A survey of therapeutic touch practitioners


Therapeutic touch is the name of a specific nursing technique that was devised by Dr Dolores Krieger, an American nurse, in the early 1970s. This article provides a brief overview of therapeutic touch, and describes the responses received to a survey exploring the views and experiences of its practitioners in Britain.

Therapeutic Touch (TT) has only fairly recently been introduced into Britain by Jean Sayre-Adams, who trained with Dr Dolores Krieger, the American nurse who devised this technique. Sayre-Adams has been instrumental in setting up TT courses validated by the University of Manchester and the English National Board, and is the co-author (along with Professor Steve Wright) of the only British book on TT (Sayre-Adams and Wright 1995). The first jointly validated TT course was held in 1994. Since then, seven courses at ENB Level 2 and two courses at ENB Level 3 have been completed. A teachers' course has also started.

To gain information on the extent of use and application of TT in Britain, and the views and experiences of British TT practitioners, a postal questionnaire was devised and sent to all members of the British Association of (BATT). It was also sent to other practitioners known to the author who are not members. BATT monitors professional standards through scrutiny of professional practice, and the approval and maintenance of a register of approved practitioners. This provides a valuable safeguard and assurance to the public.

This article provides the results of the survey, along with a discussion of the possible implications.

History and background

The history of therapeutic touch TT was developed by Dolores Krieger and Dora Kunz in the early 1970s. In her book, Krieger (1986) describes TT as being derived from the laying on of hands, in which energy from the healer is directed to another to help or heal. Exponents of TT now favour the idea of energy 'flowing' rather than being directed from the healer.

Krieger introduced and taught TT to graduate level nursing students at New York University. Since then, Krieger and Kunz have taught TT to many health professionals throughout the world (Malinski 1994) and it has been estimated that 85,000 nurses practise TT in the USA.

Booth (1993) and Meehan (1998) both provide useful descriptions of the historical background and development of TT.

The theory of TT Scholars have made a connection between TT and Martha Rogers' (1983) theory of the 'science of unitary human beings'. The link with nursing has thus been strong from the beginning – TT was jointly developed by a nurse and subsequently linked to a nursing theory. In addition, 'Krieger proposed that (TT) is a natural potential for nurses because of the central role that the therapeutic use of the hands has always had in nursing practice and the strong motivation nurses have to help ill people' (Jurgens et al. 1987).

The practice and definition of TT is summarised by Meehan (1990) as: '...a knowledgeable and purposive patterning of patient-environmental energy field process in which the nurse assumes a meditative form of awareness and uses her hands as a focus for the patterning of the mutual patient-environmental energy field process'.

The healing in TT is viewed as holistic, because the human and environmental fields are viewed as co-extensive. Therefore, a change in any part changes the whole. Accordingly, when TT is used to treat someone, from an energetic perspective, the whole person is treated.

Rogers (1983) postulates that the human and environmental fields are identified by wave patterns, and that change is propagated by waves. Nursing interventions, such as TT, are directed towards promoting the rhythmic flow of energy waves that order and re-order the human field. Symptoms are viewed as energy blockages, congestion, dysrhythmias, or areas of imbalance in the field. As dysrhythmias are corrected by TT, the whole field becomes balanced (Newsham 1989).

The practice of TT Payne (1989) writes that giving a TT treatment looks deceptively simple. A nurse, with a look of concentration, methodically passes his or her hands over the client's body, about two to four inches above the surface of the skin (Jurgens et al. 1987). The recipient is fully clothed, and the treatment may be administered while the person is sitting in a wheelchair or
Box 1. Area of work/specialty of respondents

<table>
<thead>
<tr>
<th>CLINICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal intensive care</td>
</tr>
<tr>
<td>Acute medical ward nurse</td>
</tr>
<tr>
<td>Nurse – elderly and young physically disabled</td>
</tr>
<tr>
<td>Complementary health consultant</td>
</tr>
<tr>
<td>Nursing ophthalmics (part-time), health therapist (private) massage, Bowen therapy, flower essences</td>
</tr>
<tr>
<td>Currently setting up complementary therapy clinic</td>
</tr>
<tr>
<td>Specialist nurse – complementary therapy (setting up therapies throughout hospital)</td>
</tr>
<tr>
<td>Main work until recently has been with elderly, but latterly in many different specialties</td>
</tr>
<tr>
<td>Health visitor</td>
</tr>
<tr>
<td>Hospice nurse</td>
</tr>
<tr>
<td>Mental health nurse – alcohol</td>
</tr>
<tr>
<td>Family doctor/qualified healer</td>
</tr>
<tr>
<td>Nurse – general outpatients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EDUCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecturer in adult nursing</td>
</tr>
<tr>
<td>Senior lecturer in elderly care and gynaecology</td>
</tr>
<tr>
<td>Lecturer practitioner in nursing and complementary therapies</td>
</tr>
<tr>
<td>Palliative care (teaching) and TT practitioner in private practice</td>
</tr>
<tr>
<td>Nurse lecturer – older people with mental health problems, counselling skills</td>
</tr>
<tr>
<td>Senior lecturer (part-time) and nurse practitioner in complementary therapies (part-time)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MANAGERIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of nursing (operations)</td>
</tr>
<tr>
<td>Senior nurse/clinician</td>
</tr>
</tbody>
</table>

