White Paper XVI

The Effect of Intention on Decreasing Human Anxiety and Depression via Broadcasting from an Intention-Host Device-Conditioned Experimental Space

by

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Special Background

Cindy Reed was a graduate student at the Holos University Graduate Seminary in Missouri when we first began to discuss (in 2002) the possibility of her using our intention-host device technology as a research vehicle for her to obtain a Doctor of Theology degree. In 2005, she was granted this degree after writing a truly superior thesis entitled “The Effects of Intention on Decreasing Anxiety and Depression Utilizing Intention Imprinted Devices”. The abstract of her thesis follows below:

ABSTRACT (Reed Thesis, 2005)

Two experiments, one double blind, were conducted to explore the effects of intention on anxiety and depression utilizing an Intention-Imprinted Electronic Device (IIED) on adult subjects throughout the Central United States, Canada, and Mexico. Subjects were divided randomly into two groups, with demographic information from each entered on one of two computers. The IIED was imprinted by four experienced meditators with an intention for improved health, decreased anxiety and decreased depression. The intervention group scrolled continuously in the vicinity of the IIED broadcasting the intention. At a separate location, the control group demographics scrolled continuously with no intention. The interventions were conducted at three month and eight month intervals.

> Results were compared using a mixed analysis of variance with one between groups and one within groups factor on the pre-and post-test scores on the State-Trait Anxiety Inventory for Adults and the Zung Self Rating Scale for Depression. The results for the three month group showed a marginally significant reduction on the STAI-Y-1 for the intervention group at the .089 level of significance. The control group showed no significant variance. The analysis of the pre-intervention scores to the post intervention scores after both the three and eight month group showed a significant reduction state anxiety (p=<.003), trait anxiety (p=<.000) and depression (p=<.001).
>
> The results suggest that over time, an intention broadcast to adult subjects may have an impact on anxiety and depression. More research needs to be conducted to explore the potential of IIEDs to improve health.

5 years later, I realized that this work was too important to humanity that it "die a silent death". Cindy and I had lost contact with each other so I decided to bring it into the light via the format of this "White Paper". My contribution to this work was in designing the experiment, writing the intention statements and creating, with my colleagues, the imprinted IIEDs. Cindy performed all aspects of the experiment and wrote a masterful thesis! What follows are just a few excerpts from that thesis!

INTRODUCTION (Reed Thesis)

The state of American health is declining, and the healthcare system is in crisis. Healthcare in the United States, while touted by Americans as the best in the world, is dysfunctional, costly, and a burden on the economy that threatens to bankrupt us. We need new solutions to the problems and issues that are outside the widely accepted medical model, solutions that take advantage of advances in other areas such as science and spirituality. Health is not an isolated physical condition, as depicted by the current medical model, but is an intertwined and interdependent blend of physical, emotional, social, spiritual, and environmental determinants. Health is an issue that is critical not only to the well being of our citizens, but to our economy and our way of life as well.

John McKnight, in his book *The Careless Society: Community and Its Counterfeits* [(1)] goes beyond the typical analysis of healthcare system failure to identify the roles that all the parties play in

maintaining a system that is dis-eased itself. McKnight asserts that the problem is not that we have ineffective service producing systems, but that our systems are too powerful, and our communities too weak. He believes that:

> The most significant development transforming America since World War II has been the growth of a powerful service economy and its pervasive service institutions. Those institutions have commodified the care of the community and called the substitution a service.(2)

McKnight believes that physicians, and the institutions that have grown up around healthcare systems, are exemplary models for professionals seeking imperial prerogatives. At the core of our healthcare system is a paradigm for modernized domination, which functions through the propagation of a therapeutic ideology. The basic creed of the ideology is: "1) the basic problem is you, 2) the resolution of your problem is in my professional control, and 3) my control is your help".(3) The essence of this is to mask the control that the healthcare system wields behind the smokescreen of therapeutic help.

Obviously, our healthcare crisis begs for reform of the system. Unfortunately, healthcare reforms perpetuate the dis-eased system, as the healthcare systems themselves define both the problem and the solution. Rather than significantly changing the system to benefit those it attempts to serve, each reform is a new growth opportunity for the system to exert control and expand its influence. McKnight views the current reforms in Table 1 as advancing medicine's hegemony:

Table 1. Healthcare Reforms and Their Result(4).

Reform	Result
1. *Effort to ensure equal access to medical care* (supporting doctors in underserved areas, programs to increase the number of healthcare workers, regulatory systems allocate beds based on medical need).	1. Achieving equal access broadens clientele base and establishes the *right* to consume services as a central issue, while litigation establishes the 'right to treatment'.
2. *Focus on improving the quality of healthcare* (increased	2. The guarantee of quality services reinforces the popular

professionalization and review processes are supported by federal, state and medical practitioners).	belief that that health care professionals know what health is, while the critical issue is making the professionals *produce* "it".
3. *Attempts to deal with costs* (comprehensive prepaid systems, HMO's, Medicare/Medicaid and the national health insurance discussion represents efforts to conquer the medical systems' growing capacity to consume the gross national product).	3. Cost control ensures a rationalized guarantee of the medical systems income, with the central issue being how to extend the system while lowering or stabilizing the price.
4. *The effort to involve "health consumers" in the system* (government and medical industry gradually enabling non-professionals to participate in the decision making processes of the system).	4. Consumer participation co-opts potentially disruptive citizens by providing participation in medicine as a substitute for political action that might affect the system.
5. *The increase concern over ethical issues posed by modern medicine* (organ transplants, abortion, life extension technologies provide new crises and new public and professional policies).	5. Ethical reform could limit medical hegemony by concluding that such issues are not medical prerogatives, however, theologians and clergy have been co-opted by expanding their trade and becoming counselors for decisions
6. *The preventative healthcare movement* (provides policy alternative to "get at the root of the problem", calling for continuing checkups, screenings, and outreach plans designed to encourage and enable more people to use the system).	6. "Preventative" medical care can make every person a client everyday of his life— medicalized prevention tells us that we need the medical system precisely because we do not perceive a need.

