

Does Therapeutic Touch Help Reduce Pain and Anxiety in Patients With Cancer?

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With more than 10 million patients with cancer in the United States, pain and symptom management is an important topic for oncology nurses. Complementary therapies, such as therapeutic touch, may offer nurses a nonpharmacologic method to ease patients' pain. Using 12 research studies, the authors examined the evidence concerning the effectiveness of this type of treatment in reducing pain and anxiety.

More than 10 million people in the United States had some form of cancer in 2007, including 1,444,920 newly diagnosed cases. Prostate and breast cancer rank among the highest incidences at 29 and 26 percent, respectively (American Cancer Society, 2007). A cancer diagnosis brings about feelings of fear, pain, and anxiety. Billions of research dollars are spent each year to find better, more effective, and curative treatment. Treatment currently varies depending on the type of cancer, with chemotherapy and radiation regimens being used along with traditional pain-control medications. Traditional medical management of patients' symptoms does not consider the holistic nature of the disease and the human healing process. Patients should have access to care that helps fight the cancer and alleviates fear, anxiety, and pain. Many therapies have been researched to determine the best methods for alleviating cancer symptoms and the side effects of treatment. Therapeutic touch has shown promise in helping patients with cancer find relief from pain, anxiety, and fear (American Cancer Society, 2006). This evidence-based study examines research regarding the effectiveness of therapeutic touch.

Background

Therapeutic touch is a therapy in which the hands are used to facilitate the healing process (Lafreniere et al., 1999). The therapy was introduced in the early 1970s by Delores Krieger and Dora Kuntz as a noninvasive nursing intervention derived from ancient Eastern forms of healing (Kelly, Sullivan, Fawcett, & Samarel, 2004).

Several studies link nursing care to positive cancer therapy outcomes and suggest a need to explore nontraditional therapy modalities, such as therapeutic touch, as viable options to

At a Glance

- ◆ In 2007, 1,444,920 new cases of cancer were diagnosed in the United States.
- ◆ Therapeutic touch is a complementary therapy that is used to help with the anxiety and pain related to cancer treatment.
- ◆ Therapeutic touch is an energy therapy involving hand movements to equalize and balance energy flow. Healing is promoted when body energy is balanced.

complement standard cancer therapy. A randomized, controlled study by Given et al. (2002) evaluated symptom management during chemotherapy and found that patients with cancer experience pain and anxiety during chemotherapy. The 53 patients in the experimental group and 60 in the control group were interviewed using a symptom experience scale, which measured symptoms, physical impact, and social functioning. The patients received standard care and chemotherapy, but the experimental group received additional nursing interventions for symptom management. Those interventions were tailored to individual issues and categorized as teaching, counseling

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Figure 1. Therapeutic Touch Balancing Energy Field

Note. Photos courtesy of Teresa French. Used with permission.

and support, coordination, and communication (Given et al.). Analysis of variance, chi square, and logistic regression were used to analyze the results. The investigators found that administering drugs to patients was the extent of most treatment. But the evidence suggested that nurses' interventions with the experimental group decreased the severity of the patients' symptoms (Given et al.).

A repeated measures study of chemotherapy symptoms by Braud et al. (2003) showed that anxiety was one of the top side effects reported by 49 patients. "Declared baseline anxiety scores were relatively high, suggesting that emotional distress prior to [treatment] is unrecognized by the medical team" (Braud et al., p. 474). This suggests that the healthcare team may not realize the emotional issues that patients are dealing with during chemotherapy. The study emphasized the need for more research to identify how patients feel and what the healthcare team can do to assist (Braud et al.).

In 1999, Zaza, Sellick, Willan, Reyno, and Browman examined 214 healthcare providers and their knowledge and comfort with the use of complementary methods of pain management. Healthcare professionals were questioned about their perceptions of nonpharmacologic treatment strategies through a self-report survey. The survey included a list of nonpharmacologic pain-management methods developed through expert clinician consultation. The list of options included meditation, music and art therapy, guided imagery, acupuncture or acupressure, massage, prayer, and therapeutic touch. A four- and five-point Likert scale was used to measure perceptions of pain and effectiveness of nonpharmacologic treatment strategies, respectively. Most of the healthcare professionals surveyed in the study reported that chronic cancer pain differs from chronic noncancer pain. In addition, nurses rated the effectiveness of therapeutic touch much higher than other complementary therapies, yet physicians rated it as the lowest (Zaza et al.). That finding—possible physician resistance to therapeutic touch—is useful as researchers continue to explore this therapy. Nurses showed interest in learning more about therapeutic touch and may be appropriate providers of this therapy (Zaza et al.).