One respondent did not answer this question.

wearing a brace or splint. Direct contact with the skin is not necessary, since the theory behind TT is that human beings are more than, and different from, their visible physical bodies – they are energy fields (Rogers 1983).

In the UK, successful completion of a course in therapeutic touch is required to become a registered practitioner of TT. This course covers the origins, development and practice of therapeutic touch, and is provided at ENB Level 2. A further course, at ENB Level 3, covers the art and science of TT and advanced practice. Further details of these courses can be obtained from the Sacred Space Foundation (address at the end of the article).

The survey

The purpose of the questionnaire was to discover the extent of use of therapeutic touch in Britain, and to explore some of the views and experiences of TT practitioners. Of the 50 questionnaires posted, 23 were returned. This accounts for just under half of the known TT practitioners in Britain.

The practitioners Box 1 shows that individuals work in a wide range of work places and specialties. Most of the practitioners are nurses, with the exception of the family doctor. It is not known whether or not the complementary health consultant and the person setting up the complementary therapy clinic are nurses.

Twenty of the 23 people who replied have attended the two-day introductory workshop. These two days are an ideal way of finding out more about TT itself and what is involved from the theoretical, practical and personal perspectives. This provides a person with greater knowledge on which to base a decision on whether to continue on to the practitioners’ course.

Nine replied that they had qualified at ENB Level 2, and a further eight at Level 3. Level 2 must be successfully completed to become a registered practitioner. To be accepted on to the Level 3 advanced course, the initial practitioners’ course (at Level 2) must have been successfully completed.

Approval and validation by the ENB and a university add validity to the practice and theory of TT. In addition, this provides a standard or level of competence, skill and knowledge, thereby providing further safeguards to the practice of TT.

Reasons for learning TT These were varied, and included:

- An experience or belief in energy.
- A curiosity and interest in the techniques.
- The technique appealed intuitively or sat well with the person’s own values and beliefs.

One respondent wrote that she wanted to develop the therapeutic aspect of her nursing, which is more than physical care. TT may have the potential to permit nurses to be human, to express natural compassion and to restore the heart back to nursing. In so doing, they are providing a powerful therapeutic force (Sayre-Adams 1996).

Sayre-Adams (1994) summarises the benefits of TT to nursing when she says that: ‘Nurses are drawn to it because it is safe, uses only the hands and allows practitioners to capture the essence of nursing, an essence many believe has become lost amid high technology medical care’. She further says that nurses throughout the world are drawn to TT because: ‘It is a gentle, non-intrusive but powerful healing technique’ (Sayre-Adams 1996).

Another respondent to the survey wanted to develop her personal and spiritual self. Sayre-Adams and Wright (1995) note that
Malinski (1994), in exploring Rogers' (1983) 'science of unitary human beings' theory, hypothesises that the concept of spirituality is synonymous with the principle of integrality. In this view, they say, spirituality as integrality is the belief in the notion of an underlying unity between people and their environment. Malinski (1994) believes that centring during TT treatment heightens the experience of this integrality within the practitioner and the recipient.

It can be seen that reasons for wishing to learn TT are varied and multifaceted, but there appear to be personal benefits to the nurse as well as to the recipient.

When do practitioners use TT? Responses included physical and psychological aspects in a variety of situations, as can be seen in Box 2.

In addition, some practitioners responded that TT may be included as part of nursing care, but only with informed consent or when a request has been made. One respondent teaches the parents of her 'named' babies to perform TT on their children.

Most respondents also treat staff, family and friends. Those working in an educational setting provide an introduction to TT for students and provide them with treatment.

One person replied that she is only using TT formally with staff, but is working towards getting into practice with patients.

Another replied that she is not prepared to use TT in the clinical link area because there is not yet a policy in place for the use of TT.