Dossey defines healing as a process, along with 4 different types:

Healing: Those physical, mental, social and spiritual processes of recovery, repair, renewal, and transformation that increase wholeness, and often (though not invariably), order and coherence. Healing is an emergent process of the whole system and may or may not involve curing. **Healing intentionality:** the effort by one or more persons to improve the health status of another person through conscious, purposeful, actions. **Nonlocal (or distant) healing:** a hypothesized form of healing intentionality occurring beyond the reach of the physical senses and that appears to be unmediated by any demonstrable form of physical signal. **Holistic healing:** a form of healing based on attention to all aspects of an individual-physical, mental, social, and spiritual. **Healing relationships:** The quality and characteristics of interactions between healer and healee that facilitate healing. Characteristics of this interaction involve empathy, caring, love, warmth, trust, confidence, credibility, honesty, expectation, courtesy, respect, and communication.[5]

Dossey's definitions will significantly advance future research in healing, and give us all a common language for understanding, communicating and replicating research on healing. Unfortunately, Dossey does not consider intention broadcast from a device in his definitions, but, in time this may also be incorporated into the standard nomenclature for healing.

Another useful definition has been offered by Kleinman, who describes healing as pathways of words, feelings, values, expectations and beliefs that re-order and organize (make more coherent) the illness experience,[6] and one could also add, the experience of health. Wendler defines healing as "an experiential energy requiring process in which space is created through a caring relationship in a process of expanding consciousness and results in a sense of wholeness, integration, balance, and transformation and which can never be fully known"[7] Though Wendler's experiential energy requiring process or Leddy's state of integrity of functioning may never be able to be fully known, through standardization of language and research we can come to understand the state of health, and the processes of health and healing, in ways which will assist humankind to optimize further development.

This dissertation evaluates the potential for a new kind of health improvement intervention, utilizing the cutting edge model of William Tiller, Ph.D. Dr. Tiller is a material scientist and Stanford Professor Emeritus. His model suggests that through the use of quantum physics principles, we can impact many things, one of which is the health of a population. This research is one of the first studies on humans that

utilizes Tillers' model of intention[8] to impact health, giving us more information about positive ways to impact health and healing, and suggesting directions for future research. Dossey made an excellent suggestion when he proposed that we adopt as a motto for the current state of health and healing research the comment of astronomer-physicist Sir Arthur Eddington: *something unknown is doing we don't know what*. Through further research, utilizing breakthrough innovation from a variety of other fields beyond what is traditionally considered health, we can identify the unknown and find out what it's doing.

A variety of experiments have been conducted on the impact of intention on animate and inanimate objects. Benor reviewed the research on spiritual healing in 2001, in which he defined spiritual healing as a:

> Systematic, purposeful intervention by one or more people to help another living being (person, plant, animal, or other living system) by means of focused intention, hand contact or passes to improve their condition. [9]

According to Benor, intention is part of spiritual healing. Through his annotated review of 191 randomized controlled studies, he found that 83 (43.4%) demonstrated effects at statistically significant levels which could occur by chance only one time in a hundred or less, and another 41 (21.5%) at levels that could occur between two and five times out of a hundred.[10] Though not all the studies specifically addressed intention as an independent variable, it is part of the operational definition that Benor is using to evaluate studies to answer the question "Does healing work?". This is the published review volume of healing studies in which intention research was included.

Jonas and Crawford reviewed over 2,200 published reports on spiritual healing, energy medicine, and mental intention, defining intentionality as "intentional mental effort".[11] This suggests thought that includes action, or the mind's will.[12] Jonas and Crawford reviewed research in the areas of (a) health correlates of spiritual and religious practices; (b) intercessory or healing prayer; (c) 'energy' healing approaches; (d) therapeutic qigong (Chinese energy healing); (e) direct mental interaction with living systems; and (f) mind-matter interaction studies. Jonas and Crawford used established quality criteria to review and grade the studies according to the "evidence level" presented by a category of research. See Table 2 for a summary of their evaluation:

Table 2. Evaluation of Research on Intention, Healing, and Energy Medicine.

Category	Number of Studies	Positive Outcome	Evidence Level
Religious Practices	130	97	D
Prayer	13	6	B
Energy Healing	19	11	B
Qigong (Clinical Research)	58	Almost All	C
Qigong (Laboratory Research)	33	Almost All	F
Laboratory Research On Bioenergy	45	43	B
Direct Mental Interaction With Living Systems (DMILS): Electrodermal Activity	24	9	B
Research On Mind-Matter Interactions (MMI): Individuals	516	516	A
Direct Mental Interaction With Living Systems (DMILS): Remote Staring	13	7	B
Research On Mind-Matter Interactions (MMI): Groups	80	80	E

Note. Studies were evaluated with a grade of "A" being the highest, indicating at least 3 independent, high quality studies and "F" being the lowest, indicating expert opinion without high quality research. From Jonas, W.B., and Crawford, C. C. (2003). *Healing, Intention and Energy Medicine*. London: Churchill Livingstone, p. xv-xvii.

