

# Polarity Therapy

## Background/Definition

Based in an energetic model, Polarity Therapy (PT) involves a holistic framework of healing that includes an attention to lifestyle choices (i.e. diet and exercise) as well as bodywork techniques administered by a practitioner (Gale Encyclopedia of Medicine, 2011). PT practitioners aim to release blockages of life energy and to restore balance and reinvigorate the flow of this energy within the human body, the process of which purports to bring about relaxation, healing and overall well-being (Roscoe, Matteson, et al. 2005).

Developed in 1947 by Dr. Randolph Stone, an Austrian-American osteopath, chiropractor and naturopath, PT represents an integration of Eastern and Western theories and healing techniques. Stone studied reflexology and Traditional Chinese Medicine, and became well-versed in Ayurvedic medicine which had a particularly strong influence on his development of PT (Gale Encyclopedia of Medicine, 2011).

Stone was the first to teach PT, starting in the 1960s, and in 1984 a group of practitioners created the American Polarity Therapy Association (APTA). Training and certification standards were developed with a two-tiered system distinguishing between Associate Polarity Practitioners (155 training hours) and Registered Polarity Practitioners (675 training hours). As of 2010, 900 PT practitioners were members of the APTA (Mustian, Roscoe, et al. 2011).

## Theory

According to Roscoe, Matteson, et al. (2005) there are three assumptions that lay the groundwork for many energy-based healing modalities, including PT. These are: 1) illness arises when the flow of energy in the body becomes disrupted since this interrupts the homeostasis of the body, 2) the body is capable of self-healing and 3) facilitating healing can be achieved by subtle manipulation of a patient's energy fields and bodily energy flow (life force).

Mustian, Roscoe, et al. (2011) identify five principles more specifically fundamental to PT theory: 1) an all-pervading energy in the universe exists, 2) this energy is present and flows through the human body, 3) this energy acts like a magnet because as it flows it does so between poles (positive and negative being top/bottom or left/right) and attracts and repels, 4) a healthy body means that the energy has stabilized and is flowing without hindrance, 5) and

lastly, to quote directly, “the human body possesses a ‘wireless anatomy’ operating at specific frequencies, identified as air, water, fire, and earth. Energy is postulated to step down through this ‘wireless anatomy’ via auras (energy fields in immediate proximity to the body) to chakras (core body energy centers aligned with the spinal column), and from chakras into the physical realm through nerves, muscles, bones, and fascia.”

It is also understood that stress interrupts the natural flow of this energy, causing illness and other ailments such as nausea or fatigue. Also fundamental to PT is the belief that the energy associated with the human body has a basis in electromagnetic energy (Gale Encyclopedia of Medicine, 2011).

## **Procedure**

The process of PT involves work by both the practitioner and the patient. According to Ballou (2008), one of the roles of a trained practitioner is to perform bodily manipulations which facilitate the flow of energy in the body of the patient. This technique involves subtle touching of a patient’s body at specific locations to assess levels of discomfort and/or sensitivity, and can be divided into three categories of touch which are based in Ayurvedic literature: sattvic (gentle, relaxing, energy balancing), rajasic (releases tension, stimulates energy flow) and tamasic (firm, helps to remove blockages).

Korn, Logsdon, et al. (2009) describe how this bodywork process should be performed to “polarize” and therefore balance the energy. A practitioner does this by locating soft tissue pressure points and applying physical pressure to those areas while applying concurrent manual pressure to opposing locations (i.e. left hand on forehead, right hand on abdomen).

According to Mustian, Roscoe, et al. (2011) a practitioner also uses specific hand positions to “examine energy flow, discover trigger points (energy impediments), and restore homeostatic energy flow.” This could include covering a patient’s ears with one hand on each or doing the same with the soles of the feet, and identifying potential trigger points marked by any sense of discomfort (i.e. tenderness, coolness, tightness). This is detected by the practitioner and/or expressed by the patient as pressure is applied gently to each area. Contact is maintained to relieve any discomfort felt.

The founder of Polarity Therapy, Dr. Stone, also developed Polarity Yoga (PY) – performed by the patient – to complement the process of relaxation, energy balance and flow within the body. Through daily practice, PY helps release bodily tension and gives patients an effective,

active pathway to take responsibility (an important aspect of PT) for their own health (Ballou, 2008).

