The experience of receiving therapeutic touch in clients with osteoarthritis of the knee

Paula Vandenburg
Medical College of Ohio

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FINAL APPROVAL OF THESIS
Master of Science in Nursing

The Experience of Receiving Therapeutic Touch in Clients with Osteoarthritis of the Knee

Submitted by

Paula Vandenburg

In partial fulfillment of the requirements for the degree of
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Examination Committee

A. Ann Smith, Ph.D.
(Major Advisor)

Judith Lamp, Ph.D., CNM

Catherine Kleiner, Ph.D., R.N.

Signature

A. Ann Smith, Ph.D.

J. Lamp

Catherine Kleiner, Ph.D., R.N.

Dean, School of Nursing
Jeri Milstead, Ph.D., R.N., FAAN

Dean of the Graduate School
Keith K. Schleider, Ph.D.

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Paula Vandenburg

Medical College of Ohio

2005
DEDICATION

This thesis is dedicated to my father and mother, and to my children, Jandee and April.
ACKNOWLEDGEMENTS

My sincere thanks to the clients involved in this study; it was joy and privilege to be a part of their experience. Both women were a joy to get to know and an inspiration in the living of their lives.

I would like to thank my daughters, Jandee and April, who have taught me what it means to persevere and to live my life memorably. I love you both more than I can express and hold you near to me with everything I am and everything that I do. I would like to thank all of my instructors for their wisdom and being so willing to share their knowledge as well as their hearts. I thank Dr. Kleiner and Dr. Lamp for serving on my committee. I would especially like to thank Dr. Ann Smith for her kindness and help through this process as well as Dr. Ann Baker for her inspiration as well as her sense of humor; to her I will always be “Pam Paula.”

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CHAPTER I

Introduction

The discomfort of osteoarthritis of the knee can cause limited mobility and pain. In some clients there is disruption in activities of daily living that seriously affect their enjoyment of life and perception of themselves (Agency for Health Care Policy and Research [AHCPR], 1992). Osteoarthritis typically affects persons over age 60 years and is often associated with pain and disability. Weight-bearing joints are most commonly affected. The goal of treatment is to minimize pain and its impact on client function and quality of life. Client education, psychological support, weight control, exercise, heat/cold application, and use of assistive devices are safe nonpharmacologic approaches (McCarberg & Herr, 2001).

Osteoarthritis, the most common joint disease, affects 20 million older Americans and is often associated with moderate to severe pain and physical impairment (Guccione, Felon, & Anderson, 1980). Osteoarthritis typically manifests after age 60 years. More than 80% of persons over age 50 years have radiologic evidence of osteoarthritis, and 80% of those older than age 75 years have clinical osteoarthritis. The disease seriously disables one-half of those with clinical osteoarthritis. When the costs of diagnosis, surgical and pharmacologic interventions, and lost productivity are considered, osteoarthritis is America’s most expensive debilitating disease (Gabriel & Matteson, 1995).

Osteoarthritis is primarily a disease of the cartilage of weight-bearing joints. It occurs asymmetrically. Until recently, osteoarthritis was not considered an inflammatory process and was often referred to as degenerative joint disease; however, low-grade
inflammation without systemic symptoms has been found (Brandt, 1995). The joint is made up of bone, cartilage, and connective tissue. The articular surface consists of hyaline or articular cartilage composed of collagen, chondrocytes, and proteoglycans. Collagen provides strength, and proteoglycans supply distensibility and adequate hydration. The chondrocytes make up the synovial cell layer and line the joint, producing viscous synovial fluid that acts as a lubricant. Superficial to the synovial membrane is the joint capsule, ligaments, and tendons. The synovial joint allows motion between two bones and disperses load across lubricated surfaces. Osteoarthritis can result from excessive or repetitive loading of a normal joint, which damages cartilage or subchondral bone.

Osteoarthritis can occur with trauma or abnormal pressure to the joint, as is observed in obesity. As cartilage is damaged, it becomes thinner and proteoglycan synthesis declines. The chondrocytes release lysosomal proteases, leading to cell loss (Gabriel & Matteson, 1995). Relatively innocuous and well-tolerated nonpharmacologic interventions are the cornerstone of medical treatment of osteoarthritis, according to the American College of Rheumatology on Osteoarthritis Guidelines (2000). Some of these nonpharmacologic interventions are weight loss, exercise, assistive devices and therapeutic touch.

This chapter includes a problem statement, a brief introduction of the theoretical framework, and a statement of the purpose and research question. The significance of the study is described as it relates to client outcomes.
Statement of the Problem

One of the most common problems that a nurse addresses while caring for the arthritic client is pain management (AHCPR, 1992). Nurses are primarily responsible for assessing pain levels and providing management of pain relief in the health care setting. In 1992, the Agency for Health Care Policy and Research (AHCPR) defined pain as a complex, subjective response with several quantifiable features including intensity, time course, quality, impact and personal meaning. Under-treatment of pain has been associated with negative client outcomes such as decreased mobility and increased incidence of complication (AHCPR, 1992). Older clients tend to underreport pain, despite evidence that pain perception increases with age (Wells, Kaas & Feldt, 1997).

Pain medication is usually considered the primary intervention to control pain but there are many nonpharmacological interventions such as therapeutic touch that may be effective in treating discomfort caused by osteoarthritis of the knee. Other nonpharmacological interventions include weight control, exercise, assistive devices, heat/cold therapy, client education and psychological support. Because of the chronic nature of osteoarthritis, nonpharmacologic interventions provide the client with self-care strategies that may lessen pain, improve physical functioning, and increase independence and sense of control.

Therapeutic touch is a complementary modality recognized by the National Institutes of Health (NIH) and categorized as a manual healing method (National Institutes of Health [NIH], 2001). Therapeutic touch is performed by a certified practitioner and includes the techniques of centering, assessing, redistributing energy fields and knowing when to end the treatment. Details of these techniques are discussed
further in subsequent chapters. Therapeutic touch developed by Kreiger and Kunz in the 1970s (Kreiger, 1979), is an intervention that has the potential to benefit osteoarthritic clients in many ways that are still unknown.

**Statement of Purpose**

The purpose of this qualitative study was to understand the experience of clients with symptoms of osteoarthritis of the knee receiving therapeutic touch. The design is phenomenology (Munhall, 1994), and it is used to understand the lived experience of the phenomenon of therapeutic touch and the effect on the symptoms of osteoarthritis of the knee. The data were analyzed using Colaizzi’s (1978) constant comparison method.

**Theoretical Framework**

The conceptual and theoretical frameworks used for this research study was Roger’s Science of Unitary Human Beings (Rogers, 1970) The Rogers model was used as a guiding framework. This nursing model defines client as an irreducible, indivisible, pandimensional energy field identified by pattern and manifesting characteristics that are specific to the whole and not individual to the part (Rogers, 1992). The model helps to explain how clients perceive osteoarthritis of the knee and the effects of therapeutic touch.

**Research Question**

This investigation sought to answer the question: What is the experience of clients with symptoms of osteoarthritis of the knee receiving therapeutic touch? The conceptual terms used within this study are defined as follows:

In this study, adult or client is conceptually defined as: an irreducible, indivisible, pandimensional energy field identified by pattern and manifesting characteristics that are
specific to the whole and cannot be predicted from the parts (Rogers, 1992). In this study, operationally defined adult or client is described as men or women over 50 years of age exhibiting signs and symptoms of osteoarthritis of at least one knee joint.

Therapeutic touch developed by Kreiger and Kunz in the 1970s (Kreiger, 1979), is a complementary modality recognized by the NIH and categorized as a manual healing method. Therapeutic touch is an intervention that relates to Rogers’ holistic nursing theory (Rogers, 1970), which states that all persons are highly complex fields of various forms of life energy. In therapeutic touch the certified nurse moves life energy through his or her hands to the client, thus restoring balance and increasing the client’s capacity for healing (Kreiger, 1993, 1997; Kunz, 1991; Macrae, 1988). The specific technique is discussed in detail in subsequent chapters.

**Significance**

According to Rogers (1970), nursing seeks to promote symphonic interaction between the environment and Man, to strengthen the coherence and integrity of the human being, and to direct and redirect patterns of interaction between Man and his environment for the realization of maximum health potential. Therapeutic touch is cost effective, is not invasive and requires no special equipment. This study reveals information about the perceptions of clients regarding the use of therapeutic touch and possible effects of directing and redirecting patterns in clients with symptoms of osteoarthritis. Benefits to clients would include providing another choice in providing symptom relief. Benefits to health care would be an effective treatment for osteoarthritis at low cost, low risk and high client satisfaction.
Assumptions

Support for investigating the lived experience of clients diagnosed with osteoarthritis was based on assumptions utilizing Rogers theory of the Science of Unitary Human Beings (Rogers, 1970). Cowling (1997) developed a template for Rogerian nursing practice, outlining a number of constituents, which were based on an extension of the earlier work of Barrett (1988) but also included new elements. The following assumptions of Rogers theory have been adapted to the current focus of inquiry.