Nursing care is based on the holistic view of treating the whole person as well as the disease, including psychological distress and traditional physical symptoms. Little research exists in the area of nonpharmacologic pain and anxiety-relief therapies that nurses can use to help patients with cancer.

Energy Field Theory

Therapeutic touch centers on the theory that the body, mind, and emotions combine to form a complex energy field. According to that theory, being in good health indicates a balanced energy field whereas illness represents imbalance (Basset Healthcare, 2002). Krieger and Kuntz based their theory of therapeutic touch on the assertions of nursing theorist Martha Rogers. Rogers emphasized that humans are surrounded by energy fields that extend from the skin surface (Hutchinson, D'Alessio, Forward, & Newshan, 1999). The theory states that energy fields are symmetrical and balanced when a person is healthy, which allows energy to flow evenly. Physical and psychological symptoms, such as pain and anxiety, cause imbalances in the fields. Therapeutic touch is used to restore those imbalances (Gottlieb, 1995; Krieger, 1979) (see Figure 1).

Therapeutic Treatments

Therapeutic touch, healing touch, and Reiki are closely linked touch-energy or hand-mediated energetic healing therapies that often are used interchangeably and have many similarities but also some notable differences. As noted previously, therapeutic touch is a therapy in which the hands are used to direct human energy to facilitate healing (Krieger, 1979) (see Figure 2). Healing touch uses the principle and

1. **Centering:** The process of using meditation to center on the present to begin a tension-free focus on healing the client.
2. **Assessment:** Starting at the patient's head and moving the hands along and near the body (from head to toe), the process assesses energy flow irregularities.
3. **Unruffling:** This long sweeping motion with the hands evens out areas of the body that have uneven or dense energy flow.
4. **Modulating:** Energy is directed from the environment to the patient's areas of uneven or dense energy.
5. **Assessment:** The client's energy is assessed to be even with no differences.

Figure 2. Caregiving Steps in Providing Therapeutic Touch

Note. Based on information from Krieger, 1979.

practice of therapeutic touch, touch-energy methods, or a group of therapies. Developed by Janet Mentgen and several other nursing practitioners in the late 1980s and early 1990s, healing touch uses the hands to equalize energy with different treatment modalities (e.g., magnetic clearing, pain drain, mind clearing, wound sealing) (Gastright, 1997; Healing Touch International, 2007). Reiki, a Japanese method that uses the hands to vitalize the life energy flow, relaxes and promotes healing. The goal is a high life force energy level that maintains wellness (International Center for Reiki Training, 2007). The three levels of Reiki training increase practitioners' vibrations and allow for the flow of higher healing frequencies (Potter, 2003). Students first practice Reiki on themselves and then, upon reaching higher levels of instruction, are prepared to use it on others. This is a process of attunement that is passed down from Reiki master to student (Potter).

Study Purpose

The purpose of the current study was to examine existing research on the effectiveness of therapeutic touch and to determine whether it decreases pain and anxiety in patients with cancer.

Methods

Data collection consisted of an in-depth search of sources that investigated the use of therapeutic touch as a method for decreasing pain and anxiety in patients with cancer. Keywords such as *healing touch* and *therapeutic touch* were paired with other terms such as *cancer*, *pain*, and *anxiety*. The comprehensive search did not focus on a specific cancer diagnosis, gender, or age group. Previous research on therapeutic touch is limited; therefore, the inclusion criteria allowed for studies that researched any type of cancer, used therapeutic touch as an independent variable, and used pain and/or anxiety as the dependent variable(s). The articles researched pain and anxiety in patients with cancer but did not have to evaluate both dependent variables. An initial literature review included articles validating that patients with cancer experienced pain and anxiety; however, those articles were eliminated to better address the research question. Sources that did not conduct a research study, such as articles discussing opinions about therapeutic touch as a valid therapeutic method and patient-written narratives, were excluded. Those criteria were applied to identify higher-level evidence-based research (Melnik & Fineout-Overholt, 2005) (see Table 1). The Cochrane Library, PubMed®, and CINAHL® were used to retrieve ideal information sources. Five sources were found using the Cochrane Library, four using PubMed, and three using CINAHL. This article reports on the 12 studies identified through the databases.

