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**NURSES' AND PATIENTS'  
EXPERIENCES OF CARING TOUCH  
INTERVENTIONS IN AN EMERGENCY  
CONTEXT**

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*I hereby dedicate my thesis to the memory of  
Carina Krumlinde  
My dear colleague and touch therapist*



## **ABSTRACT**

The epistemological standpoint of this thesis is the theory of the lifeworld where the lived body is seen as a unity of body and soul. The overall aim of this thesis was to explore the experiences of caring touch interventions, such as tactile massage or healing touch, in an emergency care context, from the perspective of nurses and patients. The concept of 'caring touch' was used to capture the meaning, in order to explore the phenomenon of receiving and giving caring touch, and not the treatment per se. This thesis consists of four exploratory studies of which three are qualitative and one a mixed-methods study.

The findings of study I indicate that tactile massage may help nurses and assistant nurses working in a short-term emergency ward to deal with a very stressful work environment and improve staff wellbeing.

In study II, it is pointed out that admissions to short-term emergency ward for acute illness or disease is often associated with increased stress, anxiety and pain. Caring touch was offered to patients as a complement to usual nursing care. The patients' lived experience indicated that caring touch resulted in an existential togetherness characterised by a non-verbal peacefulness, trust, consolation, safety, and a restoration of what it means to be a human being. Notably, some patients also expressed ambivalence toward caring touch.

In study III, it is suggested that given the current high-tech healthcare system with overcrowded units and a shortage of nurses, including tactile massage as a caring tool may create a more holistic approach to caregiving, allowing nurses and assistant nurses to act with compassion for both the patient and themselves.

In study IV, which is a longitudinal observational study, qualitative and quantitative perspectives are combined. Patients with minor or no physical injury after a motor vehicle accident were invited to an intervention with caring touch. Findings from individual interviews and questionnaires indicate that a caring touch intervention improve patients' wellbeing, and sense of security and pain ratings over a period of six months after the accident.

This thesis draw the attention to the potential of caring touch interventions in an emergency context with the overall conclusion that introducing caring touch interventions of tactile massage and healing touch in the short-term emergency ward context seem to benefit patient's integrity, wellbeing, and sense of security. The caring touch interventions give nurses a tool to increase their patients' and their own wellbeing in a stressful environment in general. Patients sustaining a motor vehicle accident with minor or no physical injury in particular, highly appreciated a follow-up to the hospital after discharge by the invitation to a caring touch intervention and this was also associated with reduced pain ratings.

Keywords: complementary therapies, connectedness, emergency care, mixed-methods

## LIST OF PUBLICATIONS

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- II. Airosa, F., Falkenberg, T., Öhlén, G., & Arman, M. (2013). Tactile massage or healing touch: Caring touch for patients in emergency care – A qualitative study. *European Journal of Integrative Medicine*, 5, 4, 374-381.
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## LIST OF ABBREVIATIONS

CT	Complementary therapy
MVA	Motor Vehicle Accident



## **PREFACE**

In 2004 nursing staff in the short-term emergency ward at Karolinska University Hospital, Huddinge experienced a high workload and asked for tools to help them cope with the associated stress. At that time I was working as a registered nurse and was trained in tactile massage. A colleague of mine, also a registered nurse, was trained in hypnotherapy. We developed a project plan, which we presented to the head of the Department of Emergency Medicine, offering our knowledge to help our colleagues deal with their stress. This resulted in the launching of a collaboration between Karolinska Institutet and the Karolinska University Hospital in the context of a health promotion project offering tactile massage and hypnotherapy to the nurses and assistant nurses in the short-term emergency ward. This led to my interest in further research and was the start of my doctoral education. I was able to access and to analyse the data from the health promotion project, which provided the basis for my first article. As a nurse I am interested in capturing the meanings of caring touch for patients and nurses receiving or giving tactile massage or healing touch in the context of emergency care. In your hand you hold the result of my curiosity. It was preceded by a long journey that has given me a deeper understanding of both the physical and the existential meanings of caring touch and of the needs that are addressed by caring touch given or received by nurses and assistant nurses in a high-tech emergency care environment.

An Integrative Care Unit offering tactile massage and healing touch to patients is now part of the surgical short-term emergency ward (KAVA) at the Karolinska University Hospital, Huddinge. Patients in the ward have the option of receiving tactile massage or healing touch as a complement to their usual nursing care and staffs have the option of using the treatments as health promotion. A course in 'mindful soft tissue massage' has been set up and offered to all nurses, and at the time of this writing, and 18 nurses in the short-term ward have received a diploma and begun to use soft tissue massage in their daily care provision.

Arriving at the end of my research journey I will draw some conclusions of my research education. This education has brought me a deeper understanding and knowledge about all the difficulties, but also strength involved in clinical research. Since the process of implementing this new knowledge about the meanings of caring touch from this research project continues in the clinical context, my journey will continue.



## **THEORETICAL POINT OF DEPARTURE**

The research conducted for this thesis involved a caring perspective based on a lifeworld perspective. Viewing the body as a lived, subjective body and soul “being-to-the-world” can be compared to the ontological standpoint in caring science, where the human being is viewed as an entity consisting of body, soul and spirit. The lived body can further be described as a carrier of the person’s life-history, and essential meaning – the home of existence (Eriksson, 1987; Merleau-Ponty, 2006).

### **LIFEWORLD AND THE LIVED BODY**

The epistemological standpoint of this thesis is the theory of the lifeworld (Lebenswelt). According to Husserl the lifeworld need to be understood as someone’s subjective world taken for granted – a world we know, it’s always there. The lifeworld is the world we live in and never can step out of - a world shared with other people, a world that is manifested through our lived experience (Bengtsson, 2008; Dahlberg, Dahlberg & Nyström, 2008). The concept of the lifeworld was further developed by Merleau-Ponty (2006). The lifeworld is understood by Merleau-Ponty as the lived world, it is the world to which we have access through our bodies. The lived body is a unity of body and soul. To the individual, the body is obvious. This is what Merleau-Ponty calls the natural attitude: in the natural attitude we do not reflect over our body. The experience of one’s own body teaches us to anchor the room in our existence, such that the body is not, primarily, in the room, but is rather to the room. It is in the objective room that the body takes its place as a shell, and the experience of the body and that of the soul melt together in bodily existence (Merleau-Ponty, 2006).

### **CARING SCIENCE**

Viewing the body as lived, subjective body-soul-spirit entity is the ontological standpoint in caring science (Eriksson, 1987). Characteristic for caring science is the focus on the patient and on what caring means to the patient. A basic consideration in the Nordic caring tradition is the ‘patient’s world’ where by means of a hermeneutical, phenomenological or lifeworld approach the caring abilities are expanded into an interest in, respect for, and understanding of the patient’s problems, needs and desires (Arman et al., 2015). The lived body can further be described as a carrier of the person’s self-conception, life history, and inherent meaning, as the abode existence (Lindwall, 2004). The autonomous discipline of caring science discipline is based on the core concepts of Eriksson’s caring theory: caritas, human, health, suffering and caring. The caring tradition places the focus on caring – whereas the nursing tradition emphasises the concepts of human, health, environment and caring (Eriksson, 2012). Seen from a caring perspective the human body is a nest of health and suffering, and this perspective make us aware that caring is a meeting of two opposites (Arman, 2012; Lindwall, 2012). Halldorsdottir (2008) offers a synthesized theory of the dynamics of a nurse–patient relationship introduced from the patient’s perspective. It is described as lived reality with a sense of spiritual connection involving a bond of energy. This connection is described as a life-giving nurse–patient relationship with a perceived openness in communication and connectedness in the nurse–patient relationship.

# BACKGROUND

## THE EMERGENCY CONTEXT

During the period of 2007-2012 the number of visits to the emergency departments in Stockholm County Council has increased by an average of 4.5% per year, due to e.g. the population growth in Stockholm. As a consequence, overcrowded emergency departments and lack of available beds in the short-term emergency wards have been described (Hälso- och sjukvårdsförvaltningen, 2013). When patients arrive at the emergency department, they are cared for in accordance with their acute medical needs and trauma patients are always treated with a high medical priority. Patients with less acute needs are given a lower medical priority resulting in a longer waiting time to treatment (Knapman & Bonner, 2010). Short-term emergency wards receive patients directly from the emergency room, and patients stay in the ward for several reasons, with a wide array of diagnoses, from minor illnesses to severe diseases. The length of patient time spent in the ward varies from one to several days with an average length of admission of 1.9 days.

There are several weaknesses in the Swedish health care system including impaired patient-centred care. For example, the *International Health Policy Survey* of 2014 shows that Swedish patients are less satisfied with their provided care compared with ten other countries. One of the complaints described is the dissatisfaction with the encounter between the caregiver/patient, which is experienced as too short and non-supportive (Vårdanalys, Rapport, 2014:11). Nurses in emergency care have a predominant focus on biological parameters which impairs the connectedness between nurse and patient (Elmqvist, 2011).