First, nursing interventions should arise from awareness of the mutual human-environment field pattern and should be pattern-specific rather than age-, disease- or gender-specific. It is assumed that the researcher is aware of the Rogerian concept and application of such. Second, human field pattern appraisal should occur considering experience, perception and expression. It is assumed that research clients are able to express experience and perceptions in an understandable manner and are open with information about the experience. Third, all sources of appraisal should be regarded as valid, attending to “sensory information, thoughts and feelings, awareness, imagination, memory, introspective insights, intuitive apprehensions and more” (Barrett, 2000, p. 7). It is assumed the client’s feelings, thoughts, experiences and intuition are valid and specific to that individual. Fourth, pattern recognition must involve multiple ways of knowing. It is assumed that the client, as well as the researcher, will use various ways of communication including verbal and nonverbal as well as an awareness of the multiple ways of absorbing information and processing stimuli.
Limitations

Limitations of this phenomenological nursing study are dependent on the accuracy of the self-reporting of the clients who participated in this study. The study is also limited by the researcher’s skill as a phenomenological researcher and the limited time to complete.

Summary

This chapter presents a brief overview of osteoarthritis, along with information on therapeutic touch. The research question, problem and purpose of this study are presented. This researcher also explores the significance of this study to nursing. The possible limitations and the assumptions of the researcher, as well as the conceptual definitions of the terms are discussed.
CHAPTER II

Literature

This chapter includes an overview of the Rogers Science of Unitary Human Being theory and phenomenology as they relate to this study. The chapter includes a review of the literature relating to osteoarthritis and symptoms, osteoarthritis and non-pharmacological treatments (other than TT), therapeutic touch as a nursing intervention for Osteoarthritis and therapeutic touch.

The purpose of this qualitative study was to understand the experience of clients with osteoarthritis of the knee receiving therapeutic touch. A phenomenological research design was used for this study. Qualitative methods are directed toward describing or uncovering new insights, meanings and understandings (Munhall, 1994). The Rogers theory (Rogers, 1970) is used as a guiding framework. While phenomenology is the study of lived experiences, nurses need to understand that the study of lived experience is always the study of being (Munhall). It is a quest to first, and most importantly, understand what it means to be human (Munhall). The aim of phenomenology, then, is to produce a description of a phenomenon of everyday experience, in order to understand its essential structure. Understanding the experience of clients with osteoarthritis of the knee receiving therapeutic touch will assist nurses to understand the benefits of therapeutic touch and the importance of energy fields/holistic care.

Conceptual/Theoretical Frameworks

Rogers formulated five basic assumptions that describe Man and the life process in Man (Rogers, 1970). These assumptions are “building blocks” that underlay the
conceptual framework and consist of the following concepts: Wholeness, openness, undirectionality, pattern and organization, and sentience and thought.

Wholeness, according to Rogers (1970), is to regard the client as a unified whole which is more than, and different from, the sum of the parts. Openness is the continuous exchange of matter and energy between the client and the environment. Undirectionality is how the life process exists along an irreversible space-time continuum. Pattern and organization identifies the clients and reflects their innovative wholeness. Sentience (intelligence) and thought states that of all life, human beings are the only ones capable of abstraction and imagery, language and thought, sensation and emotion. Rogers envisioned the human being as a system of energy in motion within other such systems, themselves forming more complex systems. Each human being is said to be “unitary” and he or she cannot be considered in isolation, separate from his or her environment.

From a “Rogerian” perspective, nurses’ work is to be done with unitary human beings in a state of continuous mutual exchange with their environment. Nursing’s goal is to participate in this process of change in order to maximize each client’s health potential.

Over the ensuing years, four “critical elements” emerged (Cowling, 1990) that are basic to the proposed “system” (Rogers, 1970). These are energy fields, open systems, pattern and pandimensionality (Rogers, 1992). The final concept, pandimensionality, was previously known as multidimensionality and prior to that, four-dimensionality. Rogers (1970) described energy fields as the fundamental unit of the living and the non-living. They consist of the human energy field and the environment energy field. Rogers (1992) goes on to say that the human field is an irreducible, indivisible, pandimensional
energy field identified by pattern and manifesting characteristics that are specific to the whole and which cannot be predicated from knowledge of the parts.

The environmental field is integral with the human field. Each environmental field is specific to its given human field. The human energy field finds itself in an ongoing, mutual and integral process with the environmental energy field (Pflege, 1996). Open systems (openness) describe the open nature of the fields, which allow for an interchange of energy and matter between the fields. This is an ongoing process that does not identify energy, matter, or movement between fields but, rather, a flowing energy mixing of all elements.

Pattern is the distinguishing characteristic of the energy field perceived as a single wave that gives identity to the field (Rogers, 1970). Human behavior can be regarded as manifestations of changing pattern (Rogers). The pattern is constantly changing and might be regarded as an indication of pain, illness or disease (Wright, 1987). The system is open so the fields of energy are in constant interaction and exchange with surrounding energy fields.

In therapeutic touch, Roger’s (1992) concept of resonancy explains the process by which the practitioner moves life energy through his or her hands to the client thus restoring balance and increasing the clients’ capacity to heal (Kreiger, 1993, 1997; Kunz, 1991; Macrae, 1988). Pandimensionality describes a nonlinear domain without spatial or temporal attributes (Rogers, 1992). Figure 1 illustrates the Rogers theory as described previously.
The perceived experience of the individual as energy is redirected or modulated by the Therapeutic Touch Therapist.
Review of Literature

Osteoarthritis and Symptoms

Osteoarthritis is the most common form of arthritis and is characterized by loss or failure of the functional and/or biochemical integrity of the joint (Kean, Kean & Buchanan, 2004). The clinical symptoms include joint stiffness, pain and dysfunction, but the principal problem for the majority of clients is the pain (Kean, Kean & Buchanan).

The cardinal symptom of pain is the reason most clients with osteoarthritis seek care (Ibrahim, Burant, Mercer, Siminoff & Kwoh, 2003). It is described as aching and is usually poorly localized. As the disease progresses, pain may occur with minimal activity, and in advanced cases, it may awaken the client (Rehman & Lane, 1999).

Jinks, Jordan, and Croft (2002) used the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) to investigate the impact of knee pain and disability in persons over 50 years. The study provided population data for those aged over 50 years and demographic and psychosocial associations with severity of WOMAC scores. A pilot survey (n=240), and repeatability study (n=80) were undertaken to test completion of the WOMAC. The main questionnaire was mailed to 8,995 men and women aged 50 years and over who were registered with three general practices in North Staffordshire, UK. Substantial reliability was found for pain and physical function scales (both>0.80). Fourteen percent of the over 50 years population in this study had severe knee pain, 20% had severe difficulty with at least one area of physical functioning, 12% had both. Other independent links were age over 75 years, depression, bilateral knee injury and body mass index > 30 (Jinks, Jordan & Croft).
Research done at The Center for Health Equity Research and Promotion in Pittsburgh examined whether client descriptions of chronic pain vary by ethnicity and if they correlate with important clinical measures used in arthritis care (Ibrahim, Burant, Mercer, Siminoff & Kwoh, 2003). The sample consisted of 300 male veterans who were over the age of 50 years with moderate to severe symptomatic knee or hip osteoarthritis. Structured surveys were used to assess client descriptions of pain and to collect important demographic, clinical and psychosocial variables. Factor analysis was used to assess patterns of pain description in a comparison of African-American and Caucasian. Pearson correlations were used to examine relationships between pain descriptions and clinical characteristics. The conclusion was that African-American and Caucasian elderly clients with chronic knee or hip symptomatic osteoarthritis describe the quality of their pain differently and client descriptions of quality of chronic knee or hip pain do not correlate with radiologic stage of disease (Ibrahim et al.).

Stiffness, especially in the morning and after periods of inactivity, is also common (Rehman & Lane, 1999). However, in contrast to inflammatory joint disease, the joint stiffness in osteoarthritis is of short duration, usually lasting less than 15 minutes. This stiffness is related to soft-tissue reaction to loss of normal joint function. Movement tends to ease the pain and restore mobility, but most clients experience increased pain with continued or prolonged use of the affected joint (McCarberg & Herr, 2001).

The number of clients suffering joint pain and stiffness as a result of this disease will increase rapidly in the next decade (Buckwalter, et al., 2001). Although operative treatments of clients with osteoarthritis will continue to improve, and number of operative procedures will increase slightly in the next decade, only a small fraction of the
clients with osteoarthritis will require operative procedures (Buckwalter, et al.). The most pressing health care need for the majority of clients with osteoarthritis is nonoperative care that helps relieve symptoms and improve function, and in some instances slows progression (Buckwalter, et al.). Therapeutic touch is an example of a nonoperative intervention.

The OsteoArthritis Southern Italy Study (OASIS) involved 456 doctors and 1782 clients of three different regions (Defillippis, et al., 2004). The mean age of these clients was 66.3 years. The study evaluated the prevalence of hip, knee, hand and spine osteoarthritis and correlated it to gender, age, weight and body mass index. An Italian study demonstrated that the prevalence of knee osteoarthritis is highest in subjects older than 65 years. Knee osteoarthritis is the most common subset of osteoarthritis and the one that requires the highest number of examinations and is the one that causes the greatest disability (Defillippis et al.).

