

**Nurse Healers Professional Associates International  
Learning Module  
Therapeutic Touch in Elder Care  
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**Nurse Healers-Professional Associates International**  
**Educational Module**  
**Therapeutic Touch in Geriatric Care**  
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## **1. Introduction**

The National Center for Complementary and Alternative Medicine (NCCAM) is part of the National Institute of Health (NIH) in Bethesda, Maryland. NCCAM provides grants to fund Complementary and Alternative Medicine (CAM) research. Funding has been provided for research in Therapeutic Touch, relaxation techniques, imagery, music therapy, other CAM modalities (Denison, 2001) and other CAM modalities.

Among all of the CAM therapies, there are more Therapeutic Touch (TT) studies than for other therapies. Several studies reported the effectiveness of TT with individuals experiencing chronic pain, stress, anxiety, and depression. Elderly are not excluded from experiencing similar symptoms and could therefore benefit from TT. However, not many have reported the study of TT in elder care. The purpose of this educational module on Therapeutic Touch in Elder Care is to present an overview of Therapeutic Touch and to introduce the learner to ways that Therapeutic Touch could be used in the care of the geriatric population.

## **2. History of Therapeutic Touch**

**i) Objective:** Identify the founders of the Therapeutic Touch process.

**ii) Content:**

Therapeutic Touch (TT) is a contemporary healing process that was developed by Dora Kunz and Dr. Dolores Krieger Ph. D. in the early 1960's. This healing practice is supported by the assumption that the ability to enhance healing in another is a natural potential that can be actualized.

Shortly after receiving her Ph.D. in nursing in the late 1960's Dr. Krieger was involved in post-doctoral research on the therapeutic use of the hands. At this time Dr. Krieger met Dora Kunz, an intuitive healer with the unique ability to perceive subtle energies around living beings. Dr. Krieger and Dora worked closely with medical doctors and scientists as Dr. Krieger studied healers and the processes involved in the healing act. A renowned healer named Oskar Estabany was one of the healers studied. Mr. Estabany thought that people had to be born with a gift in order to heal and that healing could not be taught; Dora Kunz and Dr. Krieger thought differently. In the early 1970's, Dora Kunz and Dr. Dolores Krieger wove the concepts of universal healing and nursing theory, related to 'man as an open system', into a healing process they called Therapeutic Touch (TT).

TT was introduced to the nursing profession in 1975 (Meehan, 1998). According to Krieger (1993), practicing TT is an extension of an individual's professional skills as a nurse and is a process performed within professional organization guidelines (NH-PAI). Within a nursing theoretical framework developed by Rogers (1970, 1990), the purpose of nursing practice is to strengthen all aspects of the client as a unitary energy field process in order to maximize healing and well being. Meehan (1998) suggested that nurses view biomedical physical-sensory frameworks from a different perspective, particularly

in chronic situations. This differing perspective could lead to more creative and effective approaches to care of the elderly.

Years of research and experiential learning took place at Pumpkin Hollow Farm in New York state. Pumpkin Hollow Farm is considered the birthplace of TT for it is there that graduate nursing students, doctoral candidates, physicians and psychologists attended annual workshops to learn, explore and integrate the universal principles of pattern and organization that were nurtured by attitudes of compassion, intentionality and altruism. Dora Kunz and Dr. Dolores Krieger modeled these 'healing attitudes' as they worked with patients who were referred to them. Camp Indralaya, on Orcas Island in Washington state, is another camp where Dora and Dolores taught a variety of health care professionals who were interested in learning about the TT process of healing.

From 1972 to the present day, TT continues to be part of numerous college and university nursing programs. TT is also taught in a wide variety of community settings. TT is practiced in hospitals and health care centers through the United States and internationally. The practice of TT continues to grow as health care practitioners and lay people alike, learn the process of TT so they can support healing in their patients, clients, families, and friends.

### **3. Therapeutic Touch:**

#### **A. Therapeutic Touch Process**

##### **i) Objectives:**

- a)** Describe the four phases of the Therapeutic Touch process.
- b)** Participate in a centering exercise.

##### **ii) Content:**

Therapeutic Touch (TT) is a gentle, compassionate self-healing process that includes the following aspects: centering, assessment, intervention and evaluation. The TT process corresponds with the nursing process of assessment, intervention, and evaluation, albeit the work of TT is primarily with the dynamic human energy field. The TT process identifies patterns of energetic imbalance, assists in reestablishing a sense of wholeness and flow in the human energetic field, and evaluates the responses, in the moment, to the interventions that facilitate restoring the inherent wholeness, rhythm, and balance of this energy field. While the aspects of the TT process are taught individually and sequentially, TT is a dynamic process that occurs simultaneously by experienced TT practitioners.

**a) Centering** is bringing one's body, mind, and emotions to a quiet, focused state of consciousness (NH-PAI). Practitioners find this sense of inner peace and strength by utilizing their own belief system with an approach that is unique to them, connecting with their inner core of wholeness and stillness. Depending on which sense an individual is more sensitive to, or aware of, that sense will help determine the optimal approach used to find one's centered state of

consciousness. A more kinesthetic person may find the flow of the breath a natural way to feel this sense of equilibrium within oneself. A more visual person may find imagery of a place in nature or visualization of a specific symbol as a useful point of reference. A person who identifies more strongly with the auditory sense may hear a tone or sound that creates the sense of peace and feel centered. Meditation is also an approach used to become centered allowing one to connect with an intuitive sense of the Inner Self. Whatever approach to becoming centered is used, centering is a critical element in the TT process. Centering is a parallel process during the TT session and the practitioner learns to maintain this centered state throughout the entire TT process. Centering ensures that the practitioner is free of energetic congestion from the TT recipient and centering also frees the practitioner of expectations of the outcome of the TT session, an outcome which is the client's responsibility. In the TT process, the TT practitioner is an instrument for healing energy and utilizes that energy for the benefit of the TT recipient. The practitioner connects with the qualities associated with compassion in order to be most effective during the TT process. The qualities of compassion involve non-attachment, non-judgment, openness, and caring.

NH-PAI does not dictate how an individual centers for the TT process; however, you might find it beneficial to experience this centering activity that is adapted from Dora Kunz. While sitting in a comfortable position, take several minutes with each segment of the activity to fully experience what is suggested.

**iii) Activities [\\*\\*link here](#)**

**b) Assessment** is using the hands to ascertain the subtle qualities of the dynamic human energy field. The hands are held two to six inches away from the recipient's physical body while moving the hands from the head to the feet and midline to periphery in a rhythmical and symmetrical manner. The spine is a useful reference point to compare the right and left sides of the field. A healthy field may have a gentle warmth and evenness of rhythm; typically these qualities will be felt throughout the entire field. The assessment aspect of the TT process is used to identify differences in the symmetrical nature of the human energy field that will help guide the intervention phase. Examples of sensations that a practitioner may detect indicating a need for intervention include heat, static, coolness, lack of rhythm or flow, pulling or drawing, pressure and/or tingling.

