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1985

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AN INTERPRETIVE STUDY
OF NURSES' PRACTICE OF THERAPEUTIC TOUCH

by

Harriett Jacqueline Lionberger

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF NURSING SCIENCE

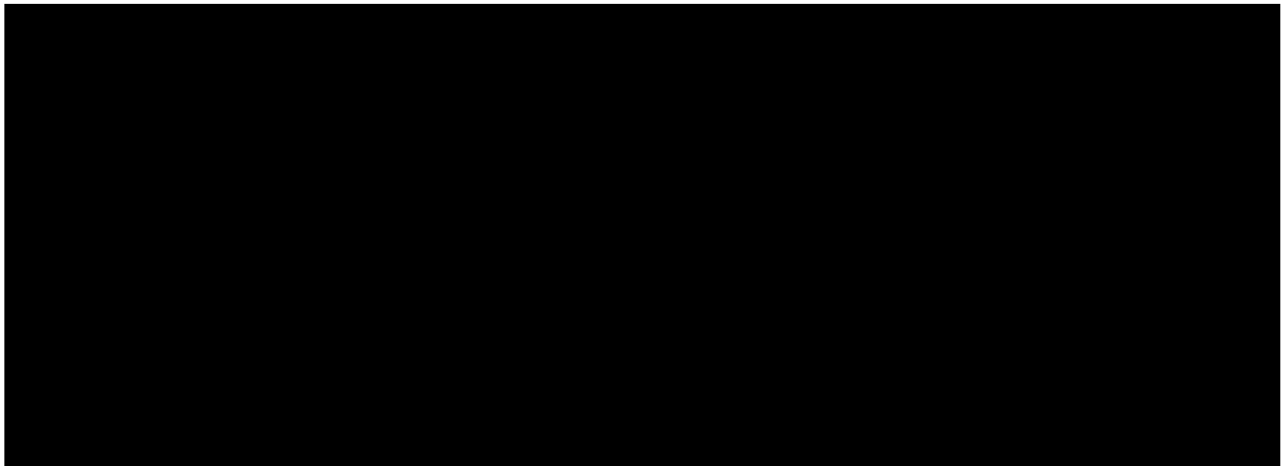
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Acknowledgments

I wish to thank my committee chairperson, Sandra Weiss, for guiding me through the dissertation process. She was a consistent source of advice and encouragement, supporting my interest in an unconventional topic. Her expertise in my broader area of concern -- the implications of touch for nursing care -- was of great value to me. Patricia Benner provided both the interpretive method for this study and a new perspective on the relationship of philosophy, and particularly phenomenology, to nursing. Beverly Hall supplied much needed support in the early stages of this work, as well as scholarly evaluation of its progress. To all of my committee members I owe an unending debt of gratitude. To the UCSF School of Nursing I extend thanks for bringing the four of us together.

Particular gratitude is also due to those who read various drafts of the dissertation, supplying consensual validation and suggestions for clarification. They included Kit Chesla, Marsha Cohen, Mary Hartfield, Erna Schilder, and Colleen Stainton, who read early sections; and Jeanne Bonadonna, Inge Corless, and Barbara Cobb McMahan, whose later readings helped to bring closure to the project.

Others provided support in a variety of ways. Special thanks go to study participants who gave their time and thoughtful input. Data collection was facilitated immeasurably by key persons who provided meeting places and social support in out of town areas. These included Norma and Steve Bonadonna in New York, LaVaughn Wilson, Harriett Savage, and Elaine and Jerold Lionberger in the Portland area, and Marie Jenkins in Sacramento. My UCSF doctoral program colleagues and

the San Francisco Bay Area therapeutic touch support groups filled this need at home.

Finally, I would like to express my appreciation for the continuing encouragement and support of my husband, Carl Lionberger, who supplied a link to life beyond the dissertation, and to Dolores Krieger for responding patiently to my questions preceding this study and during its process.

ABSTRACT

An Interpretive Study
of Nurses' Practice of Therapeutic Touch

Harriett Jacqueline Lionberger

This phenomenological study sought to identify the practices, beliefs, and intents associated with nurses' use of therapeutic touch, a clinical modality designed to strengthen the patient's natural healing capacity. Similarities and dissimilarities to usual nursing care, and characteristics of the practice associated with effective outcomes, were examined.

The investigator interviewed 51 registered nurses who had practiced therapeutic touch for at least six months, and 20 patients who had been treated at least once, to obtain descriptions of their experiences with the practice. Open ended questions were used in the audio tape recorded interviews to obtain data. Interpretation of the transcribed interviews involved three levels; (1) description of participants' stated interpretations, (2) identification of common meanings across participants, and (3) examination of implications arising from participant interpretations and common meanings.

Results indicated that participants practiced therapeutic touch in ways substantially different from the original approach proposed by its founder, Dr. Dolores Krieger. Of Krieger's proposed phases of therapeutic touch (centering, assessment, and treatment), only centering was consistently described in nurses' accounts of effective practice. The data suggested that centering and intent were the most critical features of the practice. Centering involved four distinct

characteristics: (1) disciplining attention, (2) achieving a calm relaxed state, (3) establishing receptivity, and (4) becoming a channel for the energy of healing. Nurses described intent to: (1) help, (2) promote wholeness or wellness, (3) relieve symptoms, and (4) potentiate patients' psychophysiological resources.

Caring aspects of the practice were found to be similar to, though more focused than, those associated with usual nursing care. Belief in energy exchange as underlying effectiveness of the practice was in contrast with usual nursing care, although it helped nurses to conceptualize and communicate caring and compassion. Interpersonal attraction, social learning, and stress and coping were discussed as examples of existing theories which, as components of an integrated theoretical model, might serve nursing better than that of energy exchange for understanding and explaining the characteristics of therapeutic touch.

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CHAPTER 1

The Study Problem

Therapeutic touch was first described in the literature by Krieger in 1975, and has since been incorporated into the practice of growing numbers of nurses nationwide. Close to 200 nurses annually attend therapeutic touch workshops led by Krieger, and in turn her students provide workshops for others in their communities, universities, and places of work. Consequently, therapeutic touch is gaining in use as a nursing intervention for providing comfort and healing for clients.

Therapeutic touch is a method of "using the hands to direct human energies to help or heal someone who is ill" (Krieger, 1979, p. 1). According to Krieger, it involves four phases:

1. Centering oneself physically and psychologically; that is, finding within oneself an inner calm focus of attention;
2. Using the tactile sensitivity of the hands to assess the energy field of the client for cues to differences in the quality of energy flow in various parts of the body;
3. Mobilizing areas in the client's energy field that the nurse may perceive as sluggish, congested, or static; that is, lacking in effective energy flow; and
4. Consciously influencing body energy through the use of the hands, to assist the client to repattern his or her own energy.

Therapeutic touch has been accepted readily by many practicing nurses. Yet, therapeutic touch involves certain theoretical and practical components which are unfamiliar to most nurses. The theoretical emphasis is on energy as the basic unit of man, and energy

fields as the focus of interaction. While this emphasis on energy is firmly based in Rogers' (1970) nursing theory, the theory itself is not well understood nor utilized, even in academic circles, and is as yet unknown to large numbers of practicing nurses.

Similarly, while the holistic tone of therapeutic touch and of the theory with which it is associated represents an emergent direction in nursing, the assumptions on which the concept of holism is based are unfamiliar to many nurses. Of particular interest here is the role intuition and expanded sensory awareness may play in the caring aspect of nursing. Such considerations are inseparable from the study and practice of therapeutic touch.

In addition, the use of the hands to perceive qualities of and changes in energy fields is not common to nursing practice. While touch is commonly understood to involve body contact, in therapeutic touch the hands are used -- and perceptions attained -- within an area a few inches from the body. For the newcomer to the technique, this represents a substantial shift, particularly if the theoretical explanation is unfamiliar. Too, the act of centering as one component of therapeutic touch represents a focus of attention that is different from that usually practiced in nursing. Yet, in spite of the complex interplay of factors influencing therapeutic touch, and a lack of full understanding of its meaning, use of the technique continues to increase.

Statement of the Problem

While studies are demonstrating positive effects of therapeutic touch on anxiety levels and physiological parameters (Heidt, 1980b; Krieger, 1975; Krieger, Peper & Ancoli, 1979; Quinn, 1982), more

critical research is needed to understand the actual nature of the intervention. Specifically, research must begin to identify the characteristics of therapeutic touch which represent a common definition of the technique. Such a definition would reflect current practices, and add to existing information which focuses on a more theoretical description of therapeutic touch. Increased knowledge regarding those factors which are most often associated with perceived effectiveness of the technique is also needed.

Further, nurses' descriptions of their therapeutic touch practice suggest that it enhances usual nursing care (Macrae, 1979; Quinn, 1979). There remains the question, however, of how the practice may add to or detract from nursing care, and how it may simply express already existent elements of nursing care.

Purpose of the Study

The purpose of the study is to identify shared interpretations of the practice of therapeutic touch as well as those factors which are associated with perceived effectiveness of the technique. The findings are expected to add a fresh dimension to knowledge developed in previous research, which has focused on relationships between use of therapeutic touch and certain outcomes (e.g., reduced anxiety or physiological changes), on how the hands are used, or on descriptions of nurse and patient characteristics which influence the process (Beck & Peper, 1981; Heidt, 1980b; Krieger, 1975; Krieger, Peper & Ancoli, 1979; Quinn, 1982; Randolph, 1980a). This study describes the perceptions and experiences of users to identify elusive aspects of the technique. It explicates and illustrates shared practices and meanings, and interprets them in terms of common meanings in nursing.

Recurrent patterns of practice associated with the technique, as well as the nature of the intents and meanings experienced in the process by the nurse and the client, are identified.

Significance

Individual nurses in growing numbers are adopting a variety of touch modalities into their practice. Two factors seem to underlie this trend. First, touch has long been recognized as inherent in nursing. Second, the emergence of holistic principles in the broader health care arena in recent years has provided a measure of tolerance for alternative approaches.

At the same time, nursing is assuming increased responsibility for its practice. Therefore, it is important to address issues concerning use of new modalities, in order to monitor emerging practices. As a result of the esoteric language with which therapeutic touch is sometimes described, its proponents and critics alike stand in need of a more complete description of the technique. Extant research, which is primarily experimental and focused on effects of therapeutic touch, does not clarify how it works. This study contributes to nursing knowledge by identifying patterns of practice associated with its effective use, as well as associated beliefs and intents. It also examines how this practice is perceived by practitioners to contribute to or contrast with their usual nursing care.

CHAPTER 2

Literature Review and Interpretive Framework

Literature Review

Therapeutic touch was developed in the early 1970s by Dolores Krieger, a professor of nursing at New York University (NYU). She first used the term "therapeutic touch" in 1974 to describe the technique, which was derived from earlier studies of the use of laying-on of hands by a gifted healer (Krieger, 1973, 1975, 1979). A brief description of this early research provides background regarding the impetus for the current trend in therapeutic touch studies, and a foundation for the thought behind the present work. Relevant research from the general literature on physical touch follows review of current therapeutic touch research.

Laying-on of Hands

The early laying-on of hands experiments were done by Grad, Smith, and Krieger. Grad (1963, 1967), a biochemist, and Smith (1973), a biochemist and enzymologist, used non-human subjects. Thus, they were able to minimize the effects of suggestion. Krieger used human subjects, to further develop a line of inquiry that would later be used with nurses as therapists.

Mice as subjects. Two studies looked at wound healing in mice (Grad, 1965). Identical wounds were made on the backs of all mice before their assignment to treatment and control groups. In the first experiment, three groups of 16 mice each were used. Group 1 was treated by Estebany, a gifted healer. The cage holding all animals in the group was held between his hands for 15 minutes twice daily for two weeks. His hands did not touch the mice. No attempt was made to

identify or describe the intent, thoughts, or feelings experienced by Estebany during the treatment.

In groups 2 and 3, the mice were placed in cages identical to the one used for group 1. Group 2 did not receive treatment. Group 3 mice were heated to exactly the same degree as group 1, to control for the effect of heat generated during the laying-on of hands.

Wound size was measured one, 11, and 14 days after wounding. The wounds of group 1 were significantly smaller than those of groups 2 and 3, 11 and 14 days after treatment began. This experiment was repeated with similar results.

Following these experiments Grad, Cadoret, and Paul (1961) carried out a study of three groups of 100 mice. Group 1 was treated by Estebany, Group 2 was treated by persons claiming no healing ability. Group 3 was not treated. All wounding and measurements were done by persons blind to which groups the mice were in. Again, group 1 wounds healed significantly faster than those in groups 2 and 3.

Plants as subjects. Grad's next series of experiments looked for effects of laying-on of hands on plant growth (Grad, 1963). Several replications of a study of the germination and growth rates of barley seeds were done. Each utilized experimental and control groups of twelve pots of 20 barley seeds each. Three outcome measures were made: the number of sprouted plants per pot, the mean height of plants per pot, and the yield -- the sum of the heights of all plants per pot.

To simulate a sick condition, the seeds were first irrigated with saline. Subsequently, all pots were handled identically in regard to watering, lighting, temperature, etc. The experimental treatment in all cases took the form of variations in handling of the saline used

for the initial irrigations. In the first experiment, group 1 was irrigated with a solution which had been held in open beakers by Estebany during the laying-on of hands. Group 2 was irrigated with untreated saline. Group 1 barley seeds sprouted earlier, grew faster, and yielded more plant material than did those in group 2. A second experiment in which neither group received laying-on of hands by Estebany produced no significant differences in any of these measures.

Four subsequent replications of the barley seed experiment introduced additional means of control (Grad, 1964). Closed and sealed beakers were used for the saline treatments. More people were used to improve the double-blind procedure, and both control and treatment saline flasks were enclosed in brown paper bags. In two of the experiments, Estebany held the treatment beakers between his hands, and in two he held only his right hand on the flask. This series of studies yielded findings consistent with those of the previous experiment. There was a statistically significant effect on plant growth.

In none of the barley seed experiments were Estebany's intent or other than observable activities considered. The healing effect was attributed to hypothetical energy activity. The nature of the energy was not defined beyond its capability to penetrate glass. Because of this property, electromagnetic energy was suggested as a possibility (Grad, 1965). Grad noted that the studies of wound healing and of barley seed growth did not indicate whether the effects could be attributed to Estebany's use of his hands, other parts of his body, his mind, or his body as a whole (1963).

Next, Grad examined the effects of laying-on of hands by persons other than Estebany. He compared the effect of watering with saline held by a psychiatrically normal man in an energetic, confident mood, but not claiming to be a healer, with the effect of watering with saline held by persons with depressive illness or not held by anyone (Grad, 1967). Significant differences were found in the number of plants in the pots on two of the nine measurement days, with pots watered with saline treated by the psychiatrically normal man producing a greater number of plants at all nine measurements. This study supported the idea of examining the healing skills of persons other than gifted healers. Also, it indicated that factors influencing the mood of the therapist may be important to therapeutic touch.

Enzymes as subjects. Sr. Justa Smith reasoned that if a healing force was channelled through Estebany's hands, it should have some effect on enzyme activity, since "enzyme failure is the ultimate physical cause of disease" (Smith, 1973). Her first study involved a solution of trypsin divided into four portions. The first was kept untreated as a control. The second was treated by Estebany by putting his hands around the stoppered flask. The third was exposed to ultraviolet light of the wavelength most damaging to protein, and then treated by Estebany. The fourth was exposed to a high magnetic field, as a control for possible magnetic field effects of laying-on of hands.

Enzyme levels were measured several times per day for 11 days. At the end of the study period, Smith reported that increased enzyme activity was found in the treated samples but not in the control samples. Replications of the study using different enzymes produced varying results. In some, laying-on of hands was associated with

increased activity, in some with decreased activity, and in some with no significant change. Smith concluded that the treatment did not affect all enzymes in the same way, but that effects which were found were all consistent with improving or maintaining health (Smith, 1973, p. 51).

In general, the laying-on of hands research with non-human subjects did not attend to treatment related variables which are not amenable to statistical measurement. For example, it did not attempt to deal with the phenomenal realm of human activity, such as the healer's thoughts or intent during the treatment. In the next phase of research -- with human subjects -- the need for attention to these variables became even more apparent.

Human subjects. Building on the studies of healing effects of laying-on of hands by Estebany, Krieger designed studies of effects on humans, still using Estebany as the healer. Drawing partly on a complex analysis of the physiology of hemoglobin and its dependence on enzyme activity, and partly on the significance of oxygen as a vehicle for transportation of "prana", an Eastern concept related to healing energy, Krieger chose hemoglobin level change as her outcome measure (Krieger, 1973). Two studies, using 76 and 85 subjects respectively, found that treated subjects had significantly higher hemoglobin levels after treatment than did subjects in a control group in which baseline levels were equivalent (Krieger, 1973, 1974).

The treatment consisted of Estebany placing his hand on the subject over the affected area for a variable period of time, and/or lightly massaging the back, neck, or extremities. Variability in the treatment was dictated by Estebany's decision as to what was sufficient

for each individual. The experimental subjects' diagnoses varied. Control subjects were not diagnosed patients. Krieger's report notes her impression that a sense of purposeful intent to help the ill person was "significantly involved in the effect" of Estebany's touch (1973, p. 46). However, one is not informed as to when or how this intent was mobilized, nor indeed, how Estebany determined the particular need of each patient.

In a critique of this study, Schlotfeldt (1973) cited failure to discuss the findings within the theoretical framework involving the notion of prana, as a major weakness of the study. She also questioned whether Krieger thought that all aspects of interaction -- particularly the intent practiced by Estebany -- could eventually be subjected to scientific scrutiny. Energy fields have since been postulated as an explanation for the process underlying therapeutic touch, as developed by Krieger based on laying-on of hands research. Energy fields, however, are also difficult to explain from a Western scientific point of view. Neither has the question of explaining the nature or effects of intent been resolved.

Summary. These studies of the effects of laying-on of hands by a gifted healer achieved several goals. The studies with non-human subjects showed that biological effects do follow use of the intervention, and that the effects are consistent with healing. Human subject research found effects compatible with those in non-human subjects. However, the reader is left uninformed about the nature of the treatment. Also missing in the case of human subjects, is information about how the subjects responded to the treatment, beyond the chemical measure which was the concern of the hypotheses.

Therapeutic touch

Through her observations and study of Estebany's healing work, Krieger became convinced that healing is a natural human potential. With another healer, Dora Kunz, she worked out a protocol for the healing act, which she then taught to a group of registered nurses. This technique she called therapeutic touch.

Krieger's research. In 1974, Krieger replicated the studies she had done with Estebany, this time using registered nurses trained in therapeutic touch as healers (Krieger, 1975). Baseline hemoglobin levels were determined for 68 hospitalized patients. Thirty-four patients were treated with therapeutic touch, which included physical contact between the healers' hands and the subjects. The patients also received usual nursing care. Thirty four others received only usual nursing care. Post-test comparison of mean hemoglobin levels revealed significantly higher levels in the treatment group.

The next study of therapeutic touch looked for physiological effects of therapeutic touch on the client and therapist (Krieger, Peper, & Ancoli, 1979). Since no controls were used, and only one healer and three patient subjects participated, it is possible only to make comparisons with known norms. Two findings of note were reported.

Measures of physiological change showed that Krieger, the healer in the study, experienced an unusual amount of fast beta activity on electroencephalographic recordings. This finding indicated a state of deep concentration (p. 661). Electromyographic control for frontalis muscle activity ruled out extraneous beta recordings due to an artifact from muscle activity. In addition, Krieger's electro-oculogram

recorded her "eyes open in slight divergence with no movement," a further indication of a state of steady concentration (p. 661).

Again, these outcomes provide valuable bits of information from which conclusions about levels of consciousness might be extrapolated. However, the report of these findings appears to equate brain and mind. Physiological indications of steady concentration can tell us nothing about the thoughts and intents of the healer. On what did Krieger focus her attention? How did she achieve this focus? What was the purpose of focusing attention, and how did the purpose relate to therapeutic touch? These crucial questions may be answered more adequately by examining the personal experience and meaning of the technique to those who use it.

Other investigators. Two doctoral dissertations done at NYU under the guidance of Dr. Krieger examined the effects of therapeutic touch on anxiety levels of hospitalized cardiovascular patients. Both found significantly greater reductions in anxiety levels in groups receiving therapeutic touch than in control groups (Heidt, 1980a; Quinn, 1982).

Heidt's operational definition of therapeutic touch required that the nurse do the following: (1) make the intention to therapeutically assist the subject, (2) center herself, (3) move her hands over the subject to detect sensory cues and to redirect "areas of accumulated tension," (4) concentrate on specific direction of energy, and (5) place her hands on the subject's abdomen just below the waist on the solar plexus area. Intervention time was five minutes (Heidt, 1980a, pp. 3-4).

Quinn's operational definition of therapeutic touch was identical to Heidt's except that in the final step the nurse directed energy to

the subject by holding her hands four to six inches from the subject's body over the area of the solar plexus instead of making physical contact (1982, p. 53). The purpose of this change in protocol was to separate the notion of energy exchange between two individuals from that of physical contact. Quinn's study also controlled for the intentionality aspect of therapeutic touch. She had control group nurses prevent intention to help by occupying their minds with a mathematical problem. Despite these changes, Quinn's experimental outcomes were virtually identical to Heidt's. The outcome indicated that physical contact is not essential to effectiveness of therapeutic touch. In a review of the literature up to 1980, Clark and Clark (1984) pointed to a need for such a sham treatment group to test the effectiveness of the purposeful intent in therapeutic touch and control for the placebo effect. Quinn's study appears to have accomplished this purpose.

Conspicuously absent from these studies of anxiety in medical patients is the link between stress and coping and health. Instead, the studies look to relaxation response investigations to support their line of inquiry into anxiety levels. A fuller understanding might be achieved by focusing also on the human issues such as empathy and meaning, which appear to be important aspects of the therapeutic touch technique.

A third study at NYU examined certain physiological parameters associated with response to a stressful stimulus, a film entitled Subincision (Randolph, 1980a, 1984). The experimental group received therapeutic touch while watching the film. The control group did not. No significant differences were found in skin conductance levels,

muscle tension, or skin temperature. Randolph's operational definition of therapeutic touch required that the nurse (1) make the mental intention to therapeutically assist the subject, (2) concentrate her attention on the subject, using her hands as focal points, and (3) direct energy to the subject by placing her hands on the lower abdomen and back (1980a, p. 3).

Randolph speculated that her failure to find effects of therapeutic touch might be due to differences between her operational definition of therapeutic touch and that used in Heidt's study. Randolph did not require that the nurses center. In common with Heidt, she also omitted the assessment process of moving the hands over the subject's field before directing energy. She posed a second possible explanation for the non-significant findings -- that the subjects' focus of attention on the stressful film prohibited their attending to the therapeutic touch intervention. The plausibility of this explanation is supported by statements of a pioneer in therapeutic touch (Kunz, 1978) and an experienced therapeutic touch clinician (Fanslow, 1978) that it is useful to encourage the cooperation of the patient in the therapeutic touch treatment.

Lazarus and others, who used the Subincision film to examine production of evidence of stress, and measures of response, indicated that the response is probably mediated by individual dispositional factors and previous experience, and that autonomic measures such as those used later by Randolph yield evidence which may differ from that obtained by asking the person about his or her subjective state (Lazarus, Speisman, Mordkoff, & Davison, 1962). Randolph did not take these variables into consideration. Neither did she comment on the

possibility that the film might provide distraction for the therapists, and thus possibly inhibit their effectiveness.

Randolph's failure to find significant effects is as compelling as the positive findings of Heidt and Quinn. Each of the deviations from the usual procedure for therapeutic touch deserves consideration. Both centering and assessment -- omitted in Randolph's study -- are held to be important aspects of therapeutic touch (Krieger, 1975). On the other hand, the therapeutic touch literature has not emphasized the subject's focus of attention.

Another study of stress suggests that the patient's focus of attention may not be crucial, since it found effects in newborn infants. Fedoruk (1984) found therapeutic touch without physical contact between the practitioner and recipient to be associated with reduction of behavioral stress in premature infants in intermediate and intensive care. Her measure of behavioral stress was the Assessment of Premature Infant Behavior scale. No statistical difference in physiological stress as measured by a fall in transcutaneous oxygen pressure was found between the therapeutic touch treatment and two control treatments. One control involved mock therapeutic touch. The other involved no therapeutic touch. An unexpected finding was that behavioral stress increased during mock therapeutic touch.

The effect of therapeutic touch on the experience of acute pain in postoperative patients was the focus of a later study at New York University (Meehan, 1985). Meehan used a pretest-posttest parallel control group design. When the 108 patients requested pain relief at least three hours after receiving pain control medication, they were randomly assigned to a therapeutic touch treatment group, a single

blind placebo control group receiving mimic treatment, and a control group receiving standard treatment. Pain intensity was measured prior to and one hour following treatment, using a Visual Analogue Scale. Multiple regression analysis and the Tukey HSD comparison technique were used. Patients treated with therapeutic touch reported statistically non-significant decreases in pain intensity compared with the mimic control group. The standard treatment control group reported significantly greater decreases than the therapeutic touch treatment group.

Alterations to the design might produce additional information. A comparison between the standard treatment control group used in the study, and an experimental group receiving standard treatment plus therapeutic touch would seem appropriate, since the technique is advocated as an adjunct to conventional treatment, not a substitute for it.

Using a new methodology for therapeutic touch research, Beck and Peper (1981), both family therapists, reported a qualitative study. They administered questionnaires to 13 patients at the close of a two week therapeutic touch workshop, to examine the subjects' impressions of patient and therapist interactions and patient beliefs regarding therapeutic touch. Clients' perceptions of comforting and discomforting effects of therapeutic touch were examined. These were related to the therapists' personal qualities and variations in technique. Clients reported that they were more comfortable when they perceived the therapist as self-confident, able to communicate well with the client, and/or empathetic. Uncertainty, anxiety, insensitivity, and abrupt movements on the part of the therapist

detracted from patient comfort. The investigators noted that patients found it difficult to give feedback to the therapist because of the implicit authority-subject relationship.

Patient beliefs which affected outcomes were related to seeing oneself as capable of growth and of improved health. Belief in God was also mentioned. Personality and social/environmental qualities affecting healing dealt largely with coping styles, stress levels, and self-image. The findings indicated that the intentions and meanings of the therapist were perceived by clients to be the most important aspects of the intervention, and that the clients felt that their beliefs and personality factors also influenced effectiveness. This study suggested a need to more carefully examine the intentions employed by therapists, and the meanings associated with use of the technique.

A descriptive survey of 70 therapeutic touch practitioners (Randolph, 1980b) found that respondents used medical care sparingly, with 65% having one or no physician visits in the past year, and 76% using no type of medication. With from 40 to 50 practitioners responding to each of the questions, non-smokers made up 82% of the sample, 80% exercised regularly at least one time per week, and 30% were vegetarian. Many participants in the study were trained in other energy related techniques including Polarity and Transcendental Meditation, and two thirds practiced meditation regularly, according to the report.

One question concerned how practitioners were affected by using therapeutic touch. Of the 41 subjects who responded to the question "Have you ever had adverse physiological or emotional effects after

healing?" 21 indicated that they had. These effects -- experienced by the nurses, not their patients -- were most frequently described as tiredness or stomach discomfort. Sixty two of the 70 study participants had used therapeutic touch for less than two years, and eight for more than two years. A higher percentage (63%) of the more experienced group reported adverse effects than the less experienced (48%).

Although response to the questions was uneven and the sample small, these findings suggest that practitioner characteristics such as attitude toward medical care and life style may either influence or be influenced by involvement with therapeutic touch. The responses concerning adverse effects indicate need for more study of phenomena associated with therapists' experience of the practice.

Summary. Development of therapeutic touch was based on earlier studies of the effects of laying-on of hands by a gifted healer. These studies demonstrated biological effects on human and non-human subjects. Krieger coined the term therapeutic touch when she developed a method of teaching healing to others. Her early studies found effects on patients' hemoglobin levels and on physiological measures in patients and healers. Her students' research confirmed that effects on anxiety levels were similar with or without physical contact during treatment. Effects on physiological measures of stress reduction were not found, except in one study in which Krieger was the practitioner. Failure to find significant effects in two studies, plus findings regarding therapist characteristics in another, indicate a need for a new perspective, to identify characteristics of therapeutic touch associated with effective outcomes, as well as to describe the

situations in which nurses use therapeutic touch, and to examine relationships between the practice and the context in which it occurs.

A single qualitative study of patient responses to therapeutic touch pointed to therapist self-confidence and ability to communicate verbally and non-verbally as important factors. Patients' stress levels and coping styles were implicated as affecting outcomes. These findings indicate that empathic variables of therapeutic touch may be a productive focus of study, and that the realm of meaning cannot be ignored.

Physical Touch

The therapeutic touch literature tends to stress its inception in laying-on of hands, and less frequently refers to other touch literature for support of its views. While some of the concerns of therapeutic touch investigators are also reflected in the general literature on physical touch, only one serious effort has been made to bring these two bodies of literature together. This was done in a recent Johnson & Johnson round table, which for the most part included separate readings on the two topics (Brown, 1984).

The available literature on physical touch is significant to the present study partly for its indication that not all of the important variables associated with touch have been identified. Inconsistent findings and failure to build a coherent series of studies compound the problem. This section relates the physical touch literature to studies of the technique of therapeutic touch, in the hope of providing a more complete view of touch than either body of literature provides alone.

Classically, touch is viewed as one of the five special senses: vision, audition, smell, taste, and "touch" or "feeling" (Geldard,

1972). It can be seen immediately that the sense of touch is less easily managed conceptually than the other four senses, since Geldard found it necessary to use two words with somewhat different connotations in its identification. Indeed, the sense of touch traditionally has been sub-classified into a number of additional senses such as pressure, pain levels, temperature perceptions, and other.

Gibson (1966) went beyond this system of classification and added categories of simple cutaneous touch, haptic touch involving what is perceived with the body, not just with the skin, or active exploration, and dynamic touch, including evaluation properties of the object being touched. These dimensions were all seen as involved in social interaction and communication -- aspects of the nurse-patient interaction. Nursing scholars have further divided touch to differentiate necessary or procedural from unnecessary or non-procedural touch (Barnett, 1972a; Goodykoontz, 1979), and casual (including procedural and non-procedural) from therapeutic touch as a unique modality (Heidt, 1980a), and to distinguish among pairs involved with touch in the clinical situation of patient with nurse, patient with family member, and patient with other health care personnel (Weiss, 1979b).

In addition, touch has been described as elaborated by symbolic processes so that it takes on an emotional dimension (Frank, 1957). Wyschogrod (1981) identified touch with the particular emotions of empathy and sympathy, relating these feeling acts to what is felt in the tactile sense, and viewed touch as differing from the other senses in that it is holistic. That is, while other senses are associated

with a specific organ of perception (the eye for sight, the ear for hearing) the organ of touch is less easily located. Wyschogrod saw the organ of touch as the living body as a whole, with effects felt in both the toucher and the one who is touched. These complex holistic views of touch lend themselves to consideration in a discussion of therapeutic touch.

Finally, a compelling value of touch seems to be related to its position as the earliest of the senses to be developed in the fetus (Montagu, 1971). Its involvement in the human being's earliest structuring of patterns of interaction set the stage for the complex meanings touch has for the adult (Frank, 1957).

Touch research. The interpersonal aspects of touch have been examined by a number of investigators. Alagna and others investigated the effects of the use of touch by counselors on client evaluative responses to the counseling experience (Alagna, Witcher, Fisher, & Wicas, 1979). Clients who were touched evaluated the counseling more positively than did no-touch controls. When a similar study generated no significant effects for touch, the differences in findings were attributed to more rigorous control for other non-verbal behaviors, such as eye contact and facial gestures (Stockwell & Dye, 1980). Therapeutic touch research has suggested that intent may be even more important than these non-verbal behaviors (Quinn, 1982).

There were also no significant evaluative effects in a study of touch as an element of nurse-patient interactions during preoperative teaching. However, a ceiling effect appeared to interfere, with all evaluations being highly favorable (Witcher & Fisher, 1979). Earlier, positive effects were found in a study of brief hand-to-hand touch

received during the process of checking out books in a library (Fisher, 1976). This study did not involve the interpersonal factors found in the nurse-patient relationship, so the ceiling effect was not present. However, we do not know what thoughts or intent accompanied the tactual act.

To examine sensory input effects on physiological responses, Hyde and Pangborn (1979) manipulated visual, auditory, and tactile stimulation, and measured changes in parotid flow rates. They hypothesized that in light deprived situations, mental concentration due to the introduction of sound or tactile stimulation would reduce saliva flow. Unexpectedly, tactile stimulation was followed by significantly lower parotid flow in both normal light and light deprived situations. The authors speculated that a central mechanism which modifies parasympathetic responses may be responsible for the effects. This notion is consistent with the calming effect of therapeutic touch, which could also be attributed to a parasympathetic, or relaxation, response (Pelletier, 1977).

Effects of tactile stimulation on heart rate have also been demonstrated (Drescher, Gantt, & Whitehead, 1980; Lynch, Thomas, Mills, Mainow, & Katcher, 1974; Mills, Thomas, Lynch, & Katcher, 1976). The results of these studies were mixed, with Drescher et al. finding a reduction in heart rate in response to the subject's wrist being touched by the investigator in an experimental study, others finding increased pulse rate in response to nurses' touch in clinical studies. The study situation, medication differences, differences in states of consciousness, or psychological significance of having one's pulse taken by the nurse in CCU are suggested by Drescher et al. as possible

reasons for the different outcomes. The variation in findings when meaningful interaction is introduced suggests that a variety of research methods may be needed to uncover or account for all of the important characteristics of the complex tactual act. Meaning, human concerns, and pragmatic activity are difficult to study using the experimental model, since operationalizing the variables necessarily calls for decontextualization -- isolating certain objects of study that have varied impact relative to the situations in which they occur.

The complexity of the study of touch is also apparent in the diverse directions taken by various writers on the subject. Among these, the developmental importance of touch stands out most clearly, as suggested by Carpenter (1981) and Hollinger (1980). Weiss (1975, 1978, 1979) isolated six characteristics of touch which she found to be correlated with development of children's own perceptions of body and body esteem. These characteristics of touch were duration, location, action, intensity, frequency, and sensation. This research sought to examine certain qualities of the tactile experience since these were missing in most prior research, which focused on the presence or absence of physical contact. Weiss's study looked at relationships between the characteristics of touch that children receive from their parents, and the children's body image.

Weiss's characteristics of touch had to do with the act of touching itself, not with circumstances surrounding the occurrence of touching. Properties of touch such as those defined by the therapist's intent in approaching the patient, his or her expectations regarding the interaction, and the patient's acceptance or resistance regarding

the interaction remain a fertile area for study. These all appear to be of concern in therapeutic touch.

The empathic use of touch has been stressed in descriptions of clinical situations (Bean, 1980; Burnside, 1973; Preston, 1973; Waddell, 1979), while Goodykoontz (1979) added that touch can convey distance or non-involvement. The importance of touch for psychosocial development of premature infants has also been examined (Kramer, Chamorro, Green & Knudtson, 1975), and R. Rubin (1963) suggested that an individual's use of touch might progress through stages and at varying rates. Significantly, Rubin related the development of maternal touch to that of maternal love. One might then look for a similar relationship between development of therapeutic touch skills and feelings of unconditional acceptance of the client.

Barnett (1972b) viewed touch as a form of communication. Ujhely (1979) took this concept a bit further, seeing touch as a means of striving for connection; and of purposeful expression, as well as perception. All of these concepts have been postulated as inherent in therapeutic touch (Krieger, 1979).

Summary. The literature treats touch as a complex sense or activity, involving both tactual and empathic concerns. Mixed findings in studies of evaluative and physiological effects of touch support the importance of recognizing this complexity. The loss of significant outcomes in touch research when other non-verbal behaviors are controlled may locate touch as only one element in a complex array of communicative behaviors which together are responsible for so-called touch effects.

The move from discussion of the tactile act as it is conceived in the studies above, to a study of therapeutic touch, however, requires consideration of the relationship between the two. One difference in therapeutic touch appears to be in the explicit focus of the toucher on the intent involved in the interaction, and on maintaining consistent positive regard for the other, rather than on the need for any physical contact as the basis for the intervention.

To its users, therapeutic touch appears to provide a model for incorporating certain positive characteristics of touch into nursing practice. Clearly, the success of the technique as such a model cannot be addressed until a more precise delineation of the characteristics of therapeutic touch is obtained. To that purpose, the part played by such variables as meaning, intent, and beliefs, as well as behaviors, must be addressed.

This section has commented on the experimental and descriptive research on therapeutic touch and physical touch. The following section introduces suggestions regarding how the phenomenological approach proposed for this study will contribute to understanding of therapeutic touch as it is practiced and interpreted by nurses and patients.