### Being a patient in the emergency context

Acute illness and disease cause stress, anxiety, and pain for the patient. The patient's integrity and personal sphere diminishes when the patient is admitted to hospital. Patients may experience the meeting in the emergency department as short and fragmented (Byrne & Heyman, 1997; Elmqvist, 2011; Wiman & Wikblad, 2004) and this fragmentation may even include patients' experience of being seen as an object (Frank, Asp & Dahlberg, 2009). In the short-term emergency care ward, patients express their vulnerability in different ways where some experience confusion over what is happening, fear of what the diagnosis will mean for them, and fear of dying. Some patients are afraid to relax and fall asleep for fear of not waking up (Sörlie, Torjuul, Ross & Kihlgren, 2006). Painful tests and examinations are part of being admitted to hospital (Byrne & Heyman, 1997; Wiman, Wikblad, & Idevall, 2007). The body stricken with illness or disease in the emergency context is perceived as something alien and mysterious. Bodily illness becomes a fight between body and soul, and the patient expresses this disharmony and suffering in different ways as he or she tries to restore wholeness (Lindwall, 2004).

Diseases and illnesses are multi-dimensional phenomena with different meanings in different cultures, as well as, of course, different meaning for different patients. Three dimensions of the meaning of disease can be identified: the biological, the phenomenologically experienced and the cultural. All three dimensions need to be

recognized by those caring for the patient, or else the patient may become objectified. The biological dimension could be explained as the cause of the disease while the phenomenological dimension tries to understand the experience of the disease. Language links biology and the phenomenological experience with culture as the third dimension. These three dimensions can be seen as a way to approach disease in the attempt to understand it (Svenaesus, 2004).

In emergency departments today, patients' need of existential care may be neglected. Although, it may be manifested during the initial caring, when the acute needs have been met and the patient is stable, nurses' interest decreases and the patient sometimes feels abandoned (Elmqvist, 2011). Mayou and Bryant (2001) also point out the risk that patients with minor or no injuries end up being neglected and that this could lead to future chronic problems. The quality of patients' interaction with the caregivers, and the shift in nursing to a more person-centred approach are key in helping patients adapt to their situation after an injury (Franzén, Björnstig & Jansson, 2006). According to Wang, Tsay and Bond (2005), PTSD, depression, and anxiety need to be identified at an early stage, and subsequent referral to treatment may decrease long-term negative outcomes. Even a slight bodily injury can lead to severe symptoms of a physical or psychological nature up to seven months after the accident and acute care (Bergsten Brucefors, Sidén Silfver & Schulman, 2001). Wiman and Wikblad (2004) describe patients with minor injuries being more likely to be neglected at the emergency department.

### **Being a nurse in the emergency context**

Working as a nurse in an emergency ward can be emotionally and physically exhausting due to the stressful environment (Yang et al., 2001). Over the past few years, 'compassion fatigue' has become a new term for nurses' and physicians' reduced productivity, increased sick leave, and high staff turnover, leading to patient dissatisfaction and risks to patient safety (Hegney, et al., 2014). There are many additional factors that may contribute to work-related stress, and many nurses complain about their inability to work in a professional manner throughout their shift (Hegney, Plank & Parker, 2003). Similarly, there are a variety of identified stress factors that increase the risk of burnout and distress in nurses. Such factors include emotional distress from contact with the severely ill patients who are close to death and high-dependency patient care (Payne, 2001). Additionally, younger nurses who worked full-time without a postgraduate qualification had significantly higher anxiety and depression levels that correlated with secondary traumatic stress and burnout (Hegney et al., 2014). Stress can have a detrimental effect on nurses' work performance, which can later lead to health problems (Kane, 2009). The need for awareness of the risks involved regarding compassion fatigue is critical. Compassion fatigue is a concept that emerged during the early 1990s and that includes burnout in nurses. The concept is associated with exposure to suffering as well as the absence of emotional support in the workplace, and nurses are exposed to an extensive amount of suffering. There is an assumption that compassion fatigue may reduce productivity and increase sick leave and staff turnover (Hegney et al., 2014).

## **Integrative nursing**

Over the past few years there has been a growing interest among healthcare staff in providing tactile massage in Swedish healthcare contexts. Initially, this was seen as a complementary therapy in addition to usual care; by the time this research was completed, tactile massage had become a part of the standard caring repertoire in many healthcare contexts (Henricson & Billhult, 2010). Healing touch is not yet provided in Swedish healthcare contexts, but in the US it is a complementary treatment used by nurses to provide holistic care (Dossey & Keegan, 2013). An ideological cornerstone of nursing practice is that it should be holistic, where the word holistic in this thesis is grounded in Florence Nightingale's integrated world view on nursing, health and human kind. Her thought of care was centered on wellness, unity, and interrelationships among persons, events, the environment and energy (Dossey & Keegan, 2013). I understand holistic nursing as focusing on the whole person (body, mind, spirit, emotion) and as being rooted in traditions of self-care, healing, and caring. The interest in integrative nursing is a global phenomenon and has been described as a caring option using evidence from a variety of knowledge sources to support a patient–nurse relationship (Kreitzer & Koithan, 2014). Integrative nurses have embraced touch and other complementary therapies as ways to understand the relationship between nurse and patient and the importance of the 'healing presence'. Self-reflection and self-care are prerequisites of skilful integrative care and self-awareness, and it is important for nurses to cultivate a capacity for reflexive practice in order to remain vital and energized, rather than drained by the challenges of nursing (Kreitzer & Koithan, 2014).

There has been a shift in language from *alternative* to *complementary* to *integrative* where Integrative care is grounded in holism. National Center for Complementary and Integrative Health (NCCIH) in the USA defines *integrative health care* as “a comprehensive, often interdisciplinary approach to treatment, prevention and health promotion that brings together complementary and conventional therapies” (Burkhardt, p 5, 2015).

This thesis focuses on nurses' and patients' experiences of caring touch interventions (tactile massage and healing touch) and hence, hypnotherapy which was also briefly explored in Study I, will not be further discussed in this thesis.

## **TOUCH**

It is difficult to survey the literature on human touch, due to the proliferation of different concepts and terms involved – for example, patient-centered comfort touch; comforting touch; touching with intention; non-necessary, intentional touch; and instrumental, task-oriented and technical touch (Connor & Howett, 2009). Massage is a form of intentional touch that has been used for millennia (Wigforss Percy, 2006). Rubbing the physical body – massage – was the primary form of medical treatment given until the pharmaceutical revolution in the 1940s (Field, 1998). From around 1880 and well into the 20th century, massage was believed to be an important treatment for both mental and physical conditions. Historically, massage was used as a basic form of providing comfort in nursing care. By the 1930s, however, the use of massage began to decline, due to the new discipline of physical medicine (Ruffin, 2011).

## **Touch in caring**

Many scientists have shed light on the importance of touch as a phenomenon that involves something more than just physical contact (Chang, 2001; Cronfalk, 2008; Eriksson, 1987; Estabrooks & Morse, 1992; Henricson, 2008; Lindgren, 2012; Ozolins, 2011). Touch is one of the most profound experiences a human being can experience, and stress and frustration may be a result of not being touched (Wigforss Percy, 2006). Being in contact with another person's soul is also a kind of touching, according to Uvnäs-Moberg (2001). In this tradition, Montagu (1986), the 'father of touch', emphasizes the importance of human touch, particularly as regards the relationship between physical and mental health, touching being an important form of non-verbal contact/communication. For nurses, touching the patient's body is a natural part of caring: during the caring act, nurses touch their patients, both consciously and unconsciously (Routasalo, 1996). The concept of touch in caring adds a deep ethical and existential aspect to the caring relationship between the nurse and the patient, and may contribute to the patient's health. In Eriksson's nursing theory, basic natural care of the patient's body is called 'tending' (Eriksson, 1987; Eriksson, 2002). Tending is one of the most profound elements of caring and entails taking care of the patient in body, soul, and spirit. Tending means to take care of the patient's body unconditionally, to nurse and protect someone by giving bodily care, not only through a series of hand manoeuvres but also through tending features such as warmth, closeness and in doing good for another human being (Erikson, 1987). In a previous study by O'Brien and Fothergill-Bourbonnais (2004), findings revealed that touch was one of the factors that were important in giving the patient a sense of safety and contributes to a positive experience during trauma resuscitation in the emergency department.

## **Different kinds of bodily touch**

Just as in the old Swedish saying, 'a beloved child has many names', bodily touch is performed using different techniques in different parts of the world. Dora Kunz and Dolores Krieger developed Therapeutic Touch (TT), a method that has been taught to hospitals and in universities since 1972. The therapist uses his or her hand to connect with the patient (Kunz & Krieger, 2004). Healing touch was developed by nurse Janet Mentgen in the 1980s (Hover-Kramer, 2002) and is an energy-based therapy that fosters nurse-patient contact and is used to enhance patients' wellbeing, whereby the therapist holds his or her hands on or over the patient's body (Umbreit, Lindquist & Kirksey, 2000). Rosen therapy was developed by Marion Rosen, and is a form of bodily touch with the aim of releasing muscular tension by releasing the feelings behind them – 'body tensions are expressions of our emotional attitudes'. The technique has been taught in Sweden since the beginning of the 1980s (Hoffrén-Larsson, 2013; Rosen, 2005). Tactile massage and tactile stimulation are techniques that use the oiled palm of the hand to massage the patient's bare skin. Both techniques were developed in Sweden by nurses – tactile massage by Siv Ardeby and tactile stimulation by Gunilla Birkestad in the mid-1960s (Ardeby, 2003; Birkestad, 2001). Rhythmical embrocations, by Wegman and Hauschka, are used in anthroposophical care as a preventive and therapeutic form of care. The aim of the rhythmical embrocations is to stimulate the body's life processes and improve the individual's natural healing process (Ranheim, Kärner, Arman, Rehnsfeldt & Bertö, 2010).