The assessment phase is another aspect of the TT process that is subject to the individuality of the practitioner in the way that the differences or "cues" in the field are identified and perceived. The cues come through the practitioner's energy field and need to be interpreted. These sensory cues may be intuitive, as well as cognitive, and vary for each practitioner. Discipline is necessary to learn how to interpret these cues, to determine the difference between what a normal healthy field feels like versus loose or tight congestion, local imbalances or deficits of a field where there are challenges.

**c) Intervention** is facilitating the symmetrical and rhythmical flow of energy through the field by unruffling, directing, and modulating the energy as based on the practitioner's assessment, thereby assisting the reestablishment of balance and flow inherent in the human energy field (NH-PAI). The three components of intervention may occur sequentially, simultaneously, or in a varied order throughout the entire TT process because intervention is based on frequent reassessment of the human energy field. This reassessment allows the practitioner to respond, in the moment, to the cues obtained from the energy field. The intentionality of the practitioner determines which component of the process she/he is engaged in, the hand movements of the practitioner accompany the practitioner's intention.

**c- i) *Unruffling***, often referred to as clearing, helps to facilitate the symmetrical and rhythmical flow of energy through the field. *Unruffling* can be accomplished by the practitioner's use of intention to mobilize non-flowing energy or re-pattern energy congestion. *Unruffling* allows access to underlying imbalances in the field yet to be revealed (NH-PAI). The human energy field, as perceived during the TT process, presents its cues or imbalances in phases so that these cues appear to exist in multiple layers.

**c- ii) *Directing*** is the knowledgeable transfer of energy through the practitioner, who is the instrument, to the recipient with the intent to fill in areas of energy deficit. This *directing* helps restore balance within the recipient's field. Directing

energy to areas of tight congestion may also help loosen such patterned energy so that the energy can be mobilized. Following the law of opposites, the practitioner will re-pattern areas of imbalance in order to reestablish the inherent rhythm of the field. Energy may be directed into specific areas of the body as based on the practitioner's assessment while maintaining the intentionality of wholeness (NH-PAI). It is important to recognize that it is the inherent order within the universal healing energy field, coupled with the recipient's body wisdom or self-healing capacity, that accomplishes the changes during the TT process. Synchronicity is the key, and, if the timing is right and the person is open and receptive, a change or healing may occur (Kunz, 1991; Macrae, 1987)

**c- iii) *Modulating*** is modifying or adjusting the flow of energy during the TT process. Sensitive populations such as the very ill, elderly, young, or those with psychological disturbances require a light, gentle flow of energy during modulation. When directing or modulating the flow of energy based on the recipient's sensitivity to the interaction, the practitioner does not push, force or constrict the flow, rather the practitioner remains centered and allows the recipient's field to draw the energy through the practitioner. Colors may be used to modulate energy flow; for example, pastel colors may offer a softer more gentle energy versus a more intense color, which may provide energy that may be too strong for some fields to absorb. Imagery or visualization may also be used to modulate energy flow, by focusing one's attention on the end result of the



Now shift your awareness to a place in nature, a place you have been before that is comforting. Allow yourself to be there again with all your senses and feel the oneness and unity with the rhythm of nature. Or you may choose an image or symbol that represents peace for you. Say to yourself, I am that peace.

With an awareness of coming from that peaceful place within your heart space, ask to become an instrument for healing by connecting with the universal healing field in a way that is meaningful for you...connect with that which is greater than yourself that represents peace...and send its light and love to someone you know who is in need or someone whom you love . . . simply by thinking this thought, the energy will follow your thoughts.

Experience fully the feeling of being centered.

## **B. Theoretical Foundations**

### **i) Objective:**

**a)** Discuss the philosophical, theoretical and research foundations of Therapeutic Touch (TT).

**b)** Describe the meaning of at least one principle that underpins the TT process.

## **ii) Content:**

### **a) Philosophy**

#### **a- i) Laying on of Hands**

Therapeutic Touch is described as a “contemporary interpretation of various ancient healing practices” (Krieger, 1993, p.11). Ancient cave drawings dating back 15,000 years depict the therapeutic laying on hands and history is filled with stories of healing by ‘laying on of hands’. A computer search for ‘laying on of hands’ reveals thousands of religious references ([www.google.com](http://www.google.com), [www.dianedew.com/layhands.htm](http://www.dianedew.com/layhands.htm), <http://bibletools.org/index.cfm/fuseaction/Library.show>). Therapeutic Touch is not a religious practice. It does, however, have a spiritual element that is rooted in the Eastern philosophy of life force or ‘Prana’.

#### **a- ii) Prana**

‘Prana’ is a Sanskrit term for the energy flow or life force that vitalizes all living beings (<http://en.wikipedia.org/wiki/Prana>). This universal life force is non-physical and permeates every cell of living organisms. In some cultures, it is referred to as ‘Chi’ or ‘Ki’ as in the martial art forms of ‘T’ai-Chi’ or ‘Ai-Ki-Do’. This philosophy underlies the practice of medicine in Eastern cultures. Krieger and Kunz found this philosophy supported TT as an interaction of energy fields. A person with healthy vibrant ‘Prana’ can, with intention, transfer vitalizing energy and affect the energy flow of a person whose flow is depleted or imbalanced.

Life energy or Prana is concentrated in centers called chakra’s ([www.healer.ch/Chakras-e.html](http://www.healer.ch/Chakras-e.html)). The chakras are cores of high concentrations of

energy through which all other energies are synchronized in the body.

Description and discussion of chakra anatomy is found in Hindu and Buddhist literature. Dora Kunz has written extensively about chakras (see references). It is accepted that there are seven major chakras. They are constantly changing in the process of transmitting and transforming energy from one field to another (Brennan, 1987; Krieger, 1979, 1993; Kunz, 1989, 1991). Krieger (1993) refers to the chakras as centers of consciousness.

In addition to philosophical foundations that support the practice of Therapeutic Touch, there are also theoretical foundations.

### **b) Theory**

#### **b - i) Martha Rogers Theory of the Science of Unitary Human Beings**

(<http://www.nyu.edu/nursing/center/martharogerscenter.html>.,

<http://www.medweb.uwcn.ac.uk/martha/>,

<http://www.washburn.edu/sonu/rogers/htl>)

Martha Rogers was a Professor and Dean of the doctoral nursing program at New York University (NYU) at the time when Dr. Dolores Krieger, a nursing professor at NYU, with Dora Kunz a natural healer, began the development of TT. In 1970 Dr. Martha Rogers published her theory on the Science of Unitary Human Beings (Rogers, 1970). Her theory was derived from advances in quantum physics and viewed the universe as an open system with which the individual person is in continuous interaction.

The Rogerian theory is based on the assumption that human beings are energy fields and are characterized by wholeness, dynamic motion integrality,

pandimensionality, and an ability to establish patterning. The practitioner of TT seeks to strengthen and balance the human energy field by directing and redirecting patterning of both the person and environmental energy fields with the intent to create wholeness and maximum health. The outcome of the TT process results from the interaction of the energy fields between the practitioner and the client.