Another component of PT is the cultivation of a mindful relationship towards food consumption. Since Ayurvedic philosophy played a large role in the development of PT's health framework, foods are associated with the five elements (earth, air, fire, water, ether) and the bodily relationship to those elements. It is believed that disease can arise partly as the result of inappropriate combinations of food and/or a generally poor diet, thus a PT practitioner aids patients in choosing a diet that is appropriate for them (Ballou, 2008).

## **Review**

Very few studies investigating the efficacy (or the mechanism) of Polarity Therapy exist. Those that have been conducted have produced some promising data, although it is often reported on with warranted caution given the preliminary/pilot nature of the studies (i.e. small sample sizes, lack of control group, etc.). Most authors do suggest that their data warrants future research of PT as a healing modality.

The research for one doctoral dissertation explored the potential of using PT as complementary approach for the treatment of bulimia nervosa (Ballou, 2008). Conclusions drawn from this investigation included: 1) PT could be beneficial as a treatment since it is likely to increase self-love, improve body image, and deepen a connection and awareness of one's body. The author also concluded that complementing PT with psychotherapy would be ideal, especially since the former may bring out more intensified emotions with which the latter would be more effective at addressing. PT is also distinguished as a useful alternative for culturally diverse populations since bodywork requires no verbal communication, thus a practitioner and patient do not need to speak the same language.

The author notes that the research was conducted with a very small number of PT practitioners (five were interviewed) in the United States so the results remain speculative. Suggestions for future research include conducting long-term studies on PT's effectiveness for bulimia nervosa, collecting and analyzing data on patient reporting after participating in treatment, and focusing on PT treatment for cultural minorities.

A pilot study by Roscoe, Matteson, et al. (2005) examined Polarity Therapy's potential effectiveness in ameliorating cancer-related fatigue (CRF) and improving health-related quality of life (HRQL) for women undergoing radiation treatment for breast cancer. Participants were

divided into three groups, one which received no PT treatment, another which received treatment after Week 1, and a third which received treatment after Week's 1 and 2.

The authors reported that 80% of the women receiving PT showed a significant decrease in CRF after Week 1, while 80% of those who received no treatment showed an increase in CRF. There was also a statistically significant difference between the groups at the week 2 assessment, which the authors suggest points to the "plausibility of a dose response concerning PT."

With regard to HRQL, the patients at the Week 1 assessment reported an overall statistically significant improvement compared to the non-treatment condition. The week 2 assessment did not show a statistically significant difference, although the authors assert the sustained improvement in the treatment group as compared to the control was enough to "provide preliminary evidence of a dose response."

Limitations of this study include: 1) a homogenous and very small sample, 2) the use of patients with an interest/affinity for alternative therapies which makes it more difficult to generalize the results to a population that is less open to such modalities, 3) therapy given by only one practitioner which, while a good control for variability, doesn't control for "provider-patient interaction," and 4) the lack of blinding or placebo control leave the data open to experimenter bias, expectancy effects and/or nonspecific treatment effects.

The authors conclude that the data from this preliminary study (which was an attempt to attain feasibility data to prepare for a larger similar study) are still strong enough to warrant future research on PT as a noninvasive, non-pharmacological intervention for CRF. They emphasize that such research should address the limitations noted above as well as other factors such as potential environmental issues (i.e. investigating how PT treatment efficacy differs when performed in a patient's home), specific dose-response levels and cost-benefit analyses.

In a later study, Mustian, Roscoe, et al. (2011) also investigated PT's effectiveness for CRF (and also assessed HRQL) in a randomized controlled pilot study with women receiving radiation treatment for breast cancer. In contrast to the previous study, this protocol used a three week intervention for all groups with massage as an active control, standard care as a passive control and PT as the experimental condition.

Data from the primary measure used for assessing CRF, the Brief Fatigue Inventory, yielded a small effect size compared to standard care, while the secondary measure for CRF (daily CRF diaries) showed a much larger effect size. Little difference was reported between the modified

massage condition and PT in the effect on HRQL (the authors report a “medium” effect size for this measure in both conditions).