## **Negative outcomes of touch**

When patients experience touch as intrusive or constraining, the positive outcome of the touch is inhibited. Touch that is impersonal or careless may reduce the patient to an object and lead to disappointment, and if the nurse talks a lot during the touching, the patient may feel unimportant and ignored. Talk during the touch session may impede the patient's ability to gather oneself (Borch & Hillervik, 2005; Ozolinz, 2011). In a previous study by Cronfalk, a few of the patients who received tactile massage had a negative reaction to the experience at first, as they felt exposed; however, once they got used to the massage they thought it was wonderful (Cronfalk, 2008). Another aspect of touching is its association with sexuality, with men, more than women, having been found to put a sexual dimension into touching (Harding, North & Perkins, 2008; Whitcher & Fisher, 1979). Even nurses express concern about the sexual connotations of touching the patient: because of these connotations, some male nurses are afraid to touch the patient (Cronfalk, 2008; Gleeson & Higgins, 2009). In a previous study by Harding, North and Perkins (2008), male nurses' touch is described as being sometimes sexual, leading to stress in male nurses in the caring act: sometimes neither men nor women want to be cared for by a male nurse, even though male nurses are keen to explain the aim of touching. Johansson (2013) explored 'touch avoidance', finding that men were more avoidant of touch than were women. This was explained as being an effect of the female sex identity being more tolerant of physical touch than is the stereotypical male sex identity. Touch between men is seen as unmanly, intimate and inappropriate, whereas, touch between women is seen as socially acceptable. Touch avoidance could also imply a lack of trust for another person (Johansson, 2013).

## **PREVIOUS STUDIES OF CARING TOUCH INTERVENTIONS**

In this thesis, the patients could choose between tactile massage, which requires direct contact with the patient's skin using vegetable oil, or healing touch, which can be performed without direct contact with the patient's skin. In this way, patients who were ambivalent about having their skin touched directly could choose the fully-clothed option.

### **Tactile massage**

Many of the earlier studies carried out on tactile massage – or effleurage (i.e., slow stroking with firm pressure) – in acute and intensive care environments have focused mainly on addressing symptoms, such as pain relief (Hulme, Waterman & Hillier, 1999; Adams, White & Beckett, 2010), tranquillity (Hattan, King & Griffiths, 2002) and sleep (Culpepper Richards, 1998). Patients may find that tactile massage decreases their need of painkillers (Brattberg, 1999; Ozolins, 2011). In the past few years, patients' narratives have been the subject of a number of studies. Henricson's (2008) thesis, for example, considers patients' and hospital staff's experience and perceptions of tactile massage in an intensive care unit (ICU) using qualitative methods. Her findings indicate a need for nurses to be prepared to provide tactile massage in order to help patients maintain balance. Patients in the ICU enjoyed the tactile massage, finding it enhanced their comfort and decreased their anxiety. It would appear that the patient enters a 'tactile space' together with the nurse and experiences togetherness with the nurse that is disconnected from the annoying environment of the ICU. Previous studies

of soft tissue massage (being equivalent to tactile massage) in palliative care have demonstrated the value of caring for a patient by using touch to promote the patient's general wellbeing and give the patient a feeling of being special. Soft tissue massage increased a sense of existential respite leading to a feeling of transcendence – of being somewhere beyond their current situation and suffering (Cronfalk, 2008). Tactile massage significantly decreases anxiety levels in patients (Billhult & Määttä, 2009; Lindgren et al, 2013), which may be of great value in a surgical ward. Patients noted that tactile massage gave them a feeling of inner calm and an opportunity to get to know their own body in a different way and to be in harmony with their own body. It is also important for the patient to trust the nurse who performs the tactile massage (Bergsten, Petersson & Arvidsson, 2005; Ozolins, 2011).

### **Healing touch**

Healing touch has been shown to provide pain relief, decrease anxiety and increase relaxation (Maville, Bowen & Benham, 2008; So, Jiang & Qin, 2008; Thomas, Stephenson, Swanson, Jesse & Brown, 2013; Wardell, Rintala, Duan & Tan, 2006), and can also be useful in treating insomnia (So, Jiang & Qin, 2008). A previous study on healing touch revealed significant improvement of PTSD after treatment with healing touch (Jain et al., 2012). Lincoln et al. (2014) reported a significant reduction of moderate to severe pain and anxiety in patients undergoing surgery when receiving healing touch. So far, little is known about the possible mechanisms underlying the described effects of healing touch, and the specific effects of the various components of healing touch has not been extensively investigated.

## **RATIONALE**

The increasing involvement of technology and the high work demands in the healthcare system creates stress, for both patients and nurses, whose primary focus is the patient's medical condition. Working as a nurse or assistant nurse in an emergency context can be exhausting due to the elevated stressful environment. Here, a low level of person-centred care is common, as well as the lack of a holistic perspective. It can be argued that today, nursing staff in general and in the emergency context in particular, have limited tools of their own to improve healing in their patients. As a consequence, patients may suffer from fragmented encounters where their existential needs are not met. An ideological cornerstone of nursing practice is that it should be holistic. For decades, the profession has debated the hi-tech low-touch blend, given the high demands of the complex life-preserving technology in emergency care. However, caring touch interventions may hold the promise of providing an excellent environment for the nurturing of connectedness in the nurse/patient emergency encounter. In this thesis, the integration of complex emergency care with caring touch interventions was explored from nursing staff and patient perspectives, with implications for improving emergency care nursing.

Hopefully, this thesis will help to assist in the future elaboration of the concept of caring touch interventions in different hospital contexts and encourage healthcare providers generally to explore the relevance of touch interventions in nursing.

## **AIMS**

The overall aim of this thesis was to explore the experiences of receiving or giving caring touch, for patients and nurses, respectively, in an emergency context.

### **SPECIFIC AIMS**

#### **Paper I**

To explore nursing personnel's experiences and perceptions of receiving tactile massage or hypnosis as a part of personnel health promotions activities at a short term emergency ward.

#### **Paper II**

This study aimed to explore the patient's lived experience in receiving caring touch after sustaining an acute illness or disease while being cared for in a short-term emergency ward.

#### **Paper III**

The aim of this study was to illuminate the nursing staff's lived experiences and meanings of giving tactile massage while caring for patients in short-term emergency ward.

#### **Paper IV**

The aim of this study was to explore patients' subjective experience and perspectives on pain and other factors of importance after an early nursing intervention consisting of "caring touch" (tactile massage and healing touch) for patients subjected to a motor vehicle accident with minor or no physical injuries.

**TABLE 1. OVERVIEW OF STUDIES**

Study	Study population and context	Sample	Data collection	Analysis
Paper I	Nurses working in a short-term emergency-ward	16 nurses	4 focus groups discussions	Qualitative Content analysis
Paper II	Patients admitted to a short-term emergency ward	25 patients	Individual Interviews	Qualitative Phenomenological Hermeneutical
Paper III	Nurses working with tactile massage in short-term emergency wards at two hospitals	14 nurses	Individual Interviews	Qualitative Phenomenological Hermeneutical
Paper IV	Patients arriving at an emergency department after sustaining a motor vehicle accident with minor or no physical injury	41 patients	Individual interviews and questionnaires	Mixed-methods Structured text condensation and statistical

## METHODS

### TOUCH INTERVENTIONS

Touch can be very private and intimate, and for this reason the patients could choose between tactile massage, which requires direct contact with the patient's skin using vegetable oil, or healing touch, which can be performed without direct contact with the patient's skin. In this way, patients who were ambivalent about having their skin touched directly could choose the fully-clothed option.

#### Tactile massage

The tactile massage was performed by nursing staff trained in tactile massage and holding the same qualifications. Tactile massage was carried out using slow strokes, light pressure and circling movements done mainly with the palm of the hand, fingers close together (Ardeby, 2003). The patients chose where they wanted to be massaged: hands, feet, back, or whole body. The tactile massage lasted between 20 and 60 minutes, and vegetable massage oil, natural or with lavender fragrance, was used. During the tactile massage, the patient's body was wrapped in warm towels and only the part of the patient's body that was being touched remained uncovered. During the tactile massage session the touch therapist never took away her hand from the patient. After the session the patient was encouraged to rest for a while and slowly come back to 'the here and now'.

#### Healing touch

The word *healing* is sometimes viewed as a broad, non-scientific term. However, healing may also be viewed as a natural process, where the patient is seen from a holistic view and where healing forms the very basis of nursing (Prittanen King, 2005). Especially, in Sweden the term healing is to some a controversial term and hence we decided to use the word "helhetsberöring" (wholeness touch) when offering the patients the possibility of receiving the caring touch intervention. Healing touch was given by a nurse certified at level four (of five) in healing touch (Healing Touch, 2014). In the healing touch treatment performed, the nurse provides light pressure by placing her hands on the patient's feet, ankles, knees, hips, stomach, heart, arms, throat, forehead, and scalp (Hover-Kramer, 2002). The patient was fully dressed during the treatment and the nurse used his or her hand in different positions on the patient's body. The treatment took about 45 minutes.

