

Duquesne University Duquesne Scholarship Collection

Electronic Theses and Dissertations

Fall 1-1-2015

Perceptions of Expert Practice by Active Licensed Registered Nurse Therapeutic Touch® Practitioners

Tamara Lynn Wardell

Follow this and additional works at: <https://dsc.duq.edu/etd>

Recommended Citation

Wardell, T. (2015). Perceptions of Expert Practice by Active Licensed Registered Nurse Therapeutic Touch® Practitioners (Doctoral dissertation, Duquesne University). Retrieved from <https://dsc.duq.edu/etd/73>

This Worldwide Access is brought to you for free and open access by Duquesne Scholarship Collection. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of Duquesne Scholarship Collection. For more information, please contact phillips@duq.edu.

PERCEPTIONS OF EXPERT PRACTICE BY ACTIVE LICENSED REGISTERED
NURSE THERAPEUTIC TOUCH® PRACTITIONERS

A Dissertation

Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Tamara Lynn Wardell, MSN, BSN, RN

December 2015

Copyright by
Tamara Lynn Wardell

2015

PERCEPTIONS OF EXPERT PRACTICE BY ACTIVE LICENSED REGISTERED
NURSE THERAPEUTIC TOUCH® PRACTITIONERS

By

Tamara Lynn Wardell, PhD, MSN, RN

Approved October 6, 2015

Gladys L. Husted, PhD, RN
Distinguished Professor Emeritus of
Nursing
(Committee Chair)

Lynn C. Simko, PhD, MPH, RN, CCRN
Clinical Associate Professor of Nursing
(Internal Committee Member)

Jean Kijek, PhD, RN, QTTT
Associate Professor Emeritus of Nursing
University of Central Florida
(External Committee Member)

Mary Ellen Glasgow, PhD, RN, ANEF,
FAAN
Dean, School of Nursing
Professor of Nursing

Rick Zoucha, PhD, PMHCNS–BC,
CTN–A, FAAN
Chair, Advanced Role and PhD Program
Professor of Nursing

ABSTRACT

PERCEPTIONS OF EXPERT PRACTICE BY ACTIVE LICENSED REGISTERED NURSE THERAPEUTIC TOUCH® PRACTITIONERS

By

Tamara Lynn Wardell, PhD, MSN, RN

December 2015

Dissertation supervised by Gladys L. Husted, PhD, RN

Therapeutic Touch® (TT) is a nursing modality, developed in 1972, with a long history of research completion. It is also one of the leading complementary and alternative medicine (CAM) therapies. A comprehensive review of the literature (over 350 studies) from the 1960s to 2015 demonstrated a gap related to delineating expertise related to clinical practice from the view of the practitioner. This study examined the state of expert practice as envisioned by those who themselves qualified as experts in the discipline of TT.

This study utilized a qualitative descriptive independent focus group methodology (Krueger, 1994, 2006; Krueger & Casey, 2001, 2009). This methodology has become popular in nursing studies. The choice of a synchronous method to collect data was made

to provide a unique environment supported by the university-supported online platform. Focus groups were used as a stand-alone and self-contained method to conduct the study (Hupcey, 2005; Morgan, 1997).

The sample consisted of 12 expert, registered nurse (RN) TT practitioners (TTPs), with a minimum of three years of TT experience. They also had attended a minimum of three TT workshops/courses, which included advanced training in the discipline. The use of electronic media facilitated a sample drawn from three countries across two continents. Six very small, synchronous, online focus groups (Toner, 2009) were conducted to reach data saturation and minimum sample size acquisition.

Rich data were collected from these experienced practitioners. Parameters explored were the practitioners' description of expert practice, their own expertise, how research impacted their practice, and the direction TT is headed in the future. Findings were supported by the expert practice literature. Krieger's (2002) concept of transformation was especially apparent in the lives of many of the participants in this study. Respondents described how TT had become an integral part of their lives and influenced their lives immeasurably.

The importance of practice as one factor leading to expertise was very apparent among the participants. Many of the studies stress the need for practice in order to gain expertise in specialty practice. TT is a form of specialty practice by nurses, supported in a holistic framework and caring environment.

Sharing, which includes mentorship, collaboration, and teaching, is an important part of an advanced practice model, and is apparent in the practice of these advanced TTPs. Expert practice includes the components of expert practice knowledge, which is a

necessary prequel to the ability to share it with others. It is also a necessary component to provide leadership to others, to conduct research in the field, and to further one' own practice goals.

DEDICATION

This volume is dedicated to my late father, Donald Meredith Wardell, Jr., to whom I will be eternally grateful. His encouragement allowed me to return home and complete my Master's in Nursing Education as a full-time student paved the way for my future career aspirations in teaching. I wish to recognize my mother Patricia C. Wardell, my brother Donald M. Wardell, III, MD, sister-in-law Elizabeth, and nephew and nieces, Stephen, Allison, and Jennifer, for stepping in to help with the many crises that threatened to derail my academic endeavors.

During the early coursework of this arduous process, Susan L. Whitney, DPT, PhD, NCS, ATC, FAPTA, stood by me and provided never-failing support and friendship. She cheered me on through the many challenges and obstacles along the way. I want to give her particular thanks for her continuing reminder to “focus” on the task at hand, as a necessary component to complete my degree.

Two Mensa friends remained steadfast in their support. One, my Oregon email pen pal Diana M. Maul, deserves special recognition for always making herself available, whether to discuss a problem or celebrate a success. Her encouragement led me to submit my winning Mensa Foundation Scholarship essay, where she lent her invaluable editorial assistance to produce my perfect copy on a short deadline. She continues to provide a comforting presence and a ready ear to listen to the trials and tribulations of a life that often interferes with study and scholarship.

The other, Sally Wharton, my dear Pittsburgh chum, always had time to listen to my tales of woe and provide comfort when I was at my wits' end. We were like two peas

in a pod and it was during this process we discovered the many facets in our past that we held in common. Sally left me this last spring, but her spirit of loving, kindness, and gentleness will forever remain in my memories.

Friends from the TT community have softened the journey. I met Doris Weber at Pumpkin Hollow Retreat Center, when it was the “Farm.” Her enchanting accent and smile won my heart and started a friendship which has endured both time and space. With her innate kindness, sense of tranquility, and ever-enduring healing lifestyle, she set a standard toward which to set sail.

Many from Therapeutic Touch[®] International Association (TTIA) contributed to my growing in my TT practice. Deborah “Deb” Shields, PhD, RN, CCRN, AHN-BC, QTTT, goes out of her way to be a positive role model for TT practitioners. She has been a joy to work with on projects related to TT. Beyond that, she is a never-ending source of encouragement when we meet and through email. Diane May, RN taught me how to teach TT at Pumpkin Hollow. As President, her leadership enabled the transformation of the organization from Nurse Healers—Professional Associates (NH—PAI) into TTIA, while encouraging international expansion. She personally helped me to focus my own resolute intensity and fully accept my innate talents and abilities as a TT practitioner and teacher. She continues to role model a balanced life, full of adventures to come.

Special thanks go to Mary Anne Hanley, PhD, RN and the TTIA board for their support of the project. Mary Anne went out of her way to check on the status of the project, suggest funding resources, and offer encouragement. And my eternal gratitude to the TT experts who made it possible for the study to be completed.

Without my Aunt Mary, who died just after my defense, I would not know the details of my ancestry. It has been less than a year since I discovered my paternal great grandparents walked the Trail of Tears and that my great grandmother was a Cherokee medicine woman. This information provided the link for why I knew as soon as I was introduced to it, I could “do” TT; why from the time I was a child I always knew I wanted to be a nurse; and how I ended up on the healing path for which I was destined.

My other family is not blood yet closer in many ways. The McGlone’s befriended my father when he and their boys became friends; Jerry and my father were best friends from their teens until his death 25 years ago. Gerald “Jerry” McGlone, an identical twin, remains closer to me to this day than most of my uncles to whom I was related by blood. He has always been there to proffer advice or make suggestions and stands ready to listen to my passing milestones and triumphs. Most important to me is his ability as he recounts their tales to keep my father alive for me. As he often reminds me...I am my father’s daughter. And so I remember all of the McGlones and extended family with whom I have shared so much of my life— “Babe,” Jim, and the late Bill and Gene; JoAnn, Patty, Denny, Jim, Theresa, Dan, Kelly, Edward, and Lisa; Darlena, Barb and Martin; Caroline, Jerry, Tom, Bill, Dave, and Laura; Martha and Greg; Therese and Dennis; and the aunts and uncles—Marj and the rest who have passed, her husband Bob; Doris; Clemmie and Bill; and Eleanor and Malcolm.

I would be remiss if I forgot to mention my first friend at my first job after attending nursing school. Sharon Faye Gilbert still lives in Pittsburgh where we both started our careers at The Mercy Hospital of Pittsburgh. We worked together on what came to be known as the “old 7” and later moved to the new building. It was a different

time of manual elevators and open windows that had to be closed when it rained. We still sometimes wonder how we developed a friendship that has lasted for over 40 years. I believe it is because we both were focused on the same thing, how to do the best job possible with the resources available. We enjoyed our job. We worked well together. In addition, we still enjoy talking to each other and catching up, although more often on the telephone than in person. Friendship that lasts so long is very precious.

Finally, there would be no research or TT, without the two courageous women who developed the discipline. I want to thank Dolores “Dee” Krieger, RN, PhD, and the late Dora Kunz, who provided wisdom, guidance, humor, and perspective as I made this journey into the healing realm of Therapeutic Touch®. Their choice to share TT with me and others has forever changed the course of my life.

ACKNOWLEDGEMENT

I wish to thank the members of my committee—Chair Gladys L. Husted, PhD, RN, Lynn C. Simko, PhD, MPH, RN, CCRN, and Jean Kijek, PhD, RN, QTTT—for their assistance with the completion of this body of scholarly work. Dr. Husted spent countless hours to review the body of the work for both scientific merit and conformation to university guidelines. She also provided ongoing and unflagging support to insure realization of my educational and professional goals and objectives. Dr. Simko pointed out the intricacies of doctoral level communication, read many chapter revisions for the proposal defense, and submitted pertinent feedback to improve the final product. Dr. Kijek lent her expertise related to the intricacies in the accurate description of Therapeutic Touch[®] and its practice, in the revisions of the original chapters, and in preparation of the manuscript for the oral defense.

In addition, I would like to thank those who served on my committee during this process. Ellen F. Olshansky, PhD, RN, WHNP–BC, NC–BC, FAAN introduced me to qualitative research and facilitated an experience in grounded theory. Ann J. Clark, RN, PhD introduced me to the breadth of research literature supporting the use of TT. Dorothy (Dottie) Woods Smith, RN, PhD, AHN–BC, QTTT gave of her time to teach me to teach TT and to explore the scientific method associated with the study of TT. Denise F. Coppa, PhD, RNP, FAANP, QTTT scrutinized the first three chapters for the proposal defense and pushed for superior, scholarly, and professional work. All of the TT experts shared their commitment and dedication to the pursuit of a scientific base for Therapeutic

Touch[®]. My special thanks go to Suzanne “Suzi” Ceramakis Schoon, PhD, RN, CNS, who was the first to express interest in, and agree to, assist with this project.

I wish to acknowledge that my degree would not have been completed without the significant tuition assistance and support, which I received from the Pennsylvania Office of Vocational Rehabilitation (OVR). OVR also collaborated with the Social Security Administration (SSA) for several years, under the SSA Ticket to Work program to support further my educational endeavors. During that program, OVR approved funding for my Advanced Teachers’ Therapeutic Touch[®] training at the Pumpkin Hollow Farm Retreat Center to facilitate my ongoing TT education.

I received additional tuition assistance from the Pennsylvania Higher Education Foundation (PHEF) in the form of Graduate Nurse Educator Grants (Spring, Summer, and Fall 2006; Fall 2007). Positions as a both a teaching assistant (Fall 1996; Spring, 1997; Spring 2001) and research assistant (Fall 1998; Fall 1999; Summer 2001) at Duquesne University provided tuition remission for doctoral program credits. Mary de Chesnay, PhD, RN, PMHCNS–BC, FAAN, during her tenure as Dean of the School of Nursing, was instrumental in making those experiences available.

I was the recipient of a competitive 2005 Mensa Education & Research Foundation Kuhnel Scholarship to support my education. I also received a book grant from the Allegheny County (Pittsburgh, PA) Housing Authority (ACHA) Family Self-Sufficiency Program in 2008 to purchase needed sources for research. Patricia Ernestine Cooksey Wardell provided tuition support for many terms, making it possible for me to prepare for overview and complete the defense of my proposal.

TABLE OF CONTENTS

	Page
Abstract	iv
Dedication	vii
Acknowledgement	xi
Chapter 1 Introduction	1
1.1 Background of the Study	1
1.2 Therapeutic Touch [®] (TT).....	2
1.2.1 Therapeutic Touch [®] founders	2
1.2.2 Therapeutic Touch [®] organizational history	4
1.2.3 Therapeutic Touch [®] treatment phases	5
1.2.3.1 Centering	5
1.2.3.2 Assessment.....	5
1.2.3.3 Rebalancing.....	6
1.2.3.4 Reassessment	6
1.2.4 Therapeutic Touch [®] treatment length	6
1.2.5 Therapeutic Touch [®] practice assumptions.....	7
1.2.6 Therapeutic Touch [®] frameworks	9
1.2.7 Therapeutic Touch [®] results.....	11
1.2.8 Skepticism.....	12
1.2.9 Scope of Therapeutic Touch [®] inquiry.....	13
1.2.10 Research related strengths and weaknesses	13
1.3 Purpose of the Study	16

1.4 Research Questions	17
1.5 Definition of Terms.....	17
1.5.1 Therapeutic Touch®	17
1.5.2 Qualified Therapeutic Touch teacher™ (QTTT™)	17
1.5.3 Expert Therapeutic Touch® practitioner (TTP)	18
1.5.4 Focus groups	19
1.6 Assumptions.....	19
1.7 Limitations	19
1.8 Significance to Nursing.....	20
Chapter 2 Review of the Literature.....	24
2.1 Introduction.....	24
2.2 Relationship of Therapeutic Touch® to Complementary and Alternative Medicine (CAM).....	25
2.3 Expert Practice	28
2.3.1 Expert nursing practice	28
2.3.2 Evidence-based practice support associated with Therapeutic Touch® reviews.....	30
2.3.3 Learning strategies for Therapeutic Touch® practitioners	33
2.3.4 Measures of Therapeutic Touch® expertise	34
2.4 Theoretical Perspective of Therapeutic Touch®	37
2.5 Historical Basis for Therapeutic Touch®	39
2.5.1 Grad's experimental studies.....	40
2.5.2 M. J. Smith's experimental studies	40
2.5.3 Krieger's early work on hemoglobin	41

2.6 Efficacy of Therapeutic Touch®	43
2.6.1 Evidence of Therapeutic Touch® effectiveness	43
2.6.2 Reviews supporting scientific basis of Therapeutic Touch®	44
2.6.3 Therapeutic Touch® case study examples.....	45
2.6.4 Representative Therapeutic Touch® clinical research studies.....	46
2.7 Perceptions Related to Therapeutic Touch® Practice.....	49
2.7.1 Practitioner perceptions	49
2.7.2 Attitudes toward Therapeutic Touch®	50
2.7.3 Educational interventions.....	52
2.7.4 Client perceptions	53
2.7.4.1 Adults	53
2.7.4.2 Children.....	54
2.7.4.3 Healthy populations	54
2.8 Summary.....	55
Chapter 3 Method	59
3.1 Design	59
3.2 Setting	59
3.3 Sample.....	60
3.4 Focus Groups	60
3.4.1 Definition	61
3.4.2 Sample composition.....	62
3.4.3 Sample size	62
3.4.4 Methods.....	64

3.4.5 Types of questions	65
3.4.6 Strengths and weaknesses	66
3.5 Instruments.....	67
3.5.1 Demographic questionnaire	67
3.5.2 Field notes	68
3.6 Procedures for Data Collection.....	70
3.7 Procedures for Protection of Human Subjects	76
3.8 Procedures for Data Analysis.....	79
Chapter 4 Results and Summary.....	84
4.1 Introduction.....	84
4.2 Procedures Utilized.....	84
4.2.1 Blackboard® Wimba® Live Classroom.....	85
4.2.2 Blackboard® Collaborate™ Web Conferencing	85
4.2.3 Changes to procedures	86
4.3 Demographic Data of the Sample	86
4.4 Data Analysis Results	89
4.4.1 Discussion guide	89
4.4.2 Field notes	89
4.4.3 Transcripts.....	90
4.4.4 Long Forms	90
4.5 Data Confirmation	92
4.6 Summary.....	94
Chapter 5 Discussion and Recommendations.....	96

5.1 Introduction.....	96
5.2 Discussion of Demographic Data	97
5.3 Discussion of Findings.....	98
5.3.1 Sources of Therapeutic Touch® research.....	99
5.3.2 Descriptors of personal Therapeutic Touch® practice	99
5.3.3 Descriptors of Therapeutic Touch® expert.....	100
5.3.4 The future of Therapeutic Touch®	100
5.3.5 The expert RN Therapeutic Touch® practitioner	101
5.4 Emerging Themes	102
5.5 Relationship of Findings to Published Scholarly Literature	103
5.6 Researcher Bias.....	104
5.7 Significant Findings	105
5.8 Limitations of Study	106
5.9 Recommendations for Future Research	107
5.10 Conclusion	108
References.....	110
Appendices.....	136
Appendix 1 Focus Group Microsoft® PowerPoint (2010) Slides	137
Appendix 2 Letter to TTIA Board to Request Membership Access.....	141
Appendix 3 TTIA Board Permission Letter to Access Membership List.....	143
Appendix 4 Demographic Questionnaire.....	144
Appendix 5 Discussion Guide	148
Appendix 6 Email to Recruit Subjects.....	149

Appendix 7 Duquesne University IRB Approval Letter.....	151
Appendix 8 Duquesne University IRB Amendment Approval Letter.....	153
Appendix 9 Letter to TTIA Board to Request Amended Membership Access	155
Appendix 10 TTIA Board Permission Letter for Amended Membership Access.....	157
Appendix 11 Duquesne University IRB Approved Subject Recruitment Ad Content.....	158
Appendix 12 Email Instructions for Informed Consent and Demographic Questionnaire	159
Appendix 13 Informed Consent Form	160
Appendix 14 Email to Schedule Focus Groups (Wimba®).....	163
Appendix 15 Blackboard® Wimba® Classroom Setup Instructions for Subjects.....	164
Appendix 16 Scheduled Focus Group Email Reminder	166
Appendix 17 TTP Descriptor Paragraph.....	167

Chapter 1 Introduction

1.1 Background of the Study

Therapeutic Touch[®] (TT) is a nursing modality, which is also one of the leading Complementary and Alternative Medicine (CAM) energy therapies. Dolores Krieger and Dora Kunz developed TT in 1972 (Krieger, 2002). TT has a proud history of research completion in nursing, which has successfully crossed languages, international boundaries, and disciplines to enhance its scientific practice. The art and science of TT is ensconced in nursing practice and part of the armamentarium available to nursing professionals delivering care in a multitude of settings for many conditions across the lifespan.

In a comprehensive review of the literature (over 350 studies) from beginning research efforts in the 1960s through early 2015 the investigator identified a gap in defining, describing, and delineating expert TT practice. An examination of how expert nursing practice was described by author(s) in a number of different models and studies, led to several studies that addressed scholarly nursing practice (Meleis, 1991; Riley, Beal, & Lancaster, 2007) and the relationship between knowledge, experience, and performance (Whyte, Ward, & Eccles, 2009), which support the TT process. This study explores the perceptions of expert registered nurse (RN) Therapeutic Touch[®] practitioners (TTPs) as it relates to its expert practice, use of research findings, and the future of the specialty of TT.

1.2 Therapeutic Touch®

By definition, TT is a “contemporary interpretation of several ancient healing practices” (Kunz, 2004, p. 1). It “is an intentionally directed process of energy exchange, during which the practitioner uses the hands as a focus to facilitate the healing process” (TTIA, 2009, para. 3). These concepts supported research and practice in TT from its inception until Therapeutic Touch® International Association (TTIA) introduced a revision, “Therapeutic Touch® is a holistic, evidence based therapy that incorporates the intentional and compassionate use of universal energy to promote balance and well-being” (TTIA, 2013, para. 2).

1.2.1 Therapeutic Touch® founders. Dora van Gelder Kunz (1904-1999) was a well-known healer and clairvoyant. She was born in Java, lived in Australia, and emigrated to the United States (US). Kunz was President of the Theosophical Society in America (1975-1987) and an editor of the *American Theosophist*. The Theosophical Society published several of her books, which discussed TT, healing, and energy fields. Kunz (1985/1995) was both an editor, and a co-author (Kunz & Peper, 1985/1995, pp. 213-261), in the first book. A co-authored volume (Karagulla & Kunz, 1989) and a published book (Kunz, 1991) followed it. Kunz participated in annual healer workshops, at Pumpkin Hollow Retreat Center (Pumpkin Hollow Farm) and Camp Indralaya, and did much of her healing work with AIDS patients. Kunz and Krieger were frequent invited speakers and presented programs throughout the world during the many years of their collaboration (Kunz, 2004).

Dolores Krieger, born in 1935, is a professor emerita from New York University (NYU) College of Nursing (Nurse Healers—Professional Associates [NH—PAI], 1992).

In 1975, while on faculty at NYU, Krieger (2002) started teaching TT to MA and PhD candidates in the course *Frontiers in Nursing: The Actualization of Potential for Therapeutic Human Interaction*, which Fortune (1999) described as the “first formal course on healing to be offered as part of a fully accredited university curriculum” (p. 5). Krieger is an author (1972, 1973, 1974, 1975, 1987b, 1990, 1991, 2010) and co-author (Krieger, Peper & Ancoli, 1987; Krieger & Winstead-Fry, n.d.) of many letters, papers, and articles on TT.

She has also written a number of books on holistic health and TT (Krieger, 1979/1992, 1981, 1987a, 1993, 1997, 2002), and one on TT from tapes left by Kunz and sprinkled with her own comments (Kunz, 2004). Krieger, like Kunz, participated in the annual healer workshops until she formally retired in 2009 (D. Krieger, personal communication, Summer, 2010). Krieger then started smaller group sessions for advanced TTPs near her home in Montana each summer (D. Krieger, personal communication, January 18, 2011).

The TT Dialogues[®] series of five sessions worked on the development of a TT theory of healing (M. A. Hanley, personal communication, August 8, 2014). The descriptive terminology of this practice-based theory changed so its use could be extended to other healing modalities (D. Coppa & M. A. Hanley, personal communication, August 12, 2014). Work on the theory was presented in a panel discussion at the Third International Congress on Therapeutic Touch in 2015 (Hanley, 2015, April). The second five-year series of TT Dialogues[®] began July 31, 2015 and was the third consecutive year in attendance by the investigator.

1.2.2 Therapeutic Touch® organizational history. The development of TT by Krieger and Kunz led to Krieger and the nurses she taught to form Therapeutic Touch® International Association (TTIA) in 1977, as Nurse Healers—Professional Associates International (NH—PAI), which is now the credentialing arm of the organization (TTIA, n.d.b). Members practice Krieger and Kunz™ Therapeutic Touch (KKTT™). TTIA is the official organization for TT and “sets the standards for the practice and teaching of Therapeutic Touch®” (TTIA, 2005b) in the US. To that end, TTIA publishes guidelines, which include the definition, process phases, practice assumptions, supporting frameworks, uses, and research resources for TT (NH—PAI, 1992, 1994, 2004/2006b; TTIA 2014a, 2014b, 2014c).

Krieger and Kunz demonstrated that TT was a modality, which can be taught and successfully learned by anyone. This assertion challenged current thinking that healing was restricted only to those possessing special gifts. By 1992, TT classes had been presented in 70 different countries (Krieger, 1993). In 1997, TT was practiced in 99 health facilities in Canada, Ireland, New Zealand, the US, and West Africa; and taught in 88 nursing and health-related schools in Australia, Canada, Ireland, and the US (Krieger, 1993, 1997). TTIA now collaborates with both individuals and organizations practicing TT in diverse areas, across Africa, the Americas, Australia, and Europe, with recent reports of activity from Austria, Brazil, Britain, Canada, Germany, Italy, the Netherlands, and the US (May, 2011). TTIA (n.d.a) reports TT instruction of 200,000 people since its inception, with activity reports now in more than 100 countries.

1.2.3 Therapeutic Touch® treatment phases. A TT treatment consists of four phases, which may occur simultaneously in the dynamic TT process. Although, some

practitioners refer to non-contact TT, Krieger (1997) describes the “touch” as a process “in which the hands may either rest upon the healee’s body tissues to gain information or be used as sensors several inches from the body” (p. 108). The process is utilized to achieve the treatment goal, to reestablish order in the healee’s energy field. This goal is accomplished by the healer’s intention, which may facilitate or stimulate energy flow, mobilize an area of congestion in the energy field, quiet energetic activity, and/or synchronize rhythm in the energy field. Energy follows the intention of the healers’ mind and may be directed by the use of their hands (Krieger, 1993, 1997; NH—PAI, 1992). [Note: Terminology was updated in 2014 to change “healee” to “healing partner,” reflecting a universal terminology (D. Krieger, personal communication, August 8, 2014).]

1.2.3.1 Centering. Centering is focusing one’s mind and intent on the healing process (Krieger, 1997). It is an act of self-searching, proceeding inward following your own energy flow. Centering is important, because the healer is responsible for what happens during the therapeutic process and ending it (Krieger, 1979/1992, 1993). As healers develop their skills, they increase mastery of sustained centering and are able to tap into their intuitive skills. Kunz (1985/1995) stated that intuition requires insight and is comprised of compassion, creativity, and order. She viewed the intuitive field as the source of the healing energy used for TT (Kunz, 1985/1995).

1.2.3.2 Assessment. Assessment is the evaluation of the patient’s vital energy field (Krieger, 1997). The healer uses the hands to determine the nature of the field. Descriptive terms used to describe the field are warmth, coolness, static, blockage, pulling, pressure, and/or tingling sensations. The healer holds their hands two to six

inches away from the healee's energy field, starts at the head and proceeds down to the feet in a rhythmical symmetrical manner doing both the front and back of the healee (Krieger, 1979/1992, 1993; NH—PAI, 1992; TTIA, 2005c).

1.2.3.3 Rebalancing. Rebalancing includes directing, modulating, and unruffling to facilitate symmetrical flow of energy through the patient's energy field (Krieger, 1997). The healer may sense the healee's field with the energy centers in the hands. Energy patterns can be shifted or moved to the periphery of the healee's energy field where it may dissipate by using slightly more vigorous hand movements from the midline while proceeding in a rhythmical and symmetrical manner from the head to the feet (Krieger, 1979/1992, 1993, NH—PAI, 1992).

1.2.3.4 Reassessment. Reassessment is the process to verify the effects and conclude the treatment (Krieger, 1997). It involves evaluation of the healee's energy field to elicit feedback and to determine when to end the session. The healer stops when there are no longer any cues or perceivable differences bilaterally in the healee's energy field (Krieger, 1993).

1.2.4 Therapeutic Touch® treatment length. Krieger (1975) noted TT is the “simple placing of the hands for about 10 to 15 minutes on or close to the body of an ill person by someone who intends to heal that person” (p. 784). TTIA teaching guidelines state TT delivery is an individualized process, certain populations are more sensitive to TT, and treatment length usually does not exceed 30 minutes (NHPAI, 1992; 1994). Current usual treatment length is 20 minutes (TTIA, 2012a). A study by Zare, Shahsavari, and Moeini (2010) used the 20 minute treatment length (KKTT® protocol)

that was supported by 14 other completed research studies (e.g., Philcox, Rawlins, & Rodgers, 2003; Stiller, 2007) located by the investigator.

1.2.5 Therapeutic Touch® practice assumptions. TTPs base their practice upon assumptions found within the TTIA (originally NH—PAI) guidelines. Those original guidelines attribute assumptions to the co-founders of TT, Krieger and Kunz, and to Martha Rogers, a nursing theorist (NH—PAI, 1992). TT practice assumptions (with the attributed author in parentheses) are:

1. Human beings are open, complex, and pandimensional energy systems. (Rogers)
2. In a state of health, life energy flows freely. (Kunz)
3. Human beings are capable of both transformation and transcendence. (Krieger)
4. Healing is an intrinsic movement towards order that occurs in living organisms and can be facilitated by practitioners. Life energy follows the intent to heal. (Kunz) (NH—PAI, 1992, p. 1)

Updated guidelines (NH—PAI, 2004/2006b) added and restated assumptions for practice of TTPs. Those practice assumptions (with the attributed author in parentheses) are:

1. Healing is a natural potential...and is always possible (Krieger)
2. Human beings are open, complex, and pandimensional energy systems that are not bound by their skin (Rogers)
3. TT is a way to treat the whole human field (Rogers)
4. Universal healing field (energy) is a dynamic force that underlies the life process (Kunz)
5. Practitioners of TT act as instruments for the universal healing field (Kunz)
6. Human energy fields display patterns of growth, organization, and rhythmicity (Rogers)
7. Balance, harmony, and symmetry characterize a healthy energy field, whereas illness creates disorder, disharmony, and imbalances in the field (Kunz) (NH—PAI, 2004/2006b, p. 15)

The most current guidelines (TTIA, 2014a, 2014b, 2014c) were prepared by small work groups that TTIA published for Qualified Therapeutic Touch[®] Teachers[™] (QTTT[™]s) only, to provide classes at the basic, intermediate, and advanced levels of instruction. All QTTT[™]s agree to follow the established guidelines set by TTIA as part of the organizations' code of ethics (TTIA, 2005d). The assumptions remained largely unchanged, although the emphasis shifted more to Krieger and Kunz, less on Rogers, and one assumption was added, the “universal healing field (energy) is a dynamic force that underlies the life process (Kunz)” (TTIA, 2014b, p. 2). The 2014 curriculum revisions do not change the spirit or intent of the original TT practice assumptions, which guided the selection of the framework for this study.

1.2.6 Therapeutic Touch® frameworks. Published/printed guidelines for teaching TT have evolved over time. NH—PAI (1992, 1994) provided theoretical frameworks for the beginner’s (now basic) and intermediate levels of instruction for TTPs. The frameworks included Kunz’ human energy field model (HEF) model (Kunz & Peper, 1985/1995), relativity theory (Einstein, 1929/1960), quantum mechanics (Mishlove, 1975; see also Sayre-Adams & Wright, 2001), and Rogers’ (1970/1981, 1992/1994) science of unitary human beings (SUHB) for the beginner’s level. The investigator (Wardell, 2007, 2008a) described a strong support that was provided for TT by these three frameworks and the original four assumptions on which its practice were based. The intermediate level added content about Bohm’s holographic model (Haselhurst & Howie, 2009; Pratt, 1997) and psychoneuroimmunology (Pert, 1997; see also Briones, 2007; Fleshner & Laudenslager, 2004; McnCain, Gray, Walter, & Robins, 2005; Starkweather, Witek-Janusch, & Matthews, 2005) to the section on the TT theoretical framework.

Updated guidelines (NH—PAI, 2004/2006) were developed to assist those teaching at the basic, intermediate, and advanced levels, which included a template of critical elements to address, such as philosophical assumptions and the theoretical frameworks to support the practice of TT. Some content, which appeared new, was actually part of the previous version. In the previous version, Krieger’s transformation and transcendence were included with practice assumptions. Bohm’s implicate order is properly part of his holographic model, rather than a separate entity. Quantum field theory fits within the areas of quantum mechanics and field theory, which were already included. Krieger’s “Eastern philosophy” (NH—PAI, 2004/2006, pp. 3, 20; TTIA, 2014c,

p. 1) that includes the flow of energy or *prana*, was previously discussed in relation to the HEF model. Krieger (1997) described *prana* as necessary for the vitality of the human organism, serving as a conduit for universal life energy. Dossey and Keegan (2009) see the Eastern worldview with its foundation on energy as leading to the evolution of a blending with the Western worldview to restore balance and caring with the use of these practice modalities (p. 349). TT in the category of “modalities that are derived from an Eastern medical approach” (Dossey & Keegan, 2009, p. 354). Carpenito-Moyet (2010) also noted TT “is rooted in Eastern philosophy” (p. 250).

New content in the TTIA (2014a, 2014b, 2014c) guidelines consisted of Nightingale’s spiritual philosophy (Macrae, 1998), Weber’s (1981, 1984) philosophical foundations for healing, and system’s theory (von Bertalanffy, 1950, 1972). However, while these concepts may appear new, experienced teachers have utilized them for at least 20 years, as the investigator received instruction in those areas in a beginner’s (basic) course (J. Ziegler, personal communication, May 29, 1992). Consistency of documentation has lagged behind use, which further demonstrates the importance of continued investigation of expert practice to advance the knowledge base in this growing nursing discipline. These adjustments to the curricula add to the scientific evidence-based practice presentations by QTTTs™.

