (2010). The authors

identified key individuals at risk, including premature infants and institutionalized children. Ardiel and Rankin (2010) identified the need for positive touch as an integral modality to promote growth and development, proposing that at-risk youth who receive tactile stimulation will score higher on developmental assessments. Arguing for a greater understanding of the importance of touch for at-risk individuals, the authors theorized that through such positive touch, one may possibly reduce and hopefully reverse the negative effects of early childhood maltreatment and neglect (Ardiel and Rankin, 2010).

Peifer (2008) discussed the adolescent experience of non-sexual touch in therapy. Using a qualitative survey, the author strove to examine the roles that touch plays in therapy with children and adolescents. Results indicated that the adolescents held strong, positive as well as negative opinions regarding touch in psychotherapy, emphasizing the importance of individual differences and respecting individuals' wishes. Male and female clients alike both demonstrated a difference in the type of touch preferred, ranging from handshakes to hugs, or nurturing touch. Peifer (2008) discussed the importance of human touch to emotional development. While addressing that unethical, sexualized touch is forbidden, therapeutic touch may be beneficial to the youth in need.

### **Healing Touch Therapy**

HT therapy is a nursing-based intervention considered to be included in the scope of biofield therapy (Hover-Kramer, 2011). HT therapy purports to work with a person's personal energy field to create alignment and allow the body to naturally heal. Hover-Kramer (2011) identified that HT is safe to work with all age groups and is to be used as a complementary component to traditional therapy. The participant lies on a table, fully

clothed, and the therapist places his/her hands either lightly on the individual or just above the individual in order to gain connection with the participant's energy field.

HT is considered a biofield therapy which promotes balance and/or restoration of the body's magnetic field. HT uses touch in a positive, nurturing manner that is heart-centered and promotes self-healing of the energy centers that control the individual's energy field throughout the physical body. The goal of HT is for the therapist to assist the individual to restore balance and allow the individual to self-heal (Hover-Kramer, 2011).

The therapeutic option of HT therapy has been examined in a few studies, although focus has been placed on specific disorders, including but not limited to pain control, depression, and post-traumatic stress disorder. For example, Schnepfer (2010) evaluated the use of HT therapy with 40 women receiving radiation therapy for early stage breast cancer. Participants were randomly assigned to a HT group or a placebo group, with treatment given weekly for 4-6 weeks. Schnepfer identified that the women receiving HT therapy demonstrated significant improvement with fatigue and self-reliance, ( $p < .02$ ). The author identified the use of HT therapy as a complement to traditional Western style therapy, supporting the concept that HT can be used in conjunction with traditional evidence-based therapeutic options. The general findings indicated that HT therapy has the potential to be effective with other psychiatric disorders and conditions; however, research into the benefits of HT into other forms of disorders remains paltry and non-existent with RAD (Jain & Mills, 2010, Vickers, 2008; Wardell, 2004).

Multiple studies (Jain & Mills, 2010; Jain et al., 2012; Miles & True, 2003; Schnepfer, 2010) have suggested that HT therapy has potentially multiple benefits as

complementary medicine to traditional therapeutic options for mental health/illness. Jain and Mills (2010) identified HT can assist in lowering blood pressure and improved mental clarity. However, research assessing the use of HT therapy with behavioral concerns remains lacking. The proposed study would assess the viability of HT therapy to potentially reduce behavioral concerns of self-harm in youth diagnosed with RAD.

Jain et al. (2012) conducted a study examining the use of HT and guided imagery with individuals diagnosed with PTSD. Also utilizing a quantitatively based large effect study to best suit the needs of the study, Jain et al. (2012) examined the use of HT therapy with guided imagery with returning combat-exposed active duty military personnel that have demonstrated criteria for PTSD. The authors assessed 123 military personnel to either HT with GI or standard treatment options. While no two individuals returning from active military duty in a combat zone will have completely similar experiences, neither will two maltreated youth.

Also utilizing a quasi-experimental quantitative study, van den Dries et al. (2009) examined attachment in adopted children from Romania orphanages. Outcomes assessed included PTSD symptoms, depression, quality of life, and hostility. Individuals receiving HT with GI demonstrated significant improvements, demonstrating decreasing PTSD symptoms and depression. Results for hostility remained mixed. Further studies for HT and biofield therapy are encouraged. Despite some research demonstrating positive results with traumatic emotional concerns for adults, research remains paltry for the younger population.

Research questions are geared towards this assessment by examining seclusions for self-protection, and episodes of physical aggression. HT therapy is considered as a

biofield therapeutic option. Biofield therapy is considered a subsection of CAM based services. While CAM options have been in existence for years, many CAM based therapies are rejected by Western modern medical societies. Thus, a controversy exists regarding the use and efficacy of any use of CAM-based therapy

### **Controversy with Complementary and Alternative Medicine**

CAM based therapeutic options have been in existence for centuries. According to the National Institutes of Health (2008), nearly 40% of Americans use some method of CAM. As previously stated, complimentary medicine is often used in conjunction with conventional Western medicine while alternative medicine is often used in place of conventional Western medicine.

While the terms are often used interchangeably, many individuals use non-traditional medicine and practices as a complement to traditional Western medicine. The National Center for Complementary and Alternative Medicine (NCCAM) identified complementary health practices under one of two subgroups; natural products or mind/body practices. Mind/body practices include practices and procedures generally given or taught by trained professionals, including but not limited to massage therapy, guided imagery, and biofield therapies (2014).

Studer and Busato (2011) examined the use of CAM options as a complement to conventional medicine in Switzerland. The authors identified that five methods of CAM practices were included, provisionally, in the mandatory Swiss health insurance. The authors followed practice costs of 562 primary care physicians that utilized the approved CAM practices. At present, the five CAM practices approved for use are homeopathy, anthroposophic medicine, neural therapy, herbal medicine, and traditional Chinese



medicine. Anthroposophic medicine use incorporates the premise held by many biofield therapies including massage, touch, and incorporating the mind/body/spirit concept (Steiner, 2012). The study was designed as a cross-sectional assessment of claims made to health insurance compared with patient reported outcomes. Using linear models to estimates of practice costs and patient-reported outcomes, it was determined that CAM options provided similar to lower total practice costs. In addition, patients reported an improved outcome and fewer adverse side effects than with traditional medicine practices alone. At present, Switzerland has utilized some CAM options for payments in addition to traditional Western Medicine.

A common argument against the use of CAM therapies is the lack of evidence for these practices. One side of the argument stated that studies on CAM therapies lack validity and do not account for the placebo effect (Pandolfi & Carreras, 2014). Others argued that even examining the use of CAM therapies is a waste of time and resources as it cannot account for placebo effect and individuals will ignore what they wish to ignore (Kaplan, 2012). Pandolfi and Carreras (2014) argued that it is nearly impossible to obtain valid statistical significance when the premise of the hypothesis is scientifically implausible and valid statistical corroboration is unattainable. The authors identified that any statistical significance should be treated with caution.

Proponents argued that while the research does not exist or is limited, it does not mean that CAM therapies are not effective. For example, some argued that CAM therapeutic options lack the evidence-based component of validity not because they are not valid but rather that they lack the funding necessary often provided by for-profit organizations such as pharmaceutical companies and medical device manufacturers

(Segar, 2012). In addition, many of the CAM therapies such as biofield therapies, massage therapy, and chiropractic therapy do not require FDA approval, thus research-based evidence of their effectiveness was not necessary for their dissemination and use (Ernst, 2002; Segar, 2012).

### **Controversy with Biofield Therapy**

As with many complementary and alternative medicines, controversy exists with many of the biofield therapeutic options, including but not limited to HT therapy. Rosa et al. (1998) attempted to examine whether therapeutic touch (TT), another biofield therapy, practitioners could perceive much less promote the human energy field. TT is a nursing based biofield energy based therapeutic option. Rosa et al. (1998) worked with 21 TT practitioners with various levels of experience to assess whether they could correctly identify hand placement under blinded conditions. Rosa et al. identified that TT practitioners identified correct hand placement less than half of the time, suggesting no significant correlation to reliably detect a human energy field, if in fact a human energy field exist.

Rosa et al. (1998) identified that TT makes the claim of using extrasensory perception (ESP) to detect human energy fields. TT does propose that individuals are able to detect and realign such human energy fields, often through means such as a full awareness of the “human energy field” (Krieger, 1979). However, this claim was disputed by the founder of TT (Krieger, 1979). Regardless, Rosa et al. (1998) proposed that since the most basic fundamental claim to TT rates less than chance, the concept of TT and all biofield therapy were groundless in nature.

However, Janawadkar et al. (2010) identified being able to measure magnetic fields that emanate from the human body, suggesting scientific evidence of a human energy field. The authors established a facility for the superconducting quantum interference devise (SQUID). Janawadkar et al. (2010) identified, by establishing the facility far from other magnetic activity, which small amounts of magnetic field do exist in the human body. The authors did not focus on whether another could perceive the magnetic field or not. Instead, the authors placed focus on the possible use of a potential magnetic energy field in conditions such as epilepsy and depression. Janawadkar et al. (2009) identified that the SQUID's detection of some magnetic activity offered scientific evidence that an internal energy flow did exist, contrasting findings by Rosa et al. (1998).

Jain and Mills (2010) reviewed 88 clinical studies implementing various biofield therapies from a variety of patient populations. The authors did not attempt independent research but rather examined clinical studies of others, via many of the same search engines as the present study, including but not limited to terms such as biofield therapy, chi, and HT and limited the search to clinical research. Eight were excluded for failure to randomize the groups, four were excluded for not providing analysis, three were excused with integrating more than one mind-body intervention, three were excluded for only examining outcomes for practitioners and not participants, and four were excluded for other reasons. A total of 66 clinical studies were then assessed using a variety of biofield therapeutic options, including, but not limited to Quigong, Reiki, TT and HT.

Jain and Mills (2010) identified 85% reported psychological or self-report outcomes, 54% reported biological or objective outcomes such as intended with this proposed study, and 9% applied qualitative reports. Thus the majority of the clinical

studies used objective, quantifiable outcomes as intended in the proposed study. In addition, of the 66 studies assessed, 52 utilized between subject designs and 32 utilized comparison groups of treatment/no treatments as proposed in the intended study. In addition, of the 66 studies, session lengths averaged 23 minutes with the average number of treatment sessions being three.

Several clinical studies provided strong evidence of efficacy for biofield therapies in reducing pain, cancer, and hospitalized populations. The authors also identified moderate evidence of efficacy with biofield therapies within the same population in reducing other psychological issues including anxiety and negative behaviors associated with dementia and anxiety. Jain and Mills (2010) identified that little data was available to effectively evaluate the impact of biofield therapies towards mood disorders, pediatric population, or emotion regulation. The authors identified a need for further quantitative studies regarding biofield therapies in various mental health/illness issues.