**b – ii) Bertalanffy's General Systems Theory**

A biologist and researcher, Bertalanffy looked for a theory to guide research across various disciplines. General systems theory provides the concept of open systems that are in continuous interaction with the environment, are self-regulating, and have the capacity for growth, development and adaptation. Within this theory there are nine levels of system complexity with human beings being at the seventh level and transcendence at the ninth level. These levels are important in the development of the assumptions related to TT. The human system is open, dynamic, adaptive, self-regulating, and can think abstractly and symbolically and thus is able to transcend circumstances.

<http://www.psy.pdx.edu/PsiCafe/KeyTheorists/vonBertalanffy.htm>

**b – iii) Field Theory**

Field theory describes individual living organisms as both physical and as a system of energy fields that are in continuous interaction with the environment. The individual is a concentration of energy within a universal energy field. Individual energy fields interact with one another and are part of a dynamic,

whole and interdependent system. The personal field is vital and is associated with the body or etheric field. In addition, there is an emotional field that can be projected. The mental field encompasses ones thoughts, memories, visual images, concepts and ideas. The intuitional field is the source of healing and is orderly, creative and compassionate.

(Kunz & Peper, 1982). ([http://en.wikipedia.org/wiki/Grand\\_unified\\_field\\_theory](http://en.wikipedia.org/wiki/Grand_unified_field_theory))

### **c) Therapeutic Touch Assumptions**

From consideration of these philosophies and theories, Krieger and Kunz developed a set of assumptions that inform the practice of Therapeutic Touch (TT):

1. Living beings are open, complex, self regulatory systems.
2. There is a symmetrical, balanced pattern to the Human Energy Field (HEF).
3. Human beings have the ability to transcend and transform.
4. Life energy follows intent.
5. There is an intrinsic movement toward order in living organisms.

(<http://www.therapeutic-touch.org>)

## **C. Effectiveness of Therapeutic Touch**

### **i) Objective:**

- a) Identify the most common responses to Therapeutic Touch.

### **ii) Content:**

Each individual will have a unique response with the Therapeutic Touch (TT) process that may vary from one treatment to the next. The most consistent response is the stimulation of the relaxation response which may occur within the first 5 minutes of the TT process; this is one of the ways Therapeutic Touch exhibits its effectiveness. There is research on the relaxation response that shows when the body and mind relax it activates the parasympathetic branch of the autonomic nervous system which leads to decreased heart and respiratory rates and a decrease in blood pressure. The relaxation response is the body's built in mechanism to balance the over active sympathetic system that is repeatedly stimulated in our stressful environments when a person perceives that the environment or one's self is threatened in some manner. The relaxation response has a calming effect on one's emotions and decreases muscle tension. When individuals can achieve this calm state, they are more receptive to the influx of the healing energy during the Therapeutic Touch process. Therefore, there is variability in the effectiveness of an individual Therapeutic Touch process based on several conditions: the type of symptom, emotion, attitude or physical problem that is being addressed; the degree of relaxation recipient's experiences; their attitude of receptiveness to the process and willingness to change patterns of thinking and feeling; and the expertise of the Therapeutic Touch practitioner.

Therapeutic Touch has evolved as part of research-based nursing practice since its creation. A summary of the areas where the use of Therapeutic Touch is

supported with research is included in this learning module. In general this research includes evidence based practice that Therapeutic Touch may decrease pain and anxiety, boost the immune system when it is stressed, promote comfort in the dying process, and calm agitated behavior. (Refer to Section E, Therapeutic Touch Research) **LINK**

#### **D. Safety of Therapeutic Touch**

##### **i) Objectives**

- a) Describe the processes that are in place to ensure that Therapeutic Touch is practiced safely.
- b) Identify specific safety concerns regarding the practice of Therapeutic Touch.

##### **ii) Content**

Therapeutic Touch (TT) is a safe nursing intervention when practiced within the recommended guidelines and scope of practice established by the NH-PAI.

There are established credentialing mechanisms for teachers and practitioners of Therapeutic Touch. The recommendations for a one year mentoring arrangement after completion of a 12 contact hour Basic Therapeutic Touch program, presented by a Qualified Therapeutic Touch Teacher, helps students move from novice to a more experienced practitioner within a supportive environment. (NH-PAI) During such education and mentoring a student learns about a variety of topics which include, but are not limited to, the effects of the phenomenon of energy overload and how to address this if it occurs, the skill of modulation, and deepening the centering experience so that the practitioner allows the energy to

flow freely. The credentialing is addressed in more detail in Section 7 of this module. **LINK**

### **E. Therapeutic Touch Research:**

#### **i) Objectives:**

**a)** Develop an awareness of the diverse Therapeutic Touch research that has been done.

**b)** Identify specific research on elder care.

#### **ii) Content:**

##### **a) Introduction**

Use of complementary and alternative medicine (CAM) by consumers is on the rise. Data from the 2002 National Health Interview Survey show that 36% of adults used some CAM therapy during the previous year (Barnes et al. 2004)

According to the White House Commission, “[a]lthough heterogeneous, the major CAM systems have many common characteristics, including a focus on individualizing treatments, treating the whole person, promoting self-care and self-healing, and recognizing the spiritual nature of each individual” (White House Commission, 2002; Clement et al., 2006). Other research shows two thirds of adults used at least one CAM therapy at some point in their lives (Kessler et al., 2001). One study estimated that consumers spent between \$36 and \$47 billion annually for CAM therapies in 1997, more than the out-of-pocket spending for hospitalizations that year (Barnes et al., 2004)

Some of the first research related to Therapeutic Touch was on the intentional use of energy to heal, this research was done by Dr. Bernard Grad ([http://ultramind.ws/laying\\_on\\_of\\_hands.htm](http://ultramind.ws/laying_on_of_hands.htm); <http://www.aspr.com/dynamics.htm>). At that time Dr. Grad was a Canadian biochemist at McGill University in Montreal. He met Oskar Estebany, a healer, and invited him to do experimental healing with mice in the laboratory (Grad, 1961, Benor, 1990). Mr. Estebany did experimental work with Sister Justa Smith on enzymes and later worked with Dr. Krieger and Dora Kunz. From these initial studies the Krieger Kunz method of Therapeutic Touch was developed.

Dr. Krieger, a meticulous researcher who is dedicated to the healing effects of Therapeutic Touch, published her first research in 1972. This was a clinical trial studying the influence of TT on hemoglobin concentrations (Krieger, 1972). While the research had some challenges, it is considered to be a seminal research study on the effects of TT.

Since the development of Therapeutic Touch by Dolores Krieger and Dora Kunz in the early 1970's an abundance of research, experimental and anecdotal, has been published on Therapeutic Touch. Therapeutic Touch is applicable across the lifespan. Little is known about the use of CAM by elders specifically, Shreffler-Grant, Weiner, Nichols and Ide (2005) have documented considerable use by rural elders in Montana, although figures for broader use are not available.