One significant change in the current guidelines was the addition of Watson’s theory of caring to the advanced curriculum (TTIA, 2014a), which the investigator did not encounter in 20 years of courses, workshops, and conferences. The extensive literature review completed by the investigator produced only three studies that included Watson in their theoretical rationale, none as the sole theorist. Those were a randomized

controlled trial (RCT) with 88 subjects (M. C. Smith, Reeder, Daniel, Baramée, & Hagman, 2003), a British qualitative study with sample size not stated (Hallet, 2004), and a qualitative interview dissertation study with eight adults (Shields, 2008). Watson (1985/1988) noted a transpersonal caring relationship can involve the transfer of energies between either partner (p. 63). Further, she believed that Eastern philosophy plays a part in her spiritual-existential and phenomenological perspective (Watson, 1985/1988, p.75).

For the purpose of this study, Krieger's (2002) concepts of transformation and transcendence established a framework for a focused qualitative investigation (see section 2.4). Krieger's concepts meld well with Weber's (1981) vision of a holistic philosophy that includes the elements of intentionality and compassion in healing energy.

Specifically, Krieger's (2002) description of compassion, centering, intuition, and intentionality, which are presented in an "experiential frame of reference for Therapeutic Touch" (p. 81), was used to support a theoretical perspective of transformation and transcendence for TT practice.

1.2.7 Therapeutic Touch® results. TTPs utilize TT to treat a variety of conditions, for people of all ages, in many different clinical settings. Krieger (1990) identified the top three uses of TT as relaxation, pain perception, and healing. Krieger (2002) stated "based on clinical studies and basic research, the anticipated results of Therapeutic Touch interventions with the highest reliability" (p. 218) included a reduction in anxiety along with pain, acceleration of healing, both physical and psychological, and induction of the relaxation response. Krieger (1991) previously discussed the uses and results of TT where she cited numerous studies (Fedoruk, 1984; Hale, 1986; Heidt, 1980, 1981; Hoggs [*sic*], 1985; Keller & Bzdek, 1986; Krieger, 1973,

1979; Meehan, 1985; Mueller-Hinze, 1988; Parkes, 1986; Quinn, 1982, 1984, 1989; Randolph, 1980, 1984; Wright, 1988) as support of those premises. Research studies completed since that time provide additional support, with significant results from quantitative designs and/or positive findings from qualitative designs, for these expected results for the use of TT: feelings of relaxation (Barron, et al., 2007; Kiernan, 2002); decreased pain (Xu, Sun, & Wu, 2009; Zare, et al., 2010) and anxiety (Larden, Palmer, & Janssen, 2004; Sova & Weaver, 2003; Taheri, Yaryari, & Molavi, 2013); and increased physical (Coppa & Cabral, 2005; Woods, Beck, & Sinha, 2009) and psychological (Gregory & Verdouw, 2005; Hawranik, Johnson, & Deatrich, 2008) healing.

1.2.8 Skepticism. One problem in evaluating the literature is the inordinate amount of attention TT has received from skeptics (Barrett, 2008; Glazer, 2001; Rocky Mountain Skeptics [RMS], 1999, 2000, 2001; Scheiber & Selby, 2000). Skeptics' failure to disclose their positions (P. E. Clark & Clark, 1984; Glazer, 2001; Mooney, 2005; O'Mathúna, 2000; Rosa, Rosa, Sarner, & Barrett, 1998) create a real potential for publishing bias. Careful attention to definitions, standards, and practices will elucidate those studies and publications that exhibit problems for the reader, with a goal to achieve fairness in reporting results of reviews and/or those of completed studies.

Competent, experienced TTPs believe each patient/client has the right to self-determination. Dennison (2001) shared that "nurses understand the patient's right to have a choice in one's healthcare" (p. 14). Fenton (2003) stated "patients and consumers should have the last word on whether or not they have access to such therapies," (p. 35) which they find has overwhelming support of evidence that it is "harmless and safe" (p. 35). It is important to remember that opinions proffered by skeptics do not diminish

the legitimacy of this well-researched and respected nursing discipline and specialty practice.

1.2.9 Scope of Therapeutic Touch® inquiry. TT has been studied extensively; beginning with an early historical review and 20 studies completed by Grad, M. J. Smith, and Krieger (see section 2.5). Over 350 studies have been completed since the inception of TT in 1972 through 2015. The majority (198) of studies explored TT with quantitative designs. Most (164) of those quantitative studies reported positive results, with statistically significant findings in over half (104) of the reports. Those studies, which employed qualitative designs (90), remained less than half the quantitative designs, even with case studies (30) were included. Over 150 TT research studies were published. The body of research also included independent research and many studies were completed during master's (46) and doctoral (42) degree educational programs, in nursing, healthcare, and related fields. In addition, 54 reviews of literature associated with TT practice were published. The studies that examined perceptions related to TT practice (90), which is the primary focus of this investigation, were qualitative studies, and will be discussed in more detail in the review of literature (see section 2.7).

1.2.10 Research related strengths and weaknesses. As in all types of scientific inquiry, TT research includes both strengths and weaknesses (Warber, Kile, & Gillespie, 2003). In a series of articles, the investigator reviewed the evidence for TT efficacy (Wardell, 2006, 2008b, 2010, 2013). To understand research on TT, which is a CAM modality, the state of CAM research resembles that of TT. Bondurant and Sox (2005) reviewed recommendations from the Institute of Medicine (IOM), which stated that to

compare CAM and conventional therapies, the research methods used to study them must be congruent.

Historically, randomized controlled trials (RCTs) have been the gold standard for proof of efficacy of specific therapies (Altman, et al., 2001; Thorne, 2001), but TT has not consistently met that standard. It has been proposed that different methods may be necessary to study CAM therapies (Bondurant & Sox, 2005; Herman, D'Huyvetter, & Mohler, 2006; Nahin & Strauss, 2001). Flesner, Miller, McDaniel, and Rantz (2010) discussed the expansion of evidence beyond RCTs to include research conducted utilizing various qualitative methods (p. 60). With scientific inquiry methods, Quinn (1989) cautioned, "there is a need to be cautious and creative in conducting...scientific study lest, like the butterfly that is pinned down for closer inspection, the phenomenon is destroyed in the attempts to understand it" (p. 87).

Newbold and Roberts (2007) examined scientific programs proposed by several different philosophers to describe how those stances line up with the current state of TT research. They believed the line between what is viewed as science or not by philosophers is, that of demarcation, which is an issue that remains unresolved in the scientific community. Newbold and Roberts concluded, "there is no universal, rule-based, scientific method which can be applied under all circumstances" (2007, p. 329). This lends support to the use of qualitative methodology, new methods of inquiry, and the cautious approach proposed by Quinn (1989).

Major strengths evident in this review of TT research are: the breadth of time studied (1961 to 2015), the multitude of study designs employed (e.g., case study, descriptive, experimental, historical, longitudinal, phenomenology), the variety of

populations studied (from pre-term infants, school-age children, and post-partum women, to older adults), the volume of published results (more than 150) in many different languages (e.g., English, French Canadian, German, Italian, Persian, Portuguese), and the variety of topics examined (e.g., anxiety, clinical conditions, pain, perceptions and other parameters related to TT practice, physiologic measures, stress). One illustration is Silva's (1986) use of Quinn's (1984) study on TT is an example of a research exemplar for testing the Rogerian-nursing model. Silva (1986) identified seven criteria to evaluate theory testing, which included clear statements of purpose, nursing model, framework, hypotheses/purposes, empiric testing, validity, and discussion (p.4). Quinn's (1984) study that looked at TT as energy exchange, was the first of three exemplars chosen by Silva (1986) to illustrate those meeting all of the stated criteria.

Some deficiencies found in reviews of CAM research have been small sample sizes, inadequate research design, and variable results (Kreitzer & Snyder, 2002; Nahin & Strauss, 2001). A review of energy research concluded that "given the current body of published reports, including two recent meta-analyses and a systematic review, the overall quality of evidence for this topic area, as specified by the guidelines for Quality of Evidence, is of the highest level" (Warber, et al., 2003, p. 98). More research is required for TT and other CAM therapies, to add to the body of knowledge and to guide nursing care recommendations (Kreitzer & Snyder, 2002; see also Wardell, 2006, 2008b, 2010, 2013).

The goal of this study is to investigate expert TT practice. One previously discussed gap in TT research, which supports this study, is the lack of a consistent method to determine what constitutes expert TT practice. The second gap is the paucity

of information available delineating expert practitioners' perceptions of the parameters under investigation. Only 25 of the 90 identified TT perceptions studies looked at practitioner perceptions. The majority of those studies were theses (4) and dissertations (9). Only two published studies (Coppa, 2008; Heidt, 1990) reported the use of TTPs with at least three years TT practice experience. Both studies looked at elements of the TT process, which is not a parameter of interest for this study. This investigation seeks to increase knowledge related to TT practice, which will serve to guide recommendations for future education of practitioners in the field.

1.3 Purpose of the Study

The purpose of this study is to explore registered nurse (RN) TT practitioners' (TTPs) perceptions related to their clinical practice as experts in the practice of TT. Parameters explored were practitioners' descriptions of expert practice, their views of their own levels of expertise, the impact of research findings on their practice, and their personal view of the future of Therapeutic Touch®.

The investigator found the majority of previous TT studies examined outcomes related to specific clinical conditions, while studies that looked at perceptions related to TT were the focus area of interest for this study. A change in the practitioner and/or their perceptions was the parameter investigated by 14 studies. The majority (28) of studies looked at the recipients' experience of receiving TT, while 11 examined aspects of practitioner/client interaction during TT. The remainder of perceptions' studies explored attitudes toward TT (26) and educational interventions (11) involving TT.

An identified gap in the literature is the paucity of current information regarding parameters that are consistently associated with expert TT clinical practice from the

viewpoint of the practitioner. The Subjective Experience of Therapeutic Touch Scale (SETTS) was developed in 1983 (Krieger & Winstead-Fry, n.d.) to reflect practitioner's experiences (see section 2.3.4). As determined from the scale's limited use, lack of SETTS score standards, and conflicting results with known expert TTPs, a gap exists in explicating criteria for expert TT practice.

1.4 Research Questions

1. How do Registered Nurse (RN) TTPs describe expert TT clinical practice?
2. What role do research findings play in expert TT clinical practice by RNs?
3. How do RN TTPs describe their personal level of expertise in TT?
4. What do RN TTPs envision as the direction of TT practice in the future?

1.5 Definition of Terms

Terms may be defined generally and in specifics. The components, practice, and theoretical basis of TT are understood to be that as described elsewhere in this paper. For the purpose of this study, the following terms are used in the manner specified.

1.5.1 Therapeutic Touch[®]. TT, as defined above (see section 1.2), is an energy modality, whose credentialed practice in the US was established by TTIA (as NH—PAI) in 1997, and continues to be administered by the organization (Denison, Good, Milton, & Newshan, 1998; TTIA, 2012b).

1.5.2 Qualified Therapeutic Touch[®] teacher[™] (QTTT[™]). A qualified TT teacher (QTTT[™]) possesses the credential provided by TTIA, which is a recognition process for active members of the organization who meet set criteria for competency in teaching TT. They must practice according to the TTIA “Standards and Scope of Practice” and the “Code of Ethics” and meet any governmental licensure requirements. A

qualified teacher is also recognized as a qualified TT mentor (QTTM™) and a qualified TT practitioner (QTTP™) upon receiving the QTTT™ recognition (TTIA, 2005a).

1.5.3 Expert Therapeutic Touch® practitioner (TTP). For the purpose of this study, an expert practitioner is a registered nurse (RN) with active licensure, who has a minimum of three years TT practice and attended three TT workshops (at least one taught by a QTTT™) or attended two TT workshops (at least one taught by a QTTT™) and completed a one-year mentorship program. Individuals who completed an advanced TT training course and /or were credentialed as TT teachers, mentors, and/or practitioners also qualified as expert practitioners. This was based upon the criteria for application to the TTIA invitational workshops, which include completion of basic and intermediate TT courses, and at least three years of practice experience, with a mentorship program recommended (NH—PAI, personal communication, April 28, 2011). Credentialing in nursing is recognized as one factor strongly related to expert practice, in nursing specialties.

The choice of a minimum of three years practice experience was based upon two factors: necessary time to complete basic, intermediate, and advanced training, and previous research noting a difference between practitioners with less than, and those with more than, three years TT practice experience (Krieger & Winstead-Fry, n.d.). The expectation was those individuals who attended the advanced invitational TTIA courses would be exposed to expert practitioners. This provided them with sufficient intervals between training to advance their personal practice and skills. Exclusion criteria included practitioners who did not possess an active license as a registered nurse, anyone for

whom informed consent was not obtained, and those who choose not to participate in this research study.

1.5.4 Focus groups. For the purpose of this study, a focus group methodology (see section 3.4) was utilized (Krueger & Casey, 2009).

1.6 Assumptions

1. TT exists, based upon an extensive body of research that has been accruing for over 40 years.
2. Individuals are able to learn to perform TT.
3. Participants have the required TT practice experience.
4. Focus groups are a valid methodology that may be conducted online, utilizing synchronous data collection (K. Stewart & Williams, 2005).

1.7 Limitations

1. “Group think,” which has been described as “the impact of censoring and conforming” (Janis, as cited in MacDougall & Baum, 1997, p. 532; see also Hollander, 2004), may impede acquiring perspectives of all participating group members.
2. The nature of use of the interview process environment to collect data presents threats to both reliability and validity (Hupcey, 2005).
3. Potential for bias with purposive sampling when the researcher is looking for participants who have the most knowledge and experience related to the study parameters (Hupcey, 2005).
4. Credibility of the results, with potential lack of gender and ethnic diversity, may limit generalizability (external validity) of the findings (Hupcey, 2005).

1.8 Significance to Nursing

Krieger and Kunz developed TT as a nursing modality. They conducted their initial research studies with nurses who they trained to perform TT. To increase the

credibility of energy medicine, such as TT, Feinstein and Eden (2008) noted scientific investigation is one factor that increases its credibility. This melds extremely well with Kunz's belief that scientific standards were needed to evaluate TT practice, so TT would "be considered an addition to conventional medical care, not a replacement for it" (Wager, 1996, p. ix).

In an ever-changing U.S. health care environment, research in TT and CAM (which includes energy medicine modalities, such as TT) is crucial to meet consumers' needs. Studies have demonstrated the growth of CAM services provided in hospitals (Clement, Chen, Burke, Clement, & Zazzali, 2006) and the increased acceptance of alternative therapies in our current healthcare system (Bland, 2005). Early studies established the utilization of alternative therapies has increased (Eisenberg, Kessler, et al., 1993; Eisenberg, Davis, et al., 1998) and energy healing, like TT, showed the largest increase in usage (Eisenberg, Davis, et al., 1998). Data from the 2002 NHIS revealed that approximately one-third of participants, slightly less than one percent of the U.S. population, had used a CAM therapy in the previous year (Tindle, Davis, Phillips, & Eisenberg, 2005). More recent studies have tried to compare conflicting data from the National Health Interview Survey (NHIS) conducted by the U.S. Census Bureau.

Clarke, Black, Stussman, Barnes, and Nahin (2015) examined trends of the 2002, 2007, and 2012 NHIS studies. They stated given the NHIS data represented the US population, it allowed them to perform analysis based upon population estimates (Clarke, et al., p.3). While, the authors concluded that yoga was the leader in growing CAM trends over the ten year time period; close examination of the data provided indicated that energy therapies, which include TT accounted for approximately 1% of the reported

CAM therapies. At current population figures, one percent is slightly more than 3.2 million people (U.S. Census Bureau, 2015). This represents a significant treatment population for today's practicing nurses to address.

In order to provide comprehensive individualized care for patients/clients, TTPs strive to provide holistic care, which integrates TT with traditional care. The American Holistic Nurses Association (AHNA) description of holistic nursing includes the utilization of “nursing knowledge, theories, expertise, and intuition to guide nurses in becoming therapeutic partners with people in their care” (2015, para. 2). AHNA recognizes the “totality of the human being—the interconnectedness of body, mind, emotion, spirit, social/cultural, relationship, context, and environment” (2015, para. 2) as integral to holistic nursing. Determining how experts make use of theories developed through research and how the individual views knowledge and expertise are important factors to be investigated in this specialized holistic nursing discipline (TT).

The introduction of TT by Krieger at NYU in 1975 stimulated its dissemination throughout the nursing scholarly community. In a 2003 study of nursing schools, Fenton and Morris found that TT was included in 47% of the surveyed programs. Downey (2007) surveyed baccalaureate-nursing students and graduates, who completed a holistic nursing course. Of those surveyed, 41.5% reported personal use of TT and 45% utilized TT in their professional practice. In addition, TT was the modality used most frequently in professional practice by the respondents. As noted previously, by 1997 TT was taught and practiced internationally by healthcare professionals (Krieger, 1993).

Additional early support for TT as a nursing modality was the adoption of “disturbed energy field” as a nursing diagnosis in 1994 (North American Diagnosis

Association [NANDA], 2005; see also Wardell, 2006, 2008b, 2010, 2013). This designation continued through the 2012-2014 NANDA International list (Bartelmo & Eckman, 2013, p. 272). In 2015, it was “removed from the taxonomy, but reassigned to level of evidence...theoretical level, for development and validation” (Herdman & Kamitsura, 2014, p. 455). The accompanying rationale “all literature support currently provided for this diagnosis is regarding intervention rather than the diagnosis itself” (Herdman & Kamitsura, 2014, p. 455) demonstrated continued support for the scientific basis for TT practice.

Consumers, who are more knowledgeable about available treatments, with increased use of computers and Internet access, request TT and other CAM therapies. The ability to provide safe, efficacious, evidence-based therapies is of prime importance to the nursing professions’ continued ability to maintain a position of trust in the eye of the consumer. Utilizing available sources, such as Internet resources, will expand knowledge in a specialty area (Wardell, 2005), like TT. Kiernan (2002) noted “nurses using Therapeutic Touch in their practice can often assist to put patients at ease and accelerate a dimension of intimacy in the relationship that can improve the delivery and acceptance of healthcare” (p.53).

Simko (2005) pointed out instituting evidence-based practice (EBP) creates an environment where nursing must address the need for care delivery design with the best available evidence. Seasoned TTPs (Benkofsky-Webb, Good, & Winstead-Fry, 2004) noted the importance of including “non-research variables, such as the patient’s preference, qualitative data, and the practitioner’s experience” (p.1), when EBP is a goal for nursing practice. Krau (2014a) discussed the challenges in achieving EBP in patient

outcomes. The best evidence is “only as viable as those who understand the evidence and its value and can transition this knowledge into practice” (Krau, 2014a, p. xiii). To serve their patients/clients effectively, nurses must seek out evidence-based knowledge for TT.

As the use of energy therapies increases, it is important to the nursing profession to identify characteristics of individuals seeking to become TT practice experts. The necessity to mentor individuals as future leaders provides for the successful transition of both skills and knowledge. Dracup and Bryan-Brown (2004) stressed the importance of mentors in the healthcare setting as they teach skills, provide experiential learning and professional challenges, and introduce collegial networks. Those prepared leaders create an environment to disseminate holistic education to future TTPs.

By exploring the perceptions and experiences of TTPs in the field, information enlarges the body of knowledge, which facilitates the initiation and expansion of theory development and practice changes. In order to provide care for the growing number of individuals who request TT and other CAM therapies from nurses and other healthcare providers, there is a need to address pressing gaps in our research base. Identified gaps are the lack of a consistent method to determine expert TT practice and the paucity of information collected regarding perceptions of expert TTPs. This study addresses one important area for investigation—the state of expert TT practice as envisioned by those who qualify as expert nurse TTPs in the modality of Therapeutic Touch®.

Chapter 2 Review of the Literature

1.1 Introduction

The purpose of this review is to examine relevant literature related to expert practice in Therapeutic Touch[®] (TT), a nursing modality. The review provides support to investigate the perceptions of expert nurse practitioners in this growing nursing specialty. The relationship of TT to CAM is clearly delineated. Expert TT practice is described with practice models, evidence-based practice support, learning strategies employed by practitioners, and a measure of TT expertise. Concepts of a theoretical perspective for TT practice are discussed relative to expert TT practice. Historical research findings, which form the basis for TT practice, are reviewed. This literature review is limited to pertinent studies that illustrate the efficacy of TT and perceptions related to TT practice. Information provided illustrates two gaps in completed TT research, which support conducting this study. One gap is the paucity of information collected regarding expert practitioners' perceptions related to the specific parameters under investigation in this study. The other is an absence of consistent use of a demonstrated reliable method to quantify and/or describe expert TT practice.

2.2 Relationship of Therapeutic Touch[®] to Complementary and Alternative Medicine (CAM)

Krieger and Kunz created TT as a nursing modality and intervention, but TT is also considered a leading CAM energy therapy. The definition of CAM has evolved with its increased use and acceptance. The National Center for Complementary and Alternative Medicine (NCCAM), part of the National Institutes of Health (NIH), defined CAM by exclusionary criteria, as practices are not considered part of conventional or allopathic medicine (National Institutes of Health/National Center for Complementary and Alternative Medicine [NCCAM], 2010a). The conundrum in the classification system is some therapies may fall into one or more of the NCCAM (2010a, 2010b) categories. In their five-year strategic plan (NCCAM, 2000) noted the “absence of any one CAM modality in no way implies its intentional omission” (p. 25). This statement is pertinent because the updated (NCCAM, 2010b) list of field therapies omits TT. TT is an example of an energy field therapy (NCCAM, 2010a). Biofield therapies, which involve manipulation of biofields, are classified as putative energy field practices (NCCAM, 2010b).

Other examples of energy therapies are Healing Touch (HT), Qigong, and Reiki. In HT “practitioners consciously use their hands in a heart-centered and intentional way to support and facilitate physical, emotional, mental, and spiritual health” (Healing Touch Program, n.d., para. 1). Qigong “is an ancient Chinese health care system that integrates physical postures, breathing techniques and focused attention...for health maintenance, healing, and increasing vitality” (National Qigong Association, n.d., para. 1, 3). Reiki is a

technique of Japanese origin, which is “administered by the ‘laying on of hands’” (LOOH) used for decreasing stress (The International Center for Reiki Training, n.d., para. 1).

Although TT researchers have enjoyed a positive relationship with NIH and NCCAM in terms of funded studies, funding has been sporadic. TT researchers reported funding as early as 1997 from the Office of Alternative Medicine (Olson, Sneed, LaVia, Virella, Bonadonna, & Michel, 1997). Two early reviews of the literature (Astin, Harkness, & Ernst, 2000; Kronenberg & Fugh-Berman, 2002) received funding from NCCAM. Later, a group of researchers received NCCAM funding for a series of laboratory studies looking at human cells in culture (Gronowicz, 2007; Gronowicz, Jhaveri, Clarke, Aronow, & T. H. Smith, 2008; Gronowicz, Secor, Flynn, Jellison, & Kuhn, 2015; Jhaveri, Walsh, Wang, McCarthy, & Gronowicz, 2008).

However, concern for future TT research must be raised by Rubik’s (2011) report she was unable to locate enough TTPs to conduct her approved study on TT. Rubik’s 2002 NCCAM project, “Bacterial Growth and Motility Assays for Biofield Therapy” described using 20 TTPs for a two-year long laboratory project; it included a comparison of the effect of TT to Johrei, but no design description was included for the Johrei arm of the study (NIH Research Portfolio Online Reporting Tools [RePORT], 2011). Johrei is a “philosophy,” that came to the US from Japan and is a “method of focusing spiritual energy for healing” (Johrei Fellowship, n.d., para 1-2). Rubik (2011) stated she resubmitted the three-year grant for the TT study to conduct one on Reiki instead (Rubik, Brooks, & Schwartz, 2006). It is important for TTPs to be cognizant of major research funding opportunities lost for TT; and what part research design, such as plans for

adequate numbers of trained personnel, play in approved grant applications, which do not come to fruition as completed work.

In addition, The National Center for Complementary and Integrative Health (NCCIH, 2015) was created to address changes in the use of CAM therapies, with an increase in the former (complementary) and a decrease in the latter (alternative), to rename the NCCAM. The NCCIH (2011) also brought a new strategic plan and objectives based upon the 2002 and 2007 NHS studies. With the choice of terms used to gather data in the NHS studies, Therapeutic Touch[®] is included in energy therapies and not an individual category. In the new objectives, research advances are planned for mind body disciplines, but the only examples were Healing Touch, Reiki, and Qigong (NCCIH, 2012).

Given the association of nursing's TT modality with CAM therapy, an examination of reasons for the use of CAM therapies is prudent. Posited as a link to the increasing use of CAM therapies is dissatisfaction with mainstream medicine, but researchers have provided other explanations. Kroesen, Baldwin, Brooks, and Bell (2002) conducted a focus group study of 100 veterans who used CAM, to delineate issues related to its use. They found most subjects were satisfied with the care they received in the VA health care system. Those subjects stated dissatisfaction related to several specific aspects of their care, including complaints about prescription medication side effects, lack of emphasis on preventative medicine, and a desire for a more holistic care approach (Kroesen, et al., 2002).

Fawcett, Sidney, Hanson, and Riley-Lawless (1994) in an exploratory study of 16 adults with multiple sclerosis examined use of alternative therapies. Findings indicated

subjects utilized between one and five therapies, with 6% utilizing TT. The authors found that 63% of subjects sought out CAM therapies because of a lack of cure for their condition (multiple sclerosis), but 100% of subjects reported seeing a physician for it (Fawcett, et al., 1994, 1994). These studies illustrate the need for expert practitioners to be aware of research in CAM therapies and to refer and/or provide CAM treatment for patients.

2.3 Expert Practice

It is important to investigate components of expert practice given this study's focus on nurses who are expert TTPs. Studies that examined expert practice in clinical settings are reviewed. Described are the pertinent evidence-based practice supports associated with reviews of TT literature, which influence expert practice. Discussed next are learning strategies for TTPs. Examination of existing literature that discusses a measure of TT expertise completes the investigation.

2.3.1 Expert nursing practice. Hardy, Titchen, Manley, and McCormack (2006) reported on a six-year project initiated across all of the countries in the United Kingdom to examine expertise in practice. Their goal was to develop accreditation and practice standards to recognize expertise. They utilized six geographically dispersed dyads of nurses with a "critical companion" (Hardy, et al., 2006, p. 261). The dyads, over a period of 12 to 16 months, assembled a portfolio of evidence to support expert practice. Content analysis was performed by Hardy, et al. (2006), from the submitted portfolios, then compared with, and supported by, available literature on the subject to identify five attributes of nursing expertise—patient knowledge, skills knowledge, holistic practice knowledge, saliency, and moral agency. TTPs need in-depth knowledge of their

modality, with advanced skills, such as the ability to assess and modulate energy fields, to maintain their holistic practices.

Baumann's (2006) editorial to introduce the previous study, concluded another attribute to that study report (Manley, Hardy, Titchen, Garbett, & McCormack, 2005) may be interpersonal skills, in that they represented another "form of practice-related knowledge" (Baumann, 2006, p. 259). Baumann (2006) suggested expert nurses need to "retain in some ways the attitude of the novice" mindful "that there is always much to learn" (pp. 259-260). He finished with a reminder that "expert clinical practice should be the goal of all nurses" (Baumann, 2006, p. 260). Attaining advanced levels of education and credentialing is important to those seeking designation as QTTP™s and QTTT™s.

Riley, et al. (2007) interviewed 36 experienced acute care clinical nurses, in a descriptive study of scholarly nursing practice. Content analysis revealed two primary themes—what the nurses did and how they perceived themselves. Nurses saw themselves learning, evolving, exuding confidence, leading, and sharing what they knew with coworkers. Krieger (2002) stated her belief that nurses practicing TT evolve within their own lives, experiencing what she calls transcendence.

Meleis (1991), cited in the previous study (Riley, et al., 2007), identified scholarship as an integral part of the practice of experienced nurses. Meleis defined scholarliness in nursing as a combination of "theory, research, philosophy, and...practice" (1991, p. 116), with an emphasis on inclusion of practice expertise with the attributes of becoming a scholar. Further, "because nurses deal with complex phenomena, with human beings, with behaviors, cognitions, and perceptions, the discipline cannot use one meaning of truth to the exclusion of others" (Meleis, 1991,

p. 120). Meleis stated the discipline of “nursing operates from a health and holistic approach and purports to enhance coping and harmony with one’s environment” (1991, p. 121). She summed up the importance not only of scholarly practice for the expert nurse, but also of including holistic care within that practice, which encompasses the ability to utilize perceptions to delineate truth (Meleis, 1991). The intuitive process of TT may be used to uncover disturbances in both the human energy field and its interaction with the universal field (Kunz, 1995) surrounding it.

Whyte, et al. (2009) performed an experimental study utilizing a simulated environment with a human simulator to examine the relationship between knowledge, experience, and clinical performance in a critical care setting. They observed the clinical performance of 22 critical care nurses, 12 experienced (minimum of 7 years’ experience) and 10 novice (less than 1 year experience), during four 3-minute simulated respiratory scenarios. While experienced nurses demonstrated statistically significant ($p < .001$) greater knowledge when compared to novice nurses, length of experience did not translate into clinical performance differences. A subset of six “true experts” (Whyte, et al., 2009, p. 522) included the only four experienced nurses who had achieved Certification in Critical Care Nursing (CCRN). This subset exhibited superior performance when compared to the other participants, which is congruent with the opinion of nursing professionals that the CCRN credential is a significant indicator of both competence and expertise in critical care nursing practice. Similarly, we recognize credentials in TT as an indicator of advanced performance, knowledge, and expertise.

2.3.2 Evidenced-based practice support associated with Therapeutic Touch® reviews. Experts utilize the best evidence available to structure their

performance. Utilizing principles of evidence-based practice, the expert keeps abreast of changes and improvements through education, practice, and research. Systematic reviews are one source of information to assess current practices and improve clinical practice outcomes.

Jennings and Loan (2001) performed a critical review of evidence-based practice literature from medicine and nursing to examine the terminology and its components among disciplines and across international borders. They noted that the definition varied as did the rankings of research studies in evidence hierarchies, with qualitative research receiving less weight, especially in systematic reviews. Day (2009) indicated that perils are associated with adoption of rigid rules with those standards:

The ability to step safely outside of abstract, general rules and respond to the particular in each situation is a skill that is essential to the relational practice that operates in rapidly changing situations. If we do not support expert practice and foster the development of expertise, we risk losing what is fundamentally important to nursing practice. (p. 482)

Jennings and Loan noted since conducting systematic reviews is quite time-consuming to process information, practitioners refer to those already completed. They gave an example of the Cochrane library whose results based upon their reliance on randomized controlled trials (RCTs) would only provide sources meeting their “criteria of best evidence” (Jennings & Loan, 2001, p. 125).

One way to make use of available information is to refer to best practice guidelines, such as the one developed for TT, by the Registered Nurses Association of Ontario (RNAO). Moore (2005) described the process whereby the RNAO set out in

1999 to develop nursing best practice guidelines to enhance patient care delivery. Moore discussed the essence of those guidelines as being guided by client-centered care, which involves respect, human dignity, and acceptance of clients as both experts and leaders in their care. These principles are inherent in the mutual process, engaged in between the healer and healee during a TT treatment.

Currently, the College of Nurses of Ontario (CNO, 2014) has printed practice guidelines for complementary therapies. Issues addressed include client consent, appropriateness of the therapy, skill and knowledge of the practitioner, appropriateness for client and setting, and the nurses' responsibility for the outcomes. Further, they provided scenarios to illustrate "challenges" (CNO, 2014, p.6), believed to face nurses who choose to integrate complementary therapies into their practice. A review of the guidelines by the investigator indicated they were also compatible with current practice of TT in the US.

Krau (2014b) noted that the work in Britain by Cochrane led to the founding of the Cochrane Collaboration. From this focused global research effort came the development of international nursing practice reviews. These reviews were meant to provide the best evidence for the development of clinical practice guidelines (Krau, 2014b, p. xi). With these individuals and groups may translate the evidence from the clinical practice guidelines into a format feasible to integrate EBP into local care delivery settings, such as a medical-surgical unit (Saunders, 2015, p. 2035).

Benkofsky-Webb, et al. (2004) conducted an evidence-based practice review of TT and pain. They located 14 studies with reports of reduced pain in 5 case studies and positive responses in 8 out of 9 quantitative studies reviewed. The authors concluded TT

is an appropriate intervention for patients experiencing pain, since “many reports support the efficacy of Therapeutic Touch in significantly reducing or relieving chronic and acute pain” (Benkofsky-Webb, et al., 2004, p. 9).

2.3.3 Learning strategies for Therapeutic Touch® practitioners. Sharoff (2004) employed a qualitative naturalistic method in her dissertation study to examine how holistic practitioners obtained information to support expert practice. She interviewed 10 American Holistic Nurses Association (AHNA) certified holistic nurses (HNCs) with a minimum of three years’ experience in holistic practice, whom she identified as competent and expert practitioners. However, an identified limitation was while all of the HNCs held a minimum of a baccalaureate degree, none acquired certification after the implementation of national education, experience, and testing standards. They had acquired certification under the earlier portfolio submission process, which did not include formalized testing (Sharoff, 2004). Sharoff (2004) found all HNCs reported use of informal rather than formal learning strategies, in their journey toward achieving competence. She found they employed various strategies including mentors, educational materials and conferences, experiential learning, and gaining increased awareness and confidence with their practice (Sharoff, 2004). This study illustrates the need for continuing education in CAM therapies.