Interpretive Framework

In most of the reported studies of therapeutic touch, the conceptual base used to explain the technique and to form a foundation for hypothesis testing is Rogers' theoretical basis of nursing (Heidt, 1980a; Krieger, 1979, 1981; Quinn, 1982; Rogers, 1970). Rogers' theory lends itself to the traditional explanation of the technique -- that underlying its calming and healing effects is an exchange of energy

between the nurse and client, contributing to a more balanced energy flow in the field of the client. Rogers' theory is supported by the writings of Capra (1977) and Zukov (1970), who discussed relativity theory, quantum field theory, and other recent findings in physics in terms of a theory of mind-body relationships. It is also compatible with Eastern philosophies (Capra, 1977; Wilber, 1977). However, the language required to explain therapeutic touch in theoretical terms is unfamiliar to the majority of nurses. Further, the postulated energy exchange between persons has not been demonstrated, and the therapists' method of mobilizing the energy is not explained by the theory. Thus, such crucial aspects of the technique as intentionality and the meanings associated with the practice of therapeutic touch are not addressed.

This study was undertaken with the expectation that while Rogers' theory of nursing is used to explain therapeutic touch as it is taught, individual users may interpret it in other terms. Therefore, the goal of this research was to discover the interpretations of therapeutic touch offered by nurses practicing the technique, rather than to test a theoretical stance in relation to the findings. In the cultural anthropological tradition of Geertz (1973) a "thick description" of therapeutic touch as it is practiced and experienced was undertaken. That is, an effort was made to look beyond the more evident behaviors associated with the practice, to identify underlying meanings and intents.

This study took a Heideggerian phenomenological approach to investigation as described by Taylor (1979) and Rabinow and Sullivan (1979). Based upon the works of Heidegger (1962; Dreyfus & Rabinow, 1982),

phenomenology posits that human beings both constitute and are constituted by their interpretations. Furthermore, this self-interpretation is always based on background meanings handed down in language and cultural practices. Heidegger developed the thesis that interpretation is based upon a "background" of skills, practices, assumptions, and interpretations that cannot be made completely explicit and cannot be completely rationalized (Dreyfus, in progress). Since the background practices are interpretation laden and can never be completely spelled out, the model of study is systematic textual analysis (hermeneutics) and the goal is to provide commentary and interpretation of practices (Benner, 1984a, 1984b, 1984c) and commonly held meanings associated with the practices being studied.

Traditionally, the personal experience of the therapeutic touch user has been treated as private knowledge, shared primarily as a means of indicating the broad possibilities for individual interpretation of the experience. Such a view is consistent with early phenomenologists, such as Husserl, who saw meaning as organized by the transcendental ego, and pertinent only for the individual, who gives meaning to the experience (Dreyfus & Rabinow, 1982). Heidegger's view that meaning arises not from the subject, but rather from the historical cultural practices and language in which it develops, renders these practices amenable to study. A reliable interpretation of the meaning is possible because these meanings are shared and not wholly private or individual (Heidegger, 1927/1962).

According to Taylor (1979), meanings can not be separated from the context in which they arise. The importance of this idea to a study of therapeutic touch is that in the process of borrowing portions of the

practice and its explanation from other sources, nursing may have altered the meanings involved in unanticipated ways. Understanding may then depend upon recognizing the influence of nursing itself on the emerging practice of therapeutic touch. Information about this influence can only come from practitioners. In turn, multiple individual accounts must be examined to find recurring themes. These themes will reveal interpretations common to the culture in which the practice resides, and can be expected to provide greater clarity than is found in the understanding of individual practitioners.

Similarly, Merleau-Ponty described the person's integration of new information into the fabric of previous knowledge as a process of habit formation (1934/1962). In his view, established habits of perception are not replaced by, but rather provide a style for, new perceptions. This new information is understood in the context of previous experience. The previous experience is treated as a theme which, even when it is outside awareness, can provide an "atmosphere and significance" for the present experience (p. 22). What is particularly useful for the discussion of therapeutic touch is Merleau-Ponty's notion that this theme is not simply a mental set, but that it constitutes a field which is "at the disposal of consciousness". That is, it can be seen as a perceptive set, involving all of the senses and modes of awareness available to the person. This mode of knowing is not limited to representational knowledge or concepts, but includes knowledge gained through skilled practice.

It follows, then, that a nursing practice such as therapeutic touch, which in part relies for its explanation upon Eastern philosophical thought, will be reinterpreted by its Western users in

language and nuance with which they are familiar. In order to arrive at a consensus regarding the underlying explanation of a practice, it is then necessary to go to the practitioners for descriptions of the individual experiences involved (Geertz, 1973). With this information in hand, an interpretation of the varied meanings of therapeutic touch can be made.

Taylor described interpretative science as an attempt to bring to light an underlying coherence that resides in a cloudy, seemingly contradictory object of study. He delineated three criteria necessary for such interpretation (1979).

First, there must be a practice, event, or transaction about which one attempts to make sense. For this study, the practice was therapeutic touch. Second, the meaning in the practice must be capable of more than one expression. Initial cloudiness or confusion about inherent meaning arises from the presence of different and perhaps conflicting expressions. Clarity can be approached only by distinguishing between expressions of the practice and its meaning. The expressions of therapeutic touch are individual modes of practice. Its meaning arises from its practice in a given cultural milieu. Third, there must be a cultural language group for whom the practice has meaning. Meaning as it is used here is for nursing as a discipline. In this study, the interpretive task is to describe the expression of therapeutic touch as it is practiced and interpreted by individual practitioners and recipients of therapeutic touch, and make sense of this information in terms of nursing.

Assumptions

The interpretive perspective described above provides the following set of assumptions:

1. There is an unavoidably interpretive component in the human sciences (Taylor, 1979).
2. Meanings and interpretations are derived not only from present experience, but also from previous knowledge, and that knowledge is embedded in the person's practices (Merleau-Ponty, 1934/1962; Rabinow and Sullivan, 1979).
3. Information about a lived experience can only be obtained from the person who has the experience (Geertz, 1973).

Study Questions

Heideggerian phenomenology provides a method for discerning a potential web of nursing knowledge within the practice of therapeutic touch. To probe for that knowledge, the study asks these questions:

1. What are the practices, intents, and beliefs associated with therapeutic touch as it is used in clinical practice by registered nurses?
2. How do nurse/client interpretations of therapeutic touch differ from characteristics of usual nursing care?
3. What interpretations of usual nursing care are similar to interpretations of therapeutic touch?
4. What characteristics of therapeutic touch are associated with effective outcomes, according to the self-description of persons who have had experience with the technique?

CHAPTER 3

Methodology

In order to examine the nature of therapeutic touch as it is experienced by users, a phenomenological approach was used. Practice descriptions and interpretations obtained through interviews were the basis for analysis. The main focus was on interviews obtained from nurses, although patient interviews were also used to supplement nursing interpretations.

Population and Sampling

A sample of 51 nurses and 20 patients was used. Because of the possible geographic differences in use of therapeutic touch and its interpretation by users, participants were recruited in several sections of the United States. The investigator interviewed nurses and patients in New York City and Long Island, New York; Portland, Oregon; and the greater San Francisco Bay Area. Subjects from several other geographic areas were interviewed at Eastsound, Washington.

The nurse population included registered nurses who had attended at least one full day workshop on therapeutic touch, or the equivalent, and had a period of at least six months in which they had practiced the technique. The study sample was obtained through (1) contacts at workshops teaching the technique of therapeutic touch, (2) contacts at therapeutic touch support groups, and (3) referrals from these two sources, through both verbal referral by participants, and contacts through membership lists.

The patient population included persons who were over 18 years of age, able to speak English, and had experienced therapeutic touch treatment. The study sample was obtained through (1) general

announcement at workshops where the technique was being taught, and
(2) referrals from nurse participants.

Nurse data

Demographic data for nurse participants are presented in Table 1. The data are arranged by place of residence. Two of the nurses were male and 49 female. The majority were between age 30 and 49, and had been nurses for over five years.

While nurse participants were representative of all types of basic nursing preparation, twenty nine had upgraded their education beyond entry level. Of these, four had obtained baccalaureate degrees, 16 masters degrees, and one a doctoral degree in nursing. Three had obtained baccalaureate degrees, four masters degrees, and one a doctoral degree in other disciplines. One nurse had received a masters degree in liberal studies and in nursing. One had obtained a certificate from a two year holistic practice program. Thirteen nurses were working toward higher degrees at the time of the study; seven in nursing and six in other disciplines. Three of these were in baccalaureate degree programs, eight in masters, and two in doctoral programs.

A broad variety of employment situations were represented. As can be seen in Table 1, the majority of nurses in the sample worked in traditional inpatient and outpatient settings. A number of nurses had private clients in addition to positions in health care facilities. Almost one fifth of the sample worked in the recently growing fields of home health care or hospice care. One was retired, and two were in school nursing.

Table 1
Demographic Data: Nurse Sample by Place of Residence

Variable	Frequency				Total
	California	New York	Oregon	Other ^a	
Place of residence	15	16	15	5	51
Age					
Under 30	2	2	2	0	6
30 - 39	8	5	8	2	23
40 - 49	0	8	4	1	13
50 - 59	4	0	0	0	4
Over 50	1	1	1	1	4
Years in nursing					
Under 5	1	2	2	0	5
6 - 15	9	2	8	1	20
Over 15	5	12	5	3	25
Basic nursing preparation					
Diploma	6	10	5	2	23
Associate degree	5	1	4	0	10
Baccalaureate degree	4	5	6	2	17
Highest degree					
Diploma	3	2	3	2	10
Associate degree	4	0	2	0	6
Baccalaureate degree	4	5	4	0	13
Masters degree	3	9	5	2	19
Doctoral degree	1	0	1	0	2
Type of employment ^{b,c}					
Acute inpatient	8	4	3	4	19
Long term inpatient	0	1	5	0	6
Out patient	4	4	4	1	13
Education	3	2	3	0	8
Other	4	6	1	1	12
Years therapeutic touch used					
Under 2	1	2	1	0	4
2 - 5	7	8	9	4	28
Over 5	7	6	5	0	18

Demographic Data: Nurse Sample by Place of Residence

Variable	Frequency				Total
	California	New York	Oregon	Other ^a	
Number of patients treated					
1 - 20	1	1	2	0	4
20 - 50	3	4	3	1	11
50 - 100	4	5	2	1	12
Over 100	6	5	8	2	23

^a Demographic data are missing for one nurse in this category.

^b Some nurses indicated more than one type of employment.

^c Nurses in "other" types of employment were primarily employed by home health care or hospice agencies.

Most of the nurses in the sample had used therapeutic touch for over two years, and more than a third had used it for over five years. Almost half had treated over 100 patients, and an equal number had treated between 20 and 100 patients. Two thirds of the sample had used therapeutic touch with more than 50 patients. Findings from the study, therefore, can only be generalized to use of therapeutic touch by nurses with moderate to extensive experience. Although some of the descriptions were of early use of the practice, these descriptions were almost certainly influenced by the nurses' present understanding.

Similarly, use of a convenient sample delimited generalizability of findings regarding specific practices to nurses who felt comfortable with describing their use of the technique. The question of whether other nurses might have practiced or viewed the technique differently is not answered. On the other hand, inclusion of similar numbers of nurses from three widely separated geographical areas provided assurance that a broad mix of views was included. The size of the sample, however, also limits generalizability due to restrictions of representation to the three geographical areas. This is important because of possible regional variations in attitudes toward health care modalities.

Patient data

Demographic data for patient participants are presented in Table 2. About one third of the patients were male and two thirds female. This is approximately the same ratio as was found among patients whose treatments were described in detail by nurses in the study (35:62). Most patients in the study (17) were from the West Coast. One lived in New York, one in Colorado, and one in Canada.

Table 2

Demographic Data: Patient Sample by Place of Residence

Variable	Frequency			
	California	Oregon	Other ^a	Total
Place of residence	10	7	3	20
Sex				
Male	3	2	1	6
Female	7	5	2	14
Age				
Under 30	1	2	0	3
30 - 39	3	2	0	5
40 - 49	3	2	1	6
50 - 59	0	0	1	1
60 or over	3	0	2	5
Health status				
Poor	1	1	0	2
Good	4	3	1	8
Excellent	5	3	2	10
Years familiar with therapeutic touch				
Less than 2	2	1	0	3
2 - 3	3	3	2	8
4 - 8	4	2	1	7
Over 8	1	1	0	2
Number of treatments				
1	1	0	0	1
2 - 5	2	3	0	5
5 - 10	1	0	2	3
Over 10	6	4	1	11
Where treated ^{b,c}				
Hospital	0	4	0	4
Other health care facility	1	1	1	3
Home	7	2	0	9
Other	6	3	2	11

^a One patient who lived in New York is included in "Other".

^b Seven patients reported being treated at more than one location.

^c "Other" places where treated included mostly therapeutic touch workshops and therapeutic touch support group meetings.

Patients were represented from across the age groups, and described themselves as in good or excellent health at the time of the interview. Problems for which they had been treated with therapeutic touch included those related to a number of diagnoses, including multiple sclerosis, trauma, cancer, birthing, rheumatoid arthritis, diabetic complications, cystic fibrosis, and muscular pain.

The majority had been aware of therapeutic touch for from two to eight years, and had been treated more than 10 times. Although not shown in Table 1, nine patients had been treated exclusively by nurses, and the remaining 11 primarily by nurses.

The method by which patients were recruited may have resulted in a limited patient sample. Since patients were recruited by nurse participants, they were more likely to be supportive rather than skeptical or critical of the practice. Important data could have been missed by virtue of a biased patient sample. In addition, only three of the 20 patient participants had not attended therapeutic touch workshops, and thus most were exposed to practitioner as well as patient views of the practice. The viewpoint of the naive patient is, therefore, under-represented. Nurses said that they recruited friends, co-workers, or acquaintances from therapeutic touch support groups for the study. They did not recruit others because (1) they did not stay in contact with patients they had treated as a part of their work, (2) many patients in health care facilities were not told that the nurses used therapeutic touch in their care, or (3) in the case of hospice patients and others who were terminally ill, they were no longer living.

Data Collection Methods

Data were collected via an audio tape record of face-to face interviews. An interview protocol was used to guide the questioning and to assure that specific categories of data were systematically obtained from each subject. The interview questions were loosely constructed, giving respondents opportunity to describe their perceptions in their own words.

The first nine interviews (six nurses and three patients) were carried out prior to development of the interview guide. Descriptions of the participants' experience with therapeutic touch were obtained, and information about how the technique did or did not add to usual health care was elicited. Using the data from these initial interviews and from three nurse interviews carried out for a separate project prior to this study, the investigator devised items for the protocol which guided the remainder of the data collection.

Interview protocols

The interview protocols consisted of three parts. An introduction explained the purpose of the interview and introduced participants to the kinds of questions to expect. This was followed by a section containing demographic questions. These questions were included in case it appeared that the interpretive data might be influenced by these variables. The demographic data was also used to obtain a description of the sample. A third section addressed the study questions. The introduction was similar for nurses and patients. The other two sections varied across the two protocols to reflect the different experience of the two groups (See Appendix A).

RN protocol items

In the RN interview protocol, ten demographic questions elicited place of residence, age, and education and experience in nursing and therapeutic touch. Fourteen questions comprised the section for the RN protocol related to the purpose of the study. The first five questions elicited descriptions of one time when the participant used therapeutic touch especially effectively and one time when the therapeutic touch experience was more usual. The items asked for descriptions of thoughts, physical sensations, and feelings experienced while using the technique. The nurses' expectations in each instance, and observable evidence of effectiveness were addressed. These questions had the purpose of obtaining precise descriptions of the individual practices of therapeutic touch by participants in the study.

Another six questions asked for the nurses' ideas regarding what helps or hinders the effectiveness of therapeutic touch, and how it is similar or dissimilar to usual nursing practice, as well as what underlies its effectiveness. These questions were designed to elicit the nurse's interpretation of the information obtained in the earlier questions. A final three items asked how the therapeutic touch experience influenced the nurse's knowledge or attitude toward three concepts sometimes associated with the technique -- energy fields, intuition, and spiritual healing.

Patient protocol items

The patient interview protocol was designed to assess whether the interpretations of therapeutic touch made by nurses in this study were reflected by patients who had experienced the technique. Ten demographic questions addressed place of residence, age, occupation,

health status, and information regarding amount of therapeutic touch experience and the situations in which treatment occurred.

In the section of the protocol related to the study questions, the items paralleled those of the RN protocol. Three questions eliciting patients' descriptions of the therapeutic touch experience were followed by six questions asking for their ideas about what helps or hinders the effectiveness of therapeutic touch, their interpretation of what underlies its effectiveness, and what influenced their decisions to be treated. The three final items about the influence of therapeutic touch were identical to those on the RN protocol.

Tool development

Interview items related to the study questions were devised to assure that the investigator understood the intent of each study participant's responses. To that end, similar information was elicited by two or more questions, addressing the content from somewhat different perspectives. For example, data related to the distinction between more effective and less effective methods of performing therapeutic touch were developed in two ways. First, by requesting specific descriptions of the nurses' especially effective use of the technique and of their typical use, the investigator was able to make a comparison between the descriptions. Other items requesting the nurses' interpretations of what helps or hinders effectiveness provided a second source of this information.

Protocol refinements. Changes in the questions were made during the course of data collection, when new lines of inquiry developed or the original questions appeared inadequate to address the overall research objectives. For example, after several interviews, the item

requesting description of a typical instance in which the nurse used therapeutic touch was altered to ask for a case that was less effective. This was done because it became apparent that the word "typical" lacked clear meaning for nurse participants in relationship to therapeutic touch. A sharper comparison regarding effectiveness was obtained from the new wording.

A second example of refinement of the protocol occurred when most of the nurse interviews were completed and about half of the patient interviews had been obtained. Changes were made in the patient interview protocol to insure patient input regarding an unanticipated line of inquiry emerging from the nurse data. Two items related to self care were added at that time.

The original interview protocols for nurses and for patients are included here as Appendix A. Further information concerning changes in the focus of the interview guide is included in the chapter on the study findings.

Validity. The investigator in this study was a therapeutic touch practitioner, and thus may, in some cases, have taken for granted certain meanings in participants' descriptions of their practice. An attempt was made to avoid this problem, by requesting detailed reports of phenomena with which the investigator was familiar. Throughout collection and analysis of the data, areas in which meanings might be assumed were sought, and follow-up calls were made to clarify meaning where it was unclear. For the same reason, care was taken to be aware of situations where the investigator might inadvertently avoid issues in order not to infringe upon established ways of interpreting therapeutic touch. To compensate for potential investigator blindness

to issues inherent in therapeutic touch, consensual validation of findings and analyses were obtained. Reports were submitted to both experienced therapeutic touch practitioners and nurses who had no experience with therapeutic touch, for comments and criticism.

Despite the potential for bias as a result of the investigator's allegiance to the therapeutic touch movement, there are also advantages to her experience with the practice. For example, it might be necessary to take part in therapeutic touch workshops in order to achieve a broad view of the practice if a researcher unfamiliar with therapeutic touch were to undertake an interpretive study. In addition, participants may have felt they could openly discuss their beliefs and practices in a supportive and knowledgeable rather than naive or adversarial context. Participants' knowledge about the investigator most likely influenced patient recruitment, since all but three of the patients were from the West coast, where the investigator was known. Only one patient was interviewed in New York, where fewer nurse participants (who recruited patient participants) had previously met or heard of her.

Procedure

The investigator conducted all of the interviews. Interviews took place in a variety of settings, for the convenience of participants, and depending on point of contact. Workshop related interviews were done at the workshop setting. Others were in individuals' homes, appropriate community facilities, or the investigator's lodging, at the preference of the interviewee.

Initial contact with subjects at workshops and support groups was made by general announcement inviting participation in research, and by

personal contact by the investigator. Initial contact with referred subjects was by letter or telephone, depending on time urgency in individual cases. Written contact was preferred, in order to allow prospective interviewees private time to consider whether to participate, and was used when feasible. Patient subjects were contacted by referral only after the referring nurse obtained the patient's willingness to be contacted.

In follow-up contact with each subject agreeing to be interviewed, a time and place for the interview was determined. The consent to serve as a research subject was signed at the beginning of the interview meeting, prior to the interview. After the consent was signed, the investigator read or paraphrased the introduction to the interview from the interview protocol, and then asked the demographic questions, noting the answers on a copy of the protocol. The tape recorder was then turned on and the initial research question was asked. The protocol was used as a general guide for the questions, since some data were obtained out of order because of the open-ended nature of the questions.

Protection of human subjects was assured by adherence to guidelines set down by the University of California San Francisco Committee on Human Research. The consent to be a research subject is included here in Appendix B. Only first names of participants were used in the interviews to assure anonymity. One participant asked that her name not be used, and her request was honored.

Data analysis

The transcribed interviews were treated as text. Interpretation was involved in this analysis at three levels. The first level was

descriptive and captured the nurses' stated interpretations of therapeutic touch. The second level was based on a comparison of the interviews in order to identify common meanings in the interviews. The method is hermeneutical, and is based upon systematic movement from the parts of individual interviews to the whole, and on comparing interview excerpts and wholes with each other. Finally, interpretive commentary was developed, based upon issues raised in the first two levels of interpretation.

In treating the transcribed interviews as text, the investigator attended to four ways in which Ricoeur describes text as differing from spoken language (1979, pp. 75-80). First, the transcriptions fix in time what is said, preserving it for analysis. Second, they dissociate the verbal meaning of the interview from the mental intention of the interviewee, so that meaning can be examined in the larger context of statements from a number of nurses. Third, the transcription extracts meaning from the specific incident so that the description can be seen as part of a larger situation. Fourth, the transcriptions make it possible for the investigator to excerpt relevant content to share with readers. This increases the breadth of understanding by requiring that the interpretations make sense to a larger audience.

The investigator read each interview as it was transcribed, making methodological and theoretical notes as references to guide analysis. A constant comparative method was used to develop more focused lines of inquiry during the data gathering phase, and throughout the interpretive process. When there were sufficient data to define a substantive content theme related to a study question, a separate memo elaborating that theme was prepared. Thematic categories of data were

pursued in subsequent interviews until no new information was forthcoming. Analysis of these categories is described in the findings section of the research report.

CHAPTER 4

Findings

Practices of Therapeutic Touch

Many participants in this study described their use of therapeutic touch in terms similar to those used by Krieger in her definitive book on the subject (1979). Krieger's phases of the technique -- centering, assessment, and treatment -- appeared frequently in the interviews, since they provided a natural structure for participants' descriptions of their practice.

Centering is described by Krieger as "finding within oneself an inner reference of stability" (1979, p. 35). She calls this a quiet state from which one can be aware of involvement in life. A breathing exercise is suggested as one way to attain the desired state, though Krieger notes that individuals may find other methods useful.

Krieger describes assessment as gathering data about the patient's condition and needs, both from behavioral cues and from perceptions of the individual's personal field (pp. 42-45). The personal field is said to involve the space within a few inches of one's physical body, and is characterized by Krieger as made up of biological energy which surrounds and interpenetrates the physical body. The field is seen as an integral part of every individual's being; usually ignored because it is out of awareness. Underlying the rationale for use of therapeutic touch to intervene in this field is the concept that disruptions or imbalances in the energetic field accompany physical and emotional disease or trauma. Ability to sense this personal field with one's hands is said to be enhanced by practicing certain exercises outlined in Krieger's book. In the standard use of therapeutic touch,

the patient is usually seated on a chair. However, when the patient's condition requires it, other positions are used.

The treatment is described as consisting of two parts. The first is called "unruffling" the field. Unruffling is designed to smooth out imbalances in the energy field, and to begin to mobilize the field prior to further treatment. Krieger states that persons are "always engaged in transfer of energy" (p. 56). The final treatment in therapeutic touch is aimed at directing and modulating this transfer. In purposefully working with this energy, the goal of the practitioner is to help the patient achieve a balanced state, demonstrated by a perceptibly smooth field. The treatment is expected to act as a "booster until the patient's own recuperative system takes over" (p. 17). Somehow, the subtle changes occurring as a result of the energetic intervention affect the patient's physiology, or allow changes to occur, according to Krieger.

Although the name therapeutic touch suggests hands-on contact for the assessment and treatment, such contact is the exception rather than the rule. In her 1982 study, Quinn used the term "non-contact therapeutic touch" to describe the technique of using the hands within a few inches of the subject's body (1982, p. 7). Her study was designed to compare use of the hands near the patient but not touching, with Heidt's earlier study which operationalized therapeutic touch with hand to patient contact (1980a, 1980b). Nurses in the present study usually described actions similar to Quinn's non-contact in their use of therapeutic touch.

Almost unanimously, study participants indicated that they had been taught to use the therapeutic touch phases as described by

Krieger. However, only centering was consistently described as essential, and centering was practiced differently by different nurses. Assessment and treatment components were sometimes omitted or modified extensively. The descriptions below address the important practices actually adopted by the nurses in the study, in all three phases of the technique.

Centering

What was couched in the rubric of centering encompassed four distinct characteristics: (1) disciplining attention, (2) achieving a calm relaxed state, (3) establishing receptivity, and (4) becoming a channel for the energy of healing. Although they were introduced in the centering process, these characteristics of therapeutic touch were also described as occurring during other phases of the practice. The several characteristics of centering are teased apart and discussed separately here, although they were frequently intermingled in nurses' descriptions. Examples from the interviews are used to convey the nurses' experiences.

The purpose of centering was stated in several ways. Participant 121 described it as getting "in touch with myself." Participant 142 said, "It collects my thoughts and energy to being at that place at that time It seems to help me focus on the here and now of doing therapeutic touch." The process was further described as "to become present and non-distracted by my own personal stuff" (126). Centering emerged from these typical comments as characterized by focusing on selected aspects of the self and the situation in preparation for being in touch with the patient's needs. The purposeful act of focusing implied disciplined attention to certain stimuli.

Disciplining attention. Many nurses identified clearing one's mind of extraneous thoughts as an important component of preparation for the therapeutic touch intervention. This appeared as the first step of disciplining attention. The following excerpts illustrate this step.

Participant 112 treated a neighbor who was in severe pain with a migraine headache. The investigator asked her to describe what she did.

112: The first thing I did was get centered within myself -- get relaxed and focused.

I: Let's talk about that part of the process, then. What were your thoughts when you were centering?

112: I closed my eyes, and I started to take some deep breaths, and then I just focused on being clear and being more like an instrument.

I: What do you mean by "being clear"?

112: Not allowing other thoughts to interfere with the work I was going to do at the moment, and not to ... allow other thoughts to come into my mind, about what I would be doing an hour from now, or something like that.

Participant 135 brought centering into the therapeutic touch description later in the process. Clearing her mind of extraneous thoughts was again the stated purpose. She indicated that her attention was directed toward her preparation for the treatment.

I: When you were doing the assessment, what were you thinking?

135: What I do is to prepare myself in a light meditative state.

I: Could you tell me how you do that?

135: I focus on my breathing. I clear my mind of external thoughts. I imagine my feet connected to the ground, so that I'm feeling stable in myself. I'm feeling integrated. I'm not distracted thinking about other things that I need to do.

Once extraneous thoughts were eliminated, participants described attending to their own mental readiness. For example, the following nurse said, "I'm concentrating on the field -- focusing within myself."

- I: You mentioned that you centered. Can you tell me how you did that?
- 108: I collected all my thoughts. It's like dragging all my energy and all my thoughts within myself. To where I'm not thinking about anything else. Where I empty my head of thoughts so at the time I'm doing a treatment I'm not doing anything -- I'm concentrating on the field -- focusing within myself. Clearing my head of all confusion, and getting everything out of my -- centering my thought process.

Relationships among the various issues involved in disciplining attention, such as awareness of the situation, versus awareness of the patient, were not always clear. Still, the primacy of the focusing process -- disciplining the attention -- was apparent. One nurse's comment on how it felt to become centered was a case in point. The patient was a woman in labor.

- 136: I get a sense of being very clear. Very stable.
- I: What is "clear" to you?
- 136: I concentrate and focus on what I am really there to do, and I focus on that time. I'm only -- It's [the patient] and me here now, and she will deliver, and everything else is out the window. No other thoughts.
- I: Is "stable" part of that, too, or is that something else?
- 136: Stable means that my thoughts are not being fragmented. I have taken a stand, and I'm being here for that purpose.

The implication here was that the nurse was concerned primarily with the needs of the patient. However, her words described her own awareness more in relation to the milieu than to the patient. In the following excerpt, these different foci of attention were again apparent. The phrases "part of me is quiet," "tuning in to her," and

"center on the situation that I am in," each connoted a separate focus -- on the self, the patient and the situation, respectively.

- 129: I took a deep breath, and centered myself. Which is my cue and my signal to myself ... that I'm centering.
- I: How did you know that you were centered? How did you know that that worked?
- 129: It triggers something in me so that I can be quiet. So that even if I am still talking, I know that there is a part of me that is quiet and tuning in to her, or the person. I take a deep breath, and when I let it go I let go of all the clutter and junk that I'm distracted by so that I can center on the situation that I am in. Or just let go of all my concerns so that I can be there for someone else. I put me aside, and my needs.

These excerpts began to clarify a hierarchy of foci of attention. The immediate concern was to clear the mind of thoughts or feelings unrelated to the situation. The data indicate that the reason for doing this was to prepare for directing attention wholly toward the nurse-patient interaction, which represented the next level of attention. In the next excerpt, the nurse spoke of "letting go of the external environment" in order to be aware of her own feelings and then to distinguish her feelings from those she picked up from the client during the interaction.

- 113: What I do before I begin to work with someone, is generally ... stand behind them, and I take a deep breath in, and for me, that's the keying in to relaxing and letting go of the external environment. And so, I'll breathe in, and as I expel, I let go of the tension, or anything I might be feeling, and more or less let go of myself. And the external chatter, and the internal chatter So, at that point in time, what I am doing, is trying to get rid of any external stimuli. In myself. So I'll only be involved in the process of exchange of energy, and understanding what's going on with the person.
- I: Mentally, you are focusing in on the immediate situation?
- 113: Yes. And physically, I am toning down. So there is a physical centering so that I'm not involved in my own body process (or in whether I have) an ache or a pain. I want to get rid of the concept of myself at that

point in time. I will recenter if I think there is anything that is happening in the process that I want to reexamine a second time. So, I might feel that perhaps I had gotten off center. I'll remove myself from the situation for a second; take a deep breath, which helps me key back into myself; and then reenter to see whether what I am feeling is in the individual or myself.

The nurse's use of phrases such as "get rid of the concept of myself" and "let go of myself" during focusing suggested setting aside the reflective self in favor of engagement with and concern for the patient. Again in the following statement, the nurse attended to her own preparedness for the interaction.

112: I try to maintain the breath process. It is very important in the healing situation. To constantly be breathing in and letting go of any tension that might be starting to interfere with the process.

The following nurse used a meaningful phrase, augmented by brief physical touch, as a focusing device. Although he did not share the specific words he used, the excerpt illustrates one deliberate method of focusing attention. The stated focus was the situation. The therapeutic touch was used with a dying friend under tension-fraught circumstances.

116: One thing that helped me, that I usually don't do, is that I touched my friend. That helped me concentrate on the situation. And then -- how I center a lot of times is, it's a sort of a rhyme, or more of a biblical proverb that I say. To me, it means more of a mantra. I don't know how much I believe in the spiritual aspects of the phrase, but it really helps me. I'm to the point now that I can cut out things right away.

I: So, it's a spiritual kind of phrase that you say to yourself.

116: Right. It doesn't really hold any religious significance, I don't believe that therapeutic touch is a religious experience, but it helps me center quickly. It is sort of relaxing and peaceful.

In the following two excerpts, the nurses described cases in which they did not achieve focused attention. In the first instance, the nurse indicated that other demands on his attention probably prevented centering.

I: What I'd like you to do is think of another situation, when you felt that the treatment wasn't especially effective, in some way.

142: Working here at the hospital with an elderly psychotic agitated woman. My intent in using therapeutic touch with her was to try to elicit a relaxation response, and it didn't seem effective. I don't know if it was because I had to attend to her acting out and couldn't focus as well as I wanted to on the process, or if her inner agitation -- she was so worked up it wasn't effective.

I: Were you able to center that time?

142: Probably not. I was trying to keep her in a chair.

For different reasons, the following nurse also found it difficult to focus on the situation. She described how her failure to do so influenced the interaction and the outcome.

146: There was one time that I met a young woman who was diabetic, and who was just beginning to get interested in holistic health -- wanted to stop taking her insulin. And so, somebody told her about me, that I did therapeutic touch. When I met her, I was visiting a friend in the hospital, and this woman came in. We talked about it a little bit, and I said, "Well, sometime when you want a treatment, just call me."

I went home, and she called me that evening and asked if she could come over and have a treatment. And, instead of saying, "Let's set up another date," I said, "Oh, sure." Let's do it right away, you know. Well it was bad timing. Because she came over, and I had some other things I had to do ... I didn't take enough time to explain to her what was going on.

I: Let's go back to the beginning of the treatment, as we did the other one. Did you center in the same way, or did you do something different?

146: I always center in the same way, but I don't think I really got centered. I think I went through the motions.... In retrospect, I don't feel that I actually was centered. Because I was rushed, and I think there was a lot of other stuff going through my mind. So, I went through the motions of centering.... It didn't feel good to me at all.

- I: Did she say how it felt to her?
146: I don't remember, except, I just know I didn't feel satisfied. I knew she wasn't satisfied. I never heard from her again. Never met her again.

In the following excerpt, the notion of focused attention was described as a new skill brought to nursing through therapeutic touch.

- I: What would you say therapeutic touch adds to your nursing skill that isn't a part of usual nursing care?
110: I wouldn't ordinarily spend that kind of time -- not time, but the quality of time -- in terms of the focusing and the centering that goes on. Seeing that all as being connected in a universal way. I wouldn't ordinarily think of that in patient care situations. I think it adds a spiritual dimension.

Patient interviewees indicated that the nurse's focused attention on the patient and the situation was an important aspect of therapeutic touch for them. Comparing what she received from therapeutic touch, on one hand, and other health care she had experienced (she specifically mentioned interaction with her physician), on the other, one patient (208) said that with therapeutic touch, "More time is taken with an individual, and you can talk ... and will get listened to. There's not such a hurriedness about the whole thing." Then, asked what she felt was the underlying basis of effectiveness of therapeutic touch she responded, "A relationship of common interest. A relationship between two people, with a common interest in mind -- a common goal." The sense here seemed to be that the patient perceived the nurse as taking particular care to develop the relationship, based on the patient's needs.

Similarly, another patient (209) responded to the question about the underlying basis of therapeutic touch with, "... someone is taking time out to be with you, and try to help. And you know they are working for you, and they care. And the closeness it provides."

Certain phrases in these excerpts indicated that the focused attention of the nurse contributed to these impressions on the part of patients. For example, "you know they are working for you, and they care." On the other hand, other aspects of the interactions were also implicated. Patients appeared to be responding to activity that was paced slower than that to which they were accustomed. One patient above indicated a sense of time being "taken out" from some larger context.

Another patient (201) compared the nurse-patient relationship in therapeutic touch with what he had experienced with other nurses. He made the point that, while the therapeutic touch interaction was different from what he expected in usual nursing care, the difference was in the quality of the caring interaction rather than in its presence or absence.

201: With [therapeutic touch], there was something about the attitude that brings about a closeness that, say, I wouldn't feel if I were just in a hospital being treated ... in ordinary circumstances. Or, it would be an unusual nurse if I did feel that.

I: There is something different?

201: Yes. There is that very strong, supportive, thoughtful attitude.... I suppose it is the attitude with which they approach therapeutic touch that brings that about. There is definitely a strong, supportive feeling even from people I have not known [previously]. And then, it is still there, but it is accentuated, with those people I've known and from whom I've received a great deal of support.

Frequently, when asked for a comparison of therapeutic touch with usual health care, patients distinguished between medical and surgical interventions on the one hand, and personal attention to the patient on the other. Patient 209 said that what she experienced as different was "close contact. Something that is specifically directed at the patient

-- that is helping you. Not giving you a pill, or telling you to do something."

Interpretive note. The patients' perceptions of personal attention, closeness, and caring on the part of the nurse appeared to represent an accurate assessment of the nurses' concerns in the interaction. That is, the several foci of attention during the centering process, as reported by nurses in the study, directed attention in a systematic, deliberate manner, toward the patients. It might be expected that because of purposeful disciplining of attention, which they reported, nurses exhibited behavioral and social cues which they did not report and which may have been out of their awareness. Such cues may have been perceived by patients and interpreted as caring. Indeed, nurses indicated that having focused their attention, they were ready to be aware of the specific conditions and needs of the patients.