Jonas and Crawford's review indicates intention as a variable in research has been studied with mixed results, those results being the strongest in studies with inanimate objects. Jonas and Crawford conclude that:

> Mental intention has effects on non-living random systems (such as random number generators) and may have effects on living systems. While conclusive evidence that these mental interactions result in healing specific illnesses is lacking, further quality research should be pursued.

The last type of research not previously mentioned that uses intention as an independent variable has been conducted by Dr. William Tiller, utilizing a device called an Intention Imprinted Electronic Device (IIED) to broadcast intention continually. In these studies, four experienced meditators imprint a device with an intention for change in a target subject.[13] Three specific target experiments, involving changing the pH of water, decreasing the maturation time of fruit flies, and increasing liver enzyme activity yielded robust results.[14] The replication of these experiments over time also demonstrated an unexpected effect: structural changes in the physical space where the experiment was located seemed to facilitate the robust effects that Tiller's imprinted device had on the targets.[15] Tiller calls this phenomenon the "conditioning" of the space.[15] While a number of researchers are validating that intention as an independent variable does have an impact, Tiller's work not only demonstrated a significant impact but also proposes a model for the mechanism by which intention actually alters the target.

METHODOLOGY (The Reed Thesis)

This study evaluated the impact of an Intention-Imprinted Electronic Device (IIED) imprinted with an intention for improved health on depression and anxiety in three different groups. The intention statements used for each of the three groups are provided in Appendixes A, B and C. A pilot project was conducted initially for one month, while Group A intervention was for three months, and Group B intervention was for eight months. Group A subjects were randomly assigned into the control or intervention groups, while the participants in Group B all received the intervention.

Research has shown that there is no known risk to subjects from positive intentions. Although research has suggested that there may be risks to subjects with certain forms of intercessory prayer,[16] this

study utilized positive intention imprinted and broadcast from an IIED, not intercessory prayer.

This study utilized an Intentionally Imprinted Electrical Device (IIED) imprinted with a specific intention for each group. The names and addresses of the intervention group were scrolled continuously on a computer screen with the intention broadcast by the IIED throughout the intervention period. The IIED and the computer with the names and addresses of the intervention group subjects were both in the same location, either in an office area (Group A) or in an empty room (Group B). For the Group A control group, the names and addresses were scrolled continuously on a computer screen, but there was no intention on the computer screen and there was no IIED in the vicinity of the computer broadcasting intentions. The results were measured using pre- and post-intervention indicators on the State-Trait Anxiety Inventory for Adults and the Zung Self-Rating Depression Scale. Both tests are self-report measures that are widely used to identify anxiety and depression. The State-Trait Anxiety Inventory for adults differentiates between state anxiety ("I am anxious now") and trait anxiety ("I am generally anxious"). Depression and anxiety have been shown to be precursors to disease, so that decreasing anxiety and depression may be assumed to decrease disease and/or increase health.

Hypothesis and Variable

The hypotheses for this study are contained in table 3:

Table 3. Hypotheses.

Hypothesis	Null Hypothesis
The intention will have a significant effect on anxiety and depression when broadcast in a conditioned space (Pilot Project, Groups A and B).	The intention will have a significant effect on anxiety and depression when scrolled on a computer screen in an unconditioned space without an IIED (Groups A and B only).

The variables for this study are contained in table 4:

Table 4. Variables.

Independent Variable	Dependent Variable
The independent variable for this study was the intention broadcast by an Intention Imprinted Electronic Device (IIED). Group A participants were randomly assigned to either the intervention group or the control group. Group B received the intention with no control group.	The dependent variables of the study were the state and trait anxiety scores on the State-Trait Anxiety Inventory for adults and the scores on the Zung Self-Rating Depression Scale. Baseline and post- intervention scores were collected for each group.

Subjects and Design

Interventions were conducted at one-month (pilot group), three-month (Group A), and eight-month (Group B) time intervals. Subjects who agreed to participate in each group were also offered the opportunity to participate in the next group. For example, those participants who completed participation in the pilot group, the one-month intervention, were also offered the opportunity to participate in Group A, the three-month intervention. Those who completed participation in Group A, the three-month intervention, were also offered the opportunity to participate in Group B, the eight-month intervention. Efficacy of the intervention was assessed using a mixed analysis of variance with one between groups and one within groups factor comparing the pre-and post-test scores on the State-Trait Anxiety Inventory for Adults (see Appendix D) and the Zung Self-Rating Scale for Depression (see Appendix E).