To provide a foundation for understanding of Therapeutic Touch (TT) research an overview of TT research is provided and then specific research related to elder care is addressed.

### **b) Therapeutic Touch Research – Overview:**

The following is a summary of some of the research that has been completed on Therapeutic Touch.

#### **b- i) Tension Headache**

Keller and Bzdek (1986) studied 60 volunteers ranging in age from 18 to 59 who were diagnosed with tension headaches. The results of this study showed TT reduced the headache pain in a significant number of participants (90%) to a significant degree (70%) and the effect was enhanced over the 4 hours following the intervention. TT is a natural potential which can be developed by anyone (Krieger, 1979). The researchers in this study suggested TT could be taught to a group of people who experienced tension headaches.

#### **b- ii) Multiple Sclerosis**

Payne (1989) reported a case study of a 66 year-old female who came in for rehabilitation due to multiple sclerosis and lower extremity weakness. After a lengthy session of TT the patient reported sleeping well the same night of TT without any hypnotic medication. Another 62 year-old female with below-the-knee amputation also reported being able to tolerate pain better after receiving TT. Payne suggested elderly patients may benefit most from series of brief 10-15 minutes of TT.

### **b- iii) Osteoarthritis**

Gordon et al. (1998) reported the effects of TT on 25 patients with osteoarthritis between the ages of 40 to 80. This study was conducted in a family practice center of a community hospital family practice residency program in Pennsylvania. The patients were randomized to TT, mock TT, or standard care. The total time of study was six weeks. The results showed that TT decreased arthritis pain, and improved function and general health status significantly. These results were demonstrated with both qualitative and quantitative measures. Although a larger number of participants are needed to confirm the effect of TT, the researchers suggested TT may offer a means of symptom control for osteoarthritis without the side-effects caused by current medications.

### **b- iv) Fibromyalgia syndrome**

Denison (2004) studied the effectiveness of six TT treatments for persons with fibromyalgia syndrome. The results of this study supports that participants who received TT had a statistically significant decrease in pain after each TT treatment, as well as significant improvement in quality of life from pre-first to post-sixth treatment.

### **b- v) Post-operative pain**

Meehan (1993) studied 108 post-op patients, age 23 to 79 years, randomly assigned to a three group design: TT (N=36); placebo control or mimic TT (N=36); and, narcotic analgesic (N=36). TT was performed for five minutes. Pain was measured before and one hour after the intervention using a pain

scale. The results of the study suggested TT may tentatively be classed as a mild analgesic and may decrease the need for analgesic medication. However, the same study showed that TT does not significantly decrease post-op pain during the first hour following intervention.

#### **b- vi) TT in Conjunction with Cognitive Behavioral Therapy for Chronic Pain**

Smith et al., (2002) reported in the results of a pilot study, preexperimental design, that using TT in conjunction with Cognitive Behavior Therapy (CBT) may help to improve clinical outcomes, enhance self-efficacy, promote unitary power, and decrease chronic pain and distress in the TT-CBT group as opposed to the control group. The participants' age groups were 31 to 56 years old. However, the body of knowledge in this study suggested that TT may be a useful tool to combine with a traditional program helping the elderly with chronic pain.

#### **b- vii) Burns**

Turner et al., (1997) studied the effect of TT on pain and anxiety in burn patients. Ninety nine participants, age 15 to 68, were patients on the Burn unit at a University Medical Centre in the Southeast United States. Each participant, burned less than 75% of total body surface, received a total of 5 days of TT or sham treatment in the afternoon. While receiving the treatments, the lighting in the room was dimmed and soft relaxing instrumental music was played. Treatment length varied from 5 to 20 minutes depending on the practitioners' subjective judgment. After the treatments, participants were allowed to rest for 5-10 minutes. The participants' blood was drawn, before and after treatments, for

lymphocyte subset and white blood cell analyses. The participants continued to receive-pain medication during the study. The results showed that the TT group reported a significantly greater reduction in pain after five days of therapy. This suggests that the combination of TT and analgesic medication was able to produce a more complete pain relief than analgesic medication alone. The TT group also reported significantly less anxiety after five days of therapy and reflected more satisfaction with the treatment than did the control group.

Lymphocyte subset analyses on blood from 11 participants showed a decreasing total CD8+ lymphocyte concentration for the TT group. This, in general, means there was less inflammation in the 11 burn patients treated with TT.

#### **b- viii) Anxiety**

Heidt (1980) reported the effect of TT on the anxiety of hospitalized patients in a cardiovascular unit of a large medical center in New York City. The 90 volunteer participants were between 21 and 65 years of age. Three groups were assigned: TT, casual touch, and no touch. The participants who received TT experienced a greater reduction in state anxiety and post test anxiety scores than those who received casual touch or no touch.

Gagne and Toye (1994) also reported the effect of TT on the anxiety of a hospitalized psychiatric population. Thirty one patients aged 29 to 69, who lived in a Veterans facility, were randomly assigned to TT, relaxation therapy, and TT placebo. Both TT and relaxation therapy significantly decreased anxiety.

Quinn (1982) tested that TT without physical contact would have the same effect as TT with physical contact. Sixty participants 36 to 81 years old, hospitalized on a cardiovascular unit, were randomly assigned to the experimental group (non-contact TT) and the control group (non-contact). It was hypothesized that participants receiving non-contact TT would have a greater decrease in post-test state anxiety scores than participants receiving the control intervention of non-contact. This hypothesis was supported at  $P = 0.0005$  level of significance.

Quinn and Strelkauskas (1993) reported effects of TT on practitioners and bereaved recipients in a pilot study. There were two couples, aged 47 to 73 years old, and two practitioners aged 46 and 57 years old. There was an average decrease in state anxiety of 29% in the recipients after TT treatment. This average percentage change is larger than the previous studies. The largest average percentage of change obtained by Quinn in 1984 was 17%. In the former studies, TT treatments have been administered for five minutes and the practitioners were instructed to follow protocols exactly. In this study, practitioners were permitted to administer the treatment as they determined and for as long as they determined. Quinn (1993) stated this may have contributed to the larger effect on state anxiety. Quinn, in the same study, also found TT enhances immunologic functioning in both practitioners and recipients.

#### **b- ix) Blood pressure**

Quinn (1989) replicated and extended earlier research by Heidt (1981) which indicated that TT decreased anxiety. The participants in this study were

38 women and 115 men hospitalized in a small hospital in South Carolina. Age range of the participants was 29 to 83 years who were awaiting open heart surgery on the following day. The participants were randomly assigned to TT, mimic TT (MTT), or non-treatment group. Both TT and MTT groups received the intervention for five minutes. The blood pressure and heart rate were measured before and after the assigned procedure complete. There was a significant difference in the diastolic pressure in the TT group.