In every day activity there is a parallel to the focusing process. Any time that a task is undertaken, some level of focusing must occur. Attention is placed on the task at hand. However, in the centering process described by nurse participants, the level of attention appeared to be more deliberately focused than in every day activity.

While practitioners of therapeutic touch generally treated the centering process as a new skill which differed from anything they had experienced before, there are concepts already in the lexicon of health care that are brought to mind by their descriptions. One of these which is

particularly salient to the concept of disciplining attention is the figure-ground concept of gestalt psychology; that is, the notion of differentiation of the object of attention from background considerations (Perls, Hefferline, & Goodman, 1951, p. 25).

In gestalt psychology, the same context (ground) can give rise to different figures or foci, depending on differing interests and shifts of attention by an individual. Therefore, the figure-ground -- the focus of attention and the context in which it occurs -- must be treated as a whole, in order to account for these potential shifts. Such shifts in attention were found in centering, when the practitioner selectively focused on certain aspects of the situation, such as his or her own feelings (figure), to the exclusion of others, such as the patient and the milieu (ground), and then transferred that focus to the patient or the milieu.

Achieving calm. In many of the excerpts, participants referred to a calm relaxed state associated with the technique. Some identified a relaxed state as the purpose of centering. Others identified it as their way of knowing they had achieved the desired state. It was also referred to as somehow related to the nurse's ability to practice the discipline of selectively attending to certain stimuli to the exclusion of others.

The calm, relaxed state achieved in centering emerged from the data as setting the stage for establishing receptivity and for becoming a channel for the energy of healing. For this reason, it was also a necessary precondition to practice of the assessment and treatment

phases which followed. In the excerpt below, the nurse responded to a question about how she felt when centering was achieved. Her phrase, "I'm going to deliberate exactly what I plan to do," identified the calm state as implicated in her readiness to proceed with the further phases of the therapeutic touch interaction.

- 112: It feels very peaceful, very calming, very relaxed. I feel a sense of peace, and also a sense of control ... a sense of, like I'm going to deliberate exactly what I plan to do, without anything interfering with that.
- I: And what physical sensations are associated with that?
- 112: Just maybe a lightness. I don't know if that would be a physical sensation ... My body feels very light and comfortable to be with. My heart is slow. My breathing is rather consistent and fluid.

Participant 138 noted that when you are centered, "you have left other places your head might be. Just feeling like you are in your own basic self, and kind of calm. A calm, calm place. And you have all of your consciousness or something right there, available. To put your attention towards something."

The calmness experienced by nurses during therapeutic touch was also reported by patients. In response to a question about what she felt while being treated with therapeutic touch when she had an intestinal infection, patient 206 said, "I found it really relaxing. Oh, yeah, very relaxed.... It was just very comforting. Relaxing and comforting." Another patient (208) included in her description of how she felt during the therapeutic touch interaction the comment that "it was relaxing, and warm ... [a] peace of mind type of thing ... it was just like, everything relaxed."

Nurses reported becoming calm and intending that the patient would become calm. At the same time the patients frequently reported relaxing. One psychiatric nurse participant explained how the

therapeutic touch technique gave her an increased appreciation of deliberate use of this effect in the interest of promoting health. She had just described her interaction with a patient in her office.

- 103: My training as a psychiatric nurse shows me the importance of being there in the moment. But it wasn't called centering. It wasn't a distinct training process of how to be there in the moment. Be yourself. Be a good role model, so that the person will be more calm with you. Be aware of what is you, and what is going on in the other person. Those are similar things to therapeutic touch, but they are not the same. Therapeutic touch has made more specific the process of intent and centering. It's very, very specific. I do that every day, but we didn't call it that. In a sense, therapeutic touch has made it more of a ritual. That you don't forget to do the centering, to do the intent, in any therapeutic process.

Another nurse used an elaborate visualization experience to obtain a calming response.

- I: I'd like you to describe exactly what you did.
 121: Well, I got in touch with myself -- my body and soul [laughter] -- and I felt the energy just flowing, from my visualization techniques.
 I: How did you get in touch with yourself?
 121: I do deep breathing. And I place myself in an arbor of trees. As a matter of fact, I brought to mind a particular site at Pumpkin Hollow. And I usually go back there in a momentary relaxation response. And I feel the quietude and peace. I feel very tranquil. And alongside of that, I hear the brook that runs along. I hear the splashing of the waves against the rock. The white crests, the deep blue water. The sun that is just beaming in the top of the trees, and sprinkling down. And I feel these flecks like diamonds that are all over me, and I just feel energized. And I feel very calm, as I feel now, by just talking about it.

This nurse introduced an interesting paradox. She described feeling energized and calm at the same time. Similarly, in the previous excerpt, the nurse associated the relaxed state with readiness to concern herself with the project at hand -- to proceed with her plan for therapeutic touch.

Interpretive note. The association of an energized feeling with calmness in the excerpts above is less surprising when one notes that the calm relaxed state was described repeatedly as either the purpose or the outcome of a disciplined focusing of attention. Thus, the calmness appeared not to connote a sense of detachment or distance from the situation as one might expect in another context. Rather, it appeared to represent a kind of involvement and awareness, perhaps enhancing the nurse's ability to focus on the emergent situation.

Further, the calmness felt by the nurse was described as reflected in the experience of the patient. The nurse's calm demeanor may have influenced the feeling state of the patient. That this reciprocal effect might occur has long been documented clinically in psychiatric settings, and in everyday situations is acknowledged by such statements as "laughter is infectious."

Establishing receptivity. Although use of receptivity was actually described by nurses as a feature of the assessment phase of therapeutic touch, the shift to this mode occurred as a characteristic of the centering process. A linear cause and effect chain of events was not perceptible in the emergence of the several characteristics of centering. For example, it appears from the data that in some cases receptivity was established concomitantly with experience of the calm, relaxed state described above. An example of the co-occurrence of calm and receptivity is seen in the excerpt below.

- 136: I can feel a sense about my body, as I go inward, and reinforce and become very strong and very rooted And I feel very calm and open -- very receptive.

Another nurse was asked what her thoughts were when she was centered. She said:

- 135: It isn't an issue of thinking. I focus on my hands and I feel. I take in the information, and I keep my mind clear and receptive. It isn't an issue of thinking. My hands pick up clues, and I'm just going to be receptive to register that information.

The disciplining of attention described above also appears essential to emergence of receptivity. The data suggest that disciplined attention to the patient involved preventing other stimuli from interfering with the process of therapeutic touch. Receptivity was made possible by this discipline, and involved openness to cues arising from the patient.

In the excerpts above, nurse participants described a highly skilled process which would appear to occur consistently in therapeutic touch, when the nurse's mode of attention shifted from thinking about what she was doing or expecting, or focusing on how she felt, to observing whatever information arose from her interaction with the patient. Having cleared her mind of thoughts, the nurses began to rely on perceptual awareness. That is, they no longer relied on thinking through each bit of information perceived through the hands or through behavioral or social cues. Instead, the nurses' reports suggested that their perceptions were processed through involvement with perceived information at some level other than analytic. The term perceptual awareness is used here to indicate that groups of sensory cues seemed to be understood as a whole to represent a meaning possibly derived from earlier experience with similar cues.

This shift from analytic thinking to perceptual awareness can be seen in a comparison of the two excerpts above. In the first, when the nurse was asked what she "felt", her answer flowed easily from the question. She stated her method of centering and then described her shift to receptivity. In the second excerpt, the nurse first responded to the question about what she "thought" with the comment that, "It isn't an issue of thinking." Then she spoke of receptivity. The perceptual awareness which arose in conjunction with this shift continued to be used throughout the therapeutic touch intervention, as will be seen in the following sections on practices of assessment and treatment. The data indicated that it was an important characteristic of therapeutic touch, arising during centering.

In the excerpts above, receptivity was introduced. The following more extensive excerpt illustrates one nurse's experience of the emergence of receptivity in the context of the beginning of the therapeutic touch process. She was treating a man who came to her with several complaints including aches, pains, and depression.

- I: Were there any other feelings or thoughts that you had? Thoughts that had to do with what you were doing?
- 126: About what I was doing? I don't think about what I'm doing. I just run my hands over the field, and see what information I get. Either in my hands, or my head, or in my own body. When I'm centered, I consider that patient information, not my own stuff.
- I: Being centered makes that difference for you. And, would that be how you know you are centered? Or, how do you know?
- 126: I feel present. And there is a clarity of being here now, that comes. And, I feel calm and peaceful. I'm very clear about what is going on with myself emotionally and physically. So, I really know what is me. So, anything that would all of a sudden come in when I am working with a patient, I would consider them, and not me. And that is verified, because then when I walk away from a patient, those things leave.

Sensations or thoughts leave. And I am back to just me.

I: It has something to do with your proximity to the patient, then?

126: I think it has to do with my focus. I'm focused on the patient, and I'm getting their information, when I am there, present with them. Then, when I am finished with the session, and I turn away and leave them, I break that focus and then I'm back to just me. And, sometimes I'll later get thoughts about them, that I also consider information. And, I don't know if I pick that up telepathic, or if it's just my being, processing the information, and it just takes me that long to get it down to concreteness so that I can assess the data.

The nurse said, "I don't think about what I'm doing. I just ... see what information I get." Many similar statements from other nurses underscored the importance of a shift away from an analytical mode of thinking to a perceptual acceptance of available information. The subtle influence of the use of perceptual awareness could be seen in nurses' responses when asked how therapeutic touch was different from their usual nursing practice. Many nurse participants spoke of acquiring increased sensitivity to patients' needs through their practice of such awareness, as the following two excerpts illustrate.

I: What would you say that therapeutic touch adds to your nursing skills that is not a part of your usual nursing care?

113: Much more sensitive to all the different ways that a person will be presenting themselves. I don't just accept a physical diagnosis, nor do I accept simply the verbal cues that a person gives. Because they are only a little part of what is happening. So, it has sharpened my nursing ability to assess the situation, and it has also allowed me to cue into what is really happening.

124: I think that you are much more compassionate towards people, and therefore you interact completely differently with people. No matter what you are doing with them, from a nursing point of view, whether you are interviewing them, whether you are giving them a bed bath, helping them ambulate, giving them medications, you are really responding to them as a

person. You are far less judgmental about the things that people and patients do that drive you crazy. In fact, you almost forget to get angry with a patient. You almost forget what it's like. There are still those patients who trigger those feelings, but the more involved with therapeutic touch that you are -- you are able to integrate it into your life -- the less you respond to people's negativity with anger, because you recognize that it is part of their attempt to deal with something. And, the more you are apt to focus in on that, and to wonder what the person is experiencing that makes them act this way, and to take time to check it out, rather than to respond in anger and say, oh, it's a terrible patient, or whatever. And, I think it adds a very -- I think it enhances -- I don't think it adds to nursing, but it enhances what many of us came into nursing with: the altruistic aspect of nursing.

Interpretive note. Initially the perceptual mode of awareness described in this section may seem unusual. However, on closer consideration it may be a common mode of awareness, but one we usually do not feel a need to explain. It may be so much a part of our every day activities that we take it for granted. Also, the subtle change from analytic thinking to perceptual awareness exemplified in the data may not lend itself easily to analytical description.

For example, Polanyi (1969, pp. 127-128) speaks of the sense organs, other than smell and taste, as having the "distinctive peculiarity of being projected from the interior of the body to the space outside it." He illustrates this notion with a description of the use of intentional control of eye muscles, internal details which are not clearly observable. The faint perceptions of muscle strain, he says, contribute to the complex processing of information used to arrive at conclusions about visual perception. Polanyi compares this use of internal activities and cues to the use

of tools. A tool such as a probe is used as an extension of one's hand. The feeling in one's hand while using the probe is one aspect of data the person uses in assessing the area being probed. The internal cues are not usually acknowledged as part of the data, but are projected to the area being probed. A teacher does not tell a student how to evaluate these cues. Rather, the teacher instructs the student that with practice the various sensations associated with probing will be understood. Similar cues occur when tools are not used, but since there is no "tool" to observe, the cues are less apt to be noticed.

Looked at from the perspective of Polanyi's acknowledgment of internal cues, therapeutic touch practitioners did not experience unusual cues. What was unusual was their ability to perceive the cues. Benner and Wrubel used the terms perceptual awareness and perceptual grasp of a situation to describe expert nurses' use of experience-based intuition in recognizing early signs of changes in a patient's clinical status (1982, p. 12). It seems possible that this awareness may have been enhanced by careful focusing of attention on the patient in a receptive manner.

Becoming a channel. Three aspects of centering have previously been discussed: disciplining attention, achieving calm, and establishing receptivity. A fourth characteristic of centering described by nurses in the study may be called "becoming a channel," or somehow being an instrument for, rather than a provider of, healing.

The following excerpts illustrate the relationship between channeling and the full practice of centering. Participant 101 provided a graphic description of how she achieved the desired state of being a channel.

- 101: I still try to get centered and grounded, and to feel that there is energy flowing through me. Not really from me, but through me.
- I: You're saying you let the energy flow through you. Does that mean that you make certain moves, or think certain thoughts?
- 101: [Laughter] O.K. I think of trees. I think of the tree needing sunshine, but also being grounded into the ground, to get nutrients from the earth. It's just sort of more of a universal feeling. So that's the image that I use to become centered. And so [I] just feel like a cycle all the time.
- I: And then, after you do that, in what way do you feel different?
- 101: You just feel like you are ... a part of the universe. Because, I really think that you have to be a channel for the energy. It's not that you are really giving it. You are just being a channel. It's making a conscious connection.

A similar process was described by another nurse. Again, the term "channel" was used, with allusion to the symbolism of simultaneously receiving and giving. Participant 124 was well into her description of how she performed therapeutic touch when the subject of centering arose.

- I: In the beginning, you hadn't said that you centered. Could you describe what you did?
- 124: I do that in different ways at different times, depending on my own state. I usually use an image. I focus on my breathing momentarily, and I imagine myself becoming a channel for energy. Sometimes I imagine myself as a tree, and sometimes I'm not aware of a particular image. I wait for this particular feeling. And when I feel that stillness, then I begin to do the assessment.
- I: Can you say how you recognize the stillness?
- 124: It's a feeling of peacefulness and -- I don't want to use the word centeredness.
- I: How else would you describe that centeredness?
- 124: For me it would be very -- whole -- at that moment. I'm aware of myself as a channel.... It's that I'm

able to reach out at that time. And I'm feeling whole.

Wholeness is also described by nurse 110 as involving energy that is available from some source beyond the nurse and the patient.

110: I try to think of everything as being connected in a universal way. I try to think of a universal energy that I'm in touch with and that I'm open to, and that the patient can be open to as well. And just think of a oneness with everything. That's basically it.

I: How does that feel to you?

110: Calming. It's calming. It's sort of tying everything together in a way that makes sense. As opposed to a fragmented way of looking at things.

Again, this notion of being a channel can be compared with the gestalt of a shifting figure and ground. While study participants reported taking care not to be distracted by environmental details, a continuing sense of connection with certain background qualities emerged from the data as an important concept for therapeutic touch. Participant 106 referred to this sense of connection as "grounding." Asked how grounding contributed to her preparation for doing therapeutic touch, she said it added "a feeling of the energy being really anchored to the earth and to here [indicating the top of her head]." The notion of channeling suggested a sense of an active connection among various components of the interaction -- notably the nurse, the patient, and healing energy.

In descriptions of becoming a channel, study participants began to refer to what continued to be a central theme in the data -- the concept of energy. The source of this energy was often called "universal." That is, while both the nurse and the patient were acknowledged as having perceptible energy fields, the channeled energy was taken to come from and return to a source beyond the participants.

Interpretive note. The notion of being an instrument for the energy of healing suggests a belief in some unseen force or being, which in Western thought commonly has spiritual connotations. On the other hand, the concept of energy suggests a measurable force. In therapeutic touch, this force has been taken as axiomatic (Quinn, 1982, p. 40).

In Krieger's early theoretical formulations for therapeutic touch, she conceived of the energy of therapeutic touch as related to the Eastern Indian or Tibetan concept of prana, which she identified as comparable to the Western concepts of animation or vigor (Krieger, 1975; 1981, p. 40). More recent therapeutic touch studies are founded on concepts of energy from Rogers' nursing theory (Heidt, 1980a, p. 6; Quinn, 1982, p. 38; Rogers, 1970). However, since no clear theoretical foundation for the concept of channeling of energy was identified in the data, it appeared that participants' explanations arose from their personal understanding. That understanding will be discussed in the section on beliefs associated with therapeutic touch.

Summary of centering. Centering was described in a number of different ways, but certain practices common across the accounts were apparent. First, there was deliberate disciplining of attention, leading to focus on the nurse-patient situation, to the exclusion of extraneous stimuli from the environment or from the nurse's thoughts. Second, associated with successful achievement of disciplined attention, nurses described feelings of calmness and relaxation. Third, the focus was placed more specifically on the patient, and a

characteristic receptivity to the patient's needs was described.

Fourth, the nurse prepared to offer healing to the patient, by acting as an intermediary for what nurses in the study accepted as healing energy. While these aspects of centering are presented here as distinct, they were usually described by nurse participants as integral parts of one process.

Many nurses described centering as the first step in therapeutic touch. Others brought it up later in the interview, explaining then that it was such a natural part of the technique that they had simply not thought to mention it. Others described this component only after inquiry.

Assessment

A previous section of this chapter dealt with how the centering process was described by nurse participants as helping them to establish receptivity. In turn, receptivity emerged from the data as the critical foundation for the assessment phase of therapeutic touch. What was described by these nurses as received was information obtained predominantly through extratactile, somatic, and mental perceptions.

Extratactile perception. As mentioned earlier, hands-on contact was not usually reported as involved in this phase. Instead, the nurses' hands were placed within a few inches of the surface of the patient's body, in the manner described by Quinn (1983) as non-contact therapeutic touch. The term extratactile is used here to describe this mode of hand placement because of the importance of the nurses' perceptions during the activity, even though direct physical contact was not employed. The word extratactile conveys more of a sense of the

importance of both the positioning of the hands and the perceptual possibilities than does the term non-contact.

In the following excerpts, assessment is characterized by use of the hands to perceive qualities of the patient's field. The term "field" is used here to describe the area proximal to and extending at least a few inches from the patient's body. All of the nurses in the study who were taught Krieger's touch technique learned to use their hands to discern certain variable characteristics of this field, as described below. In the standard technique, assessment is practiced as a distinct phase of therapeutic touch. However, the data indicate that nurses sometimes integrated it with other phases.

Assessment itself was often the first component of therapeutic touch mentioned by nurses in the study when they were asked to describe a specific time they used the therapeutic touch. In this interview the nurse began with a description of assessment, even before mentioning her centering process.

- I: You might start with what the problem was that the person came with, and how you began.
- 135: I'll use an example of yesterday. A client that I saw has been coming to me as a nurse practitioner for several health problems, among which was arthritis of the right ankle. And, associated with that, she's had a great deal of pain. Also, [she] tends to favor that leg in weight bearing. And, part of the treatment for her included therapeutic touch. And, yesterday, when I did an assessment I found a great deal of heat over the area of the ankle.
- I: At the very beginning, where you started to use therapeutic touch, tell me what thoughts you had, and what moves you made, if you were moving your hands.
- 135: I started at the head, and I moved my hands about four to six inches above her body, and felt for changes in the field. The most significant ones that I found when she was lying on the table, and I moved my hands from head to foot, was the warm area over her ankle.
- I: When you were doing the assessment, what were you thinking?

135: It isn't an issue of thinking. I focus on my hands and I feel. I take in the information, and I keep my mind clear and receptive ... to register that information.

Another nurse had described her centering process before mentioning assessment, but the description was very similar. The patient was seated.

I: So then, after you centered --

150: Then, I started assessing the field. I usually start at the head. With my hands at the head, feel energy, coming down over the side, out over the shoulders, then the back of the head, and around the front of the face. And just feeling, just to see what I'm feeling. I'm not doing...anything else. [During this description the nurse was demonstrating by moving her hands over her face, a few inches from her skin.]

I: You are just speaking of going over the front and back of the head.

150: I was standing behind, and I do the head first, and then I do the back. Right down to the buttocks area. Then I walk around to the front and come down a little bit more to the front of the face, down the arms, down the upper chest, across the abdomen, legs, and do the feet. All the time, seeing what I'm feeling.

I: With this person, what did you feel?

150: I felt a lot of energy in his neck, plus a lot of energy in his lower back.

I: How did that feel?

150: Well, I always notice that my left hand is more sensitive than my right, so a lot of times when I'm feeling excess energy in a particular area, I have to switch them around and see if it is really excess energy or if it's just that my hands are just going well, because the left hand is consistently much more sensitive than my right. I remember feeling energy around his neck and around his lower back. And it feels, I guess like a vibration. Like a real fast vibration.

I: What does it feel like to you where you are not feeling the excess? Where you would say it is just the normal sensation?

150: I feel the energy. It doesn't feel particularly pronounced. You know, where I'm feeling the excess, I can feel a lot more vibration.

I: And, what did you think while you were doing that part?

150: Um, I'm not sure, if that's when -- I think I was not doing a lot of thinking, as much as just perceiving. More I'm noticing, and taking note of what I was noticing, and not particularly thinking of anything.

Another nurse participant described a variation on the process.

She was working with her aunt, at the aunt's home.

125: I said to her, "I know this technique that might make you feel better." She was having an acute flare-up of gout in the large bone of her foot.... I assessed her, and the most noticeable thing, when I did the assessment, was the extreme heat coming from her left foot. It was quite red and inflamed to look at, but, with your eyes closed you could feel the heat.

I: Could you describe for me exactly how you did the assessment?

125: I'm not conscious of myself as a person. And I'm just totally focusing on the person I am trying to assess or treat.... And just try to feel a recording machine for the assessment, so I can pick up the differences that I can feel.... I started at the top of the head. And, when I work alone, though this was the first time, I've found that this still remains true, I seem to do better if I do the front and [then] the back, rather than having one hand...in the back and one on front.

I: So, you are saying that you used both hands on the back.

125: Yes, and then, both hands on the front.

I: Where did you put your hands?

125: Well, first of all ... I put my hands together, with the fingers straight, and almost touching, but not quite touching. And then, I pull my hands apart about an inch or 2 inches, and then put them back together, until -- not touching, but almost touching -- until I can feel energy there. I find that if I do that before I assess, or before I treat, my hands are more sensitive to any difference. Then, I start at the top, and I don't touch the person, and I go about an inch and a half, or two inches from the body, and I keep both hands symmetrical. Like, when I get to the shoulders, and down the arms and hands, I have one on each [side] of the patient.

I: So, you go clear from the top of the body --

125: Down to the feet.

I: With your aunt, what did you feel when you did that?

125: There was practically [laughter] -- you felt practically nothing. Until you got to the inflamed portion.

I: You say you felt practically nothing. If there was a normal level of energy, what would you feel?

125: It's even. And you can feel it. It's, I suppose you would say sort of a tingle, but very lightly. Very light tingling. All over, from the top of the head all over the body.

I: O.K., but you were not feeling that with your aunt?

125: No, until I got to her foot.

- I: And then you felt heat, you said.
- 125: A great deal of heat. And, after I finished the assessment, I gave her a treatment.
- I: Before we get into describing the treatment, I want to ask you what thoughts you had while you were doing the assessment.
- 125: Actually, I don't have too many thoughts. When I'm centered, I can't think. Because, I used to. I remember one year when I went to Orcas Island, I used to think, "Oh, I must feel something." But that overrode my ability actually to do a very good treatment.

One more brief excerpt illustrates another kind of perception that was frequently reported by participants in the study.

- 134: [I began the] assessment over the head, maybe six to eight inches over the physical body. Over the face and the chest and abdomen and as I went over her chest, I felt some congestion of energy, and warmth in the heart area. And as I got over the abdomen, over the hip area, it began to be noticeably cool. It was a very noticeable difference in temperature.
- I: You used the term "congestion," but you also said "warmth." Are you saying warmth is an indication of congestion?
- 134: It felt warm and it also felt full and congested at the same time.
- I: Can you describe more how that felt to your hands?
- Full, you said.
- 134: Well, it was, in some ways, like there was almost more to push through. My hands didn't glide as easily. There was an area that was sort of congested, sort of gooky, sort of -- that was kind of sticky, almost, in that area. And it was warmer.

This excerpt illustrates one of the difficulties faced by therapeutic touch practitioners when describing their perceptions. The term "congestion" was apparently used by the nurse to describe a class of perception which is achieving common recognition by therapeutic touch practitioners. However, when the investigator requested a further clarification of her meaning in other terms, the nurse resorted to a more idiosyncratic description which did not help to clarify the issue. In the following excerpt congestion is described differently.

- I: When you were doing it with him, then, you said you felt something with your hands.
- 126: With my hands -- I felt a heaviness or congestion against my hand over his chest area. More like a void feeling over his abdomen. And, there was a congestion -- heat -- over his right knee.

The term "congestion" was used frequently enough in the interviews to point to a probability that a common meaning for this term is accepted among users of therapeutic touch. As in the excerpt above, the term was used to denote perception of increased heat, density, or other diverse cues, as compared with what was felt in other areas of the field. The following brief excerpts illustrate this point. The first nurse was assessing an asthmatic patient. She began working in the area of the patient's chest.

- 111: The assessment phase is quite obvious. The problem is quite obvious. Difficulty breathing. And wheezing So, I know where the problem is. So, then I do a sort of assessment to see if one lung is more affected than the other ... to find out if there is a difference in feel. And then I start on the place that feels most congested.
- I: Describe what you felt.
- 111: It's lumpy.... It's sort of like some of the cheaper polyester pillows, with lumps in them.

Other nurses described heat as indicating congestion.

- 120: I started at his head, and because he was not feeling well, and because he had flu-like symptoms, he was a very easy person to assess.... He obviously had these symptoms. So, I felt a lot of heat and congestion around his head, and down into his neck and chest area. And, for the rest of his body, it was pretty even. Balanced. Symmetrical.

In some of the excerpts above, the nurses did a full assessment of the patient's field. Other nurses used their hands to assess only the area of injury, rather than the whole body of the patient. Fourteen nurses, or about one fourth of the nurses in the study described

partial assessment. An example follows, in which the nurse assessed only the particular area of concern.

115: I was able to observe swelling and redness in the area, and subjectively he was complaining of pain. I proceeded to assess the area, and I experienced a lot of heat coming from the area.

I: So, you were not touching?

115: I was not touching. I assessed at a distance of about -- by passing my hands over the area at a distance of about 4 inches. I was feeling heat emanating from the injured wrist. Which I interpreted as a lot of congestion in the area.

Similarly, another nurse provided the following quote.

I: When you did the assessment ... did you go over the whole body?

108: Well, I didn't in this case, because I knew what his problem was. If he had been hurting and I hadn't known what his problem was, I might have gone over his whole body. But, I knew it was lower back because of the way he got out of his chair, and what he'd been doing -- the cause of the pain. And what he told me. So, I knew it was lower back pain. So, I just went over his entire back.

Patient participants who had not been exposed to therapeutic touch through workshops did not distinguish between hand movements of assessment and treatment, but they did describe their experience of the movements. Some patients did not watch the nurse; some did. The following patient, who was treated for pain associated with cancer, described his perceptions of the process.

I: What I'd like you to do is tell me what you remember about how therapeutic touch was done.

211: Well, at first, she passed her hands over my whole body. With all my clothes on. And, incidentally, they were never removed. My clothes were always on. But, I could feel heat, where she moved her hands over my whole frame. The heat was like a flowing blanket of heat, while her hands passed over me. The heat would pass over me, wherever her hands were at that particular time. And, it was a little eerie, because she never touched me, but it was like that. And, when she passed her hands quickly over the top of my head like this [moving his hands down both sides of his

head], it seemed like the roots of my hair was [sic] standing on end. And, she centered in on the area she had to work with. She said, "Oh, that is hot right there." And, I said, "How can you tell?" And she said, "Because you are radiating from there, tremendously."

I: Did it feel different to you when she had her hands in that place?

211: No. It felt just the same.

The following patient, who had been treated by the investigator, volunteered to be interviewed when she heard that the study was underway. She had requested therapeutic touch because conventional treatment was not providing relief from pain.

205: I had thought that therapeutic touch meant touching. And, at that point, my pain was so severe that I was avoiding crowded elevators, and I hadn't realized that I had really been guarding.... A friend had been doing some massage, and that made it worse. Heat made it worse. And so, I approached the experience of therapeutic touch with the hope that it would make it better, but I expected to be touched, and I might have to endure some additional discomfort during the process. One of the things that was the most -- exhilarating, I suppose -- and pleasing, to me, was that you didn't touch me. And, when you have a very painful part, that is a very nice thing.

I really hadn't any precept of what was required. I just trusted you.... So, I let you know I was getting fairly desperate to -- if something would help, it sounded worthwhile trying. And then, you sat me down and explained a little about what you were going to do, but you began to do it while you were explaining it. And, your hands -- that's when I realized you weren't going to touch me. You went over the surface, about 4 inches or maybe less, from my arm. And I think I said something like, "That's nice that you aren't touching me." And you said, "I won't be touching you at all." Then, the other thing I remember is that gradually, as you moved your hands up and down my arm and you said you were feeling for energy or heat or something -- I can't remember what word you used -- but, as you did, I began to feel a tingling -- a different tingling than the painful spasms were, but it felt rather like -- like ions and molecules were beginning to move, under the skin.

Faced with unfamiliar sensations associated with therapeutic touch, this patient resorted to symbolic use of familiar language to explain the experience -- "it felt rather like ions and molecules were beginning to move."

The following account was provided by a nurse who described her experience as a patient, being treated by other participants in a therapeutic touch class. Two people were doing the therapeutic touch. They told her when they were moving their hands through her field for the assessment.

- I: What did you feel while they were doing that?
 212: I felt there was something there. It was kind of like the feeling -- you feel something, but you look, and there is nothing there.... Sort of an eerie feeling.... It's like, when you can feel someone looking at you. We have no words to describe that.... It's like a closeness, sort of, when you feel that someone is too close, and [you] need to step back.

Interpretive note. A persistent theme in practitioners' accounts of assessment was that the nurse supplanted the analytical mode of thought with a more perceptual way of gathering and processing information. One nurse explained, above, how analytical thinking interfered with the assessment process prior to her learning to set such thinking aside temporarily.

In the previous description of receptivity as a characteristic of centering, this move toward perceptual awareness was identified as probably a usual human capability, but one to which little attention is normally addressed. In describing their perceptions, some nurses used language conveying a technological sense of their experience;

e.g., the nurse who explained a feeling of movement in her body as like atoms moving. As noted above, patients were also aware of unusual perceptions associated with assessment. Both nurses and patients either provided quite vague descriptions of these perceptions or used language indicating a scientific understanding or elemental sense of the body. That is, lacking a language for their lived experience, they fell back on more technological terms to describe it.

In this process, the nurse not only learned to acknowledge awareness of perceptions, as was done in achievement of receptivity. She was also required to make sense of these perceptions in terms of health status. The way that nurse participants in the study did this was to compare unusual perceptions to the usual. That is, they identified perceptions in the field contiguous to areas where health problems existed, and compared these with perceptions in the field contiguous to areas which were not injured or diseased.

Nurses also used language in ways that seemed different from those in general use. An example was use of the term congestion to refer to certain perceptions in the field. What seemed unusual, however, was its association with the idea of energy. The word "congestion" retained its meaning as an overcrowded accumulation -- in this case of energy. Heat and fullness were cited as indications of the presence of congestion.

Somatic and mental perception. To this point, descriptions of assessment have been concerned with what is felt with the hands. Reports of nurses in the study indicated that assessment involved other kinds of perception, as well. The following excerpt illustrates two such classes of perceptions, somatic and mental. They are discussed together because they frequently occurred together in the interviews. In the following excerpt, sensations are described as coming "into my brain and my own body". The nurse provided further clarification of this distinction with the phrases, "in my mind were words of loneliness and love," and "I often feel the patients' symptoms in my own body."

- 126: I run my hands over his body, not touching, but a couple inches away from his body. And notice the sensations on my hands. And also notice any sensations that come into my brain or my own body, that would give me clues about what is going on with him.
- I: And, what came into your thoughts?
- 126: I actually felt a corresponding heaviness. Or, I often feel the patient's symptoms in my own body. And so, I felt a heaviness over my chest. And in my mind were words of loneliness and love, the need for love. Sadness. Those kind of words came to me. And I just consider that information about the patient.
- I: Were there any other feelings or thoughts that you had? Thoughts that had to do with what you were doing?
- 126: About what I was doing? I don't think about what I'm doing. I just run my hands over the field, and see what information I get. Either in my hands, or my head, or in my own body. When I'm centered, I consider that patient information, not my own stuff.

Another nurse described what she referred to as intuitive information. Her patient had congestive heart failure, and had been treated several times in the past.

- 130: I do, whenever it's appropriate, use [Krieger's] way of assessing. Using the hands over the whole field, front and back, and all the way to the feet. And with her, I could. And it was pretty fast, because I know her pretty well, so I didn't take as much time as I would with someone new.... And, as I get better, and use it longer, I don't feel with my hands so much as I feel

inside myself. I listen to my intuition. And um, I listen to what I feel about the person.

This nurse was not able to put into words how she felt intuitive information coming to her. From her description it appears that she experienced both mental and somatic perceptions about the patient. The following excerpt provides a further illustration of mental perception.

- 109: I remember one time working on her by myself. Something happened -- I don't know -- I almost felt like she was not there anymore. It was a very odd feeling. I stopped. I said her name, because I thought that she was going to fall off the chair. She was quite all right. It was just that she was somewhere else completely. And, I know that sounds a bit daft, to carry on about things like that, but, that was my experience in the treatment.
- I: Can you describe more of what that felt like?
- 109: It was a general sense ... the more I treat someone, the more I get a sense of what is happening on a more underlying level.... I do so much with my hands, but a lot of what is going on is something else completely. As I see it, I would describe it as some kind of resonancy, where somehow or other, something arises. Something comes into awareness.

The following participant described somatic sensations associated with the assessment process. After describing the use of her hands, she added further information.

- 113: And the other aspect that I felt with her, and I felt with other people, is that ... there is something happening emotionally. To them. Or that was causing the problem, or that they had a physical problem that was causing their anxiety. And that was the thing that we might be able to be working on. And the healing that might take place is more at a spiritual or emotional level than physical.
- I: Now, you became aware of that?
- 113: Very much so. What happens is, I'll often have a sensation of -- in my chest, and my heart -- I'll have a palpitation feeling ... there's an actual speeding up of a body part in myself. And, I'll verify, or talk to the client about it afterwards. To find out whether, in essence, what we're talking about is that they are feeling extremely emotionally upset. Or that there is a lot going on in them, that has emotional [content].

Another nurse was describing her use of therapeutic touch with a woman in labor.

- I: You also mentioned when you talked about moving your hands over the abdomen, that you would know if there was distress with the infant. I wondered how you know that. How would you distinguish that from the mother?
- 105: I can't tell you what sort of feeling I get in my hands. It's in my guts when I get a feeling. I intuit. And, I may have listened to the heart beat just a minute ago, and it tells me, get your dopler and listen to the heart beat. You know, it tunes -- it makes me tune in to really watching for something. It turns out to be a cord around the neck a couple times, and things like that. It just makes me tune in.

In some cases, the discrete assessment phase involving use of the hands was omitted from the interactions described by study participants. The following excerpt provides an example.

- I: I didn't hear you say anything about an assessment, per se.
- 129: Right. Well, I've found that often I don't need to do that. I get a sense immediately when I center, or when I touch someone, or just go to sit next to them, or be with them. I mean, I have just developed a sense in me that I just know intuitively what's going on, or what I need to do.
- I: Can you say something about how that comes to you?
- 129: Well, it sure wasn't there when I first started on all this stuff. I mean, assessment used to be the hardest part for me, of doing therapeutic touch, because I used to work so hard to find out what it was I was looking for. And touch is a sense -- it is not trying. It's trusting what you feel intuitively. And what you learn to perceive. But, it's not an intellectual process, and so for me, trying doesn't work. It interferes with being effective. And so, it was real hard for me because I would want to not try, and yet I'd want to do real well. And so, assessment was the hardest part. And sometimes, doing assessments would be real helpful, when you scan the body and run your hands over a person's body, and try to pick up differences. And, over the years of doing it, I've just picked up a sensitivity where -- I just know. I mean, not with everybody, and not all the time. And certainly not on demand. But, just when I'm in a situation where I know I'm there to help somebody, or to give my best or do my best, I can just by centering,

or even just by walking into the room, have a sense of what's going on with people around me.