The study population consisted of volunteers from the medical practice of Roy Kerry, M.D., the chiropractic practice of Terry Cooper D.C., the emotional healing practice of Nancy Joy Hefron, and the medical intuition class of Lori Wilson, M.S.W. Dr. Kerry is an Ear, Nose and Throat Allergist and Facial Plastic Surgeon specializing in allergy and environmental medicine, who has been in practice in Greenville, PA., for 30 years. His practice consists of patients primarily with allergenic and environmental toxicities. Participants were solicited from among patients who had been to see Dr. Kerry at least once from September 1, 2002 to August 30, 2003. Dr. Cooper is a chiropractor specializing in sports medicine who has been in practice in Cedar Rapids, Iowa, for over 10 years. Study participants were solicited from

Dr. Cooper's active patient list in September, 2003. Nancy Joy Hefron has been an emotional healer for over 20 years; study participants were solicited from her newsletter mailing list in September, 2003. Lori Wilson has been teaching medical intuition as part of her Inner Access 101 series of classes for over 10 years, and students from her spring 2003 class were invited to join the study.

The inclusion, exclusion, and discontinuation criteria for participants are listed in table 5:

Table 5. Participant Criteria.

Inclusion Criteria	Exclusion Criteria	Discontinuation Criteria
Age range from 18 years and older. Willing to participate in study via signed consent Must be able to read English at a 6th grade level. Must complete both pre- and post-tests.	Under 18 No current address or unable to locate Unable to read or comprehend the pre- and post-tests Incomplete pre- or post-tests	A subject may decline participation at anytime during the study at his/her request

HIPAA Compliance

The federal privacy regulations for human subjects research in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) were implemented in part in April, 2003. The rules apply to health plans, health care clearinghouses, and certain health care providers, with respect to the rights of individuals who are the subjects of information-sharing, procedures for the exercise of those rights, and the authorized and required uses and disclosures of the information. HIPAA regulations are specifically designed to regulate the use and disclosure of subjects' Protected Health Information (PHI). Compliance with HIPAA was considered for this study, since the study was scheduled to commence after the final HIPAA regulations were to be implemented in October, 2003. This research study was conducted in compliance with all HIPPA regulations.

APPENDIX A: Pilot Project Intention Statement

To activate the consciousness of the system so as to create that required infrastructure which elevates the electromagnetic gauge symmetry state of the particular listed individual's home environment in the best possible way for that particular individual's soul purpose in this lifetime. This elevated EM gauge symmetry state is for the purpose of reducing all unnecessary stress precursors in the individual's life so that they might manifest optimal health and functioning at physical, emotional and mental levels in their daily life, consistent with their soul's primary purpose for this particular life experience. Individuals currently being treated for particular body system malfunctions will obtain treatment from various health care practitioners that become robustly efficacious in restoring them to optimal health status consistent with their soul's purpose.

APPENDIX B: Group A Intention Statement

To activate the indwelling consciousness of the Nunley Sonrisa Office for the specific purpose of projecting/stimulating healing to specific individuals located at various identified remote site locations. The primary purpose of this stimulation is to reduce all **unnecessary** stress precursors in the individual's life so that they might manifest optimal health and daily functioning at physical, emotional and mental levels, consistent with their soul's purpose for this particular lifetime experience.

APPENDIX C: Group A Intention Statement

To activate the indwelling consciousness of Norm Shealy's designated HOLOS laboratory space in Missouri in order to significantly raise the EM gauge symmetry state of that space. The special characteristic of this state is for the specific purpose of broadcasting, via specific intention-modulated magnetoelectric (ME) radiation, to specifically identified individuals located at various identified remote site locations that are continuously scrolled through, and displayed on the screen of, a computer located in the "conditioned" space. The primary intention-information of this broadcast is (a) to significantly reduce the periodicity, magnitude and duration of depression episodes that have heretofore occurred in the lives of these identified individuals and (b) to reduce all unnecessary stress precursors in the individual's life so that they might manifest optimal health and functioning at physical, emotional and mental levels in their daily life, consistent with their soul's primary purpose for this particular life experience.

Procedure (The Reed Thesis)

This double blind study used an Intentionally Imprinted Electrical Device (IIED) with a computer and one computer without an IIED to evaluate the impact of broadcast intentions on the health status of an adult population. The results were measured by pre- and post-intervention indicators on the Zung Self-Rating Depression Scale and the State- Trait Anxiety Inventory for adults. The IIED/computer and computer without the IIED were focused on randomly assigned individuals for one-month, three-month, and eight- month intervals. The time frames were as follows:

Pilot Group: June 15, 2003 to July 15, 2003.

Group A: November 1, 2003, to January 31, 2004.

Group B: May 17, 2004 to January 17, 2005.

Post-tests were mailed within one week of the end date of the intervention period. Participants completed and returned post-tests up to 6 weeks after the intervention ended.

The names and addresses of those in each intervention group along with that group's intention statement were on a password protected computer disk and scrolled continuously on a computer screen. The names and addresses of those in the control group were also on a password protected computer disk. Only the principal researcher, dissertation committee members assisting with the study, and research assistants had access to the passwords.

The Pilot Group and Group A were conducted at a lab in McLouth, Kansas previously used for IIED experiments on inanimate objects. The lab was at the home office of Dr. Robert Nunley, who was at that time on the dissertation committee. Dr. Nunley resigned from the committee effective March 28, 2004. The imprinted IIED has been on location in use in Kansas since December 31, 2002. The device was originally imprinted via Dr. Tiller's own imprinting process in December, 2002, and has been re- imprinted using the same process every three months since that time. Group B was conducted at a lab in Fair Grove, Missouri, at Holos University Graduate Seminary. The specific intentions (see Appendices A-C) for each group were imprinted into the IIEDs by four highly self-regulated people acting from a deep meditative state.[17] Following their work to imprint the intentions into an IIED, the device then became the host for the specific intention

directed at a specific target, acting as a surrogate for the people, in effect transferring the specific intention to the experimental site[18].