Opportunities for TT continuing education include yearly TTIA sponsored basic, and intermediate courses at Pumpkin Hollow and Camp Indralaya bicoastal theosophical retreat centers. The centers also provide TTIA sponsored annual invitational advanced and mentorship workshops for advanced TTPs. In some geographical areas, practice groups exist for TTPs to share their experiences and practice TT. TTIA is endeavoring to

increase educational offerings, with plans to develop one-hour educational modules (D. Shields, personal communication, September 12, 2010). In addition, TTIA reinstated the presentation of its biannual international conference in 2009, to share current information with its membership and other interested holistic practitioners. The 2015 conference presented information on a new practice based theory of TT, as a “working theory of healing” (Matheny, Cole, Coppa, & Hanley, 2015, p. 3).

2.3.4 Measure of Therapeutic Touch® expertise. Literature to support measurement of TT expertise is sparse. Krieger developed The Subjective Experience of Therapeutic Touch Scale (SETTS) with the assistance of Winstead-Fry (Krieger, 1993; Krieger & Winstead-Fry, n.d., Winstead-Fry, 1999) to examine practitioners’ experience with TT. The SETTS contains 68-scored items on a scale from 0 (not at all) to 4 (all the time), with a range of scores from 0 to 272. In the SETTS manual, Krieger and Winstead-Fry (n.d.) described the SETTS design was to reflect practitioners’ experience in four categories, physical (#1-24), emotional (#25-42), mental (#43-54), and altered states of consciousness (#55-68).

Krieger (1993) tested the SETTS with a sample of 250 nurses to reflect practitioners’ experiences doing TT. She reported the SETTS’ internal consistency reliability was established by a Cronbach’s alpha reliability = .98. Predictive validity was demonstrated by statistically significant ($p = .001$) results that distinguished between experienced TTPs, defined as possessing a minimum of three years TT experience, and inexperienced practitioners.

In a funded dissertation study, Ferguson (1986) expanded work on the SETTS. She utilized a four-group quantitative design, with a sample of 200 nurses. Her study

results showed a statistically significant ($p < .01$) difference between experienced TTPs, inexperienced TTPs, non-practitioners doing mimic TT, and non-practitioners doing regular touch. Mimic TT (MTT) is a sham treatment, either performed by someone not trained in TT or by a practitioner who does not center and counts backward from 100 in serial sevens, for example. The SETTS scores for experienced TTPs ranged from 97 to 258 with a mean of 176.90, while those of inexperienced TTPs ranged from 51 to 211, with a mean of 137.18. Ferguson established a Cronbach's alpha reliability = .967, similar to that of Krieger's previous study. Since 1986, support for use of the SETTS has relied upon citation of these two studies.

Krieger (1983, 1987b), reported using the SETTS in a study with expectant fathers, who participated in Lamaze classes for childbirth preparation. Krieger (1987b, 1990) described a 1983 government funded, longitudinal study of 80 couples participating in classes with American Society for Psychoprophylaxis in Obstetrics certified teachers. Expectant fathers received instruction in TT to use with their spouse, and were considered to be performing TT if they achieved a score of 30 on the SETTS. Krieger (1987b, 1990) reported statistically significant ($p < .05$) increased marital satisfaction for the TT group and continued low state anxiety for the treated couples.

One thesis (Sies, 1995) and two dissertations (Mersmann, 1994; Stravena, 1993) included documented use of the SETTS to describe TTPs utilized in their studies. Sies (1995) exploratory study reported the SETTS score for TTPs in her study was greater than 97 (Ferguson's (1986) lowest score for experienced TTPs). Stravena's (1993) experimental study documented the TTPs scored 65% or greater (65% of 272 = 176.8, which is slightly lower than Ferguson's reported mean of 176.90 for experienced TTPs)

on the SETTS. Mersmann (1994), who conducted an experimental study, reported a range of 196 to 264 (all higher than Ferguson's mean for experienced TTPs) on the SETTS for four female nurses with a mean of 10.7 years' experience, who were the TTPs in her study.

Barrington (1994), who provided TT, in a 1992 funded, naturalistic study, stated she used the SETTS to assess her own competence and achieved a "high score" (p. 205), which indicated she met the criteria for an experienced TTP. Only Woods Smith and Broida (2007) described SETTS use as part of their experimental study to examine TT experience, power, spirituality, field potential, pain, and stress. They used four experienced TTPs, with a minimum of three years TT experience, whose mean SETTS score was 175, which they note "was consistent with an unpublished report of mean scores of 177 for experienced healers" (Woods Smith & Broida, 2007, p. 221). However, one TTP scored 108, which is well below Ferguson's (1986), reported 137 mean score for an inexperienced TTP. This would account for the group mean (range 51 to 211) falling below Ferguson's (1986) mean for experienced TTPs.

Woods Smith and Broida (2007) presented conflicting results for use of the SETTS as a measure of expertise, since an experienced TTP, known to the primary researcher (Woods Smith), possessed eight years TT experience but scored the lowest on the SETTS (D. Woods Smith, personal communication, July 28, 2008). P. Winstead-Fry, (personal communication, October 30, 2002) reported attempts to update the SETTS have been underway since 1999. P. Winstead-Fry (personal communication, Spring, 2010) reported work was continuing to validate the measure. The investigator attempted to

contact Winstead-Fry in October, 2015 by email but it bounced back. No additional studies testing the scale were located during a periodic update of the literature.

2.4 Theoretical Perspective of Therapeutic Touch®

Krieger's concept of transformation and transcendence, one of the theoretical practice assumptions for TT practice, creates a basis to explore the concepts related to perceptions of expert practice in this study. Krieger (2002) defined transformation as "the act of making a thorough or dramatic change in the form, outward appearance, or character of an individual; a sudden, dramatic change" (p. 24). Transcendence, by definition, is "the act of going beyond the range or the grasp of human experience, belief, or reason" (Krieger, 2002, p. 24). Embodied in expert TT practice are the concepts primary to transformation and transcendence. To become more sensitive, intuitive, and skillful, experts grow, adapt, and change with their environment. The development of compassion, intentionality, centering, and intuition by the TTP forms the crux of this transforming process, which as one becomes expert leads to transcendence (Krieger, 2002).

The first step in incorporating TT into the therapists' lifestyle is "the recognition and implementation of the power of compassion" as they decide to enter into a relationship to "help or heal those in need" (Krieger, 2002, p. 95). Krieger noted that compassion is often thought to be only a feminine quality, but is available to all. She stated that it involves the call to push beyond our usual capabilities and reach out to meet the needs of others. To accomplish this it is necessary to maintain a compassionate state of consciousness. Without it, one is not performing TT. "It is the act of compassion [which] gives access to new states of awareness" (Krieger, 2002, p. 86).

Intentionality is the second step where “the purposeful use of breath... serves to alter the biochemistry of the body. Intentionality is reinforced by the clear visualization that actualizes the healing moment” (Krieger, 2002, p. 95). Intentionality forms the basis for the TT process. It must be used “in a knowledgeable fashion, which lends surety, stability, and confidence to the effective direction and modulation of the healing energies during the TT rebalancing phase” (Krieger, 2002, p. 99).

“Throughout, the continued centering of the TT therapist’s consciousness in effect converts the Therapeutic Touch process into mindful walking meditation” (Krieger, 2002, p. 95). Centering has two functions in the TT process. “It provides entrée to the therapist-healee interaction, and supports that interaction by sustaining an appropriate milieu for the direct participation of the TT therapist’s inner self” (Krieger, 2002, p. 116). Krieger noted some of the characteristics include: “psychomotor quieting of the physical body...a sense of timelessness...a profound stillness and sense of peace...clarity in the recognition of compassion as power [and] a strong grasp of intuitive insights” (2002, p. 116).

Krieger (2002) noted, “consistent encouragement and continuous testing of the use of intuition in the process of healing may stimulate the unfolding of confidence in their higher-order resource of the self” (p.155). Krieger stated that one is able to recreate the intuitive state, which is facilitated by achieving the state of consciousness achieved during the sustained centering experience. Further, as one develops their abilities in TT with transcendence, “one can develop seemingly unreasonable trust in strong intuitive perceptions” (Krieger, 2002, p. 156) during the assessment process.

Krieger (2002) described aspects of the personal transformation achieved through adopting TT into one's lifestyle.

As the TT therapist makes these attributes [compassion, intentionality, centering, intuition] her own, and her experience presents other alternatives to her perceptions, her world-view changes dramatically to accommodate her glimpse of the multiple realities that have enlarged and vitalized her universe...The personal transformation of the individual TT therapist is as diverse as the complexity of her personality and the intricacies of her life experiences...Therapeutic Touch is both a mode of healing and a support for the personal growth of the TT therapist. It is an opportunity for increased self-knowledge, increased appreciation of subtle energy dynamics, and increased communication with the inner self...one needs to be well grounded, centered, cognizant of the inferences of one's actions, and accepting of that responsibility. (pp. 95-97)

Experienced TTPs often report an awareness of this transforming process. This current study explores the perceptual experiences as related by expert TTPs.

2.5 Historical Basis for Therapeutic Touch®

Early research efforts, including nine funded studies, which were completed by Dr. Bernard Grad (1963, 1964, 1965, 1967; Grad, Cadoret, & Paul, 1961), Sister M. Justa Smith, PhD (1972), and Dr. Dolores Krieger (1972, 1973, 1974), paved the way for modern TT research. These researchers relied on the use of a Hungarian soldier, Oskar Estebany, who had an innate gift for healing, for most of their studies. Estebany worked with injured horses in the cavalry and later transferred his healing gift to other populations and projects (Karagulla & Kunz, 1989).

Estebany was utilized as the healer in 15 of these 21 early historical studies. The populations studied included 243 adults, 3 different enzymes, 396 mice, and 160 pots of barley seeds. Parameters examined were hemoglobin, activity, wound healing, and growth and yield, respectively. Researchers reported significant results in 17 of the 20 experiments performed. One experiment (Grad, 1963) employed only two control groups (CGs), while another (Grad, 1964) reported some positive results, which did not reach the level of significance.

2.5.1 Grad's experimental studies. Krieger (1975) reported early research in the “practice of healing by the laying-on-of hands” (p. 784) starting in the early 1960s with Dr. Bernard Grad. Dr. Grad was a research biochemist in Gerontology at McGill University, Montreal, Quebec, Canada, when he met Oskar Estebany and utilized his services in experiments with mice and barley seeds, in 1961 and 1963, respectively (Krieger, 1975; Miller, 1979). In 1961, two pilot studies and an experimental study demonstrated that the wounds of mice treated by Estebany were significantly smaller than mice in the CGs (Grad, 1965; Grad, Cadoret, & Paul, 1961; see also Krieger, 1975; Miller, 1979). In a series of four experimental studies with barley seeds, the results for those seeds that received water treated by Estebany included a higher yield of plants, greater plant height, and higher chlorophyll levels than the plants in the CGs (Grad, 1965; see also Krieger, 1975; Miller, 1979).

2.5.2 M. J. Smith's experimental studies. Sister M. Justa Smith was a biochemist, on faculty at the Human Dimensions Institute, Rosary Hill College, Buffalo, New York, when she conducted five studies looking at healing and enzymatic activity. She conducted two experimental, randomized, studies in 1967, where she utilized

Estebany to provide healing for the treatment group (M. J. Smith, 1972; see also Krieger, 1975; Miller, 1979). M. J. Smith postulated an energy change during healing would be demonstrated by changes in enzymatic activity. Estebany treated a trypsin solution flask, which showed significantly more enzymatic activity than the untreated flask in the control group (CG; M. J. Smith, 1972; see also Krieger, 1975; Miller, 1979). An attempt was made to replicate the study a few months later, but Estebany was reported not to be at ease during the experimental conditions, and significant results were not reproduced. Conjecture about the failure to reproduce the results included that the living conditions were not suitable, resulting in Estebany not feeling well enough to perform his usual healing “miracles.”

M. J. Smith (1972) conducted experiments with paranormal healers/psychics, which were replications of the earlier studies in 1971. The first, which examined trypsin, demonstrated qualitative effects of treatment consistently increased the trypsin rate. The second looked at nicotinamide-adenine dinucleotide (NAD) which is necessary for the production of adenosine triphosphate (ATP). Findings indicated that treated flasks had decreased NAD activity, leaving more available for ATP production. The third experiment involved amylase-amylase, which is part of carbohydrate metabolism. These levels were unaffected by treatment and the question of sample contamination was raised as the healers serum was used for the sample. The series of experiments demonstrated a trend of the potential effects of LOOH on enzymatic activity, which influenced future research design.

2.5.3 Krieger’s early work on hemoglobin. Krieger (1981) described the process leading to her research with healing and hemoglobin levels. She “chose

hemoglobin because it is one of the body's most sensitive indicators of oxygen uptake and also because it is quite accessible for study of bioenergetic changes that might underlie this mode of healing" (Krieger, 1981, p. 141). She related this to the concept of *prana* (see section 1.2.6) and its close connection to oxygen. Krieger (1981) also stated that she found a "close similarity between hemoglobin and chlorophyll" (p. 141) structurally and felt that since there were "several enzyme systems crucial to both the biosynthesis and the functioning of hemoglobin," (p. 141) it would be a "sensitive indicator of the energy change" (p. 141) needed for healing to occur. These choices closely related to the previous research done by Grad (see section 2.5.1) and M. J. Smith (see section 2.5.2).

Krieger (1975, 1991) designed her studies with an experimental group treated by Estebany and a no treatment CG. She did the pilot study in 1971, followed by a full-scale study in 1972. She found a significant change ($p = .01$) in the experimental groups' hemoglobin levels in both studies (Krieger, 1972, 1975, 1981). A 1973 replication of the study, again produced a significant change ($p = .001$) in hemoglobin levels of participants treated by Estebany. Krieger repeated the study again in 1974, using nurses trained by herself and Kunz (Krieger, 1975, 1981, 1990). The hemoglobin levels again showed a significant change ($p = .001$) from pretreatment values.

Krieger (1975, 1990) also measured self-actualization scores of the TTPs used for her study. The RNs' self-actualization scores approached or exceeded the mean. Some of the descriptive characteristics from these scores were independent, self-directed, self-supportive, and sensitive individuals, which align well with characteristics associated with practicing TTPs. This study not only replicated previous hemoglobin research, but

also was a field study of the ability to teach others TT. The culmination of these early studies laid the foundation for continuing research in the field.

2.6 Efficacy of Therapeutic Touch®

Pertinent to examining expertise in a modality is the determination of its efficacy. The efficacy of TT was examined by looking at reviews of TT effectiveness and the scientific basis of TT reviews of the literature. Case study examples are presented to illustrate their use in disseminating information on TT. A sampling of clinical research studies across populations and conditions are reviewed. Finally, current research efforts demonstrate the legitimacy of practice in this growing discipline.

2.6.1 Evidence of Therapeutic Touch effectiveness. Six reviews of TT literature examine evidence of TT effectiveness. Peters (1999) conducted a meta-analysis of the effectiveness of TT from 1986 to 1996. Included for analysis were nine published quantitative intervention studies with human subjects. Peters concluded a comparison of the TT experimental groups to the CGs demonstrated the presence of a medium effect size on physiological and psychological variables with comparison of the TT experimental groups to the CGs.

Deenadayalan (2007) examined the effectiveness of TT for tension-type headaches. Of the 22 studies reviewed with 2628 participants, a single study looked at the effect of TT on tension headache pain. The author concluded there was moderate (Grade B) evidence that TT was superior to mimic TT (MTT) for reduction of pain after a single treatment for tension headaches.

Jackson, et al. (2008) examined the effectiveness of TT on pain and anxiety in patients with cancer. Of the 12 studies reviewed, 4 were TT studies. The TT studies

demonstrated Level II (2), Level III (1), and Level IV (1) evidence ratings. The authors concluded that TT research findings support its use for reduction of pain and anxiety for patients with cancer.

So, Jiang, and Qin (2008) looked at the effectiveness of HT, TT, and Reiki on relief of acute and chronic pain. They reviewed 24 studies that included 16 TT studies, of which 2 were unpublished theses. There were 7333 participants in the reviewed TT studies. They found that 7 of the 12 studies with statistically significant effect for pain relief were TT studies. The pooled estimates for TT studies were significant for a pain reduction on a scale of 1 to 10, of an average of .83 units ($p < .00001$). So, et al. (2008) concluded that patients' need for analgesics may decrease with the use of TT and that no harm was demonstrated with the use of TT.

In a funded study, Robinson, Biley, and Dolk (2007/2009) reviewed the effectiveness and harm of TT in an intervention review through the Cochrane Collaboration. However, this updated review for RCT studies of anxiety disorders excluded 11 available studies. The authors (Robinson, et al., 2007/2009) stated that no practice conclusions for TT were reached.

An MD Anderson Cancer Center (2006/2010) updated review on effectiveness of TT for patients with cancer identified 29 TT studies, 7 specific to TT and cancer, 3 reviews, and 19 other. Their findings stated the use of TT could be of benefit to cancer patients. The center noted that reviews of TT research had mixed results, which pointed to a need for further research.

2.6.2 Reviews supporting scientific basis of Therapeutic Touch®. Only two reviews looked at the scientific basis of TT. The review by P. E. Clark and Clark (1984)

was authored by known skeptics (see section 1.2.8; see also Scheiber & Selby, 2000). Sayre-Adams (1992) looked at examples of the vast amounts of TT research since the 1960s in a review for scientific study. She specifically looked at anxiety with her review of two studies. Sayre-Adams concluded TT treatment resulted in a significant decrease in state anxiety in those studies. In addition, the results supported the use of centering as integral to TT and TT as a healing meditation.

2.6.3 Therapeutic Touch® case study examples. All 30 of the case study reports were published. One had been published twice and two contained more than one study within the publication. None of the studies received funding, but two stated they received other support to conduct the study. Two case studies demonstrate how they disseminate information about TT.

Twichell (2008-2009) reported on two hospice patients who received TT. One 94-year-old, female patient with metastatic breast cancer complained of depression and pain. After TT, the patient had decreased pain and improved relaxation. The second patient was a 34-year-old female with obsessive-compulsive disorder, diagnosed with advanced breast cancer, who had been transferred from a group home and was experiencing sleeplessness. After TT, the patient experienced deep sleep.

Stephen, Mackenzie, Sample, and MacDonald (2007) reported on patients with cancer treated in an integrative oncology practice. Canadian cancer agency centers were the site for weekly TT clinics. Both professionals in the centers and volunteers trained in KKT™ provided TT. The report showed a history of 20 years of providing TT to patients in the practice with the ability to provide 1000 treatments per year in the three facilities using their model. A paid staff member now supervises the cost-effective

program, with services provided by volunteers. The authors noted that they generally have a waiting list for the TT services (Stephen, et al., 2007). Both of these studies showed positive effects, one in a delivery model applicable to other settings and the other in alleviating symptoms for patients requiring palliative care.

2.6.4 Representative Therapeutic Touch® clinical research studies. It is important for an expert practitioner to keep abreast of recent clinical research. TT research spans a vast array of settings, populations, and conditions. Progress in the field is highlighted by a sample of TT studies, which illustrate the variety of clinical research conducted.

Gronowicz, Secor, Jr., Flynn, Jellison, and Kuhn (2015) conducted a blinded, three-group (non-contact TT, MTT, CG) RCT on mice using an aggressive breast cancer model. Non-contact TT (NCTT) includes all of the steps of TT, without making physical contact with the healee (mouse). This was a two-phase study that used a total of 108 mice. Statistically significant findings ($p < .05$) demonstrated that the NCTT decreased the number of metastases when compared to the group who received MTT. There were additional positive findings related to NCTT and immune function, but no positive findings related to tumor size, which the authors stated might be related to the type of cancer model used for the study.

Coakley and Duffy (2010) studied the effect of TT on pain, cortisol, and natural killer cells (NKC) in a funded between-subjects intervention pilot study. Their sample consisted of 21 postoperative vascular surgery patients. Statistically significant findings ($p = .000$) for the TT treatment group compared to the CG included less postoperative pain, lower cortisol levels, and higher NKC levels.

Madrid, Barrett, and Winstead-Fry (2010) conducted an experimental, randomized, single blind, pilot study to investigate the feasibility of introducing TT into an operating room setting. Their sample consisted of 40 male and female patients who underwent outpatient cerebral angiography. Parameters examined were blood pressure (BP), heart rate (HR), and respiratory rate (RR). They dropped the RR data from analysis secondary to missing data (52%), while BP and HR changes pre-and post-procedure did not reach or approach statistical significance. The authors noted that they elected to proceed with the study, even though the sample size was not sufficient to generate power to support their hypotheses. Madrid, et al. (2010) identified other problems including utilizing a relatively healthy sample and lack of control of the BP parameter, since BP was under anesthesia control during the procedure.

Zare, et al. (2010) conducted a quasi-experimental, two-group (TT, CG) clinical trial to examine changes in physiological parameters. This study, done in Iran, utilized a sample of forty-four patients who were candidates for coronary artery bypass graft surgery. The TT group demonstrated a statistically significant decrease in HR ($p = .04$) and RR ($p = .02$). The TT group also had a decrease in mean systolic and diastolic BP, while in the CG, systolic BP increased and diastolic BP was unchanged. There were no changes in temperature in either group.

Gronowicz, Jhaveri, et al. (2008) performed a blinded, three-group (TT, MTT, no treatment) randomized controlled trial on 18 samples of human fibroblasts, tenocytes, and osteoblasts in a university laboratory. Parameters studied by the authors were [^3H]-thymidine incorporation into the DNA and proliferating cell nuclear antigen. Findings of the study showed that TT treatments produced a statistically significant

($p = .004$) difference in cell proliferation compared to MTT and CG treatments for fibroblasts (Gronowicz, Jhaveri, et al., 2008). The authors (Gronowicz, Jhaveri, et al., 2008) found, for tenocytes, TT produced a statistically significant difference in cell proliferation compared to the CG ($p = .01$) and MTT ($p = .05$).

Hawranik, et al. (2008) conducted a randomized, multiple time series, single-blind, three-group (TT, MTT, usual care control) study with 51 male and female elderly patients, who had a diagnosis of senile dementia of the Alzheimer's type and who exhibited agitated behavior. Parameters of interest included aggressive behaviors and agitation. Results for the TT group were statistically significant ($p < .05$) for a lower rate of pacing, repetitious movements, and general restlessness when compared to the CG.

Movaffaghi, Farsi, Hooshmand, and Abrishami (2006) looked at relatively healthy nursing students in Iran with a mean age of 22.6 during menstruation. The double blind, three-group (TT, MTT, CG) RCT examined hemoglobin and hematocrit pre- and post-treatment. The authors found a statistically significant increase ($p < .0001$) for both levels post treatment in the TT group. There was a statistically significant greater increase in hemoglobin and hematocrit for the TT group when compared the MTT group ($p < .05$) and the CG ($p < .0001$).

Larden, et al. (2004) conducted a three-group (TT, RN presence, standard group control) randomized controlled trial in Canada. The sample consisted of 54 pregnant adolescent and adult females who were inpatients on a chemical dependency treatment ward. Anxiety was the parameter of interest and the TT group exhibited a statistically significant ($p = .027$) lower anxiety score for the first three treatments.

2.7 Perceptions Related to Therapeutic Touch® Practice

Studies pertinent specifically to this research project are those that examine perceptions related to TT practice. The investigator located 90 studies that examined perceptions related to the practice of TT. The majority (55) of the studies utilized a qualitative design to gather data. Theses (20) and dissertations (14) accounted for unpublished sources of studies. Funding was received for 14 studies (12 published, 3 dissertations, 1 thesis). The focus of the perceptions studies were: attitudes toward TT (26), educational interventions (11), client perceptions (28), practitioner and client perceptions (11), and practitioner perceptions (14). Review of examples of pertinent studies provides an overview of the available literature in this area.

2.7.1 Practitioner perceptions. Practitioner perceptions studies include those solely looking at practitioners (14), which include three theses and five dissertations, and those focusing on both practitioner and client perceptions (11), which includes four dissertations and one thesis. Many studies explored aspects of the experience, including use of TT (4), giving TT (3), and the experience of TT (3), practicing TT (2), and perceived experience (1). Other single parameters investigated included beliefs, knowing self, lifestyle changes, and perceptions of the human energy field. Studies looking at the perception of TT (4), and those describing the TT process (3) complete the studies of practitioner's perceptions.

Most investigators did not report examining perceptions of expert practitioners. The use of TTPs with at least three years practice experience was located in only two located published studies (Coppa, 2008; Heidt, 1990) and four dissertations (Coppa,

2002; Herdtner, 1999; Johnston, 2005; Kiernan, 1997). One dissertation study (Hanley, 2004) utilized a mix of experienced and inexperienced TTPs.

Coppa (2008) conducted a qualitative study with focused participant observation to examine perceptions of TT practice by nurses conducting treatments on adults and infants. She focused on the TT process to look for differences between the two populations. The sample included five groups of one RN, adult, and infant. Subjects were treated in their homes. Findings identified a core process for the delivery of a TT treatment. Coppa described this process as “three distinct phases: (a) preparation, (b) treatment/orientation (orienting, assessing, treating, reassessing), and (c) termination” (2008, p 20). The practitioners described the same core process for all subjects, though the time to treat infants was shortened and they adjusted their hand movements, to decrease the amount of energy delivered to the infants (Coppa, 2008).

2.7.2 Attitudes toward Therapeutic Touch®. Since 1990, 26 studies, (14 published, 1 dissertation, 8 theses) have delved into attitudes toward TT. Of those, five utilized qualitative designs and six were funded studies. Studies examining attitudes toward TT reported 2565 total adult participants, age 18 to 73, including community residents, faculty, mental health professionals, psychology and other students, registered nurses (RNs), staff members, and women with breast cancer. Three studies illustrate the state of current research interest in this area.

Rojas-Cooley and Grant (2009) conducted a nationally funded, descriptive, cross-sectional survey with a response rate of 24%. The sample consisted of 850 RNs who were members of the Oncology Nursing Society (ONS), involved in direct patient care. Most survey respondents were Caucasian (767) females (814). Important to this

study, was the ability of these RNs to correctly identify energy therapies as one of the NCCAM domains (97%) and TT as a specific CAM therapy (80%). On a scale of 1 to 10, the majority of RNs (802) rated the importance of CAM education at 7.66 and the right of patients to receive CAM at 7.44.

Trail-Mahan, Mao, and Bawel-Brinkley (2013) used the survey developed by Rojas-Cooley and Grant (2009) to look at attitudes and knowledge of RNs related to CAM (p. 277). Their convenience sample of 153 acute care RNs from a northern California medical center represented a response rate of 18% to their survey. Demographics did not include gender; over half (58.6%) of the respondents were Asian/Pacific Islander. With an average group knowledge score of 51%, Trail-Mahan, et al. (2013) identified the subjects' lack of adequate baseline CAM knowledge. While over half (58%) of RNs were able to correctly identify energy therapies as one of the NCCAM domains, another 25% selected "do not know." Identification of TT as a specific CAM therapy remained at over half (53%) but those that selected "do not know" increased (33%). On a scale of 1 to 7 (reverse scale) the lowest (most positive) mean score was agreement of the RNs that patients had the right to receive CAM (2.7), but a mean of 3.4 for the importance of CAM education (Trail-Mahan, et al., p. 284). The authors concluded that the 2.69 [2.7] lowest score "indicated nurses' strong agreement with the statement" (Trail-Mahan, et al., 2013, p. 281). In an examination of these data by the investigator 2.7 fits more closely into the slightly or somewhat agrees category of the scale. Although a small convenience sample was used to conduct the study, the results were disappointing since (51.1%) of the RNs had 11 or more years of experience and a BSN (62.1%) or MSN (10.5%). Trail-Mahan, et al. (2013) explained that since most of

the nurses practiced for more than six years, they would not have received CAM education in their nursing programs (p.282).

In the second part of a United Kingdom study (Aveyard, Sykes, & Doherty, 2002; see section 2.7.3), Doherty, Wright, Aveyard, and Sykes (2006) examined staff attitudes toward TT and TT practice with a descriptive design. Their sample consisted of 32 staff members in a mental health facility and 4 elderly female patients with dementia. The authors utilized a questionnaire to elicit staff data with a 90% return rate. The majority (81%) of the staff strongly agreed TT promoted patient well-being. Not all of the staff were trained in TT, but had observed the changes made in the facility after its introduction. Well-being following TT treatments to the patients was determined by dementia care-mapping and positive response schedule data.

2.7.3 Educational interventions. From 1987 to 2008-2009, 11 studies (8 published, 1 dissertation, 2 theses) focused on educational interventions related to TT. The majority (9) utilized a quantitative design, with the rest (2) a qualitative design, and one study received funding. Two studies were conducted in Britain (Aveyard, et al., 2002; Lewis, 1999) and one in Canada (Moore, Ting, & Rossiter-Thornton, 2008-2009). Details for two of the representative international studies are discussed.

In the first part of a United Kingdom study, Aveyard, Sykes, and Doherty (2002), used a descriptive design to examine staff perceptions of TT prior to an educational program introducing TT to the staff as a component of patient care. The sample included staff caring for older adult patients hospitalized with organic and functional mental illness needs in a mental health facility. Aveyard, et al. (2002), followed the staff doing TT and a group of patients receiving treatments. The authors reported results halfway through the

project. At that time, the group of staff from first contact with TT through the first year's practice felt they were developing a closer emotional bond in patient relationships (Ayeyard, et al., 2002).

Moore, Ting, and Rossiter-Thornton (2008-2009), in a funded, descriptive, exploratory, pilot study examined the experience of 12 members attending a TT practice group in Canada. The mostly female (10) sample included three nurses and two health professionals, with laypersons making up the remainder. The majority (11) had attained Level III training, practiced TT, and attended practice groups for two to six years. Four themes emerged from the collected data—value of learning with others, connecting with network, comfort-discomfort, and meaningful change.

2.7.4 Client perceptions. Client perception studies are those focused only on clients (28), which include three dissertations and six theses, and those focused on both client and practitioner perceptions (see section 2.7.1). Qualitative designs (34) make up the majority of these recipient studies, with six funded studies. Studies utilized adults, children, and healthy populations. While the use of healthy populations has been controversial for study of a healing modality, they have been utilized to examine variables (anxiety, pain) amenable to treatment with TT (Coakley, 2002/2001) and one example is provided, preceded by those utilizing adults and children.

2.7.4.1 Adults. Kelly, Sullivan, Fawcett, and Samarel (2004) conducted a nationally funded, three-group (TT, quiet-time, dialogue) qualitative study to look at patients' perceptions of home visits and interventions of 18 females with breast cancer. Data collection by telephone interviews occurred as part of a larger experimental study. The sample consisted of 18 females with breast cancer, who were visited at home before

and after breast cancer surgery. Participants' perceptions of the TT intervention were reported by 61% of the respondents as feelings of calmness and safety.

Kiernan (2002) utilized a qualitative, participant observation design to examine perceptions, experiences, and meanings of TT in the lives of five postpartum women, in the first two months after the birth of their first child. The investigator provided TT in the participants' homes. Interviews revealed five themes—feeling relaxed, open, cared for, connected, and skeptical. The participants experienced acceptance, respect, and mutual trust with the researcher.

2.7.4.2 Children. Beckendorf (2004a, 2004b) published case studies of work with an adolescent and a child in a German psychiatric facility. In both cases, the goal was to look at the experience of receiving TT. The male adolescent patient and the 7-year old female patient both requested another TT treatment from the author. Beckendorf concluded the recipients' experience of TT was positive (2004a, 2004b).

2.7.4.3 Healthy populations. Sneed, Olson, and Bonadonna (1997) conducted a funded, exploratory, interview study with female graduate students who were experiencing an academic stressor. Although they utilized content analysis, they were not conducting a qualitative study. Their findings presented 168 descriptors of the participants' experience of receiving TT. Respondents descriptions fell into five categories: relaxation (19%), physical sensations (29%), cognitive processes (32%), mental/emotional (16%), and spiritual/transcendent (4%). All of the participants identified descriptors in the first three categories, while nine and four, respectively, responded to the final two categories.

2.8 Summary

This review examines the literature relevant to expert practice in TT, which supports this study of expert TT practitioners' perceptions. TT was conceived as a nursing modality, but also is considered a CAM energy therapy. Given their complementary relationship, TT has secured NCCAM funding for ongoing and recent laboratory research (Gronowicz, 2007; Gronowicz, Jhaveri, et al., 2008; Gronowicz, Secor, Jr., et al., 2015; Jhaveri, et al., 2008). The need for expert practitioners to be knowledgeable about CAM therapies in order to provide patient treatment and referrals was supported (Fawcett, et al., 1994; Kroesen, et al., 2002).