### **Other Controversial Treatments**

As individuals with RAD often do not respond to traditional methods of currently practiced therapeutic options, at times professionals and lay persons have engaged in controversial treatment options that potentially can harm the individual. Becker-Weidman (2006) identified that one such approach is coercive therapy or coercive restraint therapy (CRT). CRT therapy is an intervention that has been utilized by some mental health practitioners that used physical restraint as a means of increasing emotional attachment with adoptive or foster families (Mercer, 2005).

One such method of coercive therapy was withholding food and water from the youth in an attempt to coerce the youth to feel dependent on a given caregiver. The

concept was this method would encourage the youth to feel that a caregiver could be trusted for the most basic needs. However, many times the youth resorted to survivalist techniques such as stealing or running away (Kallert, Mezzich, & Mohahan, 2011; Mercer, 2005).

Holding therapy is another controversial program that was popular in the 1980s and 1990s reportedly designed to treat attachment disorders (Becker-Weidman, 2006). Also known as the Evergreen model, attachment therapy, compression therapy, and coercive restraint therapy, Holding Therapy was established in 1970 in Evergreen, Colorado (Becker-Weidman, 2006).

Focused on children with attachment impairment, the concept of holding therapy followed the tenet that a youth's inability to connect with positive parents is due in part to the inability to move past previous maltreatment and abandonment. Holding therapy is a process of restraints and constraints on the child to invoke rage and despair. In theory, when the child moved past rage and despair, the child is as vulnerable as a newborn child and thus a "rebirthing" process would ensue. The parent would then "re-parent" via cradling and rocking the youth, promoting a sense of trust with the new caregivers (Mercer, 2013).

Becker-Weidman (2006) identified that this program lacked any scientific validation and was implicated in several child deaths. In addition, despite the name, holding therapy was not based on attachment theory in any manner. Mercer (2013) identified that holding therapy has not been utilized in the United States in nearly a decade although is still utilized in some European countries. However, statistics remained

unclear as Holding Therapy has been identified by several names. At present, the APA does not advocate the use of Holding Therapy (APA.org, 2014).

Several CAM based therapeutic options and medicines are often under scrutiny by Western medicine. Regardless of whether the health care practice is a natural product such as St. John's Wort ® or a mind/body practice such as HT, all are generally rejected by many in Western medicine as lacking scientific evidence and possibly being harmful to their users (Becker-Weidman, 2006; Kallert et al., 2011; Mercer, 2005; Rosa et al., 1998). However, scientific based studies of non-invasive therapies may help bridge the gap between traditional Western medicine and CAM based therapeutic options.

### **Other Therapeutic Options at Chaddock**

Along with the more non-evidenced based Healing Touch therapy approach, Chaddock employs a variety of therapeutic options for the residents, each depending on the needs of the individual. Initially founded as a ministry outreach of the United Methodist Church in 1853, Chaddock has expanded to meet the needs of youth nationwide (Chaddock, 2014). Chaddock is a nationally recognized, licensed and accredited program working with children, many that have been exposed to significant abuse and neglect. Chaddock strives to find positive, and when possible, evidence based treatment options aimed towards connecting the youth with the positively formed family unit (Chaddock, 2014).

Chaddock utilizes the Developmental Trauma and Attachment Program (DTAP) which is reported to help three out of four in the DTAP program to be able to live in a least restrictive environment within approximately 2 years (Chaddock, 2014). Chaddock is a member of the National Child Traumatic Stress Network (NCTSN) which seeks

possible treatment options intended to improve services for those who have experienced traumatic events and a developmental period of emotional growth. The NCTSN is a collaboration of over 70 academic, clinical, and community programs, under the tutelage of the University of California-Los Angeles and Duke University (NCTSN, 2014).

Within the DTAP program, a variety of techniques and programs are utilized. The DTAP program is geared towards children aged 8-16 who have experienced significant trauma and struggling forming attachments with others. Many of the children are adoptees from other countries and within the United States foster care program. While most currently have a loving home in which to return, the early years of the child's life was a representation of extreme cases of abuse and neglect. Programs include psychotherapy, medication therapy, and Theraplay, which like biofield therapeutic options, remains under debate regarding its effectiveness.

Traditional psychotherapy is also utilized at Chaddock. Psychotherapy refers to the treating of mental health problems by talking with a psychiatrist and/or other mental health providers. Chaddock currently has a several master's level therapists. The medical director is a board certified child and adolescent psychiatrist with over 40 years' experience (Chaddock, 2014). Psychotherapy is geared towards helping the individual take control of their own feelings, thoughts, and behaviors. A variety of psychotherapeutic options are utilized at Chaddock, including CBT, which focuses on changing inaccurate perceptions of the self and world; Psychodynamic therapy, which encourages talking about past negative experiences for unresolved conflict; and Interpersonal psychotherapy, which focus on behaviors and interactions between the client and others (Chaddock, 2014). The psychotherapeutic option applied is highly

dependent upon the needs of the individual and may be used in conjunction with one another.

The success of traditional therapeutic options is unknown. However, the Mayo Clinic (2014) identified that there is no specific therapeutic option for individuals diagnosed with RAD. However, the Mayo Clinic encouraged therapeutic options that promoted trust and consistency in a stable environment, including but not limited to individual and family counseling. Weir (2011) also encouraged therapeutic options focusing on building trust between the client and caregivers.

Ford, Blaustein, Habib, and Kagen (2013) also identified that there are no specific therapeutic treatment options for individuals with RAD. Regardless, many respond somewhat favorably to individual therapy that promotes moving past the traumatic events. In addition, focusing on treatment options that foster positive, nurturing touch encourages forming positive ties with caregivers and family members.

Medication therapy may also be utilized as needed for the individual. At present, there are no medications specifically identified for the treatment of RAD. Rather, medications are used when providing relief from symptoms including depression, anxiety, and aggression. While each individual is unique, commonly used medications include fluoxetine (Prozac) and citalopram (Celexa for depression and anxiety as an off-label prescription; prazosin hydrochloride (Minipress) for anxiety and nightmare/sleep disturbances as an off-label prescription; and atypical antipsychotics such as ziprasidone HCl (Geodon) and Aripiprazole (Abilify) for aggression as an off-label prescription (L. Stiles, DO, personal communication, September 27, 2014). In addition, the youth may be



prescribed other medicines as necessary for issues not directly related to RAD, including but not limited to antibiotics, birth control, and other medical conditions such as epilepsy.

Theraplay is a child and family centered therapy based on typical patterns of play between a child and parent (Booth & Jernberg, 2010). A typical Theraplay session usually entails guiding a parent and child through playful game that engage the parent and child to work together. A typical Theraplay session lasts approximately 40-50 minutes and is geared towards successful connection between the parent and child. It is designed to provide highly positive and nurturing interactions to gain affect regulation and attachment (Booth & Jernberg, 2010).

Weir (2011) also recommended therapeutic play in order to encourage the youth to express themselves and promoted methods of self-healing interventions to allow the youth to build the bonds of trust, particularly with younger individuals.

While there are no specific therapeutic options available for individuals with RAD, caregivers often seek multiple options for such individuals. Often the treatment options are reactionary in nature such as care in psychiatric hospitalization, residential facilities, or juvenile detention centers. Health care costs, including psychiatric costs, are often draining to the United States general population. Psychiatric costs for reactive treatments are staggering. A need exists to examine ways to reduce costs proactively either by reducing the situation that may result in an individual developing RAD or finding evidence based therapeutic options that reduce long term detention costs.

### **Psychiatric Costs**

Medical and psychiatric costs continue to rise throughout the United States. In addition, no one treatment is considered standardized in medical costs. According to

Aetna Insurance, a major insurance provider in the United States, (2014) total health care costs in the United States are expected to reach over \$4.8 trillion, nearly 20% of the gross domestic product. In addition, multiple individuals in the United States either lack insurance or underinsured. Aetna (2014) estimated that slightly over half of the costs are going to pay for costs of physicians and hospitalization care.

The National Alliance of Mental Health (2014) identified that psychiatric costs of juveniles in Illinois are staggering as well. In 2006, over \$1,600 per person went to direct mental health costs. While just over 29% of individuals living in Illinois are children, nearly 10% have a diagnosable mental condition (NAMH, 2013). The Illinois Department of Mental Health (IDMH) detention center in Cook County alone averaged the cost of \$600/day with over 60% of the youth with a diagnosed mental illness (NAMH, 2013). According to Blessing Hospital in Quincy Illinois (2014), the average daily cost for mental health inpatient costs for juveniles is approximately \$1,500/day. Daily costs for treatment at Chaddock average approximately half that (Chaddock, 2014).

By contrast to other mental health costs, the average Healing Touch therapy session is less than \$150 and can be completed in any setting, depending on the training and experience of the therapist (M. Vincent, personal communication, June 24, 2014).

While HT therapy is a potential cost effective treatment option, it lacks the research to assess its viability as an evidence-based therapeutic option. Since many traditional evidence-based therapeutic options are lacking in helping individuals with RAD, developing an evidence-based treatment option remains crucial to assist the individual as well as possibly reducing health care costs.

## Conclusion

HT therapy has the potential to be a non-invasive therapeutic complement to traditional therapeutic options for youth diagnosed with RAD, a highly vulnerable population. To be formally diagnosed with RAD, the youth would have a documented persistent and/or extreme pattern of extreme neglect, abuse, or abrupt/severe separation from primary caregivers without a viable substitution. Thus, youth diagnosed with RAD are potentially at risk of having experienced significant inappropriate and/or abusive touch. HT (which should not be confused with Holding Therapy) is non-invasive by nature, using either near or light touch to the fully clothed individual. HT offers the opportunity to provide a self-healing therapeutic option that promotes positive touch in a therapeutic setting. However, evidence supporting this concept is severely under represented and under explored.

Quality research focusing on positive and nurturing touch, particularly HT therapy remains limited in nature. Past research on various forms of biofield energy work has yielded mixed results. Current research identifies the limitations of past research, lacking grounded theoretical foundations and scientific evidence of the benefits of touch with attachment deprived individuals. In addition, CAM based therapies, including HT, remain controversial and often rejected by many following the Western medicine modality.

Additional research is needed for the continual refinement of the theoretical foundation of attachment theory and the various behavioral concerns that may be observed when working with children at-risk for attachment issues. Research to provide an empirical base of support for such a theoretical foundation remains a priority. The

purpose of the study was to provide additional research to assist in providing an empirical base of support for the use of alternative medicine in conjunction with traditional evidence-based therapeutic options such as medication and cognitive behavioral therapy.

