Therapeutic Touch: Why Do Nurses Believe?

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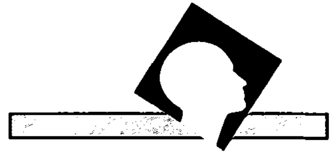
Sometimes it seems that even the U.S. government supports pseudoscience. Recently the D'Youville Nursing Center, a center established by the school of nursing at D'Youville College, in Buffalo, was given a $200,000 training grant by the Division of Nursing, U.S. Department of Health and Human Services, to treat patients using therapeutic touch and to teach student nurses the technique. The director of the Center, Paul T. Hageman, earned his doctorate in nursing at New York University, which is the main training ground for nurses in the practice of therapeutic touch. This grant, however, is the first official government recognition of the "validity" of such treatment.

The Center's literature defines therapeutic touch as a "method of facilitating healing." Believers claim that it is best practiced by keeping the nurse's hands a few inches from the patients body and that

> during the process of therapeutic healing, the practitioner, with clear focused intent, channels life energy, helping the subject to release "blockages," bringing (his or her) energy field into harmony and balance. (*Buffalo News*, March 10, 1992, C3)

Therapeutic touch in nursing was first put forth in its present form by D. Krieger (1975) in the *American Journal of Nursing* and was amplified in another journal in which she reported a study that claimed increasing hemoglobin levels in response to therapeutic touch (Krieger 1976). Krieger published a book on the theory in 1979 (Krieger 1979). From the beginning therapeutic



Therapeutic touch teaches that practitioners can channel fields of life energy, bringing a patient's energy fields into balance. Surprisingly, some leading people in nursing accept this idea.

touch has been a subject of controversy. Key to the theory was the system developed by nurse theorist Martha Rogers. From her influential position as chair of nursing at New York University she imbued a whole generation of graduate students with her beliefs; many of these students are now in influential decision-making roles in nursing. Rogers (1970) emphasized that her theory of "unitary man" was holistic nursing.

All persons, she argued, are highly complex fields of various forms of life energy, and these fields of energy are coextensive with the universe and in constant interaction and exchange with surrounding energy fields. Wellness is a product of harmonious exchange between an individual's energy field and those of the environment. Krieger (1975; 1979) claimed it was through the hands of the therapist that this energy field could be internalized by the recipient and restore the balance to the body so it could heal itself. The nurse therapist, in effect, acted as a conduit, a channel, so that environmental energy could be transferred to the recipient without physical contact. In short, belief in therapeutic touch grew out of a belief in a holistic universe and the power of energy fields to cause or cure illness.

Early experiments by its advocates demonstrated to their minds that changes did take place in the patient, although some of these could be predicted. For example, a friendly touching of an anxious patient would be likely to increase the probability of lessening the tension, and Krieger, Peper, and Ancoli (1979) found that not only did patients report feeling more relaxed but actual relaxation could be demonstrated on electroencephalograph tracings. Similar findings were reported by Heidt (1981), who dealt with three groups of 30 hospitalized cardiovascular patients, some of whom received therapeutic touch, while control groups received casual touch (taking of the pulse), and still others received no touch. The greatest reduction in anxiety was reported as taking place among those receiving therapeutic touch.

One of the more controversial studies was done by Keller and Bzedek (1986) and reported in the prestigious refereed nursing journal *Nursing Research.* It reported an experimental treatment for tension headache that involved first a period of quiet rest, then treatment of the experimental group by therapeutic-touch therapists and of the control groups by nontherapist volunteers who focused on subtracting from 100 by 7s. In this experiment the researchers avoided actual touch because they wanted to demonstrate that they were not simply using the age-old skills of hands-on nursing, but rather were manipulating harmful energy fields.

> In the therapeutic touch group the intervention began with the researcher centering herself into a meditative quiet and making a conscious intent to help the subject. She then passed her hands 6 to 12 inches from the subject without physical contact to assess the energy field which extends beyond the skin and redirect areas of accumulated tension out of the field. She then let her hands rest around, but not on, the head or solar plexus in areas of energy imbalance or deficit and directed life energy to the subject. (Keller and Bzedek 1986)

The results reported more pain relief with the TT group than with the placebo group. Whether doing an exercise that required considerable concentration is a placebo comparable to a period of relaxation and waving of hands apparently was never questioned by the referees.