Eventually, limitation of joint movement develops, owing to joint-surface incongruity, capsular contrature, muscle spasm and mechanical block caused by osteophytes or loose bodies in the joint (Rehman & Lane, 1999). A study done at Medical College of Ohio in 1999 identified predictors of performance on four functional tasks in adults with osteoarthritis of the knee. The design was descriptive correlation and involved a voluntary sample of 78 community-dwelling adults who reported knee pain and were previously diagnosed with osteoarthritis of the knee (Topp, Woodley, Khuder, Hornyak & Bruss, 2000). In the study by Topp et al., clients were timed while they performed the functional tasks of going down to and getting up off of the floor, and ascending and descending a flight of stairs. Joint pain while performing these activities, their leg
strength, perceptions of joint pain, stiffness, functional ability and other health status information also were evaluated. The conclusion was that interventions that improve quadriceps strength and reduce joint pain and body weight, along with facilitating perceptions of functional ability, may have a positive impact upon the ability to get down to and rise up off of the floor and ascend/descend stairs in adults with osteoarthritis of the knee (Topp, et al.).

**Osteoarthritis and Nonpharmacological Treatments (other than TT)**

Possibly the most important overall therapeutic intervention is spending time with the client discussing the cause, prognosis, and treatment of osteoarthritis (Rehman & Lane, 1999). Clients with OA and their families should receive education about the disease and their role in avoiding major disability by slowing its progression. Psychological support is essential. Health-promoting behaviors such as joint protection, increased exercise, and an optimistic attitude can improve client outcomes. An additional benefit may be a decrease in office visits, suggesting the education can be cost-effective in self-management programs as demonstrated by a 12-year case study that integrated theory with practice (Long & Gonzalez, 1992).

All persons with OA should be encouraged to engage in at least 30 minutes of moderate physical activity most days of the week (American Geriatrics Society Panel of Exercise and Osteoarthritis, 2001). Appropriate regular exercise can reduce pain, fatigue, depression, and deconditioning. Regular exercise also can increase range of motion, flexibility, strength, activities of daily living, balance, cardiovascular fitness and endurance (McCarber & Herr, 2001).
Associations between exercise adherence, changes in 6-minute walking distance in meters, and self-reported disability (Western Ontario and McMaster Universities Osteoarthritis Index function subscale) after 6 and 18 months were examined among an Arthritis, Diet, and Activity Promotion Trial subsample \( (n=134) \) using multiple linear regression models. The results were that higher exercise adherence was associated with greater improvement in 6-minute walking distance after 6 and 18 months and in disability after 6 months. Pain and body mass index contributed to some extent, to explaining the link between exercise adherence and changes in physical performance and self-reported disability (Van Gool, et al., 2005).

A physical therapist should evaluate clients for muscle strength, physical function, mobility, and ambulation, and instruct them in exercises to improve joint range of motion and muscle strength. For example, better quadriceps strength can decrease pain in knee osteoarthritis (Rehman & Lane, 1999). Moderate walking and low impact aerobic exercises can significantly improve pain and functional disability (Kovar, Allegrante, & MacKenzie, 1992).

A study done at Wake Forest University at the Sticht Center on Aging examined whether an exercise program can prevent activities of daily living (ADL) disability. Two hundred and fifty clients initially free of ADL disability were used for this study. Incident ADL disability, defined as developing difficulty in transferring from a bed to a chair, eating, dressing, using the toilet or bathtub, was assessed quarterly during 18 months of follow-up. The study concluded that aerobic and resistance exercise may reduce the incidence of ADL disability in older persons with knee osteoarthritis. Exercise may be an
effective strategy for preventing ADL disability and, consequently, may prolong older persons’ autonomy (Penninx, et al., 2001).

Obesity is a major risk factor for development and progression of knee osteoarthritis. A study in women has shown that weight loss can reduce the risk of painful knee osteoarthritis (Felson, Zhang, & Anthony, 1992). A study done at Wake Forest University at the Department of Health and Exercise Science was done to determine if a combined dietary and exercise intervention would result in significant weight loss in older obese adults with knee osteoarthritis. Comparison of effects of exercise plus dietary therapy with exercise alone on gait, strength, knee pain, biomarkers of cartilage degradation and physical function was done. A clinical trial conducted for 24 weeks involved 24 community-dwelling obese older adults over 60 years of age with body mass index greater than or equal to 28, experiencing knee pain, radiographic evidence of knee osteoarthritis and self-reported physical disability.

Exercise consisted of combined weight training and walking program for 1 hour three times per week. The dietary intervention included weekly sessions with a nutritionist utilizing cognitive-behavior modification to change dietary habits to reach a group goal of an average weight loss of 15 lb. over 6 months. The study concluded that weight loss could be achieved and sustained over a 6-monght period in a cohort of older obese persons with osteoarthritis of the knee through a dietary and exercise intervention. Exercise and combined weight loss and exercise regimens lead to improvements in pain, disability and performance. Moreover, the trends in biochemical data suggest that exercise combined with diet may have an additional benefit in improved gait compared to
exercise alone. A larger study is indicated to determine if weight loss provides additional benefits to exercise alone in the client population (Messier et al., 2000).

Heat/cold therapy is also beneficial to treat pain. Recently, more and more primary care providers have been leaning toward prescribing the use of ice in the treatment of pain, even in chronic cases. Studies (Cote, Prentice & Hooker, 1988) confirm the pain relieving ability of treatments involving cold application. This facilitates early return of movement and function. Assistive devices such as canes, crutches and walkers decrease pain and improve function, stability and safety. Canes increase the base of support and improve balance. These devices require instruction, as they may promote falls if used improperly. Wedged insoles and medial taping of the patella also may be of use in correcting gait abnormalities (American College of Rheumatology Subcommittee of Osteoarthritis Guidelines, 2000).

Although the nonpharmacological interventions reviewed here show efficacy, it is imperative to have available to clients a multitude of choices that are effective in treating and relieving their symptoms. This ability to choose allows greater financial and emotional freedom by allowing for an intervention or combination of therapies to better suit clients’ individual circumstances. As outlined in this information, it will become increasingly important to have available to the aging population various nonsurgical treatments as well as psychological support for those suffering with osteoarthritis. Therapeutic touch may be an intervention that would serve as an alternative or compliment other effective available treatments for all clients suffering from osteoarthritis of all degrees of disability.
Therapeutic Touch as a Nursing Intervention

Krieger (1975) did the pioneering research regarding therapeutic touch in human clients. Krieger attempted to understand the physiological effects of therapeutic touch using hemoglobin as the criteria for measurement, conceptualizing it as a holistic measure of well being. Hemoglobin is the molecule that carries oxygen to the cells of the body and is central to the life process. Krieger (1975, 1987) found that hemoglobin levels increased significantly for clients who received therapeutic touch treatments, which could be the rationale for physiological effects.

Meehan (1985, 1993) studied the effects of therapeutic touch with surgical clients. When TT was used with narcotic analgesics, clients experienced greater pain relief and delayed requests for pain medication when compared to clients not receiving therapeutic touch. Therapeutic touch has been effective in relieving tension headache pain (Keller & Bzdek, 1986). Therapeutic touch has been demonstrated in research literature to increase relaxation and decrease stress and tension (Heidt, 1990; Krieger, 1979; Newshan, Schuller & Civitella, 2003; Peters, 1999; Winstead-Fry & Kejik, 1999). Heidt (1979) and Quinn (1982,a) found that anxiety decreased in cardiac clients who received therapeutic touch. Oslon and associates (1992) studied victims of hurricane Hugo and found the TT decreased anxiety among these individuals. Hughes, Maize-Grochowski, and Harris (1996) found that adolescent psychiatric patients experienced relaxation and changes in the affect and behavior following TT treatments. Gagne and Toye (1994) compared TT with relaxation therapy and found therapeutic touch as effective in reducing anxiety among a group of psychiatric inpatients. A reduction in anxiety would have a positive effect on those clients suffering with osteoarthritis of the
knee by promoting relaxation, decreasing discomfort and allowing for an enjoyment of life.

Olson and Sneed (1995), used three self-report measures of anxiety (Profile of Mood States, Seielberger’s State/Trait Anxiety Inventory, and visual analogue scales) to evaluate equivalence and concurrent validity to determine their potential for use in future studies. The correlations among these instruments were highly significant. The small sample size prevented differences between groups from reaching statistical significance, but the reduction of anxiety in the high-anxiety group was greater for those who had received therapeutic touch than for those who did not. Reducing anxiety in the osteoarthritis client would increase their relaxation and possibly alter their perception of pain.

Lionberger (1985) used a phenomenological method to search for characteristics of TT and explored shared meanings of 51 nurses who practiced this technique. A recurring theme was the focus on centering as essential for the TT treatment. Samarel (1992) explored the experience of individuals receiving TT and found that clients perceived a close relationship with nurses who did TT. Heidt (1990) observed nurses and clients during a TT treatment and interviewed them following the treatment. The core concept of “opening” became the basis for a theory used to describe the linking of nurses and clients as they opened to the flow of energy during therapeutic touch (Heidt). The flow of energy is integral to therapeutic touch therefore, the linking of nurses and clients and increasing the flow of energy becomes of greater importance to the effectiveness of the treatment.
Interviews and observations of one treatment session each indicate that the primary experience of TT is that of experiencing the flow of the universal life energy (Heidt, 1990). The author states, “This experience includes opening intent which is allowing one to focus on getting the universal life energy moving again, opening sensitivity which is assessing the quality of its flow, and finally the opening communication which is participating in a healing relationship that unblocks, engages and enlivens its movement” (Heidt).

