

NURSING FACULTY ATTITUDES, KNOWLEDGE AND PRACTICE  
OF THERAPEUTIC TOUCH

by

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## ABSTRACT

Therapeutic touch is increasingly recognized as a nursing intervention that complements traditional medical care. Few studies specifically address nursing faculty perspectives on therapeutic touch and whether faculty include therapeutic touch theory or skills content in courses they teach. The purpose of this study was to describe nursing faculty attitudes, knowledge and practice of therapeutic touch. In addition, barriers to practicing or teaching therapeutic touch were identified. A survey (n=23) of nursing faculty teaching undergraduate students was conducted in a university-based nursing program. Faculty were in agreement about incorporating content on the theory of therapeutic touch into nursing curricula. Over 85% of faculty thought that patients could benefit from therapeutic touch and that therapeutic touch holds promise for treatment of disease. Nearly 74% of faculty thought that clinical nursing care should integrate the use of therapeutic touch. Few (30%) had received formal therapeutic touch education. Over half (56.5%) desired more education about therapeutic touch but primarily for the purposes of personal knowledge and teaching nursing students rather than for practicing therapeutic touch.

The primary barrier to using therapeutic touch in practice was identified as lack of staff training. The most important perceived barrier to incorporating therapeutic touch practice into nursing curricula was lack of faculty training.

Current faculty knowledge of therapeutic touch, in this sample, lingers behind interest, suggesting an environment ready for change. Identifying faculty attitudes, knowledge and practice of therapeutic touch could have an impact on inclusion of therapeutic touch in future nursing curricula. Understanding faculty desire for therapeutic touch education could help in faculty development critical to integrating therapeutic touch in curricula and practice. A nursing college that incorporates therapeutic touch demonstrates commitment to a holistic nursing environment.

## CHAPTER 1

## INTRODUCTION

People in western society have become reluctant to touch out of fear of it being misconstrued. Our culture has developed unwritten taboos on touching even though it is a basic need (Buscaglia, 1986). Our modern society suffers from the inability to express open and honest affection by touching without fear. Perhaps even more so in the new millennium, patients in the American health care system receive minimal if any compassionate physical contact from their caregivers and/or family members (Hallett, 2004). Health care workers and family caregivers have frequently hesitated to have physical contact with their patient or loved one because of fears and misconceptions about touching and not knowing how to make physical contact without suggesting overly intimate involvement.

Research indicates that millions of people in the United States, in the past two decades, have been seeking complementary healing modalities including therapeutic touch for disease management (Eisenberg et al., 1993). The

general public, in response to dissatisfaction with the quality of care provided by the traditional medical model, are demanding alternatives to conventional medicine. These consumers expect that their health care professionals be knowledgeable in complementary and alternative medicine (CAM) and incorporate holistic nursing care into their practices (Fenton & Morris, 2003).

As a reciprocal healing modality, touch is a means of incorporating holistic nursing care into practice. In a basic sense, touch involves a mutual process of care and concern between individuals that benefits not only the recipient of touch but also the provider (Kiernan, 2002). Nurses who bring touch into their practice will heighten their awareness of the finer distinctions of sensation and awareness of synchronous energy movement with the patient. He or she will be challenged to focus deeply and gently and become aware of the outcomes of touch. By touching in a healing way, not only does the nurse provide physical comfort, but also addresses the innate human need for tenderness and connection with another.

Therapeutic touch (TT) is one method of bringing healing touch into nursing care of patients and is an adjunct to healthcare in general (Richardson, 2003). The motivation for using therapeutic touch is in creating a milieu conducive to self-healing (Straneva, 2000). In order for nurses to create this milieu or receptive environment, they must be sensitive to the energy of the healee. Nurses who are sensitive to patients create an environment which puts patients at ease and breaks down some of the barriers people build around themselves. Therapeutic touch represents a form of caring touch with the intention to heal. This form of therapeutic touch reflects sensitivity and communicates to the patient that they have the nurse's attention, that they are safe, and that they are cared for. Nurses who practice TT accelerate a dimension of intimacy in the relationship between patient and nurse that improves the delivery and acceptance of healthcare.

The practice of therapeutic touch is recognized as one of many treatment modalities that complement conventional medical care. At least 43,000 health care professionals have been trained in TT and half of these professionals are integrating it into their practice (Krieger, 1997). Keegan

(1989) noted TT was the most recognized complementary therapy technique used by practitioners of holistic nursing. The National League for Nursing has promoted TT through books and videotapes (Quinn, 1994). The American Nurses' Association has held TT workshops at its national conventions as well as published articles on TT (Mackey, 1995). The American Association of Colleges of Nursing (AACN) included TT as one of the essential technical skills in baccalaureate nursing education (American Association of Colleges of Nursing, 1998). Nearly half of the State Boards of Nursing (47%) have taken positions that permit nurses to practice TT (Sparber, 2001). Montana is one of the states whose Board of Nursing has no formal position on the topic of therapeutic touch, but does not necessarily discourage this practice. Recognition by esteemed nursing organizations such as the AACN and the American Nurses Association provides credence to therapeutic touch as an intervention that complements traditional healthcare warranting inclusion in undergraduate nursing education.

Even though TT is a recognized nursing therapy, the question remains whether it is taught or practiced by nursing faculty. It is unknown whether faculty desire

education and training about TT and whether they perceive any barriers to practicing or teaching therapeutic touch. No studies have been done specifically addressing undergraduate nursing faculty perspectives on therapeutic touch in nursing practice or education.

### Background and Significance

The conscious intent to help another human being is the foundation for therapeutic touch. In the practice of therapeutic touch (TT), the healer intentionally attempts to redirect the client's energy into a more organized pattern through the use of their hands. Krieger (1973) first defined this technique as a form of the Biblical laying-on of hands but was careful to say it was not done within a religious context. In the conscious act of therapeutic touch intervention, the healer uses their knowledge of the needs of the healee and recollects information about human function from past experience and education. From this conscious and knowledgeable effort, the natural potential to heal through therapeutic touch can be actualized.

The human energy field is a basic tenet of therapeutic touch and is important in the dynamics of healing. Just as the universe is composed of energy, so, too, is the human body. Not bounded by the skin, man is a dynamic, open system in a constant state of energy exchange with the universal environment (Krieger, 1979). Each person has their own, unique energy pattern that requires balance and rhythmic flow to maintain health and well-being. Human energy fields have been found across cultures and throughout history. Early predecessors of this concept of energy fields included the notions of *ki* (Japan), *prana* (India), and *yang and yin* (China) (Krieger, 1973). The concept of *fields* is not so mysterious; biophysically, human body functions occur via electrical conduction throughout the neuromuscular system and in all electrical conduction there must be a field to carry the charge (Krieger, 1979). The concept of the human energy field and its place in healing must be understood before knowing the process of performing therapeutic touch.

#### Etymology and History of Therapeutic Touch

Touch is described in a simple dictionary definition as "the specialized sense by which pressure on the skin is perceived," or "a sensation conveyed through the tactile

receptors" (Bosley-Woolf, et al. (Eds.), 1977). As a verb, *touch* becomes more of an action such as "to handle or feel gently," "to lay hands upon a person to cure disease," or "to be in contact with, to come close."

Touch as therapeutic use of hands is an ancient example of man's ability to help his fellow man. Written history documents the use of hands for healing back at least 5,000 years; pictorial evidence in Pyrenees cave paintings dates back 15,000 years (Krieger, 1979). Eastern, Western, Asian, and European cultures had versions of healing touch (Krieger, 1973).

The beliefs and practices of Eastern cultures provided much of the basis for therapeutic touch. In India, *prana* is a Sanskrit word for vigor or vitality. This organizing concept is believed to underlie the life process and is viewed as a subsystem of the human energy transfer involved in the healing act of TT. In the Eastern world, *prana* was basic to such phenomena as wound healing and regeneration.

Asian *ki* is an ancient concept of energy fields that influenced the practice of therapeutic touch. Tohei (1978) explained that our lives are part of the universal *ki* (or life energy) and that human energy is in a constant state of flux with the energy of the universe. When the conflux of human *ki* and that of the universe is unimpaired, we will

be in good health (Tohei, 1978). Conversely, when the flow between our *ki* and the universe is dulled or in a minus state, we become ill and possibly die if that flow is halted altogether (Tohei, 1978).

In European cultures, specifically France and England, the touch of kings was considered good for curing illness, thus the term "King's Touch" (Krieger, 1979). In the Middle Ages, healing with the hands was common practice within the church but if done outside the church was not acceptable and perceived as witchcraft.

Innumerable accounts of healing by laying-on of hands appear in church histories throughout Western culture. The New Testament is rife with stories depicting the healing accomplished by Jesus with the laying on of hands. Some of the more well-known examples are his healing of the ten who had leprosy and his healing of a paralyzed man (Syswerda, 1989). In the early sixteenth century on the North American continent, Spanish conquistadors witnessed Native Americans cast out infirmities by imposing their hands upon those needing healing.

In the 20<sup>th</sup> century, Krieger described therapeutic touch as a primitive, elegant use of human energies while serving mankind (Meninger Foundation, 1979). In her latest book, she described therapeutic touch as a modern

interpretation of several ancient healing practices (Krieger, 2002). From the rich historical background of healing, Krieger concluded that therapeutic use of hands was a universal human act that needed resurrection in this scientific age of the 21<sup>st</sup> century.

### Conceptual Framework

Three main theories provide the framework for therapeutic touch in this study. Rogers' Theory of the Human Energy Field, Newman's Theory of Health as Expanding Consciousness and Watson's Theory of Human Caring have all provided background for basic concepts. All three of these nursing theorists acknowledged the human energy field and thought that energy could intentionally be directed to facilitate healing.

Basic to Rogers' theory of the 'human energy field' is that people are defined as indivisible, multidimensional energy fields which are integral with the environmental energy field (Quinn & Streklaskas, 1993). Lewis (1999) further described Rogers' postulate that the human and environmental fields are identified by wave patterns and that change is potentiated by these waves. Therapeutic touch is directed toward promoting the rhythmic flow of

energy waves and thus order and re-order the human energy field. Assumptions of Roger's worldview include:

- human beings are unified, irreducible wholes
- a person is characterized as a human energy field
- the unified human energy field is an open system, constantly exchanging matter and energy with the environment.
- the identity and integrity of the human energy field is maintained through patterning and organization; patterns are seen in rhythmical relationships within each human energy field and between the human-environmental energy fields (Rogers, 1970).

Based on Rogers' tenets, Smyth (1996) thought the nurse's use of self was intentional to mobilize the patient's own innate healing ability. This mobilization creates a new energy field and alters the disruption of the human field manifested by illness or disease. Therapeutic touch practice exemplifies the Rogerian view of the life process as dynamic energy exchanges on all levels of being from universal energy to human energy.

Nursing theorist Margaret Newman drew on the works of Rogers in developing her theory of *Health as Expanding Consciousness* (Pharris, 2001). She aligned her beliefs with Rogers in describing human beings as energy fields inseparable from the larger field that encompasses person, family and community. Her theory paralleled Rogers' in that

a person's consciousness was not limited to the physical environment but became part of the universal consciousness.

Jean Watson developed her *Theory of Human Caring* in the 1970's when Krieger was forming her concepts about therapeutic touch (Watson, 2001). Watson's perspective was that nursing practices of human caring were oriented toward an inner healing process. This caring consciousness of the nurse was defined as energy within the human energy field that was used with an intentionality to heal. Watson's theory drew on the paradigms of Rogers' concept of human energy fields and Krieger's use of therapeutic touch to become sensitive to this conscious caring energy and manipulate it with purposeful intent to heal.

#### Krieger and Kunz's Therapeutic Touch

Krieger became interested in the phenomenon of therapeutic touch after becoming acquainted with Dora Kunz, a natural healer who had the ability to perceive the subtle energies around life forms (Krieger, 1979). Kunz and colleagues were studying the healing abilities of famous healers. Krieger first noted modulation of energy when she observed the abilities of Oscar Estabany in healing horses by redirecting their energy with his hands (Rorvik, 1974).

These observations were instrumental in stimulating Krieger's interest in examining the phenomenon of therapeutic touch.

When plans were made to study Estabany's ability to heal humans using therapeutic touch on patients with medical problems, Krieger became involved (Krieger, 1979). After seeing positive responses in this first study, Krieger went on to practice and then teach therapeutic touch. Kunz may have originally developed the techniques of therapeutic touch, but Krieger was instrumental in propagating the technique in nursing. Her course, *Frontiers in Nursing: the Actualization of Potential for Therapeutic Human Field Interaction*, was the first class of its kind offered within an accredited master's nursing curriculum in the United States (Krieger, 1979).