#### **b- x) Stress-Induced Immunosuppression**

Olson et al., (1997) evaluated the effectiveness of TT in reducing the adverse immunological effects of stress in a sample of highly stressed students. Long term goals were to develop methods by which a variety of stress-reduction techniques could be tested for efficacy. Twenty-two participant's ages 29 to 32 years were recruited from medical and nursing students five to six months prior to their national examination. However, the results showed mean differences for IgM and IgA between treatment groups (TT and control groups). The researchers suggested that further study of TT as an intervention may be useful in reducing the adverse immunologic consequences of anxiety related to stress in healthy adults.

#### **b- xi) Cell Proliferation and bone formation in Vitro**

Gronowicz et al., (NIH grant AR43232) reported that after two weeks of TT on cells plated into culture dishes, there was a significant increase in proliferation of human osteoblast, fibroblasts and tendon cells. Thus, TT demonstrates a tendency to stimulate the growth of normal human cells in vitro. TT also

increased bone matrix protein synthesis and bone mineralization in normal human osteoblast cultures, and decreased differentiation and mineralization in human osteosarcoma-derived cell.

#### **b- xii) Bone Marrow Transplant**

Smith et al., (2003) studied 88 participants admitted to a bone marrow transplant unit in a large teaching hospital in Western United States. The age of the participants was between 18 and 70 years. Participants were randomized to Massage therapy (MT), TT, and friendly visit groups. In this study the participants perceived that MT and TT facilitated their comfort. The MT group perceived additional benefits such as feeling rested, peaceful, and less anxious.

#### **b- xiii) Terminal Cancer**

Giasson and Bouchard (1998) examined the effect of TT on the well being of 20 participants with terminal cancer in palliative care. Participants in the experimental group received three non-contact, 15-20 minute TT treatments each day for three consecutive days. The control group had a rest period of the same duration at the same time of the day and one-hour following a regular prescribed analgesic. The age of participants ranged from 38 to 68 years. The results supported both hypotheses: Persons with terminal cancer undergoing TT have a higher sensation of well being than do those participating in a rest period. In addition, a sensation of well being increased after three TT interventions. Several participants from the experimental group expressed verbally that they felt relaxed, calmer, and more at peace with themselves after receiving TT.

#### **b- xiv) Autonomic Nervous System Response and Subjective Experience of TT**

Reuss (2004) studied 60 participants receiving TT and mimic treatment on the same day with a washout period between treatments. They served as their own control, were randomly assigned to treatment order, and blinded to which treatment they were receiving. Heart rate, respiration rate, skin conductance, skin temperature, and muscle tension were monitored continuously during the treatments. Both TT and mimic TT produced a physiological relaxation response, however, respiratory rate was significantly lower during TT. The researcher postulated that breathing is a link between the physiological response and spiritual experience during TT.

Although some of these studies included elderly individuals, the focus was not specifically on the elderly. However, one could extrapolate the potential use of TT in care of the elderly from these studies. Several studies have focused specifically on TT in elder care. The use of Therapeutic Touch with persons with Alzheimer's disease to determine the effect on anxiety (Simington, 1993), and agitated behavior (Snyder, 1995; Woods & Dimond, 2002; Woods, Rapp & Beck, 2004; Woods, Craven & Whitney, 2005) has been explored.

## **c. Therapeutic Touch Research – Elder Care**

### **c- i) Alzheimer's Disease**

Maletta (1992) suggested that health care professionals carefully evaluate and understand behavior problems in geriatric populations, especially those with dementing illnesses, such as Alzheimer's disease. Many of the behaviors are nonpsychiatric behavioral disorders which nonpharmacological treatments, such as behavioral and environmental treatments, may be beneficial.

Woods, Craven and Whitney (2005) reported the results of using Therapeutic Touch as a non-pharmacological method on residents with behavioral symptoms of dementia. The symptoms consisted of six categories of behaviors: manipulation (restlessness), escape restraints, searching and wandering, tapping and banging, pacing and walking, and vocalization. A randomized, double blind, three-group experimental study using 57 residents in three long term care facilities in a western Canadian Province was conducted. The intervention consisted of TT given twice daily for five to seven minutes for three days. The results indicated a significant difference in overall behavioral symptoms of dementia, manual manipulation and vocalization which are two prevalent behaviors.

Woods and Dimond (2002) studied the efficacy of TT on decreasing the frequency of agitated behavior and salivary and urine cortisol levels in persons with Alzheimer's disease (AD). Ten participants 71 to 84 years old who resided in a special care unit were observed every 20 minutes for 10 hours a day for physical activity, and had samples for salivary and urine cortisol taken daily. TT

was performed five to seven minutes twice a day for three days after four days of baseline. The total course of the study was 21 days. The results of the study showed a significant decrease in overall agitated behavior and in vocalization and pacing during treatment and post treatment. Salivary and urine cortisol was noted to decrease over time. Although the study population is small, the researchers suggest TT has the potential to decrease agitated behaviors and may mitigate cortisol levels in persons with AD.

Snyder et al., (1995) explored the efficacy of hand massage, TT, and presence (control group) for relaxation and decreasing agitation behaviors in people with dementia. Seventeen participants age 66 to 90 were recruited from an Alzheimer Care unit. An experimental crossover design was used with each participant serving as one's own control. The order of administration of the three interventions was alternated. Group 1 received hand massage as the first intervention, Group 2 received TT first, and Group 3 received presence first. All participants were observed five days before receiving 10 days of interventions and followed by observation for five additional days. The hand massage protocol was to massage five minutes on each hand. TT was administered for 10 minutes. Presence was done for five minutes. The behaviors were recorded in three hour increments from 6 AM to 9PM during the 45 days of data collection. The results showed hand massage and TT produced significant changes in pulse rates before and after the interventions. This supported that both interventions increased the level of relaxation in participants, however, no significant difference

in agitation behaviors were found from before, during, or after administration any of the interventions.

**c- ii) TT educational program for senior**

Quinn (1992) started a project teaching two-day TT workshop to senior citizens at Senior Health and Peer Counseling Center in Santo Monica, California. Participants gathered on a monthly basis to practice TT and to support each other practice, and an expert TT practitioner supervised each of these meetings. One year later a follow up workshop was conducted to answer questions, clarify procedures, and assist in developing a plan for the future. The study started with 15 women and three men. Only six women and two men completed the entire program. All of the participants were Caucasian with a mean age of 71 years. The author suggested that guided development of senior TT educational program helped senior citizens express a way of caring for others. This could be healing for them. Most importantly, learning, practicing, and giving TT to others could stimulate physical, mental, and spiritual well being in senior citizens.

**4. Therapeutic Touch in Geriatric Care:**

**i) Objectives:**

- a)** Gain an understanding of the settings in which Therapeutic Touch (TT) is used in geriatric care.
- b)** Identify geriatric clinical challenges for which Therapeutic Touch can be of benefit.
- c)** Describe the principles of Therapeutic Touch as they relate to a geriatric client group.