Herdtner (1999) explored the knowing that occurred over time with nurses and clients as they gave and received TT. The knowing was unitary in nature, shaped by the changing rhythms of the human body and the environment, and not bounded by three-dimensional space or linear time, as it was experienced mutually by these nurses and clients. This demonstrated the totality of the experience and the non-linear flow of energy.

Therapeutic touch also may result in emotional and spiritual rewards, such as increased self-confidence, self-control and self-understanding (Ledwith, 2000). Pigg (1985) defined self-esteem as “how one feels about oneself.” It is a concept that assigns a value to who one is, how one wishes to be, and how one thinks others see or expect one to be. There seems to be a relationship between poor self-esteem and loss of control. In 1998, Barrett coined the term “health patterning” to describe a process of facilitating unitary well-being by assisting clients with their knowing participation in change. The focus of health patterning includes lifestyle changes, struggles with illness, and resolution of difficulties in living and dying. Health pattern modalities such as TT are specific ways to help clients participate in creating change. These modalities can facilitate power
enhancement whereby clients use their capacity to participate knowingly in actualizing certain potentials. Meaningful dialogue and centering are integral to many of these approaches (Barrett), as well as knowledgeable caring, love and pandimensional authenticity. These complementary modalities include therapeutic touch, imagery, meditation, as well as other modalities using sound, light color, and motion (Barrett).

It is generally recognized that some form of control over one’s life is an important psychological need (Tones, 1991) and that perceived absence of control can lead to feelings of helplessness and depression. Many researchers have shown that a positive self-esteem and an internal control over health contribute directly to a higher quality of life in people with arthritis. (Bradbury & Cantanzavo, 1989; le Borde & Power, 1980). It is essential that the nurse enters into a therapeutic relationship with the client, and identifies individual fears and expectations so that the client is able to feel in control and is able to direct his or her experience.

These findings would influence care of clients with symptoms of osteoarthritis of the knee by allowing for the intervention of therapeutic touch as an intervention to promote relaxation, decrease anxiety and give the client some control.

*Osteoarthritis and Therapeutic Touch*

A systematic review of the available data on the efficacy of any form of distant healing (prayer, mental healing, therapeutic touch, or spiritual healing) as treatment for any medical condition was done by Astin, Harkness and Ernst at the University of Maryland School of Medicine in 2000. Studies with the following features were included: random assignment, placebo or other adequate control, publication in peer-reviewed journals, clinical investigations, and use of human participants. Two investigators
independently extracted data on study design, sample size, type of intervention, type of control, direction of effect (supporting or refuting the hypothesis) and nature of the outcomes. A total of 23 trials involving 2774 clients met the inclusion criteria and were analyzed. Of the trials, five examined prayer as the distant healing intervention, 11 assessed non-contact therapeutic touch, and seven examined other forms of distant healing. Of the 23 studies, 13 (57%) yielded statistically significant treatment effects, nine showed no effect over control interventions, and one showed a negative effect. The methodological imitations of several studies make it difficult to draw definitive conclusions about efficacy of distant healing. However, given that approximately 57% of trials showed a positive treatment effect, the evidence merits further study (Astin, Harkness & Ernst, 2000).

In a quantitative study researchers at the University of Pittsburgh Medical Center tracked the self-reported joint pain of 25 clients diagnosed with osteoarthritis of the knee (Gordon, Merenstein, D’Mico & Hudgens, 1998). The purpose of this study was to determine if therapeutic touch, an alternative medicine modality, was effective in the treatment of osteoarthritis of the knee. A single-blinded, randomized control trial was conducted in a family practice center of a community hospital family practice residency program in Pennsylvania. The clients were between the ages of 40-80 years, had been given a diagnosis of osteoarthritis of at least one knee, had not had any type of knee replacement and had no other connective tissue disease. They were placed into three groups and for 6 weeks, the clients were treated with TT, mock TT, or standard care. The results showed that the group who had received TT had “significantly decreased pain and improved functions compared with both the placebo and control groups.” Baseline data
were collected using the Stanford Health Assessment Questionnaire, which measures client’s health status, functional status, medications and use of medical services. Also used was the West Haven-Yale Multidimensional Pain Inventory, version 2.1 (MPI), which addresses clients’ pain and its impact.

Two visual analog scales also were used, which are an indication of client’s identification of their pain level and well-being. Results showed that the treatment group had improved function and significantly decreased pain as compared to the mock treatment and control groups, according to the results of the MPI. The Stanford Health Assessment Questionnaire showed no appreciable difference in the three groups, but the general health status questions on the Index showed significant improvements in the treatment group. Generally, there was no difference in the visual analog scores between the groups.

At the University of Wisconsin a Rogerian study was done to determine whether therapeutic touch improved functional ability in elders with arthritis as compared to routine treatment and progressive muscle relaxation. Eighty-two non-institutionalized elders were randomly assigned to therapeutic touch or progressive muscle relaxation treatments. Subjects served as their own control for 4 weeks, and then received six treatments at 1-week intervals. Pain, tension, mood, and satisfaction improved after therapeutic touch and progressive muscle relaxation. Hand function improved after therapeutic touch; walking and bending improved after progressive muscle relaxation. Functional ability was significantly different between the two groups for mobility and hand function. Lower scores (indicating better function) were attained by the therapeutic touch group (Peck, 1998). This suggests that therapeutic touch is effective.
A meta-analysis of current studies on TT (Winstead-Fry & Kijek, 1999) concluded that some earlier trials contained methodological flaws, such as small sample size, lack of control groups and inadequate explanation of techniques applied. Despite problems with methodology, many clinical trials have shown intriguing results, particularly for the chronically ill, indicating a need for continued research with improved study designs and expanded outcome measures (Abbot 2000, Winstead-Fry & Kijek, 1999). Therapeutic Touch studies building on the early studies have improved methodological problems such as control groups, single-blinded designs, and statistical analysis (Gagne & Toye, 1994; Meehan, 1993; Olson, et al., 1992; Quinn, 1982 b; Wirth, 1990). Researchers continue to design studies measuring a variety of variables, replicating previous studies, and exploring TT with qualitative methods. Although there are still areas unexplored in the research of TT involving energy fields, this study adds to the body of knowledge relating to TT and how clients perceive the experience by sharing the findings.

Summary

This chapter provides an overview of the Rogers model and the design of phenomenology. The literature review demonstrates that recipients of TT who are experiencing osteoarthritis of the knee generally receive positive benefits. While further research measuring outcomes and describing experiences with TT is needed to validate effectiveness, current studies offer support for the use of TT as a nursing intervention. Since it provides a calming response, it would be beneficial to offer treatment to clients prior to and following procedures. Further studies are needed to determine how the client perceives the experience of TT and how that perception can be better understood.
Further studies are needed examining the therapeutic touch and the perceived effect on
symptoms of osteoarthritis of the knee. It is the intention of this study to add to the body
of knowledge that demonstrates that therapeutic touch in the client with osteoarthritis of
the knee provides to the client an opportunity for a caring, holistic and energy balance
restoring experience which would lessen the symptoms related to OA of the knee.
CHAPTER III

Method

This chapter presents the design of the study. It describes the setting and client selection. It also includes the materials used in obtaining the data to answer the research question. The method of data collection and Colazzi’s phenomenological method to analyze data is included. This study is a part of a larger study that investigated the effects of TT on osteoarthritis of the knee. In the larger study, clients were randomly placed into a control group or a treatment group. Outcome measures were used to measure pain, function, and well-being. Those in the treatment group received two treatments a week for 8 weeks. The larger study is quantitative and this study is qualitative specifically looking at the perceptions of the clients.

Design

Phenomenology is the study of the client’s life as experienced rather than conceptualized, categorized, or theorized (Munhall, 1994). The researcher looks not at what is happening, but at what is perceived as happening from the client’s unique perspective. The current research study explores the unique personal experience of therapeutic touch in clients with osteoarthritis of the knee.

This study focused on the experiences of two clients who received TT treatments twice a week for 8 weeks. A phenomenological research method was used to describe and understand experiences of clients with osteoarthritis of the knee receiving therapeutic touch. This method is designed to achieve an in-depth understanding of the perceptions of their feelings, physically and emotionally. This was achieved through client description, reflection and direct awareness. The focus of phenomenology is on understanding the
response of the client versus studying certain behaviors (Munhall, 1994). Descriptive phenomenology is an interactive approach to research in order to identify the essence of behavior. It employs direct inquiry in which questioning provides further insight into the lived experience. Perception is elicited from the clients’ not the researchers’, viewpoint (Morse, 1991). Descriptive phenomenology adopts a holistic perspective. The context is seen as a source of measuring and understanding (Hinds, 1992) and not as a source of contamination. Focus is placed on the wholeness of experience and not just individual parts.

This study applied the standard Kreiger-Kunz method of therapeutic touch as established by Nurse Healers Professional Associates International (1992, 1994). The following is the procedure performed by an experienced, qualified TT practitioner. Therapeutic touch consisted of four phases: centering, assessing the field, modulating and directing energy, and evaluating and knowing when to end the treatment. Although these phases are listed in a sequential manner for the purposes of teaching the method, they do not necessarily occur in a linear sequential manner. The centering and intention phase is the ground state that is maintained throughout the treatment and from which all the other phases proceed. Centering, as defined by Krieger (1979), “refers to a sense of self-relatedness that can be thought of as a place of inner being…” (p. 36). It is an act of self-searching that involves an exploration of the energy flow of one’s consciousness in an attempt to understand one’s being and relationship to the universe. One goes beyond the everyday stimulus and response of bodily interactions with the environment and relates to the stillness of the person and private world within (Krieger, 1993).
While remaining in a centered awareness, the nurse assesses the field by moving the hands through the field 2 to 6 inches away from the physical body. It is believed that energy centers in the hands, referred to as chakras, are used for sensing cues in the client’s field (Krieger, 1993).