Krieger first added scientific credence to the concepts of therapeutic touch in a 1972 study on hemoglobin (Krieger, 1972). Ill persons receiving therapeutic touch had an increase in mean hemoglobin values in the experimental group as compared to the control group. The study is well-reported after being presented at the 1973 American Nurses Association Conference.

Additionally, Krieger was involved in a study on alpha activity which measured physiological variables in the practitioners performing therapeutic touch (Peper & Ancoli, 1977). Krieger described a helpful effect of TT on autonomic symptoms such as decreased peripheral circulation, nausea, dyspnea and tachycardia. Krieger reported additional subjective reports of TT relieving depression, premenstrual syndrome, secondary infections of HIV and complications in premature babies (Krieger, 1979). According to Krieger, the most reliable clinical effect noted is a relaxation response in the patient within a few minutes of treatment (Krieger, 1979). The second most reliable effect is reported as an amelioration or eradication of pain. As a third clinical effect, she noted facilitation of the healing process.

Krieger's therapeutic touch teachings have evolved over the decades since the 1970's and become formalized into a program taught through the Nurse Healer's-Professional Associates International program (Nurse Healers-Professional Associates International, 2004). Her work has been continued by former students completing dissertations and conducting postdoctoral research on therapeutic touch. A good example is Quinn's work in

developing a simulated model for controlling the placebo effect (Quinn, 1984). Another of Krieger's students, Wirth (1990), was instrumental in creating a research design for TT that is truly double blind.

#### Phases of Therapeutic Touch

Krieger refined the method of providing therapeutic touch to entail four phases. The phases involved when the practitioner is performing the process of therapeutic touch are centering, assessment, unruffling, and the treatment phase. These four phases are followed by a re-assessment phase prior to completion. The healee should be encouraged to relax in a warm, comfortable environment and be open to receiving the therapeutic intervention throughout the process. Krieger emphasized the importance of visualization, meditation and observation by the practitioner when performing therapeutic touch to facilitate sensitivity to the patient's energy (Meninger Foundation, 1979).

## Centering

Centering is the initial step in the process of therapeutic touch. In a form of self-meditation, the practitioner is required to concentrate intensely and decisively shift consciousness. This shift in consciousness allows the practitioner of therapeutic touch to detect the life energy of the healee (O'Mathuna, 1998). The practitioner's inner attention and awareness of self must be maintained throughout the TT encounter to achieve integration and freedom from distractions. While cognitively detached and focused, the practitioner becomes aware of her or his healing intent and spiritually attuned to the universal healing energy (Straneva, 2000). While the practitioner is in the "centered" state, beta wave activity on the electroencephalogram is at high frequency (Peper & Ancoli, 1977). These rapid, synchronous beta waves are most commonly associated with states of arousal involving active thought, imagery and directed attention indicating a more active meditative process than traditional meditations such as Zen or Transcendental Meditation (Straneva, 2000).

Krieger (1979) emphasized that the healer must enter into centering with intentionality from a knowledgeable base; the motivation should be in the interests of the healee rather than motivated by the healer's own ego structure. The healer's motivation nourishes and guides directionality of the emotional energy by being centered (focused) during the intervention. Centering prepares the practitioner to be focused for the assessment phase of therapeutic touch.

#### Assessment

Assessment, also known as scanning, is the information gathering phase of TT. Nurses in their practice settings are constantly assessing and observing the patient and their interactions with the environment (Krieger, 1973). Assessment for the purposes of TT is merely an extension of this ongoing process and is used to supplement the practitioner's knowledge base of the patient's status. During assessment, indicators such as physical appearance, gestures, postures, intonations and voiced concerns as well as the person's energy field are evaluated (Straneva, 2000). Hands are considered energy centers (or Chakras in Sanskrit) and act as the functional agents in evaluating

the patient's energy fields during the assessment phase of therapeutic touch (Leadbeater, 1940).

In the assessment phase of TT, the practitioner's hands are passed over the healee while held 2 to 6 inches from the recipient's body to assess fluctuations in the flow of energy (Straneva, 2000). The healer "listens" with an inner awareness to the cues provided by the recipient. Some healers have felt kinesthetic perceptions such as electric shocks, pulsations, vibrations, pressure, warmth, cold, or a sense of congestion; others have seen colors or images. Some practitioners detect imbalances through cues such as hunches, insights, intuitions or passing impressions that then guide subsequent actions (O'Mathuna, 1998). The key to assessing is letting the practitioner's intuitive inclinations be the guide while avoiding judgment of the cues or rational analysis of the process (Straneva, 2000). Assessing guides the practitioner in the repatterning process that occurs in the next phase of therapeutic touch.

### Unruffling

The unruffling, or mobilizing, phase involves freeing the recipient's energy to get it moving (Krieger, 1973). This process gives the healer access to a mobile energy

field and thus prepares the recipient's energy field for a subsequent transfer of energy toward the goal of facilitating healing. This unruffling allows the healee's energy field to mobilize its own healing resources so that self-healing can occur. The recipient's energy field is "cleared" in a purposeful intervention of repatterning and mobilizing the field so that energy can flow symmetrically again. The hands are used to remove energy blocks by sweeping the palms away from the midline of the body both laterally and toward the feet (Straneva, 2000).

Krieger (1973) suggested that sweeping down the body, following the direction of the long bones of the extremities nearest the congestion, feels as if one were pushing a pressure front ahead of them. These long, rhythmic strokes smooth out the energy field, removing areas of congestion to clear energy blockages and mobilize the static energy so it can be freed for use in the healing phase (O'Mathuna, 1998). The healer commonly shakes out, wipes off or washes their hands after this phase of TT to refresh and prepare for the treatment phase.

### Treatment Phase

Direction and modulation of energy is the treatment phase where the practitioner sends energy to the healee to specifically correct the imbalances or asymmetries that were detected in the assessment phase (O'Mathuna, 1998). Directing this energy can be done in two ways: (1) by the healer directing their own excess energy to the healee and (2) by directing the energy of the healee from one place to another within the body. Modulation of energy is concerned with tempering the energy outflow of the healer to meet the particular needs of the healee. The goal is symmetry in both sides of the healee's energy field (Krieger, 1973).

Through conscious, mindful action, the practitioner responds to the cues detected in the assessment phase to send an opposing energy to that particular area (O'Mathuna, 1998). For example, if an area of cold were detected during assessment, the healer would visualize and direct heat to that area. During this phase, practitioners must continue to remain focused and completely centered on the intention to help and heal.

### Reassessing the Response

Reassessment is the phase where the practitioner evaluates the response to the TT treatment. When there are no perceivable differences noted between one side of the person's energy field and the other, there no longer are any cues to continue with therapeutic touch. At this point, the practitioner determines the patient's energy field no longer has an imbalance and treatment can be stopped (O'Mathuna, 1998).

### Therapeutic Touch in Nursing Education

The use of therapeutic touch in nursing is consistent with the teachings of Florence Nightingale, who promoted a holistic approach to patient care (Dunphy, 2001). In keeping with the holistic aspect of nursing, nurses have seen therapeutic touch as a means of instilling an increased sense of participation, hope and control in their patients. Patient participation and sense of control is an important component of healing and holism. The concept of holism (whole-ism) is thought to be "especially congruent with the essential nature of nursing" (Johnson, 1990). The patient's wholeness is promoted by the nurse who respects the patient's dignity and right to self-determination.

Nursing students, in their first years of nursing education, are taught about touch done in a compassionate way that preserves dignity and protects privacy. In order to perform a thorough physical assessment, for example, the nurse must touch the patient and from this determine the turgor and texture of the skin and if there is moisture, fever, or pain. Even in performing the technical skills that a nurse is taught to do, the nurse touches the patient. More advanced concepts of touch such as reflexology and therapeutic touch generally have not been included in basic undergraduate nursing programs in the past (Richardson, 2003).

In their role as patient educator, nurses need to have knowledge about TT before they can educate their patients about it. With this knowledge, nurses will be able to evaluate whether therapeutic touch is safe and/or effective for their patients. Formal education to promote knowledge of TT begins with nursing students. Teaching students about TT can help them become better grounded in the philosophy of body-mind-spirit wholeness and healing for themselves, individuals and communities (Halcon, Leonard, Snyder, Garwick, & Kreitzer, 2001). Students familiar with this treatment modality can then be prepared to serve as resources and health facilitators to the general public. A

nursing education curriculum that deliberately includes therapeutic touch would provide nursing students with the knowledge they need to incorporate TT into their own practice as nurses or make an appropriate referral for their clients.

A trend towards incorporating therapeutic touch into nursing curricula emerged in the late twentieth century (Fenton & Morris, 2003; Reed, Pettigrew, & King, 2000). Appropriate training to practice therapeutic touch using the technique described by Krieger requires education in both theory and practice skills. The minimum training required by the NH-PAI to become certified to practice TT is 12 hours of theory and guided practice followed by a year of mentorship with an experienced practitioner (Nurse Healers-Professional Associates International, 2004).

Providers of therapeutic touch and nursing educators both advocate for established quality guidelines to direct and endorse the practice of TT. Guidelines for standards of practice are addressed by the Nurse Healers-Professional Associates International (NH-PAI). The NH-PAI developed Standards of Care and Scope of Practice for Therapeutic Touch to provide guidelines for practitioners of TT.

Educational guidelines have been developed by the American Association of Colleges of Nursing (AACN) and the American Holistic Nurses Association (AHNA) to provide direction to nursing programs planning to implement TT in their curricula (American Association of Colleges of Nursing, 1998; American Holistic Nurses Association, 2004). The AHNA Standards are based on core values of practice in holism which emphasize commitment to education, ethical principles, theory grounded in research and an evolution of the nursing process.

The essentials for baccalaureate education established by the AACN provide a framework for developing, defining and revising curricula in baccalaureate nursing programs. The newest release of the AACN Essentials in 1998 identified therapeutic touch as one of the core competencies that should be included in an undergraduate nursing program (American Association of Colleges of Nursing, 1998). Therapeutic touch is listed as one of the technical skills that are deemed essential for every graduate of a baccalaureate program. In 2005, the Commission on Collegiate Nursing Education (CCNE) mandated that undergraduate programs adopt the AACN Essentials of Baccalaureate Education as the basic curriculum guide in order to achieve accreditation.

Standards set by both the AACN (1998) and the AHNA (2004) recommend including TT as content in nursing school curricula. The Standards of Holistic Nursing Practice share many major concepts with the Essentials; however, the Standards differ in that they accentuate the concepts of nurse self-care and managing care of the environment to promote healing. These standards raise awareness of a holistic perspective that prepares nurses to care for both client and self.

#### Problem

Recent research studies address a broad range of complementary therapies but none have focused on nurses' perspectives on therapeutic touch. In three studies on a range of complementary modalities, nurses, nursing faculty and nursing students indicated a desire to know more about therapeutic touch (Dekeyser, Cohen, & Wagner, 2001; Halcon, Leonard, Snyder, Garwick, & Kreitzer, 2001; Lewis, 1999). These studies did not specifically address undergraduate nursing faculty views on therapeutic touch and its application in nursing practice or incorporation into nursing education.

Little is known about current attitudes, knowledge and practice of therapeutic touch by nursing faculty. In addition, it is unknown whether nursing faculty are including any therapeutic touch theory or skills content in any of the courses they teach. Furthermore, desired education and training about TT and perceived barriers to incorporating TT in practice/teaching are not reported.

#### Purpose

The purposes of this study are to (1) describe the current attitudes, knowledge, and practices of TT for nursing faculty (2) describe perceived barriers to faculty use of TT in their nursing practice and (3) identify barriers, as perceived by faculty, to teaching TT in the undergraduate nursing curricula. This descriptive study will provide insight into nursing faculty's attitudes, knowledge and perspectives on therapeutic touch. The goal is to identify whether faculty are using TT in practice, whether they have the knowledge and skills to teach TT, and whether they desire more education about TT. Additionally,

this study will identify faculty's incorporation of TT into undergraduate nursing education.

The results from this study may be helpful in future decisions about the role of TT content in the curriculum for undergraduate nursing students. Secondly, the results may be useful in developing postgraduate continuing education programs on therapeutic touch for nursing faculty and practicing nurses.