Expert nursing practice consists of a constellation of factors. Several attributes identified with expert practice were patient knowledge, skill knowledge, and holistic practice knowledge (Hardy, et al., 2006). Interpersonal skills (Baumann, 2006) and scholarship (Meleis, 1991; Riley, et al., 2007) are also qualities identified as an integral to the practice of expert nursing. There are advantages and limitations to relying on evidence-based practice literature. The use of TT in the treatment of pain was supported by an example (Benkofsky-Webb, et al., 2004). Best practice guidelines for TT (Moore, 2005) are a tool that may assist expert practitioners in their delivery of holistic patient care. Achieving and maintaining competence remains an important component of expert practice, with informal learning strategies identified as a path to competence (Sharoff, 2004).

The SETTS is the only measure developed (Krieger, 1993) to look at the practitioners' experiences doing TT. A dissertation study (Ferguson, 1994) provided evidence for replication of significant results found in Krieger's study to distinguish

between inexperienced and experienced practitioners. The SETTS was developed as a measure to look at practitioners experience with TT. A few studies (Barrington, 1994; Mersmann, 1994; Sies, 1995; Stravena, 1993) utilized the scale to describe TTPs who participated in their studies. However, the most recent study (Woods Smith & Broida, 2007) produced conflicting results. This review demonstrates support existed for further examination in determining the components of expert TT practice based upon the limited use of the SETTS in research on TT, a lack of standards set to use the scores, and the demonstration of conflicting results when utilized with known expert TTPs.

A theoretical perspective of TT relying on Krieger's (2002) concept of transformation and transcendence forms the basis to explore concepts related to perceptions of expert practice. Expert TTPs exhibit transformation in the performance of the TT process, which over time leads to transcendence in their personal lives and professional practice of TT. The practice of TT leads to profound changes in individuals as their expanded consciousness leads them on a journey of self-exploration and discovery.

An exploration of historical studies, most of which utilized the same healer, Oskar Estebany, illustrates the foundation laid for continuing research in TT. A variety of studies is presented to support the efficacy of TT. Reviews of TT effectiveness support its use for pain (Deenadayalan, 2007; So, et al., 2008) and with cancer patients (Jackson, et al., 2008; MD Anderson Cancer Center, 2006/2010). Case studies provide positive results in a clinical setting (Twichell, 2008-2009) and in a delivery model of care (Stephen, et al., 2007). Representative clinical studies, with statistically significant results, crossed international boundaries (Taheri, et al., 2013; Zare, et al., 2010), utilized

human tissues in a laboratory (Gronowicz, Jhaveri, et al., 2008; Gronowicz, Secor, Jr., et al., 2015), and studied older adults with dementia (Hawranik, et al., 2008).

There are a large number of completed research project on perceptions related to TT practice. However, only 28% (25 out of 90) specifically examine practitioners' perceptions that include 52% unpublished theses (4) and dissertations (9). Only two published studies (Coppa, 2008; Heidt, 1990) report the use of TTPs with at least three years TTPs practice experience and they examined elements of the TT process. Review of these studies revealed the paucity of published works utilizing expert TTPs and the need not only to identify criteria but also to include descriptions of practitioner's qualifications. None of the studies addressed how TTPs described expert practice or their own level of expertise, a focus of this investigation.

Positive attitudes toward the modality after education (Doherty, et al., 2006) and practicing nurses support of patients' right to receive CAM (Rojas-Cooley & Grant, 2009) are important to delineating provision of expertise in practice. Educational interventions (Aveyard, et al., 2002) were found to be successful with staff, while TT practice groups were valued by participants for learning with others (Moore, et al., 2008-2009). These studies point out the importance of determination of the components of expert practice and its maintenance by the practitioner. In client perception studies, positive descriptions of the TT experience were described by women with breast cancer (Kelly, et al., 2004), a male adolescent hospitalized in a German psychiatric facility (Beckendorf, 2004a), and healthy stressed female graduate students (Sneed, et al., 1997).

This review clearly demonstrates the lack of both a consistent quantitative and/or qualitative measure of TT expertise and pertinent information related to perceptions of

expert TTPs and expert practice in the modality. None of the studies reviewed, describe the facets of expert practice, which this study examines. These gaps support the need for research into perceptions of experienced TTPs, which seek to delineate the characteristics related to expert practice in the modality.

Chapter 3 Method

3.1 Design

This study utilized a qualitative descriptive focus group methodology (Krueger, 1994, 2006; Krueger & Casey, 2001, 2009) using purposive sampling in a unique online environment (Blackboard® supported technology). Krueger (1994) provided a clear definition of a focus group, as a “carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive nonthreatening environment” (p.6). In that small group setting a skilled interviewer allows the group members to share perceptions and ideas. The members influence each other by way of their comments and response to ideas presented during the discussion. It is for that reason that Hollander (2004) suggested the importance of recognizing social contexts in the composition of group members, with the analysis of focus group data. The focus group design clearly supports an examination of TT practitioners’ perceptions.

3.2 Setting

The setting was synchronous on-line focus groups that were conducted by the researcher utilizing the Blackboard® Wimba® Live Classroom and Blackboard® Collaborate™ Web Conferencing technology supported by Duquesne University. Those focus group sessions allowed the researcher to pose questions orally to the participants and in some sessions post them on Microsoft® PowerPoint (2010) slides (see Appendix

1). Participants responded to the questions orally, either by using a microphone or headset through their personal computer or by calling in to the secure session by telephone. At the end of the session, a voice archive of the session was available to the researcher. The researcher used available settings in the technology to prevent archive access by the participants.

3.3 Sample

A purposive sample consisted of 12 adult, experienced Therapeutic Touch[®] Practitioners (TTPs), who were registered nurses. Experienced practitioners possessed at least three years of Therapeutic Touch[®] (TT) practice and attendance at a minimum of two TT workshops, at least one taught by a Qualified Therapeutic Touch Teacher[™] (QTTT[™]). Permission to access the membership list was requested (see Appendix 2) and received from the TTIA Board of Trustees (see Appendix 3). TT experts were recruited from a sample of 578 members of Therapeutic Touch[®] International Association (TTIA, 2010) identified on February 28, 2012. Additional experts were obtained from referrals from TTIA members contacted who were not eligible to participate and from volunteers participating in an educational session at the 2013 TT Dialogues[®].

3.4 Focus Groups

Morrison and Peoples (1999) described that focus groups were originally known as group interviews. Walden (2006) reported one early use of focus groups in the 1930s by the U.S. government and by the 1970s and 1980s focus groups were the dominant method for market research. By 2000, focus groups were adopted by other disciplines, such as banking and healthcare (Walden, 2006). Nursing has adopted focus groups to

collect data for projects in practice, education, and research (McLafferty, 2004; Morrison & Peoples, 1999). Focus groups have evolved as a research design and are described as a research methodology (Hupcey, 2007; Morgan, 1998; Patton, 1988; Walden, 2006).

Happell (2007) discovered that the use of focus groups as an independent method and with other methods has dramatically increased in the past 20 years, from the absence of references prior to 1985, to 781 located between 2000 and 2004. In this nursing research study, a qualitative descriptive independent focus group method was utilized.

3.4.1 Definition. For the purpose of this study, focus groups are utilized as “a technique for data collection that uses group interactions to obtain an understanding of participants’ experiences and beliefs [and] as stand-alone method” (Hupcey, 2005, p. 217) by which to conduct a study. Morgan (1997) described focus groups as group interviews, led by a moderator, who is often the researcher.

Morgan (1997) noted topics provided by the researcher supply the basis for group interaction during discussion. Morgan stated this interaction is the basis for insights and produced data, which supports the use of focus groups (1997, 2010). Over 25 years ago, Patton (1988) identified focus groups as “an approach that can be used alone [or] employed with other methods both quantitative and qualitative” (p. 17).

Morgan (1997) supported the use of focus groups as a self-contained method, which “provides the basis for a complete study” (p. 3). He also noted, “the key distinguishing feature of a self-contained group is that the results of the research can stand on their own” (Morgan, 1997, p. 18). Further, Morgan (1997) described what favors their use “is that they reveal aspects of experiences and perspectives that would be not as accessible without group interaction” (p. 20).

3.4.2 Sample composition. Identification of sample participants for focus groups includes consideration of how to divide people into categories, such as “geographic location, age, gender, income, participation, characteristics, family size, and employment status” (Krueger, 1994, p. 47). Information collected pertinent to this study was reported by the participants on a demographic questionnaire (see Appendix 4). The information provided a description of the study sample. It was expected that the majority of nurse participants would be white females, who represent the majority of members in the international TT organization. However, diversity in geographic location, age, and other characteristics in the sample was expected.

3.4.3 Sample size. The ideal size of focus groups varies based upon the goal of the study. In market research, the expectation is a group of 10 to 12 participants but Krueger (1994) noted they tend to be too large for complex discussions or when utilized with topic experts. Krueger stated that while the “traditionally recommended size of the focus group has ranged from 6 to 12 participants” (1994, p. 78), it can even be dropped to 4 to 6 to ease recruitment problems. He noted it does limit the range of the data collected, but smaller groups may also allow for more in depth insights. In the case of this study, it was found that scheduling difficulties and subject availability led to smaller groups and that the participants were able to speak as long as they needed to complete their thoughts on each item.

Krueger and Casey (2009) noted that chat room focus groups are often limited to eight participants with a shorter session length than a traditional face-to-face group. It was expected that a specialized sample of expert TTPs might allow for smaller focus

groups since they should have more information to share. The plan was to recruit a minimum of four participants and a maximum of eight participants per focus group.

Toner (2009) discussed the validity of very small focus groups in light of feminist research principles to accommodate exigencies. That proved to be the ultimate decision to complete this study. Since TTIA had adopted a feminist practice of consensus for management of its board many years ago (see Wheeler & Chinn, 1991), members were comfortable with that leadership style. This information contributed to the decision to complete the study with the use of six, two-person focus groups, which resulted in the production of rich data, demonstrated by the repetitive nature of the categories (Polit & Tatano Beck, 2010) discovered by the investigator upon examination of the data that were collected to describe RN TTP expertise (see section 5.3).

Krueger (1994) found that it takes a surprisingly small number of subjects and groups to complete a focus group study. Krueger (1994) pointed out that most of the new information is acquired from the first two groups, but after that, much of it has already been covered. Morgan (1998) agreed that the best reason for the use of fewer groups is a “lack of diversity in responses” (p. 81). Krueger (1994) noted that if the area of interest is narrow and relates to those with similar backgrounds, the number of focus groups required is reduced. In addition, Côté-Arsenault (2013) discussed that although her recommendation is groups of 5-8 participants, “with a topic of intensity even a group of three could create good interaction and yield rich data” (p.311). She stated that data saturation required conducting at least two groups, dependent on the diversity, availability of the subjects, and the topic (Côté-Arsenault, 2013, p. 311). It was decided

that the use of six very small groups was sufficient to meet the minimum subject recruitment goal of 12.

Simon (1999) and colleagues found that the ultimate purpose must be kept in mind in determining the number of focus groups necessary, but they discovered that with three sessions most major themes are discovered. The plan was to conduct three focus groups. With a narrow interest area such as TT and subjects with similar expert performance backgrounds in TT, it was anticipated the suggested number of participants and groups would be sufficient to obtain desired data saturation. As mentioned previously, in order to reach the minimum desired number of subjects the plan was amended.

3.4.4 Methods. Focus groups have evolved from face-to-face discussions to those conducted in Internet based environments. With the advent of electronic media, focus groups have been conducted in both synchronous (Franklin & Lowry, 2001) and asynchronous (Kenny, 2005; Rezabek, 2000) modes successfully. Researchers have documented advantages and disadvantages associated with both. A prime advantage of this method is the completeness of the session, as each encounter (voice or typed) is preserved in an electronic generated record, which the investigator may produce immediately for review (Franklin & Lowry, 2001).

Franklin and Lowry (2001) documented difficulty with data collection, utilizing a synchronous method, but acknowledged their moderators were not familiar enough with the technology to apply all the needed functions to maximize data collection.

K. Stewart and Williams (2005) liken the synchronous method more to in person collection because of the speed of the data collection, while the asynchronous method

allows for lengthier and more considered responses. In a comparison study of face-to-face and synchronous focus group, Schneider, Kerwin, Frechtling, and Vivari (2002) found that there was more uniform participation of the online participants, although their typed comments were shorter and took longer to provide than those spoken by the live group members. This study utilized a synchronous method to facilitate data collection and participation by all group members.

Krueger (1994, 1998b) discussed that while available technology does allow for videotaping, historically it has not been supported as a worthwhile effort. For this study, the researcher would need to have additional equipment and technical support; all participants would need to have access to a webcam setup in a secure private setting; and additional training would be required to conduct and participate in the sessions. Equipment costs and training time outweighed any proposed benefits for its use in this preliminary study.

3.4.5 Types of questions. Krueger (1994) identified five types of focus group questions. An opening question is a quick response factual question asked to each respondent. Introductory questions, from the semi-structured interview guide, facilitate interaction among the participants and introduce the topic for discussion. Transition questions broaden the discussion, leading up to the key questions (Krueger, 1998a). Krueger (1994) noted that “two to five” key questions “drive the study” and require the greatest attention in the analysis (p. 55). The investigator was the moderator. Seven open-ended questions were developed in a discussion guide (see Appendix 5) and used with each focus group.

It is important to pay particular attention to the individual responses, since consensus building is not the focus in this method of data collection (Krueger & Casey, 2009; Morgan, 1998). The moderator proceeds through the guide allowing for input of information from the participants until all of the data are collected. At the conclusion of the session, participants are allowed to make a closing remark, which allows them to clarify comments made and bring closure to the discussion. Krueger (1994) related these data are often crucial to the analysis phase of the study.

3.4.6 Strengths and weaknesses. The purpose of utilizing a focus group in this study was to generate data on the perceptions of expert TTPs. Morgan (1998) noted a strength of focus groups as a qualitative research method, is its ability to provide in depth understanding of the experiences of the participants. The purpose is to look at the individual's experiences on a topic of interest. Krueger (1994) pointed out one benefit of the method is the high value placed on gathering information directly from the participants in their own words.

Morgan (1998) described how to view strengths of the method through aspects of the group discussion. First, the discussion of the participants allows for exploration of a topic, for which data may be lacking or poorly understood. Second, during conversation, the context and depth of the material may be defined by examining the differences and similarities between participants as they define the context and depth of the material. Finally, Morgan noted interpretation arises as participants seek out insights from each other and react to one another as they talk about the subject at hand.

Benefits of focus groups include quick data collection with less expense. Focus groups provide a number of benefits, especially in respect to collecting data quickly and

with less expense. Use of focus groups in qualitative studies is advantageous because of the richness of data produced from a relatively inexpensive method, which is stimulating and flexible for the participants, and provides both cumulative and elaborative information (Fontana & Frey, 1994; MacDougall & Baum, 1997; see also Speziale & Carpenter, 2007). Happell (2007) identified one weakness of focus groups as lacking rationale for the use of the method in the particular situation under study. D. W. Stewart, Shamdasani, and Rook (2007) discussed the problems with generalizability of the findings, uneven participation of the subjects, and placing too much faith in personally received information.

All of the identified strengths add substance to the data collected. This method was used to examine similarities and differences among expert practitioners, as well as the interplay and reaction of subjects during data collection. In conclusion, a focus group methodology, which is “designed to obtain the participants perceptions in a focused area” (Burns & Grove, 2001, p. 425), is an appropriate method to use to examine expert practice of TTPs.

3.5 Instruments

Utilization of instruments augmented the data collection process in this study. While the focus groups generated much rich data, the need to describe the subjects more fully supported use of a demographic questionnaire. Field notes provided another way to collect data while the focus groups were conducted.

3.5.1 Demographic questionnaire. After subjects expressed interest in participating in the study, they all completed the demographic questionnaire (see Appendix 4) sent to them as an email attachment. Participants were asked to provide

information about their TT experience/education, professional education, occupation/practice setting, residence, age, sex, marital status, race/ethnicity, and religion/spiritual practices. The purpose of the data was to describe the study participants and the homogeneity or heterogeneity of the sample. Since TT is often mistaken as a religious practice, an item was included to look for any trends in the data set. Since the participants are nurses, it is possible that their level of education will influence practice. With nursing research integrated into upper level curricula, this demographic information may present additional data for examination. TT education and experience also validate expert practice, the topic of investigation. The primary goal of demographic data collection was to describe the prevalence or trends of certain factors in relation to this sample of expert practitioners.

3.5.2 Field notes. Field notes are one data collection tool utilized by qualitative researchers. Hupcey (2005) discussed they may be used in studies with diverse methodologies, such as phenomenology, grounded theory, ethnography, case studies, narratives, and focus groups, the design for this investigation. Field notes are a method of supplementing other data collected that provide a way to describe events, identify relationships between data, and give the impressions of the investigator during the data collection (Morse & Field, 1995; D. W. Stewart, et al., 2007). Morse and Field (1995) related while these notes are descriptive of the encounters, they are also an objective retelling of the event as experienced by the researcher.

Field notes may be written by the primary researcher (focus group moderator) or an assistant. Gibbs (1997) stated in the case of two moderators, one should be assigned to recording and note taking. Bender and Ewbank (1994) stressed the importance of the

recorder's role during a live (traditional) focus group; when conducting an online focus group, where the transcript is generated automatically, not by manual recording, a recorder is not required, but is optional. Krueger (1998b) suggested that the moderator utilize field notes to guide the discussion, by noting ways to redirect the flow and remembering points that require more discussion or further exploration by the group. Important points considered include distinguishing between notes and quotes, capturing details and information, which is descriptive, and identifying the person who provided the information (Krueger & Casey, 2009).

Bender and Ewbank (1994) described the use of the investigator's notes as a means to describe perspectives of the participants and the course of the interview, such as identifying pauses in the flow. The investigator utilized her personal notes of the focus group interaction as a supplement to transcripts of the session archived recordings. Notations might include uneven participation of the subjects, interrupters, those who go off topic, missing data, or incomplete ideas presented. The purpose is to describe in more detail, participant relationships to the data gathered from them, during the focus group sessions. The investigator utilized her personal notes of the focus group interaction as a supplement to the prepared transcripts.

As the sessions were being conducted, the investigator took notes of what was being said, by whom, and any other interactions. For example, during one session, the investigator could not hear one of the participants and needed to arrange for the subject to telephone in to the session. On another occasion the investigator herself, needed to telephone into Blackboard® Collaborate™ Web Conferencing in order to complete the session. The notes were also a way to keep track of who spoke first and to encourage the

participants to take turns going first in responding to the open-ended questions. Even with the downloaded MP4 recordings, the notes helped fill in gaps and garbled or indistinct areas in the taped sections and added clarity to the transcripts and the interactions between the participants. Field notes were an adjunct to the transcripts, the demographic questionnaire, and the long forms completed from their data.

3.6 Procedures for Data Collection

Permission was obtained from the TTIA Board of Trustees (see Appendix 3) to utilize their membership list to contact prospective study participants by email. Potential participants were contacted by e-mail (see Appendix 6) to determine eligibility and interest in participating in this research study. The purpose of the study was reviewed, along with the method (focus groups), and time commitment involved (1 ½ to 2 hours). Participants were notified the study was approved by the Duquesne University Institutional Review Board (see Appendix 7) and the TTIA Board of Trustees approved access to their contact information (see Appendix 3). The study was conducted on a university platform with online synchronous focus groups using Blackboard® Wimba® Live Classroom and Blackboard® Collaborate™ Web Conferencing.

The author attempted to utilize a table of random numbers (Downie & Starry, 1977, pp. 332-334) to randomize a sample of TTIA members who had documented email addresses. The initial contact required approximately 50 contacts to produce a pool of participants for the three original proposed focus groups, since not all members would meet the sample selection criteria. Utilizing the last three digits on the table, one proceeds from the number with an asterisk and proceeds in any direction until 50 numbers are located that fall under the total number of current TTIA members. The problem with the

table was that the full sample of 188 could not be located on the table. The investigator proceeded trying both using single to double to triple digits and triple to double to single and was never able to locate all of the integers from 1 to 188 inclusive, so that if needed all of the sample subjects might be included in a random fashion.

Therefore, the investigator looked into other means of determining a random sample. A British website (Haahr, 1998) was located that generates random numbers in any form of groups of integers and in multiple sets if desired, so that an entire sample of subjects could be randomized. So, unlike simply picking 50 with multiple duplications in the process, this process provides a randomized sample with no duplicates and randomizes the entire sample, so that the researcher is prepared to utilize the entire sample in a random fashion if needed to acquire the prescribed number of participants. The email addresses of the investigator and an external committee member at that time (current members of TTIA) were deleted from the list of eligible email addresses to be selected.

The sample was the provided list of TTIA members, which was then searched for identifiable RN members. Only 10 of the 578 listed entries included RN credentials, one of which was the author. The printed member list included first and last name, city, state, country, and notes, which listed abbreviations for modalities practiced. All members who did not practice TT (52) or who did not list the modalities practiced (63) were eliminated from the list. To access other identifying information, including zip codes, phone numbers, email addresses, etc. each entry was hand accessed through the name link on the online database for further searching. In addition, all names were searched using public online state and country online licensure verification sites, as available, to

determine if the member held current active RN licensure in the state or country/territory of residence.

All the records located with inactive, Licensed Practical Nurse (LPN), Massage Therapist (MT), retired, or expired licenses were removed from the list of eligible participants. Then each incomplete entry was searched using online White Pages® and Google® for phone numbers, addresses, and occupation to cull additional non-nursing subjects from the database. Once all possible leads had been utilized, those subjects with active verifiable nursing licenses and documented email addresses were alphabetized into a list, which numbered 188 individual entries. A random numbers table was generated for the 188 subjects (Haahr, 1998) insuring all subjects were equally guaranteed to be included in this sample in a very random fashion.

From this random sampling, the first 50 active licensed RN members with documented e-mail addresses were sent a personalized inquiry email (see Appendix 6) requesting their participation in the study. Exclusion criteria included practitioners who did not have access to a computer with a high-speed Internet connection, anyone for whom informed consent could not be obtained, and those who chose not to participate in this research study. The first email resulted in a 10% (5 out of 50) bounce back of undeliverable email. One person declined to participate and two individuals stated they did not qualify for the study. Four members agreed to participate, one with a delay to complete the consent and demographic questionnaire, one with forms completed, and two without forms completed.

At day eight, a second personalized inquiry email requesting participation in the study was sent to the next 50 randomly sampled active licensed RN members with

documented email addresses. The bounce rate increased to 18% (9 out of 50) with one immediate decline to participate secondary to a lack of the necessary experience; that individual stated she had only two years of TT practice with no advanced training. A third personalized inquiry email requesting participation in the study was sent to the next 52 randomly sampled active licensed RN members with documented email addresses. The bounce rate decreased slightly to 15.38% (8 out of 52).

At this point, still not having enough participants, the investigator consulted with her dissertation chair and the school of nursing (SON) IRB representative, which led to the submission of a request for an addendum to the study to the IRB, which was approved along with an extension of the study (see Appendix 8). The investigator requested (see Appendix 9) and obtained (see Appendix 10) permission from the TTIA Board of Directors to contact the entire membership in the monthly electronic newsletter using the format approved by the university IRB (see Appendix 11). TTIA published a request for study volunteers approximately one month later, which resulted in one response. The following month they republished the request for volunteers, which resulted in one additional response.

The fourth and final personalized inquiry email requesting participation was sent to the remaining 35 randomly sampled active licensed RN members with documented email addresses from the original list the end of the following month. The bounce rate was 11.43% (4 out of 35). Overall, 13.83% of the provided emails were not working emails for the members of the organization at the time of the request for volunteers (26 out of 188)

Although initially planned, it was not necessary to obtain permission for Blackboard® access for each participant. By utilizing the guest access feature with the participants' pseudonym, participant access was arranged by the investigator supplying the link to each focus group participant prior to their scheduled session. Once the participants agreed to participate, the investigator provided each with instructions by email (see Appendix 12) to complete the informed consent (see Appendix 13) and demographic questionnaire (see Appendix 4) forms, which were included in attachments to the email. With this procedure, the participants only required a pseudonym for privacy. Famous nurses (non-living) were used for the pseudonyms, e.g., Clara Barton. Only the investigator had access to the participant contact information (e-mail addresses) and their pseudonyms, which determined eligibility for the participant to schedule a time for a focus group session. Participants were reminded that they would need the pseudonym to enter the site to participate in the focus group session. [Note: To further protect the privacy of the participants, five-letter future (2016 to 2025) female hurricane names (hurricane.com, n.d.) were used as pseudonyms in the text of the paper.]

Once the consent and demographic form were complete, participants were contacted again by email (see Appendix 14) and asked to select from a list of available times for the online focus groups. Instructions on how to access the online forum on Blackboard® using their provided Wimba® Classroom wizard link (see Appendix 15), screen setup, and basic instructions, were included as an attachment with the list of scheduled focus group sessions. One day prior to the study (time-permitting), a second reminder (see Appendix 16) was sent to the participants that included directions to

access the online forum on Blackboard® for the focus group and another reminder of the date and time.

The Blackboard® educational system at Duquesne University was utilized to conduct synchronous online focus groups using Blackboard® Wimba® Live Classroom technology. This feature allows the investigator to pose questions, control response order of the participants, and allow participants to respond. It also generated an archive of each session at its completion. These interactions were by voice and some with Microsoft® PowerPoint (2010) slides presented by the researcher, while participants responded to the researcher and each other by voice and/or typed responses. Participants used microphones and speakers (or headset), and when necessary telephones, to participate in the sessions.

At the time of each focus group session, the investigator reviewed the purpose of the session with the participants. To facilitate group confidentiality, participants were reminded that any personal or privileged information shared during the group, may not be disclosed to anyone outside the group. Participants in the focus group were asked a series of open-ended questions to elicit data for the stated research questions.

The researcher utilized a discussion guide (see Appendix 5), which included questions to guide the participants in their discussion of the parameters under investigation. The opening question addressed the participants' length of time practicing TT. Introductory questions were used to elicit information on a description of the participants' individual level of TT expertise and transition into the first key question.

The key questions to be examined for this study are the four research questions posed for the study:

- How do you describe expert TT practice?
- How do research findings impact your practice?
- What do TT practitioners see as their own level of expertise?
- Where do you envision the future direction of TT practice?

The discussion guide was used to direct the discussion, allowing input from the participants. When data collection was completed, participants were permitted to make a closing remark. At the conclusion of the focus group session, subjects were thanked for their participation in the study. Participants were also asked if they would like a copy of the results and all responded in the affirmative. The researcher accessed the archived tapes, listened to them, and then prepared the transcripts of the session for later analysis.

3.7 Procedures for Protection of Human Subjects

Before data collection began, the investigator obtained Duquesne University Institutional Review Board (IRB) approval to conduct the study (see Appendix 7) and TTIA approval (see Appendix 3) to utilize their membership list to contact participants. Participation of the subjects in the study was on a strictly voluntary basis. The decision was made not to compensate subjects for their participation in the study and each subject agreed to this stipulation in the informed consent for the study.

D. W. Stewart, et al. (2007) stated that most focus group participants do not find the time-consuming process appealing enough without an incentive, which is usually in the form of monetary compensation. Krueger and Casey (2009) reviewed the use of monetary incentives in medical research, its move into academics, and how “researchers

needed to develop processes for providing these incentives” (p. 147). However, Sears (2001) pointed out ethical concerns related to paying patients in clinical research studies. He discussed the very real conflicts related to “voluntariness of participation” (Sears, 2001, p. 657) when financial and other incentives are used to promote participation of subjects in any type of study. Since the population being recruited is professional nurses, it is anticipated that the contribution to the body of science will provide sufficient motivation to encourage participation in the study.

Informed electronic consent was obtained from the participants, prior to conducting the focus groups. Participants were able to make a copy of the consent for their own records. Hicks (2011) described that when a study involves minimal risk, choosing to take part after reading the consent information provided and clicking to the next screen may be thought of as the virtual equivalent of deciding to take part in a telephone survey, a procedure for which the requirement for documentation of consent is often waived. (Documenting consent section, para. 4)

For this online study, participants were instructed to check or highlight a box next to a statement that they had read the study description and were agreeing to participate.

A review of the risks and benefits for participants is important to protect subjects. The need to minimize risks is reviewed by Byers (2004) as necessary for implementation of ethical principles. There were no foreseeable risks anticipated in this study. Subjects were be in any danger of physical harm nor was there any expectation of associated mental harm. Byers (2004) noted benefits will be maximized by the use of capable researchers. In this study, the investigator is a doctoral student, with prior group facilitation experience, who was guided by three experienced university faculty

researchers. No reports of harm were made during or up to eighteen months after the collection of the data were completed. Participants were aware (informed consent) that any benefits would be realized by analysis of the data, which was expected to expand the scientific knowledge base related to expert TT practice.

While it is desirable to assure subjects of both their anonymity and confidentiality of the data collected to protect their right to privacy (Ary, Jacobs, & Razavieh, 1979; Polit & Tatano Beck, 2010), it is the nature of this type of research to share information (Morgan, 1998). Morgan (1998) noted common practice is to promise confidentiality, not anonymity, with the collected information about the individual being protected. K. Stewart and Williams (2005) in a discussion of online focus groups noted, “in computer-mediated communications, complete anonymity is almost impossible to guarantee” (p. 411). Arwood and Panicker (2011) summed up that “confidentiality cannot be guaranteed for information shared in a focus group” (Balancing risks and potential benefits section, para. 4).

Morgan (1997) posed additional ethical concerns related to “invasion of privacy” (p.31) when utilizing recording as a method of collecting data. Since records of the sessions were produced, several steps were taken to maintain confidentiality of collected data. First, the need for group confidentiality was reviewed at the beginning of each focus group. Individuals were instructed that information shared during the group must remain within the group and not shared outside the group (Gibbs, 1997).

Second, subjects’ data were protected by removal of identifying data and the use of pseudonyms to complete forms and to participate in the focus group. No attempt was made to compare participants’ names with their pseudonyms, which were only used to

verify a set of data were complete and available to be included as a part of the study. Only the investigator had access to that data. Third, electronic transcripts, field notes, demographic questionnaires, and consent forms were stored securely in a locked filing cabinet by the investigator. Electronic computer files were stored in password-protected computers, kept with the investigator, locked in the investigator's automobile trunk, or secured in the investigator's Vivint® protected premises. All confidential materials related to the study will be destroyed at its completion.

3.8 Procedures for Data Analysis

Data analysis is an inductive process, which addresses three areas, collecting, organizing, and analyzing the data (Polit & Tatano Beck, 2011, p. 79). The investigator reviewed the qualitative data, which were retrieved from electronically produced archives of the focus group sessions. Krueger (1994) pointed out transcript-based analysis takes the most time and is the most rigorous of the four analysis strategies, which include tape-based, note-based, and memory-based analysis. Krueger and Casey (2009) stated this method is “useful for studies being conducted in academic settings” (p. 117), such as this doctoral candidate's study. They also noted field notes may be used to supplement the transcripts, which were analyzed utilizing the same transcript-based analysis (Krueger & Casey, 2009).

Transcripts may be a combination of voice and typed comments. Voice comments must be transcribed. The investigator, a skilled typist who prepared transcripts for a previous qualitative project, accomplished this. To examine the data, the researcher reviewed those sources several times to get a sense of the data. Demographic data were utilized to describe characteristics of the sample relevant to the data collected.

Krueger (1994) discussed factors to be considered during analysis, included the words, context, internal consistency, frequency of comments, intensity of comments, specificity of responses, and locating the “big ideas” (p. 151). Webb (1999) noted while computer-assisted qualitative data analysis software (CA-QDAS) is available, cost and the small size of the sample may preclude its use. Webb (1999) suggested that small data sets associated with most PhD student studies may not justify the additional work associated with data management associated with CA-QDAS programs. Krueger (2006) noted an additional disadvantage of “computer analysis of qualitative data generally takes more time” (p. 3). St John and Johnson (2000) concurred, adding that program selection, training, and updates posed threats to researcher “interaction with data” (p. 397). For the purpose of this study, the decision was made not to utilize CA-QDAS data management.

Knodel (1993) stated textual data, which are produced must be sorted and coded. This may be accomplished by hand, such as cutting and pasting, or with the aid of word processing and other available computer software. Knodel suggested utilizing each item from the discussion guide and assigning a code to it, prior to coding the data. If additional topics arise, he suggested developing additional codes. In the interpretive phase, a grid or table may be utilized to organize the codes and make intergroup comparisons (Knodel, 1993). Morse and Field (1995) noted the researcher must not only be able to recognize the categories of the data, but also be able to locate the data in a systematic manner. Krueger (1994) stressed the importance of attaching labels to all data to enable easy retrieval. The method used to code and label the data initially was to highlight similar concepts with colored markers.

Krueger's (1994) instruction to look at both frequency and extensiveness of discussions leads to the development of these themes. Krueger (2006) suggested the use of a "long table approach" (p.4) which is a system of cutting up the transcript, sorting, and forming categories from the responses, which accommodates the presented views of examining data sets. Utilizing the long table approach described by Krueger and Casey (2001) two sets of transcripts were prepared so that one may remain intact and one used to prepare the table.