While success rates for medication and/or cognitive behavioral therapy are unknown at this time, rates for negative behavioral outcomes such as truancy, destruction of property, and aggressive behaviors remain higher in populations of individuals diagnosed with RAD (Stinehart et al., 2012). A need exists to examine other possible therapeutic options for such a vulnerable population. While biofield therapy has been examined with positive results for other psychiatric conditions such as anxiety and dementia, there remains a gap in literature regarding the use of HT therapy with youth diagnosed with RAD (Hover-Kramer, 2011; Schnepfner, 2010, & Stubenbort et al. 2010).

The success of traditional therapeutic options for individuals with RAD remain unknown at this time. Still, literature suggests that additional therapeutic options need to be examined. Financial and emotional costs for the individual and society as a whole remain draining to all. The proposed study will be a quantitative examination of one possible therapeutic option for a vulnerable population in need of help. Individuals with RAD have often been used and abused by several individuals. A study of secondary data analysis from a nationally recognized facility geared towards helping the intended population will allow for a study without adding additional risk of trauma to an already marginalized population.

### Chapter 3: Research Method

Attachment with another human being is often formed by an individual as a foundation for a potentially positive long term relationship between two individuals. When the relationship between an infant and caregiver has a strong foundation in trust and positive interactions, the youth is more likely to form future positive relationships. When a youth fails to form positive relationships of attachment at developmentally pivotal stages, the youth is at risk of attachment impairment (Bowlby, 1980). Youth that fail to form positive attachments are at risk of RAD (APA, 2013). Youth diagnosed with RAD are more at risk of violating societal norms and expectations (APA, 2013).

The purpose of the study was to assess the effectiveness of HT therapy with youth diagnosed with RAD. In the study, I placed focus on the use of the biofield energy based therapy of HT. Youth diagnosed with RAD are generally at risk to never be able to form positive relationships based on attachment, mutual trust, and respect and often do not respond well to traditional therapeutic options.

The variables I addressed in the study included seclusions, acts of physical aggression, suicidality/self-injury, destruction of property in excess of \$50, and running away from the residential facility. Examining such variables allowed me to explore the effectiveness of HT therapy for the intended population vs a control group. The baseline group was comprised of individuals diagnosed with RAD, but who have not received the HT therapy. My quasi-experimental quantitative research study, using secondary data, attempted to examine the effect of HT therapy with such youth (IRB code 04-03-15-0355263). The remainder of this chapter discusses the research design, the sample, proposed data analytic techniques, and validity-related issues.

### **Research Design and Rationale**

The proposed study used quantitative secondary data that is ex post facto quasi-experimental in nature. Participants were a convenience sample of youth residing at a nationally recognized long-term residential facility for youth facing attachment impairment. Because participants were not assigned to groups via random assignment, the study was quasi-experimental in nature (Creswell, 2014).

Quantitative data analysis was best suited for understanding the possible relationship between the independent variable of HT and the dependent variables of seclusion frequencies, episodes of physical aggression, suicidality/self-injury, property damage in excess of \$50, and running away.

This study used a design that was quasi-experimental (i.e., ex post facto) in nature and used secondary data (Creswell, 2014). The study involved youth who resided at a long-term residential facility and received treatment for behavioral and emotional issues. The between-subjects variable in this study was the receipt of HT. Approximately one-half of the participants received HT, while the other half did not receive HT. At this facility, youth were assigned to receive HT based on prior behaviors; they were not randomly assigned to receive HT. Because participants were not randomly assigned to the HT group or the control group, this study was quasi-experimental in nature (Creswell, 2014).

All data collected was secondary in nature, obtained for purposes other than this study. The data had been collected by Chaddock employees. A comparison was made between youth residing at the long term residential facility that received HT therapy and those living at the long term residential facility that did not receiving HT therapy. The

within-subjects variable in this study was the timing of the dependent variables assessment. Dependent variables (e.g., seclusion frequencies) were assessed both pretreatment and posttreatment for all participants.

### **Independent Variable**

The independent variable for the study was the application of HT therapy for the therapy group. While all participants have been formally diagnosed with RAD and all resided at a long term residential facility designed for treatment of RAD, only those in the experimental group have been included in the HT program. Inclusion in the HT program is done via referral from the primary clinical therapist. In addition, the treatment team of the HT practitioner, medical director, and ancillary treatment team staff all had to agree that HT may be beneficial for the individual. HT therapy was conducted a minimum of four sessions.

### **Dependent Variables**

There were five dependent variables for the study. The first dependent variable dependent variable was seclusion frequency. For the purpose of the study, seclusion was defined as the act of physically removing the participant from a potentially harmful situation to self and/or others. The person was placed in a secluded or locked facility until he or she could regain enough physical/emotional control to no longer be considered at risk of injury to self and/or others. Seclusion must be accompanied by a physician's order or police documentation justifying seclusion as a means of protecting the individual and/or others. During seclusion an individual was locked in a room or secluded area that he/she was unable to leave until an independent provider determines that it was safe for the person to be released.

The second dependent variable was physical aggression frequencies. All episodes of physical aggression were documented by caregivers in the residential facility. Episodes of physical aggression included but were not limited to threatening others, throwing objects, or striking another person.

The third dependent variable was suicidality/self-injury. All episodes of suicidality/self-injury were documented by caregivers in the residential facility. Each episode of suicidality/self-injury was defined as requiring medical and/or psychiatric assistance. Episodes of suicidality/self-injury included but were not limited to cutting, placing belts/shoelaces around neck, or attempting to stand in front of a moving car.

The fourth dependent variable was destruction of property. The episode of destruction needed to have an estimated cost of at least \$50 or more in monetary value. Episodes of destruction of property included but were not limited to, vandalism, putting holes in walls, or stealing a car.

The fifth and final dependent variable was running away from the residential facility. To qualify for this criterion, the youth must have left the physical premise of Chaddock without the knowledge or consent of providers at Chaddock. The youth must have been gone from the facility for a period of 15 minutes or more.

### **Research Design Rationale**

A quasi-experimental quantitative research design with a series of mixed ANOVA's was intended to best address the research question, assuming concepts such as normality and homogeneity as well as meet the needs of the agency. Secondary de-identified data was utilized for the purpose of the study. HT therapy had already been in use at Chaddock for a period of approximately five years. Individuals chosen for the HT



program were not selected by random assignment but rather by recommendations of the treatment team. A pretest/posttest design examined the dependent variables before and after the implementation of HT therapy. A control group of like participants who had not received the HT therapy helped reduce the potential of the change coming from conditions other than the HT program.

Chaddock requested quantifiable information to best demonstrate the effectiveness of the program to other entities (i.e., insurance, board of trustees, etc.). At the time of the study, Chaddock did not require data analysis on the HT program by the abovementioned agencies. However, Chaddock had identified that quantitative data may help in the future to provide numerical analysis for possible evidence-based therapeutic options for a vulnerable population.

Quantifiable data interpretation is often utilized by Chaddock to clarify effectiveness of treatment options. The research questions examined the association between HT therapy with seclusions, episodes of physical aggression, suicidality/self-injury, destruction of property, and running away from the residential facility. Many individuals with RAD demonstrate the inability to form positive nurturing relationships. Commonly, individuals with RAD have higher rates of aggression to self and others (APA, 2013).

Quantitative analysis provides analysis of the possible relationship between the independent and the dependent variables, addressing the research questions:

2. After treatment, will youth diagnosed with RAD who receive HT therapy have significantly different seclusion frequencies than the control group?

- c.  $H_{01}$ : After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different seclusion frequencies as compared to the control group.
  - d.  $H_{A1}$ : After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different seclusion frequencies as compared to the control group.
2. After treatment, will youth diagnosed with RAD who receive HT therapy have significantly different physical aggression frequencies than the control group?
- c.  $H_{02}$ : After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different physical aggression frequencies as compare to the control group.
  - d.  $H_{A2}$ : After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different physical aggression frequencies as compared to the control group.
3. After treatment, will youth diagnosed with RAD who receive HT therapy have significantly different suicidality/self-injury frequencies than the control group?
- c.  $H_{03}$ : After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different suicidality/self-injury frequencies as compared to the control group.

- d.  $H_{A3}$ : After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different suicidality/self-injury frequencies as compared to the control group.
4. After treatment, will youth diagnosed with RAD who receive HT therapy have significantly different property damage frequencies than the control group?
- c.  $H_{04}$ : After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different property damage frequencies as compared to the control group.
  - d.  $H_{A4}$ : After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different property damage frequencies as compared to the control group.
5. After treatment, will youth diagnosed with RAD who receive HT therapy have significantly different running away from the residential facility frequencies than the control group?
- c.  $H_{05}$ : After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different running away frequencies as compared to the control group.
  - d.  $H_{A5}$ : After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different running away frequencies as compared to the control group.

### **Time and Resource Constraints**

Time and resource constraints were limited as the data being analyzed is secondary in nature. The HT program has been in existence for a period of approximately five years at Chaddock. At the point in time of the study, no analysis of data had been conducted on any of the individuals engaged in the HT program. The study was limited to only those diagnosed with RAD who has been residents of Chaddock for a period of at least six months. While Chaddock serves individuals both residentially and on an outpatient basis, the average length of stay for an individual residing at Chaddock is 18 to 24 months (Chaddock.org, n.d.). Chaddock is a nationally recognized residential facility for attachment impaired youth, however, the constraint remained that there were a finite number of individuals Chaddock could serve at any one time. No additional costs were procured as a result of the study.

### **Alignment of Research Design**

The study was in alignment for research design with other studies intended to advance the knowledge in the field of RAD therapeutic options. Jain et al. (2012) conducted a study examining the use of HT and guided imagery with individuals diagnosed with PTSD. Jain et al. (2012) also used a quantitatively based study to best suit the needs of the research. In addition, van den Dries et al. (2009) also utilized a quasi-experimental quantitative study examining attachment in adopted children from Romania orphanages. Completing a quasi-experimental quantitative is in alignment with other like-minded research (Jain et al., 2012; Smyke et al., 2010). Based on the needs and desires of the agency, this study applied quantitative reasoning to secondary archival data collected by the agency for other purposes. Quantitative reasoning was best suited to understand

the relationship between the variable of HT therapy and the effect it had on outcomes of harm to self and others, including seclusions, physical aggression, suicidality/self-injury, property damage in excess of \$50, and running away from the residential facility.

The study used quantitative secondary data that was ex post facto quasi-experimental in nature. Participants were youth who resided at a long-term residential facility and received treatment for behavioral and emotional issues. The between-subjects variable in this study was the receipt of HT. Approximately one-half of the participants received HT, while the other half did not receive HT. At this facility, youth were assigned to receive HT based on prior behaviors rather than random assignment. Thus, because participants were not randomly assigned to the HT group or the control group, this study was quasi-experimental (Creswell, 2014).