### DESIGN

To meet the overall aim of the thesis, both qualitative (**I, II, and III**) and quantitative (mixed-methods **IV**) approaches were used to gain new knowledge about caring touch. The rationale for mixing both types of data was that when used in combination qualitative and quantitative methods complement each other, resulting in a more complete answer to the research problem (Creswell & Plano Clark, 2011; Plowright, 2012). Creswell and Plano Clark (2011) argue that mixed-methods research should be based on philosophical assumptions that can guide the collection and analysis of data to avoid the risk of the research becoming fragmented. The mixed methods approach of this thesis allows the qualitative data to dominate. This, referred to by Kettles,

Creswell, and Zhang (2011) as ‘embedded design’, allows one type of data to dominate over the other.

## RECRUITMENT AND CONTEXT

### Paper I

Fifty-seven nursing staff working in the short-term emergency ward volunteered to participate in the staff health promotion project. Thirty-eight of these received the health promotion intervention involving either tactile massage or hypnosis (table 2). Subsequently, 16 of the 38 participants who had received either tactile massage or hypnosis volunteered to share their experiences and perceptions in a focus-group discussion.

**Table 2.** Characteristics of the staff in study I

<b>Intervention</b>	<b>Age: median (range)</b>	<b>Sex</b>	<b>Profession</b>
Tactile massage n=19	36 (27-61)	18 female, 1 male	9 nurses, 10 assistant nurses
Hypnosis n=19	36 (27-55)	17 female, 2 male	11 nurses, 8 assistant nurses

### Paper II

Twenty-seven patients admitted to the short-term emergency ward were convenience-sampled and included in the study. Of these, two dropped out, so the total number of participants included was 25. Most of the patients in the present study were surgical patients, for whom the cause of admission is specified in table 3. The inclusion criteria consisted of being able to speak and understand the Swedish language, being cognitively intact and being 18 or older. Depending on the patients’ preferences, they were offered a choice between tactile massage and healing touch, as shown in table 4.

**Table 3.** Characteristics of the included patients in study II

<b>Number of patients</b>	25
<b>Sex</b>	Male 36% Female 64%
<b>Age (years): median (range)</b>	56 (22-90)
<b>Cause of admission (number of patients)</b>	Cholecystectomy (5) Ascites (1) Pyelonephritis (1) Back pain (3) Foot pain (1) Costa fracture (1) Cancer ileum (1) Urine bladder problem (1) Abdominal pain (5) Operation ileum (1) Pancreas cancer (1) General illness (1) Pancreatitis (1) Laparoscopy (1) Appendectomy (1)

**Table 4.** Sample in the intervention, Healing Touch (HT) Tactile Massage (TM) both HT/TM in study II

<b>Intervention</b>	<b>Sex</b>	<b>Age: median (range)</b>
HT n=6	5 female, 1 male	56 (33-80)
TM n=16	8 female, 8 male	48 (22-90)
HT/TM n=3	3 female	48 (34-54)

### **Paper III**

A total of 14 nurses working with tactile massage in short-term emergency wards of two hospitals in Sweden (one university hospital and one small hospital in a small city) participated in the study. The nurses were convenience-sampled and invited by e-mail to participate in the study, and all agreed to participate. All were female (33–62 years of age) and had been trained in tactile massage as described by Ardeby (2015). Five were certified touch therapists (level 3), while the remainder (n=9) were trained to level one. The tactile massage described by Ardeby consists of three levels. At level one, during a weekend course the participant learns how to practice tactile massage on the back, hands, and feet; certification (level 3) includes whole-body training and requires one week (total) of theory and practice, plus an additional 60 hours of documented practice.

### **Paper IV**

A total of 41 patients seeking acute care after sustaining a motor vehicle accident with no or minor injury participated in the study (table 5). All patients were invited to participate in the study by convenience sampling. The inclusion criteria consisted of being able to speak and understand the Swedish language, and be cognitively intact, age 18 years and above. Depending on the patients' preference, they were offered a choice between tactile massage or healing touch.

**Table 5.** Characteristics of the patients in study IV

<b>Patients, n (%)</b>	41 (100%)
<b>Women, n (%)</b>	29 (70%)
<b>Age: mean (sd); median (min-max)</b>	42 (14) years; 41 (19-69) years
<b>Caring touch interventions of; tactile massage healing touch</b>	41 (100%), of those 5 (10%) of those had also tried healing touch

## **DATA COLLECTION**

### **Paper I**

Nurses' focus-group discussions were performed to elicit nurses' views about receiving tactile massage or hypnosis as a health promotion intervention. After the tactile massage and hypnosis interventions were finished, the informants were invited to participate in focus-group discussions to share their experience and perceptions of

receiving treatments involving either tactile massage or hypnotherapy. Sixteen (28%) informants volunteered for four focus-group discussions conducted over an eight-month period from May 2005 to February 2006. An external moderator and an assistant who were not involved in the clinical treatments conducted the focus-group discussions, which were one hour in length. For the focus-group discussion in study **I**, a semi-structured interview guide that allowed for follow-up questions was used (appendix I).

## **Paper II**

In study **II**, individual interviews were conducted from January through May 2011 to elicit the patients' lived experience of receiving caring touch when suffering from acute illness or disease. The interviews with patients admitted to the short-term emergency ward were conducted at the time of discharge from the hospital or at the patient's home during the first week after discharge. The patients were asked to freely narrate their lived experience of receiving caring touch with the following open-ended request: 'Please tell me about the meaning in receiving caring touch during your stay at the short-term emergency ward'. Follow-up questions (for example, 'Is there anything else you would like to tell me about it?') were asked to obtain more information from the participants and to encourage them to use more detail. The interviews, which were digitally recorded, lasted between 30 and 80 minutes and were transcribed verbatim by three of the secretaries at the emergency department and by the first author. The first author compared the digitally-taped interviews with the transcribed versions of the interviews to validate the data.

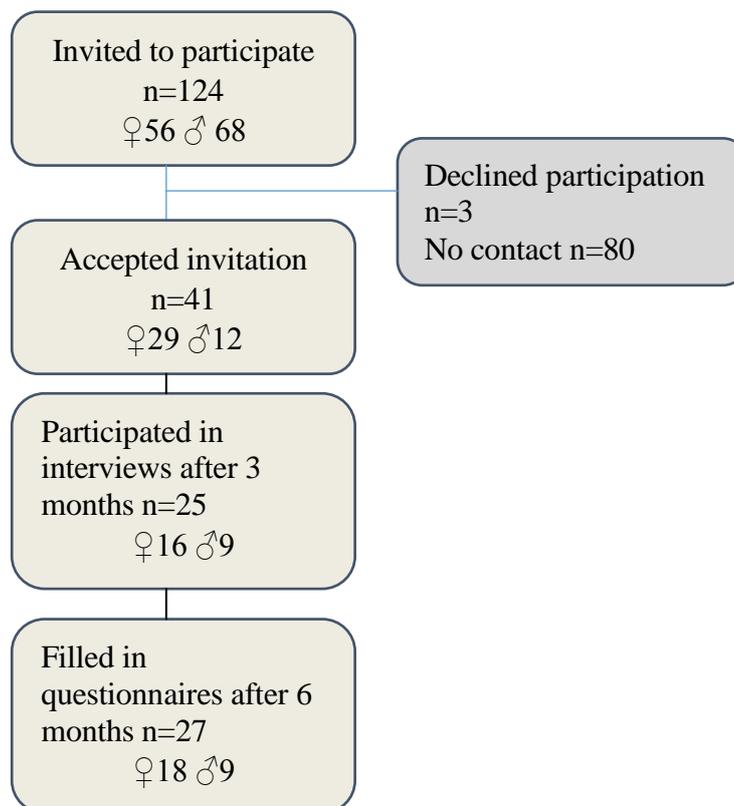
## **Paper III**

In study **III** individual interviews with the nurses were done at the two different hospitals in order to elicit their lived experience of giving tactile massage to patients suffering from acute illness. The nurses were interviewed in a room near their workplace. The interviews took place between January 2012 and October 2012. The nurses were asked to describe their experience of working with tactile massage as freely as possible, using the interview opener 'Please tell me about your experience in a situation when you gave tactile massage'. Follow-up questions like 'Could you explain further?' or 'Could you give me an example?' were asked to obtain more information. The interviews were digitally recorded, lasted approximately 20–60 minutes, and were transcribed verbatim by the first author. The first author then compared the digitally recorded interviews with the transcribed versions of the interviews to validate the data.

## **Paper IV**

Individual interviews with patients in study **IV** were conducted at the hospital about three months after the accident using an open-ended question "Please tell me what you experienced were when you had your motor vehicle accident" and then a following question "Please tell me what you experienced when you received the caring touch". During the interview follow-up questions like "could you explain further" or "could you give me an example" were asked. Interview data in this study were collected from January 2013 until March 2014. The interviews were digitally recorded, lasted approximately 20-60 minutes, and were transcribed verbatim by the first author.

The selection of questionnaires was discussed in the research group. The questionnaires were administrated at inclusion and at follow-up by mail after six months; data were collected from September 2012 until May 2014 (fig. 1).