## CHAPTER 2

## LITERATURE REVIEW

A general review of the literature reveals three proposed nursing theories that are supportive of the underlying concepts behind therapeutic touch. In addition, the literature review reveals a plethora of research articles on therapeutic touch. The three theories supportive of TT concepts are Rogers' theory of the human energy field, Newman's theory of health as expanding consciousness and Watson's theory of human caring. These theories evolved parallel to Krieger's development of the practice of therapeutic touch. Review of these theories and research literature on TT indicates the nursing community supports therapeutic touch and the inclusion of it in basic nursing education. Research studies both in support of and in opposition to therapeutic touch are presented. The current status of therapeutic touch in professional nursing educational programs is addressed.

### Theory of Human Energy Field

Rogers (1979), a nurse theorist, described an energy field as the fundamental unit of any living system. This energy field is the core concept of her theory. In Rogers' theory, humans and the environment are both energy fields with no real boundaries between them. Instead, they (humans and the environment) are identified by the organization or pattern of the fields themselves. According to Rogers, healing occurs through the simultaneous, mutual interaction of these two energy fields.

Rogers (1990), envisioned therapeutic touch as an example of pandimensional awareness, a way to transcend perceived limitations of time and space. Rogers explored the concept of energy fields and believed humans had an ability to modulate them (Malinski, 2001). According to her, human and environmental energy fields (what Rogers called *biofields*) are in a constant state of change involving frequency wave (field) patterns where human and environmental energy are inseparable.

Research that supported the Rogerian concepts of energy fields was done in the 1960's and 1970's by Burr who was successful in mapping and measuring L-fields (fields of

life) (Burr, 1973). Burr found that corresponding alterations occurred in life energy fields between two humans. According to the physical and mental condition of the individuals, changes detected in the energy fields could be used to diagnose various disorders such as arthritis and psychogenic illness. Burr's studies and Rogers' concepts were instrumental in influencing Krieger in her development of therapeutic touch.

Rogerian theory has evolved since its original inception in 1970 (Rogers, 1990). Rogers added the principle of integrality to explain the continuous nature of the mutual communication of open energy fields. The human and environmental fields are reciprocal systems that are changing and being changed simultaneously; as one field changes the other also changes. The working together of practitioner and recipient during therapeutic touch incorporates this principle of integrality and demonstrates the simultaneous mutual interaction of energy fields. Human-environment interactions are continuous in Rogers' view.

The second principle in Rogers' theory, helicity, predicts that as man develops, the complexities of pattern and organization increase (Rogers, 1970). This life process proceeds in stages along a spiraling curve rather than on a single plane. This helicity principle explains the intent of healing behaviors which is a continuous diversity of fields (in the healer and healee) in the direction of wholeness or field integrity.

Rogers' (1970) third principle, resonancy, suggests that pattern and organization changes in both the human and environmental fields are caused by energy waves including those emitted by sound, light, gravity and heat. Although humans cannot see these waves, people are influenced by the rhythms of these waves. This principle of resonancy, which suggests the influence of these unseen energy waves on mankind, correlates with Krieger's (1979) description of illness as a disruption or change in the energy flow within an individual. In the practice of therapeutic touch, the healer intentionally attempts to redirect the client's energy so that it is in a more organized pattern. Rogers' Theory of Human Energy Field had a strong influence on another nurse theorist, Newman, who described energy patterns and their relationship to the health or wholeness of an individual.

### Theory of Health as Expanding Consciousness

Newman's (1990) theory of health as expanding consciousness described how a person could be identified by their unique energy pattern which is evolving through order and disorder. Newman described the energy pattern in health as varying from the energy pattern in disease; together, these patterns are manifestations of the wholeness of the evolving pattern in a human.

Newman (1990) defined the concept of consciousness as the informational capacity of the human system or, more specifically, the ability of the system to interact with the environment. Newman identified consciousness as awareness as well as the overall potential and responsiveness of a human being in the process of enfolding and unfolding within the environment (Newman, 1989). She further clarified by adding that consciousness was not only the affective and cognitive awareness, but also the interconnectedness of the entire living system which is part of a larger, undivided pattern of an expanding universe. To Newman, health and the evolving pattern of consciousness are the same; health and illness are not viewed as a continuum from wellness to illness as in the typical medical paradigm.

In accordance with Newman's theory, a person seeks a health care provider when the energy pattern is in disorder and the person pursues assistance to evolve as a whole (or complete) entity. Recognizing the individual's energy pattern is the key to the process of evolving to higher levels of consciousness, i.e. health. Regardless of the level of the person's disease, the potential for their energy pattern is focused on their reciprocal relationships with others.

Both Rogers and Newman defined health as a process involving the rhythmic fluctuations of healthy life with disease. Newman (1989) saw well being as energy fluctuations in the life process called health. Newman best described an interface of caring-healing within the patient-nurse encounter as an engagement that requires the nurse to interface with the whole person. A nurse practicing TT is using this caring-healing interface described by Newman to assist their patient in evolving toward health. A third nurse theorist, Watson, added credence to nursing's model of caring and healing and connected it to the healing energy that is intrinsic to therapeutic touch.

### Theory of Human Caring

Watson's (2001) theory of human caring was developed in the mid-1970's. Watson clarified that nursing's knowledge, practices and values of human caring focused on subjective inner healing processes and the life-world of an experiencing person. Watson proposed that the concept "transpersonal" conveys a concern for the inner life, that the subjective meaning of another person fully embodied, goes beyond the ego self to connections of the spirit.

Through the processes of caring and healing, the care provider in a transpersonal relationship seeks connection with the spirit or soul of another. Such a relationship implies a focus on the uniqueness of self, the other and the moment and is influenced by the intentionality of the nurse with a caring consciousness. Transpersonal caring requires the nurse to enter into the other's frame of reference in order to connect to their inner life world of meaning and spirit—a spiritual transcendence where both merge in the search for meaning and wholeness of being or becoming.

Smyth (1996) expanded on Watson's ideas about healing through nursing. She stated that the act of caring-healing within the nurse-patient encounter is whole (holistic). This caring-healing encounter requires that the nurse interface with the flow of the whole (or entire) patient and experience an interfusion of the explicit wholeness of each. Smyth connected the transpersonal caring described by Watson with the lived experience of therapeutic touch.

#### Summary of Theoretical Basis

The three theories proposed by Rogers, Newman and Watson provide a philosophical base for therapeutic touch. In the Rogerian view, the life process is envisioned as dynamic energy exchanges with the universe. Newman's theory, generated from Rogers' ideas, brought theory closer to reality for the practicing nurse. Performing TT with an expanding consciousness, the nurse engages with the patient in a synchrony of healing. Finally, Watson's theory connects the consciousness between the nurse and the patient. In TT, this fusion of conscious energies between nurse and patient demonstrates holistic healing. From the theoretical background one might extrapolate that in TT,

manipulating universal energy with conscious intention has a positive effect on physiological and psychological well-being of the individual.

### Therapeutic Touch Research

A synthesis of nursing research on TT indicates that holistic care is provided when the nurse healer uses TT. The practice of therapeutic touch has been used with positive results in a variety of settings including: critical care units, oncology settings, neonatal units, Alzheimer centers and pain clinics (Hallett, 2004; Peck, 1996). In addition to successful use with cancer patients (Giasson & Bouchard, 1998), drug addicts (Hagemaster, 2000), and recently bereaved (Quinn & Streklaukas, 1993), TT has been employed effectively to reduce anxiety (Cox & Hayes, 1997), improve the well-being of older adults (Bush, 2001), decrease agitation in people with Alzheimer's (Woods & Dimond, 2002), and decrease pain and improve quality of life for fibromyalgia patients (Denison, 2004). Research on TT is still evolving. Many of the studies have been pilot studies where credibility needs verification with further rigorous research to establish a solid body of evidence in support of therapeutic touch (Peters, 1999).

### Process of Therapeutic Touch

A qualitative approach was used to describe the experiences of nurses who were in the process of providing therapeutic touch (Heidt, 1990). A constant comparative method was used to generate a grounded theory explaining the process of TT. The seven nurses selected as providers had all practiced therapeutic touch as taught by Krieger and Kunz. Each nurse selected a patient who had received an average of 30 treatments prior to the research. One treatment session for each nurse was observed. The primary experience of therapeutic touch was "opening to the flow of universal life energy" (Heidt, p. 182). Opening was further defined as the nurse focusing intent on getting the universal life energy moving again and assessing the quality of its flow. The nurse, along with the patient, participates in a healing relationship that unblocks, engages and enlivens this energy movement. Heidt concluded that research needed to be directed toward understanding more fully the complexities of this nurse/patient relationship that facilitates the healing process. Similar studies duplicating the Heidt study and using the same research methods and measurements have not been done.

### Therapeutic Touch with Cancer Patients

A Canadian study supported the use of therapeutic touch with persons with terminal cancer for improving their well-being (Giasson & Bouchard, 1998). Twenty palliative care patients were randomly assigned to one of two groups. The experimental group received three noncontact TT treatments that lasted 15 to 20 minutes. The control group participated in three 15-20 minute rest periods. Well-being was measured before and after each session using the Well-Being Scale that measured anxiety, nausea, pain, activity, depression, shortness of breath, relaxation and inner peace. Intervention with TT resulted in reported improvement in well-being and a reduction in analgesic use. Internal and external validity of this study were insured by rigorous control of the environment, the homogeneity of the participants and weighting of medication use as a covariable. One limitation of the study was the small sample size. A larger study sample of persons with terminal cancer using the same research method and measurements is needed to verify the results of this initial study. Although three TT treatments had a positive outcome on the terminal cancer patients, it is unknown whether fewer or more treatments may have had the same effect.

An additional study on the use of TT on cancer patients supported the benefits of using TT to improve quality of life in terminal patients (Post-White, Kinney, Savik, Gau, Wilcox, and Lerner, 2003). A randomized, prospective, cross-over intervention study of cancer patients in the Midwestern United States was done. The effects of touch with the intention to heal were compared to presence alone or standard care. For this study, touch was defined as an energy therapy used to assess and determine areas of energy imbalance. After the assessment, the practitioner would unblock the patient's energy to promote physical healing and emotional balance. A group of 230 patients were randomly assigned to three groups. Participants received four sessions of their assigned condition (intervention or control or standard treatment alone) then "crossed over" to an alternate assigned condition (either intervention or control) for another four sessions. All groups received the standard treatment for cancer. In addition to one group receiving only standard care, a second group also received standard care with presence and the third group received standard care with touch therapy. Touch and standard care were more effective than presence with standard care or standard care alone in inducing a relaxed state, reducing short-term pain and

fatigue, and reducing mood disturbance in patients with cancer. No effects on nausea were noted. This study provided support for the positive short-term effects of touch with the intention to heal on cancer patients. Further study is needed to test the long-term effects of TT and the duration of specific effects on symptoms commonly experienced by cancer patients.

#### Therapeutic Touch with Chemical Dependency

In a pilot study, Hagemaster (2000) used therapeutic touch as a treatment for persons who abuse alcohol and/or drugs with positive results. Participants who met the criteria for alcoholism and were not being treated for mental disorders were randomly assigned to groups. A between-subjects design was used to compare treatment outcomes of 3 groups with 5 participants each. One group received therapeutic touch. A second group received mimic therapeutic touch. The third group received no intervention other than weekly phone calls to determine the frequency of drug use. The group receiving TT showed improvement as measured by the Addiction Severity Index in family/social relationships and employment; a reduction or elimination of alcohol/drug consumption was seen only in the TT group.

Mean levels of depression on the Beck Inventory were reduced for those in the TT intervention group. The results of this study have implications for enhancing the attainment and maintenance of alcohol/drug abstinence. Secondly, an enhancement of sobriety through reduction of social stressors in general is implied. A limitation of this study may be that the sample size was small; a larger sample would add credibility to the findings.

A second study on chemical dependency investigated the effect of TT on 54 pregnant women withdrawing from opioid addictions (Larden, Palmer, & Janssen, 2004). The women were randomly assigned to 3 groups for a period of 7 days. In the experimental group, TT was administered each day in the standardized fashion according to Krieger's technique. Participants in the presence group chose an activity to share with the nurse. Contact in the standard care group was limited to daily collection of data. Anxiety scores (as measured using Spielberger's State-Trait Anxiety Inventory) were significantly lower in the TT group compared to the other groups during days 1, 2, and 3 of treatment. These results are meaningful in recognition of the high incidence of anxiety in chemically dependent women. There were no significant findings related to withdrawal symptoms. The study was limited by the small sample size, which may limit

the ability to identify a causal relationship. Attrition among study participants and inability to blind study participants were additional limitations. A strength of the study was the randomized, three-group design which allowed for homogeneity of participant characteristics within groups. The results of this study have implications for enhancing the treatment of anxiety in the patient withdrawing from chemical dependency.