A further respondent replied that she would love to use it on babies in her care but that she is not allowed to, although she always centres herself and focuses on the baby prior to any procedure and has found this very useful in helping to maintain stability in babies' conditions.

When asked: 'If you use TT in your nursing practice what steps did you take to implement its use?', one practitioner replied that she is not allowed to use TT because there is not a policy that allows for its use. Another replied that she is not allowed to practise on patients because not enough research evidence is available. A third wrote that permission to practise TT was given by the line manager, but it was then stopped following instruction from Board level. The reason for this was not given.

The trust for which one of the respondents works has a specific policy on complementary therapies, and she is therefore allowed to practise TT. The Trust where another respondent works has agreed to TT being researched. One person replied that if a patient requests TT, it is then cleared with the doctor.

Implementation of TT in practice appears to be generally slow and varied. For successful integration of TT into practice, education, discussion and policy making are needed. This involves providing professionals with relevant literature and good quality research. Meehan (1998) provides a useful up-to-date overview of the theoretical frameworks and intervention process, and a review of the practice literature and controlled efficacy studies. Her conclusion is that TT may have some potential as a nursing intervention, even if this is only due to the placebo effect. However, she writes that: '...data from studies indicate that even when patients do not believe TT will help them, it can still have a beneficial...

Box 2. Situations in which therapeutic touch is used

PHYSICAL
- Babies who are too ill for massage or regular cuddles/handling – for example, under 1kg, intubated and ventilated
- Children who have fits
- Pain – headaches, body pain, dysmenorrhoea, acute pain relief, post-trauma/labour, chronic pain, post-operative pain, orthopaedic problems, amputees (phantom pain)
- Oedema
- HIV
- ME/chronic fatigue syndrome
- Anyone who cannot tolerate physical pressure, such as massage, and if there is only a short time available with clients (5-10 minutes)
- Acute injury – for example, in a first aid situation
- Acute muscle spasm/strain
- For boosting immune systems, for example in shingles or infections
- For degenerative bone disease
- Whenever children are ill, whatever the illness may be

PSYCHOLOGICAL
- HDU – anxiety, restlessness
- Intensive care – evidence of distress/sleep disruption despite sedation
- Depression
- Relaxation for stress, panic, anxiety; regular top-ups for chronic anxiety; general relaxation therapy in healthy individuals
- Distress – feeling of inability to cope
- Hysteria
- Psychosomatic problems
- Insomnia

OTHER
- Sometimes only TT is used, particularly with very sick patients
- Patients undergoing chemotherapy/radiotherapy
- Most situations lend themselves to TT, as it puts the person in the best possible state for self-healing regardless of other treatment
effect' (Meehan 1998).

In addition, the comments and views of clients and practitioners cannot easily be discounted. Even if half of the claims for TT are found to be correct for half of the people for half of the time, providing TT is worth serious consideration, especially where pain and suffering are involved.

As Sayre-Adams and Wright (1995) believe: 'research into TT' cannot be ignored and, of course, much more yet needs to be done. As nurses continue to sift through the rapidly accumulating scientific data at the frontiers of practice, many also find themselves drawn to TT for a different reason... simply, that it seems to work'.

**Benefits to practitioners**

These were identified on several levels and grouped into categories. It must be noted, however, that any separation into categories is arbitrary, as an effect on one aspect of a person affects other aspects — as one respondent said: 'TT affects a person's whole life'. Responses have therefore only tentatively been categorised into physical, emotional, self-esteem, spiritual and focus of control aspects.

Physical aspects related to a sense of feeling physically well, strengthened and energised. One respondent said that it helped to reduce her back pain. Others replied that TT also helps to maintain mental health.

On an emotional level, statements included a feeling of calmness, stress relief, feeling more relaxed, and a sense of feeling well in an emotional sense. One person replied: 'I seem more peaceful and easy going since doing the course'.

The above may be linked to the sense of feeling 'centred', focused and grounded, as identified by some respondents. These are interesting concepts that need to be explored further, particularly in relation to their benefit to nurses. These aspects may relate to the perception of feeling and being in control of oneself, as illustrated by a respondent who wrote that it gave her the strength to stop smoking.

A sense of increased self-esteem was also identified, including an increase in confidence, knowledge/skills and job satisfaction, and a feeling of being more positive.

At a deeper level, some respondents that they had become more reflective — their self-awareness and awareness of others had expanded. For at least one person, this lead to an exploration of spirituality.

One practitioner replied that there are benefits from the more holistic approach that TT provides.