Characteristics that the nurses have felt in the energy field during the assessment phase include temperature differential such as heat or cold, a magnetic pull, an emptiness or fullness, tingling, and pulsations (Krieger, 1993; Macrae, 1987). The whole field is assessed even when the nurse is aware of specific symptoms. The assessment proceeds from head to toe and usually the client is seated on a chair or a stool. The client needs to be seated in a manner that the nurse can assess the client’s front and back.

During the treatment phase, the nurse modulates and directs energy related specifically to the cues that are felt during the assessment (Krieger, 1993). Energy can be balanced using the hands in the same manner as during the assessment. If the nurse feels pressure, that pressure can be reduced by moving the hands over the area out toward the periphery of the field away from the area of pressure. This represents a modulation or redistribution of the energies in the client’s field.

The treatment is ended when the nurse no longer picks up cues in the energy field (Krieger, 1993). Each treatment is unique and will unfold in its own time (Macrae, 1987). An average treatment usually lasts for approximately 20-25 minutes. There are no specific time limits for the phases and, except for the centering phase, they fade in and out as needed (Krieger). Assessment is an ongoing process, and most nurses reassess several times during the treatment (Krieger, 1979, 1993).
Clients

In phenomenological research clients are obtained from the population who have experienced the phenomena of interest. A purposeful sampling of clients experiencing osteoarthritis in at least one knee joint who are participating in a larger study of the effects of therapeutic touch on osteoarthritis of the knee were recruited. Inclusion criteria included male and female clients age 50 years and above who have been diagnosed or have symptoms (pain, loss of mobility, sleeplessness) of osteoarthritis in one or both knees and who have not had knee replacement surgeries. Also, they do not have a connective tissue disorder.

Each of the clients in the current study received two treatments a week for 8 weeks for a total of 16 pre-treatment and 16 post-treatment interviews. The clients were mentally capable to express or verbalize their perceptions and were able to communicate in English. Clients were recruited via newsletter (See Appendix A). Interviews were conducted at a complementary medicine center of a major urban hospital in northwest Ohio. The setting for this study was in a clinic location that is quiet, comfortable and private.

Material

The researcher collected data using a semi-structured interview. The following question was used to initiate the interview: “Share with me your experience or response to the treatment you received.” Additional open-ended questions were used to guide the interview (See Appendix B). These questions helped to keep the clients focused on their experiences. The open-ended questions also allowed the researcher to get more in-depth responses.
Protection of Clients

Anonymity was provided and confidentiality was assured by assigning them numbers. Signed consent forms (See Appendix C) were stored separately from interview transcripts and all data were reported as aggregate. The consent form provided an overview of the research study, study purpose, identified risks involved, benefits, and addressed confidentiality of the clients. A copy of the consent was provided to each client.

There was no coercion to recruit clients and the clients were able to withdraw from the study at any time. The clients were at no risk from losing services of agency or employment for not participating in the study. Data are stored in a fireproof, locked file in the researcher’s office. Destruction of materials was done by fire or shredding at the end of the study with the exception of signed consent forms, which will be kept for 6 years in a locked file and then destroyed by fire or shredding.

Data Collection

After Internal Review Board approval, the data collection for the study was initiated. The interviews were conducted in fall of 2004 and winter of 2005. The researcher interviewed clients who met the inclusion criteria. These clients were unfamiliar to the researcher prior to the interviews. Each client was given an explanation of the study and offered the option of participating.

Appointments were made with the clients who expressed interest, the treatments were provided by a qualified Therapeutic Touch Provider and the interviews were conducted before each TT treatment and after a brief rest period following the TT. This occurred twice a week for 8 weeks for a total of 64 interviews. The interviews were done
before and after each treatment to explore how the participant described experiences since the previous treatment. The clients were informed that they could withdraw at any time from the study. Each participant received 16 total treatments. A total of 64 interviews were done.

The researcher collected data in open-ended interviews (written and recorded) with the client in a private room where the TT was performed. The researcher scheduled the sessions that lasted for approximately 15-20 minutes before and after the treatments. The interviews were done before and after TT in order to obtain information about the perceived experience, the perceived accumulative benefits and assured accuracy of information as verified by the clients.

A summary of the comments provided by the client was provided to the client and they were asked to comment on how well these descriptions fit with their own perceptions and experience. They also were asked for any more thoughts or additions since the treatments began. The Chair of the researcher’s thesis committee also was given transcripts verbatim, lists of significant statements and formulated meanings, and the descriptions of the lived experiences. Agreement was reached between the researcher and the Chair of the committee at each step of the analysis.

Bracketing, or setting aside of recognized ideas and beliefs from our personal lives, is imperative and should go on constantly (Munhall, 1994). Since the researcher also has osteoarthritis of the knee, a journal was used to bracket her thoughts and feelings. Some examples of her thoughts and feelings dealt with changing lifestyle to accommodate the pain and stiffness as well as adjusting to not being as quick and
spontaneous as she was at a younger age. Bracketing allows the researcher to get out of her own way of her own beliefs, and then wonder what it is like for others (Munhall).

Data Analysis

Data were analyzed using Colaizzi’s phenomenological method. This method assisted the investigator in studying the emergence of patterns in the lived experience of the clients coping with osteoarthritis of the knee. The following six-step process guided the analysis of the research study. In the first step the researcher explored perceptions of the osteoarthritic individual receiving TT as an intervention. The researcher attempted as much as possible to remain open to the text and avoided imposing presuppositions or fitting the description into some theoretical explanation. The clients’ interviews were read several times in order to obtain a global or holistic sense of data or to grasp the data in its entirety.

In the second step the researcher discriminated the meaning units or self-contained meaning blocks that directly pertained to the experience. The assumption behind this step was that experiences are not chaotic, but are structured and organized by certain processes in the consciousness. Such experiences manifest themselves as meaningful, clear and discriminatory (Polkinghorne, 1989). The researcher then extracted these significant phrases, statements or blocks that directly related to the phenomenon being studied (Colaizzi, 1978). For example “I feel so much better after the treatment” and “I feel 20 years younger.” In discriminating meaning units the researcher read the descriptions and marked the text each time that there was transition in meaning (the end of the meaning unit).
In the third step the researcher attempted to detail the meaning of each significant statement (Colaizzi, 1978). This step involved the reduction and linguistic transformation of the meaning units within individual transcripts into more precise descriptive terms. In order to formulate meaning, the researcher used creative insight to separate what the participant said and identified what was meant. This process allowed the researcher to narrow a general everyday life perspective to a more specific psychological perspective.

Step four involves organizing the aggregate formulized meanings into clusters of themes (Colaizzi, 1978). Once meaning units had been transformed into psychological terms, the researcher started working on synthesizing them into consistent and systematic general themes. Information may have been limited due to the number of clients in the study.

In step five the themes are used to provide an exhaustive description of the experiences (Colaizzi, 1978) presented in chronological order including facilitating events, actual experience, coping mechanisms and after-effects. The final step of the data analysis was the formation of the “fundamental structure” or a “common story” of the experience, returning the description to the original source for confirmation of validity (Colaizzi).

Methods of increasing trustworthiness of the interpretations of the data include making explicit presuppositions and acknowledging subjective judgments. In the present study the researcher kept a journal to describe preconceptions or judgments. Prolonging engagement with the data (Lincoln & Guba, 1985) also increases trustworthiness of the interpretations of the data. In the present study the researcher spent many hours reading and rereading the transcripts as well as listening to the audiotapes. Verifying with the
client (Johnson, 1997) also increases trustworthiness. After each interview the client’s words were reread to them and any clarification was obtained at that time. Finally peer debriefing and ongoing analysis increases trustworthiness. The data were presented to the committee chair for examination and evaluation.

Transferability is the extent to which findings are transferable to, or fitting for, other situations (Conway, 1998) and is achieved through comparisons made with similar clients, settings and times (Johnson, 1997). Therefore, in the written account of the study, detailed information regarding clients, selection methods, context and data generation and analysis methods were provided in order for the reader to decide how far and to whom the findings may be transferred.

Summary

In phenomenology, the nature of a phenomenon is sought. The goal of phenomenology is to understand the lived experience. In order to achieve this, data were obtained from the clients who volunteered and met the criteria for the study. As with qualitative research the researcher was the instrument for the study. Data were collected ensuring protection of human rights. Factors that establish validity of findings were carefully considered. The procedural steps of Colaizzi’s method were followed to analyze the data. The design of this study intended to reveal the lived experience of the osteoarthritic client receiving TT.

In this chapter the clients provided a description of the lived experience of the osteoarthritic knee client receiving TT. The study design, clients, setting, material, protection of human subjects, data collection and analysis were discussed.
CHAPTER IV

Results

In this chapter, the results of the data analysis utilizing Colaizzi’s method, sample description, and findings are presented. Themes emerged from the client’s descriptions of their lived experience of receiving therapeutic touch. A brief exhaustive description of the investigated phenomenon is presented at the conclusion of the chapter.

