Therapeutic touch and dementia care: an ongoing journey

Abstract

Touch is considered a core aspect of care provision and therapeutic relationships. Therapeutic touch allows nurses to facilitate healing and forge therapeutic relationships through touch or non-touch and maintain channels of communication often lost in dementia as the disease progresses. This article reports the findings of a research project to examine the effectiveness of therapeutic touch in dementia care.

This article seeks to share the findings of the research project and the benefits that therapeutic touch has for both patients and nursing staff.

Defining therapeutic touch

The concept of therapeutic touch lies in the belief that life-force energy is a fundamental force found in all living entities and that this energy flows outside the body.

Practitioners will centre themselves on the patient and then move their hands over the patient without actually touching.

They will feel various energy sensations coming from the patient and the intention of therapeutic touch is to rebalance that energy. This element of the technique has contributed to its notoriety. Many people have found it hard to accept that there could be any benefit in a therapy which relies on practitioners being able to detect changes in the body's energy fields simply by passing hands over the body.

Despite this concern, in some quarters it is estimated that there might be as many as 40,000 practitioners of therapeutic touch worldwide; and it reasonable to expect that number is ever increasing (Robinson 2000).

The previous article (Aveyard 2002) set the scene in discussing how Kendray Hospital practice development unit began working with Professor Stephen Wright and the Sacred Space Foundation.

This article is the second of two articles that follows the journey of a research project through unexplored territory. The first article, Therapeutic touch in dementia care (Aveyard 2002), set out the basic theory and importance of therapeutic touch and touch within the dementia care setting.

Neither this nor the first article has sought to debate the importance of either touch or therapeutic touch in this specialty. The importance of touch in nursing care is certainly not in debate here as the principles of touch in nursing practice are accepted as fundamental to its very core (Autton 1989, Estabrooks and Morse 1992).

In its purest sense, touch is considered by many as a core aspect of care provision and a therapeutic relationship (Autton 1989, Estabrooks and Morse 1992; Edvardsson et al 2003; Savage 1985).

With the concepts of healing and touch being inextricably linked it is also important to value the nurse's role as healer and facilitator of that healing process through therapeutic intervention and compassionate care-provision (Chang 2003).

Therapeutic touch allows the nurse to facilitate healing and forge therapeutic relationships through touch or non-touch and maintain channels of communication often lost in dementia as the disease progresses (Kim and Buschmann 1999; Wardell and Weymouth 2004).

Key words

- Touch
- Nurse patient relations
- Dementia

These key words are based on the subject headings from the British Nursing Index. This article has been subject to double-blind review.
Space Foundation to implement a programme of therapeutic touch training for its staff. The study examined both the effects of therapeutic touch for patients and the effects on staff and clinical practice.

At the time of the study staff training had been ongoing and staff were using therapeutic touch on a regular basis. As a result the study took an action research approach. The advantages of this were that the whole practice development unit 'community' was involved in the process of changing practice and felt mutual ownership (Hartrick 1997).

The research team comprised of a university lecturer linked to the practice development unit, a staff nurse and a lecturer-practitioner working within the unit. The researchers knew the unit, its staff and many of the patients well. They had an established relationship that outside researchers would not have had.

The study sought to gain information from staff going through the therapeutic touch training. In particular, about their perceptions of therapeutic touch prior to entering the programme and about their feelings. Also of significance was how they implemented it into their practice in the months after completing initial training.

**Literature review**

In the nursing literature, touch has been variously defined. A simple definition of therapeutic touch is ‘a process whereby the nurse (the healer) directs attention using the hands to achieve a therapeutic effect for the patient (the healee)’ (Sayre-Adams and Wright 1995; Sayre-Adams and Wright 2001).

A comprehensive literature review of the use of therapeutic touch in nursing (Meehan 1998) suggested strong evidence of potential benefits for some patients, but cautioned that prolonged debate about how it works could deprive patients of any potential benefits.