As in the excerpt above, the following nurse described herself as not doing an assessment. Again, the patient was a woman in labor.

136: I didn't do an assessment, because she was getting quite distressed by this time. She was getting a little hyper. And she was extremely relieved to see that I was there, and I wanted to get her calmed down. And, I had talked with her before about doing therapeutic touch during the delivery, and I wanted to talk with her about doing some work so she would be more ready.

Assessment skills acquired through practice of therapeutic touch were also described by some nurses as used outside the formal therapeutic touch process.

I: You were talking about the assessment. It's as though you were saying that with psychiatric patients this takes a longer time, and perhaps a different form than working with others. Are you suggesting that [assessment] takes place while you are interacting verbally?

103: While I am interacting verbally. While we are talking. And it is an assessment -- trying to follow your hunches of what's going on in the emotional area. Once in a while I see auras around people ... and I can see if there is an expanded energy.... I may just sit and be quiet. Let's see, what is the greatest need -- is there anything in the emotional realm? What is the feeling I get when the patient comes in? And, I look at the whole being. I watch the patient come in ... and just let the patient sit there quietly.... What is their posture? Are they fidgeting? I look for all the clues that I can. And then, we just start to talk. And usually, it is just in the way of establishing rapport.

Twenty one of the 51 nurses in the study described at least one case in which they did not include an assessment phase in the procedure. Nevertheless, they used language regarding the treatment phase, indicating that assessment was occurring at that time. The following excerpt is a case in point. The nurse omitted the assessment

phase. These remarks were made after she had described the extratactile hand movements of the treatment.

- I: What did you feel in your hands while you were doing that?
- 128: Uh, I felt with her, hardly anything in her extremities. Because she is very physically paralyzed. And, I felt heat around her chest. That's where her problems are now. She had respiratory arrest about a year before. That's why she's on the ventilator. And, she -- her personality is such that -- she's a very angry person. At life. And, she didn't have a lot of love in her life. And I could feel that. Anger.
- I: Tell me how you felt that?
- 128: Well, maybe because I was prejudiced, because I knew her. But, just, it felt real heavy.
- I: What you were feeling in your hands?
- 128: Yeah. Especially around her chest. It just felt like there was a lot of blocked -- things. Blocked emotions. I think what she needed to say and didn't say. Or couldn't say.

These remarks indicate that both extratactile and mental perceptions experienced during the treatment were used by the nurse to evaluate the patient's needs and guide the treatment. The same phenomenon occurred with another nurse (104), who first indicated that she did centering, assessment, and then treatment. Her detailed description of the process, however, involved assessment only as a component of the treatment phase. In the treatment section of this chapter, additional descriptions of this ongoing assessment will be found. It appears that an integrated assessment may have been practiced as part of the treatment when the formal assessment phase of the technique was not used.

Although about two fifths of the sample did not always use a discrete assessment phase, the practice was described by others as contributing to increased perceptivity. Importance of the early practice of scanning for extratactile cues by less experienced persons

was emphasized in the excerpt below. The nurse was describing some unusual sensations which she noticed when treating a woman who had a headache.

- I: Did you do the general assessment with her?
 115: No. I don't do that a lot, and that is, I think, a part of what I need to do. Because sometimes the problem is not in the area where I am feeling the discomfort, but, perhaps somewhere else. And, if I would develop better assessment skills, I would feel more comfortable. I still sometimes get the feeling that I am dabbling. And, though I have a lot of successful outcomes, I'm never quite sure how come. But, I think that the key is probably in assessment. Of having some sense of monitoring what is going on with a person, and to reassess, and to treat and reassess, and that kind of thing. I think that is where a lot of the skill of this technique rests, and I feel I need a lot more skill.

In this excerpt, the nurse appeared to see experience with use of the hands during assessment as a means of developing expertise in recognizing cues to the patients' problems. The nurse did not consider herself an expert. Rather, she seemed to assume that expertise would confer increased certainty regarding assessment findings.

Interpretive note. The data indicate that the hand movements of assessment as described by Krieger (1979, pp. 42-51), however helpful they may have been in some instances, were not essential to the successful use of therapeutic touch. If the standard movements of the assessment phase are not essential, then the question arises -- what is their role in the therapeutic touch process? One excerpt above indicates that the hands were used in the classic manner early in the nurse's therapeutic touch career, and could be dispensed with as she became more expert at perceiving patient information. Nevertheless, nurses who omitted the

formal assessment phase described integrating features of the assessment phase into the treatment phase of therapeutic touch. Usual nursing assessments were also integrated with therapeutic touch practices.

Not all of the nurses who at times dispensed with the assessment phase mentioned a relationship between expertise and their departure from the standard technique. Only one of these nurses, however, had used therapeutic touch with fewer than 20 patients, and two thirds had used it with over 50.

This phenomenon of telescoping and simplifying the procedure is consistent with development of expertise in nursing as described by Benner (1984), based on the Dreyfus model of skill acquisition (Dreyfus, 1982). Dreyfus described a progression through five stages of business skill acquisition, from novice to expert. According to this model, the worker moves from learning to recognize and utilize certain specific interpretation-free rules which require no experience (novice), to ability to make intuitive decisions based on holistic recognition of salient situational factors (expert) (1982, pp. 141-148).

Benner has identified the existence of these five levels of skill acquisition in nursing. Her expert nurses' descriptions of practice indicate that they act on intuitive comprehension of perceptions which they need not take the time to process in a linear fashion (Benner, 1984, pp. 31-36; Benner & Wrubel, 1982).

Some excerpts in this section exemplified features of expertise according to the Dreyfus model, as explicated for nurses by Benner, when they indicated movement from the structured and observable hand movements of the standard therapeutic touch assessment to a more intuitive awareness of patients' needs. According to study participants, this awareness was frequently based on somatic and mental perceptions, described in some instances as feelings about the patient. That these feelings were difficult for participants to describe hinted that they had been incorporated as personal knowledge through repeated experience rather than through description and demonstration. Like Dreyfus, Polanyi (1962) also concluded that such "ineffable knowledge" is a factor in connoisseurship, or the ability to make expert judgments.

Benner found such expertise operating in skilled nursing practice. The findings in this study indicate that some experienced participants found the practices of centering and assessment in therapeutic touch to be a means of speeding acquisition of the skillful use of intuitive knowledge.

Summary of assessment. Therapeutic touch assessment was practiced by study participants in a number of ways. In the standard technique as taught by Krieger (1979, pp. 42-51), the hands were used to perceive changes in the field around the patient's body. Some variations included assessing only with the hands over the particular area where symptoms were reported or signs observed, and using an intuitive

process involving somatic or mental cues instead of sensing with the hands.

Given their deliberately focused attention and receptivity, as developed during centering, nurses in the study reported perceiving what was described as heat by one nurse, and vibrations by another, in the space near the patient's body. In these cases and others, the nurses' perceptions over the area where a problem existed (and in some instances in unexplained places, as well) were different from the perceptions over most of the rest of the body, where normality was assumed. Similar preceptions were described by patients, even though they did not deliberately focus their attention. Patients' perceptions, however, seemed more closely associated with awareness of the presence of the nurse's hands than with particular areas where problems might exist.

The perceptions themselves varied among nurses. If there was a pattern to the variations, it was not discernible from the study data. However, the frequency with which the term "congestion" was used suggests an emerging vocabulary associated with the practice. Also, perceptions of heat and vibrations appeared to be linked by nurses to the idea of energy activity. That is, increased heat or vibrations were equated with increased energy, while decreases were equated with lack of energy.

In addition to the extratactile perceptions described above, nurses reported experiencing mental and somatic perceptions which were sometimes referred to as intuitive. Nurses who were more experienced in therapeutic touch described modifying their assessment technique by

increasing use of intuitive perceptions and relying less on extratactile perceptions.

Treatment

Previous sections of this chapter have discussed nurses' reports of their cognitive and affective preparation for use of therapeutic touch, and their practices associated with obtaining information on which to base treatment decisions. These constitute two of the phases of therapeutic touch as developed and taught by Krieger -- centering and assessment. The third phase is treatment.

Three major characteristics of the practice of therapeutic touch treatment emerged from the interviews: (1) smoothing the field, (2) modulating transfer of energy, and (3) modeling expected outcomes. The first two practices are conventional features of therapeutic touch, described in the introduction to this chapter as typical stages of therapeutic touch as taught by Krieger. Modeling of expected outcomes appeared concurrent with the two conventional features of therapeutic touch treatment, as well as being practiced independently of the other features. It was a practice not normally described in standard therapeutic touch.

Smoothing the field. Smoothing was described as involving use of the hands to intervene in the patient's field. The study participants' rationale for smoothing the field appeared to be based on imbalances in the field found during the assessment, or, when assessment was omitted, on the assumption that where disease or discomfort existed it was accompanied by such imbalance in the field. This rationale was based on the nurses' understanding of the concept of the personal field as described earlier in this study.

The following nurse provided a graphic description of what smoothing the field meant to her.

- 107: I put my hands over [the patient, and] what I did was unruffle his energy field -- just smoothed it out.
 I: What did you do, exactly? What does that mean?
 107: I imagine that the person is a crumpled up sheet that you are going to put over a bed. And I just imagine smoothing that sheet out. So I can stretch it over the bed and make it. So, I'm just smoothing out the wrinkles and getting rid of the uneven places. Whatever. So, I just usually go ... down his neck, to his arms and hands, and then down his chest, and imagining the back, and down his abdomen and out his toes.

Smoothing the field is presented in the textbook version of therapeutic touch as a beginning stage of the treatment phase, to be followed by energy transfer modulation. Seventeen participants indicated that sometimes in practice only the smoothing was done. The next excerpt is such a case. The excerpt includes introductory and outcome information in order to provide a contextual view of the episode.

- 140: One time that comes to my mind quite readily is working with a Parkinson's patient, an in-house patient at (a large metropolitan hospital). He was an elderly gentleman, with severe tremors due to Parkinson's, and the psychologist had been attempting to teach him progressive relaxation, but because of his severe tremors, he hadn't been able to learn that. So, the psychologist, through the neurologist, contacted us.... Another person who also does therapeutic touch went with me the first time. And when we were doing (the treatment) he was trembling so that the bed rails were shaking.... And as we passed our hands over him and worked with him, he took a big, large, deep sigh, and then everything went still.... he had relaxed so deeply, his tremors stopped.
 I: What I'd like you to do, then, is to start right at the beginning, and tell me how you began.
 140: Well, we had met this gentleman prior to this date through the neurologist, and he had requested that we see him.... And when we went back the next day, he was having the tremors. We just reintroduced ourselves, and began to do therapeutic touch. We told him we

would be passing our hands over his body, and it should not be uncomfortable, but if he wanted us to stop at any time, to let us know. And so, that's basically what we did. We were just attempting to think about peace and relaxation, and he took this big gasp [and the tremors ceased]. It wasn't more than just two or three minutes.... We just generally attempted to brush him and bring balance in the field.

I: Can you describe what the brushing was?

140: Using the hands perhaps in a way that one might think of combing hair. And, as a brush, attempting to remove the snarls, or move the differences out of the energy field, and moving from the head down towards the feet. With a lot of concentration over the trunk region. There seemed to be a lot of differences -- I don't know a better word-- a lot of differences in that area. Moving down toward his feet. But it was pretty dramatic. For me, that was the most dramatic response I'd ever seen, to have someone be trembling so severely, and immediately just cease that. There were no tremors.

I: Do you know how long that lasted?

140: Well, yes, because I checked with the staff. They said, about a half an hour. The same thing recurred two days later, when we did it again. We only saw this gentleman a few times, over a period of a week, but, he was able to relax enough that the psychologist was able to come in ... and teach him some relaxation techniques.

The brushing hand strokes in the patient's field were described as accompanied by thoughts of peace directed to the patient. In the following two typical descriptions of smoothing, the nurses again indicated that they used their hands to smooth the energy field.

114: What I usually do is unruffle the field a little bit.

I: You are moving your hands from the center of your body to the periphery as you say that. Not touching. Is that how you went over his body?

114: Sort of like smoothing the field. From the head down, at the back, and then just throwing off the excess energy than you get on your hands. Just smooth out the field.

I: Could you tell me, then, how you did the unruffling?

112: Well, I just went over his body with a sweeping kind of motion, and started brushing away the blocked areas.

I: You are moving your hands in a way that indicates to me that you start at the center of the body with your hands, and then move outward --

112: Right. And again, I started at the head area, and I spent more time there than I did with the rest of the body. And that's where the concentration of energy was. There was more heat there, and the coolness.... And then I continued with the process of unruffling the rest of the body. And then, just sort of terminating by making sure that the whole body felt in sort of synchrony and ... that the energy felt more patterned.

Each nurse described use of the hands to smooth the patient's energy field. Usually, the field was referred to as consisting of energy. However, the descriptions of what was felt were similar to the perceptions noted in assessment; e.g., differences in heaviness, uneven places, or coolness. The nurses described moving their hands over the field to make the field more even to their perceptions. In addition to the hand movements, nurses described focusing their thoughts on peace and relaxation as a means of smoothing the field.

Patient participants verified the soothing effect of the smoothing phase of therapeutic touch, as the following excerpts indicate.

212: It feels pretty similar to the assessment. And, it didn't feel ... quite as strong as the assessment because the assessment had already smoothed things out a little bit. It's like, when their hands went over, the energy they were touching -- the lumps and bumps -- had already been smoothed out during the assessment.

I: Were the "lumps and bumps" something you had perceived, or was that something that had been talked about during the process?

212: I'm calling that the places where I would feel the closeness, where I would feel there was someone there when it wasn't so.... When they unruffled, I didn't have such a strong feeling that there was something there. It's sort of an uneasy feeling, actually, because you're not sure what's happening. So, when they unruffled, it was a much smoother feeling. Kind of like petting, you know. Petting the fur the right way. That sort of thing.

The following patient described a time when he was experiencing neck and shoulder pain which he attributed to stress. He was lying down during the treatment. The nurse had suggested some strategies for

clearing his mind of extraneous thoughts. Soothing music was playing in the background. The patient's eyes were closed.

- I: If you had your eyes closed, you didn't necessarily know what she was doing.
- 217: Well, you could feel ... her hands going over, without actually touching.
- I: How did that feel?
- 217: There's no real definitive answer I could give. It had a soothing effect. A total one. It was almost like, I don't want to say trance, but, hypnotic like. The feeling that I was getting from the music, from [the nurse] talking through it, and -- her hands going over, and what she was saying -- because she uses a lot of verbalization.

This response suggests that the meaning of the experience to the patient was related to the total effect rather than to discrete aspects of the intervention, such as use of the hands. Also, the setting -- e.g., soothing music -- was contrived to heighten the calming effect of therapeutic touch.

Modulating transfer of energy. As indicated in the introduction to this chapter, Krieger used in her conceptualization of therapeutic touch the notion that constant transfer of energy exists between individuals. In therapeutic touch treatment, according to Krieger, steps are taken to intervene in this assumed energy transfer, and exert some control over it in the interest of the patient's well-being.

Data from the study indicated that smoothing, as described above, involved the notion of a rearrangement of the patient's own energy, frequently in localized areas. Descriptions of modulation of the energy flow, in comparison, assumed an increased interaction between the patient's field and that of the nurse. That is, there was more of an idea of energy moving through the nurse, to and through the patient, to achieve a balanced flow throughout the patient's field. It was

noted earlier that seventeen nurses described times when they did not use this phase of treatment. An equal number described times when they used modulation of energy but not the smoothing phase of treatment.

Imagery was frequently used to symbolize movement of energy in this phase. Three nurses described situations in which the hands were not used, but in which they either used mental imagery symbolizing energy flow, or felt particular compassion for the patient. It was also in this phase of treatment that nurses most often described acting as a channel for healing energy. Preparation for this activity was discussed earlier in the section on becoming a channel as an aspect of the centering process.

In the following two excerpts, the nurses used light and color as images symbolizing movement of energy. For example, the first nurse said, "You picture the blue light coming through you," and "I'll just picture him surrounded in the light -- whole, harmony, balanced...." The second related green and blue to the movement of ocean waves as symbolic movement of energy.

114: After doing his whole body, I had gone back, and I still found some heat in that area, and so I concentrated in that area. I worked on his shoulder. And sometimes I do touch the body.

I: Is that what you were doing?

114: Yes, that's what I was doing with him. With his shoulder. Sometimes if I can't get that heat out, then I will touch and just concentrate on filling up the area with blue.

I: Could you describe that?

114: Well, I guess it would be like using imagery, where you picture a blue light coming through you and out your hands, just filling the area. You know, you picture what you want in the area.... I'll work on the shoulder first, and I'll give a blue or a green light, or whatever, just to work through. And then, afterwards, I'll really seal it with a white light. I'll use the white light just at the end, to sort of close his field.

- I: And then, the thoughts that you had during that part of the process?
- 114: Well, usually when I work with the white light, I'll just picture him surrounded in the light. Whole, harmony, balanced. I'll just think of these -- just sending love, you know. Harmony. And then I just finish the work. And, he'll tell me, if he needs more. The pain went away in his shoulder, and he was able to move his arm up and down, which he couldn't do before I got there....His abdominal pain was still there.
- 112: I did spend some time on the solar plexus area, sending some healing color.
- I: If you used color, I'd like to know how you did that.
- 112: I concentrated with blue ... and closed my eyes and visualized ... an ocean, and the waves were coming in, and going up and down, and coming into the sand, and just smoothing it out. And, that this was sending a lot of peace. And the colors were greenish and blue, and very calming. And, the client's reaction was that...he started to fall asleep, now that I recall the situation.

The following nurse also used symbolic imagery while modulating energy flow. In this case, the energy was imaged as coming from a universal source.

- 115: I began to transfer energy, and I did that by visualizing a network in his wrist, of tightened up blood vessels. And, I began to transfer energy thinking and imagining that this mesh was kind of straightening out these fibers. And, I did that for about 3 minutes, and he was startled, looking around, and saying, "I feel better. What are you doing to me?".... I was about 4 inches from his wrist, and pretty much focusing -- staying at his wrist. Maybe sweeping very gently, but primarily directing energy.
- I: What were your thoughts associated with how you dealt with the energy?
- 115: I imagine my energy coming from universal energy. And, I try to be consistent about the symbol that I'm using. To draw energy from the universe. And, the symbol that I used is the rainbow, that is angling itself into my head. Literally visualize a rainbow coming into my head and sending energy into my head. I visualize it very, very methodically, coming through my arms into my hands.

Again, another nurse described using images of color as a treatment technique.

105: The physician I work with does some therapeutic abortions. And, when he does, I am the support person for the client, and I also assist him. Basically, there isn't much medical assistance that goes into it. Mostly, it is supporting and counseling. And, I always use [therapeutic touch].... What I do is put my hands on their shoulders, and send the color blue. I go through the process of getting centered, and feeling the energy flowing through me, and, you know, I have my hands on the woman's shoulder, and I send blue. And I do meditate. We do use some morphine, but it still is a painful procedure for them. And so, I also visualize.... I usually visualize blue going into her uterus. And, I notice that on the days I do use this -- some days I don't use it when I don't feel very centered -- they seem to do better, and they are calm and they have less pain when I do it.

Many nurses described directing love to the patient, as though the feelings of good will and caring which they felt might be projected as a force moving through the patient's field. The excerpt below involved such mental direction of love to the patient, apparently as a symbol for modulating movement of energy.

128: I was sending her love. Loving energy.
 I: How did you do that?
 128: I just think a lot of loving things that represent love to me. And, moving down through my heart and hands, and into her body. A lot of visualizing.
 I: Do you mean you actually are seeing a picture of this happening?
 128: Yes. I visualize the loving force moving from my body to hers. It's not love from me. It's love from the universe.... I visualize the top of my head opening up, and all the love from the universe ... coming into my head, and coming down through me, and through my arms and hands. Things that represent love to me.

Below, another nurse used the word love to exemplify the energy she moved through the field. This excerpt also indicated systematic use of the hands, as was the case in most accounts of modulation of flow in the field.

I: You said that you also worked around her head.
 128: Yes. After smoothing out the energy around her head, I just sent the love to her head.

- I: You're holding your hands at both sides of your head.
- 128: Yes. I put my hands at both sides.... After I did her head and chest, I put a hand at each end of a long bone -- for instance, I put a hand here [indicating her hand] and here [indicating her elbow]. Her forearm. And, I would just, between my hands, I would just send a lot of love to her. To her bones and her muscles. Her muscles were atrophied, and she was doing exercises to get them stronger. So, I would visualize them healthy, and blood circulating. And the nerves, pink and healthy. Picturing what that would look like to me. Sending her energy. Because her extremities were real cold. And, I would do that to her calf, and her thigh, and her arms.
- I: So, did that conclude your treatment, then?
- 128: No. I think that I finished up by working on her feet. Pulled that energy out from her feet. I would just hold her feet, and feel the energy coming out from her feet.
- I: How did you know when you were finished with the treatment?
- 128: I just felt done. I looked at her face, and she was real restful, and she had changed since before I started. And, I just felt done.

One nurse, when asked for a description of a time when she used therapeutic touch effectively, told about an experience which occurred prior to her introduction to the therapeutic touch technique. The idea of sending love was one way she saw the experience as similar to therapeutic touch.

- 151: This was before I became involved with therapeutic touch. I've always been a toucher. I've always used my hands with patients, and had physical contact with them when I've taken care of them. And, I remember my physical contact having an effect on a patient when I was working in the intensive care unit. I had a 5 year old who was comatose from a car accident, and, he'd have tachycardia. His heart rate would be in the 180-200 range.... I remember standing there with him -- holding his hand, or just having my hand on his forehead, and his monitor, his heart rate, would slow down. He'd come down to about the 120-130 range. [At first] I didn't know that I was having an effect on that, but, it was obvious, after about the 4th or 5th time of noticing the physical changes in him.
- I: Was there anything special about the way that you were relating to the boy, that was different from your usual way?

- 151: I was always different with kids.
 I: How?
 151: I think I just put out more of my own love, because I felt they were more vulnerable than adults and they needed me that much more than adults, in a way that adults didn't. But, I think it was just, generally, the love I was putting out.

In the excerpts above, nurses described visualizing color or love as moving through the patient, to symbolize a flow of energy. Other nurses described using imagery of the movement of their own respirations as a symbol of flow. In the following excerpt the nurse imaged movement in the patient as she herself breathed.

- 108: One patient that stands out in my mind is a little girl, about 5 years old. She's severely retarded, both physically and mentally.... She had no flexibility of muscles, so she was stiff, and she was real cross. She'd have times when she would just cry and cry and cry. And, I went to work one day, and they said she'd been crying all day.... So, I went down, and, rather than evaluate her, I just started at the top of her head, and went down toward her feet, and --
 I: What do you mean, you started at the top of her head and worked down?
 108: I centered myself, and then projected energy through my hands, and stroked, gradually, from her shoulders, or the top of her body, to her bottom of her feet.
 I: You say you stroked. Were you actually touching?
 108: No. I was, oh, an inch from her body. And ... I felt a lot of static building up in my hands, as I went down her body. And so, I'd shake it off, and start over. All the time, I was projecting energy.
 I: How does that --
 108: I took a breath and imagined that I drew a energy in as I inhaled. And then, as I exhaled, I could imagine that energy going out my arms and out my hands. You know -- into the energy that was rising from her body. And ... I would say, it took me four or five minutes of this until she started to relax, and went to sleep.

In the following excerpt, a nurse identified both the need for and the experience of modulation of energy transfer. The patient was at home, dying of cancer, and in great pain. His physician had requested that the nurse visit him to determine whether she could help him to be

more comfortable. The excerpt began with a comment about her assessment.

107: When you get experienced, what you can feel is people that are more in their body, people that are less than their body. This man was close to death. He was in a great deal of pain, and he just wasn't there, you know. He was in his head a little bit, but for the most part I would say he wasn't there.

I: It felt like he had emotionally detached himself from the whole situation?

107: Yeah. More like his energy field -- his force -- just wasn't within his physical body. It was barely attached. I find this a lot with people. I've worked a lot with people who are close to dying.

As I moved down his head with my hands, what I was imagining was that I was also moving his energy down, past all the different parts of his body, and through the feet. So, as I was going down the abdominal part, I had to do a lot of work in that area. To bring it down past the part, say, his waist area, past the top of his hips, had to work more to move his energy down. As I was moving it down, I could feel it more, coming down. And it was a very slow process, because it hadn't been down there in a long time. And, as I moved it down, and got finally to his feet, and as I did a final assessment on him, I could feel it -- though it was very slight -- all through his body at that time. It felt less prickly to my hands. It felt smoother, but it also felt very low. It still wasn't a lot.

I: What you were thinking about while doing this was moving energy?

107: Yes. Moving energy. Making him as a whole unit instead of parts.... back to the wholeness. You know, having him not all up in his head or all down in his feet. Having him even, throughout. He did need more treatment, and what I did ... intentionally thinking of different parts of his body, ... was run energy from the lower part of his neck, down to the tip of his spine, his tailbone, so it would make a complete circuit, and then I took each individual arm from his shoulder down to his hand, and ran energy so I could feel energy running smoothly.

I: You are talking about running energy from behind his head down to his tailbone. How were you doing that? What were you doing with your hands?

107: While I was doing that, I had one hand behind his neck, and the other over his abdomen, because he was lying on his back, and I just imagined that the energy was flowing between my two hands, and it was filling up the space in between. Then that section of his body was having energy running through it, and then I would do

each section of his body ... and I was able to get the energy flowing pretty good down through his feet.... I just imagined he was like a pipe, and it was running through him to my hands, and out, and it was like a complete circuit. Through the two of us, and out.

So, when I was finished, I said, "Well, what do you think about that, Jimmy," and he said, "Well, I don't know." But, his eyes were clear as bells. He was totally in tune with everything that was going on. He had no pain. No pain at all. He was totally relaxed. He had no pain. He remained pain free for three days, until he died. He did die after three days. No pain at all. And, he was in excruciating pain, with no relief from any pain medicine.

Patients also described feelings of movement through their bodies during this phase of the treatment.

- I: Can you remember what she was saying?
 217: Yes. Again, it's the feeling of being grounded to the earth. And, also, the white light. She'd try to imagine that. The other thing that I could feel was when she'd grab hold of my feet, and you could just feel the energy running through your body, almost as though you could feel your blood course -- but, I mean, it wasn't like going around and back up. It was a movement, all towards her.
 I: You're moving your hands over your head and down over your body. You could feel it all through your body?
 217: Right. While I was lying down. Yeah. That's the best way to describe it.

The following patient, who had multiple sclerosis, seldom experienced perceptions in her body during treatment. When she did, however, she described it as a flowing feeling.

- 202: Very occasionally, I have felt some warmth from somebody's hands.... Sometimes I feel the energy going through ... like warm water. Just warm water flowing through where it was maybe cool before. Just sort of a nice soft feeling.

Another patient described a different kind of perception during the stage of treatment referred to here as modulation of energy.

- 204: Most of the time, I had my eyes closed during the treatment. The thing that I noticed the most was, there would be a specific time when I did not know where [the nurse's] hands were, but I would feel heat.

And, as we became more attuned to one another, as the treatments went on, I knew when she was in front of me because I would see violet.

I: What did you think about during the treatment?

204: Different things. I tried not to focus on the therapist at all. I tried to focus on colors, trees -- I didn't think about the treatment at all.

The data presented in this section have been drawn primarily from descriptions of interventions perceived by the nurses and patients to be effective. Some nurses were also asked to describe instances in which effective outcome was not achieved. One such case provided a stark contrast with previous accounts of careful modulation of energy. The nurse described working with her daughter, with whom she had done therapeutic touch effectively in the past.

I: I'd like you to describe one more situation. What I would like you to do is think about a time that was not apparently effective.

140: I have a dramatic one, in relation to my daughter, who is now 17. I think it was about 3 or 4 years ago. She suffered from muscle spasms in her neck, and had actually gone into torticollis a few times.... One time my son came down and said, "[She] can't move. Her neck is spasming."

I ran upstairs, and immediately moved in with my hands. And as soon as I did she screamed, "Get away, get away, you're making it worse, you're making it worse." And so, I withdrew.

It took me a long time to work that one through. But, I really didn't go through the process of touch with her, at that time. What I've come out of that with are a couple of things. One is the concerned mother, who certainly wasn't centered, moving in on the hurting child, and I think because of not being centered, and probably because of my emotional involvement with [her], I must have just blasted her, and really did feed into the discomfort.

It was apparent from this description that the nurse was aware that anxious solicitude associated with being a concerned parent influenced effectiveness of her use of therapeutic touch. In another case, the nurse attributed poor outcome to "... sending too much love

or energy." Since the nurse also mentioned that she was tired, it is possible that her involvement in the situation may have been atypical, also.

128: It was a woman who was dying at home of cancer, and, I think it was probably about 36 hours before she died. She was very restless, very anxious; doing a lot of moaning and groaning, and moving her eyes around.... My goal was to help her be more peaceful. And, while I was doing it, she started to get more agitated. And, I was feeling tired because it was in the middle of the night, and I hadn't had any sleep. I didn't feel depleted or anything, myself, but, she was not responding as I had hoped.... It was the opposite effect.... I talked with [my teacher] later, and she said that probably I was sending too much love or energy, or whatever, and I had to send her just softer energy.

One patient described an instance of adverse effects, although she did consider the treatment successful. She was treated by several people at a therapeutic touch support group meeting. The patient was undergoing medical treatment for rheumatoid arthritis, and was receiving therapeutic touch for pain relief.

206: I didn't have the energy or strength to sit up, so I would lie down on the rug. And, they were really quite perturbed that all the energy they felt -- and I felt -- stopped here -- at my lower ribs.

I: How did you feel that?

206: Warmth. I could feel -- their hands were cold -- but I could feel warmth to my floating ribs, or just above. Then from then on [down my body] it was just like north wind blowing.... And, they didn't want me to go home without this energy flow complete, so they really worked on me. And, finally -- nothing seemed to work. And, I had been through biofeedback, a small amount of it, so I said, "O,K,, let me work with you. I will do my own work mentally. Don't talk to me. You do your thing, and I'll do my own thing, and see if I can't help you bring that energy down." So, I kind of went into ... a biofeedback meditative state. I was trying to visualize the energy going down. And, it worked. It wasn't twenty minutes, when they had the energy completed.... They couldn't get it all out. I was really awfully cold.

But, that night was the only night it was too much for me. I came home, and I was very restless. I had very little sleep. But, it was between my determination, I think, and my wanting, maybe too much. And, I tried to go to sleep, but even with a sleeping pill, I did not go to sleep. An awfully restless night. But, I felt O.K. the next day.

Another patient became uncomfortably warm during a treatment, and asked that it be stopped. She was at a therapeutic touch class, assuming the patient's role, though not being treated for a particular problem.

209: They were channeling energy, and directing it into my adrenal area. It was the first time that I really felt -- not that it was uncomfortable or anything -- but they were channeling this energy, and they had their hands placed at my back. One of the partners was at my back and the other was at the front, and they were supposed to channel the energy through me and out, and into the other partner, and she was supposed to take it out. And, I remember feeling really -- I got really hot. In fact, I asked them to stop, because I got really warm. It seemed like the upper part of my body got really warm, and really flushed, and I got really pink.

These two patients demonstrated willingness to participate in decisions about their treatment in different ways -- patient 206 by suggesting how she could use visualization to enhance effects of therapeutic touch, and patient 209 by requesting termination of the treatment.

Although nurses used their hands during modulation of energy, less hand movement was reported in this phase of treatment than during smoothing. Imagery was often described as an adjunct to modulation of energy. Images of moving light and water, physiological changes in the patient, and the ebb and flow of the nurse's respiration were mentioned. Also, feelings such as love were commonly projected. These

images and feelings were presented by nurses in the study as the method of modulating changes in the patient's field.

Interpretive note. In the smoothing and modulating phases there emerged for the first time in descriptions of therapeutic touch practices the notion of interaction between the energy of the nurse and that of the patient. Whereas in assessment nurses described being aware of characteristics of the patient's field, in treatment they indicated that intervention in the configuration of the patient's field was achieved. At this point a serious challenge to understanding of therapeutic touch in terms of the Western medical model occurs. The Western model of disease has been characterized as biomedical because the concept of disease is based on physiological, chemical, and structural facts. While social and psychological factors are acknowledged as implicated in disease, they are usually not seen as necessary features of it (Engel, 1977, p. 129; Fabrega, 1975, p. 969). The concept of energy associated with descriptions of therapeutic touch treatment is a factor even more difficult to substantiate than social and psychological factors, and thus more easily dismissed by those who subscribe to the biomedical model.

Even though nursing has a long history of acknowledging implications of psychological and social factors, and focusing on health rather than disease, cultural beliefs make it difficult to entertain ideas which seem incompatible with the biomedical model. Because of the substantial differences which exist between that model and the concept of energy

transfer, the energy model is discussed more fully in a later chapter on beliefs associated with therapeutic touch.

The feelings of love and compassion represented by nurses as involved in modulation of energy flow can be seen as related to concepts commonly associated with nursing. For example, Travelbee saw sympathy and rapport as features of the nurse-patient relationship concerned with conveying feelings to the patient. She said, "Sympathy is warmth and kindness, a specific expression of compassion, a caring quality experienced on a feeling level and communicated by one human being to another" (1964, p. 70). This expression of sympathy is described as one component of rapport (1963, p. 71). The data from this study indicate that therapeutic touch users understood the communication of such feelings as involving energy movement in the fields of the nurse and patient.

Thus, the concept of energy emerged as more complex than presence of a physical energy forming a field surrounding the patient and responsive to changes initiated by the energy field of the nurse through use of the hands. Reports of manipulation of the proposed energy in the patient by way of feeling states of the nurse suggested a quite subtle relationship between the two persons. Although nurses defined the interaction as based on energy exchange, psychosocial considerations such as the nurse-patient relationship and the expectations of both parties were important to the practice. On the other hand, extratactile

perceptions of changes in the patients' field, as reported by nurses, are difficult to explain on the basis of an abstract concept such as psychosocial configurations. For this reason, one can understand the nurses' reliance on a biomedical -- albeit postulated -- explanation such as energy.

Modeling. Participants' descriptions of modeling differed from descriptions of smoothing and modulating characteristics of therapeutic touch primarily in that modeling never involved use of the hands. Instead, descriptions of modeling focused on the therapeutic value of the feeling state of the nurse.

For example, nine nurses in the study specifically described experiencing a particular emotion or feeling -- often calmness -- which they wanted to see reflected in the patient. In addition, there were indications that other nurses conveyed calm and that patients responded to the feelings of calm, as described earlier in the section on centering (see pp. 58-60). The data indicated that modeling was practiced even when it was not recognized as such.

The excerpt below indicates the depth of involvement felt by nurses who practiced modeling as a feature of therapeutic touch treatment. A very experienced therapeutic touch practitioner, the nurse described working with a cancer patient in a home hospice situation.

129: On one level, I was aware of what I was doing. On another level, I was aware of just being there. Another part of me was tapping into that place in her; and by being there and being centered and calm, and bringing calm to the situation, was also bringing calm into her being.... I could see her relax her grimaced face, and her furrowed brow relaxed, her clenched fists

relaxed. And her breathing changed. And I could see that it was being effective.

In this excerpt, the nurse used the phrase "tapped into that place in her," indicating an emotional connection with the patient. It seems apparent from the phrase "another part of me" that the nurse saw modeling as distinct from intervening in the patient's field with her hands. Instead of, or in addition to, projecting her feelings, she described "being centered and calm."

Although it occurred in the context of treatment and in conjunction with other treatment characteristics of smoothing and modulation, the excerpt above exemplified the importance of the calmness described earlier as attained during centering. Below, a "generalized feeling of peace and harmony" was modeled for the patient.

I: How would you describe what you were thinking during the early part of the treatment?

125: Well, again, I don't know that I had particular thoughts. It's more like a kind of generalized feeling of peace, and harmony. Because that's what you are trying to have the patient feel. For me, that would probably be the most -- it's sort of a preparation for the actual treatment.

In a response characteristic of study participants when asked questions regarding the cognitive content of therapeutic touch treatment; e.g., "what were you thinking?" this nurse responded with a description of her feelings rather than her thoughts. In this case, as in many others, the nurse appeared to be modeling the feeling in her own attitude with the expectation that the feelings would be somehow transferred to and reflected in the patient. This modeling of the intended outcome was described by another nurse in the initial overview of her interaction with a young patient.

- 147: [Another effective time was with] a 16 year old girl. She wasn't my own patient. I think that she had been sleep deprived. She was just off the wall. And her parents just came out and grabbed me, because I was wearing a uniform, and said, "I can't get her calmed down." And so I just talked to her, calmly. I don't remember what I said.... [I] told her to breathe deeply ... I know that I was doing therapeutic touch.... And I didn't really have time to center myself, in a sense, with her.
- I: You say you didn't have time to center "in a sense." Does that mean you did some part of it?
- 147: Well, I think that part of it is centering while I'm doing it. And I guess I think of it as that, if I'm getting centered, and I'm getting calmer, hopefully that is radiating to her.