All transcripts and field notes are reviewed together once and then several times line for line for content. Krueger and Casey (2001) suggested the use of different colors for each different focus group so they can be easily discerned from each other. In addition, they noted it is helpful to be able to distinguish between the participant and moderator comments. Comments from the participants can be cut from the transcripts and placed onto the appropriate questions (Krueger & Casey, 2001).

Krueger and Casey (2001) suggested the placement of similar comments into piles to develop categories. Next category labels need to be identified, with no more than 10 to 15 utilized, since too little data will fit in categories that are too narrow (Morse & Field, 1995). As the categories develop, subcategories may emerge. The long table approach then calls for the preparation of a descriptive paragraph for the responses to the question. It is at this point that the researcher may be able to identify themes, compare categories, discuss differing views, or elaborate on aspects of the data (Morse & Field, 1995).

Bender and Ewbank (1994) pointed out data analysis will include content analysis to identify common themes and incidence density of those themes. Lie, Shapiro, Pardee,

and Najm (2008) suggested an actual count of key words and phrases to formulate categories and subgroups; they identified several criteria to evaluate the data groups. Those criteria were the frequency of the responses, along with detail provided, and the intensity of the response, which supports Krueger's (1994) direction to closely examine the group interaction.

Kitzinger (1995) noted that with most qualitative data the researcher is examining the data for themes. Morse and Field (1995) discussed how content, semantic, and thematic, analysis could be applied to the data. The two types pertinent to this study are content analysis, which the authors explained involves examining the data for categories, and thematic analysis looking for themes (Morse & Field, 1995). Morse and Field (1995) noted latent content analysis is most often utilized in qualitative studies. It looks at portions of data in relation to the entire data set, with tabulation of occurrences. However, Krueger (2006) pointed out that the "strength of focus group research is not based on counting, but on understanding the discussion" (p 4).

When utilizing this type of research method, the focus is on the group as a unit of analysis, not on the individual participant. As such, Bender and Ewbank (1994) pointed out the investigator is looking for not only "sought information" but also "emergent themes" that may be unexpected in relation to the questions posed to the subjects (pp. 70-71). The authors concluded that looking at incidence density is to identify how many times a theme occurs (Bender & Ewbank, 1994). This measure may point out the importance of themes to the respondents.

In summary, utilizing the methods described, the researcher reviewed the MP4 audiotapes, prepared the transcripts, and then reviewed the field notes and transcripts

several times to get a sense of the data. The long-table method was adapted by using a Microsoft® Excel (2010) spreadsheet to sort the comments made by the participants. Each participant and the moderator were labeled on the spreadsheet and were easily identifiable. Coding was done utilizing the discussion guide questions as a starting point. Data were entered for each group and then the results combined for each question posed to the group.

Relationships between categories were studied, followed by an examination of the incidence of categories. As identifiable categories developed, they were compared between individual focus groups. Group consensus emerged which led to exploration of the present categories as descriptors (see section 4.4). Final data analysis was based upon the interpretation of collected focus group data in relation to the four research questions posed by the investigator, validation by TT experts, and reexamination of literature supporting the study.

Chapter 4 Results and Summary

4.1 Introduction

This study examined the perceptions of expert RN TTPs to determine their view of expert Therapeutic Touch[®] practice. Synchronous online focus groups were utilized to collect rich data from the 12 participants. Data collected were analyzed using a focus group methodology design from transcripts prepared from archived recordings of the sessions.

The implemented procedures are examined, along with changes made to complete the study. The demographic data for the sample is discussed. Initial analysis from the tools used to collect data is reviewed. Finally, the procedure of checking the validity of the assumptions made about the concept clusters by the investigator is examined to demonstrate subject agreement on descriptors for a nurse TTP expert.

4.2 Procedures Utilized

Many procedures were required to complete this research study. The goal of the investigator was to find out how one could describe expertise in TT in terms that are more concrete. More importantly, do this in a way that would allow them to be universally communicated and understood, not only by practitioners but also by the nursing and medical community at large. First, the investigator obtained permission to conduct the study from the Duquesne University Institutional Review Board (IRB) (see

Appendix 7). Then permission was requested and obtained from the Therapeutic Touch® International Association (TTIA) Board of Directors to utilize their membership list to contact members by email for the study (see Appendices 2, 3).

4.2.1 Blackboard® Wimba® Live Classroom. This system was used for the first three focus groups. Group 2 was not completed due to a power failure at the home of one subject and the other was unavailable at the scheduled time. Groups 1 and 3 were held as scheduled. The system was upgraded mid-study and storage features were eliminated. The investigator chose to download the MP4 files and store them securely with the other study data. In order to proceed, the investigator completed additional training on the upgraded system.

4.2.2 Blackboard® Collaborate™ Web Conferencing. This was an upgraded system installed by the university. The investigator chose to continue to download the MP4s and store them securely with the other data, as she had with the previous converted data sets. The remaining five scheduled groups were on this system. One group was cancelled because the system could not be accessed remotely. The other four groups were held using the system, often with a participant using the telephone option to participate. Slides were not used, except for the Welcome slide (see Appendix 1), so that the participants would not have access to them prior to the focus group sessions. Features prohibited preloading the slides without participant access secondary to the graduate student permissions that were available with the investigator's Blackboard® account. As the investigator, the decision was made that the integrity of the study was more important than providing the audiovisuals.

4.2.3 Changes to procedures. The School of Nursing IRB representative was contacted to clear the use of a volunteer subject, at the onset of the study. An email was sent to a TTIA member, who the investigator believed was an RN. She replied that she was an EN (Enrolled Nurse), but had forwarded my request to another local member. That person responded enthusiastically wishing to participate in the study. This participant was from Australia and an integral part of the study. The SON IRB representative approved the inclusion of the volunteer, with disclosure in the text. In the course of events, the subject became a member of TTIA and might have volunteered in the next phase of the study. After the completion of four focus groups (six attempted) the minimum sample set (12) had not been reached. An amendment to the IRB proposal was submitted and approved (see Appendix 8). An additional request was submitted to (see Appendix 9), and approved (see Appendix 10) by, the TTIA Board of Directors to have an announcement published in the email newsletter sent to all of the members (see Appendix 11) to acquire additional subjects.

4.3 Demographic Data of the Sample

The sample consisted of 12 active licensed registered nurse subjects from the US (10), Australia (1), and Canada (1). All of the subjects were White females between the ages of 30 and 79, with age 30-39 (1), 50-59 (2), 60-69 (5), and 70-79 (4). Most subjects were married (8), one was widowed, two were divorced, and one was single. Only two participants indicated that they were retired; both of them maintain a private practice and one is also in education. A total of 9 of the 12 participants maintained private practices. Interesting to note, 75% of the sample were in the age 60 or over category.

Education was a characteristic of interest to the investigator prior to collecting data (see section 3.5.1). Initial nurse training was a diploma for 58% of the sample (7) and represented the final nursing credential for 17% of the participants. The majority (83%) of the subjects (10) held a nursing baccalaureate degree and for half it was their final nursing degree. A master's degree in nursing was held by 33% of the subjects (4) and was the final nursing degree for 75% of them, while another 33% of the participants held a non-nursing master's final degree. Another 16% of participants were prepared at the doctoral level, one with a PhD, as their terminal nursing degree and the other with a non-nursing doctorate. In addition, one subject was enrolled as a part-time student in a non-nursing master's program. Investigation of the data did not reveal the expected link between advanced education and TT education.

The subject with the terminal PhD in nursing had the second lowest amount of reported TT training courses (6), with over 21 years of TT experience. The two participants with final diploma credentials in nursing, one with a non-nursing Master's degree and the other taking classes at that level, had participated in 50 and 33 TT courses, respectively, both with over 21 years of experience. Based on a review of the data, there appears to be no pattern between advanced nursing education and expert TT practice that stands out in this sample.

All of the participants had attended the advanced invitational intensive courses; the subject with the least experience had attended more courses (4) than four other subjects with 16-20 years (2) and over 21 years (2) of experience. Each of those more experienced dyads had one person who attended one intensive and one who had attended three intensives. The advanced invitational intensive is a five-day course that currently

provides over 30 hours of continuing education hours. The range in years of TT experience fell between a minimum of 6 to 10 years (1) and a maximum of 21 or greater (7). The rest of the participants had 11 to 15 (2) and 16 to 20 (2) years of experience. The combination of TT education and experience did seem to account for the expertise of the subjects. While one of the retired subjects with 16 to 20 years of experience has only attended one course (the required advanced intensive), the subject with the least experience (6 to 10 years) has been to 17 courses. Three of the participants have attended 50 or more educational offerings.

A composite subject may be described as a White, married, female, age 55 to 65, who resides in the Pacific Northwest. She has at least 21 years of TT experience; holds a bachelor's degree in nursing; and maintains a private practice. In addition, she has completed basic, intermediate, and advanced TT classes; has attended TT intensives, TT conferences, and the TT Dialogues[®] (small group advanced study and practice theory development with Dr. Krieger).

Another area of interest prior to beginning the study was to examine religious/spiritual practices, since it had been stated by others that TT is a religious practice (Bullough & Bullough, 2000). This is a popular opinion of the skeptic community, which extends to denouncing the practice of TT in nursing schools and healthcare facilities. The majority (75%) of the participants selected a single religion or spiritual practice; the remainder chose 3, 5, and 6 different practices, respectively. The first, also the only subject who chose non-religious, included "eclectic, many spiritual practices" under other. The second selected 80% Christian traditions and the other a single Eastern religion. The final subject included 50% Eastern religions, 33% related to

Christian traditions, and the last to various indigenous groups. Eastern religions included Buddhism, Hinduism, and Islam/Sufi. The conclusion reached by the investigator is that individually, TTPs have spiritual practices or adhere to a religion, but their personal choices do not equate with TT as a religious practice.

4.4 Data analysis Results

Data were obtained from focus groups held online utilizing Blackboard® Wimba® Live Classroom and Blackboard® Collaborate™ Web Conferencing university-supported platforms. The discussion guide was used to conduct the sessions, field notes were taken to augment the investigators memory of them, and the MP4 tapes created after the sessions were completed. Verbatim transcripts were produced in typewritten form from the MP4 audio files. Finally, the transcripts were used to create long forms to code and analyze the data.

4.4.1 Discussion guide. The discussion guide (see Appendix 5) was utilized as written for all except one session, which included the use of follow-up questions (see Appendix 5) to delineate whether or not any additional meaningful additional data would be elicited. It was determined by the investigator that asking probing questions did not elicit more meaningful data, and were not necessary to include (dependent on time, circumstances, subjects, connections, etc.). Subjects had covered the material completely in the previous sessions without the follow-up questions.

4.4.2 Field notes. Field notes were utilized primarily to keep track of who, what, where, and why for the researcher. It kept her organized as far as who was being interviewed, when and with whom, what documents were needed, and when, and why there was a delay in transmission. Additionally, the researcher kept copious notes during

the interviews, which could come in handy in case of tape failure or loss of data. They were a backup and worked quite well in the initial transcription phase for a quick data run-through. They also facilitated who talked when and about what. They did not supplant the actual data, but provided another layer for thoroughness.

4.4.3 Transcripts. Transcripts were typed by the investigator for all of the focus group sessions. They were transcribed verbatim from MP4 tapes downloaded from the two Blackboard® system archives after the focus groups were completed. The investigator listened to the tapes multiple times to discern nuances, garbled words, times where participants talked over each other, indistinguishable words, noises, etc., until no more useful information could be obtained. Questions of accuracy remaining in the transcript were compared with the field notes kept by the investigator for clarification.

4.4.4 Long forms. Long forms were created with a Microsoft® Excel (2010) spreadsheet to sort the data into meaningful groups of terms. These terms fell into several different sets. Those sets began to look very familiar. They were color-coded with markers to delineate the sorting process further. At that point, the investigator went back to review expert practice (see section 2.3) and discovered that the majority of the terms the participants used to describe expert practice fell into categories already described by those authors (Baumann, 2006; Hardy, et al., 2006; Meleis, 1991; Riley, et al., 2007). One group included the learning and seeking knowledge, teaching, mentoring, sharing, expert practice knowledge, learning (research also a component), education, studying, professional organizations, credentials, holistic, practice, and enhancing skills. The perplexing part of this search was the time the investigator had been away from the review of the literature prepared prior to beginning the data collection phase.

Therefore, with a cluster of terms that seemed very familiar and yet not, the investigator kept searching through the manuscript. She then turned to the theoretical framework (see section 3.4), Krieger's (2002) transformation, and transcendence, where the last cluster of terms was located. This cluster included intuition, spiritual, change, surprise, self-care, transformative, influencing life, living TT, deeper inner peace, compassion, meditation, loss of ego, not connected to outcome, centered, and integral part of life. The search had come full circle. None of the concepts or terms had been provided to the subjects. And yet, independently, in their small groups, they had described not only the concepts of expert practice but also those of the theoretical framework used to support conducting this study.

It was at this point that the investigator was able to confirm data saturation had occurred prior to the completion of data collection by comparison of groups. Data saturation is said to have been reached when there is redundancy or repetition in the data collected (Munhall & Chenail, 2008; Polit & Tatano Beck, 2010; Rebar, Gersch, Macnee, & McCabe, 2011). In the confusion of trying to reach the minimum required data sample (submitted in the IRB proposal), the multitude of emails for subject recruitment, document retrieval, and session scheduling, preparing the IRB amendment, and graduate study; initially the point of saturation was not recognized.

In addition, given the nature of a graduate student study, it was necessary to meet the minimum number of subjects projected in the university IRB proposal to conduct this study. Another point of consideration was the desire of the investigator to expand the sample to include both international recruitment sites, which was accomplished with the additional groups. This is supported by LoBiondo-Wood & Haber (2010) who stated that

while in qualitative studies “there usually is *not* a predetermined number of participants...one important exception to this is if a researcher is very interested in getting different types of people in the study” (p. 92), such as an additional international participant.

However, the solidity of the data retrieved from the multiple experts in TT over the June to December period provided rich data to mine their experiences in the field. Munhall and Chenail (2008) noted that the investigator might decide on how many “narratives...she wishes to have in the study, as long as a good rationale is given that is acceptable” (p. 38). In this situation, the investigator and her advisor determined that a minimum sample size was necessary. More subjects than needed do not compromise a qualitative study. In fact, it allows for the discovery of outliers and diverse opinions in a sample. In this instance, neither of those occurred. Although, a sample of 12 may be considered a small sample, saturation was achieved as was suggested by the criteria of participants who “are good informants who are able to reflect on their experiences and communicate effectively” (Polit & Tatano Beck, 2010, p. 321).

4.5 Data Confirmation

Polit and Tatano Beck (2010) discussed the issues related to the investigator as the data collection instrument in qualitative research studies. As such, they noted the importance of demonstrating the “trustworthiness” of the data as a reflection of the participants’ viewpoints (Polit & Tatano Beck, 2010, p. 79). The authors further described data confirmation with the participants as “going back...and sharing preliminary interpretations with them so that they can evaluate whether the researcher’s

thematic analysis is consistent with their experiences” (Polit & Tatano Beck, 2010, p. 79).

After the data were transcribed, read, long forms completed, and lists made, the clusters of descriptors were then organized. A paragraph (see Appendix 16) describing the expert nurse TTP was written from the responses of the focus group participants to the questions posed by the investigator/moderator. Since all of the subjects had previously indicated they would be interested in seeing the results of the study, several were approached at a meeting of advanced practitioners and agreed to review the paragraph (TT Dialogues[®], August 12, 2014). The goal was to have them verify that the concepts represented a description of an expert TTP to them, based upon the data they had provided during their focus group session.

Three available study participants, at separate times, reviewed the paragraph on a lap top computer screen in a secluded space outside the conference room. They were asked to read it and to provide their comments. These subjects reviewed the paragraph, asked some questions, and made comments. It was explained to them then that the yellow highlighted portions were those that came directly from the literature. There was general agreement that the paragraph summarized for them qualities of an expert TTP.

Joyce responded at the end “it’s so right on.” Joyce noted that it was interesting that several of the participants came up with the same information. Grace felt it was a “pretty good” description. But Grace had concerns with the statement about research and theory. Grace said, “I think there are people I would consider experts that would not be developing theory here.” Grace concluded with, “I would like to think TTPs do things ‘such as’ research, theory...” Karen, as did Grace, questioned the meaning/wording of

skill, patient, and holistic practice knowledge. The investigator clarified that it meant knowledge in all three areas. Karen's conclusion on the paragraph was "all good."

The concept clusters were congruent with both the research literature used to support conducting the study and the theoretical framework underpinning the study. This step of data validation was exciting for the TTPs, too. They were amazed that the data supported the literature and Dr. Krieger's theory of transcendence. They were aware of the latter, as it is included in her book (Krieger, 2002), but they did not put it together until they saw the paragraph describing the expert TTP. These nurses are clearly committed to advancing the practice of TT and their responses added to the final analysis of the data.

4.6 Summary

There are pros and cons to utilizing electronic methodology for data collection. The advantages outweighed the disadvantages for this researcher. The ability to collect data across two continents and three countries was amazing. To set such a goal as a beginning researcher was daunting but well-worth the considerable time and effort. No funding is necessary to conduct this type of study. [Disclosure: the investigator received educational support (see Acknowledgment, para. 3-5).] The cost was limited to maintaining Internet access and telephone service, which were already available in the researcher's residence(s).

The utilization of online focus groups has become an accepted research methodology in nursing and other fields. The use of a synchronous time frame allowed for immediate interaction of the participants and provided them the opportunity to build on ideas from each other. Although consensus building is not the purpose of focus

groups, in this instance consensus was reached as to what qualities describe TTPs expert practice.

Chapter 5 Discussion and Recommendations

5.1 Introduction

This seminal study provides the basis for aligning expert RN TT practice with expert RN practice in allopathic healthcare settings, validating the modality not only as a nursing practice, but also in line with the researched delimiting factors associated with achieving expertise in the nursing field as a whole. While the subjects were volunteers, they were recruited from three countries, across two continents, and represented a wealth of TT knowledge, practice, and specialties. This sample represented nurses in staff, education, and administrative positions; advanced practice nurses, CNP, CNS, and CNM; and consultants and those maintaining private practices. Further, a composite of this sample of one dozen TTPs represents over 200 years of TT experience and attendance at over 350 TT programs/courses. That wealth of knowledge cannot be underestimated in disseminating the findings from this work.

Limitations affect the conduct of studies and are addressed. One weakness was utilizing a university based technology platform that underwent many changes during the course of the research. Limitations mentioned by a previous researcher about data storage (Mraz, 2010) with system changes did not seem a genuine concern since data could always be copied (MP3 or MP4) and stored by the researcher for backup and content review. The need for an IRB amendment mid-study to combat insufficient sample sizes,

while stressful, was not a significant obstacle. The themes that were revealed, will be discussed, along with their significance, and suggestions will be proffered for additional research in this area.

5.2 Discussion of Demographic Data

Demographic data were collected for all of the study subjects. Two subjects omitted one item each and were contacted to see if they were willing to provide the missing information. Each agreed, providing the researcher with 100% of the demographic descriptors for the study sample. The investigator's supposition prior to the study that level of education might influence practice did not seem to be borne out by the demographic data. The TTP who held a terminal nursing PhD had only attended six educational programs, compared with a nurse with a final nursing diploma and similar years of TT experience who had attended 33 TT programs.

However, the relationship between education and experience clearly validated expert practice. A combination of education and practice experience or experiential learning contributes to expert practice. One example is a TTP with 6 to 10 years of experience who attended 17 TT courses compared to another retired participant with 16 to 20 years of experience who reported attending only one formal course. Some older participants had attended fewer formal classes, but were still maintaining private practices and teaching classes. Overall the older adult participants (60 to 79 years old) had 21 or greater (6) years of experience with the rest (3) in the 11 to 20 year range. The number of TT courses taken ranged from 1 (1), 6 to 17 (3), 23 to 33 (5), and 50 to 64 (3).

5.3 Discussion of Findings

The findings were extraordinary in light of the manner in which the study was conducted. The focus group data were collected online. All of the questions were open-ended. When subjects asked for clarification, they were told by the investigator that she would only repeat the questions, therefore no hints or suggestions were provided. The focus group method, however, did provide help for the participants. As questions were posed I alternated participants to respond. However, if the one selected was having difficulty, often the other participant would begin the discussion in that area of inquiry, giving her time to gather her thoughts.

The importance in sharing the participants' own words tends to be efficient and effective in delivering the message (Morgan 2010). Morgan (2010) noted it is also easier to group together a set of individual remarks that support a similar position, in this instance, the discussion questions posed in the focus groups. Finally, the use of multiple respondents "adds credibility by demonstrating that this topic reaches beyond a few isolated portions of the data (Morgan, 2010, p. 719).

Participants stated they felt they were able to respond to the thoughts of the other participant and it led them to think in more depth about the questions and the areas of discussion. One mentioned she did not know how they would have completed the session if there had been more participants. One said she felt as if the two of them were almost thinking the same thing at times. Another was wondering about the choice of focus groups, but afterward felt that "it does pull out more information than one-on-one interviews would." She attributed it to the "magic of free association." One of the

strengths of the focus group method is the ability of the participants to share ideas and expand on thoughts as they express themselves.

5.3.1 Sources of Therapeutic Touch® research. The majority of the subjects only used research when they taught TT classes. Joyce reported using research findings with patients who were not comfortable with TT or skeptical of its use. Laura reported going online to access the TTIA bibliography for information. Fiona counted on her colleagues and connections within TTIA. However, the use of our international professional organization, other professional TT organizations, TT colleagues, and TT newsletters for such information, supports scholarship, an important component of nursing expertise.

5.3.2 Descriptors of personal Therapeutic Touch® practice. The participants used descriptors that met the criteria used to delineate expert practice and those to support the theoretical framework. Dolly mentioned, “caring, . . . wholeness, holistic” as descriptors of her practice. Hanna also describes her practice as “holistic.” Beryl stated she passed on her TT with “surprises while teaching, not thinking it will be spectacular.” Cindy had the opportunity to teach “all levels of TT as part of [her] nursing practice.” Erika felt it was “really important to share knowledge and experience with those coming up.” Mindy added the component of “safe practice.” Support of the framework examples include when Fiona alluded to the “transcending essence of what I am and what I do as a nurse.”

Subjects were also asked to share examples of influences on their TT practice. Fiona chose “intuition.” Beryl said, “I am meant to be doing what I am doing.” Dolly described how much a difference you could make on all these different levels. Hanna

shared, “TT seems natural to me, an old nurse, a holistic nurse.” Cindy referred to research results and not knowing what the outcome will be. Karen referred to becoming “much more sensitive to the world around me, my practice is influenced by everything I do.” Mindy stated you “get to the point that where you are actually living TT, there is very little that doesn’t influence you in some way.” In other words, TT transforms one’s life. Erika speaks to “trusting in intuition, emerge with information, and trusting what you know.” Joyce notes that “compassion” is a component of influence to her TT practice. Erika also speaks about “compassion.” “Transformative” was a descriptor for Dolly.

5.3.3 Descriptors of RN Therapeutic Touch® practitioner (TTP) expert. The participants supplied their view of an RN TTP expert. One factor identified was intuition (Beryl, Cindy, Dolly, Fiona, Hanna) Another descriptor was being a role model for others and teaching (Beryl, Hanna). Also considered significant to being expert involved the qualities of a deeper practice and more practice experience (Beryl, Hanna, Irene, Karen, Mindy). Others described the need to continue seeking knowledge (Hanna, Irene, Mindy) and the ability to be centered more deeply (Cindy, Hanna).

5.3.4 The future of Therapeutic Touch®. Fiona stressed the importance of bringing TT to the younger generation. Beryl stressed the “need to draw in evidence-based science.” Both Fiona and Beryl discussed the need to utilize electronic media to spread knowledge about TT. Dolly identified the problems incorporating it into nursing practice and her five-year goal is to have a private practice, where she plans to charge a fee for her services. Hanna sees a need for instruction in marketing since “people don’t value therapy” that is not accompanied by a professional charge. Because of that, Hanna fears that “TT is in danger of being extinct as a unique therapy.”

Karen feels we are missing the certification piece, while Cindy countered with “TT has standards...where 30 years and one week look like they are doing the same thing.” These standards are the guidelines for practice and teaching that produce the image of beginner and expert TTPs seemingly performing the same process to the observer. Irene said she is hopeful “it will continue and grow.” Mindy focused on her personal mission to continue teaching TT for the next 15 years because she believes “it would be a good thing for most of humankind to learn and understand TT, as a healing modality.” Erika sees both possibilities of limitless expansion and TT “falling apart” as the group ages. Joyce also spoke about attracting younger people to TT and marketing to different “age brackets” and “thinking of multicultural dimension.” Monsivais (2011) discussed cultural competency in relation to EBP to effect change in patient outcomes. In this example, collecting information and developing expanded cultural competence has the potential to expand the reach of the discipline.

5.3.5 The expert RN Therapeutic Touch® Practitioner. After data verification, the investigator went back to the data, the supporting literature, and the informants comments. At that time the investigator began pulling together all of the components, based upon all of the information available, to begin to describe the expert RN TTP. The expert RN TTP is an experienced nurse, whose practice evolves with confidence. She implements a holistic approach utilizing perception to delineate truth. She is able to utilize knowledge of skills, patients, and holistic practice as she learns, practices, and hones her TT skills. During this process the RN TTP expert develops confidence, is able to utilize self-reflection, and maintain a lack of ego in the treatment outcome. This transforming journey comes with compassion, intentionality, centering, and intuition

becoming ever more present in their lives. These changes result in transcendence. The journey involved is one that is beyond the usual and fills her with its mystery, new discovery, amazement, and surprise.

An expert RN TTP leads by example and shares TT by practicing, teaching, and mentoring those new to the discipline. She seeks out credentials to practice and teach. She may go on to write, perform research, obtain an advanced degree, and generate theory. She supports her colleagues through distant healing and practice support groups. The RN expert TTP makes the quest for new knowledge a lifetime goal, utilizing the professional organizations, journals, bibliographies, literature searches, conferences, courses at the retreat centers, such as Pumpkin Hollow and Indralaya, and her TT colleagues. She continues to study the publications and handouts of the co-founders of TT and with Dr. Krieger when she is available. She commits herself to a continuous process of learning and growing in TT.

5.4 Emerging Themes

Themes that were identified from the groups of descriptors included knowledge, holistic practice, practice, learning, evolving, sharing, and transforming. Knowledge incorporated knowledge of self, patients, and skills. Skills included both practice and interpersonal, the bond between the practitioner and the healing partner. Learning, sharing, and evolving are part of scholarship. Learning and evolving are part of practice expertise where the holistic approach utilizes perceptions to delineate truth. Experts also exude more confidence, which allows them to be surer of their decisions and their course of actions while administering treatments. Interpersonal skills are another form of practice-related knowledge.

5.5 Relationship of Findings to Published Scholarly Literature

To me as a researcher, the most astounding “aha” moment came when I realized that the clusters and subsets of descriptors used by my subjects fit into the very categories used to describe nurse expertise, in the literature used to support conducting the study. There had been a gap between the literature review and the data collection. Thus, I was quite surprised to find the remaining cluster of data being supported by the theoretical framework for the study. Krieger’s (2002) theoretical framework or underpinning of transcendence accommodated the remainder of the subjects’ descriptions related to expert practice of active licensed RN TTPs.

Findings from this study supported a number of previously published studies. Krieger’s (2002) concept of transformation was especially apparent in the lives of many of the participants in this study. They described how TT was not just something they practiced but had become an integral part of their lives and influenced their lives immeasurably. One said that she could not imagine her life without TT.

The importance of practice as one factor leading to expertise was also much apparent among the participants. Many of the studies stress the need for practice in order to gain expertise in specialty practice. TT is a form of specialty practice by nurses, supported in a holistic framework and caring environment.

Sharing, which includes mentorship, collaboration, and teaching, is an important part of an advanced practice model, and is apparent in the practice of these advanced TTPs. Expert practice includes the components of expert practice knowledge, which is a necessary prequel to the ability to share it with others. It is also a necessary component to

provide leadership to others, to conduct research in the field and to further one' own practice goals.

5.6 Researcher Bias

Researcher bias is based upon the experience of the researcher or investigator. The investigator is an active licensed RN, who has practiced TT for over 20 years. She has studied with both of the co-founders of TT and has attended over 300 hours of training and education in TT and CAM. Her initial interest was spurred after receiving TT, while a biofeedback patient of a licensed social worker. She was referred to a member of TTIA, took the beginner's training, and attended her first conference the next year. She knew intuitively that she had the gift/ability to do TT and she was correct. It was many, many years later that she found out about her heritage with a paternal grandparent who was a Cherokee medicine woman. Nurse, healer, researcher, volunteer, Christian, published author, presenter, and scholar are but a few of the words, which describe the investigator's background.

It was interesting to note that from the participant's responses to the questions it is clear that just having knowledge of a subject will not prevent a knowledge gap in research. All of the questions were open-ended. At one point, when a subject was requesting more information about a question, I simply stated that although I thought the questions were self-explanatory when I wrote them, I did not want to influence their response, in case I had written a bad question.

5.7 Significant Findings

This study utilized an international sample of participants drawn from the US, Canada, and Australia, where TT is most widely practiced. The study demonstrated a link between the concepts of expert practice in TT, a CAM or integrative therapy and expert allopathic nurse practice. This doctoral candidate investigator illustrated that online synchronous focus groups present a cost-effective method of data collection for novice researchers. In addition, focus groups may be utilized to reach specialized research populations and those difficult to reach utilizing traditional methods.

The significance of the study findings to TT lies in the ability to describe expert TT practice for active licensed RN TT practitioners. Further, it allows for the incorporation of expert markers in teaching and further research on TT. Advanced practice in TT requires utilization of expert practitioners to disseminate knowledge of the discipline, not only to new practitioners but also to the public. This research explored an area not previously studied and contributed to the body of nursing science (Wardell, 2015).

To CAM, this study sets a benchmark for expert nurse TTPs to be aligned with allopathic practice expert nurses. It validates TT practice at the same level as other expert nursing practice. As an accepted part of nursing care delivery, TT may now be easily integrated into an allopathic model, with research-based findings to support its use. It paves the way for other CAM therapies to look at their practice in relation to expert markers in a different way and determine if their models of care delivery may also fit into the allopathic model. The possibility exists that the path to integrative nursing and holistic practice may be facilitated for other CAM practitioners.

To holistic nurses, this study provides another research-based modality for holistic nurses to add to their armamentarium of services they are able to provide to their patients. In addition, since TT expertise equates with expertise in nursing, its value is enhanced for practicing nurses. In the end, patients benefit from additional care options.

5.8 Limitations of Study

Generalizability of findings due to lack of diversity of the sample, specifically gender and race/ethnic diversity, was one expected limitation. However, this self-identified, White female sample not only represents the majority of members of the sampled organization, of which the investigator is a member, but also the last sampled US registered nurse (RN) population (U. S. Department of Health and Human Services, Health Resources and Services Administration [HRSA], 2010). In addition, studies found the majority of RNs are female in both Canada (2010 Workforce Profile of Registered Nurses in Canada) and Australia (2013 National Health Workforce Data Set). Neither of those studies provided information of the race/ethnic diversity of their entire samples.

The project involved a time-consuming process using email for recruiting subjects and collection of all pre-study materials. Technical difficulties presented challenges that resulted in an extended period to acquire the minimum sample target and required additional investigator training. In addition, up-to-date resources were not available in all areas of inquiry. Two university libraries, one public and one private, in different states, were searched for updated sources, specifically texts, on focus groups. They both had the primary references used in this paper, one had one new book, the other three electronic books; these were not available to the investigator and one had not yet been obtained. The few articles that were located on focus groups discussing their design and procedures,

also used the 20 to 30 year old primary resources as the references for their works. This practice carried over into recent TT articles, which made use of landmark reports as the basis for their studies, making it more difficult to provide new insights in some practice areas.

5.9 Recommendations for Future Research

First, a replication of this study with another sample of expert active licensed RN TTPs looking for similarities in findings is suggested. Second, an extension of this work to then validate the findings with retired, lapsed, expired, and other not active licensed RN TTPs for fit with their perceptions of what constitutes expert TT practice, would further define the nature of expert TTP practice. Another important area to explore is expert TT practice with non-expert and non-nurse TTPs related to these descriptive features, in order to advance the science of this discipline. Finally, a comparison of study results with the SETTS to look for similarities and differences might yield another way to look at the objective measurement of TT performance to complement this qualitative descriptive measure of expert RN TTP performance.

To further meet the needs of clients we serve it is important to expand the research arena into hospitals, extended care facilities, hospices, and outpatient clinics to look at the impact of TTP expertise on perceived quality of care (Chinn & Kramer, 2011). Chinn and Kramer (2011) identified areas of interest to the public as “satisfaction with specific dimensions of care, perceived benefits obtained from the care, and perceived dissatisfactions (p. 241).” Examples of public interest related to future research from this study might include time to receive a treatment, comparison of expertise between TTPs and expert bedside nurses, relief of pain or anxiety related to ordered

medical treatments, and distrust of alternative practices related to perceived dissatisfaction.