The within-subjects variable in this study was the timing of the dependent variables assessment. Dependent variables (e.g., seclusion frequencies) were assessed both pretreatment and posttreatment for all participants.

Because the dependent measures included behaviors that could vary in their patterns of results, each dependent measure was examined separately. It was unknown if the dependent measures of the study were correlated to the extent that multivariate analyses would be appropriate (Tabachnik & Fidell, 2007). For example, suicidality may not be correlated with property damage; therefore, a multivariate analysis that includes both of these dependent measures would not be suitable. Univariate examinations of the dependent measures enabled the researcher to assess if HT therapy is associated with different outcomes for different problematic behaviors.

## Methods

The target population of the proposed study was youth diagnosed with RAD. RAD is a psychiatric disorder marked by a severe disruption of developmental attachment (APA, 2013). According to the *DSM-5* (2013), RAD is often the result of severe abuse or neglect from a primary caregiver, often before age 5. It is assumed that the abuse/neglect manifests in disturbed behaviors, including but not limited to, abuse to self and/or others. The prevalence of RAD is currently unknown but considered rare in nature (APA, 2013). While exact numbers of severely abused/neglected children worldwide are uncertain, it is identified that even within the abovementioned population, the disorder is not considered common even among the severely abused and neglected.

### Sampling Population

Chaddock has served approximately 300 individuals diagnosed with RAD over the past 5 years, and approximately 50 of these individuals have also received HT therapy (M. Vincent, personal communication, March 20, 2014). *A priori* power analyses were conducted using G\*Power software (G\*Power 3.1.9.2). In order to have sufficient power (.80) to test the within-between interaction with a medium sized effect of 0.25 and a 0.05 criterion of statistical significance, a sample size of 20 individuals was needed for the parameters specified above. There were 20 participants in each group with a total of 40 participants. According to sensitivity analyses in G\*Power, with 40 subjects, a power of .80, and an alpha criterion of .01 (to accommodate for a Bonferroni correction), a sample of 40 participants will enable the researcher to detect a medium sized effect of .28.

## **Sampling Frame**

The individuals selected for the purpose of the study were determined by a variety of factors. Chaddock's secondary data included 40 individuals who met the criteria set forth by the study. All participants resided at Chaddock at approximately the same time with the same residential facility providers. Those in the HT program all received treatment from the same HT provider. All participants were formally diagnosed with RAD. Based on the criteria, Chaddock provided secondary data for 20 individuals meeting the criteria who have been involved in the HT program. Chaddock also provided secondary data for another 20 individuals meeting the criteria who also lived at Chaddock approximately at the same time as the experimental group who were not engaged in the HT program.

## **Procedure**

Data were provided by Chaddock staff from de-identified medical records from individuals residing at Chaddock residential facility in Quincy, IL. Since secondary data analysis was conducted, permission was gained from Chaddock, the guardians of record. The information was de-identified by Chaddock staff to protect confidentiality. All identifying markers were removed by employees of Chaddock prior to my viewing. While all information is included in medical records, the medical records department de-identified the information before release of information to me. Permission was gained by Dr. Angel Knoverak, director of medical records, first verbally and then in writing (Appendix A).

The intervention being assessed was the use of HT therapy. For acceptance into the HT program, the participant must have been receiving treatment services from

Chaddock and referred to the Core treatment team. Consent was gained from the participant as well as the guardian/parent. The first treatment averaged 30-45 minutes in length while subsequent treatments were 15-20 minutes. The course of treatment and decision for discontinuation was dependent upon the diagnosis, symptoms, and the needs of the participant (Appendix B).

Treatment was delivered in the HT room which was a quiet, dimly lit room with relaxing music. The participant remained fully clothed with their shoes off and either sat in a chair or were lying on a table, depending on what they desired. Techniques and times limits used were at the discretion of the HT therapist and based on the needs of the participants. All techniques were HT approved. HT sessions were scheduled around the needs of the practitioner and the participant (Appendix B).

### **Instruments and Operationalization of Constructs**

The five dependent variables in this study are seclusion frequencies, physical aggression frequencies, suicidality/self-injury frequencies, destruction of property in excess of \$50, and running away. All are indicators of harm to self and/or others or destructive behaviors. Seclusions are operationally defined as frequency of physician ordered isolation for any length of time. Seclusion frequencies were measured from zero to infinity and will be measured monthly from three months prior to treatment to three months post starting HT therapy.

Physical aggression was measured using a checklist form issued and maintained by the caregivers at Chaddock. All types of aggression are recorded in the participant's medical records. However, for the purpose of the study, only physical aggression resulting in intended or actual contact with another were identified, such as striking



another individual, throwing objects at another, or head butting another individual.

Frequencies was measured from zero to infinity, measured monthly from 3 months prior to treatment to 3 months post starting HT therapy.

Suicidality/self-injury was operationally defined as thought or intent of self-harm or suicide. All self-injury was recorded in medical records. However, for the purpose of this study, only self-injury/suicidality that resulted in medical/psychiatric care was reviewed. Frequencies were measured from a scale of zero to infinity.

Destruction of property in excess of \$50 events is measured on a frequency of zero to infinity. Measurements were taken three months prior to HT therapy to 3 months post starting HT treatment. All episodes of destruction of property in excess of \$50 were recorded in medical records and in police records if needed.

All episodes of being absent without leave (“running away”) were recorded in the participant’s medical record. However, for the purpose of the study, only episodes of running away from the residential facility were assessed. If the person left the presence of the staff but remained on the residential premise, the data was not identified. Episodes of running away were measured from a scale of zero to infinity.

### **Data Analysis Plan**

Data was intended to be analyzed in accordance with a 2 x 2 mixed factorial design using mixed (between-within) ANOVAs to address each research question, pending validation of assumptions of normality and homogeneity (Creswell, 2014). The independent between-subjects variable in this study was the treatment type: HT therapy and traditional therapeutic options vs strictly traditional therapeutic options.

Approximately one-half of the participants received HT, while the other half did not

receive HT. The five dependent variables were seclusion frequencies, physical aggression frequencies, suicidality/self-injury frequencies, destruction of property in excess of \$50 frequencies, and running away from the facility frequencies. These dependent variables were measured at 3 months prior to beginning HT therapy to baseline and again from baseline to 3 months into HT therapy. The control group had monitoring within the same time frame.

The same individuals (HT group and control group) were measured independently at specific set times on the same dependent variables (Creswell, 2014); the within-subjects variable was timing of the dependent variables assessment. Within-between repeated measures ANOVAs was intended conducted for each dependent variable.

Mixed (within-between) ANOVAs are appropriate for these analyses, pending affirmation of assumptions of normality and homogeneity. First, ANOVA is suitable for a between-within design involving a two-level between subjects variable and a two-level within subjects variable (Tabachnick & Fidell, 2007). Second, independent ANOVAs are appropriate tests to conduct when dependent measures are uncorrelated (Tabachnick & Fidell, 2007).

As noted above, while the dependent measures being considered are often common manifestations of RAD, the dependent measures may not be correlated with each other in that they may be independent expressions of the disorder. For example, suicidality may not be related to running away in that individuals who are suicidal may not also have high rates of running away from the facility. Because the use of a multivariate analysis of variance (MANOVA) is not recommended if the dependent measures are not correlated (Tabachnick & Fidell, 2007), a series of ANOVAs is a more

appropriate way to assess the dependent measures. Although MANOVA controls for familywise Type I errors, this error rate can be also controlled in ANOVAs by applying a Bonferroni correction (Tabachnick and Fidell, 2007).

Assumptions of these statistical analyses were examined. Descriptive statistics were used to examine the distribution of the dependent measures and to check for outliers. Additionally, data was checked for approximation of a normal distribution using a Shapiro-Wilk test for normality. The Levene's test for homogeneity of variances in SPSS was used to test the assumption for homogeneity of variance, while the Box's test for equality of covariances matrices was used to test the homogeneity of variance-covariance matrices. Bonferroni was utilized to minimize Type I errors. SPSS assisted in addressing the above mentioned assumptions, and the appropriate statistical corrections were made for analyses in which these assumptions were violated (Creswell, 2014). When assumptions of normality and homogeneity were not supported, a Mann-Whitney U was utilized instead of a within-between repeated measures ANOVA.

### **Threats to Validity**

External validity examined the extent to which one can generalize the study results to other groups and others settings beyond those in the current experiment (Creswell, 2014). While the study examined the effect of HT at one long term residential facility, threats to external validity were minimized. The participants of the study came from a variety of backgrounds and prior situations. Because Chaddock is a nationally recognized facility for children who have been exposed to severe trauma and neglect, children have been placed at Chaddock from 29 various states, Washington D.C, and a variety of tribal nations (Chaddock.org, n.d.). In addition, while residing primarily in the

United States, many of the residents are adoptees from nationwide foster care programs and overseas orphanages, including but not limited to Haiti and Romania (Chaddock.org, n.d.).

External validity was positively addressed with the participants coming from all over the world and with a variety of prior living situations. However, it should be noted that since Chaddock is a national recognized treatment facility for youth exposed to severe trauma and neglect, it should be considered that the outcomes may not generalize to other treatment facilities that do not meet the standards of Chaddock.

Internal validity questions of the observed effects of the independent variable (HT) on the dependent variables are not caused by extraneous factors. This was minimized by a variety of factors. All participants were formally diagnosed, and each participant a resident of Chaddock, a nationally recognized long term residential facility geared on treating the attachment impaired. While each individual has a unique experience at Chaddock, the treatment plan is fairly consistent for those facing attachment issues, aside from the addition of the HT program.

That noted, this study used an ex post facto quasi-experimental design. For the purpose of this study, random assignment of participants was not possible due to the use of secondary data. Because participants were not randomly assigned to groups, it was not possible to make conclusions about causal relationships between the variables. To mitigate this threat to validity, both the HT and control groups were similar in that both groups resided at Chaddock and had other similarities (e.g., diagnosis, age, caregivers). Future studies with more substantial resources could conduct randomized clinical trials regarding the effects of HT therapy in attachment impaired youth.

Moreover, each participant in the experimental group received HT therapy from the same provider (M. Vincent, personal communication, March 20, 2014), thus minimizing the risk of internal validity threats due to different care providers. Maturation was minimized as the data was only be accessed for a period of 6 months.

Because there was no true placebo condition in this study (i.e., the baseline group knew they did *not* receiving HT and the HT group knew they *did* receive HT), any possible effects of HT may be due to this knowledge rather than the treatment itself. While both groups knew whether they were receiving HT or not, no two individuals at Chaddock received identical overall treatments because treatment plans are tailored to the needs of each patient. Because of this individualized approach to treatment, an individual receiving HT would not necessarily have questions or concerns regarding the specific use of HT over another program. That noted, future studies could examine the use of HT therapy using double blind study procedures in order to reduce the risk of placebo effects (Creswell, 2014).