At the beginning of the intervention periods, (June 15, 2003, November 1, 2003, and May 17, 2004), the password protected names and addresses of all volunteers who consented to participate were randomly assigned to Condition One or Condition Two, placed on a computer disk and loaded on to either an imprinted IIED/computer with intention (Pilot Group, Group A, and Group B) or on to a computer with no intention and without an IIED (Pilot Group and Group A). These remained in place until the end of the intervention periods (July 15, 2003, January 31, 2004, and January 17, 2005). The intervention group demographics (names and addresses) and intention were scrolled on a computer screen in close proximity to the IIED for a period of one, three or eight months. The control group demographics were scrolled on a computer screen that was not in proximity to the IIED for a period of one or three months. The computer used for the control groups for the Pilot Project and Group A was approximately 375 miles away from the IIED.

The pre-test and post-test measures were completed 1 week prior to the study start date, and completed again 1 week after the study end date. The measurements used were the Zung Self-Rating Depression Scale published by GlaxcoWellcome (www.fpnotebook.com/PSY85.htm) and the State-Trait Anxiety Inventory for Adults published by Mind Garden (www.mindgarden.com). The test scores were statistically analyzed by multivariate analysis to measure differences (if any) between the pre- and post-test scores in aggregate. No individual analysis of variance was performed.

Post Intervention

After the study period, the control groups had the opportunity to receive the full intervention of an imprinted IIED/computer for one month (Pilot Group) or three months (Group A). Pilot Group controls received the intervention from September 15, 2003 to October 15, 2003. Group A controls received the intervention from May 17, 2004 to August 17, 2004. As a thank you for participation, all volunteers who completed both the pre- and post-tests received a cassette tape on relaxation by C. Norman Shealy, M.D. after the post-test was returned. After Group B, all participants received a two-page summary and a thank you letter.

Material, Apparatus, and Tests

The Intentionally Imprinted Electronic Devices are host devices consisting of a physical case, measuring 7 inches by 3 inches by 1 inch, which houses the electronics. The electric circuits are simple, involving only an EEPROM (Electrically Erasable Programmable Read Only Memory) component (not conventionally connected to the circuit), an oscillator component (1-10 MHz range), no intentional antenna, and a battery power supply.[19] The radiated electrical power of this device is less than 1 microwatt and they are generally placed 3-6 inches from the target subject, which, in this study, was the computer. There is no known risk when using this device.[19] This design utilizes the consciousness of specially trained individuals to imprint the specific device so that another dimension is added to the electron properties of the host device.[20]

The computers are host devices that will act as controls. The names and addresses of those in the intervention group along with the intention statement were on a password protected computer disk and scrolled continuously on one computer screen in one location, while the names and addresses of those selected randomly as controls were on a password protected computer disk and scrolled continuously on a computer screen in a different location. Two Gateway 233 computers were programmed to continuously scroll names and addresses. The computer used for the intervention also scrolled the intention at the beginning of the demographics, while the computer used for the control group did not have the intention. The computer scrolling the names and addresses of the control group (Pilot Group and Group A) was in an office in Cedar Rapids, Iowa while the intervention group IIED and computer were in an office in McLouth, Kansas, approximately 375 miles apart. The computer used for Group B (intervention only) was located at Holos University Graduate Seminary in Fair Grove, Missouri.

The names and addresses were in a program that ran under macro commands that booted up automatically, so that no names or other information were visible on the screen. In McLouth, Kansas, one of the study monitors, Dr. Robert Nunley, had access to the computer itself, up to the operating system level to make sure that it was restarted after a prolonged power outage. A green light would be displayed on the screen when the list that is being cycled through was running as it should and a red light displayed when it was not. Dr. Nunley monitored the computer daily and, when the red light came on, rebooted the system until the green light came on and stayed on. The computer had to be rebooted twice during the Group A intervention period. As an additional protection, all devices used at all locations

were locked in offices or rooms with limited access. As an additional unplanned design feature, Dr. Nunley read the names of all participants in Group A every morning to classical music, stating the name and the phrase “be well” after each name. The IIED and computer for Group B was in an empty room at Holos University Graduate Seminary in Fair Grove, Missouri, and was monitored by a research assistant at that facility in the same manner as the monitoring of the device for the previous intervention trials.

The data were analyzed to evaluate the hypothesis that intention broadcast from an IIED may improve health by decreasing anxiety and depression in human subjects. Efficacy was assessed by comparing the pre-and post-test scores on the State-Trait Anxiety Inventory for Adults and the Zung Self-Rating Scale for Depression. The statistician hired specifically for this study utilized multivariate analysis to calculate any differences pre- and post- for both the intervention and the control group to assess statistical significance.

Validity and Reliability of Measurements

The Zung Self-Rating Depression Scale (Zung) and the State-Trait Anxiety Inventory for Adults (STAI) were chosen for his study due to their demonstrated reliability and validity. Both instruments have been utilized extensively to measure anxiety and depression, and have widespread acceptance in both the research and medical community. They were also selected for their simplicity, user-friendliness, availability, and ease of scoring. Both measures are credible assessments of the impact of the IIED on anxiety and depression.

