

# Does therapeutic touch reduce pain?

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## **ABSTRACT:**

With at least 1.5 million American and 298,000 British patients in the UK diagnosed with cancer, (noted as a leading cause of death), each year, as well as other debilitating diseases, the need for symptom and pain management has become increasingly important. This has been recognised, particularly by nurses within the oncology field. It has been suggested that alternative, or complementary therapies, such as therapeutic touch, may have the potential to offer health practitioners different means to conventional pharmacologic approaches for the purposes of pain reduction. By analysing some of the latest work in the field, the evidence for whether there is a role for therapeutic touch in relieving pain will be evaluated.

## **Introduction**

Therapeutic touch (TT) is a form of “energy healing” which was first developed in the 1970s and gained much of its popularity within the American nursing community. The therapy was originally introduced by Dora Kunz (a contemporary healer) and Delores Krieger (Ph. D., R. N.), a theosophist and nurse, as an alternative to surgical intervention for the purpose of pain relief. There is no scientific basis to TT and thus this practice has been criticised by many sceptics.

For the approximately 1.5 million American and 298,000 British patients diagnosed with cancer in the US and UK respectively each year however (PD Sasieni et al., unpublished observations, 2011), TT may offer a viable means of pain reduction and an alternative to more traditional therapy modalities (Jackson, et al., 2008). TT has been heralded as useful in the treatment of

such health problems as chronic pain, cancer, multiple sclerosis, thyroid problems and headaches. TT is supported by Rogers' theory of holistic nursing (Rodgers, 1970). This practice has been supported by many health professionals, particularly within the United States (U. S.) and United Kingdom (U. K.).

Therapeutic touch relies on the hands as a means of assisting healing (Lafreniere, et al., 1999) and was first introduced by eastern medical practitioners (Kelly, et al., 2004). Nursing is particularly suited to the administration of TT (and other therapeutic techniques) as this branch of health balances treatment of the whole body (termed holistic treatment) against treatment of the disease itself. TT practitioners claim the technique works by adjusting the particularly energy field of the human patient in order to stimulate healing, reduce pain and aid relaxation.

TT is based on the concept that humans are “ complex energy fields” continually interconnecting other individual energy fields and those of the surrounding environment. This field is believed to extend from the skins' surface. With each human at the centre of an energy field, illness is believed, according to the principles of TT, to induce disruption and an imbalance' in a patients' energy field, equating to their illness (Hutchinson, et al., 1999). Conversely, a medically healthy person would be considered ' balanced' (Jackson, et al., 2008). Practitioners view TT as a means of reparation to the patients' energy field (Gottlieb, 1995; Krieger, 1979).

The following sections will summarise some of the main uses of TT in practice today and present a case for whether TT may be a useful complement to modern pain reduction techniques.

### **Therapeutic Touch and Osteoarthritis**

Osteoarthritis (OA) is a disease that is often seen in older patients and is a prominent cause of disability. Currently, more than 21 million Americans and 8 million British patients and an estimation of 3 in 4 individuals over the age of 75 years are afflicted. OA impairs physical and psychological functions, is chronic in nature and has no established cure (American Pain Society, 2002). Currently prescribed treatments often incur a risk of toxicity, and OA is expensive to treat (CDC, 2006). Thus, alternative effective analgesic treatments, including TT, are being sought.

In 1998, a study by Gordon and colleagues looked at 25 patients with knee-bound OA over 4 weeks. Three trials were given; either TT, a control, or mock therapeutic touch (MTT). For pain reduction, such tested parameters as outdoor work, interference and life control, were shown to be higher with TT in relieving OA associated pain, compared with either the control or MTT groups (Gordon, et al., 1998). This promising trial indicated that TT might be effective at considerably reducing pain and improving the patients' use of the affected areas.

### **Therapeutic touch and progressive muscle relaxation**

Another study pioneered by Peck (1998) involved either the use of TT, or progressive muscle relaxation (PMR) to reduce OA-associated pain in elder patients. The TT and PMR groups both reported improved limb use and

overall pain and discomfort reduction. In the trial by Peck (1998), TT specifically improved the use of the patients' hands whilst walking. A greater overall function of the affected area was seen for the TT group. TT and PMR groups were both shown to improve either hand function or mobility, respectively.

### **Further OA of the knee trial using TT**

#### **Trial outline**

A third study by Smith, et al. (2010) looked at three parameters; value of life, functionality of the limb and the effects of TT on pain, in patients coping with OA of the knee. The nature of the study was single-blinded and patients were assigned either a treatment group, (wherein patients could receive two TT therapies twice a week for two months) or sorted into a control group, wherein the patients' normal treatments were used. Grouping was assigned at random. The three parameters were measured in patients at time 0, 8 weeks and 12 weeks, using the Knee Society Score (KSS), Western Ontario and McMaster Universities Index (WOMAX) and the Medical Outcomes Study (MOS) Short Form (SF36).

#### **Trial results**

Although pain is considered to be subjective, it may be defined as an “unpleasant sensory and emotional experience” (Smith, et al., 2010). On this basis, a noteworthy difference in pain was found between time 0 and 8 weeks, as measured by SF36 ( $p = 0.009$ ), for limb functionality. The WOMAC scoring additionally revealed statistical differences between 0 weeks and 8 weeks ( $p = 0.006$ ) and again from 8 weeks to 12 weeks ( $p = 0.001$ ) in the

same parameter. Measurements by the KSS scale revealed pain reduction between weeks 8 to 12, in the treatment comparative with the control group.

### **Trial conclusion**

The study by Smith, et al. (2010) indicates the potential for TT, when administered twice a week for 8 weeks for the reduction of OA-associated knee stiffness and pain. However, results from the KSS revealed that patients did not report an effect by TT on knee stability or joint locomotion.

There are limitations, however, when calculating the effectiveness of OA related treatments. During the trials, some participants may be liable to discontinue treatment (e. g. Peck (1998)). Furthermore, parameters including environmental humidity, which lie beyond experimental control may introduce experimental bias and thus reduce the reliability of some TT trials. This was the case with the study by Peck (1998), wherein warmer weather alone reduced OA-associated pain.

### **Conclusion**

The above trials have shown that there is potential for TT in improving knee function in patients suffering from OA (Peck, 1998). TT has been shown to reduce OA-associated symptoms, as well as reducing discomfort and pain associated with cancer and median nerve function (Baird, 2001). Overall, particularly with treatment of chronic illnesses such as cancer, a combination of holistic medicine such as TT and PMR with proven effective conventional medicine is likely to be the most effective means of improving a patients' condition.

These studies reinforce the potential for TT as a useful therapeutic technique. However, further research is necessary to examine more fully the effect of TT on other affected somatic regions, as well as its long-term application as a combined therapy for cancer patients.

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