### **Ethical Procedures**

Access to data was gained via written permission of the guardian of record, Chaddock (Appendix A). Treatment was followed via standard protocol of HT therapy for human participants. Consent to the HT treatment was gained by guardians and participants alike. HT therapy was performed in a well-lit but relaxing HT treatment area. Participants remained fully clothed at all times in comfortable clothes, depending on the needs and wants of the participant. The participants were allowed to withdraw from the HT program at any time without penalty or prejudice (Appendix B). However, all data

being analysis was secondary in nature so anyone removing themselves from the HT program were not included in the study.

### **Treatment of Data**

Secondary data were provided by Chaddock and was de-identified before review from the researcher. All data were stripped of any identifying markers that may identify the participants in any form. All data were stored electronically on an external hard drive that is fingerprint password encrypted for the researcher. All data and results was shared with Chaddock at the conclusion of the research. I does not have access to participants' medical records. Chaddock has identified an understanding that the de-identified data was used for the purpose of a dissertation research study under the supervision of Dr. Kelly Davis, Dr. Sandra D. Mahoney, and Walden University. All data will be destroyed electronically after a period of 5 years.

### **Other Ethical Issues**

The study examined the use of HT therapy on youth diagnosed with RAD. While a vulnerable population was examined, risk to the population was minimized. It is disclosed at this time that the medical director at Chaddock is related to me (husband). However, I used secondary data that was collected by the facility not specific to this research project. In addition, since data was secondary in nature, it minimized the ethical consideration of having a conflict of interest regarding assessing diagnosis and possible treatment options, including inclusion or elimination from the potential study.

In addition, the results of the study will have no effect on the employability or economic compensation of either the medical director or the HT provider or any other individual at Chaddock. Chaddock has identified that funding for the HT therapy

program is not dependent upon the findings of the study. Still, Chaddock does receive financial gains from the HT program.

In addition, the ethical considerations of early withdrawal were minimized. The individual had the right to withdraw or not participate at any time. For the purpose of the study, the participant, for consideration for inclusion in the study, had a minimum of four sessions of HT. As all secondary data were de-identified by employees of Chaddock, the identity of the participants was kept anonymous, thus protecting the rights of the participants.

### **Summary**

Many with RAD have the inability to form positive nurturing relationships. Commonly, individuals with RAD have higher rates of aggression to self and others (APA, 2013). A quasi-experimental quantitative base research design best met the needs of the study and the needs of Chaddock. Other studies regarding similar issues have utilized similar based studies (Jain et al., 2012; van den Dries, 2009). Research questions were aimed to examine the association between HT and seclusion frequencies, frequencies of physical aggression, episodes of suicidality/self-injury, property damage in excess of \$50 and episodes of running away from the residential facility. All variables were intended to reduce risk of harm to self and/or others and may be an indicator of HT efficacy.

A quasi-experimental study using secondary data examined the potential for HT therapy. There are no specific evidence-based therapeutic options for individuals diagnosed with RAD (Mayo Clinic, 2014). Secondary data analysis provided timely data

collection and analysis of individual behaviors. Chapter 4 presents the results of the proposed statistical analyses.



## Chapter 4: Results

Many individuals diagnosed with RAD have the inability or difficulty to form positive nurturing relationships. Commonly, the *DSM-5* has identified that individuals with RAD have higher rates of aggression to self and others (APA, 2013). The purpose of this study was to quantifiably explore the use of HT therapy with youth diagnosed with RAD. Youth who have been diagnosed with RAD often do not respond well to traditional therapeutic options, including but not limited to cognitive behavioral therapy and medication management (Stinehart et al, 2012). If alternative therapeutic options are available for such a vulnerable population, perhaps positive nurturing relationships may be able to develop and survive with the recovering individual.

Research questions were designed to examine the association between HT and seclusion frequencies, frequencies of physical aggression, episodes of suicidality/self-injury, property damage in excess of \$50 and episodes of running away from the residential facility. Each hypothesis examined the value of HT therapy as an option to demonstrate a significant different frequency for each dependent variable.

In Chapter 4, I provide information regarding data collection, treatment administration, and the results of the secondary data analysis of the variables.

### **Data Collection**

Data collection was secondary in nature. The data were provided by Chaddock employees after de-identifying any information that may have served as markers for identification, including but not limited to name, medical record number, or physical description. The only identifiers were markers requested by me, including date of birth, gender, and dates of residence at the facility (Chaddock, 2014). Forty participants were

recruited for the study (20 who had received HT and 20 comparable residents who had not received HT). Six individuals were removed from the intervention group and five were removed from the control group. Of the six removed from the intervention group, four were removed for insufficient data, one was removed because HT was not administered until after discharged from the inpatient residential setting to a home maintenance setting, and one was removed as duplicate individual.

Of the five individuals removed from the control group, one was removed for insufficient data. Two were removed for not meeting the parameters of the study. One was removed for being a duplicate individual. The final individual was removed from the study as the participant was removed from Chaddock before the study's requisite amount of time in treatment had elapsed.

A final population of 29 participants was examined using secondary data analysis (14 HT; 15 control). Participants ranged in age from 10 to 21 with a mean age of 16.88 ( $SD = 2.51$ ). All participants in the HT program had a minimum of four sessions for consideration with a mean session completion of 14.93 sessions ( $SD = 13.44$ ).

Participants were a representation of both male and female participants (10 males and 19 females). All participants resided at Chaddock for various times (but within the normal parameters of Chaddock's typical stay) with ranges from 6 to 42 months of residential living with a mean residential stay of 22 months ( $SD = 10.09$ ). Each research question and hypothesis was examined in turn. The scores were assessed using the Mann-Whitney U for non-parametrical analysis.

### **Treatment Fidelity**

Fidelity of treatment refers to the confirmation that the independent variable occurred as planned. This ensured that a fair and valid comparison of replicable treatments can be made (Creswell, 2014). As the data were obtained secondary in nature and de-identified, it is assumed that the treatment was administered as planned for consideration for inclusion in the study. It was determined by secondary data analysis that each participant attended a minimum of four HT sessions as set forth by the standards adopted by Chaddock. No known adverse events were related to the intervention of HT.

### **Statistical Assumptions**

According to Creswell (2014), in the course of statistical analysis, parametric tests may be conducted if the characteristics of the data meet certain assumptions. Violations of these assumptions may change the conclusion of the research and interpretation of the results. Within many parametric tests, the assumption of normality is to be met with a fairly symmetrical bell shaped curve. Normal distribution was assessed using a Shapiro-Wilk test for normality. In addition, the Levene's test for homogeneity of variance was used. Levene's test is often used with ANOVAs and t-tests (Creswell, 2014). The Box's test for equality is often used to test the null hypothesis of independence when using a time series (Creswell, 2014). In addition, the Mauchly's sphericity test was used to validate the use of an ANOVA to ensure the variances of the differences between the groups were equal (Creswell, 2014).

The Shapiro-Wilk test is often used to assess for normality with small sample sizes (Creswell, 2014). If the significance value is greater than 0.05, the data is normal. If it is below 0.05, the data is significantly deviated from a normal distribution. For each of

the dependent variables, as shown in Table 1, the Shapiro-Wilk demonstrated a deviation from normal distribution: seclusion ( $p < 0.001$ ); aggression ( $p = 0.007$ ); injury/self-harm ( $p < 0.001$ ); property damage ( $p < 0.001$ ) and running away ( $p=0.001$ ) (See Appendix C for histograms).

Table 1

*Shapiro-Wilk Significance Tests of Normalcy*

Dependent Variable	Shapiro-Wilk significance
Seclusion pre	< 0.001
Seclusion post	< 0.001
Aggression pre	0.007
Aggression post	0.007
Injury/Suicidal pre	< 0.001
Injury/Suicidal post	< 0.001
Property Damage pre	< 0.001
Property Damage post	< 0.001
Running away pre	0.001
Running away post	0.001

If the data is not approximately normally distributed, a Mann-Whitney U test, which is a non-parametric test, can be used as it does not require the assumption of normality (Creswell, 2014). Using a Mann-Whitney U requires the assumption that the dependent variable was measured on an ordinal or continuous level (Creswell, 2014). Each dependent variable was continuous in nature, for 3 months prior to the implementation of HT therapy and for the 3 months after implementation. The control group was monitored for the same time interval, so this assumption was met.

The second assumption of the Mann-Whitney U is that the independent variable consists of two categorical, independent groups (Creswell, 2014). The independent variable (IV) in this study was the utilization of HT therapy. There are two independent

groups: those receiving HT therapy and the control group that did not. This assumption was also met.

The third assumption of the Mann-Whitney U is that there should be an independence of observations (Creswell, 2014). There is no relationship between the observations in each group or between the groups themselves. Each participant only belongs to one group and each participant, while having similar characteristics, were independent of each other, so this assumption was also met.

The final assumption is that variables are not normally distributed (Creswell, 2014). The Shapiro-Wilks test demonstrated that the variables were not normally distributed (see above). The final assumption was met as well suggesting that the Mann-Whitney U is determined to be the best statistical analysis to be used.

### **Results**

A Mann-Whitney U test was conducted in an effort to examine the impact of the IV on the five dependent variables. The independent variable was the addition (or lack thereof) of the HT therapy. Two separate groups were assessed: those engaged in the HT program and the control group. The five dependent variables included seclusion frequencies, physical aggression frequencies, suicidality/self-injury frequencies, destruction of property in excess of \$50 or more, and running away from the facility. DVs were measured at two set intervals: a period of 3 months prior to the beginning of HT and from the beginning of HT for a period of 3 months beyond. The control group was followed for a similar 6 month period. Both groups were measured independently of each other at specific times on each dependent variable, the within-subject variable being

the timing of the measurements of the DV (Creswell, 2014). Dependent variable frequencies were fairly low and skewed (see Table 2).

Table 2

*Means and Standard Deviations*

Dependent Variable	Group	Mean	Standard Deviation
Seclusion pre	HT	1.07	2.13
	Control	1.93	3.90
Seclusion post	HT	1.50	2.14
	Control	0.73	2.31
Physical aggression pre	HT	4.85	5.47
	Control	3.86	6.26
Physical aggression post	HT	4.71	6.10
	Control	4.00	5.75
Suicidal/Self Injury pre	HT	2.78	4.74
	Control	1.53	1.68
Suicidal/Self Injury post	HT	2.35	3.71
	Control	1.66	2.79
Property Damage pre	HT	0.07	0.26
	Control	0.20	0.41
Property Damage post	HT	0.21	0.57
	Control	0.40	1.05
Running Away pre	HT	1.28	1.85
	Control	0.53	0.74
Running Away post	HT	1.21	0.76
	Control	1.66	3.03

An analysis based on change from baseline can be considered more efficient and powerful than comparison of final values, as it removes the within person variable from the analysis. In addition, change scores are also preferred with skewed distributions as is the case in the abovementioned data (Peat, Barton, & Elliot, 2008). Change scores were computed by subtracting the pretreatment scores from the posttreatment scores in order to observe a change in the DV. Creswell (2014) recommended using this concept when

assessing changes in dependent variables over time and when skewness such as above occurs. The change scores are in Table 3 below.