The order of testing materials was determined following the recommendations of Spielberger [21], who advises that the state anxiety test, or STAI Y-1, be administered first, followed by the STAI Y-2. This is done to avoid the emotional climate that may be established if the STAI Y-2 is administered first. In this study, the STAI Y-1 was the first page of the testing packet, the STAI Y-2 was second, and the Zung test for Depression was the third page of the testing packet.

The State-Trait Anxiety Inventory for Adults

The State-Trait Anxiety Inventory for adults (STAI) by Charles D. Spielberger is the most widely used self-report of anxiety in America today[21]. It assesses anxiety at a specific point in time and as a general personality trait. The STAI differentiates between the temporary condition of “state anxiety” (S-scale, or Y-1) and the more

general and long-standing condition of “trait anxiety” (T-scale, or Y-2). The two separate self-report scales consist of twenty questions each that evaluate how participants feel right now (state anxiety), and how they feel in general (trait anxiety). The essential qualities evaluated by the STAI Y-1 scale are feelings of apprehension, tension, nervousness, and worry. Scores on the STAI Y-1 scale increase in response to physical danger and psychological stress, and decrease as a result of relaxation training. On the STAI Y-2 scale, consistent with the trait anxiety construct, psychoneurotic and depressed patients generally have higher scores. The reliability and validity of the STAI has been well established over the past 3 decades.[22] The STAI test items were required to meet internal validity testing at each stage of development, and over the years concurrent, convergent, divergent, and construct validity have been demonstrated through thousands of research studies.[23] The alpha coefficients, a more meaningful measure of internal consistency than test-retest correlations, provide an index of reliability for both the S-scale and the T-scale. The median S-scale alpha coefficient was .92 for the subject group of working adults, students, and the military. For the same subject group, the T-scale median coefficient was .90.[22]

Appendix D: The State-Trait Anxiety Inventory for Adults

mind garden

SELF-EVALUATION QUESTIONNAIRE STAI Form Y-1

Please provide the following information:

Date_____ _____

DIRECTIONS:

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel *right* now, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	NOT AT ALL	SOMEWHAT	MODERATELY SO	VERY MUCH SO
1. I feel calm	1	2	3	4
2. I feel secure	1	2	3	4
3. I am tense	1	2	3	4
4. I feel strained	1	2	3	4
5. I feel at ease	1	2	3	4
6. I feel upset	1	2	3	4
7. I am presently worrying over possible misfortunes	1	2	3	4
8. I feel satisfied	1	2	3	4
9. I feel frightened	1	2	3	4
10. I feel comfortable	1	2	3	4
11. I feel self-confident	1	2	3	4
12. I feel nervous	1	2	3	4
13. I am jittery	1	2	3	4
14. I feel indecisive	1	2	3	4
15. I am relaxed	1	2	3	4
16. I feel content	1	2	3	4
17. I am worried	1	2	3	4
18. I feel confused	1	2	3	4
19. I feel steady	1	2	3	4
20. I feel pleasant	1	2	3	4

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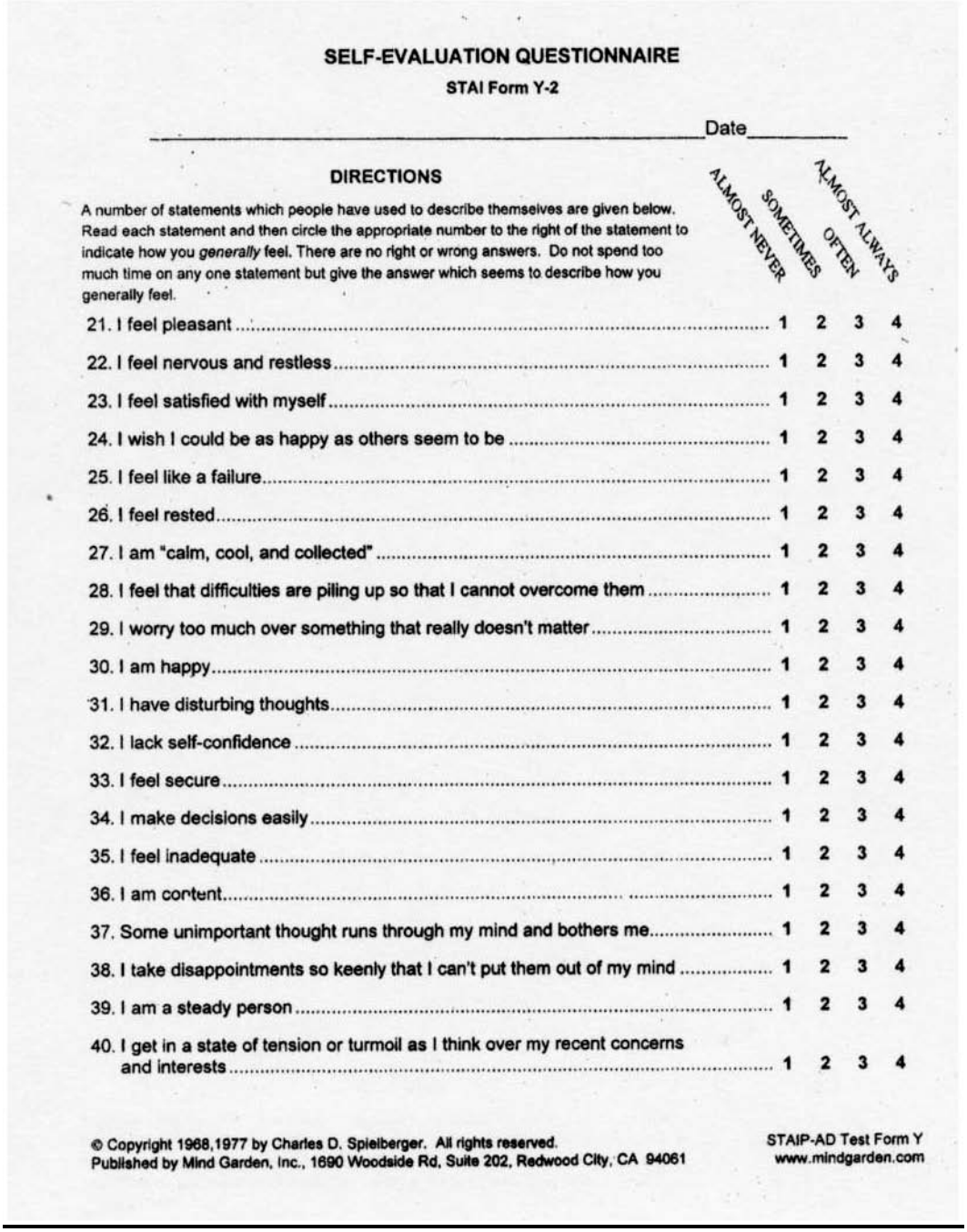
STAIP-AD Test Form Y
www.mindgarden.com