Another related area to explore might include further examination of the relationship between spiritual/religious practices and TTPs and the influence if any on TT practice. Exploration of the impact of expertise in TT and its introduction and use with patients in allopathic healthcare settings is another possible avenue of research. Further investigation into the multitude of clinical conditions suitable for treatment with TT with expert TTPs as defined in this study, utilizing quantitative methodology, such as three-group blinded RCTs. The goal of all further study is to add the body of evidence supporting the scientific basis for this nursing discipline.

5.10 Conclusion

This work utilized a sample of expert active licensed RN TTPs, from three countries, representing the largest active centers of TT practice in the world. Sampling utilized very small focus groups with a specialized population of expert TTPs drawn from the TTIA database and through referrals and volunteers from that database. Rich data were obtained during the focus groups and a description of a TTP expert from that data was validated by several of the subjects after the data collection was complete. The data provided by the subjects were supported by previous research done with expert nurses and by the theoretical framework underpinning TT practice for this study. The information provided by these expert RN TTPs represents a new viewpoint to support the integrated practice of TT in allopathic healthcare settings and everyday nursing practice. The participants' descriptions of expert practice highlight the need for further research

(see section 5.8) in this discipline. The use of qualitative inquiry methods to further explore this area also provide essential support for evidence-based practice.

The investigator advocated for many years ways to include the use of TT by nurses in both acute and critical care settings (Wardell, 2006, 2007, 2008a, 2008b, 2010, 2013). Rogers (1980) noted early on that research findings lead to system changes equivalent to the amount of new knowledge generated and science “emerges out of scholarly research (p. 330).” This research demonstrates that a group of expert RN TTPs described the same documented characteristics for allopathic expert RNs, as being necessary for their expert practice and the practice they expect of other expert TT practitioners. Expertise crosses the allopathic, complementary, and integrative boundaries. Expert RN TTPs now have specific data from this study to further the initiation and dissemination of TT practice, with their colleagues in the setting in which they practice. It is imperative that going forward, all nurses set a goal to implement holistic nursing practice, while embracing expert nursing practice as a standard for the profession, supported by ongoing clinical research projects.

REFERENCES

References marked with an asterisk indicate studies included in the meta-analysis.

Altman, D. G., Schulz, K. F., Moher, D., Egger, M., Davidoff, F., Elbourne, D. . . . Lang, T. (2001). The revised CONSORT statement for reporting randomized trials: Explanation and elaboration. *Annals of Internal Medicine, 134*, 663-694.

American Holistic Nurses Association (AHNA). (2015). *What is holistic nursing?* Retrieved from <http://www.ahna.org/AboutUs/WhatIsHolisticNursing/tabid/1165/Default.aspx>

Arwood, T., & Panicker, S. (2011, June 9). *Social and behavioral research: Assessing risk in social and behavioral sciences*. Retrieved from CITI (Collaborative Institutional Training Initiative) website: <https://www.citiprogram.org/default.asp?language=english>

Ary, D., Jacobs, L. C., & Razavieh, A. (1979). Guidelines for writing research proposals. In D. Ary (Ed.), *Introduction to research in education* (2nd ed., pp. 367-387). New York, NY: Holt, Rinehart, & Winston.

Astin, J. A., Harkness, E., & Ernst, E. (2000, June 6). The efficacy of “distant healing”: A systematic review of randomized trials. *Annals of Internal Medicine, 132*, 903-910.

Australian Institute of Health and Welfare (AIHW). (n.d.). How many nurses and midwives are there? Retrieved from <http://www.aihw.gov.au/workforce/nursing-and-midwifery/how-many/>

Aveyard, B. Sykes, M., & Doherty, D. (2002). Therapeutic Touch in dementia care. *Nursing Older People, 14*(6), 20-21.

Barrett, S. (2008, February 3). *Why Therapeutic Touch should be considered quackery*. Retrieved from QuackwatchSM website: <http://www.quackwatch.org/01QuackeryRelatedTopics/tt.html>

Barrington, R. (1994). A naturalistic inquiry of post-operative pain after Therapeutic Touch. In D. A. Gaut & A. Boykin (Eds.), *Caring as healing: Renewal through hope* (Publication No. 14-2607, pp. 199-213). New York, NY: NLN Press.

- Barron, A.-M., Coakley, A., Earl, R., Fitzgerald, E., Johnson, E., Jones, D. . . . Thorley, L. (2007). *An exploration of factors that facilitate the integration of Therapeutic Touch on an inpatient oncology and bone marrow transplant unit*. Poster presented at the meeting of the Eastern Nursing Research Society. Abstract retrieved from Virginia Henderson International Nursing Library website: <http://nursinglibrary.org/>
- Bartelmo, J., & Eckman, M. (Eds.). (2013). *Nursing care planning made incredibly easy!* (2nd ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Baumann, S. L. (2006). What does expert nursing practice mean? [Editorial]. *Nursing Science Quarterly*, *19*, 259-260. doi:10.1177/0894318406289497
- Beckendorf, R. (2004a). Therapeutic Touch in der kinder-und jugendpsychiatrie: Mit den handen die seele beruhren [Therapeutic Touch in pediatric and adolescent psychiatry: Hands touching the soul]. *Pflegezeitschrift*, *57*, 552-554.
- Beckendorf, R. (2004b). Therapeutic Touch (TT) und psychiatrische Pflege [German]. *PsychPflege Heute*, *10*, 85-86.
- Bender, D. E., & Ewbank, D. (1994). The focus group as a tool for health research: Issues in design and analysis. *Health Transition Review*, *4*, 63-79.
- Benkofsky-Webb, J., Good, R., & Winstead-Fry, P. (2004, Spring). Evidence based practice and Therapeutic Touch in pain. *Cooperative Connection*, *26*(2), 1, 9.
- Bland, J. (2005). Alternative therapies—A moving target. *Alternative Therapies in Health and Medicine*, *11*(2), 20-22.
- Bondurant, S., & Sox, H. C. (Ed.). (2005, January 18). Mainstream and alternative medicine: Converging paths require common standards [Editorial]. *Annals of Internal Medicine*, *142*, 149-150, W-18. Retrieved from Annals of Internal Medicine website: www.annals.org
- Briones, T. L. (2007). Psychoneuroimmunology and related mechanisms in understanding health disparities in vulnerable populations. *Annual Review of Nursing Research*, *25*, 219. Retrieved from ProQuest Nursing & Allied Health Source database.
- Bullough, V. L., & Bullough, B. (2000). Therapeutic Touch? Should nursing schools teach Therapeutic Touch? In B. Scheiber & C. Selby (Eds.), *Therapeutic Touch* (pp. 70-76). Amherst, NY: Prometheus Books. (Originally published in 1998, *Journal of Professional Nursing*, *14*, 254-257.)

- Burns, N., & Grove, S. K. (2001). *The practice of nursing research: Conduct, critique, & utilization* (4th ed.). Philadelphia, PA: Saunders.
- Byers, J. F. (2004). Protecting patients during clinical research. *Critical Care Nurse*, 24, 53-59.
- Carpenito-Moyet, L. J. (2010). *Nursing diagnosis: Application to clinical practice* (13th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Chinn, P. L., & Kramer, M. K. (2011). *Integrated theory and knowledge development in nursing* (8th ed.). St. Louis, MO: Elsevier Mosby.
- Clark, P. E., & Clark, M. J. (1984). Therapeutic Touch: Is there a scientific basis for the practice? *Nursing Research*, 33, 37-41.
- Clarke, T. C., Black, L. I., Stussman, B. J., Barnes, P. M., & Nahin, R. L. (2015, February 10). Trends in the use of complementary health approaches among adults: United States, 2002-2012 (National Health Statistics Reports No. 79). Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.
- Clement, J. P., Chen, H.-F., Burke, D., Clement, D. G., & Zazzali, J. L. (2006). Are consumers reshaping hospitals? Complementary and alternative medicine in U.S. hospitals, 1999-2003. *Health Care Management Review*, 31, 109-118.
- Coakley, A. B. (2002). Exploration of energy expenditure between provider and recipient during a Therapeutic Touch (TT) treatment and the response to (TT) on healthy individuals (Doctoral dissertation, Boston College, MA, 2001). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 62(07), 3134. Retrieved from ProQuest Dissertations and Theses Database (UMI No. 3021571)
- Coakley, A. B., & Duffy, M. E. (2010). The effect of Therapeutic Touch on postoperative patients. *Journal of Holistic Nursing*, 28, 193-200. doi:10.1177/0898010110368861
- College of Nurses of Ontario (CNO). (2014, June). *Practice guideline: Complementary therapies* (Publication No. 41021). Toronto, Ontario: Author.
- Coppa, D. A. (2002). The internal process of Therapeutic Touch as nursing action (Doctoral dissertation, University of Rhode Island, Kingston). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 63(05), 2302.

- Coppa, D., & Cabral, M. (2005, Summer). The effects of Therapeutic Touch on chronic wound healing: A pilot study. *Cooperative Connection*, 27(3), 1, 11.
- Côté-Arsenault, D. (2013). Focus groups. In C. Tatano Beck (Ed.), *Routledge international handbook of qualitative nursing research* (pp. 307-318). London, UK: Routledge.
- Day, L. (2009). Evidence-based practice, rule-following, and nursing expertise. *American Journal of Critical Care*, 18, 479-482. doi:10.4037/ajcc2009147
- Deenadayalan, Y. (2007, August 23). Headache (tension-type); Therapeutic Touch therapy. *Evidence Summaries – Joanna Briggs Institute*. (Document ID: 1451740991). Abstract retrieved from <http://proquest.umi.com>
- Dennison, B. L. (2001, March). Consumer access to complementary therapies such as Therapeutic Touch (TT). *The Kansas Nurse*, 76(3), 12-15.
- Dennison, B., Good, R., Milton, D., & Newshan, G. (1998, October). *Standards, Curricula, and Guidelines for Practicing and Teaching Therapeutic Touch*. Paper presented at the meeting of Nurse Healers—Professional Associates International, 19th Annual Conference, Philadelphia, PA.
- Doherty, D., Wright, S., Aveyard, B., & Sykes, M. (2006). Therapeutic Touch and dementia care: An ongoing journey. *Nursing Older People*, 18(11), 27-30.
- Dossey, B. M., & Keegan, L. (2009). *Holistic nursing: A handbook for practice* (5th ed.). Sudbury, MS: Jones and Bartlett.
- Downey, M. (2007). Effects of holistic nursing course: A paradigm shift for holistic health practices. *Journal of Holistic Nursing*, 25, 119-125. doi:10.1177/0898010107301616
- Downie, N. M., & Starry, A. R. (1977). *Descriptive and inferential statistics*. New York, NY: Harper Row.
- Dracup, K., & Bryan-Brown, C. W. (2004). From novice to expert to mentor: Shaping the future. [Editorial]. *American Journal of Critical Care*, 13, 448-450.
- Einstein, A. (1960). *Field theories, old and new*. New York, NY: Readex Microprint. (Original work published 1929)
- Eisenberg, D. M., Davis, R. B., Ettner, S. L., Appel, S., Wilkey, S., Van Rompay, M., & Kessler, R. (1998, November 11). Trends in alternative medicine use in the United States, 1990-1997: Results of a follow-up national survey. *JAMA: Journal of the American Medical Association*, 280, 1569-1575.

- Eisenberg, D. M., Kessler, R. C., Foster, C., Norlock, F. E., Calkins, D. R., & Delbanco, T. L. (1993). Unconventional medicine in the United States. *New England Journal of Medicine*, 328, 246-252.
- Fawcett, J., Sidney, J. S., Hanson, M. J. S., & Riley-Lawless, K. (1994). Use of alternative health therapies by people with multiple sclerosis: An exploratory study. *Holistic Nursing Practice*, 8(2), 36-42.
- Fedoruk, R. B. (1985). Transfer of the relaxation response: Therapeutic Touch B as a method for reduction of stress in premature infants (Doctoral dissertation, University of Maryland, College Park, 1984). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 46(03), 978. Abstract and preview retrieved from ProQuest Dissertations and Theses database. (UMI No. 8509162)
- Feinstein, D., & Eden, D. (2008). Six pillars of energy medicine: Clinical strengths of a complementary paradigm. *Alternative Therapies in Health and Medicine*, 14(1), 44-54.
- Fenton, M. V. (2003). Therapeutic Touch: A nursing practice. *Alternative Therapies in Health and Medicine*, 9(1), 34-36.
- Ferguson, C. K. (1986). Subjective experience of Therapeutic Touch survey (SETTS): Psychometric examination of an instrument (Doctoral dissertation, The University of Texas at Austin). [CD-ROM]. *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 47(05), 1927. Abstract and preview retrieved from ProQuest Dissertations and Theses database (UMI No. 8618897)
- Fleshner, M., & Laudenslager, M. L. (2004). Psychoneuroimmunology: Then and now. *Behavioral and Cognitive Neuroscience Reviews*, 3, 114-130. doi:10.1177/1534582304269027
- Flesner, M. K., M. K., Miller, L., McDaniel, R., & Rantz, M. (2010). From nursing process to nursing synthesis: Evidence-based nursing education. In K. Malloch & T. Porter-O'Grady (Eds.), *Introduction to evidence-based practice in nursing and health care* (2nd ed., pp. 57-76). Sudbury, MS: Jones and Bartlett.
- Fontana, A., & Frey, J. H. (1994). Interviewing: The art of science. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 361-376). Thousand Oaks, CA: Sage.
- Fortune, M. (1999, January-April). New York Open Center Award. *Cooperative Connection*, 20(1-2), 5.

- Franklin, K. K., & Lowry, C. (2001). Computer-mediated focus group sessions: Naturalistic inquiry in a networked environment. *Qualitative Research, 1*, 169-184. doi:10.1177/146879410100100204
- *Gagne, D., & Toye, R. C. (1994). The effects of Therapeutic Touch and relaxation therapy in reducing anxiety. *Archives of Psychiatric Nursing, 8*, 184-189.
- Gibbs, A. (1997, Winter). Focus groups. *Social Research Update*, (19). Retrieved from University of Surrey Department of Sociology website: <http://sru.soc.surrey.ac.uk/SRU19.html>
- Glazer, S. (2001). Therapeutic Touch and postmodernism in nursing. *Nursing Philosophy, 2*, 196-212. doi:10.1046/j.1466-769X.2000.0061.x (Originally published in *Knowledge & Society, 12*, 319-341)
- Grad, B. (1963). A telekinetic effect on plant growth: I. Technique and First Results. *International Journal of Parapsychology, 5*, 117-133. [Cited in Grad, B. (1964). A telekinetic effect on plant growth: II. Experiments involving treatment of saline in stoppered bottles. *International Journal of Parapsychology, 6*, 473-498]
- Grad, B. (1964). A telekinetic effect on plant growth: II. Experiments involving treatment of saline in stoppered bottles. *International Journal of Parapsychology, 6*, 473-498.
- Grad, B. (1965). Some biological effects of the 'laying on of hands': A review of experiments with animals and plants. *Journal of the American Society for Psychical Research, 59*, 95-129.
- Grad, B. (1967). The "laying on of hands": Implications for psychotherapy, gentling, and the placebo effect. *Journal of the American Society for Psychical Research, 61*, 286-30.
- Grad, B., Cadoret, R. J., & Paul, G. I. (1961). An unorthodox method of treatment of wound healing in mice. *International Journal of Parapsychology, 3*, 5-24. [Cited in Grad, B. (1964). A telekinetic effect on plant growth: II. Experiments involving treatment of saline in stoppered bottles. *International Journal of Parapsychology, 6*, 473-498]
- Gregory, S., & Verdouw, J. (2005). Therapeutic Touch: Its application for residents in aged care. *Australian Nursing Journal, 2*, 23-25.
- Gronowicz, G. (2007, Fall). Therapeutic Touch affects osteoblasts proliferation and bone formation in cell culture. *Cooperative Connection, 27*(7), 1-3.

- Gronowicz, G., Jhaveri, A., Clarke, L. W., Aronow, M. S., & Smith, T. H. (2008). Therapeutic Touch stimulates the proliferation of human cells in culture. *The Journal of Alternative and Complementary Medicine*, *14*, 233-239. doi:10.1089/acm.2007.7163
- Gronowicz, G., Secor, E. R., Jr., Flynn, J. R., Jellison, E. R., & Kuhn, L. T. (2015). Therapeutic Touch has significant effects on mouse breast cancer metastasis and immune responses but not primary tumor size. *Evidence-Based Complementary and Alternative Medicine*, *2015*, pp. 1-10. Retrieved from <http://dx.doi.org/10.1155/2015/926565>
- Haahr, M. (1998). *Random integer set generator*. Retrieved from <https://www.random.org>
- Hale, E. H. (1986). A study of the relationship between Therapeutic Touch and the anxiety levels of hospitalized adults (Doctoral dissertation, Texas Womens' University, Denton, 1986). *Dissertation Abstracts International: Section B, Physical Sciences and Engineering*, *47*(05), 1928. Abstract and preview retrieved from ProQuest Dissertations and Theses database. (UMI No. 8618897)
- Hallett, A. (2004, June 22). Narratives of Therapeutic Touch. *Nursing Standard*, *19*(1), 33-37.
- Hanley, M. A. (2004). Therapeutic Touch with preterm infants: Composing a treatment (Doctoral dissertation, The University of Texas Graduate School of Biomedical Sciences at Galveston). *Dissertation Abstracts International: Section B, Physical Sciences and Engineering*, *65*(03), 1247.
- Hanley, M. A. (Panel Moderator). (2015, April). *TT Dialogues® in the Rocky Mountains of Montana: Creating a theory of healing through Therapeutic Touch*. Plenary session presented at the meeting of the Therapeutic Touch International Association, Third International Congress, Seattle, WA.
- Happell, B. (2007). Focus groups in nursing research: An appropriate method or the latest fad? *Nurse Researcher*, *14*(2), 18-24.
- Hardy, S., Titchen, A., Manley, K., & McCormack, B. (2006). Re-defining nursing expertise in the United Kingdom. *Nursing Science Quarterly*, *19*, 260-264. doi:10.1177/0894318406289911
- Haselhurst, G., & Howie, K. (2009). *Quantum Physics: David Bohm*. Retrieved from <http://www.spaceandmotion.com/Physics-David-Bohm-Holographic-Universe.htm>

- Hawranik, P., Johnston, P., & Deatrich, J. (2008). Therapeutic Touch and agitation in individuals with Alzheimer's disease. *Western Journal of Nursing Research, 30*, 417-434. doi:10.1177/0193945907305126
- Healing Touch Program (HTP). (n.d.). About. Retrieved from <http://www.healingtouchprogram.com/>
- Heidt, P. R. (1980). An investigation of the effects of Therapeutic Touch on anxiety of hospitalized patients (Unpublished doctoral dissertation, New York University, New York City, 1979). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering, 40*(11), 5206.
- Heidt, P. (1981). Effect of Therapeutic Touch on anxiety level of hospitalized patients. *Nursing Research, 30*, 32-37.
- Heidt, P. R. (1990). Openness: A qualitative analysis of nurses and patients experiences of Therapeutic Touch. *IMAGE: Journal of Nursing Scholarship, 22*, 180-186. doi:10.1111/j.1547-5069.1990.tb00204.x
- Herdman, T. H., & Kamitsura, S. (Eds.). (2014). *NANDA international nursing diagnoses: Definitions and classification, 2015-2016* (10th ed.). Oxford, UK: Wiley Blackwell. (Original work published 1994)
- Herdtner, S. (1999). The experience of knowing self and others in Therapeutic Touch (Doctoral dissertation, New York University, New York City, 1998). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering, 60*(01), 129.
- Herman, P. M., D'Huyvetter, & Mohler, M. J. (2006). Are health services research methods a match for CAM? *Alternative Therapies in Health and Medicine, 12*(3), 78-83.
- Hicks, L. (2011, June 8). *Social and behavioral research: Internet research*. Retrieved from <https://www.citiprogram.org/default.asp?language=english>
- Hogg, P. K. (1985). The effects of acupressure on the psychological and physiological rehabilitation of the stroke patient (stress, relaxation, pain). (Doctoral dissertation, California School of Professional Psychology, Berkeley/Alameda). Abstract retrieved from ProQuest Dissertations and Theses database. (UMI No. 8603265)
- Hollander, J. A. (2004). The social contexts of focus groups. *Journal of Contemporary Ethnography, 33*, 602-637. doi:10.1177/0891241604266988

- Hupcey, J. E. (2005). Measurement issues in qualitative research. In C. F. Waltz, O. L. Strickland, & E. R. Lenz (Eds.), *Measurement in nursing and health research* (3rd ed., pp. 215-228). New York, NY: Springer.
- Hurricane.com. (n.d.). Hurricane names: Atlantic hurricane names. Retrieved from <http://www.hurricane.com/hurricane-names.php>
- The International Center for Reiki Training (n.d.). Reiki FAQ: What is Reiki? Retrieved from <http://www.reiki.org>
- Jackson, E., Kelley, M., McNeil, P., Meyer, E., Schlegel, L., & Eaton, M. (2008). Does Therapeutic Touch help reduce pain and anxiety in patients with cancer? *Clinical Journal of Oncology Nursing, 12*, 113-120. doi:10.1188/08.CJON.113-120
- Jennings, B. M., & Loan, L. A. (2001). Misconceptions among nurses about evidence-based practice. *Journal of Nursing Scholarship, 33*, 121-127. doi:10.1111/j.j.1547-5069.2001.00121x
- Jhaveri, A. S., Walsh, J., Wang, Y., McCarthy, M., & Gronowicz, G. (2008). Therapeutic Touch affects DNA synthesis and mineralization of human osteoblasts in culture. *Journal of Orthopaedic Research, 26*, 1541-1546. Abstract retrieved from <http://www.missionhospitals.org/body.cfm?id=2546>
- Johnston, M. (2005). Patterns of knowing—Circles of being: Adult transformation through personal energy experience (Unpublished doctoral dissertation, Northern Illinois University, DeKalb). *Dissertation Abstracts International: Section A. Humanities and Social Sciences, 67*(02).
- Johrei Fellowship. (n.d.). About us. Retrieved from <http://johreifellowship.org/about-us>
- Karagulla, S., & Kunz, D. V. G. (1989). *The chakras and the human energy fields*. Wheaton, IL: Quest Books.
- *Keller, E., & Bzdek, V. M. (1986). Effects of Therapeutic Touch on tension headache pain. *Nursing Research, 35*, 101-106.
- Kelly, A. E., Sullivan, P., Fawcett, J., & Samarel, N. (2004). Therapeutic Touch, quiet time, and dialogue: Perceptions of women with breast cancer. *Oncology Nursing Forum, 31*, 625-631. doi:10.1188/04.ONF.625-831
- Kenny, A. J. (2005). Interaction in cyberspace: An online focus group. *Journal of Advanced Nursing, 49*, 414-422.

- Kiernan, J. S. (1997). The experience of Therapeutic Touch in the lives of five postpartal women (Doctoral dissertation, New York University, New York City). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 58(09), 4721.
- Kiernan, J. (2002). The experience of Therapeutic Touch in the lives of five postpartum women. *American Journal of Maternal Child Nursing*, 27, 47-53. Retrieved from <http://www.nursingcenter.com>
- Kitzinger, J. (1995). Education and debate. Qualitative research: Introducing focus groups. *British Medical Journal*, 311, 299-302.
- Knodel, J. (1993). The design and analysis of focus group studies: A practical approach. In D. L. Morgan (Ed.), *Successful focus groups: Advancing the state of the art*. (pp. 35-50). Newbury Park, CA: Sage.
- *Kramer, N. A. (1990). Comparison of Therapeutic Touch and casual touch in stress reduction of hospitalized children. *Pediatric Nursing*, 16, 483-485.
- Krau, S. D. (2014a). Evidence-based practice: Another passing phase, or here to stay? [Foreword]. *Nursing Clinics of North America*, 49, xiii-xiv. doi:10.1016/j.cnur.2014.07.001
- Krau, S. D. (2014b). The utilization of evidenced-based practice in nursing: Some important considerations. [Foreword]. *Nursing Clinics of North America*, 49, xi-xii. doi:10.10.16/j.cnur.2014.09.002
- Kreitzer, M. J., & Snyder, M. (2002). Healing the heart: Integrating complementary therapies and healing practices into the care of cardiovascular patients. *Progress in Cardiovascular Nursing*, 17, 73-80. Retrieved from ProQuest Nursing & Allied Health Source database.
- Krieger, D. (1972, Autumn). The response of in-vivo human hemoglobin to an active healing therapy by direct laying-on of hands. *Human Dimensions*, 1, 12-15. [Cited in Krieger, D., 1975, Therapeutic Touch: The imprimatur of nursing. *American Journal of Nursing*, 75, 784-787]
- Krieger, D. (1973, March). *The relationship of touch, with intent to help or to heal, to subjects' in-vivo hemoglobin values: A study in personalized interaction*. Paper presented at the meeting of the American Nurses Association, Ninth Nursing Research Conference, San Antonio, TX. (Archived in 1974, *American Nurses Association Proceedings*, pp. 39-58, Kansas City, MO) [Cited in Krieger, D. (1991, Winter). Therapeutic Touch: Toward an understanding of unitary human be-ness. *Cooperative Connection*, 12(1), 1, 3-4]

- Krieger, D. (1974). Healing by the laying-on of hands as a facilitator of bioenergetic change: The response of in-vivo human hemoglobin. *Psychoenergetic Systems*, 3(3). [Cited in Krieger, D. (1975). Therapeutic Touch: The imprimatur of nursing. *American Journal of Nursing*, 75, 784-787]
- Krieger, D. (1975). Therapeutic Touch: The imprimatur of nursing. *American Journal of Nursing*, 75, 784-787.
- Krieger, D. (1981). *Foundation for holistic health nursing practices: The renaissance nurse*. Philadelphia, PA: Lippincott.
- Krieger, D. (1987a). *Living the Therapeutic Touch: Healing as a lifestyle*. New York, NY: Dodd, Mead.
- Krieger, D. (1987b). Therapeutic Touch during childbirth preparation by the Lamaze method and its relation to marital satisfaction and state anxiety of the married couple. In D. Krieger, *Living the Therapeutic Touch: Healing as a Lifestyle* (pp. 157-187). New York, NY: Dodd, Mead.
- Krieger, D. (1990). Therapeutic Touch: Two decades of research, teaching and clinical practice. *Imprint*, 37(3), 83, 86-88.
- Krieger, D. (1991, Winter). Therapeutic Touch: Toward an understanding of unitary human be-ness. *Cooperative Connection*, 12(1), 1, 3-4. (Adapted from presentation during receipt of 1990 Scholar in Nursing award, New York University Division of Nursing)
- Krieger, D. (1992). *The Therapeutic Touch: How to use your hands to help or to heal*. New York, NY: Simon & Schuster. (Original work published 1979)
- Krieger, D. (1993). *Accepting your power to heal: The personal practice of Therapeutic Touch*. Santa Fe, NM: Bear.
- Krieger, D. (1997). *Therapeutic Touch inner workbook*. Santa Fe, NM: Bear.
- Krieger, D. (2002). *Therapeutic Touch as transpersonal healing*. New York, NY: Lantern Books.
- Krieger, D. (2010). "The Knowing" project [Letter]. In R. Good, Therapeutic Touch® International Association (TTIA) Connections. *Council for Healing Newsletter*, 2(1), 2.
- Krieger, D., Peper, E., & Ancoli, S. (1987, Spring). Therapeutic Touch: Searching for evidence of physiological change. *Cooperative Connection*, 8(2), 1, 6. (Reprinted from 1979, *American Journal of Nursing*, 79, 660-665)

- Krieger, D., & Winstead-Fry, P. (n.d.). *Manual for subjective experience of Therapeutic Touch scale (SETTS)*. Pawlett, VT: Author.
- Kroesen, K., Baldwin, C. M., Brooks, A. J., & Bell, I. R. (2002). US military veterans' perceptions of the conventional medical care system and their use of complementary and alternative medicine. *Family Practice: An International Journal*, *19*, 57-64.
- Kronenberg, D., & Fugh-Berman, A. (2002, Nov. 19). Complementary and alternative medicine for menopausal symptoms: A review of randomized, controlled trials. *Annals of Internal Medicine*, *137*, 805-813. Retrieved from www.annals.org
- Krueger, R. A. (1994). *Focus groups: A practical guide for applied research* (2nd ed.). Thousand Oaks, CA: Sage.
- Krueger, R. A. (1998a). Developing questions for focus groups. In D. L. Morgan & R. A. Krueger (Series Eds.), *The focus group kit* (Vol. 3). Thousand Oaks, CA: Sage.
- Krueger, R. A. (1998b). Moderating focus groups. In D. L. Morgan & R. A. Krueger (Series Eds.), *The focus group kit* (Vol. 4). Thousand Oaks, CA: Sage.
- Krueger, R. A. (2006). Analyzing focus group interviews. *Journal of Wound, Ostomy, & Continence Nursing*, *33*, 478-481. Retrieved from usf.edu
- Krueger, R. A., & Casey, M. A. (2001). Designing and conducting focus group interviews. In R. A. Krueger, M. A. Casey, J. Donner, S. Kirsch, & J. N. Maack (Eds.), *Social Development Papers: Paper No. 36. Social analysis: Selected tools and techniques* (pp. 4-23).
- Krueger, R. A., & Casey, M. A. (2009). *Focus groups: A practical guide for applied research* (4th ed.). Los Angeles, CA: Sage.
- Kunz, D. V. G. (1991). *The personal aura*. Wheaton, IL: Quest Books.
- Kunz, D. (Ed.). (1995). *Spiritual healing*. Wheaton, IL; Quest Books. (Original work published 1985)
- Kunz, D. (with Krieger, D.). (2004). *The spiritual dimension of Therapeutic Touch*. Rochester, VT: Bear.
- Kunz, D., & Peper, E. (1995). Fields and their clinical applications: Parts I-VI. In Kunz D. (Ed.), *Spiritual healing* (pp. 213-261, 307-326). Wheaton, IL: Quest Books. (Original work published 1985)

- Larden, C. N., Palmer, M. L., & Janssen, P. (2004). Efficacy of Therapeutic Touch in treating pregnant in patients who have a chemical dependency. *Journal of Holistic Nursing*, 22, 320-332. doi:10.1177/0898010104269242
- Lewis, D. (1999, April 14). A survey of Therapeutic Touch practitioners. *Nursing Standard*, 13(3), 33-37.
- Lie, D., Shapiro, J., Pardee, S., & Najm, W. (2008). A focus group study of medical students' views of an integrated complementary and alternative medicine (CAM) curriculum: Students teaching teachers. [Serial online]. *Medical Education Online*, 13(3), 1-13. doi:10.3885/meo.2008.Res00252
- MacDougall, C., & Baum, F. (1997). The devil's advocate: A strategy to avoid groupthink and stimulate discussion in focus groups. *Qualitative Health Research*, 7, 532-541.
- Macrae, J. (1998, October). *Nightingale's spiritual philosophy as a framework for Therapeutic Touch*. Paper presented at the meeting of the Nurse Healers—Professional Associates International, 19th Annual Conference, Philadelphia, PA.
- Madrid, M. M., Barrett, E. A. M., & Winstead-Fry, P. (2010). A study of the feasibility of introducing Therapeutic Touch into the operative environment with patient undergoing cerebral angiography. *Journal of Holistic Nursing*, 28, 168-174. doi:10.1177/0898010110369173
- Manley, K., Hardy, S., Titchen, A., Garbett, R., & McCormack, B. (2005). *Research reports Changing patients' worlds through nursing practice expertise: Exploring nursing practice expertise through emancipator action research and fourth generation evaluation*. London, England: Royal College of Nursing. doi:10.1177/0894318406289497 [Cited in Baumann, S. L., 2006, What does expert nursing practice mean? [Editorial]. *Nursing Science Quarterly*, 19, 259-260.]
- Matheny, S., Cole, P., Coppa, D., Hanley, M. A. (2015, Spring). Excerpts from the panel: TT Dialogues in the Rocky Mountains of Montana: Toward a practice based theory of healing (Third International Congress on Therapeutic Touch, April 2015). *Cooperative Connection*, 37(2), 1, 3-4.
- May, D. (Moderator). (2011, April 9). *International panel*. Symposium presented at the meeting of the Therapeutic Touch International Association, Third International Congress, Seattle, WA.
- McLafferty, I. (2004). Focus group interviews as a data collecting strategy. *Journal of Advanced Nursing*, 48, 187-194. doi:10.1111/j.1365-2648.2004.03186.x

- McN Cain, N. L., Gray, D. P., Walter, J. M., & Robins, J. L. (2005). Implementing a comprehensive approach to the study of health dynamics using the psychoneuroimmunology paradigm. *Advances in Nursing Science*, 28, 320-332.
- M. D. Anderson Cancer Center. (2010). *Therapeutic Touch detailed scientific review*. Retrieved from <http://www.mdanderson.org/education-and-research/resources-for-professionals/clinical-tools-and-resources/cimer/therapies/energy-therapies/therapeutic-touch-scientific.htm>
- Meehan, M.-T. C. (1985). The effect of Therapeutic Touch on the experience of acute pain in postoperative patients (Doctoral dissertation, New York University, New York City). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 46(03), 795. Abstract and preview retrieved from ProQuest Dissertations and Theses database. (UMI No. 8510765)
- *Meehan, T. C. (1993). Therapeutic Touch and postoperative pain: A Rogerian research study. *Research Science Quarterly*, 6, 69-78.
- Meleis, A. I. (1991). *Theoretical nursing: Development and progress* (2nd ed.). San Francisco, CA: Lippincott.
- Mersmann, C. A. (1994). Therapeutic Touch and milk letdown in mothers of non-nursing preterm infants (Doctoral dissertation, New York University, New York City, 1993). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 54(09), 4602.
- Miller, L. (1979). An explanation of Therapeutic Touch using the science of unitary man. *Nursing Forum*, 18, 278-287.
- Mishlove, J. (1975). *The roots of consciousness: Theory, consciousness and the new physics, Part 2: Consciousness and the new physics*. Retrieved from <http://www.williamjames.com/Theory/PHYSICS.htm>
- Monsivais, D. B. (2011). Finding the (cultural) clues that make a difference in patient outcomes. [Preface]. *Nursing Clinics of North America*, 46, xi-xiii. doi:10.1016/j.cnur.2011.02.012
- Mooney, S. F. (2005). Worldviews in conflict: A historical and sociological analysis of the controversy surrounding Therapeutic Touch in nursing (Doctoral dissertation, University of Rochester School of Nursing, NY), *Dissertation Abstracts International: Section, Physical Sciences and Engineering*, 66(03), 1398.
- Moore, T. (2005). Best practice guidelines: An invitation to reflect on Therapeutic Touch™ practice. *Journal of Nursing Care Quality*, 20, 90-94.