#### Therapeutic Touch with Mood Disturbance

A single pilot study evaluated the effects of TT on biochemical indicators and mood in healthy women (Lafreniere, Bulent, Cameron, Tannous, Giannotti, Abu-Zahra, & Laukkanen, 1999). This study examined blood levels of hormonal and neurotransmitters, cortisol and dopamine. Urine levels of nitric oxide (NO), detected as nitrite, are implicated in the regulation of vomiting. Mood and anxiety were measured in a sample of 41 healthy women who were randomly assigned to a treatment group that received standard therapeutic touch while listening to soft music or to a control group in a quiet room. All participants completed a questionnaire before the first session and after three sessions that included the Profile of Mood States (POMS) and the State-Trait Anxiety Inventory (STAI).

After the three sessions, nitric oxide (but not cortisol or dopamine) decreased significantly in the experimental TT group. This has particular relevance for patients undergoing chemotherapy as reduction in NO may reduce the associated nausea. Mood disturbance decreased in the TT group. Therapeutic touch reduced self-reported tension and confusion as well as increased vigor. A limitation is that this study was done with healthy women and the results may not be generalizable to women with cancer. Further limitations were related to procedural differences between the control and experimental conditions. Unlike the experimental participants, the control participants were not given the opportunity to recline and listen to soft music. The results of this study, however, may have important implications for TT reducing symptom distress and mood disturbance in women with cancer.

#### Therapeutic Touch with Recently Bereaved

In a pilot study by Quinn and Streklaukas (1993), data was collected to examine changes in immunologic and psychologic measures related to TT. The authors evaluated the effects of TT for two experienced practitioners administering TT and four recently bereaved recipients. The recipients' length of bereavement periods varied from 7 to

24 weeks. Treatment consisted of the practitioner administering therapeutic touch using the Krieger-Kunz method. A profile of the immune functions of all participants was drawn before and following first and last treatment. One participant received 4 treatments, the other three received 7 treatments. There was a reduction in state anxiety after treatment with therapeutic touch for 25% of recipients. On the Affect Balance Scale, positive affect increased and negative affect decreased for all the recipients. On the Effectiveness of Therapeutic Touch Scale, perceived effectiveness by the recipient varied according to provider. On the immunological profile, percentage of suppressor T cells diminished by 10% to 21% depending on the recipient. The significance of this study is that changes in recipients' lymphocyte response after TT may enhance immunologic functioning.

#### Therapeutic Touch in a Clinical Setting

A continuous quality improvement (CQI) study of therapeutic touch in a hospital clinical setting indicated positive anecdotal responses (Newshan & Shuller-Civitella, 2003). As part of a CQI program, the effects of therapeutic touch were evaluated in a variety of patients. All patients

admitted to the hospital were invited to participate, 605 agreed to take part in the study. The practitioners had received formal training in the Krieger-Kunz method of TT. A new tool specific to TT was developed and was composed of two parts: a Patient Satisfaction Survey and a TT Performance Improvement Tool. All patients who received TT treatments two or more times were asked to complete the anonymous Patient Satisfaction Survey and return it in a preaddressed envelope. The TT Improvement Tool was completed by the practitioner at the end of the TT treatment and evaluated discomfort response change and outcome of the treatment. The Discomfort Response Scale used the Numerical Rating Scale of 0 to 10. The Outcomes Response Scale measured commonly reported outcomes of TT such as patient feeling calm, relaxed, falling asleep, reduced nausea, less headache, a positive comment or no change. Physiological response to TT was characterized as objective signs such as patient closing eyes, relaxing face, sighing deeply or having facial flushing. Almost half (48%) of patients reported a decrease in pain from 1 to 3 points on a pain scale of 1 to 10, with 27% of the patients falling asleep after the treatment. Most patients reported positive outcomes such as feeling relaxed or calmer. A positive physiological response was noted in 48% of

patients with eyes closing, face and hands relaxing and deep sighs reported. Patients anecdotally reported feelings of relaxation, reduction in pain medication use, feeling spirits lifted, and amazement at how quickly it worked. Overall, patients indicated a high level of satisfaction with TT. Limitations of the study included that, as a CQI study, a control group was not used for comparison and confounding variables such as medication were not controlled. However, the quality improvement data can be used to identify problems involving patient care for future research. The data from this study is significant in that it suggests that TT, when provided in the clinical setting, promotes comfort, calmness and well-being among hospitalized patients.

#### Therapeutic Touch with Nurse Recipients

In a study on the effects of touch therapy on nurses, Taylor (2001) hypothesized that coping, general health and self esteem would be higher for those who received touch therapy than for those in the control group. Taylor defined healing touch as a multi-level energy based approach to therapeutic healing that derived from therapeutic touch. She completed a study using mixed methodology including interviews and an experimental design. The participants

consisted of 51 first and third year nursing students randomly allocated to experimental and control groups. The experimental group received four treatment sessions of 50 minutes of music and touch therapy. The control group was exposed to music only for the 4 sessions with the same music as the experimental group. The measure of coping, general health and self-esteem were rather inconclusive. In the qualitative analysis, participants noted that the general effects of the sessions included: feeling more able to study and think, positive changes in sleeping patterns, being more open-minded, more relaxed and less rushed, and feeling good in general. Taylor concluded that an objective measure may not be appropriate or adequate for a subjective experience like healing touch. The measures of coping, general health, and self-esteem may not be precisely measured or four sessions may not be sufficient to change these characteristics.

#### Practitioners Perspectives on Therapeutic Touch

In a Britain study, therapeutic touch practitioners were surveyed to determine the extent of use of therapeutic touch as well as the attitudes and experiences of British therapeutic touch providers (Lewis, 1999). A postal questionnaire was sent to all members of the British

Association of Therapeutic Touch (BATT) and to other known practitioners of TT. Of the 50 questionnaires posted, 23 were completed and returned. The practitioners listed several reasons for learning therapeutic touch including using it for pain from a variety of causes, babies too ill for handling, muscle spasms, edema, chronic fatigue, boosting immune systems, relaxation therapy, depression, anxiety, critically ill patients, and patients undergoing cancer treatment. Respondents indicated they also treated family, friends, students and fellow staff members. Most of those working in an educational setting acknowledged teaching an introduction to TT to their students. Benefits to practitioners that were identified from the survey included a sense of physical well-being, feeling energized, a sense of calmness, becoming centered or focused, having an increased self-esteem, and becoming more reflective. Positive responses were reported by the practitioners of TT for those who had received TT. Some of the responses they described were having a more refreshing sleep, being energized, obtaining relief from constipation, healing wounds, and providing comfort to those in the dying process. Some of the barriers respondents reported to using therapeutic touch on patients were lack of policies on use of TT, insufficient research evidence in support of TT, and

the need to obtain permission from patient's doctors. Overall, these practitioners thought there was a need for the profile of TT to be increased in Britain. Because this study was done in Britain, which has cultural and healthcare differences, the survey results may not necessarily be similar or apply in the United States.

The purpose of a study done in Israel was to determine the knowledge level and attitudes of Israeli nurses towards complementary and alternative medicine and measure health locus of control (Dekeyser, Cohen, & Wagner, 2001). A random sample of 279 Israeli nurses was selected and four questionnaires were distributed to each. Nearly 70% of nurses replied that they do not use complementary therapies (which include TT) in their nursing practice. The knowledge level of complementary therapies among nurses in Israel was low. The nurses with higher levels of internal health locus of control were associated with more positive attitudes and knowledge levels of complementary and alternative medicine. The significance of this study is that it may imply support of TT as a treatment modality by those who have higher levels of internal health locus of control.

### Faculty and Students Perspectives on Therapeutic Touch

The purpose of a survey at the University of Minnesota nursing school was to describe knowledge and attitudes of nursing faculty and students regarding complementary therapies (including TT) and their integration into nursing practice (Halcon, Chlan, Kreitzer, & Leonard, 2003). The results were reported as statistically significant at alpha .05 or less by Halcon et al. (2003). Graduating BSN nursing students (n=73), masters students (n=47), and faculty (n=50) were surveyed in the spring of 2001. Ninety-one percent of the BSN students, 52% of graduate students and 66% of faculty returned the forms. Only 11% of undergraduate students, 7% of graduate students and 6% of faculty reported having sufficient training to personally provide TT. Nearly 20% of faculty, 22% of graduate students and 33% of undergraduate students thought they had sufficient information about therapeutic/healing touch to advise patients about it. TT was viewed as highly or moderately effective as a treatment modality by faculty (58%), graduate students (66%), and undergraduate students (49%). In addition, faculty and students indicated a desire for more education about TT but not necessarily the skills to perform TT themselves. Both groups also expressed positive attitudes about incorporating CAM practices that

may include TT into curricula and nursing practice. On the basis of the faculty and student responses, Halcon et al. (2003) concluded that therapeutic touch therapy would have a high acceptance by faculty and students when included as basic nursing skills in nursing curricula. A limitation of this study is that it did not fully explore what other conceptual frameworks were important in defining nursing faculty members' and students' views of health and health care. A strength of the study was the cross-sectional design which facilitated a comparison between faculty and student knowledge, attitudes and beliefs. The findings of this study have implications for curricular change to include modalities such as TT in faculty training and undergraduate nursing education.

#### Validity and Safety of Therapeutic Touch

Along with all the proponents of TT, there are opponents who question the validity and safety of TT. Many of the objections are based on concern with the lack of empirical research. Moylan (2000) called for more rigorous scientific methods in testing alternative treatments such as TT rather than relying on anecdotal reports. She doubted the validity of research studies on therapeutic touch,

thinking they were seriously flawed because they had no controls, no accounting for placebo effect, too few participants, lack of randomization of participants, and failed to use blind methodology. Glickman and Gracely (1998) also doubted the validity of therapeutic touch and defined it as a pseudoscience, a system of unsubstantiated claims weakly supported by the jargon of science to sound convincing. In response to concerns about the lack of scientific evidence to support the benefits of therapeutic touch, they tested the ability of one touch provider to detect the human energy field (HEF) but met with several refusals from therapeutic touch providers. Though the results of this singular test were negative, one test does not rule out the possibility of energy fields or that other therapeutic touch practitioners can detect energy fields. The authors, however, remained doubtful of the likelihood of HEF existence and of the practitioner's ability to detect HEF's. Glickman and Gracely (2000) doubted Krieger's first published study in 1973 because they felt there were methodological weaknesses including the fact that the study was nonrandomized. According to Glickman and Gracely, the control group as well as the experimental group had a rise in hemoglobin levels and they felt this was not adequately explained.

O'Mathuna (1998) was concerned about safety as well as scientific rigor. His concerns were about potential harm to the practitioner and harm to the patient. He feared there was potential for holistic harm because TT religious origins were similar to auric or pranic healing found in Western occult or Wiccan religions. O'Mathuna believed that therapeutic touch practitioners had an ethical duty to inform research participants and patients of potential religious conflicts. Similar to Moylan, Glickman and Gracely, O'Mathuna claimed that anecdotal reports by therapeutic touch providers made impressive claims but had little scientific evidence to support their claims. The detractors of therapeutic touch, however, do not address the multitude of empirically based research studies done on therapeutic touch resulting in positive findings. Research has yet to address the safety concerns of these protractors by exploring the potential side effects of therapeutic touch.

#### Therapeutic Touch and Nursing Education

Only three studies have been done to evaluate whether nursing schools across the United States are incorporating content on CAM's into their curricula. Therapeutic touch is

considered one of the CAM therapies in the category of manual and energy healing. Only the Richardson study clearly separated out incorporation of TT content into the curricula. A web-based survey sent to 585 United States schools of nursing indicated that nearly 85% of the responding schools included CAM modalities in their curricula (Fenton & Morris, 2003). In a study by Dutta et al. (2003) to evaluate CAM education in United States nursing schools, nearly half of the responding schools offered some form of education on CAM in their curriculum with electives being the primary form of instruction. Richardson (2003) surveyed nursing programs accredited by Collegiate Commission on Nursing Education (CCNE) in 2001 to evaluate the current status of complementary health and healing in undergraduate nursing education in the United States. The majority of nursing programs responding (66%) included didactic content on TT and 20% included experiential learning. One of the schools incorporating therapeutic touch in their curricula is the nursing program at the University of Minnesota (Chlan & Halcon, 2003). No other studies are available that address the number of nursing schools specifically incorporating therapeutic touch into their curricula. Recent research and nursing

education literature supports adding therapeutic touch to nursing curricula so that students are prepared to discuss TT with their patients in an informed manner (Gaydos, 2001).