Analysis and Synthesis

Studies were organized according to level of evidence to best structure the analysis. The seven levels of evidence were used to rate the strength of each study (Melnik & Fineout-Overholt, 2005). Each study provided information on sample size, level of evidence, purpose, factors examined, method and instruments, and outcomes (see Table 2).

Table 1. Rating System for Levels of Evidence

LEVEL	DESCRIPTION
I	Evidence from a systematic review of randomized, controlled trials or evidence-based clinical practice guidelines based on systematic reviews of randomized, controlled trials
II	Evidence from at least one well-designed randomized, controlled trial
III	Evidence from well-designed controlled trials without randomization
IV	Evidence from well-designed case control and cohort studies
V	Evidence from systematic reviews of descriptive and qualitative studies
VI	Evidence from a single descriptive or qualitative study
VII	Evidence from authorities' opinions and/or expert committee reports

Note. From *Evidence-Based Practice in Nursing and Healthcare* (p. 10), by B. Melnyk and E. Fineout-Overholt, 2005, Philadelphia: Lippincott Williams and Wilkins. Copyright 2005 by Lippincott Williams and Wilkins. Adapted with permission.

Pain and anxiety were the two factors initially addressed in the research; however, after the researchers examined the evidence, pain was studied in conjunction with other physical symptoms, such as nausea, shortness of breath, and fatigue. Similarly, several psychological symptoms were studied with anxiety, including mood, relaxation, and quality of life. The focus of the research then was expanded into two broad categories: physical and psychological.

The best sources of evidence, level I, are from "evidence from a systematic review or meta-analysis of all relevant randomized controlled trials or evidence-based clinical practice guidelines based on systematic reviews of [randomized controlled trials]" (Melnik & Fineout-Overholt, 2005, p. 10). Research from Bardia, Barton, Prokop, Bauer, and Moynihan (2006) fell in this category. The authors concluded that therapeutic touch is a promising therapy but could not determine how effective the therapy is in alleviating cancer pain.

Sources assigned level II have evidence that was "obtained from at least one well-designed randomized controlled trial" (Melnik & Fineout-Overholt, 2005, p. 10). The four studies assigned level II indicate and affirm that therapeutic touch does improve physical and psychological symptoms. Giasson and Bouchard's (1998) findings showed that therapeutic touch increased the sense of well-being in patients with terminal cancer. Categories showing improvement were pain, nausea, depression, anxiety, shortness of breath, activity, appetite, relaxation, and inner peace ($p < 0.002$). Lafreniere et al. (1999) found that patients receiving therapeutic touch showed increased vigor ($p < 0.05$) and a reduction in mood disturbance ($p < 0.01$), tension ($p < 0.05$), confusion ($p < 0.01$), and anxiety ($p < 0.01$) compared to the control group. Post-White et al.'s (2003) study showed that healing touch was effective in reducing total mood disturbance ($p = 0.06$) and fatigue ($p = 0.03$) in adult patients undergoing chemotherapy. Healing touch also reduced respiratory rate ($p < 0.001$), heart rate ($p < 0.001$), and systolic ($p < 0.001$) and diastolic blood pressure ($p < 0.001$). Levels of pain lowered with healing touch ($p < 0.01$). Cook, Guer-