**Figure 1.** Flowchart of patients included in the study through each stage

The primary outcome was current level of pain measured by VAS, ranging from 0 (no pain) to 100 (worst imaginable pain) (Scrimshaw & Maher, 2001). The visual analogue scale was used, as it was seen as a feasible instrument for the nurses to use to measure the pain before and after treatment. Additionally, the Impact of Event Scale (IES-R) has been well used in previous trauma research and was decided as being an appropriate tool to explore to what extent the patients experienced post-traumatic stress disease. IES-R, 22-item scale shows the degree to which the traumatic experience is felt on a consciousness level, and if the person exhibits avoidant behaviour. The IES-R is based on a 4-point frequency scales (i.e., 0=not at all, 1= a little bit, 2= moderately, 3=quite a bit, and 4=extremely). An average of the total scale sum of 1.8-2.0 indicates post-traumatic stress disorder. The IES-R seems to be a solid measure of post-traumatic phenomena that can augment related assessment approaches in clinical and research contexts (Beck et al., 2008; Weiss & Marmar, 1997). We were also interested in measuring health related aspects and the EQ-5D instrument was selected because of the short-form and that it has been widely used to measure quality of life among the County Councils of Sweden. EQ-5D is a standardized instrument for measuring health outcome. Respondents classify their health in terms of five dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Each dimension has three levels of severity: (1) no problems, (2) moderate problems, and (3) severe problems. From the sum a number of total 243 combinations of health can be created. Each health combination generates an index value from -0.59 to 1.0, where 1.0 indicates full health. Additionally, the EQ-5D has a visual analogue scale for self-rated

health with the anchors at zero (worst imaginable health) up to 100 (best imaginable health) (EuroQol, Group, 1990). The Sense of Coherence scale (SOC) was of interest since this instrument captures the patients' experiences of comprehensibility, manageability, and meaningfulness which we assumed could be linked to patient recovery. SOC, a 13-item rating scale, developed using the subscales of comprehensibility, manageability, and meaningfulness, was constructed by Antonovsky and formulated from a salutogenic model. Total scores of 21-59 indicate low sense of coherence, 60-74 an average sense of coherence, and 75-91 high sense of coherence (Antonovsky, 2005).

## **ANALYSIS**

### **Paper I**

#### **Manifest content analysis**

Manifest content analysis was used to analyse the data from the focus-group discussions. Content analysis is described as a research method that provides a systematic and objective means of making valid conclusions. According to Granheim and Lundman, content analysis deals with systematic descriptions (manifest) but over time has also come to include interpretations (latent) (Granheim & Lundman, 2004). The analysis is conducted in five repetitive stages: (1) reading of each interview transcription with the intention of understanding its general content, (2) dividing the text first into meaning units, then into condensed meaning units, which are then abstracted into codes, (3) comparing the codes based on their differences and similarities, and sorting them into sub-categories, (4) scrutinizing the sub-categories and comparing them until categories emerged, and (5) formulating an overall theme based on interpretations of the codes, sub-categories and categories.

To ensure the trustworthiness of the findings, all steps were validated by three researchers who first independently and then together scrutinized the data until consensus was reached.

### **Paper II and III**

#### **Phenomenological hermeneutical analysis**

The interviews in papers **II** and **III** were analysed using a phenomenological hermeneutic method based on Ricoeur's philosophy developed for nursing research by Lindseth and Norberg (2004). Three methodological steps were taken in the interpretation process. The first was a naïve understanding, in which the text was read several times to grasp the text as a whole. The second was a structural analysis, in which the text was divided into meaning units and the meaning units then condensed (without losing the essential meaning) into condensed meaning units. The condensed meaning units were then reflected upon and abstracted to create themes and subthemes. In the third step, the themes were compared to the naïve understanding to validate them. During the interpretation process, the principal researchers' pre-understanding was considered. The analysis moved back and forth between the steps in order to capture a deeper meaning in the comprehensive understanding.

## **Paper IV**

### **Phenomenological analysis**

In paper **IV** the interviews were analysed using systematic text condensation (STC) by Malterud (2012). With a phenomenological attitude, one looks at phenomena from the perspective of how they are experienced while bracketing one's presuppositions, allowing the essence of the phenomenon to emerge. The procedure consists of the following steps: 1) total impression – from chaos to themes; 2) identifying and sorting meaning units – from themes to codes; 3) condensation – from code to meaning; 4) synthesizing – from condensation to descriptions and concepts. STC, like Giorgi's method, implies an analytic reduction with shifts between de-contextualization and re-contextualization of data. First, we established an overview of the data by reading through all the interview transcripts to get an impression of the whole, while trying to 'bracket our presuppositions'. Second, we systematically reviewed the interviews line by line to clarify our research question. Third, we carried out a systematic abstraction of meaning units and sorted them into thematic code groups across individual participants. Fourth, we synthesized the data from the thematic code groups.

### **Statistical analysis**

Data from VAS pain ratings was manually transferred from paper into an electronic database before statistical analysis. Summary characteristics of patients were presented as proportions, mean, median, standard deviation and/or min-max values. Change scores of VAS pain ratings, SOC, IES-R and EQ-5D over time between baseline and follow-up after six months were analysed for patients with complete data. Considering rating scales and ordinal types of data, and the relatively small sample sizes, non-parametric statistical analysis, i.e. the Wilcoxon signed-rank test, was employed for assessing change scores over time. All p-value calculations were conducted with a 5% significance level. An additional descriptive analysis was conducted for VAS pain ratings before and after each treatment session with caring touch. Computational software included STATA 13, StataCorp, USA and Microsoft Excel 2011, Microsoft, USA.

## **ETHICAL CONSIDERATIONS**

The research project was approved by the regional ethics committee at Karolinska Institutet (Ref. No. 2005/831-31; Ref. No. 2010/514-31). Patients received oral and written information about the research project and were informed about the nature and purpose of the research and the intended use of the data. They were assured that they could withdraw from the research project at any time and that it would not affect their care. Written consent was obtained from all participants. Some ethical issues needed to be considered; for example, patients suffering from an acute illness or trauma are vulnerable and the caring staffs need to be extra careful when offering caring touch. Since the patients in this project could have been in a time of crisis a social worker was available to provide support if needed.

Touch can also be very private and intimate, and for this reason the patients could choose between tactile massage, which requires direct contact with the patient's skin using vegetable oil, or healing touch, which can be performed without direct contact with the patient's skin. In this way, patients who were ambivalent about having their skin touched directly could choose the fully-clothed option.

## **FINDINGS**

The findings of the studies will be presented in two steps, the first being a brief presentation of each study, and the second, a synthesized understanding of the whole. More detailed and specific presentations of findings can be found in the separate papers (I-IV).

### **PAPER I**

The findings indicate that tactile massage helps some nurses working in a short-term emergency ward to cope with a very stressful work environment. This study confirms earlier research suggesting that nurses experience high levels of work-related stress. Tactile massage may therefore be a useful complement to other health promotion activities. The following categories were found: *feeling relaxed and having more energy and work ability; dealing with workload; reliving physical and psychological pain; being treated and knowing oneself*. The findings illustrate how tactile massage affected the nurses' general sense of wellbeing and their ability to relax and allow oneself to be taken care of. Tactile massage affected their lives both at work and at home in a highly positive manner. At work, their sense of wellbeing gave them the ability to support their colleagues and cope with stressful situations. Tactile massage interventions were appreciated by most of the nurses as they gave them the ability to cope with the high-dependency nursing care environment.

### **PAPER II**

The grasp of the phenomenon is *existential togetherness*, an in-depth encounter between the patient and the caregiver and following these appeared: *experiencing an encounter, transcendence through hands; a nourishing touch; the complexity of intimacy*. This encounter appears to take place in a dimension of nonverbal communication involving a feeling of togetherness between the two individuals. An impression of unconditional compassion running through the hands of the therapist onto the patient gave a sense of existential togetherness. During acute illness, caring touch gave consolidation and a feeling of being in the body: one knew where one's body started and ended, and landed in a feeling of consolidation and trust. In that moment, caring touch may restore the patient's feeling of being a human being as it may keep the body, soul, and spirit together in wholeness. The existential togetherness engendered by touch could be associated with an underlying complexity and ambivalence to touch relating to the fine line between intimacy, sensuality, and sexuality. Some of the male participants described feeling guilt, shame, and an ambivalence toward intimacy after receiving caring touch. Despite the complexity of the intimacy experienced by the male patients, the feeling of compassion expressed in the deep encounter was still there.

### **PAPER III**

Nurses operate in a multifaceted and paradoxical environment in which the medical details can have an impact on patients' experiences of care. In an emergency ward, decisive life-changing moments frequently occur, right in front of caregivers' eyes. Three themes arose from the narratives: *touch as a tool in caring acts; being mindful in*

*touch*; and *becoming changed by touch*. The grasp of the phenomena in the comprehensive understanding is *an aware presence in connection with the patient* which leads to an experience of the core of caring. When providing touch through tactile massage to patients in short-term emergency wards, nurses were given an opportunity to act in a caring manner. Tactile massage implied time with the patient, becoming a tool for doing something with just one’s hands to alleviate a patient’s suffering – an opportunity to approach patients in a new way. Providing this little extra bit of care created a great sense of wellbeing and relaxation – for the patient and the nurse as well. For nurses, being able to be together with and to connect with the patient to ease his or her suffering may have created a deeper understanding of how to touch a patient.