### Summary of the Literature Review

In summary, a number of consumers and nursing educators across the country are embracing the healing modality of therapeutic touch. The plethora of literature on therapeutic touch over the past two decades indicates that the techniques involved with providing TT have been widely accepted by consumers, nurses, and more recently by nursing schools. Three proposed nursing theories provide a framework for energy fields as the mechanism of action for therapeutic touch. Newman's theory of health as expanding consciousness, Rogers' theory of the human energy field, and Watson's theory of human caring help conceptualize TT as a viable treatment modality.

Studies on TT since the 1970's have become more refined as they build upon the studies that precede them. Current uses of therapeutic touch were described, including treatment of cancer patients, patients with drug addictions, patients with mood anxiety states, Alzheimer

patients, critically ill, and the recently bereaved. Positive effects of TT were reported with reductions in pain levels, suppressor T cells, anxiety states, depression, shortness of breath and mood disturbance. Anecdotal reports described a sense of well-being and relaxation, feelings of inner peace, and an improved ability to cope. Most of the studies discussed were pilot studies or were done with small samples and need verification with statistical significance in further research.

A large number of nursing schools across the United States are now at least including didactic content on CAM's including TT, if not education on the practice. The science of therapeutic touch is still in its infancy but evolving as it becomes accepted in the nursing community. More research needs to be done to build on scientific description, prediction and explanation which can provide support for TT intervention and its outcomes. In addition, as more nursing programs incorporate TT into curricula, further studies evaluating the effects of this educational intervention on nursing faculty and student attitudes, knowledge and practice of TT could be useful for future program development.

## CHAPTER 3

## METHODS

This descriptive study was designed to provide insight into nursing faculty perspectives on the use of therapeutic touch by nurses. A web-based survey was used to gather data about faculty attitudes, knowledge, and practice of therapeutic touch. In addition, barriers to personal use of TT by faculty and teaching TT in the nursing curriculum were identified. For this study, "attitudes" addresses faculty opinions, viewpoints, and beliefs about TT. "Knowledge" encompasses beliefs and education related to TT. "Practice" includes use of TT in nursing practice or plans to use it as a practitioner as well as teaching of TT content to nursing students. "Barriers" refers to impediments to using TT in practice or teaching TT to nursing students. Demographic data were also collected.

Sample and Setting

The study was conducted at Montana State University-Bozeman College of Nursing which includes campuses in Bozeman, Great Falls, Billings, and Missoula with its

satellite in Kalispell. The college is part of a land grant institution and provides generic baccalaureate nursing education to more than 600 students. Faculty reside around their local campus. Montana is a rural, sparsely populated state and the distance between campuses ranges from 100-200 miles. Faculty must commute periodically to Bozeman, the main administrative center, for college business.

The study sample was composed of nursing faculty and adjunct faculty from Montana State University–Bozeman College of Nursing. Clinical resource nurses have another position classification because they have not completed advanced degrees. These clinical nurses do not participate in program development and therefore were excluded. Nursing faculty and adjunct faculty teaching (with the exception committee members for this thesis) at the baccalaureate level in the Spring term of 2005 were eligible to participate. Faculty names and email addresses were obtained from the Montana State University–College of Nursing website, which is available to the public. The campus administrative assistants confirmed those who were actively teaching undergraduates in the spring of 2005 from a current list of faculty names.

### Questionnaire

A questionnaire titled "Survey of Attitudes, Knowledge and Practice of Therapeutic Touch" (see Appendix A) was developed to measure nursing faculty attitudes, knowledge and practice of therapeutic touch. A demographic section was added to solicit sample characteristics. The questionnaire and demographics section were adapted from the "Survey of Knowledge and Attitudes of Health Professions Faculty" developed by Kreitzer at the University of Minnesota in 2001. "Permission was granted to use or modify this questionnaire by M.J. Kreitzer, PhD, University of Minnesota" (see Appendix B). The Minnesota survey was designed to determine faculty and students attitudes and information about training, personal use, perceived barriers, and the intent to integrate complementary alternative medicine (CAM) into practice.

The adapted questionnaire for the present study specifically addressed therapeutic touch rather than including all the complementary therapies as the Minnesota survey did. There is no established evidence of reliability

or validity for the adapted survey. The basic format of the questions was the same as the Kreitzer survey, with the words "therapeutic touch" being substituted wherever "CAM" had been used. Changes were made for readability and relevance to TT as well as comprehensive ideas about therapeutic touch. The new questionnaire was designed to assess overall knowledge and attitudes towards therapeutic touch as well as information about training, personal use, perceived barriers to practicing or teaching therapeutic touch and intent to integrate therapeutic touch into clinical practice or teaching.

The last section of the questionnaire has nine questions about demographics of participants, i.e., gender, age, race, employment, education, and ethnic background. These demographic variables were selected to describe participant's general characteristics and experience.

Questions in the survey address faculty attitudes, knowledge and practice of TT. Most questions on the survey allow a range of responses structured as Likert scales. Attitudes toward therapeutic touch are assessed in questions 1, 4, 5, 15 and 16. Knowledge about therapeutic

touch is assessed in questions 6, 7, 8, 9, 14 and 17. Question 13 specifically addresses teaching TT to nursing students. The practice or intent to practice therapeutic touch is assessed in questions 10, 11 and 12. Barriers to the use of therapeutic touch in teaching or practice are assessed in questions 2 and 3. Question 18 is an open-ended question that assesses knowledge or education, depending on the response. The remaining questions describe the demographics. The 27 question survey takes less than 10 minutes to complete.

#### Human Subjects Committee Approval

Montana State University-Bozeman Human Subjects Committee approved conduction of this research study according to their specific criteria. An application for exempt status was submitted based on the following criteria: anonymity, no risks or benefits were anticipated from participation, research does not deal with sensitive material and participants' employability would not be affected. Approval for exempt status and conduction of this research study was received prior to data collection (Appendix C). Though there were no direct benefits to

participants, faculty may experience satisfaction in assisting with research that helps to understand nursing faculty perspectives on therapeutic touch. No discomfort or adverse effects were anticipated from completion of the questionnaire. Participants were asked questions that were personal but could voluntarily not answer any question that they considered private.

#### Procedures

The nursing college's Associate Dean and administrative assistants assisted in making arrangements for data collection. The investigator sent an information cover letter (with the survey link) by electronic mail to all eligible nursing faculty at the Montana State University-College of Nursing, Bozeman. Initially, the letter (see Appendix D) was sent to 44 potential nursing faculty participants. In the letter, the investigator explained the purpose of the survey, its voluntary and confidential nature, and that responses were not individually identifiable. Participants were given a two week deadline in which to complete the survey. A follow-up email was sent four days prior to the March 28<sup>th</sup> deadline to

encourage participation in the study. Submission of completed surveys signified consent for participation in the study.

### Data Analysis

Analysis tools within the Survey and Analysis Program (SNAP) software, version 8.0, were used to analyze each item in the survey separately and then calculate as frequencies and percentages. The SNAP program allows for accessing the survey on the web. The confidential responses are returned directly to the web site. Once data is entered by the participants, the investigator requests program analysis of the responses and presents results. Quantitative data from this survey was analyzed using standard descriptive statistics to ensure validity and reliability.

Descriptive statistics were used to report the sample's demographics. Frequencies and percentages were calculated for all questions including those asking about gender, age, ethnic background, and employment status. Additionally,

descriptive statistics were used to describe nursing faculty attitudes, knowledge, practice of TT and barriers to teaching or using therapeutic touch. Percentages of participants who agreed with the statements were calculated for questions 1, 2, and 3. Percent of responses for each item were calculated for questions 4, 5, 7, 9, and 10. Yes on No responses to questions 8 and 11 were calculated as percentages; if a Yes response was indicated, then sub-items were calculated as frequency counts. In question 6, percentages were calculated for responses marked "effective". Responses to questions 17 and 18, which were open-ended, were printed in group format.

## CHAPTER 4

## RESULTS

Data was collected in the spring of 2005 from nursing faculty about their attitudes, knowledge and practice of therapeutic touch. Participants were allowed two weeks to complete the survey. Completed surveys were submitted electronically to a website for computer analysis.

Demographics

Of the 44 eligible nursing faculty teaching undergraduate nursing students, 23 submitted completed questionnaires for a response rate of 52.3%. All of the returned surveys were used for data analysis.

The general demographics for the sample of nursing faculty at Montana State University-Bozeman were congruent with expectations for the general population in Montana (see Table 1). The majority of participants were women (95.7%) and listed their ethnic/racial background as

White/nonHispanic (95.7%). The other options for ethnicity were African American, Native American, Asian and Multiracial, none of these were selected. The mean age was 50.1 years, with the majority (56.5%) over 50 years in age. Participants had a mean of 8.2 years teaching experience. Most (60.9%) listed Master's as their highest level of education. More than half (56.5%) reported they worked in direct patient care in addition to teaching. For those who did work in direct patient care (n=13), the major area of work was identified as an acute care hospital setting (53.8%). Only one respondent reported practicing in a private practice setting. More than two thirds (78.3%) of respondents have been practicing nursing for over 20 years.

Table 1. Demographics of Nursing Faculty\_(N= 23)

<u>Characteristic</u>	<u>Frequency</u>
<u>Gender:</u>	
Female	22 (95.7%)
Male	1 (4.3%)
<u>Age in Years:</u>	
20-29	1 (4.3%)
30-39	3 (13.0%)
40-49	6 (26.1%)
50-59	12 (52.2%)
60-69	1 (4.3%)
<u>Education Level:</u>	
Master's	14 (60.9%)
Doctorate	7 (30.4%)
Bachelor's	2 (8.7%)
<u>Employment Status:</u>	
Full time	17 (73.9%)
Part time	6 (26.1%)
<u>Years Teaching:</u>	
0-5	8 (34.8%)
6-10	9 (39.1%)
11-15	3 (13.0%)
16-20	1 (4.3%)
21-25	1 (4.3%)
26-30	1 (4.3%)
<u>Years in Nursing:</u>	
>30	8 (34.8%)
26-30	4 (17.4%)
21-25	4 (17.4%)
16-20	2 (8.7%)
11-15	2 (8.7%)
6-10	2 (8.7%)
0-5	1 (4.3%)
<u>Major Area of Work:</u>	
Hospital	7 (53.8%)
Home Care	3 (23.1%)
Outpatient	2 (15.4%)

### Attitudes

The general attitudes of nursing faculty toward therapeutic touch were positive. As shown in Table 2, the majority thought that nurses should be able to advise their patients about TT. Over 85% of the faculty expressed views that TT has potential as a treatment modality and 82.6% thought nursing programs should include content on the theory of TT. Nearly all (73.9%) thought that clinical nursing care should integrate the use of therapeutic touch with conventional medical therapies and that knowledge about TT was important to them as faculty. A slightly smaller number (69.5%) agreed that knowledge about TT was important to them as a practitioner.

Most of the faculty (56.5%) responded that their spiritual or religious beliefs did not influence their attitudes toward TT and the majority (78.3%) thought a combination of biomedicine and another health tradition guided their personal health view. Respondents' comments acknowledged an interest in other views and cultures and a belief that successful results could occur from health

practices other than Western biomedicine. Although faculty attitudes in general were positive towards TT, a good number of them thought that TT was clearly alternative as a therapy (65.2%). Most of the remainder (26.1%) responded that TT was neither mainstream nor alternative. None thought that TT would be harmful.

Table 2. Frequency of Agreement on Attitudinal Statements  
about Therapeutic Touch (N= 23)

<u>Attitudinal Statement</u>	<u>Frequency</u>
Patients could benefit from it	20 (86.9%)
Holds promise for treatment of disease	20 (86.9%)
Should teach theory in curriculum	19 (82.6%)
Integrate into clinical care	18 (73.8%)
Results due to placebo effect	6 (30.3%)
Not tested scientifically	13 (13.0%)
Limited benefits/impact	4 (17.4%)
Nurses should be able to advise patients	23 (95.7%)
Knowledge important as faculty	17 (73.9%)
Knowledge important as practitioner	16 (69.5%)
Should teach practice in curriculum	13 (56.5%)

When asked about using or recommending TT therapy, respondents were allowed to choose more than one option. Faculty most frequently endorsed a preference for patient

reports as a type of evidence about therapeutic touch (n=18) (see Table 3). Other important sources of evidence were published case studies, randomized controlled case studies involving humans, colleague recommendations, personal experience, and proven mechanism of action. The type of evidence least cited by faculty was "epidemiological studies" followed by "randomized controlled clinical trials involving animals" (n=6).