- d) Describe the research and clinical outcomes of Therapeutic Touch in aged care.
- e) Examine the clinical application of Therapeutic Touch for specific geriatric care issues.
- f) Explore additional benefits of Therapeutic Touch for staff health and organizational culture.
- g) Identify resources for further information on the use of Therapeutic Touch in aged care.

## ii) Content

### a) Therapeutic Touch Settings:

Therapeutic Touch is used in residential care settings, hospice and by health professionals and volunteers in community based care as an adjunct support to assist in maintaining function of elderly people to continue living in their home setting. It is used as a stand alone therapy or in conjunction with the delivery of nursing and medical care, and other therapies such as occupational therapy, physiotherapy, and diversional therapy

### b) Clinical Challenges in Care of Elders that Benefit from Therapeutic Touch:

Therapeutic Touch has an extensive research base. Studies have investigated the benefits of this therapy in a number of care areas. Within elder aged care, Therapeutic Touch is beneficial in:

- **Managing challenging behavior** - vocalizing, wandering, aggressive behavior
- **Social and human needs** – anxiety, depression, loneliness and disconnection from others, and bereavement.

- **Technical and complex care** – pain management, palliative care, wound management, breathlessness, fever, and constipation.
- **Therapy** – improvement of range of movement for performing activities of daily living and participating in leisure activities, to improve quality of sleep, and general relaxation and well being.

Therapeutic Touch is also relevant as a support for an organization's health and safety programs; for example Therapeutic Touch can help to settle agitated persons prior to dressing or showering, thereby minimizing risk of injury to staff from aggressive incidents.

### **c) Principles of Therapeutic Touch in Elder Care:**

A guiding principle in Therapeutic Touch in elder care is the intent to offer energy very gently. The forceful use of energy can overload the elderly very quickly, sometimes resulting in agitated behavior. Therapeutic Touch is best offered for short time periods. Clinical experience (Gregory, 2006) has indicated that the average time of Therapeutic Touch interventions with the aged is five to seven minutes. The length of time varies from client to client. Another key principle is letting go of the outcome. The outcome of the TT process is in the client's domain not the practitioner's domain. Letting go of the outcome is particularly important when working with people who are dying (Gregory, 2006).

## **d) Elder Care Research and Case Study Examples**

### **i) Disruptive Behavior**

In a study on the effect of Therapeutic Touch on disruptive behaviors of people with dementia of the Alzheimer's type, residents exhibited a marked decrease in vocalization and manual manipulation when compared with the control group (Woods, Craven & Whitney, 1996).

Similarly, evidence based case studies by caregivers providing Therapeutic Touch in elder care facilities in Victoria and Tasmania (Gregory, 2004) report settling of people who are calling out or *sundowning* - wandering behavior that begins mid to late afternoon that can last for several hours of into the evening. For example, one case study reports a resident who was objecting to changing into her nightgown and was being abusive to staff was provided Therapeutic Touch. This resident calmed down, accepted assistance, and then settled in her chair. In another case study, a resident was swearing, pulling at clothes and furniture, and disrupting other residents. Therapeutic Touch was given, she subsequently sat quietly and went to sleep.

Case studies (Gregory, 2004) also suggest the benefits of Therapeutic Touch for reducing the effects of *sundowning* because Therapeutic Touch can be administered while client is walking. One example was a resident who was pacing continually around the day room. The caregiver walked beside the resident while providing Therapeutic Touch. The resident's pacing slowly subsided as breathing slowed and facial muscles relaxed. The resident was led to a chair where he rested quietly for half an hour.

In another case study, the organization was on risk alert for a wandering resident who had gotten out on the street several times. Staff members were checking the resident frequently which took a great deal of their time. The resident would also wander from her room at night and enter other people's rooms. Therapeutic Touch was introduced. After the first session of approximately 10 minutes the resident settled on her bed and slept for an hour. TT was continued once daily, and there was only one incident of wandering over a five day period (case studies from Katen Parsell, In Gregory, 2006)

**Other case studies outcomes:**

Resident details	TT time	Outcomes
Wandering, dementia Resident had a fall. Very agitated, upset and crying	5 min.	Started treatment and she calmed down and relaxed immediately.
Dementia Sometimes hitting out but mostly verbal aggression. Restlessness. Wandering 3 – 4 hours during the day	5 min.	Sat her in the chair to do her hygiene and she was very resistive and agitated. After TT resident was yawning and remained still for rest of her hygiene. Put her back to bed and she instantly went to sleep.
Dementia – anxious, crying, angry, wanting to go home. This pattern has been constant after tea time and escalating afterwards.	5 + 5 min.	Wandering ceased. Settled well for sleeping.
RESIDENT 1 – 29/9/01		
Dementia - as above. TT administered immediately after tea due to potential of sundowning beginning at this time.	5 min.	Anxiety was minor. Normal pattern of sundowning did not occur. Normal relaxed conversation. Resident remained settled for the rest of the evening. No wandering, crying or repetitive questions were reported.
RESIDENT 1 – 30/9/01		
Dementia -as above. Resident had become very anxious due to urine	10 min.	1800h Resident washed and changed while verbally calming. TT given in armchair while resident continued to relax.

incontinence, wandering early, refusing to use frame, crying, angry, leaving to go home, pushing writer away.		Moved to bed and continued TT until relaxed and settled. Resident left with classical music playing. Found asleep at 1930h
Swearing, resistant	5 min.	Resident settled down, became quiet, fell asleep. Woke after 1/2 hour, became restless but no longer swearing or resistant.
<b>RESIDENT 6</b>		
Vocal, pacing, agitation		During TT was quiet & started to doze off. Then wanted to get up, began pacing although at a lower pace & volume. Within 10 minutes back to full volume & pace.
<b>RESIDENT 7</b>		
Calling out "nurse", "Nell", "matron" incessantly even though attention & reassurance given (one hour)	10 min.	Drifted off to sleep, relaxed & peaceful appearance.

## ii) Palliative care

Caudell (1996) reports that interventions such as Therapeutic Touch (TT) have been found to reduce pain and relieve side effects associated with chemotherapy. In introducing TT into Allegheny Hospice, Snyder (1997) describes TT as a useful addition to more conventional hospice treatments. This view appears to be shared by Messenger and Roberts, (1994); they found that a person near death often desire inner peace and serenity. However, Messenger and Roberts determined that information about interventions to facilitate serenity was absent from the literature. In their study, TT, pain control, and assisting clients to build trust were the three highest-ranked interventions for both effectiveness and frequency of use for hospice clients.

Evidence of change after TT sessions have been reported to include deepening and slowing of breathing rate, muscle relaxation in the face and

shoulders, reduction in calling out, or expressed reduction of the fear of dying. Where family members have been shown how to give aspects of Therapeutic Touch such as the *Heart Hand Connection* (Fanslow-Brunjes, 1988) to use at the bedside of a loved one, the families have reported increased feelings of connectedness with their loved one, and each other, during the interaction (Gregory, 2004). Further, families have expressed a lessening of the experience of anxiety and sadness regarding imminent loss, being replaced with acceptance and peacefulness (Gregory, 2004).