Despite such balanced views, there is still a significant prejudicial feeling about the therapy. For example, the whole field of complementary therapy has been described as ‘quackery and fragile nonsense’ (Rayner 1999). However, therapeutic touch does have qualitative research evidence to reinforce its use alongside conventional nursing practice (Hallett 2004). Importantly, it offers patients and nurses a way to communicate and demonstrate the mutuality of caring (Hallett 2004).

**Aims**

The aims of the study were to:

- examine staffs attitudes to therapeutic touch and its practice
- examine the effectiveness of therapeutic touch as a therapeutic intervention for individuals with dementia.

**Methods**

The research began with a focus group session to explore staff perceptions of therapeutic touch. These sessions were recorded and transcribed.

The main findings established themes that helped to develop questions for the semi-structured interviews that were conducted with staff.

The interviews occurred both before and after therapeutic touch training to ascertain whether attitudes changed. From these interviews the questionnaire was further developed and sent out to more than 40 staff who had all attended the therapeutic touch training across several intakes.

The study followed a group of staff from their first contact with the concept of therapeutic touch through their first year of practice using the intervention. Initially, there appeared to be a theme emerging that staff who were practising therapeutic touch felt their relationships with patients were developing a closer emotional bond.

Then the effectiveness of therapeutic touch in practice was examined using two valid, reliable and published tools, Dementia Care Mapping and the Positive Response Schedule. Patients were assessed before and after intervention by trained dementia care mappers over three separate days.

On day one, patients were monitored using both tools and received no intervention in-between dementia care mapping. On day two, patients received therapeutic touch in-between mapping. And on day three, patients received an intervention in-between mapping.

Semi-structured interviews were performed using headings derived from initial focus groups. These had taken place during stage one of the project where a cross section of health professionals who already used therapeutic touch identified issues emerging from their use of the intervention.

It was seen of profound importance not to ignore the perceptions of the patient group who were being offered therapeutic touch as a therapy. Inevitable limitations were identified which were associated with any study that aims to involve people with some degree of cognitive impairment. These challenges were magnified when their perceptions were sought.

Although touch was a common factor in dementia care, therapeutic touch in the form that it is discussed in this piece was not widespread in the care setting and its use raised some issues that needed to be explored for both the client group and the staff.

Issues pertinent to dementia care were:

- whether or not the mechanisms of therapeutic touch were understood by those using it and those potentially likely to use it
- what implications its use would have for staff and whether or not it would alter their perceptions;
whether or not the culture of the organisation and the units would affect the use of therapeutic touch
whether or not staff were truly aware of the sensory needs of the client group
whether therapeutic touch would affect staff and their practice post training
whether or not therapeutic touch would increase patient well-being
whether or not therapeutic touch would be a beneficial therapeutic intervention for the patient group and encourage the formation and development of therapeutic relationships.

Sample selection
A purposive sample of four individuals over the age of 65 was selected with a history or diagnosis of dementia. They also had MMSE scores ranging from 0-25 to take in a cross section of cognitive abilities.

All members of the sample group were female but this was not intentional.

Consent was sought from patients and if they were unable to consent, it was sought and obtained by proxy from their next of kin.

Ethical approval was gained for the study from Barnsley Research Ethics Committee.

Results
Findings of focus groups: At the beginning of the project, the views of staff were varied. Some were interested and others sceptical about what therapeutic touch entailed. A purposive sample of staff including qualified, unqualified and various therapy staff were invited to take part in the focus group.

Staff had a strong sense of wanting to develop practice and care for individuals who had progressed to more cognitively impaired stages of dementia. A desire by staff to improve their own practice and working life was also highly evident.

Findings from the interviews and questionnaires: Findings from the staff interviews and questionnaires were as supportive of the technique as the focus group transcripts had suggested.

The questionnaires had an 80 per cent return rate (32 respondents) which demonstrated the staff’s commitment to the client group, the ideals of the practice development unit and therapeutic touch.

A total of 26 out of the 32 respondents strongly agreed that therapeutic touch promoted patient well-being therefore reflecting the impact that therapeutic touch training had on their views.

Findings from Dementia Care Mapping/Positive Response Schedule: It is evident from data analysis that there is an increase in well-being following therapeutic touch. Although the Dementia Care Mapping data was limited it was decided with the Bradford dementia group project officer that the well-being of patients who participated in the study did improve.