Table 3

*Change Scores for Dependent Variables*

Change	Mean	Standard Deviation
Seclusion change	-0.41	2.68
Aggression change	0.00	2.19
Injury/Self harm change	-0.14	2.53
Property damage change	0.17	0.80
Running away change	0.24	1.70

**Hypothesis 1**

*Null hypothesis 1:* After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different seclusion frequencies as compared to the control group.

*Alternate hypothesis 1:* After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different seclusion frequencies as compared to the control group.

A Mann-Whitney U test was conducted to evaluate the hypothesis that youth diagnosed with RAD who receive HT therapy would have significantly different seclusion frequencies as compared to the control group. As seen in Table 4, the medians of the HT therapy group and the control group were 17.29 and 12.87 respectively. The

results of the test were not significant,  $U = 73.000$ ,  $Z = -1.705$ ,  $p > 0.05$ , and the effect size was small,  $r = 0.316$ .

### **Hypothesis 2**

*Null hypothesis 2:* After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different physical aggression frequencies as compare to the control group.

*Alternative hypothesis 2:* After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different physical aggression frequencies as compared to the control group.

A Mann-Whitney U test was conducted to evaluate the hypothesis that youth diagnosed with RAD who receive HT therapy would have significantly different physical aggression frequencies as compared to the control group. As seen in Table 4, the medians of the HT therapy group and the control group were 13.50 and 16.40 respectively. The results of the test were not significant,  $U = 84.000$ ,  $Z = -0.956$ ,  $p > 0.05$ , and the effect size was small,  $r = 0.175$ .

### **Hypothesis 3**

*Null hypothesis 3:* After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different suicidality/self-injury frequencies as compared to the control group.

*Alternate hypothesis 3:* After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different suicidality/self-injury frequencies as compared to the control group.



A Mann-Whitney U test was conducted to evaluate the hypothesis that youth diagnosed with RAD who receive HT therapy would have significantly different self-injury/self-harm frequencies as compared to the control group. As seen in Table 4, the medians of the HT therapy group and the control group were 14.93 and 15.07 respectively. The results of the test were not significant,  $U = 104.000$ ,  $Z = -0.045$ ,  $p > 0.05$ , and the effect size was small,  $r = 0.175$ .

#### **Hypothesis 4**

*Null hypothesis 4:* After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different property damage frequencies as compared to the control group.

*Alternative hypothesis 4:* After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different property damage frequencies as compared to the control group.

A Mann-Whitney U test was conducted to evaluate the hypothesis that youth diagnosed with RAD who receive HT therapy would have significantly different property damage in excess of \$50 frequencies as compared to the control group. As seen in Table 4, the medians of the HT therapy group and the control group were 15.000 and 15.000 respectively. The results of the test were not significant,  $U = 105.000$ ,  $Z = 0.000$ ,  $p > 0.05$ , and the effect size is small,  $r = 0.000$ .

#### **Hypothesis 5**

*Null hypothesis 5:* After treatment, youth diagnosed with RAD who receive HT therapy will not have significantly different running away from the residential facility frequencies than the control group.

*Alternative hypothesis 5:* After treatment, youth diagnosed with RAD who receive HT therapy will have significantly different running away frequencies as compared to the control group.

A Mann-Whitney U test was conducted to evaluate the hypothesis that youth diagnosed with RAD who receive HT therapy would have significantly different running away from the facility frequencies as compared to the control group. As seen in Table 4, the medians of the HT therapy group and the control group were 13.500 and 16.40 respectively. The results of the test were not significant,  $U = 84.000$ ,  $Z = -0.949$ ,  $p > 0.05$ , and the effect size was small  $r = 0.176$ .

The test statistics for each dependent variable are presented in Table 4 below.

Table 4

*Test Statistics for Dependent Variables*

Dependent Variables	Mann-Whitney U	Z score	Group	Mean Rank
Seclusion	17.29	-1.70	HT	17.29
			Control	12.87
Aggression	84.00	-0.95	HT	13.50
			Control	16.40
Self-injury/ Self-Harm	104.00	-0.04	HT	14.93
			Control	14.93
Property Damage	105.00	0.000	HT	15.00
			Control	15.00
Running Away	84.00	-0.94	HT	13.50
			Control	16.40

\* All  $p$  values > 0.05

The main empirical findings suggested promise but lacked statistical significance. Seclusion frequency averages increased in the HT group (pre = 1.07, post = 1.50) while decreasing on average in the control group (pre = 1.93, post = 0.73). Aggression frequencies averages decreased in the HT group (pre = 4.85, post = 4.71) while increasing in average for the control group (pre = 3.96, post = 4.00). Suicidality/self-injurious frequencies averages requiring medical care decreased in the HT group (pre = 2.78, post = 2.35) while increasing slightly in the control group (pre = 1.53, post = 1.66).

Property damage in excess of \$50 increased on average in the HT group (pre = 0.07, post = 0.21) while the control group also increased on average (pre = 0.20, post = 0.40).

Episodes of running away averages decreased for the HT group (pre = 1.28, post = 1.21) while increasing dramatically by average for the control group (pre = 0.53, post = 1.66).

Averages of frequencies were promising for episodes of aggression, suicidality/self-harm, and running away from the facility. For these three variables, averages demonstrated reductions of averages for those involved with the HT program. By contrast, averages for the control group increased, some dramatically such as with running away from the facility. Seclusion frequencies for the HT group increased on average while decreasing for the control group. Finally, property damage averages increased for both the HT group and the control group, doubling for the control group while tripling for the HT group. Overall though, none of these changes were statistically significant. Thus the null hypotheses could not be rejected for any of the tested research questions.

### **Summary**

The purpose of this study was to explore the use of HT therapy. In particular, focus was placed on the use of HT therapy with youth diagnosed with RAD. Stinehart et al. (2012) identified that youth who have been diagnosed with RAD often respond less than favorably to traditional therapeutic options such as cognitive behavioral therapy and medication management. Alternative therapeutic options need be explored to assist a vulnerable population, allowing the youth to develop and nourish future positive relationships.

Research questions were designed to examine the association between HT and seclusion frequencies, frequencies of physical aggression, episodes of suicidality/self-injury, property damage in excess of \$50 and episodes of running away from the residential facility. Each hypothesis examined whether HT therapy had a significant influence on frequencies of the dependent variables. Due to the strong skew in the data, nonparametric tests were used to test all hypotheses. Although the HT and control groups did not significantly change from pre- to post-treatment on any of the dependent measures, an examination of the means suggested some improvement in episodes of aggression, suicidality/self-harm, and running away from the facility.

In Chapter 5, I discussed how the results may extend knowledge of therapeutic options for such a vulnerable population with limited options. Limitations, implications, and recommendations are also addressed based upon the findings of the study.

## Chapter 5: Summary

### Introduction

The purpose of this study was to explore the use of HT therapy with youth diagnosed with RAD. The study placed focus on the use of biofield energy practices (HT therapy) as a complementary therapeutic option to augment traditional evidence-based therapeutic options for a vulnerable population.

Youth who have faced life adversities that either result in or place the youth at risk for an attachment impairment disorder often do not respond well to traditional therapeutic options, including but not limited to cognitive behavioral therapy and medication therapy (Bernard et al, 2012; Connors, 2011; Ford et al., 2013). Without additional therapeutic options, many of these individuals face a lifetime of behaviors that are destructive to themselves and others around them. I sought to examine questions about common manifestations of attachment impairment and how HT therapy may influence such behaviors. Specifically, it investigated the following research questions:

1. Do individuals with RAD who are engaged in HT therapy have significantly different seclusion frequencies than a control group?
2. Do individuals with RAD who are engaged in HT therapy have significantly different frequencies of physical aggression than a control group?
3. Do individuals with RAD who are engaged in HT therapy have significantly different frequencies of suicidality/self-injury than a control group?
4. Do individuals with RAD who are engaged in HT therapy have significantly different frequencies of property damage than a control group?

5. Do individuals with RAD who are engaged in HT therapy have significantly different frequencies of running away from the residential facility than the control group?

The purpose of this investigation was to examine the use of HT therapy with youth diagnosed with RAD living in a residential facility. The investigation was important as many individuals with RAD do not respond well to traditional therapeutic options such as cognitive behavioral therapy and medication management. The data collected did not support the alternative hypotheses regarding changes in frequencies of specific manifestations of RAD, including frequencies of seclusion, aggression, suicidality/self-injury, property damage, and running away from the facilities ( $p > 0.05$ ).

Based on the data collected, the independent variable of the use of HT therapy did not have an influence on the DV outcomes. These findings suggest the possibility that HT therapy may not be statistically supported as a complementary and alternative practice for individuals with RAD.

Children with RAD have experienced a break in attachment from primary caregivers, often through neglect and/or abuse (APA, 2013). Such children have often experienced painful touch from caregivers or complete lack of touch. Both can lead to the youth questioning any forms of future touch (Bruskas, 2010). Implementing a program that promotes positive, nurturing touch such as HT therapy may offer options for such a population but will most likely be met with distrust and guardedness. While the caregivers in the residential facility are geared towards positive, nurturing touch, historically touch for these individuals are neglectful or painful. Care needs be given to

provide time for the youth to learn that touch can be positive (*DSM-5*, APA, 2013; Bernard et al., 2012).

HT therapy is geared towards allowing the individual to self-heal from past emotional concerns in an environment that promotes safety and positive, nurturing touch (Hover-Kramer, 2012). HT therapy utilizes light touch to the individual in a safe environment that is intended to allow the individual to be aware of oneself and take control of their own individual healing (Hover-Kramer, 2012). HT therapy has been used in other psychological disorders such as anxiety and PTSD (Jain et al., 2012). However, other disorders did not include the use of touch with a population that has experienced neglectful and/or harmful touch at such an early age in life. While theoretically, teaching youth with RAD that touch can be therapeutic, HT therapy for children with RAD face the additional issue of overcoming past traumatic/neglectful touch in addition to present psychological concerns. These may be some of the reasons for the lack of significant findings in the present study.