In the excerpt above, as boundaries between centering and treatment disappeared, calmness and disciplined attention to the patient appeared to be a component of the treatment itself. A very focused and disciplined use of the nurse's feelings was demonstrated. Below, the nurse described modeling calm, in response to a question regarding what therapeutic touch added to her nursing skills that was not a part of her usual nursing care.

- 136: I think the most beneficial thing that it does for me, is that it accelerates and deepens the communication between myself and the client. There's almost an unspoken bond of communication that occurs very suddenly between people.... [It is something] I use by being very centered and very calm, that I teach students who are learning to give injections. I go with them with their first injection, with the client. The client is very anxious, because maybe he's going to get a pre-op injection, and he never has before. And the student of course is scared, too. What I do is use that centering to project calm. And, the patient picks up on it as quickly as the student does. The patient picks up on it right away.

Interpretive note. Modeling was seen to be concerned with the nurse's focused use of feelings and the expectation that the feeling state would be experienced and assumed by the patient. In contrast with their descriptions of

modeling, nurses who described initiating the traditional movements of therapeutic touch treatment often spoke of explaining the hand movements to patients, and the movements could be observed. In modeling, the patient would have to perceive the feelings in some other way. It is possible that the nurses' state was conveyed by body language, demeanor, and facial expression. However, the data suggest that nurses in the study acted on the assumption that feelings underlying body language, demeanor, and facial expression have a direct effect on the patient's field.

The nurse-patient interaction has long been described as involving communication of affect. Travelbee says that rapport is "characterized by the ability to translate feelings and attitudes into intelligent and creative action, to communicate them to another in both verbal and non-verbal ways" (1963, p. 70). She further notes that through a sense of trust and confidence in the nurse, the patient anticipates that the nurse represents help. It seems possible that this expectation on the part of the patient might contribute to his or her reflection of the affect modeled by the nurse. As was noted earlier in the section on centering, the calm, relaxed state achieved by nurses in preparation for doing therapeutic touch was also experienced by patients, who commented on the reciprocal nature of the relationship fostered by use of therapeutic touch. That is, patients acknowledged changes in their own demeanor, related to that of the nurse.

Summary of treatment. In their accounts of the smoothing phase of therapeutic touch treatment, nurses indicated that the receptive state achieved during centering and utilized during assessment was continued. Indeed, an ongoing assessment was described as assisting the nurses in decisions regarding the course of treatment. During this time, disciplined attention and a sense of calm were also maintained.

In a good number of cases, only the smoothing phase of treatment was done. In other cases, features of centering were also described during the next phase of treatment -- modulating energy. In this phase of treatment, one could see the influence of the centering characteristic described as becoming a channel. An increased sense of flow, enhanced by visual imagery, characterized this phase of treatment.

Nurses in the study used the term energy to identify what was being smoothed and channeled during treatment. Their descriptions used language similar to that used in assessment to indicate changes perceived during the process. The term energy appeared to provide a unifying theme to account for such perceptions as heat, vibrations, and heaviness in the patient's field.

A third feature of treatment was identified as modeling. Modeling did not involve use of the hands. Instead, what emerged from the data was a technique wherein the nurse achieved a particular feeling state with the expectation that it would be reflected in the patient. As in assessment, the data indicate that as nurses became more skilled they relied more heavily on such feeling states in carrying out the treatment techniques.

Beliefs Associated with Therapeutic Touch

In the most general sense, by their participation in therapeutic touch treatment, nurses in the study have demonstrated a willingness to go beyond established scientific boundaries for knowledge development in the interest of learning and using a new method of helping patients. This section examines those beliefs which underlie or arise from therapeutic touch as described by nurses in this study, and which emerged from the data as important to its practice.

The Decision to Use Therapeutic Touch

The data indicate that the decision to use or not to use therapeutic touch with a particular patient was usually made prior to what was called the assessment phase of the technique, before even the centering was done. The data further indicate that while therapeutic touch might be used with patients with almost any medical diagnosis, or without a diagnosis, nursing diagnoses rather than medical diagnoses were the focus of the intervention.

Problem related decisions. Most of the nurses took into account whether they believed that already identified problems might be alleviated by use of the technique. One nurse (131) said, "If the situation looks like it can be improved by the use of therapeutic touch, I'll use it." Often, therapeutic touch was instituted when other interventions had failed. An example is a nurse (117) who said she would use it for "a pain that was not relieved by medicine." Following is an excerpt provided by a nursing faculty member who occasionally used therapeutic touch with her students' patients.

I: What would you say influences your decision about
 whether to use therapeutic touch in a particular case?

125: I do use it two or three times during each semester with the patients, and, usually with patients who haven't responded to the usual medical things. I remember one time I used it this past semester with a rather obese gentleman who had a gallbladder operation. He hadn't gotten any bowel sounds back. He couldn't pass gas ... We encouraged him to get up and walk and move around, and, his usual description was "passing gas", and I'd ask him, and he'd say, no, he hadn't done it. And so, I said, "You stand there, and I'm going to see if I can smooth out your energy field and maybe that will help you." And, he smiled and said "O.K." And so, I did that while the student was making the bed ... and it was successful ... I was pleased for him, because they were talking about putting down an NG tube and all those things.

There is evidence in the data that through their practice of therapeutic touch, nurses continued to acquire information about circumstances related to effectiveness. This information may have provided them with a data base for future decisions regarding whether to use therapeutic touch in particular cases. In this study, such information came not only from descriptions of cases which had satisfactory outcomes, such as have made up the bulk of the data so far; they also came from accounts of less effective interventions.

Some nurses attributed poor outcome to the particular diagnosis, as exemplified in the following excerpt. The nurse said there were no differences in her practice of therapeutic touch when treating this patient and others with whom she had success.

I: I'd like you to tell me about another time you used therapeutic touch. I'm wondering whether you've had a time when you don't feel there was a successful outcome.

150: One was the first person I ever did therapeutic touch on out of the classroom. And, I did the same routine. She had a tremendous amount of energy over her knees, and over her lower back.... I didn't realize it at the time, but her whole body, her energy field was extremely intense.

I: How do you mean that you didn't realize it at the time?

150: Well, she was the first person I'd done it on, so I didn't have anybody to compare to, to realize her energy field was terribly dynamic all over. A strong, strong feeling. And, I was just patting myself on the back -- look at this, I was really getting sensitive hands. I could feel it so well all the way around her. And, her knees -- I could hold my hands way out here, and just feel, even heat. There was such an extreme vibration that it was almost warm in those areas ...

At that time, I would judge success by being able to feel what I needed to feel, and I didn't have any expectation of what she should be. When I felt the excess energy, I was judging that I wanted to smooth it out. And what actually happened was that she then told me that her knees were bothering her terribly, for about a week. They were really bothering her. She was amazed when I commented about the knees.

About a month later, she was diagnosed as having lupus. And that energy field, I think, had something to do with the fact that she had a systemic disease, because she has continued to always have this energy field that is five times more potent than anyone else's energy field. And I've never been able to make a dent. And her knees were so painful, and her other joints, that sometimes she couldn't walk. And I've done therapeutic touch, and -- nothing at all. No relaxation. No pain relief. Couldn't touch it.

The patient's attitude. A second frequent consideration in the decision to use or not to use therapeutic touch concerned the wishes of the patient.

114: Usually, in the hospital, it depends on the patient. If they don't want therapeutic touch, [that] is fine. Some don't know anything about it ... In the beginning, I would sort of hesitate about bringing something like that up with patients, because it is just so very strange and new to a lot of people. But, it would depend on the patients ... I'll pick up clues, whether it would really work for him or her.

Here, the implication was that if the patient did not want the intervention, it would be less likely to be effective. How the patient might interpret use of therapeutic touch was mentioned as a factor in the decision in the excerpts below.

I: What influences your decision regarding whether to use therapeutic touch with a particular patient?

- 122: If I don't think that it would be interpreted correctly, that would stop me ... and I might do that more mentally then. I might just reach over and touch the person or something.
- 139: Anyone who might be threatened by it, I'm not even going to introduce it to them.
- 132: (One) thing has to do with the person's -- how the person might accept that as a treatment. It's kind of hocus-pocus to some people. There's some people that I think might benefit from it, but -- I maybe make the judgment that they probably wouldn't be accepting of that. Sometimes I ask, and [my judgment is] accurate, and sometimes I don't even bother asking.
- I: It's just a feeling you have about the situation?
- 132: Yeah. And mostly, its just thinking that I don't have the time to stop and do it. There's lots of reasons around here to use it, you know. There's lots of people who have fractures that have difficulty healing. And, I think it's good for people who have bed sores.

The excerpts above referred to the patients' willingness to receive therapeutic touch treatment. A few nurses indicated that therapeutic touch was sometimes requested by patients or families for reasons not considered appropriate by the nurses. In the following case, the family seemed to seek therapeutic touch in desperate hope for a cure, while nurses caring for the patient did not share that outcome expectation.

- 139: There was a patient, a young girl of 31, who had a myeloma. She was terminal, and her family had a very hard time with her dying. And, they used every kind of treatment that was available. And, they weren't having only medical treatment. They were having chiropractors and many other types of disciplines. And, naturopath. And, it got real confusing. Too much going on. And reflexology. Hand massage. And, they wanted us to do therapeutic touch. It's almost like it was overstimulation, and they weren't really processing. They were just out of control. So, the negative part of that was that they had heard of therapeutic touch, and they wanted it to be done. This was the family, mostly. And, we chose, basically, not to use it with her on a demonstrative level in front of the family, because of the demand -- because of expectations.

A similar assessment of the patient's motives was made in the excerpt below, after therapeutic touch treatment was done. In this case, the nurse did not feel that the intervention was successful. The decision to use therapeutic touch was made on the basis of the patient's request.

132: There was a gentleman who [was an outpatient]. He had a friend, I guess, who was a nurse. I had given a talk about therapeutic touch to one of the nursing groups, and she recommended me to him. And he came in. He had a history of, I think he had had four or five car accidents, and he was overweight, and had a lot of emotional problems, and had a lot of back pains, and came thinking, I think, looking for a miracle. And, he was doing lots of different things to get help. He was doing some psychic kinds of things. And he came with the thought, I guess, that he was really looking for some relief from pain.

He'd come in like once a week ... He would come back and say there was some relief, and he felt more energized, in certain ways. But, in listening to him talk, it seemed like he was jumping from one person to another looking for an answer to his problems. My mental health nurse stuff clicked, and it was very difficult to work with him and just do therapeutic touch, because it seemed like there were a lot of other problems going on.... And so, we talked about it.... And so, I didn't feel real successful with that. He felt that there were some benefits for him.

The data indicate, however, that not all patients were equally ready to accept therapeutic touch as a mode of healing. The following two excerpts suggest that patients' beliefs about healing may be an important factor in its effectiveness. In these cases the technique was used for relief of symptoms, but was ineffective. The nurses attributed the poor outcomes to the patient's attitude toward therapeutic touch. In the following case, the nurse used the technique although the patient was convinced that only medication could relieve her pain. Instead of relief, the patient experienced increased pain during the assessment.

- I: Can you think of a particular time when you did use therapeutic touch when it was less effective?
- 111: A patient with metastatic carcinoma, who was convinced that the only thing that would relieve her pain was drugs ... but she was on a maximum dose, and was not able to get another dose for another hour and a half.
- I: What did you do? How did you begin?
- 111: By trying to find what areas were the most painful, and that seemed to be the places with pathological fractures.
- I: Do you mean you were asking her, or you were using your hands to do --
- 111: I was using my hands ... starting at her shoulder, and down the arm, then along the body ... but not touching.
- I: What were you thinking while you were doing that?
- 111: I was just trying to see what was going on. It was like trying to look through a fog. There is a big difference between someone cooperating and not cooperating.... It's as though they are setting up a barrier.... They don't want to be bothered. Occasionally I will use it with a patient without telling them, and with a situation like that, it is not as severe a problem.
- I: What did you do after you had finished your assessment?
- 111: She refused to allow anything further. And, I just called one of the house staff for more pain medication, and they changed the schedule. She kept insisting that it hurt more ... even though I wasn't touching her.

There was almost a tone of disbelief in this nurse's report regarding the patient's experience of increased pain. The phrase "even though I wasn't touching her" indicated a belief that physical touch might be expected to intensify the patient's pain, but extratactile use of the hands might not. The nurse appeared not to take into account that patient perceptions of therapeutic touch might influence the experience of pain in other ways.

The patient's reservations about the value of therapeutic touch may also have been a factor in the following situation. The nurse was treating her father, a physician.

- 129: My father is a doctor, and I couldn't wait to go home and show him when I first learned. And he said it didn't do anything. And, I know that there are visible signs you can see in people with the effectiveness of

touch. And he exhibited all those signs -- breathing changes, voice lower, flushing. Another time he had shingles -- this is a good example -- he had shingles on his neck, and I went to do touch for him, and he got to feel so much worse, he didn't sleep all night. And after that, he wouldn't let me do touch for him, because he thinks I made it worse.

I: The pain got worse?

129: Right. And it's interesting that he thought I had that much power, to do that to him. But it was -- I did that to him, and made it worse. But, it also cleared up shortly after that, so maybe it did help. I don't know.

With the phrase, "it's interesting that he thought I had that much power," the nurse conveyed some surprise that her father attributed effect to the technique she was using although, at least in part, her intent had been to demonstrate effectiveness.

Patient participants in this study were, by virtue of the method of selection, willing to be treated. Still, they were able to contribute some insight regarding skepticism about therapeutic touch. The following patient indicated that her confidence in the practice was influenced by the level of congruence between her own experience and explanations or descriptions provided by practitioners. At the beginning of this excerpt, she was describing how she had attributed pain relief to a relaxation effect, but had come to believe that such an explanation did not account for all of her experience.

202: I was [no longer] feeling a great effect, and [I was] questioning how much of this had been me being convinced.... About this time, several of the [people who had been treating me], either four or six of them, at different times, had picked up a disturbance in my back -- the low cervical, high thoracic area, and questioned me, was something going on there? Had I hurt my back? It must have been significant enough. Not just a little tiredness. I think I explained it away at the time, oh, I'd been doing a little sewing, and maybe had tension. But this came up on three different occasions, and ... I was really beginning to question this whole process.

I: Was that kind of frightening to you?

202: A little bit. Not that I was worried there was something going on there, but it made me question what they were doing and how much validity there was to this. And, this coincided with not having as much effect from the treatment, and I had other priorities, and I quit going.

[Almost a year later], I was diagnosed as having multiple sclerosis. And, the first thing I thought of was that several of the girls had picked up a disturbance in the area where I had the highest MS activity, according to my symptoms. That made me -- the hair stood up on the back of my neck when I realized that. I went back to them right away, and they've been working with me ever since.

A second patient described a similar situation, in which he associated a subsequent medical diagnosis with the nurses's assessment, and became more firmly convinced of the value of therapeutic touch. He was being treated for neck pain, which he attributed to tension.

211: I was lying down in the bedroom and I had my shirt off, and I was lying face towards the mattress. She passed her hands over me, and as she got to my right shoulder blade, she said, "There's a problem there," or "There's a lot of heat there." And, I said, "It's up here" [indicating his neck]. So, she worked on that ... But, [about a year later], I was diagnosed with lung cancer. And, I told my wife, [the nurse] knew that was there in 1980.

At the time of his first treatment with therapeutic touch, however, the same patient had experienced reservations about its validity. This patient was not exposed to theoretical explanations of therapeutic touch as were most of the patients in the sample. His process of rationalizing whether the practice was congruent with his religious beliefs provokes questions about the degree to which the patient's participation in therapeutic touch may depend on his or her confidence in the practitioner.

211: I was thinking, is this right, or not?... Is this like a witch or something? And I said, "Well, now, I believe in God." I thought that I shouldn't do

something like this if it was like a witch or something. And so, I said, no, that's not right. She is a healer, and she does not draw on idol worship, or -- that ran through my mind. Because I didn't want to be [involved] with something that wasn't from God.... So, I resolved that. I felt in myself that, it's O.K. And I talked with my wife over that, too. She said it was all right, because of the mere fact that nurses receive everything from the Lord. That was that.

Another patient received some support for her use of therapeutic touch from her physician.

204: And even the doctor, even though he laughed a little about [my having therapeutic touch], he said he definitely did feel that self-involvement in your own care improved your reaction to [medical] treatment.

Nurse-patient relationship. Another consideration mentioned by some nurses was their relationship with the patient.

141: What kind of rapport have I already set up with that patient? How are we getting along, so I can introduce this as part of their regular nursing care? But, it doesn't have to be my favorite patient.

140: If a rapport is there between myself and the patient, and the time is there, those would be the two things that would influence me to say perhaps this is something I would do.

139: I would not feel comfortable going into a patient's room, who did not know me, and I did not have a relationship with.... If I had a close relationship with a person who was alert and aware of what was going on, and I felt they were open to alternatives, then I would mention that therapeutic touch was something that I used sometimes, and some people feel like it's helpful in relaxation and even with pain. And, if they felt open with that, I would. I would be very selective.

In the last excerpt, it was evident that the nurse perceived the presence of rapport as closely associated with her ability to assess the patient's willingness to accept the technique.

Summary of the decision to use therapeutic touch. The decision to use therapeutic touch was most often made prior to the assessment phase

of therapeutic touch, and was based on both problem related and patient related issues. Nurses tended to use therapeutic touch more often for relief of certain problems which they deemed more responsive to the practice than others. In addition, the patient's receptiveness to the practice and the relationship between the nurse and patient were considered. Patients in the study indicated that individual beliefs influenced their receptiveness to therapeutic touch.

The Healing Intent

Therapeutic touch as taught by Krieger has traditionally been understood to be a method of healing. This understanding has been fostered by the use of the terms healer and healee to denote the therapeutic touch practitioner and the recipient of healing, respectively (Krieger, 1979). This section examines the meaning of healing to practitioners of therapeutic touch, in terms of their beliefs about use of the technique.

Central to the nurses ideas about healing was identification of the intent of the nurse in the nurse-patient interaction. The nurse's intent is taught to be an important aspect of therapeutic touch, though its use is less clearly described by Krieger than are other aspects of the technique. Krieger indicates that identification of one's intent is at least as important as the focus of the intent -- perhaps more so. That is, in order to practice therapeutic touch successfully, one must acknowledge one's motives. While intention to help the patient achieve his or her maximum state of well-being is held out as ideal, practitioners are also said to profit from trying to understand their desire to help (1979, pp. 77, 116).

Intent to help. In this study, participants' initially stated intent was usually to help the patient in some way. This aspect of intent may be seen as another indication of the nurses' beliefs regarding the healing potential of therapeutic touch. The intent to help was described by nurse participants as both specific to the practice of therapeutic touch yet similar to other nursing practice. In the following two excerpts a distinction can be seen between a nurse who thought of her work as generally helping, in the first excerpt, and one who systematically specified her intent in an attempt to communicate it to the patient, in the second.

138: Well, you want to make people comfortable, and feel better.... And just that you're caring, and have that kind of interest in them.

In contrast, the following excerpt -- a description of the use of intent in therapeutic touch, indicates the nurse's heightened awareness of and active involvement in her intent.

141: I try to, in my mind, intensify my intent. I try and say more to myself how much I want to be able to help. So, while I'm assessing, I try and keep saying to myself...that I really want to be calm, and I really want to be helping.

Below are two excerpts that typify responses of nurses to the question, "How would you say therapeutic touch is similar to usual nursing care?" In both cases intent to help was primary.

126: I think the intent. The nurse's or the practitioner's intent to help someone is the same. And to help them by the use of their hands, or the use of their being, isn't the same. I think therapeutic touch is a more conscious and direct use of the self than regular nursing care, but, they both have the intent to help the person with the use of the self.

134: I think the main thing about therapeutic touch is our intention to help. And, I think that's universal. I think we intend to help, whatever it is that we do --

whether it be giving medication, setting limits, or whatever.

In the excerpt below, the nurse emphasized that therapeutic touch helped her to understand her use of intent in nursing.

- I: What would you say therapeutic touch adds to your nursing skills that is not a part of usual nursing care?
- 123: Actually knowing what you are doing. You know, for years, I gave back rubs and touched patients, and sat with them and held their hands, and did all of that, and I was doing therapeutic touch, but I didn't know it.
- I: It didn't have a name.
- 123: That's right. I was caring. I was intending to help. I was being there. I was doing all the things. I was filling all the criteria, but I didn't know what I was doing. And now that I know, it's just 100 times better.

The nurses providing the following two excerpts spoke of intent as a necessary initial component of therapeutic touch. Each nurse identified her intent to "help" while the form of the help was undefined. The first nurse identified helping in a very general way.

- 107: Your personal expectation, your intent -- is it to get Brownie points from the people you are working with, or is it to help this patient?
- I: Could you say a little more about intent? We haven't talked about that, much.
- 107: Intent is more or less a question that you ask yourself. What are the reasons you are doing this? I mean, are you doing it for your own personal satisfaction, or -- just exactly what are you doing it for? Be clear with what you are doing it for. Personally, my intent is to help.

Similarly, the following nurse mentioned the intent to help almost casually, yet with the implication that being aware of her intent was essential. She had mentioned that it was important to be sincere in her intentionality. Asked to clarify that statement, she said:

- 114: The intentionality? Well, basically, the most important thing about therapeutic touch is the centering, but you need also to come to terms with why

you are doing it -- your intent. To be sincere -- at least honest. Because some people can do it for popularity, or ego. You just have to come to terms with why you are doing it. If you want to help, just be sincere in that way.

Implied intent to help is evident in the excerpts below.

- 113: The only impact we can have on someone else is our openness to want to help. But, the ability to let go of the outcome, and realize that healing only happens on the level that the person wants, or is ready to have. I think it is as much a philosophy as anything else, and the more I use it, the more it becomes my philosophy.
- 122: I think therapeutic touch is by far one of the most integrated experiences that I've ever had. And, I think what it does is really heal the healer....It changes you. It helps you become a clear instrument, a truly compassionate person. Because, it seems to burn away, or erode away, the ego, and so many of those things that are counterproductive. (It helps you to) be really sensitive to people, and to reach out to people.

Intent to achieve specific outcomes. The data showed that nurses believed they could achieve certain outcomes through use of therapeutic touch. Overwhelmingly, the nurses' expectations in using therapeutic touch were for relief of symptoms associated with nursing diagnoses, rather than to bring about resolution of the underlying disease described in medical diagnoses.

Cancer and labor and delivery were the most common diagnoses among 97 cases described in detail by nurses in the study. The expected outcomes associated with treatment of patients with these diagnoses are summarized in Table 3. Relief of pain, anxiety, and dyspnea were the most common expected outcomes reported in the 97 cases. Diagnoses associated with these expected outcomes are summarized in Table 4. While most of the cases which were described in detail fell into one of

Table 3

Summary of Expected Outcomes Related to the Most Common
Diagnoses Among 97 Cases Treated with Therapeutic Touch

Diagnoses	Expected Outcomes
Cancer (19) ^a	Relief of: Anxiety Discomfort Insomnia Low energy Nausea and vomiting related to chemotherapy Pain Patient's acceptance of condition
Labor and Delivery (5)	Relief of: Discomfort Pain Tension Facilitation of the process

^a Numbers in parentheses indicate number of cases described.

Table 4
Summary of Diagnoses Related to the Most Common
Expected Outcomes

Diagnoses	Expected Outcomes
Unspecified Etiology (10) ^a	Relief of Pain
Cancer (7)	
Headache	
Migraine (4)	
Other (4)	
Trauma (5)	
Premenstrual cramps (3)	
Post-operative pain (2)	
Burns (2)	
Other (8)	
Neurological disorders (6)	Relief of Anxiety
Cancer (4)	
Peri-operative anxiety (3)	
Psychiatric disorders (3)	
Unspecified etiology (3)	
Burns (2)	
Other (3)	
Asthma (3)	Relief of Dyspnea
Cystic Fibrosis (2)	
Other (2)	

^a Numbers in parentheses indicate the number of cases described.

the categories summarized in Table 3 and Table 4, some did not. The 97 diagnoses and associated expected outcomes are listed in Appendix C.

Following are examples of data where these diagnoses and the related decision to use therapeutic touch are described. One nurse treated a man who had an unspecified injury to his arm. She described the decision to offer therapeutic touch treatment.

- 115: The person had an on-the-street injury that week. I hadn't seen them that week, and then we were invited to their house for dinner, and he had a dressing on his arm -- an elastic bandage on his arm -- and explained what had happened to him. He had injured his arm. He didn't seek any medical help, but he was in pain. I was able to observe swelling and redness in the area, and subjectively he was complaining of pain, and I suggested that I try therapeutic touch.

In the following excerpt, the nurse intended to help relieve the pain of cancer.

- I: What I'd like you to do is to think about a specific time that you used therapeutic touch, that stands out in your mind because you used it effectively. I'd like you to tell me what the patient's problem was.
- 132: I guess the one that stands out in my mind is the woman who had cancer, and was having a great deal of pain, both emotional and physical. And the medication that she was getting for pain was not very effective. I think she was on quite a bit of demerol and morphine. And she was very upset. Very distraught, physically and emotionally. And so, she'd been given her medication, and it didn't seem to work. And so, I just went in to do some therapeutic touch with her, and saw an almost immediate response -- just her whole -- the body movements. She became quiet. And her facial expressions looked peaceful, and she just seemed to be doing better.

The following interview excerpts also illustrate nurses' intent to relieve symptoms. No other intervention had alleviated the patient's pain. Asked what she intended to accomplish with the treatment, participant 108 replied:

108: To relieve her pain. I didn't know where her pain was. I knew she was terribly uncomfortable.... She couldn't talk, and my main interest was to relieve her discomfort.

Participant 113 was also specific about the relief of symptoms constituting her intent.

I: What was your intent?

113: With the headache? Relief. Simple. Very simple. I wasn't really thinking about any global changes with her, or about getting into anything on a deeper level. It was a casual kind of interlude. And I felt very happy that that would be enough. I wasn't really intentionally thinking about anything more.

In the following excerpt, the nurse's motivation to relieve pain was reinforced by the meaning that pain relief would have for the patient.

I: Maybe you could just say what kind of patient you were working with, and describe what you did.

117: My most rewarding experience was with a terminal cancer patient. Cancer of the bone. [She] was in excruciating pain in her right arm and shoulder. And, she wanted to get out of bed to walk to the window, just to see the sunrise. And, we tried several attempts at getting out, and she said, "I just can't do it. I can't move this side of me." So, I said, "You just lie back, and lets see what we can do about it" I said to myself, I'm going to concentrate on getting this pain out of her so she can be satisfied with getting out of bed pain free. And I felt that I knew that I could do it.

I: You said that this was your most rewarding experience. What would you say there was about it that was especially rewarding to you?

117: Well, she made another sunrise, which I wanted her to appreciate ... Probably the timing.

Participant 102 was describing her first experience of using therapeutic touch with a patient having an asthma attack. The patient was hospitalized for hip surgery at the time of the event, and the nurse learned of the problem during shift report. Describing how she began the treatment, the nurse said:

- 102: I knew what I wanted to do with the lady when I heard of her having this problem. I went in with the intentionality that I was going to calm her, and relieve the symptomatic problems, and her anxiety state.

In the following excerpt, the nurse had a rather specific intent, but one which allowed for interpretation of a sort on the part of the patient. Her intent was to conserve the patient's energy.

- 136: My intent was to help her be relaxed, so that she could control. I had expected that the labor would be long, and that she would need a lot of encouragement. And I'd work with her -- talk with her coach. I expected him to coach her in the activities they had practiced, and to give her encouragement, and that I would work with her in terms of being more comfortable. And to work with her contractions, and pain from the contractions.

A few nurses spoke of doing therapeutic touch to speed healing of certain problems. The following excerpt includes this purpose among others.

- 120: I use it when the opportunity arises. If someone is very anxious, or -- another area that I found it useful in is working with decubitus ulcers that are relatively large. Therapeutic touch can speed up the healing process. Or, not just decubitus ulcers, but, surgical incisions as well. It speeds up the healing process ... I also do it when I feel someone is near death.

The following nurse indicated that the duration of headaches following spinal anesthesia might be reduced, even though immediate pain relief was not obtained with the patients she treated.

- 104: I've tried to use it to relieve the spinal headache after C-sections. It has not been dramatic ... It will often given them relief -- they'll feel relaxed and maybe be up for a while, where they weren't able to be up. But, it comes back again. It appears to shorten the days that (the pain) lasts.

Patients also had the impression that therapeutic touch had speeded the healing process. The following excerpt is such a case.

The patient also felt that the nurse was especially understanding about the pain he experienced following an injury.

220: I had severe injury to my foot, which [the doctor] didn't want to look at. After three days of bugging him, he agreed to have my foot x-rayed. He said, "Well, there were no broken bones there." Despite the fact that I had five fractures between my knee and my ankle, it was my foot that was giving me the most pain. And, it was [the nurse] -- she knew exactly where she was feeling the most pain -- where the most blockage was in my foot.

And, of course, at that time, we didn't realize what had happened was that, I had these external pins for the frame, put through my leg, and the doctor -- the two lower pins he put through my ankle, he either severed or at least really traumatized the nerves that go down to my foot. And, I would have just incredibly fiery pains in my foot ... these were things I couldn't talk to the doctor about. It didn't mean anything to him. He said, "Well, there's no broken bones." And, I could talk to [the nurse], because, through her assessment, she could corroborate what I was telling her.

And, the day that she could first feel that there was a reduction of blockage, I made significant progress at physical therapy. And then, every day she could do the treatments, she could feel (the blockage) better. My foot, the swelling got less. And, every day, there was significant progress in physical therapy ... The P.T. people were just impressed to no end that -- how fast I had progressed, and the doctor himself couldn't believe how fast I was doing.

The data suggest that intent to achieve specific outcomes was very much influenced by the nurses' beliefs regarding effective uses of therapeutic touch. Some nurses noted that therapeutic touch practice also gave them a sense of autonomy in working with certain symptoms; of having at their disposal a technique which they could use to help patients without a physician's order. Following are several examples, in which intent to relieve pain stands out as a primary focus. While the nurses were generally pleased that they had acquired a useful tool for pain relief, one participant commented on the awkwardness of using

a pain relief method which was not understood by the patient's physician.

- I: What would you say that therapeutic touch adds to your nursing skills that is not a part of usual nursing care?
- 117: A very rewarding part of healing, that I can do on my own without a doctor's order -- without anybody knowing what is going on, except the patient and myself. And, a lot of self satisfaction.
- 141: The relationship with the patient. That's the big one. It provides me with a way to relieve pain, without having to give medication. And relaxation.... I don't need a doctor's order, I don't need a lot of people, or I don't need to go get anything. It's right there. So, if I have someone who is agitated or upset, I can bring some amount of calmness to them right there.
- 111: I use it basically with patients to control pain. And, it's caused some problems with some of the doctors who don't understand why the patient isn't getting pain medication. They come in and say, "Why aren't you giving pain medication?" And, the patient says, "I don't need an injection now."

Closely tied to the sense of autonomy provided by being able to do therapeutic touch interventions without an order was the associated responsibility. The following nurse elaborated on the problem noted above, of the physician not understanding therapeutic touch, and of possible danger when it was not understood. She made a comparison between using therapeutic touch at a hospital where the physicians were acquainted with the technique, and at other hospitals, where the physicians have not been introduced to it.

- 149: Therapeutic touch takes away pain, and without a whole lot of difficulty. And, that is not always advantageous. I had a woman who had, either a ruptured cyst or something wrong with her ovary, and she came to me before she was going to the doctor. And, I took away that pain without any difficulty, or the woman took away her own pain, however you want to put it. And then the doctor couldn't diagnose what was wrong. So, there is that whole element.

I had another friend who was in a motorcycle accident. She came to me before she went to the emergency room. When she got to the emergency room she had very little swelling. So, [the emergency physician] basically made a misdiagnosis of the situation. So, why I'm bringing this up is that, at Orcas you can do something like that, and you can bring someone in with no swelling, and you can feel fine about that, whereas, if you are [elsewhere] and you brought someone to the emergency room with no swelling, what are you going to say to the practicing physician?

Also, I used to use therapeutic touch in labor. It meant that the person dilated a lot faster, so I used to have a very hard time getting doctors there. "What do you mean, this person went from 5 cm. to complete in 45 minutes? With her first baby?" You know, sometimes it was really awkward. People know about therapeutic touch, but people don't believe. There's still all this hoo ha about it.

Intent to promote wellness or wholeness. While most nurses indicated an initial intent to relieve symptoms, many also expressed intent to promote wellness in a less explicit way. Some used the term "wholeness" to describe this intent. Intent for wholeness emerged from the data as having a dual message. First was the idea that it was helpful to keep in awareness the complexity of being -- acknowledging the mental and spiritual aspects of personhood as well as the physical. Second was the idea of intention for wellness, even when there might not be a "realistic expectation" of cure of the presenting problem.

One nurse provided the excerpt below. The nurse indicated that treatment itself involved anticipating the wholeness of the patient.

- 102: At that point, her problem was -- seemingly very anxious. I think it was the whole hospital situation that was causing her a lot of distress, and her pain. I think that is how she got in distress. I came on from days off, on the night shift, and we always get a taped report. They said Mrs. S. was having an acute asthmatic attack, and so in about five minutes I went to her. I thought I could help her. And it did help.
- I: Can you describe what was in your mind while you were in the process?

- 102: Whenever I go to a patient, I always think of wholeness, as we had it in our training. And for every patient, I ask for wholeness, and for whatever else I perceive they need at the time. My immediate perception was that she needed to be calmed. Visibly, there were no two ways about that.... My intentions were mainly to calm her down, and to relieve her bronchospasm. Wholeness -- I always ask for wholeness.

Nurses who identified their purpose as to promote wellness or wholeness often found the concept difficult to explain. The following excerpt states nicely what many of the nurses described as wholeness. This nurse used the term "wellness". The point she and other interviewees made is that the more nearly the patients' several levels of being -- physical, mental, and spiritual -- are in awareness simultaneously, the more nearly the patients may approach an optimum level of wellness.

- 103: The intention is to really see the person, and the notion of synchrony, balance, wellness. Or promoting that wellness. When I think about centering, the next step of intent really comes right after that. After the centering, the intent just flows.

I: Could you say more about the intent?

- 103: My notion of intent is that you are involved in a compassionate way to try to promote in the person the optimum of wellness. With chronic people, they are obviously not going to be totally well again, but you are trying to promote the highest sense of living -- of experiencing life. I don't just think of the physical body being equal or symmetrical. I think of emotionally, that they will heal their hurts -- mentally that they will be able to have positive thoughts -- spiritually that they will have peace and a sense of greater hope. Reach out beyond themselves. I think of thoughts like that. And sometimes, in just a mini prayer asking just to be open to what I need to know. To be of greater service. That is what I mean by intent.

Another nurse said:

- 107: What I'm thinking about when I'm working with a patient is their wholeness. That's it. Their wholeness ... the thought I have for them is nothing but their wholeness. And through their wholeness, they maintain

their centeredness and move toward things that you want to elicit. Plus, they heal themselves. They move toward that wholeness themselves.

I: What does that mean to you?

107: Well, the word, whole, means complete. A lot of us walk around everyday fragmented. We've got our mind going off someplace, and our body somewhere else, and our spirits off on their own. They have to fend for themselves. What I imagine [wholeness] to be is just a drawing together of all the aspects of what we own.

Below, a nurse participant made a connection between the terms "wholeness" and "wellness" in a very brief statement.

134: I began by ... asking if I could be used in whatever way is in her highest good. Focus on her wholeness. I was seeing her dancing ... and very, very well, and very cheerful, and dancing.

Another nurse described a time of decision, in which she came to a new understanding of purpose in therapeutic touch. She began with intent for a specific outcome, and emerged from the experience with a new understanding of patients' needs.

145: Well, I broke from having any intention as to what to do. I know Dolores talks about this, that you should have intent. And, I'll tell you the story about when I decided I could no longer have an intent. It was a man at the cancer research institute. He had lymphoma. He came in very, very ill, and he felt that his life was at an end. And he asked me if I would do touch with him, to help him leave his body gracefully. And I do do touch with people as they are dying. I said, "Of course. I'm here, I'm yours. I was assigned to you. It seems to be fate." Because I was no longer working there. I just came back to work that one shift. And it seemed like it was a coincidence that I had been there.... What had happened to him [prior to admission], he had got very very bad very quickly. Got very short of breath, and was having a lot of pain. His blood pressure was dropping. All those signs that later on, a chest x-ray [indicated] he had thrown a pulmonary embolus. At the time I was doing touch, nobody knew that he had an embolus to his left lung, right where I was working. What happened to this man, was that they decided not to treat him, because he was so near the end anyway. They really thought this was the end for him. So, they decided to not treat him other than just for pain. And what happened to him is

that he didn't die. The embolus was resolved spontaneously, without treatment. His sister came to be with him, and they finished up all their business that they had to finish up. And he did die about ten days later.