While health care professionals and family may want to help but feel at a loss, or are unsure about what to do when someone is dying, Therapeutic Touch can provide a meaningful and valid means of providing care to someone who is dying. As family members and caregivers realize they can help a dying person in this exquisitely human interaction, they are able to begin their own separation and letting go. Instead of feeling helpless, staff can feel empowered through the compassionate act of in being able to offer a peaceful support, to enable people to let go of fear and die with dignity.

### **iii) Anxiety:**

Therapeutic Touch is particularly effective in reducing anxiety and stress (Quinn 1984; Olson & Sneed, 1995) including psychological relaxation (Gagne & Toye, 1994). It is also effective in various aspects of care for elderly persons. For example, a double-blind, three group study design (also accounting for placebo effect) amongst the institutionalized elderly has resulted in a significant

reduction of a state of anxiety for the group exposed to Therapeutic Touch, whereas little improvement is shown amongst the two groups who received a regular massage by a nurse (Simington & Laing, 1993).

Case studies from aged care facilities (Gregory, 2004) have also shown the benefit of Therapeutic Touch on anxiety as exemplified by one example of an elder who was anxious to go home and becoming very distressed. After Therapeutic Touch, administered for seven minutes, there was an increased depth of respiration, reduced respiratory rate, blood vessel dilation (pinking of the cheeks) and relaxation of the face and shoulders.

**Another case study:**

Holding/ rubbing body parts. Restlessness e.g.: Shuffling, fidgeting, pulling at clothes, picking up/putting down objects, walking aimlessly	10 mins	Hand fidgeting slowed down. Shouting slowed down.
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**iv) Sleep:**

A controlled study of nursing home residents has demonstrated that Therapeutic Touch significantly benefited recipients' sleeping patterns post-treatment (Braun et al 1986). Clinical reports from practitioners of Therapeutic Touch in aged care indicate responses such as going to sleep more easily and waking less frequently (Gregory 2004).

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## **v) Pain Management**

According to Benkofsky-Webb et al., (2004), to date there are nine quantitative studies that report the use of Therapeutic Touch (TT) with pain. Those relevant to the area of elder care include the use of TT for terminally ill cancer patients (Giasson & Bouchard, 1998), persons with osteoarthritis of the knee (Gordon et al, 1998), tension headache (Keller & Bezdek, 1986), and degenerative arthritis (Eckes-Peck, 1997). These studies have internal and external validity. Chronic pain was found to respond to weekly treatments that go on for at least 6 weeks (Gordon et al, 1998; Eckes-Peck, 1997).

Case studies and qualitative data are available in evidence based practice. They can be valuable in generating research (Benkofsky-Webb et al, 2004), Leskowitz (2000) reports treating a 62 year man with phantom pain with TT. The man experienced a decrease in pain.

Case studies collected from elder care facilities where Therapeutic Touch (TT) is practiced (Gregory, 2002) also suggest the value of this modality to relieve pain:

- Bilateral hip replacement – now displaced. Severe pain. TT administered. Reported pain reduced from 5/10 to 0/10. Stated he felt the pain in his R thigh being pushed down & out his legs. Stated it made his leg muscles relax. Breathing deeper than before treatment.
- Pain. TT administered for 3 – 5 minutes. Breathing more deeply, face a pink colour, reporting headache dulled. Checked back after 25 minutes and she was asleep.

- Pain. Crying out incessantly. Other residents agitated, staff becoming stressed. TT given for 10 minutes. Sighed, smiled and was quiet for 1.5 hour.  
Looked peaceful and said “thank you”. Adjacent residents more settled.

Neck pain. Resident said neck was extremely painful and she was having trouble moving it	15 min.	Verbal rating scale: Pain reportedly reduced from 7/10 to 0/10. Resident smiling and no longer holding body parts.
Frail aged. Arm pain	5 min.	Resident said arm was not as painful. Stated the pain had reduced from 3/10 to 1/10.
Bilateral hip replacement – now displaced. Severe pain		Pain reduced from 5/10 to 0/10. Stated he felt the pain in his R thigh being pushed down & out his legs. Stated it made his leg muscles relax. Breathing deeper than before treatment.

#### vi) Other Care issues

Leg ulcers		Legs white at commencement and turned quite pink by end of TT. Resident relaxed.
Pressure areas/broken skin on buttocks, groaning, eyes screwed up, complaining of pain, rolled up in fetal position		Relaxed, rolled over and asleep by end of treatment. Slept 2 hours.
<b>RESIDENT 9</b>		
Parkinson disease: Delusions & hallucinations	7 min.	Reported she felt warmth through her body. Very relaxed, slept one hour after TT. Very calm during treatment – normally talks excessively & intrusive behaviour
<b>RESIDENT 11</b>		
Depression		Patient looked very relaxed, almost asleep. Said she was disappointed when we finished, she wanted to stay in that calm relaxed state. On wheeling her back to the dining room, she had cheered up considerably & told the other residents how wonderful she felt. Did not appear depressed at all.
<b>RESIDENT 12</b>		

Headache	3 - 5 min.	Breathing more deeply, face a pink colour, reports that headache has dulled & feels more relaxed & sleepy. Checked back after 25 mins & she was asleep.
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- Pressure areas/broken skin on buttocks, groaning, eyes screwed up, complaining of pain, rolled up in fetal position. Given TT. Relaxed, rolled over and asleep by end of treatment. Slept two hours.

#### e. Clinical Application of Therapeutic Touch - *Serenity Settling*<sup>TM</sup>

Traditionally Therapeutic Touch is practiced with the client seated or lying down, and the hands are held two to four inches away from the body with energy offered compassionately through the hands in rhythmical downward flowing movements. This stationary client approach is not always applicable, the case in point is with clients who are moving.

A process known as *Serenity Settling*® was developed by Sue Gregory QTTT (Gregory, 2006). This process evolved from the need to settle the pacing behavior of people with dementia who were wandering or *sundowning*. *Serenity Settling*® involves the staff member centering herself and then approaching the client with the intent to calm. One hand is then held over the adrenal gland offering a sense of deep peace, while the other hand supports the client's other hand. The benefit of this approach is that it can be combined with activities of daily living, for example, while the practitioner assists the client with dressing.

*Serenity Settling*® is linked to a daily performance management system which supports staff in staying calm and which helps staff manage challenging behaviors in elder settings. Through the implementation of a systems based approach, *Serenity*

**Settling**® has resulted in benefits across three spheres of influence: the residents, the employees, and the elder care organization. A pilot study is currently being conducted; however, to date, case studies provide the data to describe the benefits experienced (Gregory, 2006, Presentation at CEO Leadership forum).