Numerous studies followed the original experiments, including some early debunking ones by such researchers as Sandroff (1980a), who said that therapeutic touch was nothing more than a placebo effect brought about by the presence of a loving and caring person. The most devastating criticism was by Clark and Clark (1984), who examined therapeutic-touch studies going back to the early 1960s and then concentrated on early nursing studies. In examining the Krieger (1976) study reporting a significant increase in hemoglobin, they found that the study was poorly conceived and methodologically poor, used inappropriate statistical data, and had resulted in erroneous conclusions. Krieger's other early studies (Krieger et al. 1979) were also examined and found methodologically flawed. Similarly, Heidt's (1981) experiment did not control for the possible placebo effect. The problem in doing research on TT is to demonstrate that real energy passes between therapist and patient, which no one has been able to do. Certainly any reduction in tension is likely to reduce pain, particularly headache pain, but this could also be done by watching a comedy on television or tapes of old movies, as Norman Cousins (1979) did. There have also been other negative findings, such as those by Randolph (1984), who measured the physiological response of 60 healthy college students to a stress-producing film while receiving either TT or placebo touch. Randolph reported no difference between the anxiety level of the two groups. None of the experiments reporting positive results seem to offer an effective alternative placebo when simply resting could bring about improvement. It might also be that patients can simply relax more if they feel someone is doing something. Even when subjects are aware of the possibility of a placebo treatment, double-blind studies have shown a 30 to 40 percent response rate to an inert placebo (Sandroff 1980b).

In spite of the critiques, the popularity of therapeutic touch in nursing seems to be growing, and nurses who embrace modern science in many other regards are willing to believe that TT therapists can control unseen energy fields in the environment through their thought processes. Why should this be so?

One reason is that nurses collectively have a kind of mystical view of the role bedside nursing played in the past before the intrusion of the vast numbers of new pharmaceuticals and before the hospital became such a complex and expensive place. They visualize nurses historically as having been supportive, loving, and helpful persons, who by their interventions brought patients back to health. Such care involved backrubs, bathing, and caring for patients, feeding patients who could not feed themselves, changing dressings, turning patients to prevent bedsores, helping families adjust to the patients' hospitalization, as well as administering drugs and overseeing the more technical and scientific aspects of bedside care (Bullough and Bullough 1978).

In reality, with the development of hierarchical nursing, which includes care by nurses aides and practical nurses, this mystical historical view of nursing has not existed since before World War II, if it ever did. Nurses increasingly have been occupied with administration of medications, checking IV turbes, and monitoring the various machines to which patients are hooked up. By necessity nurses now have to delegate much of the hands-on bedside nursing to aides and practical nurses. Although traditional nurses continue to exist in long-term-

A Statement Presented to

The following is excerpted from a statement drafted by Bill Aldorfer of the Rocky Mountain Skeptics (RMS) and presented to the Colorado Board of Nursing by Linda Rojas, a registered nurse and vice president of RMS. With her were Bela Scheiber, president of RMS, and Susan Houck, another of the group's board members. The group requested a hearing to express concern about the growing use of Therapeutic Touch and other questionable treatments in continuing-education classes for nurses.

We represent a group of citizens interested in the Board of Nursing's current policy on continuing education and would like to pose a few questions regarding this. Specifically, we are concerned about a growing number of continuing-education classes instructing nurses in practices which have no scientific research to back them up.

A few representative class subjects which have been approved for credit in Colorado include: Therapeutic Touch (TT), Neurolinguistic Programming (NLP), Reflexology, Applied Kinesiology, Crystal Healing, and Acupressure.

Where is the data to substantiate any of the claims made by these unconventional practices? What evidence has persuaded the Board of Nursing to lend their tacit endorsement to these practices through the continuing education and relicensing process? Who is accountable?