Table 3. Importance of Types of Evidence  
 \_\_\_\_\_in Support of Therapeutic Touch (N= 23)\_\_\_\_\_

<u>Type of Evidence:</u>	<u>Frequency</u>
Patient reports	18 (78.3%)
Published case studies	15 (65.2%)
Randomized trials with humans	14 (60.9%)
Personal experience	13 (56.5%)
Colleague recommendations	13 (56.5%)
Proven mechanism of action	10 (43.5%)
Successful use in practice	9 (39.1%)
Proposed mechanism of action	7 (30.4%)
Nonrandomized clinical trials	6 (26.1%)
Randomized trials with animals	6 (26.1%)
Epidemiological studies	5 (21.8%)

Note: More than one response was allowed.

Knowledge

Questions about knowledge assessed faculty beliefs about TT, whether they had received any training in TT, if they had a desire for training in TT and if so, for what reasons. A relatively high percent (69.5%) of faculty reported they had either no training in TT or an insufficient amount to advise patients. Thirteen of the 23 respondents (56.5%) wanted further training in TT. The main reasons faculty wanted more training were for personal knowledge (n= 12), to be able to teach students about TT (n= 12), for their own professional practice (n= 9), and to be able to advise patients about TT (n= 9). Open responses indicated an interest in further training about the research evidence for TT. Over half (56.5%) of nursing faculty thought TT was an effective therapy and none considered it harmful. Most (n=18) identified patient reports as important evidence in considering use of TT. The other types of evidence they identified were: published case studies (n= 15), randomized controlled clinical trials

involving humans (n= 14), colleague recommendations (n= 13), personal experience (n= 13), proven mechanism of action (n= 10), successful use in their own practice (n= 9), proposed mechanism of action (n= 7), randomized controlled clinical trials involving animals (n= 6), nonrandomized clinical trials (n= 6), and lastly, epidemiological studies (n= 5).

The main sources of information about TT that faculty used were peer professionals, professional journals, and other health care providers. In describing any TT training they had, seven faculty members indicated they had taken formal coursework or training in TT; this training occurred as workshops, formal undergraduate training, continuing education and a one-on-one session with Krieger. Although the preponderance of faculty (n= 17) indicated the importance of having knowledge about TT, two also commented on inhibitions they had for TT touch incorporation into nursing education. These respondents were concerned about diminishing the reputation of nursing and being viewed as non-scientific if TT were incorporated into practice.

Practice

Few faculty (n= 6) had actually used TT in practice (see Table 4). Of those who hadn't used it in practice, most (n= 13)) indicated they would consider doing so. The greater part (n= 14)) of the faculty group had no intention to use TT in their future nursing practice. Of those (n= 7) who had intentions to use TT in practice, the primary reasons they listed were to recommend or provide to family and friends (see Table 5), to recommend to patients, or refer patients or family and friends to a TT practitioner. Two did not indicate a response about their intentions to practice TT.

Table 4. Use of Therapeutic Touch as a Practitioner (N= 21)

<u>Statement:</u>	<u>Frequency</u>
No, would consider using	13 (61.9%)
No, would not consider using	2 (9.5%)
Yes, used with positive results	3 (14.3%)
Yes, used with neutral results	3 (14.3%)
Yes, used with negative results	0 (0%)

Table 5. Intent to Use Therapeutic Touch in Practice (N= 7)

<u>Reason for use:</u>	<u>Frequency</u>
Recommend to family/friends	5 (71.4%)
Provide to family/friends	5 (71.4%)
Refer family/friends to practitioner	5 (71.4%)
Recommend to patients	4 (57.1%)
Refer patients to practitioner	4 (57.1%)
Provide to patients	2 (28.6%)

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In response to questions about teaching TT, nearly two thirds (60.9%) indicated they would consider including TT content in nursing courses they teach. Nearly 22% indicated that they would not consider including any TT content in their student coursework. The other 17.3% stated they already included TT content in courses they taught. None of those who teach TT were including both theory and practice skills in their teachings.

Barriers

Lack of staff training is the most significant barrier to the use of TT in Montana health care settings (see in Table 6). Respondents also identified unavailability of credentialed providers, lack of reimbursement, and lack of evidence for practice as additional barriers to practice of TT. The factors least frequently viewed as barriers to use of TT by faculty were lack of appropriate practice space, time required to provide TT, and institutional concern about legal issues. No other barriers to use of TT were identified.

Table 6. Barriers to Use of Therapeutic Touch (N= 23)

<u>Barriers:</u>	<u>Frequency</u>
Lack of staff training	19 (82.6%)
Unavailability of credentialed provider	17 (73.9%)
Lack of reimbursement	17 (73.9%)
Lack of evidence for practice	16 (69.6%)
Lack of appropriate practice area	13 (56.5%)
Institutional concern about legal issues	11 (47.8%)
Too time consuming	11 (47.8%)

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Note: Not all responded to each statement.

Faculty reported lack of faculty training as the primary barrier to teaching TT in Montana nursing curricula (see Table 7). Another major barrier to teaching TT to students was the lack of an appropriate practice area.

All other items listed were identified as barriers by almost half of those who responded. Although less than half identified time as a barrier to teaching TT, additional comments indicated a concern over having the time to teach full content (both theory and practice skills) and suggested offering TT as a specialty course or seminar.

Table 7. Barriers to Teaching Therapeutic Touch (N= 23)

<u>Barrier:</u>	<u>Frequency</u>
Lack of faculty Training	21 (91.3%)
Lack of appropriate practice area	16 (69.5%)
Lack of evidence	12 (52.1%)
Institutional concern about legal issues	11 (47.8%)
Too time consuming	10 (43.5%)

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Note : Not all responded to each statement.

## CHAPTER 5

## DISCUSSION

Prior to this study, nursing faculty attitudes, knowledge and practice of therapeutic touch were unknown. Nursing faculty at Montana State University-Bozeman were surveyed about their perceptions of TT. In addition, faculty were questioned about the inclusion of any therapeutic touch theory or skills content in the courses they teach. Furthermore, faculty were asked if they desired education and training in TT and if they perceived any barriers to incorporating TT in practice or teaching.

A limited number of studies were available for comparison to the present study. The only study found to address nursing faculty attitudes and knowledge of therapeutic touch included it as one of many complementary therapies (Halcon, Chlan, Kreitzer, & Leonard, 2003). Other studies assessed practicing nurses attitudes and knowledge of complementary therapies (DeKeyser, Cohen, & Wagner, 2001; Hessig, Arcand, & Frost, 2004). One study in Britain

explored views and experiences of TT practitioners but did not delineate nursing faculty in the study (Lewis, 1999). None were found that addressed nursing faculty attitudes and knowledge of therapeutic touch. The purpose of this study was to specifically address the attitudes, knowledge and practices of TT for nursing faculty at the undergraduate level.

More than half (n= 23) of the 44 eligible undergraduate nursing faculty participated in this study. The demographics in this study describe faculty who are teaching nursing students at the undergraduate level at Montana State University. The majority of the faculty consisted of women who were of white/nonhispanic ethnicity. Their mean age was 50.1 years. These women were well-educated with most having a Master's degree in nursing. The majority of nursing faculty worked full time.

The general attitudes of nursing faculty toward therapeutic touch were positive. The majority of participants recognized the contribution that therapeutic touch can offer to the conventional health care system. Similar to the Minnesota faculty respondents (Halcon,

Chlan, Kreitzer, & Leonard, 2003), over half of the faculty thought that therapeutic touch was an effective treatment modality. Responses on attitudes indicated faculty supported TT as a viable modality and thought nurses should know enough about TT to advise their patients about it.

Most faculty (78%) identified patient reports as important evidence in considering use of TT in contrast to the Minnesota respondents who gave priority to clinical trails (80%) as the most important type of evidence. What this implies could be explored further in another study.

Over half of faculty responded that they consider TT as "clearly alternative". Although this corresponds closely to the responses of the Minnesota faculty, it is somewhat surprising because this is one of the therapies emerging from a nursing paradigm.

Current knowledge levels about TT indicate faculty have had insufficient training to practice or be able to advise patients about TT. As in the Minnesota study, faculty agree that knowledge about TT is important to them as faculty members. More specific to the present study, faculty indicated a willingness to learn more about TT primarily

for personal knowledge and to facilitate teaching TT content within the undergraduate nursing curricula. Data corresponded closely to the Minnesota results in strongly indicating a faculty desire to have TT theory taught at the undergraduate level. However, faculty admitted to having limited knowledge and experience that would enable them to teach TT. Practicing nurses also expressed a desire to learn TT for personal knowledge in order to develop the therapeutic aspects of nursing (Lewis, 1999). These results are significant because those in nursing have an ethical responsibility to first become educated in a treatment modality. In turn, those who are educated then guide the field of nursing in incorporating a holistic mind-body-spirit unity into its philosophy, training and practice. Holistic and integrative nursing practice that incorporates therapeutic touch can be a bridge to comprehensive care of patients. The public looks to nurses for competent advice about health care practices and therapies and expects them to be informed about treatment options including complementary alternative practices.

Findings suggested a faculty desire to have TT available within their care network and work with TT practitioners within a system of referrals rather than to use TT in their own practice. From a faculty development perspective, faculty need to communicate with and learn from TT practitioners, to have basic training in TT and gain a perspective on how best to work with or refer to TT practitioners.

As in the Minnesota study, lack of staff training was identified as one of the most frequently named barriers to use of TT in medical settings. None of the other studies specifically inquired about barriers to teaching CAM's or more specifically TT. In the Hessig (2004) study, lack of time was identified as the foremost barrier impeding use of CAM's in nursing practice. Other barriers to use of TT identified most often were lack of reimbursement, unavailability of credentialed providers, and lack of evidence for practice. Nearly half (47.7%) of faculty thought that use of TT was too time consuming.

Barriers to teaching TT were similar to those identified as barriers to practice of TT. None of the other studies addressed barriers to teaching CAM's, let alone to teaching TT. Faculty most often identified lack of faculty training as the foremost barrier to teaching TT in nursing curricula. The other most often identified barriers to teaching TT were lack of appropriate practice area, lack of evidence, and institutional concern about legal issues. About half of faculty responded that teaching TT would be too time-consuming (43.5%).

A strategy to bridge the reported gap in faculty training might be for faculty to partner with a TT practitioner to develop both didactic and practical curricula for their undergraduate students using an evidence-based approach. In turn, faculty who are candid in discussing TT with their students present a nonjudgmental atmosphere so that graduating students will be empowered to explore alternative therapies that would enhance their own future nursing practice.

Given that therapeutic touch is consistent with the nursing traditions of holism and valuing the patient's experience of health and healing, faculty were supportive of undergraduate nursing education providing a solid foundation in theory on therapeutic touch. This same support is evidenced nationally by the recommendations of the AACN to include teaching of TT in baccalaureate nursing education. Informed baccalaureate prepared nurses can better assess patients' use of TT therapy and credibly advise them on potential benefits or contraindications of this modality. Faculty were moderately receptive to teaching the practice skills of therapeutic touch to undergraduates. The preference for including theory in nursing education might suggest that the focus for baccalaureate students ought to be more on the underlying philosophies and beliefs from which TT therapy derives. These evolving nurses need to be knowledgeable of the theory and research background for TT as a treatment modality and of the necessity of including knowledge of patient use of TT in their nursing assessment. In addition,

nursing students nearing graduation need to know how to evaluate the impact of TT treatment on the patient's health status and where to locate the resources available for providing information about TT practices.

### Implications and Recommendations

Identifying faculty attitudes, knowledge and practice of TT could have implications on the future inclusion of TT training in nursing curricula. An improved understanding of faculty desire for more TT education may help in faculty development critical to integrating TT into nursing curricula and practice. Faculty's primary sources of information about TT were from peer professionals and professional journals followed by other health care providers and coursework or formal training. Faculty value input from other professionals and continuing education and in-service opportunities offered by peer professionals are likely to be well received by faculty. Faculty development would be a logical starting point for integrating TT content into the undergraduate nursing program.

A nursing college that allows faculty input about incorporating TT into their educational programs can demonstrate its commitment to an environment that promotes holism and to following recommended standards of practice as suggested by the AACN. Faculty and students can look to The American Holistic Nurses Association for guidance in establishing such a program. The AHNA has developed standards for practice and has guidelines for certification which could serve as resources for schools of nursing. In addition, the AHNA has a core curriculum developed for integrative holistic practice by institutions and practicing nurses.

#### Strengths and Limitations

A strength of this study is the quantitative, descriptive design which allowed for control of response choices. An additional strength is associated with offering a survey through the web-based SNAP program. This program assures absolute anonymity of the respondents. Furthermore, another strength is that faculty from a large nursing school (600 nursing students) were surveyed.