That was when I knew that for me I could no longer have any intent as to what I was going to do. Intending that he should die. The higher being -- his higher self and my higher self, knew better. But, that's what I work on now. I will somehow channel this energy, give it to that person, and do whatever we do, but I will not longer have any intent as to what I will do. I do not have all the information. There is no way for me, I feel, to have all the information.

I: So, it sounds to me as though, if you had to describe an intent, it would be to let your help be used in whatever way --

145: For the highest good.... He was saying, "Please let me die." And, I was saying, "Yes, of course." His higher self had business for him to do, before he died.

While this nurse said that she decided not to have any intent when using therapeutic touch, her story indicated that she had identified but not put into words a more general intent, consistent with that of others who identify wellness or wholeness as their goal for their patients. Other nurses also spoke of allowing wholeness to occur.

109: I think about harmony.... What needs to happen will happen ... I need to know what is going on more or less, but I'm not attached to that.... My major thing is a sense of wholeness, the resonancy of the interaction, and the balance -- intending that process.

126: I think what we support when we do therapeutic touch is ... a life growth process in the person.... The patients tell me they feel support for that. If they are changing, and they don't know where they are going... therapeutic touch somehow supports this process.

Intent for wholeness, like that for relief of symptoms, was mentioned as similar to usual nursing care. One nurse said the similarity was in "The caring aspects of it -- the facilitating wellness." The following excerpts are characteristic of many nurses' comments.

123: I guess the reaching out and touching -- seeing the person as a whole being, as opposed to the parts. I think nursing has always been into the whole patient, as opposed to the parts, which has been the biggest distinction between us and medicine. We didn't just see his gall bladder, or his fever. We saw the whole person.

110: It's caring for the patient in a physical way, even though it is not tangible. It's seeing your patient as a whole being, and not as the specific problems they may have.... I don't think it is different from nursing. I think it is different from medicine. It's not different from nursing as I learned it.

However, other nurses described the intent for wholeness as a feature of therapeutic touch which was dissimilar to usual nursing care. Asked what therapeutic touch added to her nursing skills, one nurse said:

138: Well -- the idea that the person is a whole person, not just the part that's sick, or the physical part. It connects aspects of them.

Intent to assist with self healing. Intent to assist with self healing was more often than not described in the context of description of the treatment itself. Its frequently casual introduction to the interview indicated that it was almost taken for granted -- as much a part of the nurse's assumptive world, as a component of therapeutic touch.

While many nurse participants included suggestions for patient involvement in their therapeutic touch treatments, the involvement often took the form of visualization or relaxation exercises rather than activities specifically related to therapeutic touch. Some spoke about establishing an intent to help the patient with self-healing at an energetic level. That is, they acted on an assumption that therapeutic touch constitutes manipulation of and balancing of energy,

and that such intervention in the patients energy field would have physiological effects.

Intent to assist the patient with self-healing was mentioned by some nurses and could be discerned in the treatment descriptions of even those who did not name it as a component of the treatment. The self-healing implied by use of this intent often appeared to be expected to occur in the form of enhancement of natural healing tendencies rather than through conscious effort or activities on the part of the patient.

Asked the general question, "what is your intent when you use therapeutic touch?" one nurse replied:

137: I think it's just to help the person -- the woman in labor -- to organize control over energy flow. So, it goes the same as having her breathe, and having her breathe with the idea of sending tension out with her exhalation -- just the picture of movement going down and out her feet. And so, it's just one more way to contribute to her control to moving that out. Not holding on to it or storing it in her cells.

Several nurses commented briefly about intending to help the patients to be able to help themselves in some way.

138: ...the basic idea [of intent] was being able to help people heal themselves. To be part of that process with them.

141: My intent was for [the patient] to be able to help to make herself better. And, to do that, I felt like she really needed to relax.

I: What was your intent as you went to work with this man?

140: I don't know that I had any. I certainly didn't fantasize that the tremors would cease. My intent was to be an instrument, to be a vehicle, and help him have energy that he could use best for him. And I don't really know, or did not know, what that would be.

112: I wanted to be clear on my intentionality.

I: Which was?

112: Well, the purpose for me would be to not let my ego interfere with the process. Not to influence me in the sense that I have to rescue this person from his pain.... In this particular case, my intentionality was to explore the energy process with this particular individual, and to explore where his level, and his willingness was, to allow the healing process to take place within him.

116: I think it's the person healing themselves.... The literature says that I'm the healer and the person is the healee. I think [that's] backwards. I mean, ... I'm the helper, and the other person is the healer. They heal themselves.

In these excerpts, the precise nature of expected patient self help was not detailed by study participants. However, the tone of the explanations was that given the therapeutic intervention, patients' normal healing capabilities, whether physiological, emotional, or other, were expected to be enhanced. That is, it appeared less that the nurses expected to teach patients how to improve their health, than that they expected natural recuperative tendencies to be enhanced.

One nurse was quite specific regarding the way in which the patient might be able to respond to her help.

136: What I wanted to do was help her to conserve her energy...and to really rest, so she could restore her energy, so that when she was really in labor she'd have the energy left. But, we never got to that. [Laughter] Went right through.... Every contraction was so productive, there was no backflow of progress. Everything just moved ahead better than you might have hoped.

Another nurse seemed to identify the self-healing as more of a physiological event than a cognitive one. As she was describing how she did the therapeutic touch with one patient, the investigator asked:

I: What was your purpose in doing that part of it?

150: Just to even out the energy field so he'd be in a better position to heal himself. So his own body was in a better equilibrium for taking care of itself, doing whatever it needed.

While the following nurse did not explicitly refer to self healing in her description of the treatment, the concept appeared in her more general statements about use of therapeutic touch. In her explanation of why she had her patient do visualizations, she associated that activity with manipulation of energy flow. She was asked:

- I: What would you say enhances your effective use of therapeutic touch?
- 143: It's always more ideal if you can be in a place where there isn't disruption. I don't have a problem concentrating, because I can shut it out, but sometimes the [patients] do. So, if I can find a place where they won't be disrupted, either -- because I like to have them visualize even when I do it. If nothing else, I like them to concentrate on blue and quiet.
- I: So, you usually have them visualize, and they have to concentrate on that, so it is helpful to have a quiet place. What is your purpose in having them visualize?
- 143: Just to facilitate the treatment, so the energy will run smoothly and they won't be thinking about the pain they are having, for instance. Which will maybe block the energy flow. It also gives them an opportunity to participate in their own treatment, and take responsibility for their own recovery.

From the nurse's perspective, then, self-healing was viewed as enhancement of the patient's natural healing tendencies. Manipulation of energy was treated as one way to promote self-healing. In the earlier section on treatment, a patient described her own visual imagery as a way that she helped nurses with the treatment (see p. 102). The excerpts below indicate other methods that patients used to heighten the effects of therapeutic touch.

Although not a nurse, the following patient was familiar with therapeutic touch, having attended several classes and support group meetings. She was treated at home for back pain by a nurse friend, several days after she fell in her garden. She began her description with a comment about her reaction immediately after the fall, saying

that she centered herself, as she had learned to do at the workshop.

Asked what centering meant to her, she said:

214: Well, centering is quieting myself. And, I guess if it were religion, you'd say I was reaffirming the fact that I am perfect. I'm whole. And, this is what I was trying to do.... Sort of feeling myself a little more put together.

I: And, then, you felt like that was successful? That you were able to center yourself?

214: Yes. Maybe not as completely as I might some other time, but at least, I was thinking about it. Knowing that if this happens, then this and this is the result. And I have to take care of it.

I: So, you were also, in addition to your affirmations, kind of calming yourself, so you could think logically about what you were doing.

214: Right.

The term centering was used again in the same patient's description of how she participated in the therapeutic touch treatment a few days later.

214: I quieted myself again. You see, I was trying to center myself so that she could work, and I could help myself at the same time.

I: And, what were you thinking while you were doing that?

214: Just a quieting time, to push away any interference that might be around.

Another patient assumed responsibility for the outcome when he was asked to describe a time when therapeutic touch was used less effectively

217: I think it was more my fault it wasn't working, because I was too stressed out ... getting ready to take a test. [The nurse] would try to talk me through the meditation, or just do the touch on my ... going through the process with the music and relaxing. And, I was just resistant to it. Just, I was too preoccupied with worrying about the test.

The following patient indicated that what she learned about helping herself was a very important part of her therapeutic touch experience.

- I: I wonder if you could describe a time, perhaps during your pregnancy or delivery, when therapeutic touch was used with you.
- 209: Well, two things. We did a lot prior to my delivery about working with therapeutic touch and imagery. [The nurse] who was working with me, had me do a lot of imagery about how my labor was going to be. Thinking about it positively. Getting ready for it, and thinking about it actually happening. And going to the hospital. Thinking about things going really smooth. Thinking of my cervix, like a rosebud, just opening up. And thinking about the whole process, how it would be, and how I wanted it to be.

A quite different view was taken by the following patient, who was asked what had influenced her decision to attend the therapeutic touch workshop where she was being treated for back pain. Her response suggested that a sense of isolation and self-responsibility had been implicated in her decision to seek help.

- 203: I didn't even know what therapeutic touch was. I was referred by a massage therapist. I had said I needed a therapeutic community, where I wasn't the one who was responsible for everything. He actually arranged it for me.

In keeping with nurse participants' conceptualization of self-healing as promotion of natural healing tendencies, therapeutic touch could be seen as contributing to the healing milieu sought by this patient.

Again, intent to assist with self healing was mentioned by some nurses as a feature of therapeutic touch similar to usual nursing care. Asked if there were similarities, one nurse said:

- 132: I see part of nursing [as] helping people ... mobilize their resources. And I think therapeutic touch can help a person [be] more able to deal with whatever is going on.

Interpretive note. It appeared that the intent component in therapeutic touch most often acted as an aid to

giving purpose and focus to the nurse's interaction with the patient. For example, a nurse using medication for pain relief might be able to act mechanically, following guidelines which do not require attention to her beliefs about effects of the nurse-patient interaction. In contrast, the nurse offering therapeutic touch appeared in a sense to be using herself. She was bringing herself to the situation with the knowledge that she has so acted previously, with the result of relieving patients' symptoms.

A comparison can be made between use of intent in therapeutic touch and Sudinow's description of intent in his anthropological account of how he learned the moves and understanding of jazz piano. He speaks of "repetitional intent ... to do things with things formerly done (1978/1981, p. 145). To Sudinow, learning an improvisational activity such as jazz piano is not accomplished by acquiring the technique alone. It must be done with constant attention to one's intent coupled with bringing to bear one's history in similar but never identical situations. It is in such a situation that nurses appear to find themselves when approaching a patient with intent to use therapeutic touch for relief of symptoms. Their belief that they can provide help may enhance their ability to do so.

Support for the notion that the practitioner's expectation can effect outcome is found in Benson and McCallie's (1979) literature review concerning angina pectoris and the placebo effect. The review examines reports

of studies of angina pectoris treatment with four interventions now considered to be inactive. Crediting placebo with all the effects in these studies, the authors compare outcomes in research carried out by enthusiastic versus skeptical investigators. Benson and McCallie conclude that enthusiasts' investigations have the components necessary to evoke placebo effects. In other words, the expectations of providers of health care can be seen to effect the outcome.

The possibility of such interpersonal effects in health care is closely associated with the concept of wholeness. It is through other than clearly physiological processes that such effects must occur. Participants in this study referred to mental, psychological, and spiritual aspects of the patient which might be involved.

The concept of the whole person is not new to nursing. In 1971, Travelbee proposed a definition of health as "defined individually, i.e., in accord with each person's appraisal of his physical - emotional - spiritual status as perceived by him" (1971, p. 9). This definition acknowledges several levels of being, and at the same time allows the patient to define health in a way that is meaningful to him.

Summary of the healing intent. The data indicate that beliefs about healing and intents associated with therapeutic touch were a pervasive part of the practice. Intent to help the patient in a general way was seen by different nurses as either specific to

therapeutic touch, or similar to the intent common to usual nursing practice. Intent to achieve specific outcomes focused on relief of symptoms, or promotion of healing in conjunction with other health care measures. Intent to promote wholeness focused on affirming wellness for the patient and promoting integration of the several aspects of being; e.g., physical, mental, and spiritual. Intent to assist in self-healing appeared to assume the patient's natural healing tendencies, and the ability of therapeutic touch to support these tendencies.

Energy as The Underlying Basis of Therapeutic Touch

One way to assess study participants' beliefs about therapeutic touch is through their definitions of therapeutic touch. The data indicate that basic to such beliefs is that, in the words of one participant (107), the intervention involves "working with the patient's energy field."

All study participants mentioned energy as implicated in use of the technique, as was evident from the nurses' descriptions of practice in the section on treatment. The concept of energy exchange as the underlying basis for therapeutic touch received additional emphasis when participants were questioned about their definitions of the technique. Emphasis on energy as the effective factor in therapeutic touch was typified in the following comments.

- 125: I would say therapeutic touch has to do with energy fields that surround all of us. And, it's the assessment to see if the energy field is harmonious and smooth and even all over the body. And, if it is not, smoothing it out, and then, actually giving energy appropriately to the person, according to whatever you have assessed.

133: I guess what it seems like to me is an interaction of energy fields. So that one person is interacting with another person's energy field in an attempt to smooth it out, would be the best way I would know to describe that.... It's kind of a concentrated effort -- a focused effort -- on transmitting energy. It's not that, even, so much as interacting with another person's energy field in a creative, focused way.

112: Well, therapeutic touch is a specific modality ... that's used by the practitioner to determine the individual's energy levels and energy centers ... to see whether they are blocked or open, and in some way, to diagnose that with the assessment, and to move on and treat the individual.

Many nurses in the study identified the energy as "universal."

I: Can you tell me in your own words, what is therapeutic touch?

138: ... Connecting with a universal kind of energy that's available to everybody. And sort of bringing it to the person, or helping the energy that's moving through her. Balancing the energy.

140: In my own words, I believe that therapeutic touch is using the energy that is around, everywhere, attempting to use my body as an instrument to direct that energy in a way, into another, so that they can use it in a way that's best for them.

118: I think that therapeutic touch is a ... noninvasive treatment ... by utilizing energy that is in us and around us. If I can be a channel, and have this energy flow through me to a patient whose energy has been stifled ... if it works, it's wonderful. If it doesn't, it will relax them, anyway.

In some interviews, a definition of the energetic character of therapeutic touch arose when the nurses explained how they introduced the technique to their patients.

I: What I want you to do is start at the beginning with however you approached the patient, and just describe what you did.

118: Well, he came in to this clinic -- our patients' room. I introduced myself, and explained what I did was therapeutic touch, which is channeling energy, or getting energy flowing in your body again. And, I felt that was the simplest way to explain to this patient.

- 136: First of all, when I talk about therapeutic touch with anybody, I tell them that one of the things they have to acknowledge is that we don't end in our physical body. That there is something that we usually refer to as an energy field. That is, there is something that isn't physical, but that does extend beyond our physical bodies. And that therapeutic touch is a technique, a skill that we can teach people, that they can work within this area, and can help people feel better.
- 108: With someone who has a headache, I would say, "Well, would you like me to try something for that headache, with a little therapeutic touch?" Explain to them what I was going to do. I think that we are all energy beings, you know, a flow of energy, and that pain is sometimes a stopping of this energy flow, and all I'm going to do is smooth it out. "Smooth out your aura, so to speak." And they say, "How?" And, I just say that, without touching them, I am going to manipulate the energy that is coming from their body.

The following patient provided a vivid account of how he experienced therapeutic touch as involving energy. He was describing his first experience with therapeutic touch, although he was familiar with other unorthodox healing methods. He was being treated for severe foot and leg pain as well as other symptoms attributed to diabetic neuropathy. The nurse, a friend, was treating him at home.

- 218: Towards the end [of the treatment, the nurse] found there were a lot of problems getting [me] grounded. Getting the energy flowing through my legs. My legs were really blocked.
- I: Is that a definition of grounding? Getting the energy flowing through your legs?
- 218: Yes. Grounding is making contact with the earth and letting the energy flow to the earth from the universe, and back and forth. That sort of thing. The body being a channel, you know. And, when she started to work on my legs, I didn't feel anything for a long time.... All of a sudden she did something. I don't know what she was doing.... Suddenly there was this sensation of electricity -- pscheew -- there was a powerful jolt going right down through my legs. It was almost like a sewer was cleaned out. I just felt like this gunk had just shot right down this tube, right down my legs. And, it made me a little uneasy. My feet got tingly, and, a little wierd. And, she kept

on. The energy just kept flowing through and through.
And, finally, my legs were feeling fine.

Another patient had her first experience with therapeutic touch at a one week workshop, and was interviewed there toward the end of the week. During that time, the patient had been treated several times. Although she attributed her feeling of increased well-being to the workshop milieu rather than to therapeutic touch treatments, she described one specific treatment during which she had felt what she described as energy.

203: Last night [one of the nurses] gave me a treatment, and I could feel the energy and tingling through my sleeping bag and everything. I was lying down. And, I could tell where her hands were at all times, with my eyes closed. And that was very different than [treatments I had from] anyone else.

I: You said you felt the energy and the tingling. Do you consider those the same thing, or was there some other feeling?

203: I felt the tingling, and I addressed that as energy. I felt tingling as her hands passed over. She was way out in the air -- a sleeping bag away from me.

Earlier accounts by nurses commented on the energy, but said little about their methods of using it. Two other nurses stressed the need for active use of intent on the part of the nurse as a way of manipulating energy. Each was responding to a question about her definition of therapeutic touch.

126: I think it's the intentional use of hands to sense and move energy in another person. And the intent is very important, because that makes therapeutic touch different from using your hands in an ordinary way. I guess, to sense and move energy in the other person. I guess I'd have to say, it is the intentional use of my hands -- or, it quickly becomes extended to my whole being -- to nurture this flow of light in someone else.

115: Therapeutic touch is a healing technique that requires the healer to be used as a channel for energy from the universe, and that energy being transferred to a person requiring healing. And that the healer somewhat

augments, or directs the healing energy. Not simply a matter of holding one's hand, but rather that the healer does something with the energy, and transfers it.

Below are further examples of beliefs of nurses in the study regarding how the energy involved in therapeutic touch is manipulated. In the following excerpt, the nurse's intent was again identified as important to the active process of working with the energy field.

- I: Can you tell me in your own words, what is therapeutic touch?
- 113: Therapeutic touch is the exchange of energy from one person to another, tapping into a universal source of energy. It's the concept of the person who's engaged in acting the role of healer, wanting to act as a conduit to allow energy to come through themselves to another person. And, I think very much so, it's the concept of understanding that there is a mutual exchange between people.

The following excerpts suggest another way in which the nurse's intent was involved in the energy exchange of therapeutic touch. Each used the term "love" to indicate the nature of the energy involved in therapeutic touch.

- I: In your own words, what is therapeutic touch?
- 128: I think it's a gift. How to funnel that loving energy through me to somebody else.
- I: Some people use the words that healing is a gift to mean that some people have that gift and some do not. Is that the sense in which you mean it?
- 128: No. I think anybody can do it.... I feel like it's a gift from my teachers, and I can pass it on.
- 129: It's certainly a goal in my life to be aware of energy and spread as much love as I can.... Knowing therapeutic touch has helped me to be able to do that more.

Previous excerpts described nurses' beliefs about therapeutic touch as involving energy. Below are examples of how nurses related their understanding of energy to nursing.

- I: Did you see therapeutic touch as something that fit quite naturally into nursing care, or something that was different?
- 108: I saw it as something that fit quite naturally. I had been using it for years, not knowing. I mean -- a type of it, not knowing. I had been using touch, but I'm sure it was the same thing. Touching my patients.... Looking back, I'm sure I did project energy, unconsciously.
- I: What would you say therapeutic touch adds to your nursing skills that is not a part of usual nursing practice?
- 135: I think the concept that the body has energy fields -- that the body is an energy field that interacts with the environment. While that is a part of Martha Rogers' theory, that's not generally a concept that nursing is based on. And, it's a whole different paradigm. It's a whole different philosophical basis from which to practice. And, therapeutic touch is part of that. And that, from my experience, is not commonly experienced as part of nursing education.
- 115: [I have] always viewed interaction as a therapeutic tool, throughout my nursing career. No matter where I am, no matter what nursing site I would be working in ... nursing is a communication of skills, energy, personality, caring, techniques. It's all nursing. And this is another modality. Another form of communication.
- 128: Well, my style is to lay hands on. Therapeutic touch is just another way. When I started nursing, I used to love to rub people, and actually rub their skin. And, it is nice to know that I don't actually have to do that. I can just touch their hand, and I can send them love, if all I have time to do is adjust their I.V. So, I feel like touch has broadened my -- what I like to do in nursing. I like to touch.

When asked the same question, the following nurse expanded her answer to express how therapeutic touch modifies nursing care.

- 134: I think the transfer of energy is very similar [to usual nursing care]. I think that any time that we relate to another person, we transfer our energy to them. We do that through physical touch, when we give a bath, when we give a shot, or when we're helping someone up out of bed to the bathroom. Any time we have physical contact, we are transferring energy. And, I think that's similar. Many times, in traditional nursing, we're not centered when we do

that, maybe, or we're not aware that it's a universal flow that's coming through us. I think sometimes we're giving our own energy rather than channeling universal energy. That's why we end up so tired. Giving our own personal energy to someone, and they feel better, and we go home with a headache.

Interpretive note. It is not surprising that nurses using therapeutic touch predominantly define it in terms of energy flow. Krieger's conceptualization of the technique was in terms of energy, and virtually all of the nurse participants in this study learned therapeutic touch directly from Krieger or from her students. Although no coherent theoretical explanation for the relationship of the postulated energy of therapeutic touch to health emerged directly from the data, the influence of an existing theoretical stance was suggested by use of similar language and explanations of energy flow. Participants' descriptions of the practice are consistent with a theory of fields and their implications which is itself in process of development (Kunz & Peper, 1982, 1983a, 1983b). According to Peper (1984) the ideas they present constitute a descriptive theory based on how Kunz experiences the phenomena of healing. Kunz has long observed healers and worked with physicians and nurses in research concerning healing (Karagulla, 1969, pp. 123-146). She was also instrumental in the development of therapeutic touch (Krieger, 1979, pp. 4-10), and with Krieger, teaches annual therapeutic touch workshops.

Kunz and Peper conceive of humans as local concentrations of energy within a universal field. The human

field is then "perceived in terms of sub-categories related to specific functions" (1982, pp. 396-397). The four sub-categories outlined by Kunz and Peper are the vital field, which is associated with the body and its electro-chemical manifestations, as in the rhythm of the heart; the emotional field, made up of feelings; the mental field, which incorporates visual images and ideas; and the intuition field, characterized by order, creativity, and compassion. Kunz and Peper identify the intuition field as the source of healing. All of the sub-fields are said to interpenetrate each other. It is suggested that to maintain health one needs to be aware of how to maintain the energy in each sub-category of the human field. Techniques are offered for doing this (1983a, pp. 3-4).

The techniques offered by Kunz and Peper for maintaining the integrity of one's field will be recognized as similar to the strategies nurses reported for interacting with patients during therapeutic touch practice. For example, relaxation is suggested by Kunz and Peper for maintenance of the vital field. Letting go of emotions, and assuming positive rather than negative thoughts about others is recommended for maintenance of the emotional field. Letting go of fixed ideas and focusing on a task are suggested for the mental field. For the intuition field, the recommendation is to become quiet and centered through meditation. In healing, the energy should be allowed to flow

outward to the patient while one thinks of the flow as a harmonizing force, according to these authors.

There are strong similarities between the interactive connection postulated by Kunz and Peper, on one hand, and development of rapport as described by Travelbee (1964), on the other. Each speaks of the role of caring, sympathy, empathy, and compassion, and a need to not be personally involved in the outcome of a therapeutic interaction. Kunz and Peper suggest that to avoid excess personal involvement, one can think of oneself as a conduit. This technique is also said to aid one in avoiding being drained of one's own energy. Travelbee considers the danger in personal involvement with the outcome or with the patient's feelings to be that such involvement indicates a focus on one's own problems or needs, to the detriment of the helping relationship.

Spirituality

Although Krieger makes clear in her description of therapeutic touch that the technique is not to be equated with spiritual healing, the data indicate that the meaning of therapeutic touch for nurses in the study frequently involved the concept of spirit. This concept of spirit was seen earlier in descriptions of intent for wholeness, which showed that nurses saw wholeness as involving balance among several aspects of being, including spirit. However, the data further show that nurses' understanding of spirit or spirituality -- in those terms -- remained quite individual. That is, although they had a fairly uniform understanding of the term wholeness as involving spirit, nurses

had not reconciled this understanding with their understanding of spirituality or spiritual healing, in most cases. This difficulty became most clear when nurses were asked about the influence of their involvement with therapeutic touch on their understanding of energy fields and of spirituality or spiritual healing.

No definition of spirituality or spiritual healing was offered by the investigator, so that the nurses' own meanings could be explored. The data are examined here in an attempt to identify underlying similarities in beliefs about spirit as related to therapeutic touch.

Spirituality as individually defined. The data show that nurses in the study considered their views on spirituality to be individually defined. Nevertheless, two threads of meaning emerged. Nurses commonly expressed belief that their ability to be nonjudgmental and accepting of the patient's values, and their ability to use intentionality as an intervention, were spiritual phenomena.

The following nurse referred to spiritual healing in two ways, as related to laying-on of hands, which she saw as a usual meaning of spiritual healing, and as associated with intentionality, which was her own belief as to the nature of spirituality. The excerpt was in response to an inquiry as to whether she had been aware of spiritual healing prior to her experience with therapeutic touch.

- 112: On some level I was aware of it because I am a member of a meditation group. So, I had some awareness of spiritual healing. Now, I have more awareness of it, because I've been involved in it a lot longer.
- I: Do you see therapeutic touch as related to spiritual healing, or is that a separate thing you are interested in?
- 112: Well, I do, because in some ways, it is derived from the laying-on of hands. So, in that sense, it can be coming from a spiritual place. For me that would be very individual. I know a lot of people separate that.

I know Krieger would not want it to be associated with that -- the spiritual healing aspect. But again, it goes back to my own intentionality and what kind of a relationship I want to establish And, for me, it would be a more spiritual type of relationship.

Most nurses in the study shared this view that the meanings associated with therapeutic touch and spirituality remain idiosyncratic to each practitioner. In the excerpt below, the nurse found that therapeutic touch helped her to identify her spiritual values and not attempt to impose them on others. She shared a definition of spirituality as concerned with one's values and beliefs.

- I: Is spiritual healing something you had experience with prior to your involvement with therapeutic touch?
- 136: Spiritual is a word that I have a hard time dealing with, because most of the people -- are you talking about spiritual in the context of religion?
- I: Whatever it means to you.
- 136: Well, I am not a very religious person, but I am a very spiritual person. And I think using therapeutic touch has allowed me to let that spirituality grow. Allowed it to take a proper place in my daily life, and how I feel about things. And my values and belief systems Spirituality is, I think, my values and beliefs, and how I formulate those, and how I relate those to other people. How I respond to other people's values and beliefs. I have very strong beliefs and very definite values, and yet I don't have a need to impose those on other people.... When I say this has allowed me to grow, [I mean] I don't feel like I have to defend my beliefs and values to anybody. One of the things that other people have noticed about me -- I think I'm the same as I've always been, but everybody else says to me --"You have become more open, mellow." If I don't feel a need to react, I don't react.... And I guess a lot of that has to do with being able to deal with my own spirituality.... This has really helped me. I guess it's that looking into self that occurs when you begin to meditate, and examine intuitive feelings, and what not.

In the two excerpts above, spirituality seemed to be taken as related to one's way of interacting with other persons. The following

nurse also mentioned a relationship between therapeutic touch and her way of interacting with hospice patients.

126: It's very hard to separate out therapeutic touch from my quest to look at spirituality [and] my study of physics, because I did them all that the same time. Therapeutic touch, I think, is a tool to use all that you know about physics and spirituality. But, it's just a tool. I could do therapeutic touch in the beginning, and I hadn't looked at anything else yet, and it worked. But, the way that I see the world, and, I think its effectiveness, is different now that I've gone farther.... I think the key for me is that the practitioner begins to develop a different philosophy in life. And, in nursing, we are always taught to keep people alive. And, when you start to use therapeutic touch, you value life, but you do not see that as the goal. The goal is to help people in their process, and if that is to die, that's fine. It is an acceptance of what is trying to happen, that allows you to work with the patient, instead of fighting against what is trying to happen. And, there is a calmness when that happens. There is not a frenzy to save people.

Here, the nurse's discussion of spirituality centered on her quiet acceptance of the goals of the other person. The following nurse also mentioned the quieting effect of therapeutic touch on the practitioner when asked about spirituality.

118: For me to do therapeutic touch, I have had to learn how to meditate, and become quiet -- to tune in to, uh, another spirit. In order to be that source. So, in that sense, I've just become -- doing meditation every day has helped me to become -- more aware of patients, of what is going on within them, without really saying something. I'm just aware.

Secular versus religious views. The nurses above did not necessarily associate spirituality with a supernatural being. Some did, but still disassociated the concept of God from the basic therapeutic touch technique. Nurses who had well established religious beliefs tended to identify how they differentiated religion from the spirituality associated with therapeutic touch. They frequently

identified spirituality with the idea of a universal source of energy or healing, but did not call this source God in the Judeo-Christian tradition. In general, though they did not state it in these words, the nurses below identified spirit as a unifying force which was a source of healing.

In the excerpt below, the nurse defined God as a being, and spirit as a concept or, as she put it, a source. She further indicated that while therapeutic touch was a spiritual experience to her, she did not teach that it was a spiritual experience.

- I: You said earlier something that indicated to me that while spiritual healing was not a term associated with therapeutic touch, that -- it seemed to me you were saying there was a relationship there.
- 120: Well, for me -- I define what happens to me as a spiritual experience. Although I'm not thinking about God when I do this. If you asked me what I am reaching out to, I also would not say God. I am not reaching out to a person. What I am reaching out to is a higher source of energy -- a higher source of, however you want to define it -- I'm not sure I can. But, for me, that reaching out is a spiritual commitment. Maybe commitment is a better word. I am committing myself to a belief in a trust in a higher energy. I'm not sure that's the right word. A higher intelligence. A higher being that I believe is out there. But, that is my way, and when I teach it, I don't get into God. I mean, I try to keep it as a tangible, physical, energy kind of stuff. But, for me, it is a spiritual experience.
- I: Would you say that your experience with therapeutic touch has influenced those feelings for you? [You have indicated that] you already were aware of that.
- 120: Yes. For the last three years, I've also, along with therapeutic touch, been involved in a different religious kind of group, so it coincided. I really cannot separate them.... And so, therapeutic touch has definitely enhanced my spiritual development.

The nurse above mentioned "reaching out to a higher source" in defining the spiritual aspect of therapeutic touch for herself, but was careful not to identify the source as God. Also, as did other nurses

quoted above, she distinguished between her own beliefs and how she explained therapeutic touch to others.

The data indicate that for some practitioners notions about spirituality arising from the therapeutic touch experience were related to previously held religious views. The following nurse reported coming to adopt an understanding of therapeutic touch as related to spirituality. Her new understanding incorporated her belief in a deity which already had meaning for her.

- I: Before you were introduced to therapeutic touch, what was your knowledge of or attitude toward spiritual healing? You mentioned that it changed.
- 124: I was very skeptical about it. I didn't out and out disbelieve in it, but I had a great deal of skepticism. I always was looking for a rational explanation of the little I knew about it.... It definitely had nothing to do with me.... Maybe these people have these wonderful gifts, but, I certainly had nothing to do with that.
- I: Would you say that there is a relationship between therapeutic touch and spiritual healing?
- 124: Yes. I do believe that. Now, I do. That has become a strong basis for doing therapeutic touch, and it wasn't in the beginning. I always had my strong spiritual beliefs. But, therapeutic touch for me, initially, was a skill. But, as I worked with people, and as I did reading and became involved, it became more and more a part of my life. It became more and more of a spiritual experience for myself.
- I: Can you put into words what a spiritual experience is?
- 124: Well, I think the energy source, for me, is God. And the higher spiritual being. And so, when I become a channel ... I feel that the compassion that you feel is part of being able to use yourself as a channel for God's healing.

Few nurses in the study identified their religious preferences. Some of those who did drew a distinction between spirituality and religion.

- 109: I don't like to use the word religious because it has a lot of connotation I don't care for. If one is going to deal with the person as a whole, and oneself as a whole, then, there is a component of the life process that is not included in the scientific views and all

that kind of thing. It would maybe best be called spiritual. In essence of the life -- that has to do with wholeness.... Actually, I can teach therapeutic touch workshops or talk about it in any way at all, based on Meister Eckhart's sermons, which are certainly spiritual, even though they were condemned for many hundreds of years. Eckhart said that God is within. Then the whole idea of God is this vitality. And, he talks about all the components of therapeutic touch. All you have to do is read his sermons to recognize it. So, that is a very deep -- the usual religion business I'm not so sure about.

Meister Eckhart, an early 14th century philosopher and mystic, proposed a revolutionary view of God as an infinite Being, or Divine essence -- an integral feature of every living being (see Blakney, 1957). This nurse equated Eckhart's God with the "vitality", or energy, of therapeutic touch.

The following nurse identified spirituality with the concept of oneness previously noted as a component of therapeutic touch treatment.

- I: Before you were introduced to therapeutic touch, what was your knowledge of or attitude toward spiritual healing?
- 116: Well, I think from a traditional Catholic background, I think I always believed that miracles can occur, but they were very Catholic oriented.
- I: Do you equate spiritual healing with religious context?
- 116: Almost exclusively, in the past. But now it's taking on a different --- Therapeutic touch is very spiritual to me now, but it's not at all religious.
- I: What would you say now that spiritual means?
- 116: Spiritual is being in touch with your inner self. And your inner abilities ... to help other people. That I can connect with someone else's spirituality ... Centering and that feeling of oneness is very spiritual.

Asked about her ideas regarding spiritual healing, another nurse indicated she had previously identified it with religion. However, she described a growing interest in spirituality which was not religion oriented.

141: It was more of a formal atmosphere. My father's a minister. And he believes in spiritual healing. And my brother, too -- he's in the evangelical church. And I thought they were kooks. I thought -- this is just ridiculous ... Now, I think that we have something in common. I feel that I have some ability to help people. My spiritual side is something that I know is lacking in me, that I need to develop. I haven't found a way to do that.... Aikido [a Japanese martial art that focuses on the integration of body and mind] is the most spiritual sense thing that I have ever done. The philosophy, and then the actual art, and the discipline. I need to exercise discipline, and to be practicing a belief system in a more structured manner And I think when I can do those, that my ability to use therapeutic touch, or whatever, will be much, much better. Because my centeredness will be better.

The following nurse spoke of the concept of energy expanding her understanding of spirituality. For her, the meanings associated with a universal energy source were related to her religion. However, she indicated that others might use other explanations.

122: I kind of went from a Catholic background, with its spiritual healing, to bringing in this concept of energy -- a universal source of energy. But, I solved that in my own mind by saying to people when I teach, or even to myself, that you name the source of universal energy. And that is really spiritual, whether it is God, or whatever.... I used to think of healing as miracles. But now, I don't think of that. I think healing doesn't have to be a miracle, but there is always a transformation. Little or big, there is always a transformation. I feel that.

Interpretive note. The data suggest that individuals who had well defined religious views (taken here to mean church related), had sorted out, or were in the process of sorting out for themselves the relationship between religion and spirituality. Many study participants equated spirituality with tolerance for others' values and beliefs.

Tolerance for others' beliefs may be a crucial point in discriminating between secular and religious views of

spirituality. If so, the need to develop such tolerance may also present an obstacle to the process of developing therapeutic touch skills for those who hold firm religious beliefs.

A dictionary defines spirit as "The life principle, especially in man," and as "the thinking, motivating, feeling part of man, often as distinguished from the body." (Webster's, 1977, p. 1750). If a theory of energy exchange is used to explain therapeutic touch (see pp. 149-150), this definition is consistent with the notion that energy may be expressed in feeling states, and that thoughts and intents might affect the energy flow. A more universally accepted definition of spirit, however, might involve transcendence of feelings, thoughts, and intents, which are usually associated with the mind.