This, of course, is a consumer issue. What is ultimately at stake here is the delivery of quality nursing care. In our opinion, unproved practices, promising dubious benefits, cannot even be considered harmless—along with the risk of interfering with, or delaying proven, effective therapies, comes the problem of wasting time, money, and other resources.

care facilities, low levels of reimbursement by insurers, both private and public, have meant that most nursing care in such places is given by nurses aides and practical nurses, with nurses performing supervisory functions. Specialized roles have developed with more bedside expertise, such as in critical care, but these roles demand so much continuous intervention and monitoring that even here the mythical bedside nurse of the past is no more. Other nurses, such as nurse practitioners, nurse midwives, and nurse anesthetists, have taken on additional tasks that give considerable patient contact but not in the role of traditional bedside nursing.

There is also a desire to stress the independence of the nurse from the physician in order to emphasize a unique nursing role. Nurses pride themselves on their ability to communicate with patients, to help them face their illnesses effectively.

Therapeutic touch for many then becomes symbolic of what nursing can do. It is probably no accident that the first center for therapeutic touch was established in a Catholic oriented

the Colorado Board of Nursing

As a profession, we are duty-bound to regulate reasonable boundaries of acceptable care. Whenever possible, we must protect our patients from unsubstantiated claims. And here the link between excellence in patient care and quality nursing education is undeniable. . . .

I'm sure we can all agree that, minimally, nurses need scientifically validated standards to provide the public with the best possible care.

While there are members of the nursing profession who readily employ questionable practices, unencumbered by the lack of empirical evidence, it might be wiser for regulatory bodies to seriously contemplate how the application of unsubstantiated claims could have clinical, ethical, and political, as well as legal repercussions. One day, accountability for the tolerance of unproved, unscientific, and questionable policies may be demanded.

In conclusion, we would kindly request the Colorado Board of Nurses to respond, at their convenience, to the following question: "How can Board-recognized credentializing organizations be made responsible and accountable for the content of continuing-education classes?

The Colorado Board of Nursing subsequently appointed a subcommittee to consider better accountability in approving course content in continuing education courses. After a review, however, this subcommittee recommended maintaining the Board's policies. The Board subsequently voted "to reaffirm its previous determination that therapetuic touch was an acceptable study area for continuing education credit," Karen D. Brumley, the Board of Nursing's program administrator, informed Rojas in a June 8, 1992, letter. The Rocky Mountain Skeptics has now asked the Board for copies of the research literature used to support its decision.

nursing school, since basically it is a revised version of the traditional religious "laying on of hands." It differs in that to be effective it does not entail a belief in the method or any other precept on the part of its recipients, just on the part of the caregivers who can allegedly transfer life energy to the patients. Patients are often willing to accept TT as an alternative treatment because they are so disillusioned with the excesses of modern medicine that many of them long for an alternative other than chiropractic.

Nurses' use of therapeutic touch effectively demonstrates why many more or less sophisticated people believe in the paranormal—it fulfills a need. Nurses who believe in therapeutic touch can do all the touching they have time to do in their practice and in the process feel better about themselves for so doing. Moreover anything that would make them feel that they are better nurses probably transfers to the patients. Since most nurses always have access to people with pain and anxiety, it is inevitable that they want to feel they are making

a difference. Even many who don't believe there is a real magnetic force out there adopt some of the concepts of therapeutic touch because it allows them to become much more personally involved with their patients. Moreover, it is something they do without orders from the physician, and often without the physician even knowing.

Thus in spite of the evaluations showing major flaws in studies that claim to demonstrate that therapeutic touch exists, the will to believe takes precedence, and that is frequently the case with the paranormal. However, when the government gives $200,000 for such training, it raises serious questions about the place of pseudoscience in our society.

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The Opportunity to Understand Nature

We are aware of prodigious feats in the arts, law, and religion that endure for ages. Yet none of these disciplines offers individuals, as science does, the opportunity to contribute to a progressive understanding of nature. . . . The practice of science enables scientists as ordinary people to go about doing generally ordinary things which, when assembled, reveal the extraordinary intricacies and awesome beauties of nature.

—Nobel laureate Arthur Kornberg, Stanford University, in an editorial in *Science,* August 14, 1992.