Table 2. Research Evidence Sources for Therapeutic Interventions

STUDY	LEVEL OF EVIDENCE	SAMPLE	PURPOSE	RESEARCH VARIABLES	METHODS AND INSTRUMENTS	OUTCOMES
Giasson & Bouchard, 1998	II	20 patients receiving palliative care. Participants were aged 18–70 years, spoke French, and were not presenting with symptoms of confusion.	To examine the effect of three therapeutic touch treatments on feelings of well-being	Pain, nausea, depression, anxiety, shortness of breath, mobility, appetite, relaxation, and inner peace in patients receiving therapeutic touch versus periods of rest	Patients were divided into a control group that did not receive therapeutic touch and an experimental group that received 15–20 minutes of therapeutic touch several times per week. Patients then completed an assessment tool evaluating comfort, pain, nausea, anxiety, shortness of breath, appetite, relaxation, and inner peace and any changes in their condition.	Therapeutic touch treatments increase sensation of well-being in patients with terminal cancer ($p < 0.0015$). The experimental group showed a mean increase of 1.70 (on the well-being scale) with a standard deviation of 1.28, and the control group showed a decrease of 0.31 with a standard deviation of 1.12.
Kelly et al., 2004	VI	18 women with early-stage breast cancer	To compare therapeutic touch with dialogue to a controlled quiet rest	Perceptions of the effects of dialogue and therapeutic touch or quiet rest	Telephone interviews were completed after experimental or controlled nursing interventions were administered in the women's homes.	Content analysis revealed few differences in patients' perceptions of experimental and controlled interventions. Patients expressed feelings of calmness, relaxation, security, comfort, and a sense of awareness regardless of the intervention.
Lafreniere et al., 1999	II	41 healthy female volunteers	To evaluate therapeutic touch's effect on hormonal and neurotransmitter indicators, mood, and anxiety	Hormones and neurotransmitter levels that regulate vomiting: cortisol, dopamine, and nitric oxide	Participants were randomly assigned to an experimental group that received therapeutic touch or to a control group that completed questionnaires but did not receive therapeutic touch. Experimental group patients listened to music while a trained practitioner administered therapeutic touch. Patients then rested for 5–10 minutes before completing a questionnaire.	Patients in the therapeutic touch group showed a significant reduction in mood disturbance compared to the control group ($p < 0.01$). Therapeutic touch reduced tension ($p < 0.05$) and confusion ($p < 0.01$) and increased vigor ($p < 0.05$). Anxiety significantly declined ($p < 0.01$), as did nitric oxide levels ($p < 0.05$).
Olson et al., 2003	IV	9 men, mean age of 59.5 years, and 15 women, mean age of 56 years	To compare standard opioid management plus rest with standard opioid management plus Reiki	Independent variables such as opioids, Reiki, and rest period, and dependent variables such as decreased pain level and perceived quality of life	Patients from an inpatient palliative unit, a hospice, and an outpatient symptom management clinic were randomly assigned to a group. Patients completed pain and quality-of-life assessments on the first and last days of study. Patients also kept diaries rating and describing the pain at different times of the day. Patients assessed the pain before and after the rest period or the Reiki session.	Overall, patients receiving Reiki experienced improved pain control and a more positive quality of life. Patients receiving opioids plus Reiki on the first day of treatment reported a significant drop in pain level ($p = 0.035$). A significant drop also was recorded by the fourth day ($p = 0.002$). Patients' psychological state during that time improved as well ($p = 0.002$).
Post-White et al., 2003	II	164 patients were placed in massage therapy ($n = 63$), healing touch ($n = 56$), or presence ($n = 45$) groups.	To determine whether massage therapy and healing touch were more effective than standard care	Heart rate, respiratory rate, blood pressure, pain, and nausea levels in patients in the control groups	Patients received four 45-minute sessions of intervention per week and were assessed before and after each session. Heart rate, respiratory rate, and blood pressure were recorded. Pain and nausea were measured with the Brief Pain Index and rated on a 0–10 linear analog scale.	Patients in the healing touch and massage therapy groups reported a more relaxed feeling and a reduction in short-term pain, mood disturbance, and fatigue compared to patients in the presence group.
Samarel et al., 1998	III	14 patients in the experimental group, 17 in the control group	To obtain preliminary data and determine feasibility for a large-scale experimental study	Independent variables such as therapeutic touch, quiet time, and music, and dependent variables such as mood, anxiety, and pain	Patients were tested using the State-Trait Anxiety Inventory, Affects Balance Scale, and Visual Analog Pain Scale. Testing was done seven days before surgery and 24 hours after. Treatment was 10 minutes of therapeutic touch and 20 minutes of dialogue.	More research is needed, but anxiety decreased moderately when therapeutic touch was combined with quiet time and guided imagery. Several limitations, including length of treatment time, could have been improved ($p = 0.03$).