#### PAPER IV

The results in this study imply that experiencing a motor vehicle accident resulting in no or minor physical injury has a great impact on the patient’s distress and pain. Four themes emerged from the qualitative data – *turning off the body*; *becoming aware of the body*; *suffering* and the *caring touch as a bodily anchor*. Many of the patients continued to suffer from pain three months after the accident and found it difficult to be physically active. The pain disturbed their sleep and they felt physically weak and had trouble concentrating. Caring touch seemed to produce a feeling of wholeness, enabling patients to feel where their body started and where it ended. It appears that caring touch could make the patients aware of their physical boundaries. For some patients, pain was experienced as totally disappeared during the caring touch treatments and for some hours thereafter. Some of the patients were even able to decrease their intake of painkillers. The findings indicate that caring touch may be a bodily anchor, integrating body and soul as a way to recover from trauma that benefits clinical impact on motor vehicle accident patients’ VAS pain ratings. These ratings were significantly decreased, both in conjunction with treatment sessions involving caring touch and at follow-up six months after the accident.

There were 27 patients that had complete VAS-pain ratings at follow-up after six months. At follow-up after six months, there were both clinically and statistically significant differences over time (Table 6).

**Table 6.** Pain ratings in study IV

	Baseline		Follow-up		Diff	
	Mean (SD)	N	Mean (SD)	N	Mean (SD)	<i>p</i>
VAS	54.8 (24.1)	27	22.0 (22.2)	27	-32.9 (32.3)	<0.001

VAS. Visual analogue scale, ranking from 0 (no pain) to 100 (worst pain).

SD. Standard deviation. Testing by Wilcoxon signed-rank test

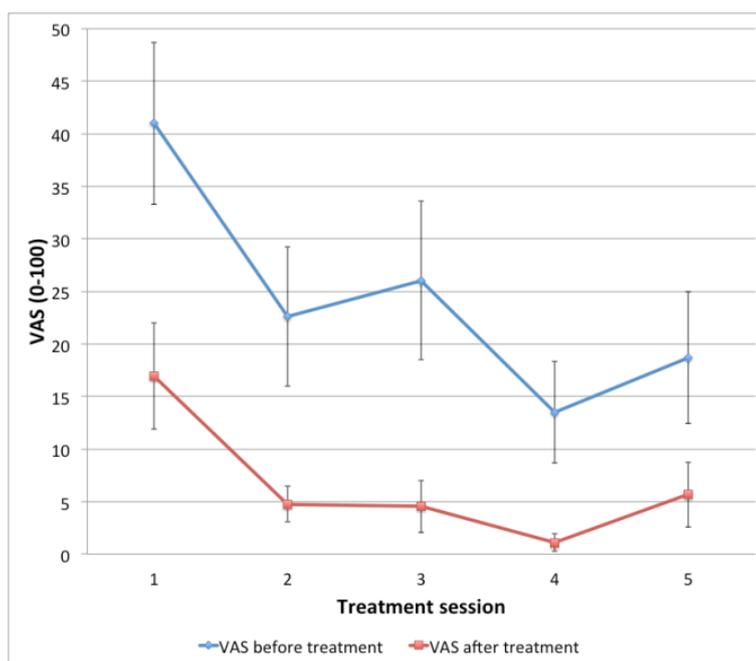
Furthermore, there were significant changes in EQ-5D index and IES-R over time. There were no differences over time in SOC or in EQ-5D VAS. Sensitivity analysis by applying parametric testing procedures did not change this general trend (Table 7).

**Table 7.** Secondary outcomes study (IV)

	Baseline		Follow-up		Diff	
	Mean (SD)	N	Mean (SD)	N	Mean (SD)	<i>p</i>
<b>IES-R</b>	1.3 (0.9)	23	0.6 (0.7)	23	-0.6 (0.8)	0.002
<b>SOC</b>	59.3 (6.7)	26	56.5 (7.3)	26	-2.8 (7.3)	0.121
<b>EQ-5D index</b>	0.66 (0.21)	26	0.77 (0.19)	26	0.12 (0.15)	<0.001
<b>EQ-5D VAS</b>	65.6 (24.4)	26	73.0 (23.1)	26	7.4 (24.7)	0.092

IES-R; Impact of event scale; SOC; Sense of Coherence; EQ-5D index (health status 0-1); EQ-5D VAS (self-rated health 0-100). SD, Standard deviation. Testing by Wilcoxon signed-rank test

The patients additionally rated their pain on VAS before and after each treatment session with caring touch. Approximately half (n=18/41; 44%) of the patients received at least 5 (range 1 to 8) treatments with caring touch. This corresponds to a majority (n=18/27; 65%) of patients completing the study at follow-up after six months. A chart describing the changing pain trajectories for these patients is depicted in figure 2.



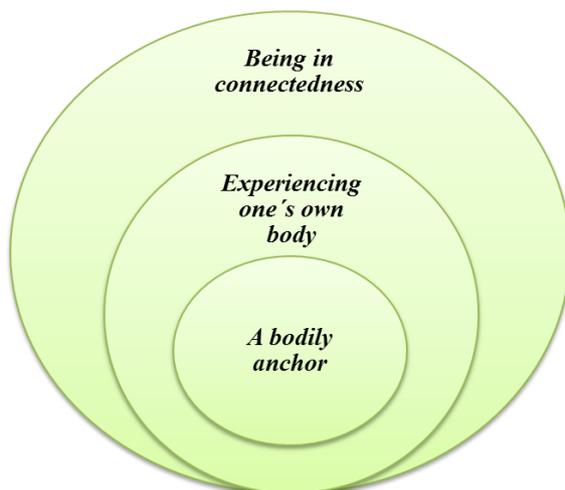
**Figure 2.** Description of pain ratings on the visual analogue scale (VAS, ranging from 0 no pain, to 100 worst pain) before and after each treatment session with caring touch. Average (+/- standard error of the mean) values for patients that had received at least 5 treatment sessions

## SYNTHESIS OF FINDINGS

A synthesized understanding of the findings elucidates the lived body's needs. Caring touch seems to respond to the individual's specific needs of being bodily anchored or in a connectedness between the nurse and the participant. In this thesis the participants can

be categorized as: healthy or relatively healthy nurses, patients suffering from illness, or as trauma patients. Synthesizing the findings therefore reveals quite different needs. It seems that the trauma patient needs to be anchored in her/his body and feel secure; for the patient suffering from illness, a sense of trust, security and comfort is an important need to address. To the ‘healthy’ – that is, nurses receiving caring touch as a health promotion intervention – relaxation and wellbeing are in focus.

Caring touch dimensions to address needs include: *a bodily anchor, experiencing one’s own body, being in connectedness* (fig. 3). The experience of receiving caring touch differs for people who are healthy, those experiencing illness (II) or survivors of trauma (IV). There is also a need to ‘keep together’ body and soul, knowing the bodily boundaries when suffering from a trauma (IV). Patients admitted to the short-term emergency ward and nurses receiving caring touch are more likely to experience a movement between the dimensions of the experience of the body and the state of being in connectedness (II).



**Figure 3.** The three dimensions of caring touch

### **A bodily anchor**

When suffering a trauma, caring touch was shown to help the patient to feel safe in his/her body and to create an awareness of one’s bodily boundary. Caring touch allows the patient to rest in trust, comfort, and to feel valuable and important. Trusting the nurse giving the caring touch was of significance for the patient’s feeling of safety. A motor vehicle accident is an immediately life-threatening event and the bodily responses to the trauma may cause dissociation in which a need to be ‘grounded’ in the body appears. Patients express their need to be embraced, and to feel safe. Caring touch may help the patients feel safe in his/her body, and the touching becomes a bodily anchor.

### **Experiencing one’s own body**

The moments of caring touch create a feeling of integration of body and soul, in which a sense of wholeness exists. There seems to be a difference in how the body is experienced between illness and trauma. When a patient is admitted to hospital due to illness a caring touch may provide a sense of security and trust, a comforting touch

allowing the patient to rest in body and mind, enjoy feelings wellbeing and nurturing, and to let go of stress, anxiety, and pain. Some of the motor vehicle accident patients reported that when the acute condition had been taken care of, the patient became of less value – a non-important person – and how this created stress, frustration, and a sense of loneliness and being abandoned. In the trauma room they had experienced the full attention of professional staff, but later, nobody seemed to care and it was difficult to get their complaints heard. Much of the patients' suffering continued after they were discharged from hospital, as they struggled with pain, sleep disturbance, and frustration.

### **Being in connectedness**

Caring touch may lead to self-awareness, by the nurses reflecting on the feelings that arise during treatment – both those transferred from the patient and one's own. Caring touch may have the potential to produce an existential togetherness – an encounter beyond bodily borders, in a non-verbal place. Through the nurse's compassion and desire to benefit another human being, love flows through the hands of the nurse. This moment was experienced by the patients and nurses as healing as it gave them greater energy, wellbeing and a sense of being valued. It was not just the nurses giving caring touch that changed and became more self-aware and reflecting; even those who had received a caring touch changed, experiencing personal growth. The nurses receiving caring touch achieved more patience with patients and colleagues and a greater ability to reflect over themselves and the caring act. Patients also described this personal growth as an awareness of oneself – an increased ability to reject others' demands and to reflect over what is valuable in life; they described their having achieved new insight into their own reactions, feelings and thoughts.