For more information on **Serenity Settling**® contact the Sue Gregory at:

[www.healthyoutlook.com.au](http://www.healthyoutlook.com.au)

**Case studies using Serenity Settling**® (Gregory, 2006).

An elderly lady who disappeared from an elder care home was found wandering on the street. When asked to return she began hitting out and screaming. A staff member who had learned **Serenity Settling**® approached the resident offering the process with her intent. The client settled enough for the staff member to be able to touch the resident and offered the process described previously. The lady's pacing and vocalizations slowed down. She stopped hitting out and walked quietly back to the home where her family was waiting to celebrate her 90<sup>th</sup> birthday.

**Benefits for residents:**

"I used Serenity Settling ® when giving tablets to a resident who doesn't like taking them. She was willing to take them without any hassle" (Staff member, Fernhill Hostel).

"[The resident was] very resistive, refusing to go to the toilet. Sat on the bed beside him, placed my hands over the adrenals, spoke quietly and soothingly – he immediately calmed down and went to the toilet" (Staff member, Fernhill Hostel)

“I felt really good. I was able to comfort the resident in a way I hadn’t been able to do before. I settled her without giving medication. She was glowing” (Cindy Adam, Personal Carer, Cambelltown Health and Community Centre).

### **Benefits to Employees:**

A local GP noted “how clients in our facility were settling more easily. He wondered if night staff in other places could learn **Serenity Settling®** as it would save staff calling him three times at night to 'do something' " (Staff feedback from in-house training at a Northern Rural health facility, Tasmania). “It gives the power to the staff. When they are calm in all the confusion, it flows on. It reduces staff burn out, it’s a life skill they can use at home & work.” (personal communication, *Anita Carter, DON, Sunrise Private Nursing Home, Victoria, Australia*).

### **Benefits to the Organization:**

“During a recent staff grievance we used **Serenity Settling®** to focus on what we are actually doing and why we come to work. It had a great affect on the outcome.” *Anita Carter, DON, Sunrise Private Nursing Home, Victoria*

### **5. Benefits of TT for Staff Health and the Organization:**

Examples of case studies and organizational benefits arising from the application of Therapeutic Touch in aged care are currently being compiled in the book, *Silver Energy: Therapeutic Touch in Aged Care* by Sue Gregory (in process). For more information email: [sgregory@healthyoutlook.com.au](mailto:sgregory@healthyoutlook.com.au)

Some areas addressed in the book are included here:

**Occupational Health and Safety:**

Therapeutic Touch (TT) is also a support for organization’s occupational health and safety. For example, TT can help to settle agitated persons prior to dressing or showering, thereby minimizing the risk of injury to staff and residents.

**Case study example:**

Client behavior prior to <b>Serenity Settling™</b> : Objecting to going to shower. Struggling & swearing, “You are not going to get me in there” (shower)		Client behavior following <b>Serenity Settling</b> : Resident calmed down and said, “We might as well get it over” stood quietly while she was showered. Still quiet while being dressed but then started swearing again once dressed.
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**Benefits for Employee Health:**

Besides helping the recipients, Therapeutic Touch was found to affect the practitioners, with most practitioners reporting a greater sense of calm and well – being (Cugelman, 1988). Similarly, case studies from diversional therapists, nurses, personal care attendants & pastoral caregivers using Therapeutic Touch in aged care facilities in Victoria, Tasmania & NSW, report an experience of peacefulness for both the recipient and the giver (Gregory, 2004; Gregory, 2002).

**Supporting the Culture in an Elder Care Facility:**

As a purely team building exercise alone the introduction of Therapeutic Touch and **Serenity Settling®** provides an energetic synergy which is transformative to the workplace culture. The practical exercises, education materials, reflection and analysis, all combine to break down barriers and create harmonious bonds

of respect among participants. Staff members came to know each other more deeply during the course, and their empathy and tolerance expanded. Learning Therapeutic Touch “facilitates personal growth and all participants recorded changes in their attitudes and thinking, extending to time outside work hours” (Sandy May, Executive Director, Fernhill Hostel for the Aged cited in Gregory, 2006).

## **6. Learning Therapeutic Touch**

### **a) Process**

Learning Therapeutic Touch (TT) involves a process of attending workshops and completing a practicum under the guidance of a qualified TT practitioner and mentor. TT classes are offered at the Basic, Intermediate, and Advanced levels. It is recommended that a student completes his/her training with Qualified TT Teachers (QTTT).

A Basic Level TT workshop is a minimum of 12 hours. TT is best learned through experience with the process so practitioners should complete at least two TT sessions on a weekly basis while working with a qualified practitioner (QTTP) for at least a year of mentorship.

Intermediate Level is a minimum of 14 hours and can be taken after of six months of regular practice. Advanced Level programs can be taken after Intermediate and consist of a deeper understanding of the transpersonal nature of TT.

### **b) Locating a Qualified Teacher**

For a complete listing of Qualified Therapeutic Touch Teachers (QTTT) and their contact information, please visit the NH-PAI website [http:// www.therapeutic-touch.org](http://www.therapeutic-touch.org) and click on the icon **LINK**

### **c) Locating a Qualified Practitioner**

For a complete listing of Qualified Therapeutic Touch Practitioners (QTTP) and their contact information, please visit the NH-PAI website <http://www.therapeutic-touch.org> and click on the icon **LINK**

## **7. Therapeutic Touch Credentialing:**

NH-PAI offers courses in Basic, Intermediate and Advanced Therapeutic Touch, Mentorship opportunities, and a course for developing teaching skills in Therapeutic Touch entitled *Intensive for Teachers of Therapeutic Touch*. Each of these courses is designed to provide the learner with theory and practice in the TT process. For specific requirements to become a QTTP (Qualified Therapeutic Touch Practitioner) or a QTTT (Qualified Therapeutic Touch Teacher) check the NH-PAI website at: <http://www.therapeutic-touch.org> **LINK**

## **8. Resources:**

### **a) TT in Elder Care:**

Further articles and information on courses on TT in aged care can be located on Sue Gregory's website at: [www.therapeutictouch.com.au](http://www.therapeutictouch.com.au)

Gregory, S. (2003). *Therapeutic Touch in Aged Care* (DVD).

Gregory, S. *Power in your Hands* (DVD).

Gregory, S. *Being on centre* (CD).

**b. Therapeutic Touch – Available from NH-PAI**

1. *The Vision and the Reality* (1997) (Video)
2. Kunz, D. (1997). *The Role of the Physical, Mental and Emotional Bodies in Healing*. New York: NH-PAI (Video)
3. Quinn, J. (1993). *Therapeutic Touch: A video course for health care professionals*. (series of 3 videos): I. Research (45 min.); II. The Method (45 min.); III. Clinical Applications (45 min.). National League for Nursing.
4. Quinn, J. (1996). *Therapeutic Touch: A Video Course for Family Caregivers*. New York, New York: National League for Nursing.
5. *Guidelines for Teaching Therapeutic Touch*. (1994) Revised 2004. NH-PAI.
6. *The NH-PAI Bibliography* (2007). NH-PAI **LINK**

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