Methodological issues, particularly connected to the small sample size and outliers, may have also negatively affected the statistical outcomes. G\* Power analysis (G\*Power 3.1.92) identified that in order to have sufficient power (0.80) to test the within-between interaction with a medium sized effect and a 0.05 criterion of statistical significance, a sample size of 20 individuals was needed. While 40 participants were initially recruited for the study, 29 individuals were eventually used for the study. This sample size may simply have not been large enough to detect the potentially small effects of HT for individuals with RAD, particularly given the extreme non-normality of the data.



In addition, while using the most common manifestations of RAD, some of the behaviors studied were relatively rare. Individual differences in response rates may not be strong enough to identify group differences. Participants were only followed for 3 months post HT treatment. For most of the participants, the maladaptive behaviors associated with RAD have been present for years. A period of 3 months of treatment for such a population may not be able to identify a viable difference.

While the analysis did not support the hypotheses regarding significant group differences, case by case examination of individual participants' change scores from the HT group indicated that some participants decreased their potentially self-destructive behaviors during the 3 month follow-up period. For example, during the 3 months of implementation, Participant # 6's aggressive episodes decreased from 11 episodes to seven episodes. Participant # 19's episodes of suicidality/self-injurious behaviors requiring medical care decreased from seven episodes to two. Participant # 24 demonstrated improvements in multiple areas. This participant decreased from four episodes of aggressive behaviors to none. Participant # 24 also decreased from four episodes of suicidality to none during the same time frame. Finally participant # 24 also decreased from four episodes of running away from the facility to one during the period of 3 months of HT therapy. It should be noted that participant # 22 of the HT program demonstrated increases in seclusion from zero to two episodes, aggression episodes from seven to 13 episodes, and suicidality/self-harm from six to eight episodes during the same time frame.

### **Interpretation of the Findings**

The findings of the study were statistically unable to refute the null hypothesis, but do show promise for clinical importance. Guyatt, Rennie, Meade, and Cook (2008) identified that while clinical importance is often used interchangeably with statistical significance, clinical importance is less about statistics and more about the magnitude of the effect being studied at a smaller level. A study may be statistically insignificant but be clinically important and vice versa. Several of the dependent variables demonstrated promise for some individuals in reducing potentially self-destructive behaviors such as aggression, suicidality/self-harm, and running away from the residential facility.

In addition, the participants all resided at a residential facility designed for at-risk individuals who had various difficulties living in mainstream society and could afford residential care. While the DVs were common manifestations of RAD, the individual behaviors represented may be outliers of the general RAD population. Participants were only followed for a period of 3 months following the implementation of HT therapy. Additional time may be needed to achieve viable results.

A lack of statistical significance may also be attributed to individual differences to response to the treatment that may have skewed results. While individuals with RAD often exhibit the behaviors measured in this study, no two individuals display the same behaviors for RAD nor respond the same to various therapies (APA, 2013). Even within the disorder of RAD or those that are at risk for attachment impairment, no two individuals have the same reasons for the onset of the disorder. At present, there does not exist a test to quantifiably determine the severity of the disorder. While all participants

have the diagnosis of RAD, the severity of the disorder for the individual cannot be ascertained.

Multiple studies (Jain & Mills, 2010; Jain et al., 2012; Miles & True, 2003; Schneppter, 2010) have suggested that HT therapy has potentially multiple benefits as complementary medicine to traditional therapeutic options for mental health/illness. Several others have identified the need for treatment options for youth either experiencing or are at risk for attachment impairment (Aideuis, 2007; Bruskas, 2010; Prather, 2009; and Stubenbort et al., 2010). This study helps to extend the knowledge sought by others seeking therapeutic options for such a vulnerable population.

Although the hypotheses were not supported, this may have at least in part been due to the small sample size. Examination of individual changes suggested that some individuals demonstrated improvements on the dependent measures following HT treatment while others did not. While HT therapy has been demonstrated to be a complementary medicine option for other mental health/illness issues, further studies would be needed to assess the efficacy of HT for individuals with attachment impairment.

Many variables demonstrated changes in both directions. However, it may be considered possibly viable on a clinical level despite demonstrating regression in behaviors. While seclusion episodes increased for the HT group over the control group, it is not unusual for individuals with RAD to have increased behaviors when implementing a new treatment, particularly those promoting positive touch. When faced with a new situation, it is common for an individual with RAD to temporarily revert to previous behaviors that have been self-protective including but not limited to harm to self and others that would require implementation of seclusion. Such behaviors are common

manifestations but often dissipate with time (Dr. Lanny E. Stiles, personal communication, July 20, 2015).

### **Limitations of Study**

In this study, I examined the use of HT therapy for a highly vulnerable population that does not often respond well to traditional therapeutic options. As this was a secondary data analysis of one residential site for a therapeutic option that is not yet evidence-based, the study encountered a number of limitations which need to be addressed. First, the scope of the study was very narrow. Only participants residing at a long term residential facility for behaviorally disturbed individuals were included. To be eligible for the study, it was indicated that all participants had demonstrated difficulties with attachment impairment to the point that the individual needed residential care. The participants in the HT program were referred only after the traditional therapeutic options at Chaddock had not been successful. Therefore, the participants in the HT program were doubly disadvantaged regarding behaviors exhibited.

Secondary data was only collected from Chaddock. While Chaddock is a nationally recognized facility for working with attachment impaired individuals, data was limited to one facility and only one provider. At the time of the study, Chaddock only used one provider of HT therapy, so the population remained low in an effort to provide quality care. The one provider, Marilyn Vincent, is a certified HT therapist and she remained the sole provider for the facility. These factors limited the generalizability of the study.

The small sample size was another study limitation. G\*Power analysis (G\*Power, 3.1.92) identified a sample size of 20 individuals were needed to test for a medium sized

effect for the within-between interactions of the variables. 40 participants were initially recruited for the study. However, after removing those not meeting the parameters of the study, only 29 participants were included in the study. All of the dependent measures were quite skewed. This was minimized by computing change scores for the dependent measures and conducting non-parametric analysis through the Mann-Whitney U which does not require normally distributed data.

The limitation of maturation and improvement were also minimized by the creation of a control group and only following the individuals for a short linear time of 3 months after implementation of the HT program. While no two individuals received exactly the same treatment, common characteristics did emerge. It is likely that both groups did have the potential for some degree of improvement; the control group minimized this limitation.

Following the individuals for only 3 months post implementation of HT treatment is another limitation of the study. Often known as the *honeymoon* phase (Dr. Lanny E. Stiles, DO medical director, personal communication, June, 21 2015), an individual may temporarily alter behaviors if the individual thinks that positive outcomes can occur with temporary positive behaviors. However, this limitation is minimized as the participants' average stay at Chaddock is for 18-24 months and implementation of the HT program is usually not implemented until the participant has been at Chaddock for at least a year.

### **Recommendations**

The study was unable to demonstrate statistical significance for hypotheses regarding the use of HT therapy for youth with psychiatric conditions. The limitations of the study may have negatively influenced the outcomes though. A need exists for future

studies to allow further assessment into the use of HT therapy as a complimentary therapeutic option.

Future studies would have a couple of options in order to better facilitate more accurate outcomes. At the present time, Chaddock is the only known provider of HT therapy for youth diagnosed with RAD. However, if other providers are discovered and included, a larger sample pool may be incorporated. Chaddock is considering adding additional certified HT therapists. This would also increase not only the sample pool, but minimize the limitation of only having one provider. Inclusion of other providers and other facilities may be able to generate larger sample pools in an effort to obtain a more generalizable study.

Further studies might be able to assess individuals with attachment impairment that are not residing in a residential facility. This would improve the concept of generalizability as well. If participants are not behaviorally challenged enough to require long term residential care, changes in improvement may be more noticeable.

It is recommended that future studies include data that is not secondary in nature so other confounding variables could be addressed. For example, seeking individuals soon after the break in attachment has occurred may yield different results than individuals that have had a decade or longer of learning maladaptive behaviors. Being able to randomly assign individuals and not waiting for failure from traditional methods may yield different results if incorporated from the beginning of treatment for the individual.

It is also recommended to consider reaching the youth earlier in life. While each participant had experienced a break in attachment at a young age, the average age of the

participants was 16.88 years of age. Therefore, all participants had a large, perhaps significant, time gap between the ages of the break in attachment before the treatment of HT was implemented. Closing the gap from when the break in attachment occurred to receiving therapeutic options may reduce the severity of the disorder. If the youth can have less time to develop maladaptive behaviors, less time may be needed to undo such behaviors. Earlier intervention may also decrease negative family dynamics and reduce or eliminate residential stay.

### **Implications**

The study has the potential for positive social change on many levels. The need for non-invasive treatment options remains crucial for such a vulnerable population. Guyatt et al. (2008) identified that a study may be statistically insignificant but be clinically important. The findings of the study are statistically unable to refute the null hypothesis but do show promise for clinical importance. Several of the dependent variables demonstrated promise in reducing potentially self-destructive behaviors such as aggression, suicidality/self-harm, and running away from the residential facility to the unknown, and so, demonstrate potential clinical importance.

As individuals with RAD often do not respond to traditional methods of currently practiced therapeutic options, at times professionals and lay persons have engaged in controversial treatment options that potentially can harm the individual. Many authors identified coercive therapy or CRT, using physical restraint and withholding food and water (Becker-Weidman, 2006; Mercer, 2005, Mezzich & Mohahan, 2011).

HT therapy offers a therapeutic option that is non-invasive and promotes positive nurturing, adding rather than withholding (Hover-Kramer, 2012). HT therapy is not

restrictive in nature and allows the individual to withdraw at any time. HT therapy allows control for the youth who has often lacked control of situations in the past. HT therapy has the potential as a non-invasive, empowering therapeutic complement to traditional therapeutic options for individuals with RAD. Youth diagnosed with RAD have faced significant abuse/neglect at such a young age often have faced inappropriate and/or abusive touch. HT therapy offers an opportunity to promote positive touch in a therapeutic setting.

Another implication is the overall costs associated with the utilization of HT therapy. While psychiatric costs vary greatly from one individual to another, Blessing Hospital of Quincy Illinois (2014), in the same town as Chaddock, has average daily costs for mental health inpatient of approximately \$1,500 per day. By contrast to other mental health costs, the average Healing Touch therapy session is less than \$150 and can be completed in any setting, depending on the training and experience of the therapist (M. Vincent, personal communication, May 20, 2014).

Clinical importance was evident for several participants, one in particular. Participant # 24 demonstrated improvement in multiple areas such as aggression, suicidality/self-harm and running away. Improvements were made in several areas, including episodes of aggression, suicidality/self-injurious behaviors, and running away from a safe facility. If the trend of aggression continues to be reduced, social change may improve safety for all, including but not limited to the client and staff. At present, it is recommended that future studies address as many of the limitations addressed as possible, particularly the larger sample size.