Using caring touch interventions gives nurses a tool by which to alleviate pain and suffering. In the beginning there is a focus on 'doing' – concentrating on the body and one's own movements. When giving caring touch, they noted a need to be centred and continuously focused on the patient. Spending some time alone focusing their energy was seen as important, as was establishing, in advance, the intention to 'do the best, from your heart to another's'. In this way, the nurse achieves a sense of connectedness to the patients, which may set the stage for a caring encounter. Becoming a compassionate nurse involves personal growth: reflecting on different aspects of one's own actions and reactions in the caring act, and daring to be close and to touch the patient's body and emotions. This was not easy at first: when the nurses began giving caring touch to patients, there was a sense of insecurity and fear of doing something wrong. At first, the nurses focused exclusively on the physical body and had difficulty noticing the patient's state of mind, their mood. Eventually, the nurses felt more secure and trusted themselves during the caring touch – they could maintain an empathic presence with the patient, and establish an attitude of compassion, of beneficence, before commencing the caring touch treatment. In time, they started to reflect over what was happening during the act, and different feelings appeared. For some of the nurses, this was quite overwhelming.

# DISCUSSION

## REFLECTIONS ON FINDINGS

The overall aim of this thesis was to understand the experiences of caring touch in an emergency context – for nurses, the meaning of receiving/giving caring touch, and for patients, the meaning of receiving it. Additionally, in study **IV** the aim was also to find out if there were any quantitative differences in outcomes of pain (VAS), post-traumatic stress (IES-R), health (EQ-5D, index and VAS) or sense of coherence (SOC).

Emergency department patients may not feel confirmed in their suffering and they may feel objectified since their acute medical condition is the priority (Frank et al, 2009). This was in line with the finding in this thesis were the patients felt abandoned and their needs not cared for. There is a need for a more holistic caring in the emergency department; the lack of patients' experience of existential support has been illuminated in this thesis, and in previous studies (Arman & Rehnsfeldt, 2012; Elmqvist, 2011; Frank et al., 2009; Franzén et al., 2006).

Caring touch has the potential to let patients experience a moment in which they feel a secure sense of connectedness with the nurse, a moment of calm and security. This is in line with recommendations by the European Network for Traumatic Stress (TENTS), to the effect that supporting people after trauma should include: 1) strengthening their sense of security; 2) strengthening their confidence; 3) strengthening their sense of fellowship; 4) creating tranquillity; and 5) increasing their the sense of hope (Michel et al., 2010).

While synthesizing of the data from studies **I**, **II** and **IV**, a pattern of human needs arose. From a theoretical point of view, it felt natural to relate the lifeworld, having been inspired by Merleau-Ponty's (2006) lifeworld, to Maslow's behavioural theory of needs. Maslow's hierarchy of needs may be interpreted as addressing the three dimensions of caring touch. The three dimensions of caring touch correlate to some of Maslow's needs, which range from the basic to the abstract and transcendent, as follows: 1) basic physiological needs; 2) the need for safety; 3) the need for love – to belong to someone; 4) the need for knowledge and understanding – to know ourselves and to understand our world; and 5) the need for transcendence – to become an integrated and valued part of the world (Maslow, 2013; Ventegodt, Merrick & Andersen, 2003). While we may view touch as a human need, we still need to be aware of the complexity of touch, and of the fine line separating it from intimacy, sensuality, and sexuality (**II**). This complexity can be discerned, not only in patients receiving caring touch, but also in staff giving touch (Cronfalk, 2008). When caring touch is adjusted to the patients' needs it may have the ability to establish or strengthen a caring encounter (**II**, **IV**).

### **A bodily anchor**

The body connects us to the world (Bengtsson, 2005) it becomes our anchorage in this world. This anchorage becomes lost during illness or trauma (**II**, **IV**), as the body is then 'switched off', possibly as a natural reflex to protect the individual (Levine, 1997).

In a lifeworld perspective, we are our body and we experience ourselves, the world, and others through our lived subjective body; we enter the world as a subjective being (Merleau-Ponty, 2006). The body becomes an object in the world – something alien, something unfamiliar to the patients who have experienced a motor vehicle accident with bruises, pain and stiffness invading the body (IV). When admitted to hospital, the patients felt that some nursing staff objectified the patient's body, ignoring the patient's existential needs, which created a form of suffering (II, IV).

### **Experiencing one's own body**

This intertwined body – 'the lived body' and soul – is seen as a single entity rather than two parts. This entity has been characterized by Merleau-Ponty as human beings' continuing interacting with the world and could be described as a lived relationship to the world. It is through this relationship that human experience is perceived (Bengtsson, 2005; Merleau-Ponty, 2006). Touch is of great importance to human beings. It is profoundly life-giving, helping to nurture and restore the health of the individual (Montagu, 1986). This nurturing aspect in particular was referred to by the patients in study (II). Caring touch makes it possible to become aware of the body; normally the body is just 'there', requiring no deeper consideration. Merleau-Ponty's (2006) ideas of the lived body describe the sense we all have of being body and soul in every moment without reflection. The subjective body is simply 'there' for us and we can never free ourselves from this embodiment.

To be human is to suffer and it is a natural part of life, as well as alleviating suffering is a natural part in oneself or in community with others (Arman, 2012). In studies II and IV patients described their suffering from their needs not being addressed, as they felt alone, abandoned, or frightened. In this thesis, the suffering alleviated refers to both physical and existential suffering; bodily pain decreased or even disappeared during caring touch and continued to be decreased over time (I, II, and IV).

Pain is a multi-dimensional experience in which different factors play an essential role. Four dimensions of pain are presented: physical, psychological, social, and existential. Pain is more than just noxious stimuli mediated via receptors, and existential pain causes intense suffering (Brattberg, 1999; Strang, 2003). In alleviating pain, caring touch may be a useful tool that can decrease a patient's intake of painkillers and anxiolytics during the period of treatment (Brattberg, 1999; Ozolins, 2011). In study IV, the patients reported that they continued to suffer from avoidance and intrusion in traffic three months after the accident, sometimes with severe physical symptoms such as pain, increased heart rate, nausea or sweating. Clapp, Gayle Beck, Palyo and Grants' (2008) findings indicate that the synergistic relationship of pain and PTSD may vary across domains of quality of life. There were more female than male patients in their study, as in our study IV. Earlier research suggests that women are at greater risk of developing chronic pain and PTSD than men (Clapp et al., 2008).

### **Being in connectedness**

To Merleau-Ponty, it is through the communicative and interactive encounter that we gain access to other human beings and things in the world. This means that the world is social (Bengtsson, 2005). This access to an experienced space during tactile massage

was described in a study by Henricson (2008), where the space was expressed as an imagined room where the encounter between the patient and nurse took place. Ozolins (2011) describes the room as a room for the ‘naked self’ which neither censors nor is censored. A naked self, needing to feel safe, is something which patients in the current studies narrated as being in a place of trust and security during the caring touch (II, IV).

During caring touch (III) the nurse come close to the patient. In the beginning it is just a matter of taking care of the patient’s body, trying to create a comfortable moment. Over time the encounter required that the nurse starts to ‘tune in’ to the patients’ reactions and emotions (III). This striving to ‘tune in’ to the patient may be seen as a striving for existential care, according to Arman et al. (2013), allowing closeness to emerge in the relationship. To ‘tune in’, one needs to ‘open up’, to let the body’s boundaries fade and connect to the patient in awareness. These moments of connectedness created a spiritual feeling of belonging to something ‘bigger’ in life, a sense that not everything in life can be explained, a sense of energy flow (III). This energy flow was experienced by the patients receiving caring touch during their stay at the short-term emergency ward (II). Nurses receiving caring touch also described this energy flow (I). According to a concept analysis by Phillips-Salimi, Haase and Carter Kooken (2011), connectedness is a concept that in the context of patient–provider relationships has the potential to improve patient health outcomes. Connectedness can be broadly defined as the extent to which a person perceives that he/she has a meaningful relationship with another person or an aspect of the inner self.

Caring touch becomes a tool by which to deepen the caring act. Using one’s hands to alleviate suffering gives the nurse a tool by which to create healing in a high-tech environment in a more ‘natural’ way. Nurses experienced themselves as valuable, professional, and caring, and were proud of their work. To have the opportunity to create a caring act, with love and an intention of doing good, gave them a sense of work satisfaction (III). This is in line with previous studies that describe an increased satisfaction resulting from using touch as a tool. When using caring touch as a tool, the nurses may become changed, developing a new capacity for self-reflection and a new awareness. The importance of knowing *how* to touch emerged and the nurse changed from ‘doing’ to ‘being with’ (Edvardsson, Sandman & Rasmussen, 2003; Eschiti, 2007; Henricson, Berglund, Määttä & Segesten, 2006; Swengros, Friesen & Anderson, 2014). Halldorsdottir (2008) offers a synthesized theory of the dynamics of a nurse–patient relationship, introduced from the patient’s perspective. It is described as a lived reality with a sense of spiritual connection involving a bond of energy. This connection is the *life-giving* nurse–patient relationship. From my point of view, one could say that working with caring touch is a journey towards oneself. The difference between the training levels of nurses, with the less trained nurses being more focused on the patient’s physical body and the more experienced nurses describing this connectedness. Halldorsdottir describes, from a patient’s perspective, how presence makes the caregiver more attentive to the patient and increases the ability to listen and respond. Caring touch can thus be seen as a way to use the nurse’s experience to develop a ‘compassionate competence’ that can form the core of good professional nursing (Halldorsdottir, 2012). When working with caring touch one needs to be aware of one’s own feelings and reactions to emotions that arise (Andersson et al., 2007). My findings

**(III)** indicate that working with caring touch over time may give nurses the skills and professional wisdom to work from a position of compassion, knowing oneself and being comfortable with one-self as well as with others.