**Benefits to recipients**

Comments from recipients support the multidimensional benefits identified above, and are listed in Box 3. Responses are reported as always being positive, with TT having a calming, relaxing effect, helping to promote refreshing sleep and a feeling of being energised.

Practitioners stated that they also find TT of benefit for wound healing, relief of constipation and diarrhoea, giving some people permission to pursue feelings of 'inner knowing', and for any condition provided the patient gives consent. One stated: 'I haven't found one situation not to use it.'

The list of responses from recipients of TT is consistent with some of the literature. Sayre-Adams (1996) lists conditions for which nurses who use TT find it useful. These include upper respiratory tract infections, allergies, headaches, sore muscles and bruises, fretful babies, mothers in labour, and anything in which smooth muscle is involved. It is of greatest value in degenerative disease, as pain and anxiety can be reduced. It is also found to be a great comfort in the dying process.

It is obvious that more research is needed into the uses and benefits of TT. However, Sayre-Adams and Wright (1995) believe that: 'Tentative empirical support for TT should be no reason to discourage the practice. Many people have voiced an increased wellbeing from the treatment, evidenced from the number of case studies on the phenomenon, and there are no reports showing it to be harmful (Haviland 1986)'.

Accordingly, TT can be summarised at the very least as a pleasant experience that provides a unique holistic quality.

The practice of TT does seem to provide positive benefits for both the practitioners and the recipients of treatment. More widespread use of TT could therefore have considerable implications for health, well-being and morale of nurses.

The replies support some of the claims made in the literature. Lothian (1993) writes that: 'The wealth of experiential evidence that "something" is happening [in TT] is compelling.'

Some TT practitioners have noted that staff with whom they work have become interested in TT and its effects. This has helped to broaden colleagues' outlook on complementary therapies as a whole. One replied that GPs were very sceptical at first, but now refer regularly, indicating a positive change in attitude towards the technique.

**Research into TT**

Two practitioners replied that they have performed some research into TT (apart from searching the literature). One has explored perceptions of student nurses to the experience of receiving TT, and has research proposals submitted to the ethics committee to undertake a study on patients with psoriasis. The other has completed an experimental study into the effects of TT as part of a Bachelor of Nursing course, and has further explored TT for a Masters Degree in Nursing.

As can be seen, there is little research on TT in this country. However, there is a great deal of research, both quantitative and qualitative in nature, that has been carried out by nurses in other countries, especially the US. A useful critical review of the development and status of TT is provided by Meehan (1998).

TT practitioners support the need for more research in all aspects of the technique. Sayre-Adams (1996) believes that the first, and perhaps the most obvious, need is the application of TT to a range of real-world clinical problems — clinical trials or outcome studies. Second, there is a need to develop an explanatory model/theory of TT.
which is validated and refined through the research process. While US studies are useful, we need to consider cultural and healthcare differences.

Practitioners feel that there is a need for the profile of TT to be increased in Britain. This will promote debate, encourage research and further increase the knowledge of nurses and other healthcare workers, and patients.

Further comments were largely about the hope that TT will become an acceptable nursing intervention that is available in all settings where nursing care is given.

Conclusion

The practice of TT in the UK is still in its infancy. However, with the current number of TT practitioners, and further practitioners qualifying on the courses run in this country, the profile of TT is set to rise. If the increasing amount of literature on TT is also taken into account, the practice of TT will undoubtedly increase and cannot be ignored.

At worst, TT may be viewed as nothing more than two people quietly spending 20 minutes of their time together, the nurse being relaxed and focused and attempting to provide a soothing and relaxing environment for the patient. There is sufficient evidence to suggest that something positive is happening during this time. While it is essential that claims made for TT should be studied further, in the meantime, the practice of this gentle form of intervention should be given serious consideration by practising nurses.

Further information
The Sacred Space Foundation can be reached at Highland Hall, Renwick, Nr Penrith, Cumbria CA10 1JL.

Acknowledgements
Jean Fayre-Adam and Mick Coleman, programme manager. I am grateful to everyone who took the time and effort to complete and return the questionnaire. I hope that I have done justice to their responses.

Box 3. Comments received from recipients of therapeutic touch

- Too many to list – 95 per cent said it had a desired effect and asked for more TT
- Comments demonstrate positive outcome/always positive
- Fell into deep, refreshing sleep/sleepy
- Calming/able to relax/feel so relaxed/peace of mind
- Felt energised
- Headache gone
- Feel more positive about myself/about things
- It feels wonderful
- Feel warm/feel wonderful after it
- Glowing all over
- TT helped me get my head around cancer
- My psoriasis has completely cleared
- That was wonderful/‘Wow’

REFERENCES