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Table 2. Research Evidence Sources for Therapeutic Interventions (Continued)

STUDY	LEVEL OF EVIDENCE	SAMPLE	PURPOSE	RESEARCH VARIABLES	METHODS AND INSTRUMENTS	OUTCOMES
Sparber et al., 2000	VI	100 patients in a convenience sample	To examine the use of complementary and alternative medicine (CAM) therapies	CAM therapies, beliefs, and communication with physician	Patients were interviewed with a standardized, 99-item questionnaire assessing the use of CAM therapies before and after cancer diagnosis.	63% of patients used at least one CAM therapy, with an average using two. Women were more likely to use numerous therapies ($p = 0.003$). The type of cancer diagnosed had little influence over the frequency of CAM use. CAM was used to treat physical conditions as well as depression, anxiety, and insomnia. Patients said their quality of life improved after they learned how to cope with stress and decrease the discomforts of treatment and illness. CAM gave them a sense of control.
Weze et al., 2004	IV	35 patients with cancer	To evaluate the safety and outcomes of using healing by gentle touch as a treatment for cancer	Changes in physical and psychological function	Patients received a questionnaire with visual analog scales to rate their symptoms and quality of life. The patients were treated to four one-hour healing sessions in a four- to six-week period. Researchers monitored patients' assessments of their physical and psychological function before and after treatment.	Patients reported improvements in psychological and physical function and quality of life. Pronounced improvements were seen in stress and relaxation, severe pain and discomfort, and depression and anxiety. Stress, rated the most severe symptom, fell by 3 points following treatment ($p < 0.0004$). Pain and fear were reduced by 2 points ($p < 0.019$ and $p < 0.012$, respectively), and levels of relaxation and coping ability increased by 3 points and 1 point ($p = 0.001$ and $p < 0.0004$, respectively). Severe depression or anxiety levels fell from 5 to 3 points ($p = 0.005$)
Wilkinson et al., 2002	IV	22 patients in a convenience sample	To determine the clinical effectiveness of healing touch and whether practitioner training levels are related to effectiveness	Three quantitative variables were examined: concentration of immunoglobulin A, self-reported stress ratings, and perceptions of health enhancement.	Patients were evaluated by naturalistic and quasiexperimental methods. Data were analyzed with nomothetic and idiographic models. Qualitative data were collected by asking open-ended questions about healing touch. Conditions were no healing touch, healing touch, and healing touch with music and guided imagery.	Significant increases in immunoglobulin A levels were achieved by more experienced practitioners. Patients reported decreased stress, with 59% reporting better overall health and 55% reporting pain relief. The overall p value was 0.109.
Cook et al., 2004	II	62 women at least 17 years old with newly diagnosed breast or gynecologic cancer. Patients were placed in healing touch ($n = 34$) and massage therapy ($n = 28$) groups.	To investigate how healing touch affects health-related quality of life	Sociodemographic and medical characteristics, attitudes about healing touch and beliefs about group assignment, and subjective evaluation of quality of life	Patients were evaluated with a standard sociodemographic interview to determine baseline information; a four-item, five-point Likert scale to assess beliefs about healing touch; and the Short Form-36 instrument from the Medical Outcomes Study. Each group received six 30-minute treatment sessions conducted immediately after radiation therapy. Patients could not see what the practitioner was doing. All healing touch practitioners had at least level II certification. Massage therapy providers did not perform therapy on the patients.	Nothing significant was found regarding sociodemographic characteristics or patients' beliefs in healing touch, but differences were found between massage therapy and healing touch in three subscales: pain, vitality, and physical function. Healing touch had better outcomes in all quality-of-life domains, with the most distinctive changes occurring in emotional role function, mental health, and health transition.