Limitations of this study should be considered in evaluation of the methods and results. The study was limited by a small sample size and a single group which limits the ability to extrapolate to other populations. In addition, the link to the survey was sent in both the original cover letter to faculty and in the reminder letter. This could have resulted in a participant responding more than once. Because of the complete anonymity of the survey, it is not known what courses the respondents teach or what their clinical specialty area might be. It also is not known whether the respondents taught full or part-time or whether they were actually interested in the topic of TT or not.

### Summary

Faculty attitudes toward therapeutic touch indicated an acknowledgement of the contribution that therapeutic touch can offer as an adjunct to conventional medicine. Faculty indicated a desire for further training in TT for personal knowledge and to advise or refer patients. Although they

lacked sufficient training to use TT in their own practice, given the proper training, faculty would consider using it for patients. Faculty had a strong interest in knowing enough about TT to teach nursing students. This interest in knowledge of TT reinforces the historic role of nurses as advisors, mentors and counselors to their patients. That faculty identified lack of training as the primary barrier to both use of TT in practice and to teaching TT has significance in future planning for education of nursing faculty and students.

With increasing consumer demand for complementary therapies such as therapeutic touch, the nursing profession has an obligation to become informed about this modality and incorporate training on TT into nursing education. To better ground students in both holism and traditional biomedicine, it is first necessary for nursing faculty to be knowledgeable. An educational environment that reflects the caring and holistic philosophies inherent to nursing encourages self-care and self-healing by both faculty and students. This paradigm enhances change towards wholism or truly holistic nursing care.

REFERENCES CITED

- American Association of Colleges of Nursing (1998). *The essentials of baccalaureate education for professional practice*. Washington, DC: AACN.
- American Holistic Nurses Association. (2004). *Standards of holistic nursing practice*. Retrieved January 30, 2005, from <http://www.ahna.org/about/standards.html>
- Bosley-Woolf, H., Artin, E., Crawford, F. S., Gilman, E. W., Kay, M. W., & Pease, Jr., R. W. (Eds.), (1977). *Webster's new collegiate dictionary* (8<sup>th</sup> ed.). Springfield, MA: C & G Merriam & Co.
- Burr, H. S. (1973). *The fields of life*. New York: Ballantine.
- Buscaglia, L. F. (1986). *Loving each other: The challenge of human relationships*. New York: Ballantine Books.
- Bush, E. (2001). The use of human touch to improve the well-being of older adults. A holistic nursing intervention. *Journal of Holistic Nursing*, 19(3), 256-70.
- Chlan, L., & Halcon, L. (2003). Developing an integrated baccalaureate nursing education program infusing complementary/alternative therapies into critical care curricula. *Critical Care Nursing Clinics of North America*, 15(3), 373-9.
- Cox, C. L., & Hayes, J. A. (1997). Reducing anxiety: the employment of therapeutic touch as a nursing intervention. *Complementary Therapies in Nurse Midwifery*, 3(6), 163-7.
- DeKeyser, F. G., Cohen, B. B., & Wagner, N. (2001). Knowledge levels and attitudes of staff nurses in Israel towards complementary and alternative medicine. *Journal of Advanced Nursing*, 36(1), 41-48.
- Denison, B. (2004). Touch the pain away: New research on therapeutic touch and persons with fibromyalgia syndrome. *Holistic Nursing Practice*, 18(3), 142-51.

- Dunphy, L. H. (2001). Florence Nightingale, caring actualized: A legacy for nursing. In M. Parker (Ed.), *Nursing theories and nursing practice* (pp. 32-50). Philadelphia: F.A. Davis.
- Dutta, A. P., Bwayo, S., Xue, Z., Akiyode, O., Ayuk-Egbe, P., Bernard, D., Daftary, M.N., & Clarke-Tasker, V. (2003). Complementary and alternative medicine instruction in nursing curricula. *Journal of National Black Nurses Association, 14*(2), 30-3.
- Eisenberg, D. M., Davis, R. B., Ettner, S. L., Appel, S., Wilkey, S., Von Rompoy, M., & Kessler, R. C. (1993). Unconventional medicine in the United States: Prevalence, costs and patterns of use. *New England Journal of Medicine, 328*(4), 246-252.
- Fenton, M. V., & Morris, D. L. (2003). The integration of holistic nursing practices and complementary and alternative modalities into curricula of schools of nursing. *Alternative Therapies in Health Medicine, 9*(4), 62-7.
- Gaydos, H. L. (2001). Complementary and alternative therapies in nursing education: Trends and issues. *Online Journal of Issues in Nursing, 6*(2). Retrieved December 7, 2004, from Nursing World Web Site: [http://www.nursingworld.org/ojin/topic15\\_5.htm](http://www.nursingworld.org/ojin/topic15_5.htm)
- Giasson, M., & Bouchard, L. (1998). Effect of therapeutic touch on the well-being of persons with terminal cancer. *Journal of Holistic Nursing, 16*(3), 383-98.
- Glickman, R., & Gracely, E.J. (1998). Therapeutic touch: investigation of a practitioner. *The Scientific Review of Alternative Medicine, 2*(1), 43-7.
- Hagemaster, J. (2000). Use of therapeutic touch in treatment of drug addictions. *Holistic Nursing Practice, 14*(3), 14-20.

- Halcon, L. L., Chlan, L. L., & Kreitzer, M. J., Leonard, B. J. (2003). Complementary therapies and healing practices: Faculty/student beliefs and attitudes and the implications for nursing practice. *Journal of Professional Nursing, 19*(6), 387-97.
- Halcon, L., Leonard, B., Snyder, M., Garwick, A., & Kreitzer, M. (2001). Incorporating alternative and complementary health practices with university-based nursing education. *Complementary Health Practice Review, 6*(2), 127-133.
- Hallett, A. (2004). Narratives of therapeutic touch. *Nursing Standard, 19*(1), 33-37.
- Heidt, P. R. (1990). Openness: A qualitative analysis of nurses' and patients' experiences of therapeutic touch. *Image: the Journal of Nursing Scholarship, 22*(3), 180-6.
- Hessig, R. E., Arcand, L. L., & Frost, M. H. (2004). The effects of an educational intervention on oncology nurses' attitude, perceived knowledge, and self-reported application of complementary therapies. *Oncology Nurses Forum, 31*(1), 71-78.
- Johnson, M. B. (1990). The holistic paradigm in nursing: The diffusion of an innovation. *Research in Nursing and Health, 13*, 129-139.
- Keegan, L. (1989). Holistic nursing. *Journal of Post Anesthesia Nursing, 4*(1), 17-21.
- Kiernan, J. (2002). The experience of touch in the lives of five postpartum women. *The American Journal of Maternal/Child Nursing, 27*(1), 47-53.
- Kreitzer, M. (2003). *Center for spirituality and healing*. Retrieved May 3, 2004, from <http://www.csh.umn.edu>

- Kreitzer, M. J. (2002). *CAM curriculum evaluation plan*. Retrieved August 26, 2004, from Center for Spirituality and Health, University of Minnesota Web Site:  
<http://www.csh.umn.edu/csh/about/camgrant/evaluation/home.html>
- Krieger, D. (1972). The response of in-vivo human hemoglobin to an active healing therapy by direct laying-on of hands. *Human Dimensions*, 1, 12-15.
- Krieger, D. (1973, March). *The relationship of touch, with intent to help or heal, to subject's in-vivo hemoglobin values: A study in personalized interaction*. Paper presented at the meeting of the American Nurses Association Ninth Nursing Research Conference. San Antonio, TX.
- Krieger, D. (1979). *The therapeutic touch: How to use your hands to help or heal*. Englewood Cliffs, NJ: Prentice Hall, Inc.
- Krieger, D. (1997:162). *Therapeutic touch inner workbook*. Sante Fe, NM: Bear.
- Krieger, D. (2002). *Therapeutic touch as transpersonal healing*. New York: Lantern Books.
- Lafreniere, K. D., Bulent, M., Cameron, S., Tannous, M., Giannotti, M., Abu-Zahra, H., & Laukkanen, E. (1999). Effects of therapeutic touch on biochemical and mood indicators in women. *The Journal of Alternative and Complementary Medicine*, 5(4), 367-370.
- Larden, C. N., Palmer, M. L., & Janssen, P. (2004). Efficacy of therapeutic touch in treating pregnant inpatients who have a chemical dependency. *Journal of Holistic Nursing*, 22(4), 320-33.
- Leadbeater, C. W. (1940). *The Chakras*. Wheaton, IL: Theosophical Publishing House.

- Lewis, D. (1999). A survey of therapeutic touch practitioners. *Nursing Standard*, 13(30), 33-37.
- M. Kreitzer. (2003). *Center for spirituality and healing*.
- Mackey, R. B. (1995). Discover the healing power of therapeutic touch. *American Journal of Nursing*, 4, 27-33.
- Malinski, V. M. (2001). Martha E. Rogers, Science of unitary human beings. In M. E. Parker (Ed.), *Nursing theories and nursing practice* (1<sup>st</sup> ed., pp. 194-203). Philadelphia: F.A. Davis Company.
- Meninger Foundation. (1979). *The therapeutic touch: Healing in a new age* [Motion picture]. (Available from Cat Rock Road, Cos Cob, CT 06807)
- Moylan, L. B. (2000). Alternative treatment modalities: The need for a rational response by the nursing profession. *Nursing Outlook*, 48, 259-61.
- Newman, M. A. (1989). The spirit of nursing. *Holistic Nursing Practice*, 3(3), 1-6.
- Newshan, G., & Shuller-Civitella, D. (2003). Large clinical study shows value of therapeutic touch program. *Holistic Nursing Practice*, 17(4), 189-192.
- Nurse Healers-Professional Associates International. (2004). *Therapeutic touch policy and procedure for health care professionals*. Retrieved January 27, 2004, from <http://therapeutictouch.org/content/policyprocedure>
- O'Mathuna, D. P. (1998). Therapeutic touch: what could be the harm? *The Scientific Review of Alternative Medicine*, 2(1), 56-62.
- Peck, S. D. (1996). The effect of therapeutic touch for decreasing pain and improving functional ability in elders. *Nursing*. Minneapolis: University of Minnesota.

- Peper, E., & Ancoli, S. (1977, March). *The two endpoints of an EEG continuum of meditation*. Paper presented at the meeting of the Biofeedback Society of American Conference. Orlando, FL.
- Peters, R. M. (1999). The effectiveness of therapeutic touch: A meta-analytic review. *Nursing Science Quarterly*, 12(1), 52-61.
- Pharris, M. D. (2001). Margaret A. Newman-Health as expanding consciousness. In M. A. Parker (Ed.), *Nursing Theories and Nursing Practice* (pp. 264-74). Philadelphia: F. A. Davis.
- Post-White, J., Kinney, M. E., Savik, K., Gau, J. B., Wilcox, C., & Lerner, I. (2003). Therapeutic massage and healing touch improve symptoms of cancer. *Integrative Cancer Therapies*, 2(4), 332-344.
- Quinn, J. F. (1984). Therapeutic touch as energy exchange: Testing the theory. *Advances in Nursing Science*, 6(2)
- Quinn, J. F. (1994). *Therapeutic Touch: Healing Through Human Energy Fields [video tapes and study guide]*. New York: National League for Nursing.
- Quinn, J. F., & Streklaskas, A. J. (1993). Psycho-immunologic effects of therapeutic touch on practitioners and recently bereaved participants: A pilot study. *Advances in Nursing Science*, 15(4), 13-26.
- Reed, F. C., Pettigrew, A. C., & King, M. O. (2000). Alternative and complementary therapies in nursing curricula. *Journal of Nursing Education*, 39(3), 133-9. Retrieved May 3, 2004, from <http://www.umn.edu>
- Richardson, S. F. (2003). Complementary health and healing in nursing education. *Journal of Holistic Nursing*, 21(1), 20-35.
- Rogers, M. E. (1970). *An introduction to the theoretical basis of nursing*. Philadelphia, PA: F.A. Davis.