While success rates for medication and/or cognitive behavioral therapy are unknown at this time, rates for negative behavioral outcomes such as truancy, destruction of property, and aggressive behaviors remain higher in populations of individuals diagnosed with RAD (Stinehart et al., 2012). HT therapy demonstrated promise of clinical importance for aggression, harm to self/others, and running away from a safe environment.

The findings support the need for future studies regarding the use of HT therapy as a possible complimentary therapeutic option. Social change can occur on the individual level. If the cycle of negative behaviors can be broken, the individual exhibits fewer behaviors that may result in harm to self and/or others. If future studies can continue to demonstrate the trend, the family unit, whether it be foster parents, adoptive parents or intimate partners/future children can be spared the negative outcomes of residential care, incarceration or the continue cycle of neglect and abuse. By reducing the number of self-injurious or destructive behaviors, this treatment could reduce disruptions in the family dynamic, ultimately improving family relations.

### **Conclusion**

If an infant or child has not received a positive secure base of attachment, the youth will potentially fail to form a secure attachment with any individual (Bowlby, 1984). Such youth often face additional issues such as psychiatric and behavioral issues as well as placing future relationships in jeopardy as well (Thompson-Jinariu, 2011). Unfortunately, youth who have not been able to form an adequate attachment foundation often do not respond to traditional evidence-based practices of therapy for additional psychiatric and/or behavioral issues (Thompson-Jinariu, 2011).

Bernard et al. (2012) identified that early intervention may help the individual at risk for attachment impairment to self-heal and form future positive relationships. While the concept of attachment impairment is not a new condition, therapeutic options for this vulnerable population remain limited. If the cycle of attachment impairment can be broken, current therapeutic options may be revised. As mental health care costs rise, it remains integral to find cost effective methods that can best serve the local and global community. Taking a proactive rather than a reactive approach may help this and future generations.

While lacking current statistical significance regarding the use of HT therapy as a CAM based intervention for such a vulnerable population, future studies may be able to seek a further understanding of biofield therapy such as HT therapy for various psychiatric conditions such as RAD. Even if such alternative methods may only help a few, that help may make the difference in the life of a child. One cannot always save everyone, but it may be worth it if even one can be reached. As the motto of Chaddock states, every child deserves a chance.

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## Appendix A: Data Usage

*Chaddock*

Every child deserves a chance

May 29, 2014

[REDACTED]

[REDACTED]

RE: Data Transfer Agreement for Chaddock

Dear Kelli Stiles:

We are pleased to inform you that the Chaddock has approved your request for a data set from Chaddock for use in your research project, "The Effect of Healing Touch Therapy for Youth Diagnosed with Reactive Attachment Disorder." The data will be provided in deidentified and anonymized form; that is, it will have all HIPAA identifiers removed, and will not contain any link fields allowing anyone to make connections back to individual subjects or community treatment centers in which the data were collected.

In order to provide this data we must ask that you agree to the following: a) You agree to use the dataset only for the project described above. b) You will not license, sell, or otherwise distribute the dataset to any third party; however, you may provide access to the dataset to bona fide collaborators for the purposes of your research project. c) You will not attempt to identify or contact any individuals from whom the data was collected. d) You agree to comply with Chaddock's Policies and Procedures relating to the use of

data and publication. e) All publications will acknowledge Chaddock as the provider of the data.

Chaddock shall have the right immediately to terminate this agreement if you breach any of these provisions, and such breach is not cured within thirty days of receipt of written notice from Chaddock. Upon termination for any reason, you shall immediately cease use of the dataset, and return the dataset to Chaddock or, if Chaddock requests, destroy the dataset and provide Chaddock with written certification of such destruction.

We wish you the best success with this research project.

Sincerely,

Angel Knoverek, Ph.D., LCPC, ACS Director of Clinical Services

Chaddock

AGREED: I agree to comply with the guidelines and provisions of this letter agreement:

Name: Kelli Stiles

Title: Doctoral Student

Organization: Walden University

cc: Chaddock

Appendix B: Policy and Procedures Healing Touch

*Chaddock*

Every child deserves a chance

Chaddock Procedure Res 1.13

LAST REVIEW/REVISION: 11/30/10

PROCEDURE:

A. PROGRAM INFORMATION

a) PROGRAM ADMINISTRATION

- 1) Director of Treatment Services who will hold a minimum of a LCSW
- 2) Health Services Manager who will hold a minimum of a BSN.

- 3) Healing Touch Practitioner Apprentice who has completed the course of study through Level 4 and is participating in a minimum 1 year mentorship with a Certified Healing Touch Practitioner.
  - 4) Healing Touch Practitioner, who has completed the course of study through Level 5, competently practices the energy-based modality of Healing Touch, has received a Certificate of Program Completion, and is eligible to apply for certification in Healing Touch.
- b) PROGRAM TYPE: HEALING TOUCH PROGRAM
- c) PROGRAM MISSION STATEMENT : To provide Chaddock clients and staff with an energy based therapeutic approach using a collection of energy based noninvasive treatment techniques to assess and treat the human energy system affecting the physical, emotional, mental, and spiritual health and healing.
- d) HEALING TOUCH DEFINITION: Healing Touch is an energy therapy in which practitioners consciously use their hands in a non invasive heart centered and intentional way to support and facilitate physical, emotional, mental and spiritual health and healing. Healing Touch may be used safely with individuals of all ages and in all stages of health and illness. Healing Touch creates an environment of safety and harmony to sooth and comfort the individual. Healing Touch complements conventional health care and is used in collaboration with other approaches to health and healing.

## B. PROGRAM GOALS AND OBJECTIVES

### a) PROGRAM PHILOSOPHY

- 1) Chaddock's philosophy is that relationships are primary and essential to the development and life of a healthy individual.
- 2) Healing Touch philosophy is that the body has memory and stores the emotional experiences we have had. At some point our inner wisdom guides us to the opportunities to release the stored.
- 3) Memories which have blocked the energy flow and weakens our life force. Healing Touch helps release the blocked energy flow allowing the therapist to work with the client. By assessing, treating, and evaluating the energy system, the practitioner assists the client to self heal.

b) PROGRAM GOALS AND OBJECTIVES: Healing Touch goal is to restore harmony and balance in the energy system, placing the client in a position to self heal. Healing Touch complements conventional health care and is used in collaboration with other approaches to health and healing.

- 1) Indications for Healing Touch

- Facilitation of wound healing
- Reduction of pain
- Decrease anxiety, stress, tension, phobias
- Prevention of illness
- Enhancement of spiritual development
- Preparation for medical treatment and procedures and manage side effects
- Support for dying process
- Strengthens immune system
- Create sense(sic) of well being
- Works through grief process, depression

#### C. INTAKE PROCESS FOR CLIENT

##### a) INTAKE CRITERIA

- 1) Client must be receiving treatment services through Chaddock.
- 2) Client must be referred through Core Treatment Team.

- 3) Referral form completed by therapist and sent to Healing Touch Practitioner.
- 4) Referral form reviewed by psychiatrist and writes order for Healing Touch.
- 5) Guardian notified, Healing Touch procedure explained and questions answered.
- 6) Verbal consent obtained and consent sent to guardian for written consent.
- 7) Healing Touch Practitioner meets with therapist and client – Healing Touch procedure explained.
  - aa) Quiet, dimly lit room with relaxing music
  - bb) Staff member remains in room with client during treatment
  - cc) Client fully clothed with shoes off
  - dd) Client sitting in chair or lying on table
  - ee) First treatment 30-45 minutes; all other treatments 15-20 minutes
  - ff) Course of treatment varies depending on client, diagnosis, symptoms presenting
  - gg) Decision to end treatments depend on client/Core Treatment Team, therapist, and guardian input
  - hh) Pre and post assessment done by client and staff/therapist

#### D. INTAKE PROCESS FOR STAFF



a) INTAKE CRITEREA

- 1) Staff may request Healing Touch as a Wellness Benefit based on the practitioner's availability
- 2) Staff may be referred per Human Resources as part of Workman Compensation
- 3) Staff may be referred per supervisor
- 4) All sessions are confidential. If referred by Human Resources or Supervisor, they will be notified of starting date and ending date.
- 5) Intake interview form and written consent for treatment will be obtained prior to session. Healing Touch Practitioner will explain the procedure to staff prior to doing the session.
  - aa) Quiet, dimly lit room with relaxing music
  - bb) Staff fully clothed with shoes off
  - cc) Staff sitting in chair or lying on table
  - dd) First treatment 30-45 minutes; all other treatments 15-20 minutes
  - ee) Course of treatment varies depending on client, diagnosis, symptoms presenting
  - ff) Decision to end treatments is agreed upon by practitioner and staff member

gg) Pre and post assessment done by client and staff/therapist

#### E. DOCUMENTATION FOR CLIENTS AND STAFF

- a) Healing Touch Intake Interview Form
- b) Healing Touch Session Documentation Form
- c) Progress Notes
- d) All documentation goes into main files for clients and in medical file for staff

#### F. SERVICE DELIVERY

- a) Techniques
  - 1) Basic Healing Touch Sequence
  - 2) Magnetic Clearing
  - 3) Chakra Connection
  - 4) Headache Techniques
  - 5) Pain Management Techniques

- 6) Heart to Heart Meditation
  - 7) Chakra Spread
  - 8) Mind Clearing
  - 9) Scudder Meditation
  - 10) Spiral Meditation
  - 11) Back Techniques
  - 12) Full Healing Touch Sequence
  - 13) Full Body Connection
- b) The North America Nursing Diagnosis Association (NANDA) identifies and recognizes the human energy field theory.
- Nursing Diagnosis: Energy Field Disturbance – the state in which a disruption of the flow of energy surrounding a person's being results in a disharmony of the body, mind, and/or spirit.
- c) The American Holistic Nurses Association recognizes Health Oriented Diagnosis:
- 1) Adequate health maintenance
  - 2) Effective individual coping

- 3) Adequate support system
- 4) Functional grieving
- 5) Regular elimination
- 6) Adequate nutrition
- 7) Controlled Pain
- 8) Maintenance of independence
- 9) Adequate self-care
- 10) Effective coping
- 11) Active role in health maintenance
- 12) Active participation in decision-making
- 13) Effective stress reduction activities
- 14) Compliance with health regimen
- 15) Effective home maintenance management
- 16) Effective health maintenance

17) Adequate self-concept, body image, self-esteem, role performance or personal identity

18) Adequate socialization

19) Adequate activity tolerance

d) Steps in a Healing Touch Session:

1) Data collection

2) Problem Statement

3) Mutual goals/intentions

4) Interventions

- Opening techniques
- Specific interventions
- Closing techniques

5) Response/evaluation

6) Processing/planning

e) Healing Touch sessions will be scheduled around practitioner's routine work schedule.

## Appendix C: Histograms





