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Table 2. Research Evidence Sources for Therapeutic Interventions (Continued)

STUDY	LEVEL OF EVIDENCE	SAMPLE	PURPOSE	RESEARCH VARIABLES	METHODS AND INSTRUMENTS	OUTCOMES
Bardia et al., 2006	I	5,457 patients from 18 articles identified in a literature review	To evaluate the literature about complementary and alternative therapies related to cancer pain	Therapeutic interventions for cancer pain	All clinical trials with randomization that had an alternative medicine intervention were included and appraised with the Jadad scale. The Jadad scale was used to evaluate trials based on their level of randomization.	Therapeutic touch seems to be a promising therapy in alleviating cancer pain, but there is inadequate evidence to really recommend therapeutic touch as an effective remedy for cancer pain.
Gotay, 1999	VI	343 cancer patients were identified through the Hawaii Tumor Registry for the survey portion. 24 participated in the interview portion.	To gain in-depth information about why CAM was used and to examine how patients evaluated their experience	CAM and perception of results	Patients were surveyed via questionnaire and the use of logistic regression to determine the best predictors of CAM use. Selected participants were interviewed and responses to questions were coded and clustered to determine perceptions of CAM results.	34% of patients reportedly tried CAM. Most common were herbs (n = 13), vitamins (n = 11), and massage (n = 5). On a scale of 1–10 rating satisfaction, patients gave a mean score of 8.7 (n = 17). CAM appeared to meet symptom control and psychological support needs. Age (p = 0.022), religion (p = 0.044), and education (p = 0.012) were predictors of use.

erio, and Slater (2004) found statistically significant differences for pain, vitality, and physical functioning. The most distinctive changes occurred in emotional role functioning, mental health, and health transition.

The studies all had experimental and control groups. In Giasson and Bouchard's (1998) study, 20 participants were randomly assigned to receive either rest or 15–20 minutes of therapeutic touch several times per week. In Lafreniere et al.'s (1999) study, 41 participants were randomly assigned to an experimental group receiving therapeutic touch or to a control group that completed questionnaires. In Post-White et al.'s (2003) study, 164 participants were randomized into massage therapy, healing touch, or presence groups (participants rested on the same table and listened to the same relaxing music but did not receive massage therapy or healing touch). The Cook et al. (2004) study selected 34 women with breast or gynecologic cancer being treated with radiation for the experimental group and 28 for the control group. Anxiety, mood, and fatigue symptoms improved in the studies' experimental groups. The studies by Cook et al., Giasson and Bouchard, and Post-White et al. also showed improvements in relaxed state and pain symptoms.

Sources assigned level III have evidence that was "obtained from well-designed controlled trials without randomization" (Melnik & Fineout-Overholt, 2005, p. 10). In Samarel, Fawcett, Davis, and Ryan's (1998) study, 14 patients were placed in the experimental group and 17 in the control group. The State-Trait Anxiety Inventory, the Affects Balance Scale, and the Visual Analog Pain Scale were used to evaluate patients seven days prior to surgery and 24 hours after surgery. Treatment consisted of 10 minutes of therapeutic touch and 20 minutes of dialogue. A decrease in anxiety—also found in the Giasson and Bouchard (1998) and Lafreniere et al. (1999) studies—was found in those receiving therapeutic touch (p = 0.03).

Polit and Beck (2006) reported that many clinically important nursing questions can be answered from the rich descriptive and

qualitative data discovered in level IV and V studies. Three of the sources that were reviewed—Olson, Hanson, and Michaud, 2003; Weze, Leathard, Grange, Tiplady, and Stevens 2004; and Wilkinson et al., 2002—were assigned level IV, which is evidence that is obtained from well-designed case control and cohort studies. The three sources support touch-energy therapies after finding significant improvement in physical (p = 0.002) and psychological health (p = 0.005) (Melnik & Fineout-Overholt, 2005; Polit & Beck). Weze et al. and Olson et al. conducted studies in which patients with cancer rated their levels of pain and quality of life at two different points in the experiment. This allowed researchers to establish a baseline level of pain and some aspect of psychological disturbance, mainly focused on stress. Olson et al. searched for patients who had not received Reiki, chemotherapy, or radiation for the past month; required two to five doses of analgesic the day prior to recruitment; and were receiving palliative care for advanced cancer. The criteria raised further questions about what types of therapy are best. Weze et al. and Wilkinson et al. supported the effectiveness of healing and gentle touch in increasing health and providing pain relief. Wilkinson et al. also found that more experienced practitioners achieved more significant results.