Sample

Study participants were 2 female adults who have osteoarthritis of at least one knee. They each received two treatments a week for 8 weeks. Interviews were done pre-treatment and post-treatment for a total of 64 interviews. Client #1 was 50 years of age, height 5’7” and weight 270. She was African American and single. Client #2 was 68 years of age, height 5’5” and weight of 260. She was Caucasian and divorced. Both have children and are the primary income provider. One is retired and one works as a seamstress.

Findings

Common themes emerged from the osteoarthritic clients’ description of their experiences receiving therapeutic touch and were organized into theme clusters. Theme clusters derived from the data sources include the following:

1. Pain experience
2. “sensing the therapist”
3. Visual and tactile sensations
4. Sleep experience
5. Relaxation
6. Improved attitude  
7. Sense of timelessness  
8. Sense of peace  
9. Increased energy  

**Pain Experience**  

The pain experience included explaining the nature of the pain, disliking the pain and implementing interventions to ease the pain. Both clients had tried pain medication, one client had tried physical therapy including electrical stimulation. Both clients had many comments about stiffness and soreness being an everyday occurrence. “My back and knees hurt, hurt when I get up, hurt all the time.” “I am achy in my knees, shoulder and sometimes in my back; it takes me awhile to limber up after sitting.” The pain for one client was in the right knee, shoulders and neck, and the other client had pain in both knees and lower back. They both related an increase in the discomfort when the weather was cold and damp.

In relation to the treatments, the clients said “I feel so good after the treatments, I feel good all over.” Both commented several times “I feel better physically and am able to function better and have more energy.” “I continue to feel good, I don’t have the pain.” “I feel really good, I walked outside and had no pain, and this is wonderful.” Both clients commented about having to take less medication for pain and that some days they didn’t have to take any medication at all, which was different than their usual routine.

One client said, “before the treatments it was an effort to do anything, but after a few weeks into the treatments I would walk and didn’t feel winded” from her asthma or have the “gimpiness that I so often experienced.” She also added that after 2 weeks into
the treatments she was having times when she didn’t hurt at all in comparison to hurting all the time prior to the beginning of treatments. “When I started this I felt better by the end of the second week. I saw a change. I was taking Aleve twice a day and still hurt, but now I take less Aleve and sometimes none.” The other client said that she got better every time she had a treatment. “I feel good. It’s like its carrying over now. The well feeling. I am feeling good all over.”

One client warned the investigator several times “not to get old.” She talked about how it takes her longer to do things compared to even a year ago. She talked about going to lunch with her friends of the same age and how they all were having aches and pains. She expressed that “I feel lucky that at my age I have no more wrong with me than I do. They are just minor things.” The other client talked about how she can’t do the things she use to do, for example, raking leaves. She said she uses the leaf blower now and it takes much more time to do physical tasks.

After the TT treatments the comments included “I am warm and pain free,” “I feel so much better,” “My knees feel real good, I feel great from head to toes.” Both clients expressed much relief and satisfaction with the results of therapeutic touch.

*Sensing the Therapist*

Clients “sensed” where the therapists’ hands were and described a change in temperature or a sensation of a rush of wind, “a flutter.” There was a feeling of weightlessness that was expressed and it was enjoyable, “like I was floating, very peaceful, like a cloud.” One client felt the therapist’s hands on her feet and shoulders at the same time. She knew that was not possible but could feel it just the same. “At first I
couldn’t tell where she was, but then I sensed around my shoulders and knee before she
touched them.” Sensations were heightened and led to visual and tactile sensations.

**Visual and Tactile Sensations**

There were many experiences with colors. While receiving the treatment with
eyes closed one client described lights bouncing around and said it was “very calming.”
After another treatment she described a rainbow, “a purple color that turned into a ball of
yellow with black in the middle.” This process repeated itself with the black forming a
tunnel.

After one of the treatments, this same client said, “I felt the room was filled with
people in my life, some that had died and some still living.” “I felt them touch me in a
comforting way, like I was being hugged.” This client also smelled a scent of cinnamon,
nutmeg, allspice, reminding her of cooking at Christmas.

One client stated “I think I felt more movement of air around my head and
shoulders today. I still felt her around my legs-heat in my legs before she touched me.”
With another treatment the same client stated “….seemed to feel shadows and breezes, I
felt warmth on my shoulders, I usually feel warmth on my ankles but didn’t today.” She
also stated “I felt warmth on my knees, especially the right knee during the whole
session, more than normal.” The sensations were comforting and relaxing.

**Sleep Experience**

One client said that she feels refreshed and quality of sleep has changed also.
“I use to be a light sleeper but now I sleep very deep. Both clients commented about
the interrupted sleep and early morning rising. “I get up in the middle of the night and
take some Aleve.” “Didn’t sleep good last night, got up at 2 a.m.and folded some clothes,
went back to bed at 3 a.m. after taking some Aleve.” She compared this to after starting the Therapeutic Touch treatments by saying “I was taking Aleve twice a day and still hurt but now I take less Aleve, and sometimes none, and have very little discomfort.” She expressed that she was benefiting from the treatments so much, “I am taking less Aleve and am moving better and sleeping better.” “I feel good, and everything is ok. Next day is worse; by the third day I need a treatment to bring me back up.” Both clients experienced an improvement in sleep after therapeutic touch treatments.

Relaxation

Both clients included descriptions of feeling more relaxed and “ready to receive benefits.” They both expressed the feeling of being able to “conquer the world” or “much more of a positive attitude.” She stated that walking was easier for her to do and the walks to the mailbox are much more enjoyable. She added that she was resting better also, “I am a lot more relaxed,” “very relaxed,” “I feel more relaxed.” The clients expressed the idea that being more relaxed led to a better attitude.

Improved Attitude

One client commented about how she has a “new attitude,” “mentally better” and “spirits are better.” Both clients commented on how the treatments are making a real difference in their lives and they benefited from them. “No matter what is going on, I will benefit from this.” One client remarked that we should have taken a picture before and after to visualize the change externally that she felt internally. “I haven’t been here for years; I am bringing my mental focus up, off of me, off the pain. I feel higher and better, in a better place.” She continued by saying, “By the time I leave here, everything is
better. I have a good rest of the day, very positive.” This was very often what was confirmed with the next interview pre-treatment.

*Sense of Timelessness*

One client experienced a changed sense of time; she imagined that she was receiving the treatment for a longer period of time than the actual time. She was very surprised to see the time as she was leaving. The other client expressed an urgency to share what she was thinking right away before having the rest time after the treatment. “I wanted to tell you right away what I was thinking so I wouldn’t forget, the feeling of not being here, being gone.” Both clients expressed that they were glad that they were in the program. “I look forward to being here.” “When I get here I know I will feel better.” Their devotion and attendance demonstrated their level of commitment.

*Sense of Peace*

Spiritual responses included the feelings of being free or at peace. One client related information about her emotional state. “Everything feels like it is ok, I have felt depressed all these years, crying in the middle of the night, I feel better emotionally, not depressed anymore.”

One client stated “I felt calm with the treatment, had more of a feeling of well-being today.” “My spirits are better.”

*Increased Energy*

One client related the fact that she was getting up in the morning at a regular time and reading the Bible and praying, something that she had not done for years. She remarked about how she feels younger in many ways since beginning therapeutic touch treatments. “I have so much energy now, I feel younger mentally and spiritually, like 20
years ago.” One client expressed that she felt very “good,” “my spirits are better,” “and I feel like the therapist was really focused on me, sending me healing. I feel like helping the world. I can mentally get where I can’t physically. I care for things.” She shared “I am feeling so energetic, ready to tackle the day.”

Exhaustive Description of Experience of TT

The exhaustive description for this study on the experience of receiving TT in clients with osteoarthritis of the knee was that the clients experienced helicy in their energy field and they expressed it as physically decreasing the perception of pain, improving quality of sleep, being more relaxed, improving attitudes, and promoting the perception of peacefulness as well as increased energy. The clients expressed this as demonstrated by the many statements quoted in this study.

Summary

The results of the data analysis using Colaizzi’s method were presented. Nine theme clusters were described with references to client’s original statements and audio recordings. The findings are that these two clients found relief in their symptoms of osteoarthritis of the knee as expressed by their lessened discomfort, increased relaxation and improved attitude and energy level.
CHAPTER V

Discussion

This chapter presents a discussion of the results describing the clients’ experiences. Findings from the interviews with the clients who received two TT treatments a week for 8 weeks, resulting in 64 interviews, are discussed in relation to the literature and theoretical framework.

Conclusions are presented based on the data from this study, literature and theme content. Study limitations and implications for nursing theory, nursing practice, and nursing education are discussed. Recommendations for further research are presented.

Findings

The purpose of this study was to understand the responses of clients experiencing symptoms of osteoarthritis of the knee being treated with TT. The experiences of the clients have been identified as nine themes. The themes experience by the clients were pain experience, “sensing the therapist,” visual and tactile sensations, sleep experience, relaxation, improved attitude, sense of timelessness, sense of peace and increased energy. The clients shared that they were using less medication and in some instances none at all. They both were able to move better and had experiences of lightness or floating sensation that gave them an altered sense of comfort during the therapeutic touch sessions. They both commented on the quantity and quality of sleep experience that, since beginning TT, both had improved.