- Moore, T., Ting, B., & Rossiter-Thornton, M. (2008-2009, Winter). A pilot study of the experience of participating in a Therapeutic Touch practice group. *Cooperative Connection*, 27(11), 1-2, 4-6.
- Morgan, D. L. (1997). Focus groups as qualitative research. In J. Van Maanen, P. K. Manning, & M. L. Miller (Series Eds.), *Qualitative research methods series* (Vol. 16, 2nd ed.). Thousand Oaks, CA: Sage.
- Morgan, D. L. (1998). *The focus group guidebook*. In D. L. Morgan & R. A. Krueger (Series Eds.), *The focus group kit* (Vol. 1). Thousand Oaks, CA: Sage.
- Morgan, D. L. (2010). Reconsidering the role of interaction in analyzing and reporting focus groups. *Qualitative Health Research*, 20, 718-722.
doi:10.1177/104973231034627
- Morrison, R. S., & Peoples, L. (1999). Using focus group methodology in nursing. *The Journal of Continuing Education in Nursing*, 30(2), 62-65.
- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd. ed.). Thousand Oaks, CA: Sage.
- Movaffaghi, Z., Farsi, M., Hooshmand, P., & Abrishami, F. (2006). Effects of Therapeutic Touch on blood hemoglobin and hematocrit level. *Journal of Holistic Nursing*, 24, 41-48. doi:10.1177/0898010105282527
- Mueller Hinze, M. L. (1989). The effects of Therapeutic Touch and acupressure on experimentally-induced pain (Doctoral dissertation, The University of Texas at Austin, 1988). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 49(11), 4755. Abstract and preview retrieved from ProQuest Dissertations and Theses database. (UMI No. 8901377)
- Munhall, P. L., & Chenail, R. (2008). *Qualitative research proposals and reports: A guide* (3rd ed.). Sudbury, MS: Jones and Bartlett.
- Nahin, R. L., & Straus, S. E. (2001). Research into complementary and alternative medicine: Problems and potential. *British Medical Journal*, 32, 161-164.
- National Center for Complementary and Alternative Medicine (NCCAM). (2000, September 25). Expanding horizons of healthcare: Five-year strategic plan 2001-2005 (NIH Publication No. 01-5001, pp. 1-45). Retrieved from <http://nccam.nih.gov/about/plans/fiveyear/fiveyear.pdf>
- National Center for Complementary and Alternative Medicine (NCCAM). (2010a, April). CAM basics: What is complementary and alternative medicine? Retrieved from <http://nccam.nih.gov/health/whatiscam/D347.pdf>

- National Center for Complementary and Alternative Medicine (NCCAM). (2010b, November). CAM basics: What is complementary and alternative medicine? Retrieved from <http://nccam.nih.gov/health/whatiscam/D347.pdf>
- National Center for Complementary and Integrative Health (NCCIH). (2011, December 28). Introduction. Retrieved from <https://nccih.nih.gov/about/plans/2011/introduction.htm>
- National Center for Complementary and Integrative Health (NCCIH). (2012, January 4). Strategic objective 1—Examples of CAM mind and body interventions. Retrieved from <https://nccih.nih.gov/about/plans/2011/objective1.htm>
- National Center for Complementary and Integrative Health (NCCIH). (2015, January 16). Director's page. Retrieved from <https://nccih.nih.gov/about/offices/od/nccam-new-name>
- National Qigong Association (NQA). (n.d.). Resources: What is Qigong? Retrieved from <http://nqa.org/resources/what-is-qigong/>
- Newbold, D., & Roberts, J. (2007). An analysis of the demarcation problem in science and its application to Therapeutic Touch theory. *International Journal of Nursing Practice, 13*, 324-330. doi:10.1111/j.1440-172X.2007.00646.x
- NIH Research Portfolio Online Reporting Tools (RePORT). (2011). Project information: 1P20AT000774-01, 0001. Retrieved from <http://projectreporter.nih.gov>
- North American Nursing Diagnosis Association (NANDA). (2005). *Nursing diagnoses: Definitions and classification, 2005-2006* (6th ed.). Philadelphia, PA: NANDA International.
- Nurse Healers—Professional Associates, Inc. (NHPAI). (1992). *Therapeutic Touch (Teaching guidelines: Beginner's level[®])*. Allison Park, PA: Author.
- Nurse Healers—Professional Associates, Inc. (NHPAI). (1994). *Therapeutic Touch (Teaching guidelines: Intermediate level[®])*. Allison Park, PA: Author.
- Nurse Healers—Professional Associates, Inc. (NHPAI). (2006b). Guidelines for teaching Therapeutic Touch. In *Intensive for teachers of Therapeutic Touch[®]* (pp. 12-26). Warnerville, NY: Author. (Original work published October 1, 2004)
- *Olson, M., & Sneed, N. (1995). Anxiety and Therapeutic Touch. *Issues in Mental Health Nursing, 16*, 97-108.

- Olson, M., Sneed, N., LaVia, M., Virella, G., Bonadonna, R., & Michel, Y. (1997). Stress-induced immunosuppression and Therapeutic Touch. *Alternative Therapies in Health and Medicine*, 3(2), 68-73.
- O'Mathúna, D. P. (2000). Evidence-based practice and reviews of Therapeutic Touch. *Journal of Nursing Scholarship*, 32, 279-285.
doi:10.1111/j.1547-5069.2000.00287.x
- O'Mathúna, D. (2010a). About Donal O'Mathúna. Retrieved from Xenos Christian fellowship website: <http://www.xenos.org/ministries/crossroads/donal/about.htm>
- O'Mathúna, D. P. (2010b). Nursing's new alternative: Therapeutic Touch. Retrieved from Xenos Christian fellowship website:
<http://www.xenos.org/ministries/crossroads/donal/ocahf.htm> (Previously published in 1996, Winter, *Ohio Council Against Health Fraud Newsletter*, 7, 2-4)
- O'Mathúna, D. P. (2010c). The subtle allure of Therapeutic Touch. Retrieved from Xenos Christian fellowship website:
<http://www.xenos.org/ministries/crossroads/donal/thetch.htm>
- Parkes, B. S. (1986). Therapeutic Touch as an intervention to reduce anxiety in elderly hospitalized patients (Doctoral dissertation, The University of Texas at Austin, 1985). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 47(02), 573. Abstract and preview retrieved from ProQuest Dissertations and Theses database. (UMI No. 8609563)
- Patton, M. A. (1988). Foreword. In R. A. Krueger (Ed.), *Focus groups: A practical guide for applied research* (pp. 7-8). Newbury Park, CA: Sage.
- *Peters, R. M. (1999). The effectiveness of Therapeutic Touch: A meta-analytic review. *Nursing Science Quarterly*, 12, 52-61. doi:10.1177/08943189922106413
- Philcox, P., Rawlins, L., & Rodgers, L. (2003, Spring). Therapeutic Touch and its effects on phantom limb and stump pain. *Cooperative Connection*, 24(3), 1, 10-11. (Originally published in 2002, *Journal of Australian Rehabilitation Association [JARNA]*, 5(1), 17-21.)
- Polit, D. F., & Tatano Beck, C. (2010). *Essentials of nursing research: Appraising evidence for nursing practice* (7th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Pratt, D. (1997). Consciousness, causality, and quantum physics. *Journal of Scientific Exploration*, 11, 69-78.

- Pumpkin Hollow Retreat Center: The Northeast Theosophical Foundation. (2015). Advanced invitational Therapeutic Touch program. Retrieved from <http://pumpkinhollow.org/therapeutictouch/workshop>
- Quinn, J. F. (1982). An investigation of the effects of Therapeutic Touch done without physical contact on state anxiety of hospitalized cardiovascular patients (Unpublished doctoral dissertation, New York University, New York City). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 43(06), 1797.
- Quinn, J. F. (1984). Therapeutic Touch as energy exchange: Testing the theory. *Advances in Nursing Science*, 6(2), 42-49.
- *Quinn, J. F. (1989). Therapeutic Touch as energy exchange: Replication and extension. *Nursing Science Quarterly*, 2(2), 79-87.
- Randolph, G. L. (1980). The differences in physiological response of female college students exposed to stressful stimulus, when simultaneously treated by either Therapeutic Touch or casual touch (Unpublished doctoral dissertation, New York University, New York City, 1979). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 41(02), 523.
- Randolph, G. L. (1984). Therapeutic and physical touch: Physiological response to stressful stimuli. *Nursing Research*, 33, 33-36.
- Rebar, C. R., Gersch, C. J., Macnee, C. L., & McCabe, S. (2011). *Understanding nursing research* (3rd ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Rezabek, R. J. (2000, January). Online focus groups: Electronic discussions for research. *Forum: Qualitative Social Research*, 1(1), Article 18. Retrieved from <http://www.qualitative-research.net/index.php/fqs/article/view/1128/2509>
- Riley, J., Beal, J. A., & Lancaster, D. (2007). Scholarly nursing practice from the perspectives of experienced nurses. *Journal of Advanced Nursing*, 61, 425-435. doi:10.1111/j.1365-2648.2007.04499.x
- Robinson, J., Biley, F. C., & Dolk, H. (2009). Therapeutic Touch for anxiety disorders. (Rev. ed.). *Cochrane Database of Systematic Reviews*, (1), 1-16. doi:10.1002/14651858.CD006240.pub2 (Original work published 2007, Issue 3)
- Rocky Mountain Skeptics (RMS). (1999, May 27). Who we are. Retrieved from <http://www.rationalmagic.com/RMS/rms~who.html>

- Rocky Mountain Skeptics (RMS). (2000, September 15). The RMS database of negative testimony for alternative medicine. Retrieved from <http://www.rationalmagic.com/RMS/rms~altmd.htm>
- Rocky Mountain Skeptics (RMS). (2001, June 15). Therapeutic Touch: Skeptics challenge pseudoscience in nursing. Retrieved from <http://www.rationalmagic.com/RMS/rms~ttl.htm>
- Rogers, M. E. (1980). Nursing: A science of unitary man. In J. P. Riehl & Sr. C. Roy (Eds.), *Conceptual models for nursing practice* (2nd ed., pp. 329-337). New York, NY: Appleton-Century-Crofts.
- Rogers, M. E. (1981). *An introduction to the theoretical basis of nursing*. Philadelphia, PA: Davis. (Original work published 1970)
- Rogers, M. E. (1994). Nursing science and the space age. In V. M. Malinski & E. A. M. Barrett (Eds.), *Martha E. Rogers: Her life and her work* (pp. 256-267). Philadelphia, PA: Davis. (Reprinted from 1992, *Nursing Science Quarterly*, 5, 27-34)
- Rojas-Cooley, M. T., & Grant, M. (2009). Complementary and alternative medicine: Oncology nurses' knowledge and attitudes. *Oncology Nursing Forum*, 36, 217-224. doi:10.1188/09.ONF.217-224
- Rosa, L., Rosa, E., Sarner, L., & Barrett, S. (1998, April 1). A close look at Therapeutic Touch. *JAMA: The Journal of the American Medical Association*, 279, 1005-1010. Retrieved from <http://jama.ama-assn.org>
- Rubik, B. (2011, April). *The Biofield in Healing and Health*. Paper presented at the meeting of the Therapeutic Touch International Association, Second International Congress, Boston, MA.
- Rubik, B., Brooks, A. J., & Schwartz, G. E. (2006). In vitro effect of Reiki treatment on bacterial cultures: Role of experimental context and practitioner well-being. *Journal of Alternative and Complementary Medicine*, 12, 7-13. Abstract retrieved from <http://www.ncbi.nlm.nih.gov/pubmed>
- Saunders, H. (2015). Translating knowledge into best practice care bundles: a pragmatic strategy for EBP implementation via moving postprocedural pain management nursing guidelines into clinical practice. *Journal of Clinical Nursing*, 24, 2035-2051. doi:10.1111/jocn.12812
- Sayre-Adams, J. (1992, September 2). Therapeutic Touch-Research and reality. *Nursing Standard*, 6(50), 52-54.

- Sayre-Adams, J., & Wright, S. G. (with Biley, F. C., & Richardson, M.). (2001). *The theory and practice of Therapeutic Touch*. (2nd ed.). Edinburgh, Scotland: Churchill Livingstone.
- Scheiber, B., & Selby, C. (Eds.). (2000). *Therapeutic Touch*. Amherst, NY: Prometheus Books.
- Schneider, S. J., Kerwin, J., Frechtling, J., & Vivari, B. A. (2002, Spring). Characteristics of the discussion in online and face-to-face focus groups. *Social Science Computer Review*, 20, 31-42.
- Sears, J. M. (2001). The payment of research subjects: Ethical concerns. *Oncology Nursing Forum* (28), 657-663.
- Sharoff, L. (2004). *Qualitative study of how experienced certified holistic nurses learn to become competent practitioners* (Doctoral dissertation, Columbia University Teachers College, New York, NY). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3148110)
- Shields, D. (2008). The lived experience of receiving Therapeutic Touch in people with heart failure (Doctoral dissertation, Union Institute and University, Cincinnati, OH). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 55(05), 1808. Citation retrieved from ProQuest Dissertations and Theses Database. (UMI No. 3312816)
- Sies, M. M. (1995). An exploratory study of relaxation response in nurses who utilize Therapeutic Touch (Unpublished master's thesis, Michigan State University, East Lansing, 1994). *Masters Abstracts International*, 33(01), 180.
- Silva, M. C. (1986). Research testing nursing theory: State of the art. *Advances in Nursing Science*, 9, 1-11.
- Simko, L. C. (2005). Evidence Based Practice: A Nursing Research Assignment. *Home Health Care Management & Practice*, 17, 281-285.
doi:10.1177/1084822304272934
- Simon, J. S. (1999). *The Wilder nonprofit field guide to conducting successful focus groups*. Saint Paul, MN: Wilder Foundation.
- Smith, M. C., Reeder, F., Daniel, L., Baramée, J., & Hagman, J. (2003). Outcomes of touch therapies during bone marrow transplant. *Alternative Therapies in Health and Medicine*, 9, 40-49.
- Smith, Sister M. J. (1972, Spring). Paranormal effects on enzyme activity. *The Human Dimensions Institute*, 1, 15-19.

- Sneed, N. V., Olson, M., & Bonadonna, R. (1997). The experience of Therapeutic Touch for novice recipients. *Journal of Holistic Nursing, 15*, 243-253.
doi:10.1177/089801019701500305
- So, P. S., Jiang, Y., & Qin, Y. (2008). Touch therapies for pain relief in adults. *Cochrane Database of Systematic Reviews* (4), 1-45.
doi:10.1002/14651858.CD006535.pub2
- Sova, R., & Weaver, B. (2003). *Effects of an anti-anxiety intervention using Therapeutic Touch on the anxiety levels of clients expressing anxiety after a cardiac event*. Presented at the meeting of the Midwest Nursing Research Society. Abstract retrieved from Virginia Henderson International Nursing Library website:
<http://nursinglibrary.org>
- Speziale, H. J. S., & Carpenter, D. R. (2007). *Qualitative research in nursing: Advancing the humanistic imperative* (4th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- St John, W., & Johnson, P. (2000). The pros and cons of data analysis software for qualitative research. *Journal of Nursing Scholarship, 32*: 393-397.
doi:10.1111/j.1547-5069.2000.00393.x
- Starkweather, A., Witek-Janusek, L., & Mathews, H. L. (2005). Applying the psychoneuroimmunology framework to nursing research. *Journal of Neuroscience Nursing, 37*, 56-62.
- Stephen, J. E., Mackenzie, G., Sample, S., & MacDonald, J. (2007). Twenty years of Therapeutic Touch in a Canadian cancer agency: Lessons learned from a case study of integrative oncology practice. *Supportive Care in Cancer, 15*, 993-998.
doi:10.1007/s00520-007-0288-x
- Stewart, D. W., Shamdasani, P. N., & Rook, D. W. (2007). Focus groups: Theory and practice. In L. Bickman & D. J. Rog (Series Eds.), *Applied research methods series* (Vol. 20, 2nd. ed.). Thousand Oaks, CA: Sage.
- Stewart, K., & Williams, M. (2005). Researching online populations: the use of online focus groups for social research. *Qualitative Research, 5*, 395-416.
doi:10.1177/1468794105056916
- Stiller, C. (2007, March). *The effect of Therapeutic Touch on fibromyalgia pain and anxiety*. Paper presented at the meeting of the Midwest Nursing Research Society, 31st Annual Research Conference, Omaha, NE. [Session III: Papers, 307c]. Abstract retrieved from Virginia Henderson International Nursing Library website: <http://www.nursinglibrary.org>

- Stravena, J. A. E. (1993). Therapeutic Touch and in vitro erythropoiesis (Doctoral dissertation, Indiana University School of Nursing, Indianapolis, 1992). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering*, 54(03), 1338.
- Taheri, M., Yaryari, F., & Molavi, M. (2013). The effect of Therapeutic Touch on anxiety patients with irritable bowel syndrome [Abstract]. [Persian text]. *Complementary Medicine Journal of Faculty of Nursing and Midwifery*, 3, 406-417.
- Therapeutic Touch[®] International Association (TTIA). (March 5, 2005a). Position statement on credentialing. Retrieved from <http://www.therapeutic-touch.org/newsarticle.php?newsID=5>
- Therapeutic Touch[®] International Association (TTIA). (March 8, 2005b). About NHPAI. Retrieved from <http://www.therapeutic-touch.org/newsarticle.php?newsID=17>
- Therapeutic Touch[®] International Association (TTIA). (March 15, 2005c). The Therapeutic Touch[®] process. Retrieved from <http://www.therapeutic-touch.org/newsarticle.php?newsID=19>
- Therapeutic Touch[®] International Association (TTIA). (October 16, 2005d). Code of Ethics: TTIA Code of Ethics. Retrieved from <http://therapeutic-touch.org/policies/code-of-ethics/>
- Therapeutic Touch[®] International Association (TTIA). (June 23, 2009). Membership information. Retrieved from <http://www.therapeutic-touch.org/newsarticle.php?newsID=13>
- Therapeutic Touch[®] International Association (TTIA). (December 7, 2010). Member list. Retrieved from TTIA members' only website: <http://www.therapeutic-touch.org/members.php>
- Therapeutic Touch[®] International Association (TTIA). (April, 2012). The process of Therapeutic Touch. Retrieved from <http://therapeutic-touch.org.what-is-it-tt/history-of-tt/>
- Therapeutic Touch[®] International Association (TTIA). (December, 2012). Bylaws. Retrieved from <http://therapeutic-touch.org/about-us/bylaws-2012/>
- Therapeutic Touch[®] International Association (TTIA). (August 5, 2013). A new definition of Therapeutic Touch and more. TTIA e-news 8-5-2013. Retrieved from TTIA members' only website: <http://www.therapeutic-touch.org/members.php>

- Therapeutic Touch[®] International Association (TTIA). (2014a). TTIA Advanced Teaching Guidelines. Delmar, NY: Author.
- Therapeutic Touch[®] International Association (TTIA). (2014b). TTIA Basic Teaching Guidelines. Delmar, NY: Author.
- Therapeutic Touch[®] International Association (TTIA). (2014c). TTIA Intermediate Teaching Guidelines. Delmar, NY: Author.
- Therapeutic Touch[®] International Association (TTIA). (n.d.a.) Homepage: The co-creators of Therapeutic Touch. Retrieved from therapeutic-touch.org
- Therapeutic Touch[®] International Association (TTIA). (n.d.b). Qualified Therapeutic Touch Teacher[™] (QTTT) application form. Retrieved from TTIA members' only website: therapeutic-touch.org/credentialing/qualified-therapeutic-touch-teacher-qttt-application-form/
- Thorne, S. (2001). Complementary and alternative medicine: Critical issues of nursing practice and policy. *Infirmière Canadienne* [The Canadian Nurse], 97, 27.
- Tindle, H. A., Davis, R. B., Phillips, R. S., & Eisenberg, D. M. (2005). Trends in use of complementary and alternative medicine by US adults: 1997-2002. *Alternative Therapies in Health and Medicine*, 11(1), 42-49.
- Toner, J. (2009). Small is not too small: Reflections concerning the validity of very small focus groups (VSFGs). *Qualitative Social Work*, 8, 179-192.
doi:10.1177/1473325009103374
- Trail-Mahan, T., Mao, C.-L., Bawel-Brinkley, K. (2013). Complementary and alternative medicine: Nurses' attitudes and knowledge. *Pain Management Nursing*, 14, 277-286. doi:10.1016/j.pmn.2011.06.001
- Twichell, E. (2008-2009, Winter). TT and the dying. *Cooperative Connection*, 27(11), 16.
- U. S. Census Bureau. (2015, July 12). U. S. & world population clock. Retrieved from <http://www.census.gov/popclock>
- U. S. Department of Health and Human Services, Health Resources and Services Administration [HRSA]. (2010). The registered nurse population: Findings from the 2008 national sample survey of registered nurses. Retrieved from <http://bhpr.hrsa.gov/healthworkforce/rnsurveys>

- von Bertalanffy, L. (1950). An outline of general systems theory. *The British Journal for the Philosophy of Science*, *1*, 134-165. Retrieved from <http://pao.chadwyck.co.uk/PDF/1270506358906.pdf>
- von Bertalanffy, L. (1972). The history and status of general systems theory. *Academy of Management Journal*, *15*, 407-426. Retrieved from Business Source Premier database.
- Wager, S. (1996). *A doctor's guide to Therapeutic Touch*. New York, NY: Berkley Publishing Group.
- Walden, G. R. (2006). Focus group interviewing in the library literature: A selective annotated bibliography 1996-2005. *Reference Services Review*, *34*, 222-241. doi:10.1108/00907320610669461
- Warber, S. L., Kile, G. L. M., & Gillespie, B. W. (2003). 'Energy' healing research. In W. B. Jonas & C. C. Crawford (Eds.), *Healing, intention and energy medicine: Science, research methods and clinical implications* (pp. 83-101). Edinburgh, Scotland: Churchill Livingstone.
- Wardell, T. L. (2005). Electronic resources to support evidence-based practice in the home healthcare setting. *Home Healthcare Management and Practice*, *17*, 333-339. doi:10.1177/1084822304273381
- Wardell, T. L. (2006, September 29). Using Therapeutic Touch in the acute care setting to improve patient outcomes. *Mosby's Nursing Consult —Clinical Updates*. Retrieved from Mosby's Nursing Consult members' only website: <http://www.nursingconsult.com/nursing/clinical-updates/home>
- Wardell, T. L. (2007). Touch therapy: Therapeutic Touch may help calm anxious, high acuity patients. *Men in Nursing*, *2*(6), 44-48.
- Wardell, T. L. (2008a). Try Therapeutic Touch: Touch therapy may help calm anxious, high-acuity patients. *Nursing2008 Critical Care*, *3*(4), 47-51.
- Wardell, T. L. (2008b, September 2). Using Therapeutic Touch in the acute care setting to improve patient outcomes. *Mosby's Nursing Consult —Clinical Updates*. Retrieved from Mosby's Nursing Consult members' only website: <http://www.nursingconsult.com/nursing/clinical-updates/home>
- Wardell, T. L. (2010, October 15). Using Therapeutic Touch in the acute care setting to improve patient outcomes. *Mosby's Nursing Consult —Clinical Updates*. Retrieved from Mosby's Nursing Consult members' only website: <http://www.nursingconsult.com/nursing/clinical-updates/home>

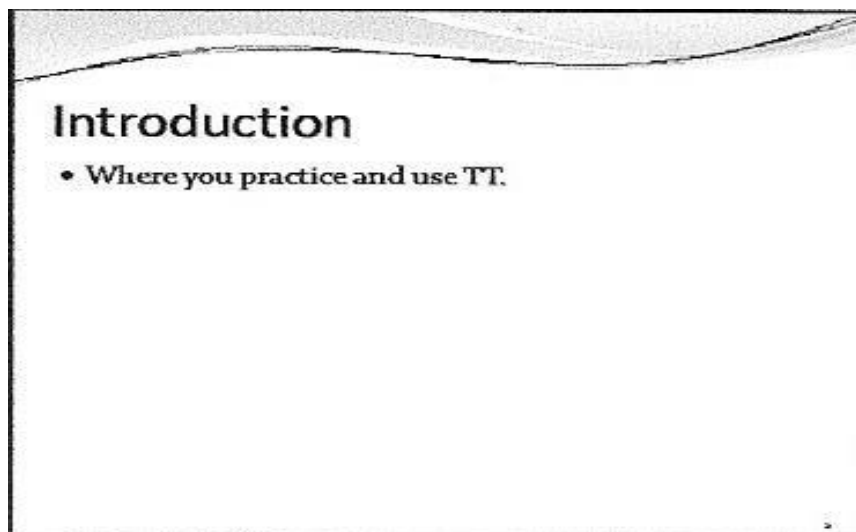
- Wardell, T. L. (2013, March 27). Using Therapeutic Touch in the acute care setting to improve patient outcomes. *Mosby's Nursing Consult —Clinical Updates*. Retrieved from Mosby's Nursing Consult members' only website: <http://www.nursingconsult.com/nursing/clinical-updates/home>
- Wardell, T. L. (with Husted, G. L.). (2015, May). *Using electronic media with a focus group methodology to collect data from expert RN Therapeutic Touch[®] practitioners*. Poster presented at the meeting of the 1st International Integrative Nursing Symposium, Reykjavik, Iceland.
- Watson, J. (1988). *Nursing: Human science and human care a theory of nursing* (Publication No. 15-2236). New York, NY: National League for Nursing. (Original work published 1985)
- Webb, C. (1999). Analysing qualitative data: Computerized and other approaches. *Journal of Advanced Nursing*, 29, 323-330.
- Weber, R. (1981). Philosophical foundations and frameworks for healing. In M. D. Borelli & P. Heidt (Eds.), *Therapeutic Touch* (pp. 13-39). New York, NY: Springer.
- Weber, R. (1984). Philosophers on touch. In K. F. Barnard & T. Berry Brazelton (with C. C. Brown) (Ed.), Johnson & Johnson Baby Products Company Pediatric Round Table Series: No. 10. *The many facets of touch. The foundation of experience: Its importance through life, with initial emphasis for infants and young children* (pp. 3-12). USA: Johnson and Johnson Baby Products Company.
- Wheeler, C. E., & Chinn, P. L. (1991). *Peace & Power: A handbook of feminist process* (3rd ed., Publication. No. 15-2404). New York, NY: National League for Nursing Press.
- Whitley, J. A., & Rich, B. L. (2008). A double-blind randomized controlled pilot trial examining the safety and efficacy of Therapeutic Touch in premature infants. *Advances in Neonatal Care*, 8, 315-333. doi:10.1097/01.ANC.0000342764.71864.28
- Whyte, J., Ward, P., & Eccles, D. W. (2009). The relationship between knowledge and clinical performance in novice and experienced critical care nurses. *Heart & Lung*, 38, 517-525. doi:10.1016/j.hrtlng.2008.12.006
- Winstead-Fry, P. (1999). The subjective experience of Therapeutic Touch scale. *Cooperative Connection*, 20(3), 1, 3.

- *Wirth, D. P., Richardson, J. T., Eidelman, W. S., & O'Malley, A. C. (1993). Full thickness dermal wounds treated with non-contact Therapeutic Touch: A replication and extension. *Complementary Therapies in Medicine, 1*, 127-132. doi:10.1016/0965-2299(93)90003-V
- Woods, D. L., Beck, C., & Sinha, K. (2009). The effect of Therapeutic Touch on behavioral symptoms and cortisol in persons with dementia. *Forschende Komplementärmedizin [Research in Complementary Medicine], 16*, 181-189. doi:10.1159/000220479
- Woods Smith, D., & Broida, J. P. (2007). Pandimensional field pattern changes in healers and healees: Experiencing Therapeutic Touch. *Journal of Holistic Nursing, 25*, 217-225.
- Wright, S. M. (1989). Development and construct validity of the energy field assessment (Doctoral dissertation, Rush University College of Nursing, Chicago, IL, 1988). *Dissertation Abstracts International: Section B. Physical Sciences and Engineering, 49*(08), 3113. Abstract and preview retrieved from ProQuest Dissertations and Theses database. (UMI No. 8821431)
- Xu, S.-H, Sun, Y.-A, & Wu, H.-Y. (2009). Effects of Therapeutic Touch on the intraoperative pain in patients undergoing percutaneous laser disk decompression. *Chinese Journal of Nursing, 8*. Abstract retrieved from http://en.cnki.com.cn/Article_en/CJFDTOTAL-ZHHL200908033.htm
- Zare, Z., Shahsavari, H., & Moeini, M. (2010). Effects of Therapeutic Touch on the vital signs of patients before coronary artery bypass graft surgery. *Iranian Journal of Nursing and Midwifery Research, 1*, 37-42.

APPENDICES

Appendix 1

Focus Group Microsoft® PowerPoint (2010) Slides



Appendix 1 (cont.)

Discussion Point 1

- Sources of TT research.

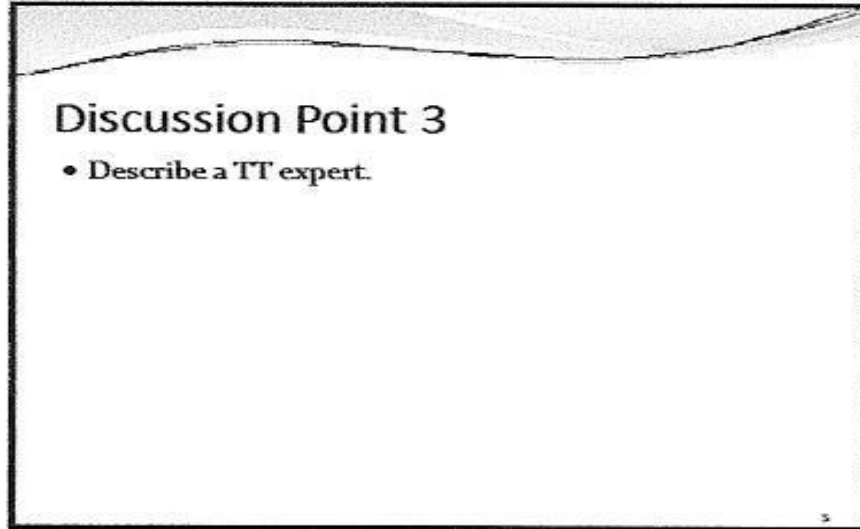
3

Discussion Point 2

- Words to describe your own TT practice.

4

Appendix 1 (cont.)

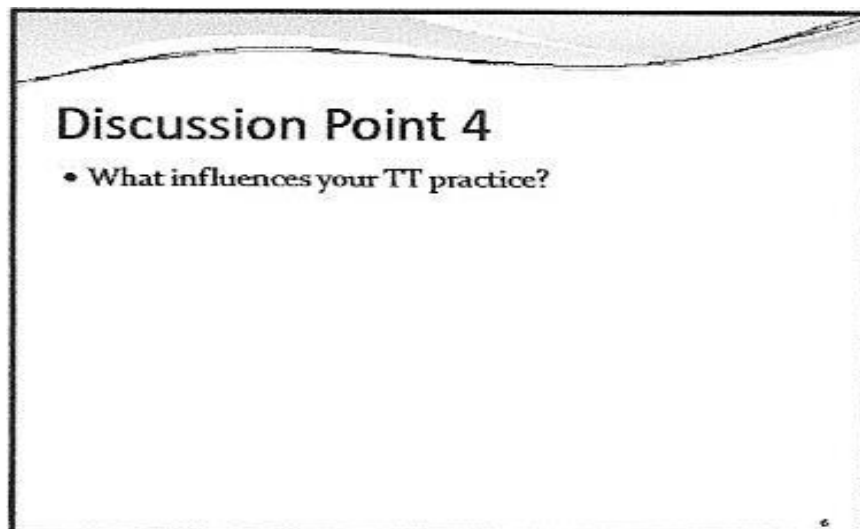


Discussion Point 3

- Describe a TT expert.