The following is offered as a possible explanation for the large effect size difference in the CRF measures:

“We think the daily diary measure showed a larger effect size because of its greater ability to detect daily fluctuations in fatigue that are common in patients undergoing cancer treatments. Jacobsen et al speak to this point in their systematic review and meta- analysis of psychological and activity-based interventions for CRF. They note that CRF can fluctuate considerably over short periods of time in patients undergoing chemotherapy or radiotherapy and suggest that daily or shorter assessments may be more appropriate for capturing variability in CRF. Frequent assessment of other psychological (e.g., depression) or physiological constructs (e.g., temperature) is known to increase the reliability of the measured variable.”

Noted limitations to this study include the possibility that the positive results are the product of report bias by the patients or any number of nonspecific variables due to lack of blinding (they acknowledge that their control group limits this possibility but doesn’t erase it). Overall, the authors encourage interpreting the data cautiously and that the overall findings from this study and others (e.g., Korn et al. 2009) do not show enough empirical strength to recommend treating CRF with PT “other than in a research setting.” Further investigation is suggested in which larger sample sizes are used and which focus on determining which characteristics of fatigue (i.e. somatic, psychological, etc.) are most effectively treated by PT.

In another of the few existing published studies, investigators didn’t attempt to discern a specific healing effect, and instead focused on determining whether performing PT had a measurable effect on gamma radiation in the electromagnetic field surrounding a patient’s body (Benford, Talnagi, et al. 1999). Using a gamma radiation detector baselines at four anatomical positions were established (as well as an averaged baseline measure of the room to control for natural fluctuations in the experimental space). Three “treatment” groups were used to attempt to induce changes: PT sessions with a trained practitioner, sham sessions (a person with no energy therapy training) and “standing-observer” sessions. The authors reported decreases in gamma counts for all subjects at every anatomical location during therapy, including in the sham sessions. They noted that the decrease was markedly more during PT as compared to the other two groups.

Sham therapy showed more decrease than “standing-observer” sessions, suggesting that the former may have a small effect regardless of energy therapy training.

Overall, the authors assert that the data suggest further study is warranted and should also include other energy healing modalities (e.g., Reiki) and a more extensive patient group (including those with diseases which can be targeted for healing). In addition, they recommend that future studies include measures of blood count (e.g., peripheral lymphocytes) in order to detect any potential biological immune response as a result of the therapy.

The last study examined in this review of PT research was born out of an attempt to address general methodological difficulties in biofield research—particularly how to maintain the holistic nature of many biofield therapies within a rigorous research model. Korn and Ryser (2007) wrote a paper discussing these difficulties and offer a PT-based protocol that aims at defining an improved experimental design. This particular protocol serves to test the efficacy of an intervention for the reduction of stress in American Indian family caregivers of patients with dementia. Overall, they aim to “maximize efficacy and cultural congruency, adhering to the integrity of the holism, while addressing challenges arising from randomized controlled trial methods.”

Korn, Logsdon, et al. (2009) conducted a study utilizing the design themes discussed in the above protocol, specifically comparing PT with an “enhanced respite control condition” (ERC) amongst American Indian and Alaskan Native family caregivers of individuals with dementia. Forty-two participants (38 were used in the final statistical analysis) were randomized into the two groups, each consisting of an 8-session trial. Baseline and post-treatment measures included: caregiver perceived stress, depression, quality of life, sleep quality, worry, and physical health.

Perceived stress was the primary outcome variable and, in addition to the measures for depression and pain, these data showed a statistically significant reduction in the PT treatment group as compared to the ERC group. Ultimately, the authors state that the data gathered in this study suggests that “PT is an effective CAM for reducing stress (and thereby potentially improving health and well-being) of American Indian family caregivers.”

In order to try to establish a protocol that honored the holistic nature of PT treatment, both the PT and ERC control conditions experienced levels of sustained and repeated social contact during the session time. ERC individuals participated in activities such as yoga, a basket-making circle, music therapy, etc. This helped to equalize the conditions although, as noted by the authors, weekly contact with a PT practitioner could contribute to deeper levels and feeling of empathy and care than those experienced by the ERC group. They suggest future studies which further mitigate confounding variables amongst control and treatment conditions.

## References

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