SELF-EVALUATION QUESTIONNAIRE

STAI Form Y-2

_____ Date_____

DIRECTIONS

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you *generally* feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

	ALMOST NEVER	SOMETIMES	OFTEN	ALMOST ALWAYS
21. I feel pleasant	1	2	3	4
22. I feel nervous and restless	1	2	3	4
23. I feel satisfied with myself	1	2	3	4
24. I wish I could be as happy as others seem to be	1	2	3	4
25. I feel like a failure	1	2	3	4
26. I feel rested	1	2	3	4
27. I am "calm, cool, and collected"	1	2	3	4
28. I feel that difficulties are piling up so that I cannot overcome them	1	2	3	4
29. I worry too much over something that really doesn't matter	1	2	3	4
30. I am happy	1	2	3	4
31. I have disturbing thoughts	1	2	3	4
32. I lack self-confidence	1	2	3	4
33. I feel secure	1	2	3	4
34. I make decisions easily	1	2	3	4
35. I feel inadequate	1	2	3	4
36. I am content	1	2	3	4
37. Some unimportant thought runs through my mind and bothers me	1	2	3	4
38. I take disappointments so keenly that I can't put them out of my mind	1	2	3	4
39. I am a steady person	1	2	3	4
40. I get in a state of tension or turmoil as I think over my recent concerns and interests	1	2	3	4

STAIP-AD Test Form Y
www.mindgarden.com

The Zung Self Rating Depression Scale

The Zung Self-Rating Depression Scale (Zung) is one of the most widely used adult depression screening instruments and is recognized by physicians and clinicians worldwide. About 82% of persons with scores on the Zung of 55 or more have major depression, as defined by the DSM IV criteria. The Zung was designed to screen depression

and mood, but is also used as a tool to track a client's progress in therapy over time. The Zung is short and simple, quantitative rather than qualitative, and is self- administered. The Zung includes 20 items that reflect the following diagnostic criteria: pervasive affect, physiological equivalents or concomitants, and psychological concomitants. Ten of the items are worded symptomatically positive, and ten are worded symptomatically negative.[23] The Zung correlated well (0.69) with the treating physician's global rating in 26 depressed outpatients in other studies.[24] The Zung Scale had the highest positive predictive value (93%) with regard to internal consistency and sensitivity. Predictive comparisons were made between the overall scores on the Beck Depression Scale, Hamilton Scale of Depression, Zung and a visual analogue rating scale in a group of depressed patients initially and at one, two and three weeks. Significant correlations between the global scores were found on these depression scales.[25]

These two instruments, the Zung Self-Rating Depression Scale (Zung) and the State-Trait Anxiety Inventory for Adults (STAI) were selected for this study due to their demonstrated reliability and validity, their widespread acceptance in both the research and medical community, their user-friendliness, and their availability as well as ease of scoring. Both measures served as useful tools in assessing the impact of the IIED on anxiety and depression.

Appendix E: The Zung Self-Rating Depression Scale

ZUNG SELF-RATING DEPRESSION SCALE

Patient's Initials

Date of Assessment

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

Make check mark (✓) in appropriate column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

Adapted from Zung, A self-rating depression scale, *Arch Gen Psychiatry*, 1965;12:63-70.

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SUMMARY OF RESULTS (The Reed Thesis)

The most significant findings of this study were the differences in the pre and post-test scores on the state anxiety (STAI Y-1), trait anxiety (STAI Y-2) and depression (Zung) scores. A marginally significant result occurred after three months of intervention between

the groups, and could be argued that it in fact is significant for this new line of research. Table 28 below summarizes the results and their significance levels:

Table 6. Significant Results for all Groups.