The discomfort of osteoarthritis of the knee can cause limited mobility and pain. The cardinal symptom of pain is the reason most clients with osteoarthritis seek care (Ibrahim et al., 2003). The two clients in this study were experiencing discomfort that, by
their own account, interfered with their function, sleep, and ability to fully enjoy activities in which they were previously involved. Osteoarthritis pain is described as aching and usually poorly localized. As the disease progresses, pain may occur with minimal activity, and in advanced cases, it may awaken the client (Rehman & Lane, 1999). This was true for both of the clients in the study causing them much discomfort and disrupted rest. One of the most common problems that a nurse addresses while caring for the arthritic client is comfort management. Ibrahim et al. (2003) conducted a study and determined that Caucasians and African Americans describe their pain differently and find that the discomfort of osteoarthritis of the knee does not correlate with radiologic findings. It would be of interest to study this further. Stiffness, especially in the morning and after times of inactivity also is common (Rehman & Lane). Both clients in the study commented many times about “stiffness” or gimpiness” that got better with in a few minutes of activity. While pain medication is considered the primary intervention to control pain, there are many nonpharmacological interventions that have been discussed. These include exercise, weight reduction and therapeutic touch treatments.

The purpose of the study was to understand the responses of clients experiencing symptoms of osteoarthritis of the knee to the treatment of TT. The responses of the clients have been identified as nine themes. The themes experienced by the clients pain experience, sensing the therapist, visual and tactile sensations, sleep experience, relaxation, improved attitude sense of timelessness, sense of peace and increased energy.

A review of research shows that TT significantly reduces pain and increases function in those with osteoarthritis of the knee (Abbott, 2000). The
experiences of the clients included an altered perception of the pain, “sensing” the therapist, experiencing varied visual and tactile sensations and changes in their sleep experience. The clients shared that they were using less medication and in some instances none at all. They both were able to move better and had experiences during the TT sessions when they experienced lightness or floating sensation that gave them an altered sense of comfort. They both commented on the quantity and quality of sleep experience and that, since beginning TT, both had improved. Review of the research also shows that TT induces deep relaxation (Abbot, 2000).

Therapeutic touch may also result in emotional and spiritual rewards, such as increased self-confidence, self-control and self-understanding (Ledwith, 2000). Many researchers have shown that a positive self-esteem and an internal control over health contribute directly to a higher quality of life in people with arthritis (Bradbury & Cantanzavo, 1989; le Borde & Power, 1980). Both clients expressed a feeling of satisfaction and control related to taking the initiative to enter into the program and receiving treatments.

Pigg (1985) defined self-esteem as “how one feels about oneself.” It is a concept that assigns a value to who one is, how one wished to be and how one thinks others see or expect one to be. There seems to be a relationship between poor self-esteem and loss of control. I believe that when the clients took the action to become involved in the therapeutic touch sessions, they took some control over their situation, and therefore, increased their self-esteem. One client even voiced this when she suggested that we should have taken a picture of before the sessions started and when they were finished. I believe she was talking about the inner strength and
renewing that happened as a result of the total experience and how this was reflected in her physical appearance.

Two case studies presented in Intensive & Critical Care Nursing (Cox & Hayes 1999), demonstrate the experience of TT assisting clients to relax bring comfort and a sense of peace. Much like meditation, TT helps clients become more in touch with themselves. They come to understand more about themselves and reality. Therapeutic touch is recommended as a practice that could contribute to the psychological well being of clients as it promotes relaxation, comfort and a sense of peace. Both clients expressed many times a sense of peace and an increase of energy.

These findings support Rogers Theory in that clients are an irreducible, indivisible, pandimensional energy field identified by pattern and manifesting characteristics that are specific to the whole and not individual to the parts (Rogers, 1992).

The sensations that these clients experienced can be explained by the concept of persons being highly complex fields of various forms of life energy and that the therapist, by directing and redirecting patterns of interaction between Man and his environment, realizes maximum health potential.

Conclusions

Nine themes emerged regarding the lived experience of osteoarthritic clients receiving therapeutic touch treatments. Both clients described improvement in perceived function and pain after receiving TT. Therapeutic touch appears to have beneficial effects for relief of discomfort, improved sleep and an overall feeling of well-being and peacefulness.
Limitations

There were several limitations identified in this study. The researcher was a novice at in-depth interviewing and data analysis. Both clients in the study were women. Because of time limits, there were only 2 clients, however, the interviews took place over the span of 8 weeks. It is possible that interviews of a wider variety of clients might have revealed more diverse themes.

Implications

Complementary therapies provide an avenue for nurses to be autonomous in furthering the relief of chronic pain, as many of these therapies fall within the domain of nursing. Incorporating selected therapies into the plan of care provides multiple opportunities for nurses to demonstrate caring, a primer characteristic of nursing. We can only understand our clients’ concerns by engaging in meaningful dialogue with them. A client who believes they can influence their condition will report less physical problems and have enhanced well-being (Newman, 1993). Evaluating the effectiveness of the complementary therapy to promote comfort in patients with chronic pain is essential. Obtaining this information is not only critical to the care of a client, but this data assists nurses in learning more about specific nonpharmacologic therapies.

The relaxation experience of TT can decrease anxiety and promote sleep. Since physical touch is not necessary when doing TT, it can ideally be used for clients to whom touch would be painful.

Most important, TT is inexpensive to use. It doesn’t require any equipment. Nurses can learn to do therapeutic touch in a seminar. It can be taught to family members and significant others, giving them an active role in the healing process. Some
precautions when using TT are to watch for energy overload and “not to do what you don’t know” (Krieger, 1993). Signs of energy overload include increasing restlessness, irritability and anxiety (Krieger). Krieger suggests that beginners work with more advanced practitioners and keep in mind that it is better to under do than overdo. Krieger recommends that TT should be used gently and for short periods of time with pregnant women, children, people with head injuries, burns, shock, and in fragile health.

As found in this study, TT can be used to promote relaxation, alter perception of pain, improve attitudes, improve the quality of sleep and provide a sense of peace. The change in attitudes improves quality of life and is important for the nurse to promote this change and build on it with education that would further enable the client to be effective in self-determination. The nurse should consider and incorporate into practice the knowledge of energy fields and the holistic approach that affects energy fields and, in turn the client as a whole being.

The advanced practice nurse (APN) with specialized training in TT can initiate TT for clients with symptoms of osteoarthritis. The goal of the nurse is to balance the energy fields by centering, assessing, modulating or redirecting energy and knowing when to end the treatment. The APN needs to educate the client and involve them in all aspects of the treatment. Significant others can be instructed in the technique, thus increasing the benefits and decreasing costs. The APN can educate other nurses, clients, families and the medical community on the advantages of TT and be instrumental in the demonstration of techniques. This could be implemented in all nursing programs as a complementary therapies course. The technique could be demonstrated and the results of research shared. Administration could support the training of APNs allowing them to
implement at minimal cost with low risk to the client. This could be revenue producing and meet the needs of clients who want an alternative treatment of the symptoms of osteoarthritis of the knee.

Recommendation for Further Research

This study has examined the lived experience of clients receiving TT with osteoarthritis of the knee. A study of more diverse clients followed over time would be useful to understand long-term benefits. A study to determine the effects of long term TT intervention versus a 16-treatment course would be useful as well. Peck (1997) suggested that the effect of TT is cumulative so it would be of benefit to research the optimal amount of weeks or months for the treatments to be continued. Possible research questions could examine the following: Does the length of time for administering TT affect pain or anxiety relief? How long does the effect last when relief is achieved? Are a set number of treatments required to achieve the desired effect? How do the client’s preconceived ideas about TT affect perceived experiences and outcomes? How do personal, cultural, or religious practices influence outcomes when TT is used as an intervention?

Summary

The purpose of this qualitative study was to describe the clients’ experience receiving therapeutic touch treatments. The design of phenomenology searched for a definition of the lived experience of the phenomenon of TT. Data were obtained through open-ended interviews and a clarifying interview of each client. For clients, the lived experience of TT was described as a process that began with the perceived need for and decision to seek treatment. It progressed through 16 treatments and continued to have an
impact upon the clients’ lives. These findings were examined within the context of Rogers’ conceptual system. This study shows that, for the 2 clients receiving treatment, TT was a fulfilling multidimensional experience that facilitated personal growth. Such an experience can only enrich the lives of those who receive treatment. Certainly a nursing intervention that can achieve such a positive influence has potential for use in all areas of nursing care and needs to be explored further.
REFERENCES


Appendix A

Therapeutic Touch Research Newsletter

Therapeutic Touch Research
Opportunity for Adults with Osteoarthritis of the Knee

People with Osteoarthritis in one or both knees are invited to participate in a research study of Therapeutic Touch treatments on pain and quality of life.

You may qualify if you:
- Are 56 years or older
- Have symptoms or a diagnosis of Osteoarthritis of one or both knees
- Have not had bilateral knee joint replacement
- Do not have a connective tissue disorder

If you decide to participate, you will:
- Be randomly placed in a control or a treatment group
- Receive two Therapeutic Touch treatments a week for eight weeks if you are in the treatment group
- Complete two questionnaires about how you experience pain and how you think about your quality of life and receive a physical exam of your knee at the beginning of the study, at eight weeks, and again at twelve to sixteen weeks.