Summary of spirituality. Although therapeutic touch practitioners had varying religious backgrounds, they did not necessarily identify the spiritual component of therapeutic touch with religion. Rather, many developed a perspective which could account for a secular view of spirituality. These practitioners identified spiritual aspects of therapeutic touch, as noted in this section and in the earlier section on intent for wholeness.

The shared meaning expressed by these nurses points to tolerance for divergent views as one aspect of spirituality. References to spirit in previous chapters have tied it to the concept of manipulation of energy by means of feeling states such as compassion and intent for well-being, suggesting agreement with the definition of spirit as

CHAPTER 5

Summary and Discussion of The Study Questions

In the previous chapter, the findings were presented under headings related to practices and beliefs associated with therapeutic touch, since these two categories addressed the findings with the least amount of redundancy. In presenting findings related to these two categories, it was necessary to include in each of the two sections excerpts which addressed content of the several questions posed in this study. This chapter discusses the findings presented in the previous chapter, as they relate to the study questions.

The findings are reviewed and examined in terms of underlying cultural influences and trends in nursing. Philosophical and theoretical models for explaining emergence of therapeutic touch at this time are considered, and an integrated holistic model for understanding the technique in the context of traditional health care is suggested.

Question 1: What are the Practices, Intentions, and Beliefs Associated with Therapeutic Touch as it is Used in Clinical Practice by Registered Nurses?

Practices, intentions, and beliefs are discussed separately in this section. A section examining relationships among the three follows. Theoretical explanations for the findings are also discussed.

Practices

Practices associated with therapeutic touch as described by study participants generally followed the pattern presented in Krieger's (1979) description of the technique. Descriptions included the characteristic stages of centering, assessment, and treatment. Not all

of the stages, however, were included in every use of therapeutic touch.

Centering. Centering was described as achieved in various ways by different nurses in the study. While all had learned some form of centering in therapeutic touch workshops, many had subsequently developed their own style or had learned different techniques from other sources. The achieved state emerged as more important than the method of achieving it. Thus, what appeared to have been learned in therapeutic touch workshops was the importance of acquiring the ability to attain a centered state, rather than a precise method for doing so. The impact attributed to centering in this study supported Randolph's (1975) explanation of her failure to find significant physiological effects when centering was among therapeutic touch features excluded from her operationalization of the intervention. It was also consistent with Quinn's (1983) identification of the specific focus of attention as crucial.

Centering was described by study participants as a method for (1) disciplining attention, (2) achieving calm, (3) establishing receptivity, and (4) becoming a channel. In many cases, centering was accomplished quickly, and initially described briefly by study participants, who had not sorted out for themselves the various aspects of the process. In addition, centering was frequently presented as taken for granted, and described only when the participant was questioned as to whether or not centering was done.

Disciplining attention involved attending in a very focused way to the particular situation involving the patient, the nurse, and their interaction, and carefully eliminating extraneous stimuli from thought.

The data indicated that focused attention was a necessary preparation for the remaining characteristics of centering. Achievement of a calm, relaxed state appeared with the process of disciplining attention. Identified as both the purpose and the outcome of disciplined attention, this calm state was seen to enhance involvement and awareness, increasing the nurses' ability to focus on the emergent situation. It, too, accompanied the remaining two characteristics of centering identified in the study.

Achievement of receptivity occurred when the nurse's attention moved from her own thoughts and actions to awareness of cues arising from the patient and the situation. This was seen to involve a shift from analytic thinking to perceptual awareness. This shift entailed the integration of groups of sensory cues which had meaning possibly derived from earlier experience with similar cues, rather than an analytical assessment of various data. Receptivity achieved during centering emerged as a precursor to, and led directly into, the assessment phase of therapeutic touch.

Similarly, the aspect of centering identified in this study as becoming a channel was seen as a precursor to and leading directly into features of the treatment phase of therapeutic touch. To nurses in the study, becoming a channel represented somehow being an instrument for, rather than a provider of, healing, which was conceptualized as communication of energy from the environment to the patient through caring feelings for the patient. This conveyance of energy was interpreted as assisting the patient to use healing potential available within themselves and the environment.

Assessment. This phase of therapeutic touch depended largely on expanded sensitivity to a variety of cues arising from the patient and the situation. These cues were perceived primarily through extratactile use of the hands to discern characteristics of what was described as the energy field surrounding the patient. The term extratactile is used to mean use of the hands within a few inches of the patient, but not touching. The cues felt with the hands included warmth, tingling, density, etc. Mental, or intuitive, awareness of information related to the patient was also reported, as were somatic perceptions, or changes in the nurse's own body awareness (e.g., gut feelings, headaches, etc., which, though felt by the nurse, were interpreted as information about the patient).

The specific assessment phase, with its typical extratactile use of the hands, was sometimes omitted. Descriptions of therapeutic touch practice, however, revealed that characteristics of assessment, including attention to extratactile, mental, and somatic cues for the purpose of planning or revising the intervention did occur during centering and treatment phases. Further, more experienced nurses tended to rely increasingly on mental and somatic awareness, and less on use of the hands.

Both telescoping of the phases of therapeutic touch, and attending to fewer extratactile cues, involved a shift from processing detailed sensory cues to intuitive awareness of the patient's needs. Such a shift is consonant with Benner's (1984a) model of development of expertise in nursing, in which intuitive comprehension of groups of perceptions obviates the need to process bits of information in a linear fashion, for the experienced nurse. According to Benner, the

ability of expert nurses' in her study to assess complex configurations of patient information appeared to derive from extensive experience in identifying and evaluating similar situations analytically.

Therapeutic touch practitioners' ability to recognize and evaluate extratactile, mental and somatic information arising from the patient, without detailed analytic processing, fits the pattern described by Benner as involved in the presence of expertise. Therapeutic touch users, however, described an extraordinary level of attentiveness that heightened their ability to read, or understand, what the patient was experiencing. Also, they described being open to changes in patient information that might occur during the assessment or between one encounter with the patient and another. These two features of nurses' use of therapeutic touch -- undivided attention to patient information, and willingness to re-evaluate the meaning of the information -- may be associated with ability to develop expertise.

Treatment. Awareness of cues such as those perceived during assessment continued during treatment, according to nurses in the study. During treatment, however, steps were taken to bring about changes in distribution and/or movement of energy flow in the patient's field. The term energy flow was used to explain apparent movement associated with changes in extratactile perceptions around the patient's body, and to explain the energy exchange postulated as a feature of channeling, as described earlier.

In the first stage of treatment, nurses described a process of smoothing imbalances in the patient's energy field by moving their hands through the field, from two to six inches from the skin, with the idea of making the field more even to their perceptions. In the

second, they described acting as channels for flow of energy from a "higher" or "universal" source. There was less hand movement in this stage of treatment than in smoothing. Often the hands were held still at selected areas in the field -- for example, one hand at the shoulder and one at the elbow, to work with flow through the upper arm. In addition, nurses used mental imagery of light and other concepts involving movement, such as flowing water, to symbolize energy flow while doing the treatment. Mental direction of feelings of compassion and caring were also identified as symbols for direction of energy.

These two stages of treatment have been described by Krieger. However, a third and non-traditional stage also appeared consistently in the data. This stage of treatment involved modeling of desired feeling states by the nurse with the expectation that the feeling would be assumed and experienced by the patient.

Despite consistent use of the concept of energy as an explanation for perceived changes in the patient's field, as well as in the interaction between nurse and patient, other explanations were possible. For example, the nurse's feelings and intentions and the patient's expectations were implicated in effective interaction. In addition, both the nurse's and patient's bodily states (psychophysiological responses) could account directly for perceptions associated with the process without secondary explanation as energy. Attentiveness to these feelings, intentions, expectations, and perceptions was emphasized in therapeutic touch treatment as it was in assessment.

Interweaving of the practices. Interrelationships among features of centering, and of centering with other practices of therapeutic

touch, epitomized the holistic nature of the process. Because of interdependency and interactions among the characteristics of the practice of therapeutic touch, the parts could not be totally isolated from each other or be described without reference to each other. Although features of assessment and treatment were sometimes not described as separate elements of the practice, their distinguishing features could be found interlaced with other phases of the practice.

Relationships among the phases which were used to describe therapeutic touch validate the suggestion made in the literature (Krieger, 1979, p. 69) that these phases of therapeutic touch frequently overlap in practice. That is, close relationships between centering and both assessment and treatment tended to blur boundaries among the various features of therapeutic touch. For example, except for the labels of centering and assessment applied by practitioners, the distinction between achievement of receptivity (a feature of centering) and receptivity (a feature of assessment) was not always clear.

Centering emerged as the only phase of therapeutic touch that was described as a part of every successful instance of the use of therapeutic touch by nurses familiar with Krieger's phases of the practice. Several nurses, however described therapeutic interactions which occurred prior to their knowledge of therapeutic touch, and which they interpreted as similar to therapeutic touch. In these cases, centering was not described. Nevertheless, these therapeutic interactions did involve features that the nurses later came to understand as components of centering. In particular, they included focusing on the patient in a caring way, with receptivity for the

patient's needs. Unlike therapeutic touch practices, these earlier experiences were described as lacking a sense of knowledgeable intervention.

Intent

As was evident in the earlier chapter on beliefs associated with therapeutic touch, the data indicated that nurses considered their intent during use of the technique to be an important factor in the practice. Intent was not described as a distinct phase of practice. Rather, it could be seen to influence all of the phases. Features of intent most often mentioned as involved in the therapeutic touch process were intent to help and intent for wholeness or wellness for the patient.

Intent to help. Intent to help appeared to be reinforced by an expectation that practitioners would be more effective if clear about their motives to help unselfishly. This form of intent was frequently expressed as a therapeutic use of self, and appeared to heighten the nurses' sense of involvement with their patients.

Intent for wholeness. Also referred to as intent for wellness, this type of intent could be seen as supporting the theoretical stance that reinforcement of patients' psychophysiological potential for wellness can promote healing. In some cases nurses came to therapeutic touch already cognizant of this potential. In others, therapeutic touch served as an introduction to the concept of innate potential for healing. In either case, therapeutic touch as a method for enhancing patients' potential for wellness was seen as a motivating force in use of the technique.

The intent for wholeness indicated attention by the nurse to a theoretical stance which differed from the traditional medical model. Where medicine takes the form of physical interventions -- usually medications or surgery -- intent for wholeness suggested therapeutic value in the meaning of the intervention. Wholeness was interpreted as involving harmony among various aspects of a person's make-up, and an effort to view the person in a unitary manner rather than as aspects to be treated separately. This notion has a long, though beleaguered, tradition in medicine. Cannon (1932) early commented on what he called the wisdom of the body, recognizing that meaning had consequences for physiological processes. Selye (1956) elaborated on this notion, and Pelletier (1977) popularized it. These writers identified their interests as relationships between mind and body. Interests in similar processes underly nursing's claim to concern for the unitary person, a claim which acknowledges a spiritual aspect as well.

Wholeness was also found to include the idea of a connection between the individual and the environment. This concern is represented in nursing theory by Rogers' model, which is based on systems theory, with the person-environment interaction occurring via energy and matter. In therapeutic touch, a part of the nurse's intent was to assist in this energy interaction between the patient and the environment.

Intent to achieve specific outcomes. In addition to the two forms of intent delineated above, the findings revealed two further levels of intent which are not taught in the Krieger tradition as specific components of therapeutic touch. These seemed to grow out of the influence of certain assumptions regarding the nature of nursing and of

healing. The first of these was intent to achieve specific outcomes. The outcome sought by most nurses in the study was reduction of symptoms -- primarily pain and anxiety. One possible assumption underlying this finding is that therapeutic touch is more effective in relieving symptoms than in altering the underlying condition. A second is that relief of symptoms -- especially anxiety -- leads to alterations in underlying conditions. Another assumption is that relief of symptoms is an appropriate function of nursing.

Intent to assist patients with self-healing. Intent to assist with self-healing was associated with nurses' considering themselves to be instruments for rather than providers of healing, as discussed earlier. This self-healing appeared to be expected by the nurses to occur at a psychophysiological level more often than it was related to expectations that the patients would take overt steps in self-care. Again, this indicated assumptions that self healing is a natural potential and that the nurse-patient interaction can be used to enhance this potential.

The expectation of the nurses was that patients' normal healing capacities were enhanced by the intervention. Support for this expectation can be seen in Benson and McCallie's (1979) finding that expectations of health care providers do affect the outcome of treatment. In the case of therapeutic touch, the patient's awareness of nurses' expectations was heightened by the context in which the interaction occurred. Since therapeutic touch was usually explained to patients in terms of energy exchange, the practice clearly involved novel expectations.

Beliefs

In addition to those concerning intent, three categories of beliefs associated with therapeutic touch were identified. These concerned the nurses' decisions to use therapeutic touch, and their beliefs about energy fields and spirituality.

The decision to use therapeutic touch. Factors considered in nurses' decisions to use therapeutic touch were the nature of the patients' presenting problems and the patients' attitudes toward receiving therapeutic touch. The overriding consideration was identified as whether the nurse believed the technique might be helpful in the situation.

Nurses in the study were involved in an ongoing process of identifying those situations in which the technique might be useful, including factors other than medical diagnosis which might be involved in effectiveness. For example, nurses sometimes referred to research on therapeutic touch documenting its usefulness in relieving anxiety, and indicated that their experience corroborated these findings. However, the most frequently mentioned use of therapeutic touch was for pain relief, for which systematic empirical study is inconclusive (Meehan, 1985). Still, the nurses clearly believed that therapeutic touch was effective in relieving these and other symptoms.

Energy. Another category of beliefs associated with therapeutic touch concerned the concept of energy as the underlying basis of therapeutic touch. This is important because from its earliest conceptualization, therapeutic touch has been attributed to manipulation of energy flow. All of the descriptions of the practice of therapeutic touch involved references to energy. In some cases the

concept of energy was treated in a matter-of-fact manner, with the apparent expectation that if means of measuring its presence were not currently available, they would one day be. In some cases, this belief could be attributed to exposure to Rogers' (1970, pp. 61-62) theoretical basis of nursing, which holds that "an energy field is the basic unit of living things." This phenomenon involved unity between people, as well as between persons and their environments. Such unity is also a feature of Rogers' theory, in which persons are seen as "open systems constantly exchanging matter and energy with the environment." Other participants appeared to use the term energy as a convenient label for a phenomenon for which no other explanation was available. Use of the term energy, however, involved an assumption not common to popular scientific views regarding the nature of human beings and their interactions. As a consequence, some of the descriptions involved terms and concepts unfamiliar to most health care providers.

Spirituality. The final category of beliefs that emerged from the data was the notion of a spiritual aspect of the technique. Spirituality deserves consideration because in spite of frequent disclaimers by its users denying identification of therapeutic touch as spiritual healing, many experienced practitioners described the technique as having a spiritual component. Of particular interest was the nurses' understanding of the nature of spirituality. It was evident that the nurses viewed the spiritual aspect of therapeutic touch as related to a kind of transcendence of the usual parameters of interaction, leading to attainment of new levels of understanding of the importance of individual values. Whereas nursing has traditionally acknowledged individual values as important, the consciously directed

focus on the patient which permeated therapeutic touch appeared to amplify concern for the patient's unique needs. Further, the basis of these needs was seen as situated in the patient's interests, concerns, and history. That is, nurses came to see the patient's perspective more clearly as relevant to treatment decisions.

For individual nurses, identification of the primacy of patient perspectives usually occurred as a result of what Benner and Wrubel (1982, p. 13) call a qualitative leap. In this case, the leap was from the experienced clinician's ability to pinpoint isolated clinical manifestations (e.g., areas of warmth or vibrations in the field), to recognition of a broader concept underlying many of the manifestations, (e.g., a pervading sense of therapeutic unity between the patient and the nurse). The usually sudden nature of this shift contributed to nurses' identification of the phenomenon as spiritual.

In addition to nurse participants' recognition of the validity of patient perspectives as spiritual, further evidence for a spiritual aspect of the technique was seen in their quest for wholeness for the patient. One aspect of wholeness was the notion of an innate tendency toward a "good" outcome, which could be nurtured by the intervention, keeping in mind that the intervention itself involved projection of positive caring feelings to the patient. The spiritual nature of this feature of therapeutic touch is suggested by James' (1958, p. 58) reference to religion as "the belief that there is an unseen order, and that our supreme good lies in harmoniously adjusting ourselves thereto." The findings indicate that therapeutic touch practitioners would substitute secular spirituality for religion as the subject of this definition, however.

Despite emergence of spirituality as a concept related to therapeutic touch, nurse participants were frequently reticent about introducing it into interviews. Reluctance to identify spirituality as an aspect of therapeutic touch was related to many nurse's perceptions that Krieger considered the technique not to be of a spiritual nature. Krieger's strong and enduring influence on nurses' use of therapeutic touch magnified the impact of their lack of clarity regarding her statements about spirituality, which seemed to contradict the nurses' own personal interpretations of their experiences.

Krieger (personal communication, November 10, 1984), however, indicated that in pointing out that therapeutic touch was not to be confused with spiritual healing, she simply wished to distinguish the practice from such different types of healing as faith healing (involving religious faith), psychic healing (usually based on gut feelings or hunches), and spiritualistic healing (involving spiritual guides), which are practiced in other contexts than is therapeutic touch and which are not derived from a research base. Krieger also indicated willingness to have therapeutic touch practitioners acknowledge their own understanding of the technique, rather than to depend on her for the final interpretation, which is in keeping with a practice that seeks legitimization through science.

Nurses' hesitation to introduce spirituality into the interviews need not be attributed entirely to their unwillingness to disagree with Krieger, however. There are also cultural prohibitions involved. Not the least among these are popular views regarding the nature of reality, which tend to categorize spirituality as being in the realm of religion rather than science. A notion of spirituality as not subject

to study, and yet as involved in therapeutic touch, is in conflict with practitioners' views of therapeutic touch as resting on a scientific basis. It is this scientific basis that provides credibility to the technique. On the other hand, recognition of spiritual aspects of therapeutic touch may indicate re-emergence of a feminine aspect of health care discarded as medicine itself sought legitimization as a science (see Ehrenreich & English, 1978, pp. 37-46).

Interactions Among Practices, Intentions, and Beliefs

An impressive portion of the data indicating belief in human energy fields which can be manipulated to improve health and well-being came from participants' descriptions of therapeutic touch practices. The hand movements and the focus of attention in both the assessment and treatment phases were concerned with awareness of perceptions attributed to the presence and movement of discernible energy. Without such a belief, the hand movements would have been without meaning. Since the presence of such energy fields appears to be in contrast to expectations based on the biomedical model of understanding health and illness, one can assume that in using therapeutic touch the nurses acted upon assumptions based on other theoretical understanding, as noted earlier.

The data indicate that the notion of the presence of energy fields came from two sources. First, the concept of human energy fields had been presented as an underlying basis for therapeutic touch in workshops where nurses learned the technique. Some of the nurses indicated that this explanation seemed logical to them on the basis of their prior beliefs, but others indicated that the concept seemed strange at first, and in some cases was still not well understood by them.

Nevertheless, all of these nurses, most of whom had used therapeutic touch for more than two years, had come to accept the concept of energy fields because it was a way of explaining their own perceptual experiences with the technique, as well as outcomes of their interactions with patients.

In this interpretation the initial trust that energy fields were possible permitted the nurses to begin to practice therapeutic touch. This practice in turn produced otherwise unexplained perceptions such as warmth or vibrations felt with the hands in the field immediately contiguous to the patient. These perceptions were seen as evidence for the presence of energy fields, thus reinforcing the belief. Belief is used here to mean the nurses' acceptance of the notion of energy fields as an explanation for these perceptions. It is not meant in a metaphysical sense, as implying trust based solely on the word of authority.

Belief in the existence of human energy fields, however, while apparently essential to explanation of therapeutic touch, did not in itself provide a complete explanation for the practice. There remained the question of how the energy was manipulated. While Rogers' (1970) theoretical basis of nursing offered an explanation for the presence of energy fields, nurses in the study adopted strategies for manipulating energy that were not explained in nursing theory.

There were two ways in which energy was thought by nurses in the study to be manipulated. Some of the nurses spoke of "setting up an energy field." The means for doing this was described as creating mental representations of the energy in the area in which intervention was to be made, while using the hands to define the boundaries of the

area. Manipulation of the field was then achieved by use of further hand movements, associated with mental images which involved visualization of energy movement. The second method of manipulating energy was conceived as mentally directing toward the patient feelings of caring, often described as sending love. It was apparent from the data that these feelings were of a nonjudgmental, compassionate, and selfless nature.

As noted earlier, in order to act upon the notion that energy fields exist and can be influenced by the thoughts of the practitioner, nurses in the study had adopted a theoretical stance developed by Kunz and Peper (1982). Some nurses in the study were aware of this theory, while others did not seem to consider the practice of therapeutic touch as grounded in known theory.

Kunz and Peper conceive of humans as local concentrations of energy within a universal field. That is, the physical body is conceived as a dense conformation of energy, surrounded and interpenetrated by several other fields of energy not visible to most persons. Each of these fields has its own energy frequency and pattern. Kunz's perception of these patterns is related by Karagulla (1969, pp. 124-126) as akin to sparkling webs of light beams. Separate fields are said to be influenced by (1) the body and its electro-chemical manifestations, (2) emotions or feelings, such as caring or anger, (3) visual images and ideas, and (4) order, creativity, and compassion, associated with a peaceful and quiet mind (Kunz & Peper, 1982, pp. 396-400. See earlier discussion of field theory, pp. 149-150).

Development of the field theory by Kunz and Peper has taken place largely apart from the scientific community. It draws from Eastern thought, without explaining links to existing Western theories. Habermas (cited in Jay, 1984) would classify such a theory as emancipatory, because its purpose is concerned with cultivation of the human potential, rather than with mastery of the natural world, as is traditional Western theory. Further, it is different from interpretive models, in that its mode of actualization is through reflection and self-understanding, rather than through re-experiencing the meanings of others, which is the method of hermeneutics (pp. 31-33).

An Alternative Explanation

The findings of this study suggest an alternative theoretical stance which may provide a fresh perspective from which to examine the phenomena of therapeutic touch, and help to explain its use by nurses. The suggested stance takes into account that given the holistic nature of the process, with its complex interactions among practices, intents, and beliefs, a variety of theoretical views may be required in order to fully examine the technique. A review of perspectives from which to conceptualize touch is offered by Weber (1984). These perspectives will serve here as a springboard for developing a more unified stance.

Weber suggests three theoretical models for examining the concept of touch; the physical-sensory model, the psychological-humanistic model, and the field model. The complexity of the therapeutic touch experience may dictate that none of these models can realistically be adopted for explanation of the technique to the exclusion of the others, since each is useful in its own way.

The physical-sensory model to a great degree influences Western theory and research. According to Weber, it is based in body-mind dualism, and assumes that all matter can be reduced to finite building blocks. Ultimately, this means that increased understanding follows increased knowledge about these building blocks. The physical-sensory model was used in early therapeutic touch research, in the sense that the research looked at physico-chemical outcomes and did not attempt to explain human concerns and meanings involved in the treatment.

The other theory that has been associated with therapeutic touch is the field model, which incorporates notions of energy exchange and direct influence of feelings and intent on the basic human structure -- energy. Rogers' (1970) nursing theory incorporates parts of both the physical-sensory and field models by identifying energy fields as the basic human structures, and suggesting quantitative methods to test the theory.

The third theory categorized by Weber, and placed by her between the physical-sensory and the field models, is the psychological-humanistic model. While the field model may be very useful in providing practitioners with a construct for explaining the unique perceptions and strategies of therapeutic touch, its method (reflection) does not provide convincing evidence for advocates of the popular scientific model. Thus, the psychological-humanistic model, which is somewhat less distanced from the physical-sensory model and already has advocates in health care (Engel, 1977), may be more useful for examining the broader meanings associated with its practices as they are incorporated into the traditional Western context. For example, Weber identifies meaning as the fundamental datum in the

psychological-humanistic model, and the shared interpretations which constitute meaning have been identified here as crucial to the practice of therapeutic touch. Further, Travelbee's interpersonal theory of nursing involves the meaning of health and illness as an important concept in nursing (1963, 1964). While Travelbee's theory remains largely untested, therapeutic touch itself may offer a vehicle for such testing.

Each of these models is useful in explaining therapeutic touch from a particular viewpoint. It is their relationship in an integrated holistic perspective, however, which can provide a more complete understanding of the technique, by supporting various types of research. Such a perspective would allow each model to be used in relation to data appropriate to it, while at the same time acknowledging the value of the other models.

Question 2: How do Nurse/Client Interpretations of Therapeutic Touch Differ from Characteristics of Usual Nursing Care?

Opinions about how therapeutic touch differed from usual nursing care were derived both from participants' statements about their beliefs, and from descriptions of their practice of therapeutic touch. The most vivid contrasts were apparent in descriptions of the practice and in implied beliefs underlying the practice. Foremost in differentiation of therapeutic touch from usual nursing practice was the concept of the human being as consisting of energy fields which interpenetrate and extend beyond the body. As discussed earlier, it was apparent from the data that belief in energy fields and the resulting decisions to act upon this belief depended upon an expanded view of what constitutes the human being, beyond the understanding upon

which usual nursing care is based. Practices related to this belief included use of the hands in ways quite different from the usual use of touch in nursing.

The second most apparent contrast with usual nursing care was the degree to which nurses in the study described paying attention to, or focusing upon, the patient. One focus of attention was for the purpose of discerning subtle imbalances in the energy field. The decision to define the focus in this way was again dependent on the assumption of energy as a natural dimension of human beings. In some cases the focus was on discerning thoughts and needs of the patient through intuitive and psychophysiological perceptions associated with the patient's problems. Nurses' ability to apprehend intuitive cues regarding patients has been documented by Benner (1984). Therapeutic touch appeared to provide a means for nurses in this study to deliberately increase their awareness of such cues.

A third contrast with nursing as it is usually practiced is that unlike most nursing techniques, which respond to medical needs and are based on the medical model, therapeutic touch is nursing derived, responding to nursing values such as the importance of caring, and concern for the patient's unique belief system. The result of this divergence from tradition is twofold.

First, nurses using therapeutic touch expressed an unusual sense of autonomy stemming from their ability to provide substantive symptom control without a physician's order. This clearly shared evaluation of the advantage of using therapeutic touch was seen both in nurses' descriptions of their practice and in responses to questions about therapeutic touch as compared to usual nursing care.

On the other hand, in tandem with this sense of autonomy there emerged a new level of responsibility for documenting and explaining the technique to patients and to other health care disciplines. Evidence of lack of understanding and acceptance was particularly acute when use of therapeutic touch cleared symptoms and masked underlying pathology, such as fracture (see p. 131). The need for nurses to take responsibility for explaining therapeutic touch was inferred partly from their discomfort with lack of understanding exhibited by others. This discomfort was at times so intense that nurses chose not to use the technique in certain situations because of it. However, no coordinated strategy for disseminating information to non-users was evident.

Inference of the need for nurses using therapeutic touch to take responsibility for explaining it also came from another source. On the rare occasions when nurses acknowledged the possibility of deleterious outcomes of therapeutic touch, these were often treated as anomalies rather than as indications of new directions for study, much in the manner that therapeutic touch itself is treated as an anomaly by the larger scientific community. On the whole, except for references to existing therapeutic touch research, acceptance of responsibility to explain use of the technique, beyond clarifying it for the individual patient or in the classroom, was almost invisible in the findings. The mood was more akin to annoyance that non-users did not take it upon themselves to learn about therapeutic touch.

The roots of the vicissitudes of introducing and sustaining a nursing practice which runs counter to the established, formally sanctioned route to cure or care can be traced to that element of

nursing history that combines responsibility with limited access to authority and control. In a discussion of problems associated with the study of caring, Dunlop (1983) suggests that nurses' traditional female socialization, as well as nursing's emphasis on the nurse-patient dyad, contribute to acceptance of responsibility for the patient without authority to control the social or physical environment. Such dynamics may well underly nurses' failure to attempt to provide more universally acceptable explanations for their use of therapeutic touch.

Question 3: What Interpretations of Usual Nursing Care are
Similar to Interpretations of Therapeutic Touch?

Therapeutic touch is widely regarded by non-users as an alternative to conventional health care. In spite of ongoing therapeutic touch research in conventional health care institutions, its image as an unusual intervention has been nurtured by the language used to describe operationalization of the technique, as well as by comparisons of therapeutic touch to laying-on of hands, which has religious implications to many people. However, certain characteristics of the practice of therapeutic touch, as well as the expectations of nurses in relation to outcomes, point to commonalities with more usual nursing practice.

The most apparent commonality between therapeutic touch and usual nursing care was seen in the process involved. Whether the therapeutic touch process was devised to coincide with the nursing process, or similarities occurred naturally, the two are enough alike to help to make nurses comfortable with the technique. Of particular note is the structure of assessment, planning, intervention, and reassessment to evaluate effectiveness of the intervention. While only assessment and

intervention were identified in the findings as separate stages of therapeutic touch, planning and reassessment were clearly included in the process. While these terms provided a comfortable framework for nurses in the study, the actual assessment and intervention techniques were quite different from other nursing skills.

The findings show that many nurses in this study viewed therapeutic touch as an extension of, rather than an alternative to, usual nursing care. For example, a number of participants described how previous experiences, in which the nurses' projection of compassion seemed to result in increased well-being in the patient, were later made understandable by their knowledge of therapeutic touch. A nurse participant even described one such pre-therapeutic touch experience as an example of effective use of therapeutic touch. Focused caring was an underlying factor in these nursing experiences. Participants indicated that in therapeutic touch they learned techniques for enhancing this caring. That is, therapeutic touch made caring as a force for healing more visible and therefore more legitimate for them. Benner (1984a, p. 170) also found the importance of caring for curing to be inherent in nursing.

Similarly, nurses saw their intent for wholeness, to help their patients in general, to relieve specific symptoms, and to help patients with self healing as similar to usual nursing care. While these philosophical orientations were present in therapeutic touch and in usual nursing care, the degree to which particular attention was paid to operationalizing them was greater in therapeutic touch. Thus, therapeutic touch seemed to provide a way for nurses to acknowledge and enhance certain aspects of usual nursing care.

This is not to say that other techniques for enhancing the practice of caring do not exist. For example, gestalt psychology offers techniques for differentiating the object of attention from background considerations (Perls, Hefferline, & Goodman, 1951). This differentiation is similar to the practice of disciplining attention in therapeutic touch. Similarly, many relaxation exercises are known to nurses. Some of these are used for alleviation of both anxiety and pain (Benson, 1975; Pelletier, 1977), as is therapeutic touch. What appears to be unique in therapeutic touch as a method for enhancing caring aspects of nursing is its association with a theoretical explanation for the perceptual and sensory experiences associated with the act of doing therapeutic touch -- i.e., the notion of energy exchange. This was true even though a framework for explaining energy as a unit of analysis was not set forth.

A further characteristic of therapeutic touch practice that could be seen as similar to usual nursing care was the nurses' concern for mediating between patients and their environment. In nursing, such mediation usually involves helping patients in their interactions with other members of the health care community, or intervening with regard to the physical environment. In therapeutic touch, nurses conceived of the patient's energy field as in constant interchange with environmental energy, including that of the nurse. In addition, the concept of wholeness involved the notion of a patient-environment connection which was facilitated by the practice (see pp. 162, 168).

Question 4: What Characteristics of Therapeutic Touch are Associated with Effective Outcomes, According to the Self-description of Persons Who have had Experience with the Technique?

Considering the amount of attention given to energy fields in explanations of therapeutic touch, one might expect that the nurse's ability to discern and manipulate the proposed energy would emerge as the most important aspect of use of the technique in terms of outcome. However, this was not found to be the case. Centering and intent appeared to underlie effectiveness, with the notion of energy manipulation serving as a useful conceptual tool for assigning meaning to these activities.

Centering

The first feature of therapeutic touch that emerged as consistently necessary for effective use of therapeutic touch was centering. The centering process constituted the sine-qua-non factor in the technique. This paramount importance of centering was evident from two perspectives; (1) every nurse's inclusion of centering in descriptions of effective use of the technique, and (2) emergence of centering as prerequisite for successful practice of assessment and treatment.

Although centering did include preparation for awareness of and attention to manipulation of the postulated energy, it also set the stage for awareness of mental and somatic cues, and for a mental set which focused on the individual needs of patients to the exclusion of preconceived notions regarding those needs.

This focus of attention was also essential to awareness of assessment cues and to manipulation of the field. Patients in the

study identified the nurses' focus on patient needs as an important part of therapeutic touch.

Intent

A second characteristic of therapeutic touch seen by nurses to be essential to effective use of therapeutic touch was their intent. As noted earlier, intent did not appear as a separate phase of therapeutic touch practice. Instead, it was seen to be involved throughout the therapeutic touch process, as an ongoing reminder of the purposes of its use and expectations regarding outcome.

The contribution of intent to effectiveness appeared to be twofold. The impact of intent on the nurse's ability to focus effectively on the situation and to interact therapeutically was primary. Intent to help, to relieve specific symptoms, and to promote wellness or wholeness were particularly expressive of this function. Second, intent to assist the patient with self-healing conferred an interactive quality on the concept of patient. That is, intent for self-healing assumed a therapeutic psychophysiological response on the part of the patient, consistent with Kunz (1978) and Fanslow's (1978) attribution of importance to encouraging the cooperation of the patient.

Energy

In the introduction to this section, it was stated that the nurse's ability to discern and manipulate the proposed energy of therapeutic touch was not among the characteristics of its practice which were essential to effective outcome. That conclusion was drawn from the observation that each of the stages of assessment and

treatment in which nurses used their hands to discern or manipulate energy flow was absent in some effective cases.

The concept of energy, nevertheless, was employed by nurses and used as an explanation for the basis of its effectiveness even when the hands were not used. It was used to explain what was taking place both during use of the hands and during direction of caring feelings or mental images toward the patient. Thus, the concept of energy appeared essential as a means of providing logic to the various activities associated with the technique. It could not be considered sufficient to effectiveness, however, since it was also present to a degree in ineffective cases. That is, its effect depended upon the quality of caring associated with its use.

Psychophysiological Effects: Potential For Self-Healing

While most dictionaries define placebo in terms of medications, more recent definitions have attempted to broaden the meaning to include psychophysiological interventions as placebo. A typical modern definition, from a discussion of placebo effects of biofeedback, is "any medication [treatment] used to alleviate symptoms, not by reason of pharmacologic action, but solely by reinforcing the patient's favorable expectancies from treatment" (cited and expanded in Stroebe and Glueck, 1973, p. 20). Another is

"any therapy, or that component of any therapy, that is deliberately used for its nonspecific, psychologic, or psychophysiologic effect, or that is used for its presumed specific effect on a patient, symptom, or illness, but which, unknown to patient and therapist, is without specific activity for the condition being treated" (Shapiro, 1971, p. 440).

Characteristics of therapeutic touch associated with effective outcomes were related to nurses' preparation for and mental state

during the interactions (centering), and their motivations for interacting (intent). Centering and intent can both be seen as strong influences on the nurse-patient relationship. Theoretical explanations for efficacy of the treatment (based on energy balance and modulation) contributed to nurses' personal expectations for effective outcome. Both therapist-patient relationships and therapist expectations regarding outcome have been identified as bringing about placebo effects (Benson & McCallie, 1979; Shapiro, 1971, pp. 443-448). In the absence of other explanations for how therapeutic touch brings about symptomatic changes, the placebo effect must be considered as a possible factor.

The therapist's contributions to placebo effects may not be independent of the patient's role. Indeed, what has been termed the patient's self healing potential can be seen as the patient's involvement in these effects. The data suggest, however, that the patient's attitude toward therapeutic touch may produce adverse effects as well. In two cases in which the nurses felt that the patients thought the technique would be ineffective, the patients reported increased experience of pain.

One explanation for this increased pain might be that using the hands near the painful area, though not touching, might direct the skeptical patient's attention to that area, and thus increase the perception of pain. Thus, it would be opposite from the placebo effect.

Another explanation might be that the subtle energy exchange postulated to relieve pain in ideal situations might be affected by the patient's resistance to use of the technique in such a way as to

inhibit the desired energy flow and thus increase the pain. It seems likely that if positive attitudes or feelings on the part of the nurse and patient can act to bring about positive change, negative attitudes or feelings might as easily promote adverse change.