Studies assigned to level VI have "evidence from a single descriptive or qualitative study as one of its weakest traits, or evidence levels [implying] that conclusions for practice are not as significant" but still valuable (Melnik & Fineout-Overholt, 2005, p. 10). Kelly et al. (2004) conducted phone interviews with women with early-stage breast cancer following therapeutic touch treatment and dialogue or the control method of quiet rest. The women reported positive feelings of calmness, relaxation, comfort, and security, regardless of the intervention.

Nurses can help patients with cancer by facilitating quiet time and dialogue without offering therapeutic touch. Furthermore, before nurses can consider therapeutic touch or other similar

modalities, they must understand the patient's openness to such treatment. Sparber et al. (2000) examined this question by administering a standardized questionnaire about the use of complementary and alternative medicine (CAM) therapies prior to and following a cancer diagnosis to 100 adult patients with cancer. Sixty-three percent of the patients used at least one CAM therapy; of that group, each patient used an average of two CAM therapies. The study also found that women were more likely to use multiple CAM treatments. Gotay (1999) surveyed 343 patients with cancer. Based on responses from a mailed questionnaire, 24 were asked to participate in an interview about their CAM experience. On a satisfaction scale of 1-10, most patients were satisfied, giving a mean score of 8.7 (n = 17). CAM appeared to meet symptom control and psychological support needs, such as stress management, spiritual concerns, and control over one's health.

The studies reviewed provide evidence that pain and anxiety in patients with cancer were reduced through therapeutic touch and other touch therapies. Presumed restoration of the energy field balanced out the cancer disruption. Therapeutic touch allows caregivers to manipulate a patient's energy fields on the skin surface and restore the balance of energy to promote wellness (Bassett Healthcare, 2002; Gottlieb, 1995; Krieger, 1979).

Conclusion

The research relating to therapeutic touch's effect on pain and anxiety in patients with cancer indicates that the therapy does help reduce pain and anxiety. Nurses have a responsibility to educate and care for patients by promoting optimal wellness and health. Evidence clearly indicates the effectiveness of therapeutic touch and other touch-energy therapies in relieving physical and psychological symptoms in patients with cancer. Pain management often is limited to prescribing drugs and abandoning the psychosocial aspects of nursing care. Evidence demonstrates that, with therapeutic touch, the body and mind may experience increased health.

This study had several limitations. Therapeutic touch terminology was very narrow, and research was expanded to articles that included healing touch, Reiki, and CAM. In addition, the terms *healing touch* and *therapeutic touch* often are interchanged, so distinguishing which therapy was used was difficult in some studies. Nonspecific to this project is the need for more research in this area. According to Polit and Beck (2006), relatively few randomized clinical trials, studies in the nursing discipline, and published meta-analyses of randomized clinical trial nursing studies have been conducted. Research is simply not as advanced as it needs to be within the realm of nursing. Nursing research, along with non-nursing research, in nontraditional treatments is even more scarce, which limited the evidence on therapeutic touch. Future research should focus on higher-level evidence studies investigating cancer outcomes when incorporating therapeutic touch as a treatment modality.

Within the scope of nursing practice, patients' psychosocial issues are predominant, and patients' subjective experiences of anxiety, stress, and overall quality of life need to be addressed. More research is needed on this topic, but the current evidence-based practice research puts great value on therapeutic touch.

The research provides education about the importance of therapeutic touch as an alternative or complement to traditional Western treatments. The research also suggests that therapeutic touch would be a relevant continuing education topic for health-care providers. Including curricular content on therapeutic touch theory and skills within nursing undergraduate programs should be considered. The holistic role of nurses necessitates emphasis on patients' physical and psychological care. Therapeutic touch may be one method of doing just that.

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