Therapeutic Touch energy treatments are intended to balance your energy and provide relaxation and relief from pain. You may sit comfortably in a chair wearing loose, comfortable clothing while the therapist moves her hands a few inches away from the body. We cannot guarantee any result from the treatment. You will remain under the care of your physician and no changes to your medical plan will be made.

To participate, please email bgwendo@mcs.edu or call 419-383-5468 and leave a message with your name, phone number, and times you can be reached. We look forward to hearing from you.

Ann Smith, PhD, APRN, BC, Principle Investigator

Approved by WHO 10-59
APPENDIX B
INTERVIEW GUIDE

Effects of Therapeutic Touch on Osteoarthritis of the Knee
Interview Guide:

BEFORE RX
Is there anything you'd like to share before we begin?

AFTER RX
Is there anything you'd like to share about this experience?

• Follow up questions –
  • How do you feel?
  • What do you mean?
  • How would you describe your experience?
  • Anything else?
RESEARCH CONSENT FORM FOR ADULT SUBJECT INFORMED CONSENT

Effects of Therapeutic Touch on Osteoarthritis of the Knee

Principal Investigator
A. Ann Smith, PhD, APRN-BC, School of Nursing

Co-Investigator:
Sanford Kimmel, MD, Family Medicine

Phone number(s)
(419) 383-5836 (Dr. Smith)
(419) 383-5525 (Dr. Kimmel)
(419) 725-3460 (MCO Complementary Medicine Center)

What you should know about this research study:

- We give you this consent form so that you may read about the purpose, risks, and benefits of this research study. All information in this form will be communicated to you verbally by the research staff as well.
- Routine care is based upon the best known treatment and is provided with the main goal of helping the individual patient. The main goal of research studies is to gain knowledge that may help future patients.
- We cannot promise that this research will benefit you. Just like regular care, this research can have side effects that can be serious or minor.
- You have the right to refuse to take part in this research, or agree to take part now and change your mind later.
- If you decide to take part in this research or not, if you decide to take part now but change your mind later, your decision will not affect your regular care.
- Please review this form carefully. Ask any questions before you make a decision about whether or not you want to take part in this research. If you decide to take part in this research, you may ask any additional questions that you may have at any time.
- Your participation in this research is voluntary.

APPROVED BY MCO IRB

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PURPOSE
You are being asked to participate in a research study of Therapeutic Touch energy treatments on persons with Osteoarthritis of the knee. The purpose of the study is to determine the effects of the Therapeutic Touch treatments on your pain, how well you can use your knee, and your quality of life. You were selected as a possible participant in this study because you are experiencing osteoarthritis of one or more of your knees and you responded to our research study advertisements. There are 60 participants participating in this pilot study at the Medical College of Ohio.

PROCEDURE AND DURATION
If you decide to participate, you will be given a baseline assessment during which you will be given a physical exam of your knee and two survey forms to fill out regarding your perception of pain and your sense of wellbeing. You will be given an explanation of the therapeutic treatments. This process will take about forty-five minutes. You will then be randomly assigned to the treatment group or to the control group.

During the next eight weeks, if you are in the treatment group, you will receive Therapeutic Touch treatments twice a week. The treatments will take place at the MCO Complementary Medicine Center in Toledo, Ohio. Each treatment will last for approximately 30 minutes. At the end of each treatment you will be asked to share any thoughts or feelings regarding the treatment and your responses will be audiorecorded. This will take about 10 minutes. During the eight-week period, a study representative will phone you to remind you of the next scheduled treatment.

If you are assigned to the control group, you will continue with your current medical care.

At the end of the eight-week period and again in 12 to 16 weeks, whether you are in the treatment group or the control group, you will be asked to again complete the two survey forms regarding your perception of pain, and your sense of wellbeing and receive a physical exam of your knee.

RISKS AND DISCOMFORTS
The risk is low. It is possible that you may experience some sensations such as warmth, tingling, and relaxation during the treatments. You may choose to share this experience with the therapist at the end of the session. The treatment is non-invasive. No instruments are used. The therapist's hands move slowly over you a few inches away from the body. You may wear loose fitting and comfortable-clothing and you may remove your shoes.

You may experience some pain or discomfort during and after examination of the knee as the examiner checks the range of motion and stability of the knee joint. Please let the examiner know if you are not able to tolerate the examination.

BENEFITS AND/OR COMPENSATION
Participants may experience relaxation and decreased pain during and between the Therapeutic Touch treatments. Participants may experience no change. We cannot and do not guarantee or promise that you will receive any benefits from this study.

ALTERNATIVE PROCEDURES OR TREATMENTS
This study does not intend to replace any ongoing treatments you may be receiving by health care professionals. You will not be asked to change any current treatments you may be receiving.

CONFIDENTIALITY
By agreeing to participate in this research study, you give to the Medical College of Ohio, the Principal Investigator and all personnel associated with this research study your permission to use or disclose health information about you for research purposes.
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information that can be identified with you that we obtain in connection with this study. We will use this
information for the purpose of conducting the research study as described in the research consent form.

The information that we will use or disclose includes your age, gender, marital status, time since
diagnosis of arthritis, medications, other standard and complementary treatments, and other relevant physical
and psychiatric diagnosis obtained from the demographic registration sheet. We will use the access on the two
surveys and your audio taped responses to the Therapeutic Touch treatments at the end of each session. We may
use this information ourselves as part of the research study. Under some circumstances, the Institutional Review
Board and Research and Grants Administration of the Medical College of Ohio may review your information
for compliance audits.

The Medical College of Ohio is required by law to protect the privacy of your health information, and to
use or disclose the information we obtain about you in connection with this research study only as authorized by
you in this form. There is a possibility that the information we disclose may be re-disclosed by the persons we
give it to, and no longer protected. However, we will encourage any person who receives your information from
us to continue to protect and not re-disclose the information.

Your permission for us to use or disclose your personal health information as described in this section is
voluntary. However, you will not be allowed to participate in the research study unless you give us your
permission to use or disclose your personal health information by signing this document.

You have the right to revoke (cancel) the permission you have given to us to use or disclose your
personal health information at any time by giving written notice to Ann Smith, Ph.D., School of Nursing, 3015
Arlington Avenue, Medical College of Ohio, Toledo, Ohio 43614. However, a cancellation will not apply if we
have acted with your permission, for example, information that already has been used or disclosed prior to the
cancellation. Also, a cancellation will not prevent us from continuing to use and disclose information that was
obtained prior to the cancellation as necessary to maintain the integrity of the research study.

Except as noted in the above paragraph, your permission for us to use and disclose personal
health information has no expiration date because the collected information may be added to future research
studies after all the personal identifying information has been removed from it.

A more complete statement of Medical College of Ohio’s Privacy Practices is set forth in its Joint Notice
of Privacy Practice. If you have not already received this Notice, a member of the research team will provide
this to you. If you have any further questions concerning privacy, you may contact the person identified in the
Notice.

ADDITIONAL COSTS
There are no additional costs to participate in this study.

IN THE EVENT OF A RESEARCH-RELATED INJURY
In the event of injury resulting from your taking part in this study, treatment can be obtained at a health
care facility of your choice. You should understand that the costs of such treatment will be your responsibility.
Financial compensation is not available through Medical College Hospital.

In the event of injury, contact Ann Smith, Ph.D. at (419) 503-6906 or Stanford Kimmel, MD at 419-383-
5525.

VOLUNTARY PARTICIPATION
Participation in this study is voluntary. If you decide not to participate in this study, your decision will
not affect your future relations with the Medical College of Ohio, its personnel, and associated hospitals. If you
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decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty.

OFFER TO ANSWER QUESTIONS

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION

YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN THIS RESEARCH STUDY. YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ABOVE, HAVE HAD ALL YOUR QUESTIONS ANSWERED, AND HAVE DECIDED TO PARTICIPATE.

BY SIGNING THIS DOCUMENT YOU AUTHORIZE US TO USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

The date you sign this document to enroll in this study, that is, today’s date, MUST fall between the dates indicated on the approval stamp affixed to the bottom of each page. These dates indicate that this form is valid when you enroll in the study but do not reflect how long you may participate in the study. Each page of this Informed Consent Form is stamped to indicate the form’s validity as approved by the MCO Institutional Review Board (IRB).

Name of Subject (please print) ___________________________ 

Signature of Subject or Legally Authorized Representative ___________________________ 

Relationship to the Subject ___________________________ 

Name of Person Obtaining Informed Consent (please print) ___________________________ 

Signature of Person Obtaining Informed Consent (as required by ICH guidelines) ___________________________ 

Signature of Witness to Consent Process (as required by ICH guidelines) ___________________________ 

YOU WILL BE GIVEN A SIGNED COPY OF THIS FORM TO KEEP.

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research subject or research-related injuries, please feel free to contact Eric Schaub, M.D., Chairmaa, Institutional Review Board, Medical College of Ohio, at 383-6796.

APPROVED BY MCO IRB

FROM 1/2/20 TO 10/30/20

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ABSTRACT

The purpose of this qualitative phenomenological study was to explore the experience of receiving TT in clients with osteoarthritis of the knee. The clients experienced helicy in their energy field and they expressed it as physically decreasing the perception of pain, improving quality of sleep, being more relaxed, improving attitudes, and promoting the perception of peacefulness as well as increased energy. The clients expressed this as demonstrated by the many statements quoted in this study.