The significance of the Dementia Care Mapping data alongside one researcher’s knowledge of the patients before, during and after the project wholly demonstrated the therapeutic value of therapeutic touch. In the following accounts of patients’ experience all names have been changed.

Judy
Judy was always agitated to differing degrees. She was always on the go wandering and tidying, worried frequently and was anxious. She was also always in conversation.

Following therapeutic touch Judy fell asleep, which was in complete contrast to her normal patterns of behaviour. Since admission, Judy had a very erratic sleep pattern and often went long periods without consistent sleep.

Not only did this have obvious therapeutic benefit for Judy, it reinforced to the ward staff that therapeutic touch had immense benefits for patients with dementia, and that the technique required further exploration and reinforcement via practice.

Margaret
Margaret was a very quiet woman who did not interact well with others and constantly wanted to find her daughter.

Before undergoing therapeutic touch, Margaret had been quiet with minimal interaction with the other patients and staff. After undergoing therapeutic touch she was more animated and slightly more agitated than usual.

On observation therapeutic touch had not necessarily been beneficial for Margaret.

However, the limited amount of observation time did not allow for conclusive evidence to be drawn. Margaret could often be more agitated after any intervention, not just therapeutic touch.

Molly
Molly was a woman who was agitated throughout any given 24-hour period and would constantly sit and shout help. She was immobile which did not help her sense of security in the busy ward setting. Molly had been shouting for varying periods on the day the mapping took place. Despite any reassurance or staff intervention Molly would always shout even when someone was sat next to her.

Following therapeutic touch Molly continued to shout so conclusions could be drawn suggesting that therapeutic touch was of limited benefit to Molly.

However, the staff member that had used therapeutic touch with Molly reported that for the dura-
Gerontological care and practice

References

Discussion: This small-scale study has provided insufficient detailed evidence to fully establish the value of therapeutic touch in dementia care. The data collected appears to show its potential value. There is stronger evidence that therapeutic touch potentially has immense benefits for staff working in the area of dementia care on several levels:

Team building: Staff clearly felt that undertaking the training had improved working relationships

Implications for Practice
As a therapy in its own right therapeutic touch lacks the substantial evidence base that touch as a concept possesses. However, there is some qualitative evidence to support its use alongside conventional therapies and conventional nursing practice (Hallett 2004).

The study’s findings suggest that for one individual with dementia, agitation was reduced and their inability to relax was affected with them falling to sleep post-therapeutic touch intervention. So for the staff who nursed this patient, therapeutic touch appeared to be of great benefit.

However, there were also benefits that staff identified from using or being trained to use therapeutic touch, such as improved working relationships. Staff felt that taking on board a new therapy had been a great learning experience and provided a new challenge. This new challenge had in turn increased motivation and allowed staff to improve their self-awareness and communication skills.

Many staff felt that after attending the therapeutic touch training their interactions with one another had improved as had their staff-patient interactions. Learning a new skill had also been viewed as valuable in providing another way to reach patients with dementia on an emotional level. Staff felt that learning therapeutic touch had given them another approach to communicating with patients with dementia who were no longer able to communicate verbally with staff or others.

To fully explore the implications for practice, further research is required to investigate the benefits of therapeutic touch for patients with dementia and the benefits in general to healthcare staff who learn and practice this intervention.

A new challenge: Staff felt that while the whole idea of therapeutic touch was something new and at times difficult to understand, taking part in the project had for most staff been stimulating and interesting.

A new skill: Staff felt that being able to use therapeutic touch was a new skill that was worth trying in care situations where they felt they were struggling to connect with a patient on an emotional level.

Conclusion
A replication of the study with larger numbers of patients conducted over a longer period of time could create a more specific and valuable evidence base. This would provide deeper insights into the range of potential uses for therapeutic touch in dementia care.

A follow-up of the project in terms of how staff might have continued to use therapeutic touch and its potential impact upon their practice would also help demonstrate any longer term benefits of the project. We would like to see continued investment with training of advanced therapeutic touch practitioners to keep the project moving and co-ordinate research activity.
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