	Between Groups	Tests within Subjects Pre to Post-test		
	STAI Y-1	STAI Y-1	STAI Y-2	Zung
Group A	.089	.001	.000	.009
Group B	NA	.001	.000	.003
8 Month Intervention	NA	.003	.000	.001
11 month Intervention	NA	.003	.000	.001

After three months, and continuing with eight to eleven and twelve months of intervention, all groups experienced a significant decrease in state and trait anxiety, as well as depression, when comparing the pre-test scores to the post test scores.

DISCUSSION (The Reed Thesis)

Benor defines Type I distant healing as the projection of healing solely through the efforts of the mind from the healer to the healee.[26]

This research tested whether or not the efforts of the minds of experienced meditators who imprinted a healing intention onto an electronic device could have an impact on anxiety and depression in an adult population. The results achieved in this research support the results achieved in Tillers' other studies, all demonstrating that:

> ...the functioning existence of a device (Type 1) that acts as a "source" to (1) lift the EM gauge symmetry state (inner symmetry state) of a macroscopic space significantly above our normal U(1) level...and (2) tune or program that space to be highly responsive towards the fulfillment of the specific intention statement programmed into that Type 1 device from a deep meditative state by ...well-qualified meditators.[27]

Functioning at the vacuum level of physical reality, this new type of information carrier wave appears to be “modulatable by human intention...seemingly independent of distance and perhaps also of time”.[27] This study demonstrates that an intention to decrease anxiety and depression broadcast from an IIED can impact human target subjects, decreasing depression to the point where the likelihood of the result occurring by chance is less than 1 in 100, and decreasing anxiety to the point where the likelihood of the result occurring by chance is less than 1 in 1000.

Other efforts to measure the impact of distant healing or healing intention have focused on healers intending healing intermittently over different periods of time, such as once a day for a month.[28,29] In this study the intention was broadcast continually for one, three, or eight months. Some participants were in multiple groups, thereby receiving a total of eight, eleven or twelve months of broadcast intention. The most significant findings of this study were the differences between the pre- and post-test scores on the state anxiety (STAI Y-1), trait anxiety (STAI Y-2) and depression (Zung) scores for all intervention groups, whereas mean scores for the Group A control subjects did not change significantly between pre-test and post-test. For Group A (the three-month intervention), a marginally significant decrease, less than one chance in ten of occurring by chance, was found for the intervention subjects in comparison to the Group A controls. For Group B, the differences between the pre-test scores and the post-test scores were statistically significant, with decreases in state anxiety and depression occurring by chance less than 1 in 100, and decreases in trait anxiety occurring by chance less than 1 in 1000. This study suggests that broadcast intention from an IIED reduces anxiety and depression after at least three months when broadcast in a conditioned space.

The hypothesis was found to be true in this study, while the null hypothesis was not found to be true. The null hypothesis states, “The intention will have no significant effect on anxiety and depression when scrolled on a computer screen in a unconditioned space without an IIED”. This speaks to the fact that there was no significant change from the pre-test to the post-test in the control groups in Group A. The results show that in fact there was no significant change in the control group whose names were scrolled on a computer without the intention and without broadcasting the intention from an IIED.

I believe that the results were achieved because the intention is a frequency of energy information that is inserted into what can be called “the field”. This information then causes a perturbation in the system of the individual, allowing for a re-organization of the system at a higher level, decreasing anxiety and depression. The control

groups did not have the information inserted into the field, thus as a group their systems were not perturbed and they had no significant change from their baseline level of anxiety and depression. Previous studies have utilized intermittent insertion of information via healers sending healing intention with varying results. The consistency of the broadcast frequency is very likely the key factor that achieves the results obtained in this study.

The hypothesis states, “The intention will have a significant effect on anxiety and depression when broadcast in a conditioned space”. This was true for Group A, where anxiety was marginally significantly decreased, and Group B over time, in which anxiety and depression were significantly decreased. Due to the design of the research, and the fact that one half of the Group B participants had already received 3 months of intention, group results between Group A and B were not in and of themselves found to be significant. However, when participants were evaluated prior to any intervention to post Group B intervention, there was found to be significant results.

This study brings us information about the efficacy of a consistently broadcast intention, the time necessary for a change to take place, as well it addresses the question of whether or not distance between healing intention and the recipient is an impacting factor. In addition, we also gather information about the level of participation required of those who are receiving the healing intention.

In every research study there is the possibility of “experimenter effect”, whereby the intention of the experimenter for a certain outcome, positive or negative, influences the results enough to skew them in one direction or another.[30] In the present case, the principal investigator had personally hoped for a positive outcome, but did not specifically meditate on the outcome, pray for the outcome, nor consciously intend that the outcome be one way or another. Early in the study, the investigator became aware of a premise put forth by David Eichler that “every thought is a prayer” (Personal communication, April 22, 2003), and so attempted to keep thoughts about the outcome to a minimum. The study design facilitated this because, during the intervention period, the principal investigator was not directly involved with the groups, the interventions, or the study itself. Although the impact that the investigator’s thoughts may have had on the study outcomes cannot be totally discounted, it is believed to have been minimal. Others involved with this study may have also hoped for a positive outcome, however, the impact of their thoughts cannot be assessed.

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