3

This slide features a decorative wavy header at the top. The main content is centered and includes a title and a single bullet point. A small number '3' is located in the bottom right corner.



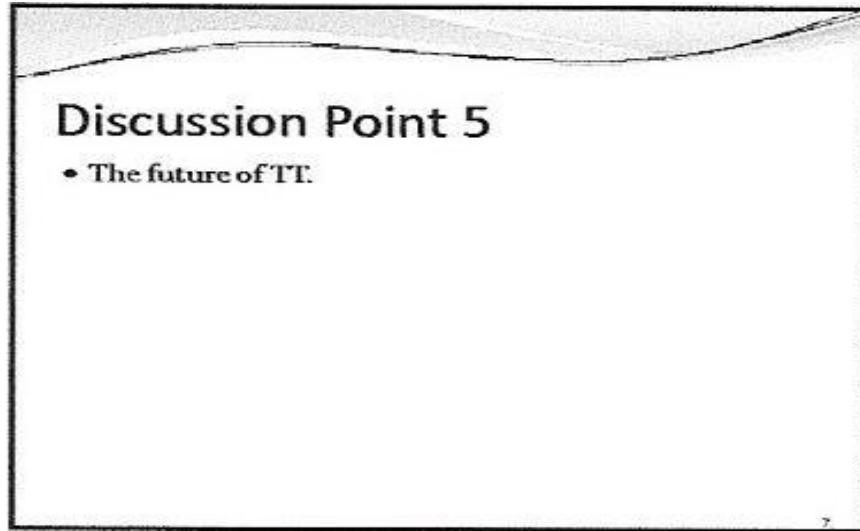
Discussion Point 4

- What influences your TT practice?

4

This slide features a decorative wavy header at the top. The main content is centered and includes a title and a single bullet point. A small number '4' is located in the bottom right corner.

Appendix 1 (cont.)

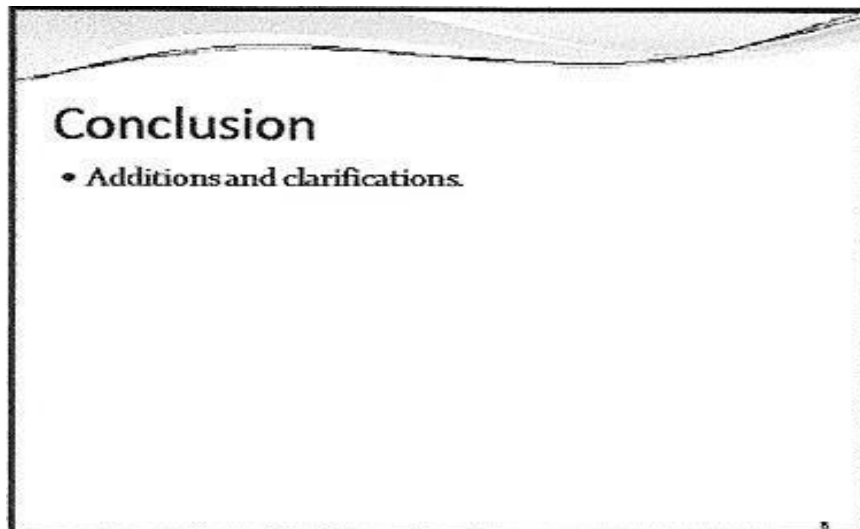


Discussion Point 5

- The future of IT.

7

This slide features a decorative wavy header at the top. The main content is the title 'Discussion Point 5' and a single bullet point '• The future of IT.'. A small number '7' is located in the bottom right corner.



Conclusion

- Additions and clarifications.

8

This slide features a decorative wavy header at the top. The main content is the title 'Conclusion' and a single bullet point '• Additions and clarifications.'. A small number '8' is located in the bottom right corner.

Appendix 2

Letter to TTIA Board to Request Membership Access

Duquesne University – IRB
Protocol Number: 11-141
Approval Date: November 3, 2011
Amendment Date: May 3, 2013
Renewal Date: November 3, 2013

TTIA Permission Request Letter



600 FORBES AVENUE
PITTSBURGH, PA 15282
TEL 412.396.6550
FAX 412.396.6346
www.nursing.duq.edu

Board of Directors
Therapeutic Touch International Association, Inc.
PO Box 419
Craryville, NY 12521

Dear Board Members:

I am requesting your permission to utilize the TTIA mailing list (specifically to access e-mail addresses) to recruit subjects for my dissertation research. I will be examining the perceptions of TT practitioners related to expert practice (abstract attached).

Data collection will be done by conducting synchronous online focus groups. Denise Coppa, PhD, RNP, FAANP, QTTT, a TTIA member, is serving as my external committee member. She will provide TT expertise for this project.

The Duquesne University IRB has given its approval for this project (copy attached). Please feel free to contact me at tamwardell@frontier.com or [REDACTED], if you need additional information. I look forward to hearing from you regarding this project to advance understanding of TT practice.

In peace and healing,

Tamara Lynn Wardell, RN, MSN, PhD(c)

Appendix 2 (cont.)

Duquesne University – IRB
Protocol Number: 11-141
Approval Date: November 3, 2011
Amendment Date: May 3, 2013
Renewal Date: November 3, 2013

Enclosures:

Perceptions of Expert Practice by Therapeutic Touch® Practitioners (Abstract)
Duquesne University IRB approval letter

cc: Gladys Husted, RN, PhD
Denise Coppa, PhD, RNP, FAANP, QTTT

Appendix 3

TTIA Board Permission Letter to Access Membership List

From: "Hanley, Maryanne" [REDACTED]
To: <tamwardell@frontier.com>
Cc: "Sue Conlin" [REDACTED]; [REDACTED]
Subject: regarding your request to TTIA
Date: Sunday, November 20, 2011 12:57 PM

Tamara,

As the Research Trustee of Therapeutic Touch International, it is my pleasure to inform you that the Board of Trustees of TTIA reviewed and approved your request to use the TTIA mailing list to recruit subjects for your dissertation research.

We wanted you to know that we have a process for providing some financial support for research projects such as yours. We would be happy to talk with you about the process. Please feel free to contact me if you are interested in this opportunity.

Mary Anne

Mary Anne Hanley, PhD, RN Associate Professor
[REDACTED]

Appendix 4

Demographic Questionnaire

Perceptions of Expert Practice by TT Practitioners

Tamara Lynn Wardell, RN, MSN, PhD(c)

Demographic Questionnaire

Directions: Please enter information by using your mouse to either (1) highlight the correct box and click, which will enter an “X” or (2) highlight and click on “Click here to enter text,” then type in your response using the keyboard. Please complete all **ten** items, which are contained within **four** pages.

Enter Provided Code: Click here to enter text.

1. Years of TT experience (check one only)
 - a. 3
 - b. 4
 - c. 5
 - d. 6 – 10
 - e. 11 – 15
 - f. 16 – 20
 - g. 21 or greater

2. Enter number of TT courses completed (include all that apply)
 - a. Basic/Beginners Click here to enter text.
 - b. Intermediate Click here to enter text.
 - c. Advanced Click here to enter text.
 - d. Mentorship Click here to enter text.
 - e. Teacher Click here to enter text.
 - f. Intensives (Pumpkin Hollow or Camp Indralaya) Click here to enter text.
 - g. Conferences (NHPAI annual, TTIA biennial) Click here to enter text.
 - h. Dialogues Click here to enter text.
 - i. Other (please specify with number) Click here to enter text.

Appendix 4 (cont.)

3. Education (check all that apply)

- a. LPN/LVN
- b. Diploma
- c. ADN/ASN/AS
- d. Associate's degree (non-nursing)
- e. BSN/BS
- f. Bachelor's degree (non-nursing)
- g. MSN/MS
- h. Master's degree (non-nursing)
- i. PhD (nursing)
- j. DNS/DNSc/DSN
- k. EdD (nursing)
- l. DNP
- m. Doctorate degree (non-nursing)
- n. Other (please specify) [Click here to enter text.](#)

4. Registered Nurse occupation (check all that apply)

- a. Staff
- b. Education
- c. Administration
- d. NP
- e. CNS
- f. CRNA
- g. CNM
- h. Consultant
- i. Private practice
- j. Student (please specify discipline and degree) [Click here to enter text.](#)
 - i. Full-time
 - ii. Part-time
- k. Retired
- l. Disabled
- m. Other (please specify) [Click here to enter text.](#)

Appendix 4 (cont.)

5. Residence (check one only)

- a. USA (please provide State) [Click here to enter text.](#)
- b. Canada (please provide Province/Territory) [Click here to enter text.](#)
- c. Other (please specify) [Click here to enter text.](#)

6. Age (check one only)

- a. 20 – 29
- b. 30 – 39
- c. 40 – 49
- d. 50 – 59
- e. 60 – 69
- f. 70 – 79
- g. 80 or older
- h. Prefer not to answer

7. Sex (check one only)

- a. Male
- b. Female
- c. Prefer not to answer

8. Marital Status (check one only)

- a. Single (never married)
- b. Married
- c. Divorced
- d. Widowed
- e. Separated
- f. Living with partner
- g. Civil union
- h. Other (please specify) [Click here to enter text.](#)
- i. Prefer not to answer

Appendix 4 (cont.)

9. Race/Ethnicity (check all that apply)

- a. American Indian or Native American
- b. Alaska Native
- c. Asian or Asian American
- d. Black or African American
- e. Hispanic or Latino
- f. Native Hawaiian
- g. Pacific Islander
- h. White or Caucasian
- i. Other (please specify) [Click here to enter text.](#)
- j. Prefer not to answer

10. Religion/Spiritual practice (check all that apply)

- a. Atheism
- b. Agnosticism
- c. Buddhism
- d. Catholicism
- e. Christian Science
- f. The Church of Jesus Christ of Latter-Day Saints
- g. Episcopal
- h. Hinduism
- i. Islam
- j. Jehovah's Witness
- k. Judaism
- l. Non-denominational
- m. Non-religious
- n. Orthodoxy
- o. Protestant
- p. Seventh-day Adventist
- q. Sikhism
- r. Wicca
- s. Other (please specify) [Click here to enter text.](#)
- t. Prefer not to answer

Appendix 5

Discussion Guide

1. To start, so that we can get a sense of the group, please briefly share where you practice and use TT.
2. Discuss what way and/or sources you use to locate information on TT research.
Follow-up: How do you apply that to your practice? What role do research findings play in expert clinical practice?
3. Tell the group what words you would use to describe your own practice with TT.
Follow-up: How do you equate that with expertise? How do TTPS describe their personal level of expertise in TT?
4. Please describe what you believe makes someone a TT expert.
Follow-up: How does that mesh with your perception of your own expertise?
How do TTPs describe expert clinical practice?
5. Give some examples of what influences your TT practice.
Follow-up: Information about research, expert practice, personal level of expertise.
6. Characterize your ideas about the future of TT.
Follow-up: Where do you see the direction of TT practice headed in the future?
7. If there is anything, you wish to clarify or add, please do so as we close this session.

Appendix 6

Email to Recruit Subjects

Duquesne University – IRB
Protocol Number: 11-141
Approval Date: November 3, 2011
Amendment Date: May 3, 2013
Renewal Date: November 3, 2013

E-Mail to Recruit Subjects



600 FORBES AVENUE
PITTSBURGH, PA 15282
TEL 412.396.6550
FAX 412.396.6346
www.nursing.duq.edu

Dear TT Practitioner (Name),

I am looking for TT practitioners to participate in my doctoral dissertation study, *Perceptions of Expert Practice by Therapeutic Touch® Practitioners*. The study will involve participating in one synchronous online focus group discussion utilizing our university electronic technology. Criteria for participation include being a registered nurse, with an active licensure, who has a minimum of three years of TT practice and has attended a minimum of three TT workshops (at least one taught by a QTTT™) or has attended two TT workshops (at least one taught by a QTTT™) and completed a one-year mentorship program. Those registered nurses who have attended one of the advanced intensives at Orcas Island or Pumpkin Hollow (Farm) Retreat Center, or who hold QTTP™, QTTM™, or QTTT™ credentials also meet the criteria to participate in this study. You will need access to a computer with a high-speed Internet connection to participate in the study.

The online focus group will take approximately 1½ to 2 hours of your time. Prior to the focus group session, you will be asked to electronically sign a consent form, complete a demographic questionnaire, and download the computer software necessary to enter the site. If you would be willing to assist me with this project, please reply to this message or to tamwardell@frontier.com. I will then send you the consent form and a demographic questionnaire to complete and return to me by e-mail. Once those are returned to me, you will receive a list of times to select from for your participation in a focus group session. Once you select a time and it is confirmed, you will receive all the instructions on how to participate in the online session. I look forward to hearing from you to help me with this important project.

Appendix 6 (cont.)

Duquesne University – IRB
Protocol Number: 11-141
Approval Date: November 3, 2011
Amendment Date: May 3, 2013
Renewal Date: November 3, 2013

In peace and healing,

Tamara Lynn Wardell, RN, MSN, PhD(c)

Doctoral Student
Duquesne University School of Nursing
[REDACTED]
tamwardell@frontier.com

Duquesne University IRB Approval Letter



DUQUESNE UNIVERSITY

Office of Research

301A ADMINISTRATION BUILDING ♦ PITTSBURGH, PA 15282-0202

Dr. Joseph Kush
Chair, IRB-Human Subjects
Office of Research



November 3, 2011

**Re: Perceptions of Expert Practice by Therapeutic Touch Practitioners –
(PROTOCOL # 11-141)**

Dr. Gladys L. Husted
School of Nursing
Duquesne University
Pittsburgh PA 15282

Dear Dr. Husted,

Thank you for submitting the research proposal of you and your student Ms. Tamara Lynn Wardell to the Institutional Review Board at Duquesne University.

Based on the review of IRB representative Dr. L. Kathleen Sekula, and my own review, I have determined that your research proposal is consistent with the requirements of the appropriate sections of the 45-Code of Federal Regulations-46, known as the federal Common Rule. The intended research poses no greater than minimal risk to human subjects. Consequently, the research is approved under 45CFR46.101 and 46.111 on an **expedited** basis under 45CFR46.110.

The approval pertains to the submitted protocol. If you or Ms. Wardell wish to make changes to the research, you must first submit an amendment and receive approval from this office. In addition, if any unanticipated problems arise in reference to human subjects, you should notify the IRB chair before proceeding. In all correspondence, please refer to the protocol number shown after the title above.

Appendix 7 (cont.)

Once the study is complete, please provide our office with a short summary (one page) of your results for our records.

Thank you for contributing to Duquesne's research endeavors.

Sincerely yours,

Joseph C. Kush, Ph.D.

C: Dr. Gladys L. Husted
Dr. L. Kathleen Sekula
IRB Records

Appendix 8

Duquesne University IRB Amendment Approval Letter



DUQUESNE UNIVERSITY

Office of Research

424 RANGOS BUILDING ♦ PITTSBURGH, PA 15282-0202

Dr. Joseph Kush
Chair, IRB-Human Subjects
Office of Research



May 1, 2013

**Re: Perceptions of Expert Practice by Therapeutic Touch Practitioners –
(PROTOCOL # 11-141)**

Dr. Gladys L. Husted
School of Nursing
Duquesne University
Pittsburgh PA 15282

Dear Dr. Husted:

Thank you for submitting the amendment to Protocol #11-141 to the Institutional Review Board at Duquesne University.

You propose to make minor changes with regard to one aspect of your study: the recruitment of subjects from the Therapeutic Touch International Association. The change is consonant with procedures and documents originally approved by the IRB and pose no foreseeable risks to subjects or potential subjects.

The research remains subject to all stipulations put forth in this IRB's original approval letter and annual review remains on the cycle determined by the original approval. The protocol number is shown above. Please use it in correspondence with our office.

Appendix 8 (cont.)

Thank you for contributing to Duquesne's research endeavors. If you have any questions, feel free to contact me at any time.

Sincerely yours,

Joseph C. Kush, Ph.D.

C: Dr. Gladys L. Husted
Dr. L. Kathleen Sekula
IRB Records

Appendix 9

Letter to TTIA Board to Request Amended Membership Access

Duquesne University – IRB
Protocol Number: 11-141
Approval Date: November 3, 2011
Amendment Date: May 3, 2013
Renewal Date: November 3, 2013

TTIA Permission Request Letter



600 FORBES AVENUE
PITTSBURGH, PA 15282
TEL 412.396.6550
FAX 412.396.6346
www.nursing.duq.edu

Board of Directors
Therapeutic Touch International Association, Inc.
PO Box 419
Craryville, NY 12521

Dear Board Members:

I am requesting your permission to utilize the TTIA mailing list (specifically to access e-mail addresses) to recruit subjects for my dissertation research. I will be examining the perceptions of TT practitioners related to expert practice (abstract attached).

Data collection will be done by conducting synchronous online focus groups. Denise Coppa, PhD, RNP, FAANP, QTTT, a TTIA member, is serving as my external committee member. She will provide TT expertise for this project.

The Duquesne University IRB has given its approval for this project (copy attached). Please feel free to contact me at tamwardell@frontier.com or [REDACTED], if you need additional information. I look forward to hearing from you regarding this project to advance understanding of TT practice.

In peace and healing,

Tamara Lynn Wardell, RN, MSN, PhD(c)

Appendix 9 (cont.)

Duquesne University – IRB
Protocol Number: 11-141
Approval Date: November 3, 2011
Amendment Date: May 3, 2013
Renewal Date: November 3, 2013

Enclosures:

Perceptions of Expert Practice by Therapeutic Touch[®] Practitioners (Abstract)
Duquesne University IRB approval letter

cc: Gladys Husted, RN, PhD
Denise Coppa, PhD, RNP, FAANP, QTTT

Appendix 10

TTIA Board Permission Letter for Amended Membership Access

-----Original Message-----

From: MAH [REDACTED]
Sent: Sunday, April 28, 2013 11:39 AM
To: tamwardell@verizon.net; Sue Conlin
Subject: your invitation to membership

Tamara,

I am the research Trustee for TTIA. I am pleased to see you are progressing in your dissertation plan.

Sue Conlin will include your participation invitation to the membership in her eNews to the membership. She will be sending this email out in the next 2 weeks.

Please let me know if you have any questions.

Mary Anne Hanley, PhD, RN
Research Trustee
TTIA
[REDACTED]

Appendix 11

Duquesne University IRB Approved Subject Recruitment Ad Content

TTIA E-Mail Newsletter Insertion

One of our members is conducting a doctoral study approved by TTIA—Perceptions of Expert Practice by Therapeutic Touch® Practitioners. This will require about 1 ½ to 2 hours of your time to discuss TT practice and expertise in an online focus group. You will complete a consent and demographic questionnaire online and download software (high-speed Internet access needed) to utilize the Duquesne University electronic technology.

Participants must be an RN (with active licensure), who has practiced TT for at least 3 years, and has achieved at least ONE of the following:

- Attended 3 TT workshops (at least 1 taught by a QTTT™),
- Attended 2 TT workshops (at least 1 taught by a QTTT™) and completed a one year mentorship program,
- Attended 1 of the advanced intensives at Camp Indralaya or Pumpkin Hollow, and/or
- Holds active QTTP™, QTTM™, or QTTT™ credentials

To volunteer to assist with the study, please contact Tamara Lynn Wardell, RN, MSN, PhD(c) at tamwardell@frontier.com or [REDACTED] as soon as possible.

Appendix 12

Email Instructions for Informed Consent and Demographic Questionnaire



600 FORBES AVENUE
PITTSBURGH, PA 15282
TEL 412.396.6550
FAX 412.396.6346
www.nursing.duq.edu

Dear Participant,

Thank you for agreeing to participate in a focus group for my study, Perceptions of Expert Practice by Therapeutic Touch[®] Practitioners. I am enclosing the forms you must complete in order to participate in the study. Please note that two documents are attached to this email.

- Open each document and complete the required information.
- Please read the directions carefully.
- On the Demographic Questionnaire you will need to “Enter Provided Code.” This code will also be your pseudonym for the study and will protect your privacy. Your code will be “Clara Barton” and should be entered in the highlighted box. [Note: Clariss “Clara” Harlowe Barton (1821-1912) was a nurse during the Civil War and founded the American Red Cross.]
- On the “Consent Form” you need to mark or highlight the check box, click to enter your name and click to enter the date (all of these are on the bottom of the second page). You may download/print a copy for your records. Researcher copies will be kept in a locked file, with all other study documents.
- Complete each document, save the changes, attach to the email, and return to me. If you have any additional questions, please do not hesitate to contact me.

In peace and healing,

Tamara Lynn Wardell, RN, MSN, PhD(c)
Doctoral Student, Duquesne University School of Nursing
[REDACTED] tamwardell@frontier.com

Informed Consent Form

Duquesne University – IRB
Protocol Number: 11-141
Approval Date: November 3, 2011
Amendment Date: May 3, 2013
Renewal Date: November 3, 2013



DUQUESNE UNIVERSITY

Office of Research

301A ADMINISTRATION BUILDING ♦ PITTSBURGH, PA 15282-0202

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Perceptions of Expert Practice by
Therapeutic Touch® Practitioners

CO-INVESTIGATOR: Tamara Lynn Wardell, RN, MSN, PhD(c)
[REDACTED]

INVESTIGATOR/ADVISOR: Gladys L. Husted, RN, PhD
School of Nursing Distinguished Professor
[REDACTED]

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in Nursing.

PURPOSE: You are being asked to participate in a research project that seeks to investigate your thoughts about expert Therapeutic Touch® practice. You will be asked to complete a demographic questionnaire, install free software to access the study, and to participate in an online synchronous focus group of approximately 1 ½ to 2 hours, which will be conducted by the co-investigator. The online sessions will generate an electronic archive. These are the only requests that will be made of you.

Appendix 13 (cont.)

Duquesne University – IRB
Protocol Number: 11-141
Approval Date: November 3, 2011
Amendment Date: May 3, 2013
Renewal Date: November 3, 2013

RISKS AND BENEFITS:

There are no anticipated risks greater than those encountered in everyday life. The benefits to the participants are contributing to the body of knowledge concerning expert Therapeutic Touch® practice.

COMPENSATION:

Participants will not be compensated for their participation in this study. The only potential cost for the participant would be phone charges if they do not have toll-free access through an Internet and/or telephone provider. Those charges will not be covered by the researcher.

CONFIDENTIALITY:

Your name will never appear on any survey or research instrument. Only the co-investigator will have access to pseudonyms utilized during the study. No identity will be made in the data analysis. All written materials and consent forms will be stored in a locked file in the researcher's home. Your responses will only appear in statistical data summaries. All materials will be destroyed at the completion of the research study.

RIGHT TO WITHDRAW:

You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

SUMMARY OF RESULTS:

A summary of the results of this research will be supplied to you, at no cost, upon request.

Appendix 13 (cont.)

Duquesne University – IRB
Protocol Number: 11-141
Approval Date: November 3, 2011
Amendment Date: May 3, 2013
Renewal Date: November 3, 2013

VOLUNTARY CONSENT:

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project. I understand that should I have any further questions about my participation in this study, I may call

Co- Investigator,
Tamara Lynn Wardell, RN, MSN, PhD(c)
[REDACTED]

Principal Investigator, Gladys L. Husted,
RN, PhD
[REDACTED]

Chair of the Duquesne University
Institutional Review Board, Dr. Joseph Kush
[REDACTED]

Marking or highlighting this box indicates that I have read the description of the study and I agree to participate.

Participant's Name/Signature

Date

Researcher's Signature

October 15, 2011

Date

Appendix 14

Email to Schedule Focus Groups (Wimba®)



600 FORBES AVENUE
PITTSBURGH, PA 15282
TEL 412.396.6550
FAX 412.396.6346
www.nursing.duq.edu

Dear Participant,

Thank you for agreeing to participate in a focus group for my study, Perceptions of Expert Practice by Therapeutic Touch® Practitioners. You have completed your informed consent and demographic forms and are now eligible to select a time to participate in a focus group session. Please select one of the following times by replying to this e-mail. If you are available for more than one you may indicate a preference, in case more or less participants are needed for a particular session.

- Friday, July 26, 7:00 pm
- Saturday, July 27, 7:00 pm
- Sunday, July 28, 7:00 pm
- Monday, July 29, 7:00 pm
- Tuesday, July 30, 7:00 pm

Please Note: All times are EDT (US & Canada) UTC or GMT – 5.00

You will receive a session confirmation as soon as possible. Meanwhile, please review the “Helpful Info” attachment, which contains information about the webinar and how to check your computer using the Wimba® setup wizard.

Your confirmation will include the link and instructions to use your pseudonym after clicking the participant button. Your follow-up reminder with repeat information will be sent the morning of your scheduled session.

If you have any additional questions, please do not hesitate to contact me at [REDACTED] or tamwardell@frontier.com.

In peace and healing,

Tamara Lynn Wardell, RN, MSN, PhD(c)
Doctoral Student, Duquesne University School of Nursing
[REDACTED], tamwardell@frontier.com

Appendix 15

Blackboard® Wimba® Classroom Setup Instructions for Subjects

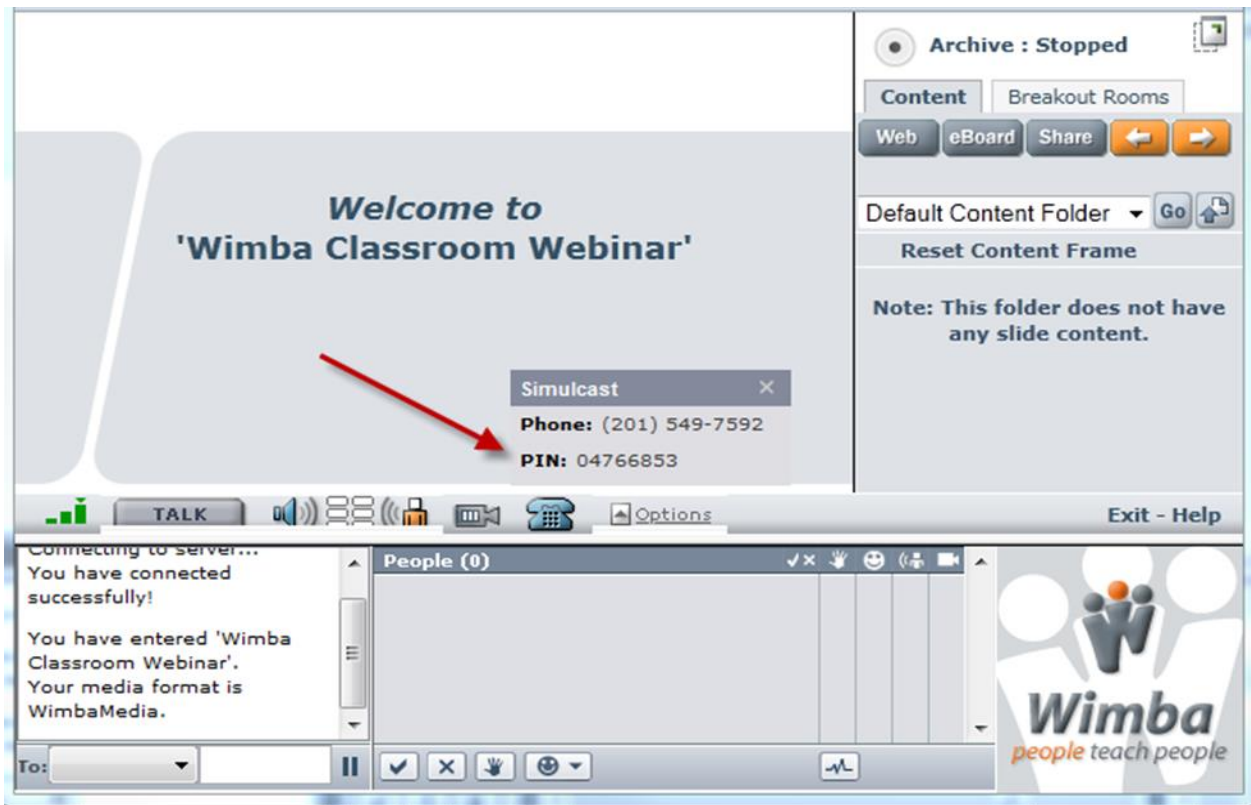
Helpful Information for the Focus Group Session

Prior to the webinar you will need to test your computer's systems. Since this tool is voice enabled you will need a microphone and speakers (or a headset with microphone) to participate in the session. Wimba® works best with Cable or DSL connections.

The link is [Wimba Classroom Setup Wizard](#)

Click on the orange Start button and follow the directions. Make sure to allow applications/popups (e.g., applet 1, choose run). It is a good idea to run the test again, just prior to or the day of the focus group session. You will have access to the study site 15 minutes prior to the start of the focus group discussion.

I have included a picture of the site template so that you will be able to review its features, which are described in more detail underneath.



Appendix 15 (cont.)

The most important features are the talk button, which must be pressed down for you to join the conversation. Also, if you lose your connection, you may press down on the phone and it will provide you with a phone number and PIN so that you may call in and rejoin the conversation. A telephone that has the mute function is needed in order to participate. If you are not using a standard landline, please make sure that you are fully charged or plugged in to a power source for the session. Please note that this is not a toll free number. If you need to phone in during the session, please contact me afterwards to discuss the matter.

You may maximize the bottom chat and people panes.

Questions to be discussed will be posted by the investigator in the top left pane on a PowerPoint® slide and posed verbally to the participants.

Next to the “To:” entry block is a “check mark” for yes, an “x” for no, a “hand” to request to be allowed to respond or enter the chat with a number to indicate your order to enter the chat, and a “smiley face” emoticon to “set status”. The set status has ten icons in a drop down menu (from left to right, top to bottom). In the top row, the open circle is to clear your status, the bird to note you have left the room, hands indicating you approve or disapprove. In the second row, the emoticons indicate confused, clap, surprise, faster, and slower.

If at any time you cannot be heard by the other participants, responses may be typed in bottom left chat block next to the “Main Room” block, you then follow the directions to request to be allowed to enter the chat, and will be placed into the order. For example, if you lose your connection, and are going to call in, you might want to quickly type that you cannot hear, or cannot talk, etc. to update the group on your status.

Appendix 16

Scheduled Focus Group Email Reminder



600 FORBES AVENUE
PITTSBURGH, PA 15282
TEL 412.396.6550
FAX 412.396.6346
www.nursing.duq.edu

Dear Participant,

This is a reminder that you are scheduled to attend a focus group session:

- Friday, July 26, 7:00 pm
- Saturday, July 27, 7:00 pm
- Sunday, July 28, 7:00 pm
- Monday, July 29, 7:00 pm
- **Tuesday, July 30, 7:00 pm**

Please Note: All times are EDT (US & Canada) **UTC or GMT – 5:00**

If you need to check your computer system use the [Wimba Classroom Setup Wizard](#) link. To enter the session, use the [Wimba Launcher Link](#) to enter the test site “Focus Group Tuesday July 30.” The link may launch two pages. Enter your pseudonym **(Clara Barton)** in the space next to name under “Participant Login” and click enter, which will take you into the Wimba classroom site for the focus group. Be sure to allow any applications (e.g. chatapplet, run). If you reach the second page (has the setup wizard at the top right corner), click on “Participant Login” and follow the instructions as above.

If you have any additional questions, please do not hesitate to contact me at [REDACTED] or tamwardell@frontier.com.

In peace and healing,

Tamara Lynn Wardell, RN, MSN, PhD(c)
Doctoral Student, Duquesne University School of Nursing
[REDACTED] tamwardell@frontier.com

Appendix 17

TTP Descriptor Paragraph

An expert Therapeutic Touch® practitioner is someone evolving with confidence, who implements a holistic approach utilizing perception to delineate truth. They use skill, patient, and holistic practice knowledge. While learning and practicing, honing skills and developing confidence with self-reflection and a lack of ego in the treatment outcome. The journey through a transforming process comes with compassion, intentionality, centering, and intuition ever more present in their lives, changes resulting in transcendence. They know that this journey involves one that is beyond the usual and fills them with its mystery, new discovery, amazement, and surprise. They lead by example and share TT by practicing, teaching, and mentoring those new to the modality. They seek out credentials to practice and teach, they write, perform research, obtain advanced degrees, and generate theory. They support their TT colleagues. The quest for new knowledge continues as they make it a lifetime goal, utilizing professional organizations, journals, bibliographies, literature searches, colleagues, conferences, and trips to retreat centers at Pumpkin Hollow and Indralaya. They continue to study the works of the co-founders of TT and with Dr. Krieger, when she is available. They commit themselves to a continuous process of learning and growing in TT.