In modern definitions of placebo effects, purposeful approaches to patient care such as therapeutic touch, that appear to stimulate internal bodily responses, thus fall under the rubric of placebo. However, the search for understanding of the healing effects of such therapies demands a more specific classification for psychophysiologic interventions. The level of understanding brought to the treatment situation by both the therapist and the patient must ultimately distinguish between hoped for and knowledgeably elicited, or placebo and non-placebo, effects. For example, the nurses' conscious use of intent to help, as well as their careful focus on the patient's individual needs, with its attendant influence on the nurses' feeling state (increased calm), constituted a planned intervention with specific expected outcomes. The outcome of reduced anxiety has been supported by Quinn's research (1983). Therefore, "psychophysiologic effects" might be a more useful term than "placebo effects" for the enhanced self healing outcomes described as associated with therapeutic touch interventions.

CHAPTER 6

Implications

Energy Versus Caring: A Question of Understanding

Nurses' use of a healing method such as therapeutic touch raises questions about the development of a nursing intervention that runs counter to the prevailing assumptions of the medical model. The viability and credibility of such practices may depend upon nursing's ability to build its own body of knowledge based on an integrated holistic model, rather than depend on a medical model which has less theoretical relevance to these practices. Users of therapeutic touch were frequently confronted with difficulty explaining aspects of the intervention, and dilemmas associated with its use, apparently because of its contrast with the dominant medical model. The survival of therapeutic touch as a legitimate nursing practice may also depend on nurses' ability to account for the practice in terms of caring, comfort, and healing -- core goals in nursing. Whether therapeutic touch continues to be utilized rests on how well the theoretical underpinnings and methods of the technique are understood. The findings from this study shed light on these considerations.

Caring in a Technological Age

Therapeutic touch as viewed by nurses in this study emerged as a practice based on trust, faith, or belief in (1) the existence of a universal force, (2) the practitioner's ability to interact with that force in the interest of the patient's well-being, and (3) the possibility of self-healing on the part of the patient, based on as yet undefined natural laws. These elements of faith run counter to notions prevalent in current technological views of reality and of health care

in particular, such as authority of the health care provider, control over specific physiological functions, and manipulation of the environment. One wonders, then, what prompts the development of therapeutic touch in a technological age.

Therapeutic touch users in this study identified the practice as filling a need ignored by technology. Many nurses identified therapeutic touch as a means of caring. Caring was seen in the nurses' efforts to be perceptive to patients' needs, in their intent to help patients to utilize their internal potential for equilibrium, and in their acknowledgment of the validity of meanings held by patients regarding their illnesses. On the other hand, nurses and patients described usual health care in more technological terms, referring to emphasis on medication or surgery, doing something to the patient, focusing on the disease rather than the patient, etc.

Both nurses and patients in the study singled out caring as an important feature of therapeutic touch. Nurses saw caring as a feature of usual nursing care that was made visible and operationalized in therapeutic touch. Patients described caring as that part of the therapist-patient interaction that set therapeutic touch interventions apart from other health care practices. Both defined caring in terms of the quality of time spent in the interaction. For instance, this study identified the nurse's focused attention on the patient, and intent to help or promote wellness, as underlying the nurse's ability to practice caring, and the patient's perception of it. These elements of caring are not always acknowledged as substantive nursing skills, but have been described as the core of nursing by some (Watson, 1979). Most often, nurses take caring for granted as basic to nursing. Yet,

neither its precise description nor its exact contribution to therapeutic outcome have been identified previously. Benner (1984a), however, recently found caring practices to be relevant in her study of development of expertise in nursing. Her findings suggest that both the healing relationship and the coaching function of expert nurses were founded -- as was therapeutic touch in this study -- on commitment to helping patients interpret meaning-laden health care situations in positive helpful ways (pp. 49, 79).

Scientific Legitimization of Therapeutic Touch

Therapeutic touch has been described by its founders as based on laying-on of hands. If the caring aspects of the practice had first been identified and acknowledged, therapeutic touch could as easily have been described as based on the healing role of caring in nursing practice. Nurse participants in this study who described clinical experiences which occurred prior to their learning therapeutic touch, and which they later found to be explained by therapeutic touch, are cases in point. These nurses did not go through a process of centering, assessment, and treatment, but they did describe intent to help and some particular focus on the patient's needs as involved in these therapeutic nurse-patient encounters (see pp. 96-97). Similarly, in her 1975 article on therapeutic touch as an imprimatur of nursing, Krieger said she had on file over 100 such accounts from nurses, which described "the spontaneous use of touch quite unknowingly, or rather unknowledgeably, during acts of nursing intervention which brought therapeutic results so unusual that they frequently came as a surprise" (p. 784). The presence of this statement in an article about the genesis of therapeutic touch suggests that the therapeutic impact of

nursing care originally stimulated Krieger's creative development of the practice.

Therapeutic touch could be described, then, as a method of conveying caring as an element of the therapeutic interaction. It's development was prompted by nurses' recognition of therapeutic outcomes of their interactions with patients, and efforts to identify the underlying mechanisms for those outcomes. In her search for an explanation for this consequence of human interactions, Krieger pinpointed laying-on of hands as another instance in which a similar human interaction occurred, and used laying-on of hands research as the foundation for a sequence of studies leading to introduction of therapeutic touch as a nursing phenomenon.

Why did Krieger bypass nursing phenomena as her focus and use laying-on of hands research as the basis for her development of therapeutic touch? One possible answer is that conventional Western scientific methods were being used to study laying-on of hands, and this scientific representation could be used to help legitimize therapeutic touch. Yet, as was noted in the literature review, little attention was given to the caring or empathetic aspects of laying-on of hands. Because they were observable and fit popular scientific methods, what was studied or controlled for were the specific placement of the hands, temperatures generated by the presence of hands, and the possibility of electromagnetic phenomena.

In the early literature (Grad, 1965), one impact of human to human interaction, suggestion, was controlled for by use of non-human subjects. It seems that the feature of therapeutic touch treatment described as modeling might involve some characteristics of suggestion.

It is ironic, then, that in the research on which therapeutic touch was based, suggestion was systematically removed from consideration. On the other hand, the presence of effects even in the absence of suggestion did establish that effects could not be attributed to suggestion alone. Following the model of laying-on of hands studies, later therapeutic touch research (Heidt, 1980a, 1980b) defined therapeutic touch particularly in terms of hand placement and only more generally in terms of focusing on the patient and intent to help the patient. Quinn (1983) did control for focusing and intent, as well as for facial expressions and demeanor of the nurse. However, she did not indicate how focusing and intent were operationalized in the treatment condition. The crucial importance of these concepts to therapeutic touch has been verified in this study.

Laying-on of hands presented a very attractive springboard for therapeutic touch study precisely because it was being examined in a conventionally scientific, impersonal manner, consistent with ideas of tight control and environmental manipulation imbedded in the technological practices of health care. The literature review for this study found only buds of acknowledgment of the human elements of therapeutic touch that emerged as all-important in the results of this research. Even participants in this study described therapeutic touch as based on laying-on of hands for the legitimization of the practice. In descriptions of their actual practice of therapeutic touch, however, its foundations in the caring, intentional, feeling aspects of their relationships with clients were central (see pp. 94-95, 105-107, 130-139).

Explanatory Models for Caring

Despite down-playing of the caring aspects of therapeutic touch as a public explanation for its use, nurse participants in the study provided voluminous evidence for the primacy of intentional and feeling aspects of the practice. The most direct evidence of use of feeling states by nurses was utilization of caring and compassion in manipulation of the postulated energy flow involved in therapeutic touch treatment. The notions of energy and of manipulation appeared to be used by some study participants largely as a convenient tool to account for a poorly understood phenomenon involving communication of feelings from one person to another.

Energy

Persons in this study who lacked direct visual awareness of energy fields (Karagulla, 1967, p. 124) were able to adopt the energy transfer explanation to account for their own experiences because these explanations "made sense" where no other explanation was available. Their own experiences, however, consisted not of energy, but of such phenomena as conscious use of their feeling states on the one hand, and perception of warmth, vibrations, etc., on the other.

Deliberate use of feeling states is probably not too difficult for most individuals to imagine or identify as part of their own experience, and they may even relate feelings to particular expected outcomes, as in the case of "laughter is infectious." Acknowledgment of extratactile perceptions of warmth, vibrations, heaviness in the air space around another person, etc., however, presents particular problems for explanation (see pp. 71-73). What in our present knowledge base might be used to help account for these experiences?

Many participants who were exposed to the energy field theory accounted for their perceptions in terms of energy. One patient participant who was not knowledgeable in the field theory, fell back on the notion of atoms in motion to explain her perception of fine movements in her body during therapeutic touch treatment (see p. 76). Both energy and atom movement as explanations for bodily perceptions are cases of using available theories to account for heretofore unlabeled experience. A more appropriate description, however, might be somatic knowledge or bodily information.

Acknowledging the Wisdom of the Body

Therapeutic touch as described by nurse participants acknowledged awareness of internal bodily sensations. It further associated this awareness with increased understanding of the perceptual resources of one's body. However, the increased awareness was treated as somehow mysterious, although it can be seen as so ordinary that it is usually not accorded attention (see pp. 64-65). One wonders what influences make it difficult to acknowledge awareness of bodily processes.

Attribution of bodily perceptions to energy movement as described earlier suggests a need to explain the phenomena at a measureable physical level. That is, participants appeared to seek an atomistic explanation, as though the phenomena must be explained at that level to be real. The same social forces that prompted a need for scientific legitimization of the practice of therapeutic touch are no doubt implicated at the more personal level of identification of bodily processes. That is, the biomedical standards of society may have been so much a part of the thinking of participants that the standards were applied even in a situation for which they may not apply.

This is not to say that bodily perceptions are unlikely to be subject to physiological explanation. It is simply that physiological states do not explain the experience. One possible reason for the attractiveness of the use of energy as an explanation is that the concept of energy exchange allows for the possibility of interaction and connection between participants in the interaction. That interaction appears to constitute an important meaning of therapeutic touch for nurses and patients. The importance of the therapeutic use of self implied by the notion of energy exchange in therapeutic touch suggests that bodily perceptions associated with intents and feelings may best be explained as associated with interpersonal interaction. In that case, they must be taken seriously in their own right, and not be explained away in terms of energy or other physicalistic theories.

Finding Meaning in Energy Exchange

Therapeutic touch was also found to acknowledge the impact of feelings and intents on the therapeutic relationship. However, when outcomes associated with participants' thoughts and understanding were perceived to be inexplicable, spiritual meanings were attached to the experience (see pp. 151-154). Moreover, spiritual meanings were described in an almost apologetic manner, as though they were without value in health care, or were at least antithetical to the notion of energy as the basis of therapeutic touch.

Why should spiritual concerns be less acceptable as an explanation for therapeutic touch than energy? If a physicalistic concept of energy is replaced by Kunz and Peper's (1982, 1983a) field theory (see pp. 148-149), some types of energy -- particularly those described as intuitional -- are seen to be associated with features of compassion

that were described by participants as underlying spiritual experiences. The dilemma is this: practitioners rely for scientific legitimization of the practice on research that identifies energy as perhaps electromagnetic, and then explain the practice in terms of energy fields related to feeling states, intentionality, and intuition. This study has found that feeling states and intentionality are important to therapeutic touch, and suggests that those features of the practice could be an appropriate explanation in themselves, although they have not been accepted as such.

It would seem, however, that the same social forces that require physicalistic legitimization of the practice also make it difficult to accept a spiritual or meaning laden explanation, despite the importance to the practice of symbolic meanings. Molding psychiatry in the biomedical image, for example, Freud attempted to legitimize it by removing spiritual meaning from psychological events, and substituting an analytical approach to understanding personality. Rieff (1966) has examined cultural forces that would reemphasize as therapeutic the unifying possibilities of religion and symbolic meaning since Freud. From C. G. Jung's self-imposed mission to return spirituality to therapy by way of an integrative personal symbolism, through what he calls Wilhelm Reich's religion of energy (an energy based on love, but manifested in a machine-like technique), to D. H. Lawrence's artistic expressions of the therapeutic impact of rhythms and conflicts of the unconscious mind, Rieff reiterates the impelling thrust of spiritual meaning to therapy. As one more expression of this cultural imperative, therapeutic touch might be seen as an attempt to meld the symbolic spiritual with the practical in such a way that the two may

find mutual understanding. In their expressions of spirituality associated with the practice, nurse participants took care to own their personal understanding of the transcendent, while ascribing to the practice itself spiritual flexibility reflective of its concern for individual psychophysiological response (see pp. 150-158).

The duality inherent in Western thinking lends itself to classifying phenomena as in the material realm (subject to measurement) or the spiritual realm. This duality does not allow for the reality of a unifying explanation such as bodily awareness of phenomena which involve both physical and meaning dimensions. Separation and isolation of these physical and meaning dimensions has led to failure to examine the unifying experience (see p. 64).

An attempt to explain the unifying experience is seen in the field theory of energy exchange associated with therapeutic touch (see pp. 148-149). By accounting for these phenomena in terms of postulated energy exchange, however, therapeutic touch researchers may be pursuing an unrealistic goal of predominantly spiritual explanation when more broadly accepted explanatory models might be more appropriate. One way to achieve this understanding would be to examine therapeutic touch from the perspective of theories which take into account the social situation in which the practice occurs and/or the coping strategies that make it useful. The concept of caring lends itself to several of these theoretical explanations.

Theoretical Constructs for Caring

The caring component of therapeutic touch occurs in a social situation, and can therefore be viewed as a social phenomenon. For

example, nurses in this study were perceived by patients to be particularly interested in and responsive to patients' needs (see pp. 54-55). Because being attractive and being liked is a major preoccupation among Americans, Hall (1977) has suggested that the major propositions of interpersonal attraction theories might be useful for examining nurse-patient relationships. However, constraints in the professional relationship such as the need to maintain therapeutic interaction may require certain modifications in the application of interpersonal attraction concepts to nursing (Hall & Mitsunaga, 1979).

Interpersonal attraction is concerned with the positive regard that develops between people. Z. Rubin (1973) identified this positive regard, or liking, as having two fundamental dimensions -- affection, experienced as warmth and closeness; and respect, based on another person's admirable qualities. Historically, nursing has both acknowledged the importance of the nurse-patient relationship and warned against personal involvement. Nurses and patients in this study identified increased feelings of warmth and closeness arising from therapeutic touch interaction as therapeutic. Further, in therapeutic touch, warmth and closeness were found to be influenced by purposeful use of feelings by the nurse. That is, in contrast with social and psychological theories of interpersonal attraction, in which positive regard is taken to occur spontaneously in relation to such variables as similarity between the persons involved, a nursing theory of interpersonal attraction may require consideration of ways to influence development of feelings of warmth toward the patient. Nurses' descriptions of their process of focusing on the patient, to the exclusion of other stimuli, may convey to the patient, and may be

experienced by the nurse as, increased respect for the patient (Rubin's second component of positive regard). Hall and Mitsunaga (1979) found that nurses evoked more respect from patients than patients did from nurses. If respect or appreciation of the patient's unique qualities is indeed therapeutic, then purposeful concepts of individual worth demand attention by the nurse. In therapeutic touch for example, potential for self-healing was treated by nurses as inherent in everyone. Thus, the nurses were able to convey a sense of high regard for that quality in their patients.

Another perspective identified by Bandura and Walters (1963) in social learning theory can also be used to examine an aspect of therapeutic touch. The social aspects of the learning process are most evident in the notion of the impact on learning of the presence of exemplary models that reflect social norms. Thus, according to these writers, learning occurs when the learner attends to demonstrations of appropriate conduct for given situations (pp. 50-51). A similar view was taken by Mead (1937) in his exposition of symbolic interactionism, which holds that meaning arises out of social interaction, and that meanings are modified in an interpretive process (see also Blumer, 1969).

Bandura and Walters, however, extend the notion of social learning beyond the idea of unacknowledged incorporation of attitudes and responses conveyed by models in the larger social milieu. Their concept of modeling includes the impact one person's attitude or action may have on another person to whom the idea of taking that attitude or action may never have occurred. In this study, nurses appeared to be readily construed as models by patients because of the nurses'

established status as health care providers. That is, patients indicated that therapeutic touch was initially acceptable to them at least in part because it was used by nurses.

Its volitional use by nurses presented a fresh perspective regarding the concept of modeling, which usually occurs as socially normative conduct based on culturally accepted responses to given stimuli (Bandura and Walters, 1963, p. 50). In contrast, patients responding to modeling of calmness, in a normally anxiety producing situation such as illness, appeared to be altering previously established norms. That is, a patient who has previously developed an anxious attitude toward illness might alter that attitude in the presence of modeling of calm on the part of the therapist.

Although indications of the relevance of interpersonal attraction and social learning theories to therapeutic touch were found in the data, neither of these alone can account for all of the phenomena associated with the practice. Indeed, just as medical theories might account primarily for physiological implications of the practice, social theories lend themselves to the broader implications, including what participants referred to as interpersonal and spiritual concerns. A framework of stress and coping might provide a better explanation for therapeutic touch than these other theories, because coping could account for the importance of the meanings associated with therapeutic touch, and identify what part they play in the healing process.

For example, Lazarus' model of stress and coping involves cognitive appraisal as an important aspect of the coping process (Benner, Roskies, & Lazarus, 1980; Lazarus, 1977). Unlike other models that attempt to identify individuals' particular coping styles in the

face of specific stress or threat, the Lazarus model focuses first on how the individual evaluates the challenge of a given situation to determine its stressfulness. Thus, a threat such as illness may result in differential psychophysiological response depending on the person's evaluation of the situation and the meaning attached to it.

In this study, both nurses and patients who used therapeutic touch formulated their views of disease to include the possibility of healing at some level, even in the event of chronic or terminal disease. The hopefulness allowed by such an appraisal of the illness might well be associated with both psychological (reduced anxiety) and physiological (heightened somatic healing) responses.

Similarly, a person's ability to respond appropriately to stress such as illness has been linked with "emotional and task oriented assistance provided by the social network within which that individual grapples with the crisis event" (Caplan, 1974, p. 4). Although social networks are usually considered to be constituted of ongoing interpersonal relationships, health care providers are sometimes seen as temporarily providing social support related to specific needs (p. 5). In the case of nurse participants in this study, provision of therapeutic touch included both emotional and task oriented assistance by conveying concern and by instituting the therapeutic touch interaction. In therapeutic touch, emotional and task related components of support were more intimately related than they are in most interventions, because of the primacy of caring in the practice.

Ambiguity and Control

Study participants did not demand a clearly defined explanation for the minutiae of the practice. Their more comprehensive interest

was in the overview that allowed recognition of the concept of wholeness, or acknowledgment of complexity in the practice, and what they saw as the uniqueness of each situation. In fact, nurses in the study appeared to be comfortable with ambiguity and uncertainty (see pp. 122, 131-133), seeing possibility in inconclusive situations. In both their tolerance for ambiguity and their associated willingness not to assert control over the situation, nurses' expectations were in contrast with the health care community in which they participated. In conventional health care, as in technology, lack of control or information is perceived as a handicap. In therapeutic touch, it was treated with optimism and hope. The nurses anticipated achieving a goal which they were unable to articulate, because the outcome of treatment was so dependent on the patient's psychophysiological response.

Therapeutic touch users' openness to continuing appraisal of the situation is in contrast with the goal of conventional health care to diagnose the patient's problem and apply specific remedies. In therapeutic touch the remedy was to heighten a healing potential that was seen to reside in the patient. In a sense, then, nurses using therapeutic touch tended to turn control over to their patients (see pp. 134-139). Patients, on the other hand, might or might not knowingly participate in the process. As with the nurse, patients appeared to accept the therapeutic impact of the practice without specific explanations. They evaluated therapeutic touch on the basis of nurses' explanations, treatment outcomes, and their own expectations of nursing. Explanations, however, are demanded by those who question the scientific merits of the practice (see Clark & Clark, 1984).

One wonders whether an assumptive view of the human potential shared by nurses and patients involved with therapeutic touch might differ in important dimensions from the views of the bulk of the scientific community. One possible explanation for the divergent views held by these two groups is found in a recent explication of North Americans' tendencies toward technological views associated with individualism (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985). While the study in question was based primarily on interviews with middle class professional persons, the technologically oriented views of study participants were contrasted with the views of upper and lower class Americans for whom rules based on abstract knowledge are less important than examples set by individuals (pp. 51-52). That is, for the upper and lower class, meanings embedded in specific patterns of relationships were seen to mitigate certain tendencies fostered by technology.

Although neither delineations between the classes nor degrees of influence of technology on the classes can be seen as precise, the notion of varying reliance on technology related to education and commitment to middle class values may be important to nursing and to understanding of the impact of therapeutic touch. In spite of nurses' view of themselves as professionals, lifestyles and commitment to technology of nurses in this study may be more nearly equivalent to those of the lay public than to those of other professionals. Furthermore, nurses in general have a closer clinical interaction with the broad range of persons who become patients than do most other health care professionals. Thus, nurses have an investment in understanding individual expectations. This is seen in the pervasive

identification of psychosocial needs as a focus of nursing. This focus is lived out more specifically in therapeutic touch than it is in most nursing interventions.

The Next Step

This study has found therapeutic touch to be gripped by the needs of practice on the one hand and the need for a scientific base on the other. One can speculate that given the subtle psychophysiological ramifications of practice suggested here, a too stringent adherence to any narrow explanatory model will interest certain practitioners who are familiar with that model, and alienate others who are not. Hence the call for a unified holistic approach that can at once add clarity to scientific understanding and confidence to practice, by acknowledging the complexity of therapeutic touch.

Although early studies based on postulated energy exchange as underlying therapeutic touch practice (Heidt, 1980a, 1980b; Quinn, 1983) served to substantiate its effectiveness in reducing anxiety, it seems unlikely that the scientific basis for the practice can be claimed or sustained solely on this foundation. The very complexity of the practice cries out for a number of research approaches. The practice itself, however, may be able to rest at the present time on the concept of energy, while scientific explanations are sought elsewhere. There are at least two possible directions for research related to the question of the involvement of energy exchange in therapeutic touch. First, there is the question of whether the presence and transfer of energy can be identified and measured in therapeutic touch practice. Second, there is the question of whether implementation of the features of therapeutic touch identified in this

study have therapeutic effect in the practice situation without reference to energy exchange. It is critical, though, that such research proceed concurrent with, and not as a prerequisite to, use of the energy concept in practice.

A number of other directions for research have been suggested here. These included examination of interpersonal factors implicated in the practice, with interpersonal attraction, social learning, and social support comprising a sample of possible theoretical perspectives from which to begin. Because of the pivotal role of the patient's and perhaps the nurse's psychophysiological involvement, the questions of cognitive and symbolic influences to coping offer promising avenues of study, as do neurobiological (Wolf, 1981) and psychological adaptive resources (Arthur, 1982).

For nurses in this study, the practice of therapeutic touch appeared to fill a need for a systematic practice of caring as a correlary to the advances of biomedicine. Similarly, the vision of an integrated holistic science demands that social, psychological, and biomedical studies be carried out in an atmosphere of awareness of the place of each approach in the broader system of human research. It also suggests that single studies might involve several theoretical viewpoints in a cooperative effort to identify, for example, the patient's phenomenological experience of therapeutic touch as an intervention in a specific illness, the neuroimmunological response to treatment, and the coping skills brought to bear in the presence or absence of therapeutic touch. In total, an integrated approach offers an opportunity to answer the question of whether therapeutic touch adds

an important dimension to nursing practice, and if so, what that contribution entails and how it fits with other modalities.

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Appendix A

R.N. Interview Protocol

Introduction

The purpose of this interview is to acquire a description of your views about and experience with therapeutic touch. That is; how you practice it, as well as the thoughts, physical sensations, and feelings that you experience while doing it. I am going to interview you as though I don't understand the technique, and I will need very specific descriptions. I will help you with that by reminding you of what I need. But first, I will start with some questions about yourself.

Demographics

1. Where do you live? (City, State)
2. What is your age? (Under 30, 30-39, 40-49, 50-59 over 59)
3. How long have you been a nurse? (Under 2 yrs, 3-5, 6-15, over 15)
4. What was your basic nursing degree? (D, AA, Bac)
5. What is your highest degree? (D, AA, Bac, M, D)
In what discipline?
6. In what kind of facility do you work?
(Acute, LT, out pt., other)
7. Briefly, what does your work involve?
8. How long have you been using therapeutic touch?
(Under 2 yrs., 2-5, 6-10)
9. How did you learn the technique?
10. With about how many patients would you say you have used it?
(1-20, 20-50, 50-100, over 100)

Guide for descriptive questions

11. Please think of a time that stands out in your mind when you used therapeutic touch especially effectively.
 - a. Think of a specific patient with whom you worked, and describe the process you used in that particular treatment.
 - b. For each component (i.e., centering, assessment, treatment) mentioned in (a) above, describe the thoughts, physical sensations, and feelings you experienced while using it.
12. What is it that you intended to accomplish with the use of each of the components?
13. Now, I would like you to describe a typical experience with therapeutic touch.
 - a. Describe the process that you used with that particular patient.
 - b. For each component (centering, assessment, treatment) describe the thoughts, physical sensations, and feelings you experienced during the treatment.
14. What evidence of effectiveness occurred, that an outside observer would accept? (For either patient, or both)
15. What would you say was different in your use in the especially effective case, as compared with the typical case?
16. What enhances your effective use of therapeutic touch?
17. What hinders your effective use of therapeutic touch?
18. What influences your decision regarding whether to use therapeutic touch as a mode of treatment?
19. Tell me in your own words, what is therapeutic touch?
20. What does it add to your nursing skills that is not a part of your usual nursing care?
21. What aspects of it are similar to usual nursing care?
22. Before you were introduced to therapeutic touch, what was your knowledge of or attitude toward energy fields, intuition, spiritual healing?
23. What are your current attitudes toward these concepts?
24. (If different) What seemed to influence the change?

Patient Interview Protocol

Introduction

The purpose of this interview is to acquire a description of your views about and experience with therapeutic touch. That is: your thoughts, physical sensations, and feelings related to the treatment. I am going to interview you as though I do not understand. I will ask for very specific descriptions, and I will help you with that by reminding you of what I need. But first I will start with some questions about yourself.

Demographics

1. Where do you live? (City, State)
2. What is your age? (up to 29, 30-39, 40-49, 50-59, over 59)
3. What is your occupation?
4. How would you describe your health status?
(Poor, good, excellent)
5. If you have a health problem, what is it specifically?
6. How long have you been familiar with therapeutic touch?
(1yr, 2-3, 4-8, more than 8)
7. How did you first hear of it?
8. How often have you had therapeutic touch treatments?
(1, 2-5, 5-10, over 10)
9. Where were the treatments done?
(Hospital, other health care facility, home, other)
10. Were the treatments always performed by nurses?
If not, by whom, mostly?

Guide for descriptive questions

11. Now, I would like you to describe a particularly effective experience with therapeutic touch. Think of a specific time that it was used.
 - a. What were your thoughts during the treatment?
 - b. What were your physical sensations during the treatment?
 - c. What were your feelings during the treatment?
 - d. What were your perceptions of what the therapist was doing?
12. Now, describe a less effective experience with therapeutic touch. What was different, compared with the outstanding experience?
 - a. In your own thoughts, feelings, or sensations?
 - b. In the practitioner's approach?
13. What evidence of effectiveness occurred, that an outside observer would accept?
14. What enhances the effectiveness of therapeutic touch?
15. What hinders the effectiveness of therapeutic touch?
16. What do you believe is the underlying basis for its effectiveness?
17. Please tell me in your own words, what is therapeutic touch?
18. What benefit do you get from it that you do not get from ordinary health care?
19. What factors influenced your decision to have therapeutic touch treatment?
20. Before you were introduced to therapeutic touch, what was your knowledge of or attitude toward energy fields, intuition, spiritual healing?
21. What is your current knowledge or attitude toward these concepts?
22. If different, what seemed to influence the change?

Appendix B

University of California, San Francisco

CONSENT TO BE A RESEARCH SUBJECT

Harriett Lionberger, a doctor of nursing science candidate at UCSF, is studying those aspects of the use of therapeutic touch that are associated with therapeutic outcome. To do the study, she needs information about individuals' personal experiences with therapeutic touch.

I agree to be interviewed by Ms. Lionberger to share this information at a time and place that is convenient to us. She may phone me at a later date for further information if necessary. The initial interview will take about one hour. If a follow-up phone call is made, it will take about 20 minutes. All interviews will be tape recorded.

There may be some inconvenience associated with arranging and giving time for the interview. Confidentiality will be as protected as possible by not using last names on the tape.

There will be no direct benefit to me. The study may produce information that will increase understanding of and enhancement of therapeutic aspects of the nurse-patient relationship.

I have talked with Ms. Lionberger about the study. I may reach her at 707-224-1730 if I have questions later.

I have received a copy of this form to keep. I have the right to refuse to participate or to withdraw at any time without jeopardy.

Date

Subject's Signature

Appendix C

Diagnoses and Expected Outcomes Associated With
97 Cases Described by Study Participants

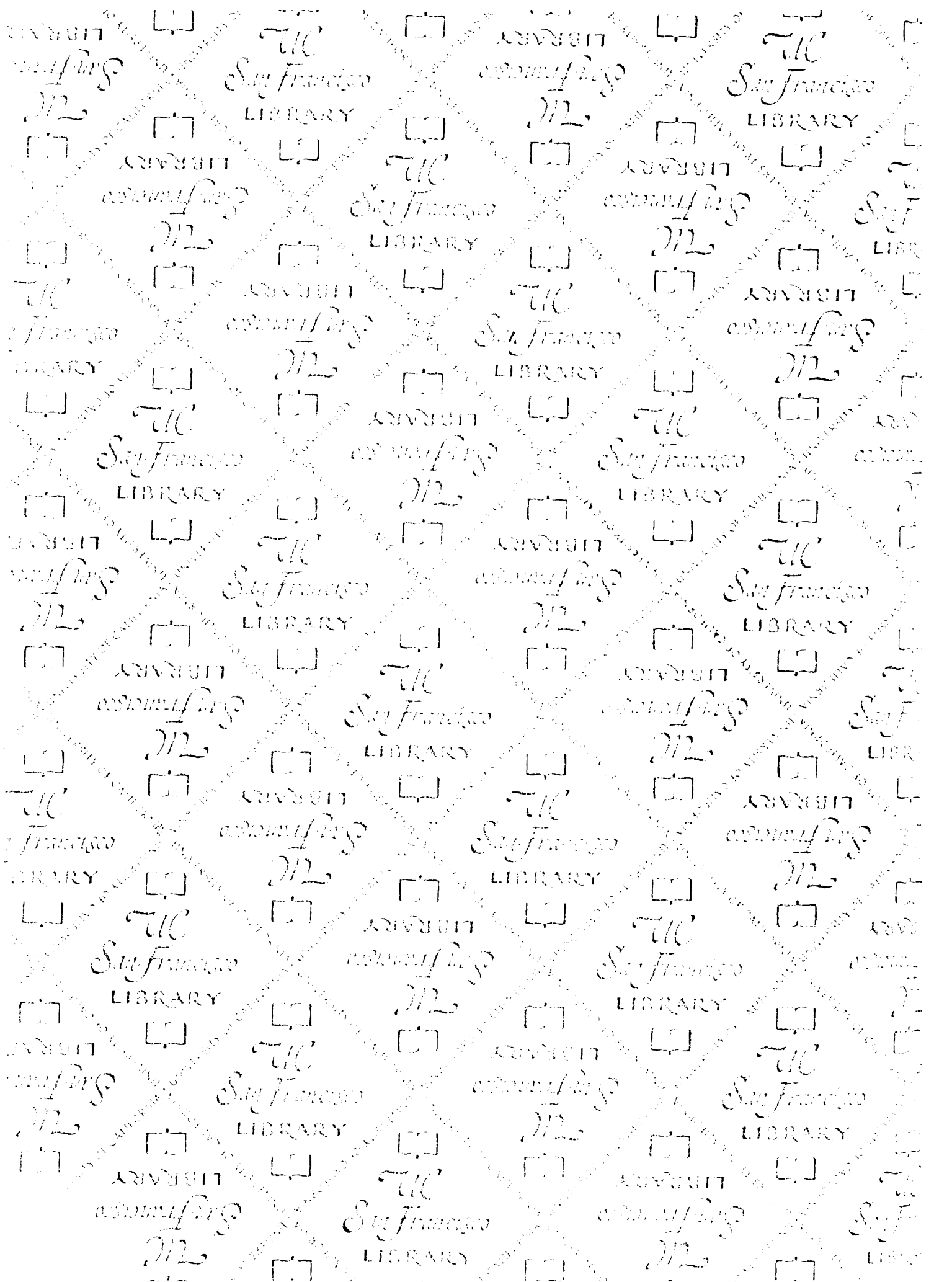
Diagnoses	Expected Outcomes
Cystic fibrosis	Relief of anxiety and pulmonary symptoms
Cancer, trouble starting IVs	Relief of anxiety
Asthma	Relief of anxiety, dyspnea
Migraine headache	Relief of anxiety, pain
Depression	Relief of depression
C-section, post-op	Relief of pain, tension
C-section, post-op	Relief of headache pain from spinal anesthesia
Labor and delivery	Relief of tension
Therapeutic abortion	Relief of anxiety
Orchitis	Facilitate healing of orchitis
Menstrual cramps	Pain relief
Hernea, pre-op	Relief of anxiety about surgery
Terminal cancer	Pain relief
Muscle tension related to severe retardation	Pain relief
Backache	Pain relief
Chronic illness	Increased ability to do daily activities
Pain	Relief of tension
Asthma	Relief of dyspnea
Metastatic cancer	Pain relief
Migraine headache	Relief from excruciating pain

Diagnoses	Expected Outcomes
Person likes to experience therapeutic touch	Relief of stress
EEG arrhythmia in infant	Help mother feel useful
Cancer	Anxiety relief
Cancer	Promote acceptance of illness
Cancer, on chemotherapy	Increased comfort; relieve pain
Injury to arm	Pain relief
Pain	Pain relief
AIDS, terminal	Increased comfort
Patient making decision unwelcome by doctors and nurses	Facilitation of understanding
Terminal cancer	Pain relief
Knee stiffness	Increased comfort
Poison ivy	Promotion of comfort
Back pain	Pain relief
Disorientation in acutely ill aged	Facilitation of coping
Sinus headache pain	Relief from headache
Flu symptoms	Relieve fever, achiness
Premenstrual cramps	Pain relief
Tremors, neurological problem	Promote relaxation, self care
Scald burns	Relief of pain, anxiety
Cancer	Control of nausea, vomiting
Ulcerative colitis	Relief of pain, anxiety
Common cold	General wellbeing
Menstrual cramps	Relief of cramping pain

Diagnoses	Expected Outcomes
Migraine headache	Pain relief
Multiple sclerosis	Relieve stress symptoms
Gout	Pain relief
Cancer	Pain relief
Multiple complaints	Mood elevation, pain relief
Back injury	Pain relief
Labor and delivery	Pain relief
ALS	Ease breathing, tension
Fetus died, prospect of D&C	Relief of anxiety
Cancer	Relief of anxiety
Terminal cancer	Relief of insomnia
Shingles	Increase comfort, relieve pain
Congestive heart failure	Ease breathing
Depression	Ease tension
Post-hysterectomy	Increase comfort
Cancer	Increase energy
Cancer	Relief of emotional and physical pain
Multiple problems	Pain relief
Leukemia	Promote comfort
Multiple sclerosis	Increase energy
Foot injury	Promote comfort, speed healing
Hip pain	Pain relief
Arthritis	Pain relief

Diagnoses	Expected Outcomes
Cancer, on chemotherapy	Relieve nausea and vomiting
Labor and delivery	Promote comfort
Ruptured disc	Pain relief
Headache, tension	Relieve pain, anxiety
Respiratory problem associated with terminal cancer	Promote comfort
Terminal myeloma	Technique was not used because of unrealistic expectations
Parkinson's	Relieve tremors
Trauma	Pain relief
Allergic reaction; rash, edema	Relieve pain, itching
Crying spells	Promote calm
Migraine headache	Relieve pain
Psychotic, agitated	Relieve agitation
Cystic fibrosis	Relieve dyspnea
Headache	Promote comfort
Burns	Promote relaxation
Leukemia	Promote comfort
Ulcer on tongue	Relieve pain
Diabetes	Promote coping
Eye enucleation	Pain relief
Anxiety	Relieve anxiety
Chronic kidney disease	Alleviate fear of dying
Asthma	Relieve wheezing
Burns, acute	Relieve pain, anxiety

Diagnoses	Expected Outcomes
Labor and delivery	Facilitation of the process
Neck and shoulder pain	Pain relief
Knee pains	Relieve pain, promote relaxation
Tachycardia episode, psot-trauma	Decrease heart rate
Multiple traumas with negative attitude toward situation	Promote positive attitude
Cancer, on chemotherapy	Pain relief
Lymphoma	Relief of anxiety
Labor and delivery	Comfort



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