- Rogers, M. E. (1990). Nursing: Science of unitary, irreducible human beings: Update 1990. In E.A. Barrett (Ed.), *Visions of Rogers science-based nursing*. New York: National League for Nursing Press.
- Rorvik, D. M. (1974). The healing hands of Mr. E. *Esquire*, 81(2), 70-71.
- Smyth, D. (1996). Healing through nursing, The lived experience of therapeutic touch: Part two. *The Australian Journal of Holistic Nursing*, 3(1), 18-24.
- Sparber, A. (2001). State boards of nursing and scope of practice of registered nurses performing complementary therapies. *Online Journal of Issues in Nursing*, 6(3), 10. Retrieved December 7, 2004, from [http://www.nursingworld.org/ojin/topic15/tpc15\\_6.htm](http://www.nursingworld.org/ojin/topic15/tpc15_6.htm)
- Standards for accreditation of baccalaureate and graduate nursing programs*. (October 2003). Retrieved March 19, 2005, from [http://www.aacn.nche.edu/Accreditation/NEW\\_STANDARDS.htm](http://www.aacn.nche.edu/Accreditation/NEW_STANDARDS.htm)
- Straneva, J. A. (2000). Therapeutic touch coming of age. *Holistic Nursing Practice*, 14(3), 1-13.
- Syswerda, J. E. (1989). Mark and Luke. In J. Syswerda (Ed.), *The adventure Bible: New international version* (4<sup>th</sup> ed., p. 1215 & 1273). Grand Rapids, MI: Zondervan Publishing House.
- Taylor, B. (2001). The effects of healing touch on the coping ability, self esteem and general health of undergraduate nursing students. *Complementary Therapies in Nursing and Midwifery*, 7, 34-42.
- Watson, J. (2001). Jean Watson-Theory of Human Caring. In M. E. Parker (Ed.), *Nursing theories and nursing practice* (pp. 344-51). Philadelphia: F. A. Davis.
- Wirth, D. P. (1990). The effect of non-contact therapeutic touch on the healing rate of full thickness dermal wounds. *Subtle Energy*, 1(1), 1-20.

Woods, D. L., & Dimond, M. (2002). Therapeutic touch eases agitation in people with Alzheimer's. *Biological Research for Nursing*, 4(2), 104-14.

APPENDICES

APPENDIX A

SURVEY QUESTIONNAIRE

## **Survey of Attitudes, Knowledge and Practice of Therapeutic Touch**

Adapted from "Survey of Knowledge and Attitudes of Health Profession Faculty" by Kreitzer, Halcon, Chlan, and Leonard. (Permission was granted to modify this questionnaire by M.J. Kreitzer, PhD, University of Minnesota)

### **DEFINITION OF THERAPEUTIC TOUCH**

*Please use this definition as you answer the next  
16 questions.*

*The nursing intervention of therapeutic touch (TT) is a conscious attempt to redirect the client's energy field. This redirection mobilizes the energy so that it can flow symmetrically and promote self-healing. The hands of the nurse may or may not actually be placed on the client's body.*

1=Very strongly agree    2=Strongly agree    3=Agree  
4=Disagree    5=Strongly disagree    6=Very strongly disagree

1. Indicate how closely each statement represents your general feelings about therapeutic touch.
  - \_\_\_ a. Clinical nursing care should integrate the use of TT.
  - \_\_\_ b. Patients receiving conventional medical therapies could benefit from TT.
  - \_\_\_ c. TT holds promise for treatment of symptoms, conditions and/or diseases.
  - \_\_\_ d. The results of TT are in most cases due to a placebo effect.
  - \_\_\_ e. TT is not tested in a scientific manner and should be discouraged.

- f. TT has limited health benefits and no true impact on treatment of symptoms, conditions and/or diseases.
  - g. TT is a threat to public health.
  - h. Instruction in the **theory** of TT should be incorporated into undergraduate nursing curriculum.
  - i. Instruction in the **practice** of TT should be incorporated into undergraduate nursing curriculum.
  - j. Nurses should be able to advise their patients about TT .
  - k. Knowledge about TT is important to me as a faculty member.
  - l. Knowledge about TT is important to me as a practitioner.
2. Which of the following do you consider barriers to use of TT practice in Montana health care settings?
- a. Lack of evidence for practice
  - b. Institutional concern about legal issues
  - c. Unavailability of credentialed providers
  - d. Lack of staff training
  - e. Lack of reimbursement
  - f. Lack of appropriate practice area
  - g. Too time consuming
  - h. Other \_\_\_\_\_

3. Which of the following do you consider barriers to teaching TT practice in Montana nursing curricula?

- a. Lack of evidence
- b. Institutional concern about legal issues
- c. Lack of faculty training
- d. Lack of appropriate practice area
- e. Too time consuming
- f. Other \_\_\_\_\_

4. What primary worldview or framework guides your personal health views? Mark one.

- a. Western biomedicine
- b. Another health tradition, please specify
- c. Combination of biomedicine and another health tradition

5. Historically, some "alternative" approaches reach a point where they are considered "orthodox" or mainstream. Which answer best explains how you think of TT? Mark one.

- a. Clearly mainstream
- b. Neither mainstream nor alternative
- c. Clearly alternative
- d. No opinion

6. Which best describes your view about the effectiveness of TT? Mark one.
- a. Highly effective
  - b. Moderately effective
  - c. Rarely effective
  - d. Not effective
  - e. Harmful
  - f. Don't know
7. How much training about TT have you received?
- a. None
  - b. Insufficient to advise patients
  - c. Sufficient to advise patients
  - d. Sufficient to practice with patients
8. Would you like further training about TT?
- a. No
  - b. Yes
9. For what purpose(s) would you like further training about TT? Mark all that apply.
- 1. Personal knowledge
  - 2. Advise patients
  - 3. Professional practice with patients

4. Teach nursing students

5. Other \_\_\_\_\_

10. Have you used TT as a practitioner? Mark one.

a. No, would **not** consider using it

b. No, but would consider using it

c. Yes, have used it with positive outcome

d. Yes, have used it with neutral outcome

e. Yes, have used it with negative outcome

11. Do you intend to use TT in your nursing practice in the future?

a. No

b. Yes

12. How do you intend to use TT in your nursing practice in the future? Mark all that apply.

1. Would recommend to family and friends

2. Would recommend to patients

3. Would provide to family and friends

4. Would provide to patients

5. Would refer family and friends to a TT practitioner

6. Would refer patients to a TT practitioner

7. Other, please specify \_\_\_\_\_

13. Do you include TT content in any of the nursing courses you teach? Mark one.

- a. No, would **not** consider including it
- b. No, but would consider including it
- c. Yes, have included content on the theory of TT
- d. Yes, have included content on the actual practice skills of TT
- e. Yes, have included content on both the theory and the practice skills of TT

14. What are your sources of information about TT? Mark all that apply.

- a. Peer professionals
- b. Other health care providers
- c. Professional journals
- d. Mass media, i.e. TV, radio, newspapers, magazines
- e. World Wide Web
- f. Professional list-serve
- g. Coursework or formal training
- h. Apprenticeship with TT practitioner
- i. Other, please specify \_\_\_\_\_

15. How important is each of the following types of evidence as you consider recommending or using therapeutic touch? Mark all that apply.

- a. Proven mechanism of action
- b. Proposed mechanism of action
- c. Nonrandomized clinical trials
- d. Randomized controlled clinical trials involving animals
- e. Randomized controlled clinical trials involving humans
- f. Epidemiological studies
- g. Published case studies
- h. Successful use in my own practice
- i. Colleague recommendations
- j. Personal experience
- k. Patient reports

16. Do you believe your spiritual and/or religious beliefs influence your attitudes toward TT? Mark one.

- a. Yes, very much
- b. Yes, somewhat
- c. No
- d. No opinion

17. Please describe any TT training you have had.

18. Any other comments you have on TT practice or education would be welcome.

DEMOGRAPHICS: Please mark an X for the best response.

19. What is your gender?     Male     Female

20. What is your current age in years?

20-29     30-39     40-49

50-59     60-69     >69

21. What is your employment status?

Full-time     Part-time

22. How many years have you been teaching nursing?

0-5     6-10     11-15     16-20

21-25     26-30     >30

23. What is your highest education level?

Bachelor's     Master's     Doctorate

24. Do you work in direct patient care other than supervising students?

a. No

b. Yes

25. If you answered yes to question 24, where is your major area of work when providing direct patient care?
- a. Acute Care Hospital
  - b. Outpatient Services
  - c. Long Term Care
  - d. Home Care
  - e. Federal/State/County Health Service
  - f. Indian Health Services
  - g. Private Practice
  - h. Other, please specify \_\_\_\_\_
26. How many years have you been in nursing practice?
- 0-5     6-10     11-15  
 16-20     21-25     26-30     >30
27. What is your Ethnic/Racial background?
- a. Asian/Pacific Islander
  - b. American Indian/Alaskan Native
  - c. Hispanic
  - d. Black/African American
  - e. White/Non Hispanic
  - f. Multi Racial
  - g. Other
-

APPENDIX B

PERMISSION TO MODIFY QUESTIONNAIRE

Web Mail Printable Message

From: Mary Jo Kreitzer [kreit003@umn.edu](mailto:kreit003@umn.edu)  
To: [alalyn3@msn.com](mailto:alalyn3@msn.com)  
CC: [halco001@tc.umn.edu](mailto:halco001@tc.umn.edu)  
Subject: Fwd: Re: C/AT study, Faculty and student beliefs  
Date: May 3, 2004 7:23 PM

Lynn, Linda forwarded your message to me. I am the PI of the NIH grant under which this study was conducted. There are two questionnaires-one for students and one for faculty. They can be accessed at the CSpH website [www.csh.umn.edu](http://www.csh.umn.edu). Look under NIH grant and evaluation. You can use or modify them. Just indicate the following statement on the questionnaire and in any publications.

"Permission was granted to use (or modify) this questionnaire by MJ Kreitzer PhD, University of Minnesota."

Best wishes in your study. We'd be interested in receiving any results. MJ

From: Linda Halcon [halco001@umn.edu](mailto:halco001@umn.edu)  
To: [alalyn3@msn.com](mailto:alalyn3@msn.com)

Thank-you for your interest in our study. I am forwarding your message to Mary Jo Kreitzer, Director of the Center for Spirituality and Healing at the University of Minnesota. We have developed a protocol for using the questionnaire and the Center can guide you in that process.

All the best, Linda

APPENDIX C

HUMAN SUBJECTS LETTER



## INSTITUTIONAL REVIEW BOARD

For the Protection of Human Subjects

960 Technology Blvd. Room 127  
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 406-994-5721  
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 Stephen Guggenheim  
 406-994-4411  
 stepheng@montana.edu

### MEMORANDUM

TO: Lynn Hughes

FROM: Mark Quinn, Ph.D. Chair *Mark Quinn Ch'*  
 Institutional Review Board for the Protection of Human Subjects

DATE: March 10, 2005

SUBJECT: *Nursing Faculty Knowledge, Attitudes and Practice of Therapeutic Touch*

The above research, described in your submission of March 9, 2005 is exempt from the requirement of review by the Institutional Review Board in accordance with the Code of Federal Regulations, Part 46, section 101. The specific paragraph which applies to your research is

- (b)(1) Research conducted in established or commonly accepted educational settings, involving normal educational practices.
- (b)(2) Research involving the use of educational tests, survey procedures, interview procedures or observation of public behavior.
- (b)(4) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these specimens are publicly available, or if the information is recorded by the investigator in such a manner that the subjects cannot be identified.
- Other

Although review by the Institutional Review Board is not required for the above research, the Committee will be glad to review it. If you wish a review and committee approval, please submit 3 copies of the usual application form and it will be processed by expedited review.

APPENDIX D

COVER LETTER FOR QUESTIONNAIRES

March 2005

Dear Nursing Faculty,

I am seeking your voluntary participation in a confidential survey about therapeutic touch as part of my Master's degree requirements. The purpose is to assess faculty knowledge, attitudes and practice. I am asking you to complete one 10 minute questionnaire. To complete this survey, please click on this link:

[http://www.montana.edu/conors/Surveys/TherapeuticTouch/therapeutic\\_touch.htm](http://www.montana.edu/conors/Surveys/TherapeuticTouch/therapeutic_touch.htm)

Please complete the questionnaire by Monday, March 28, 2005. Your responses are not individually identifiable. The information will only be reported in group format. Completion of the survey is interpreted as informed consent.

I acknowledge your time and recognize the value of your contribution to this study. Participation is of no direct benefit to you other than the personal satisfaction you may gain in assisting with nursing research. There are no anticipated risks to you in participating in this study.

If you have any questions or concerns related to this survey, please contact me at [ljhughes@mymail.msu.montana.edu](mailto:ljhughes@mymail.msu.montana.edu) or my committee chair, Dr. Rita Cheek, Missoula Campus, at [rcheek@montana.edu](mailto:rcheek@montana.edu) . If you have additional questions, specifically about the rights of human subjects, please contact the Chairman of the Montana State University Institutional Review Board, Mark Quinn, at (406) 994-5721.

Thank you for your participation and support,

Lynn Hughes, RN, BSN, FNP student

PO Box 1484

Missoula, MT 59806