## **Questionnaires**

There was a significant reduction in pain pre-/post-treatment and over time (**IV**). Suffering due to pain was of great concern to some of the patients: there may be no physical evidence of damage (**IV**), but the pain is still there. Addressing the pain-related emotions seems to benefit patients' recovery (Carroll, Liu, Holm, Cassidy & Coté, 2011). For the impact of event scale there was a significant reduction of post-traumatic stress over time despite that patients' reported experiences of intrusion and avoidance in their narratives three month after the accident. For the EQ-5D index, there were significant positive changes over time that indicate recovery; still, some patients' narrated increased difficulties in mobility and anxiety. There were no significant changes over time in the EQ-5D health index (VAS 0-100). Further, the quantitative findings indicate that sense of coherence was lower with follow-up (non-significant). Sense of Coherence is understood as set of personal beliefs that facilitates a struggle with traumatic stressors and achieves stability around the age of 30 (Antonovsky, 2005). Since many of the patients in study **IV** were below that age one could discuss if the findings of low scores would continue, or if the scores would increase over time.

## **METHODOLOGICAL CONSIDERATIONS**

### **Interviews**

In study **I**, a manifest content analysis by Granheim and Lundman (2004) was used, due to the fact that the author of this thesis was also the person who performed the tactile massage, and in order to analyse the anonymous transcribed data while staying close to the text without further interpretation. As the aim of study **I** was to capture the experience, an interpretation of data could possibly have had a richer outcome. It is also debatable whether an individual interview, instead of focus group discussions, might have been a better methodological strategy to facilitate higher informant participation and to gain a deeper understanding.

As the overall aim was to gain a deeper understanding of the meaning of caring touch in an emergency context, a phenomenological hermeneutical analysis was used in studies **(II–III)** and a phenomenological analysis in study **IV**. The choice of analysis made it possible to use pre-understanding as well as deliberate from it when the interpretation of the text goes beyond the already known and obvious, to present a deeper understanding of the phenomenon (Dahlberg, Dahlberg & Nyström, 2008; Lindseth & Norberg, 2004). In lifeworld research, it is important for the researcher to be aware of how pre-understanding affects the process and keep a critical eye on oneself during the process. According to Dahlberg, Dahlberg and Nyström (2008), 'bridling' is a way to take care of one's pre-understanding, meaning an effort to not presume to understanding the phenomena too quickly, too carelessly or too slowly.

The patients in study **IV** were conveniently invited to participate. This resulted in an unbalanced group in terms of gender which limits the generalizability of the findings.

However, the trend of predominant female participation has also been seen in a previous study of motor vehicle accidents (Ottosson, Nyrén, Johansson & Ponzer, 2005). Women are also more likely to use complementary therapies than men (Eklöf & Tegern, 2001; Hanssen et al., 2005).

### **Trustworthiness of the current studies**

The concepts of credibility, dependability, conformability and transferability are important when discussing trustworthiness in qualitative studies, whereas the concepts of internal, external and construct validity are important when discussing trustworthiness in quantitative studies.

### **Credibility**

Credibility addresses the focus of the research, its context, the participants and the approach used for gathering data (Lincoln & Guba, 1985). When using a phenomenological approach, it was highly important to identify preconceptions and be self-aware and reflective, as I was familiar with the touch techniques and had been working with tactile massage and healing touch (Dahlberg, Dahlberg & Nyström, 2008). The credibility of the results of this study could have been affected by the fact that the participants who joined the study in order to receive caring touch were probably already receptive to touch. This could imply a bias, as the participants were already motivated when they had the first caring touch session.

### **Confirmability and dependability**

According to Lincoln and Guba (1985), interaction between the participants and the researcher is both an advantage and a disadvantage and avoiding it may be impossible. As a nurse working in the short-term emergency ward and also being a colleague of some of the participants in the first study, I had to reflect on this interaction and the pre-understanding it entailed. As I was trained in both tactile massage and healing touch, I was familiar with both the environment and the techniques described in this thesis. Before I started my journey with this thesis, I recorded everything I knew about tactile massage and healing touch, and being a nurse in a short-term emergency ward in a diary, while endeavouring to keep my preconceptions bridled, and I continued my journaling throughout my the doctoral education.

Dependability is described as the degree of reliability and stability of the collecting data and is also of importance in terms of any changes in the context during the research process (Lincoln & Guba, 1985). The data included in this thesis (**I**) were collected from two doctoral students. In study **I** focus groups discussions and transcribing were done by another doctoral student (SA). In studies **II, III and IV** the same person (author of this thesis) conducted all of the interviews and collected all quantitative data. Thus the interview questions asked were presented in the same way, this can be seen as strength, but also as a limitation since the researcher was familiar with the context and techniques.

### **Transferability/extern validity**

The generalization of the qualitative findings needs to be critically scrutinized and the context carefully described. The appropriateness of transferring qualitative data to other

contexts has to be judged by the reader, and the research process needs to be well described and detailed. External validity refers to whether the results can be generalized outside the study population (Malterud, 2012). The context in which the study took place was an emergency care context. This is quite a special environment; nevertheless, touch is a human need independent of age and gender, and the results of this thesis could be transferable to other contexts.

### **Construct validity**

Construct validity concerns the question of what the instrument really measures (Polit & Beck, 2004). With regards to the outcomes measure, all of the questionnaires used in the study are widely used and their validity in various contexts has been assessed (Beck et al., 2008; Frommberger et al., 1999; Polinder et al., 2007)

### **Internal validity**

Internal validity refers to whether the study accurately measures what it purports to measure (Malterud, 2012). During the interviews in this thesis (**II, III, IV**), one way to strengthen the findings obtained was to use dialogical validation – that is, to use the questions ‘Did I understand you correctly when you said [...]?’ During the analysis of the qualitative data, two of the authors individually analysed the data and then scrutinized it, to reach consensus.

## **CONCLUSIONS**

The findings in this thesis draw the attention to the potential of caring touch interventions in an emergency context. Caring touch interventions may help to support nurses working in a short-term emergency ward to deal with a very stressful environment and be a useful complement to other health promotion activities. Introducing caring touch interventions of tactile massage and healing touch in a short-term emergency ward was shown to restore patient's integrity, wellbeing, and sense of security. Caring touch interventions provide trust and consolation for the patient during the encounter with the nurse, creating a feeling of existential togetherness. The caring touch interventions give nurses a tool to increase their patients' and their own wellbeing in a stressful environment. Patients sustaining a motor vehicle accident with minor or no physical injury highly appreciated the invitation to a caring touch (as in this thesis) as a follow-up to the hospital after discharge. Still, the gendered ambivalence and complexity of intimacy, sensuality and sexuality when receiving tactile massage need to be further investigated.

## **IMPLICATIONS FOR PRACTICE**

In clinical practice, it is important to find tools to relieve stress, anxiety and pain in patients. Integrating bodily touch such as massage and healing touch in regular nursing may create a holistic environment for both patients and nurses. In today's world of high-tech healthcare, with overcrowded units and a shortage of nurses, providing caring touch could give nurses an opportunity to perform a high quality caring act.

Trauma patients may need a contact after their discharge from the hospital as they may have many questions and different needs. Offering caring touch may provide a natural contact between the patient and the hospital and may benefit patients' recovery.

## SVENSK SAMMANFATTNING

Inom omvårdnad är det väl känt att det mellanmännsliga mötet har stor betydelse för patientens välbefinnande. Att bli akut sjuk eller råka ut för en olycka skapar existentiella frågor för den enskilde; *Kommer jag att överleva? Får jag några men? Vad händer med min familj?* För den som arbetar som undersköterska eller sjuksköterska så har de senaste årens ökade patientflöde inneburit en ökad arbetsbörda, till detta kommer även den teknologiska utvecklingen med mer avancerad övervakningsteknik. Att möta den akut sjuka eller traumatiserade patienten ställer stora krav på även ett existentiellt omhändertagande där den enskildes behov kan bemötas (Elmqvist, 2011).

Det övergripande syftet med denna avhandling har varit att studera den vårdande beröringens betydelse i form av taktil massage och helhetsberöring inom akutsjukvård. Den teoretiska och filosofiska grunden har baserats på ett livsvärldsperspektiv så som den levda kroppen beskrivs av Merleau-Ponty (2006) och tar ett avstamp i vårdvetenskapen.

Delstudie I syftade till att undersöka omvårdnadspersonalens upplevelse av att få vara del i ett hälso-befrämjande personalprojekt där hypnos eller taktilmassage erbjöds under arbetstid. Totalt deltog 57 sjuksköterskor och undersköterskor vid en akutvårdsavdelning i studien, av dessa erhöll 38 hypnos eller taktilmassage vid sammanlagt åtta tillfällen. Fokusgruppsdiskussion genomfördes med totalt 16 deltagare fördelat på fyra tillfällen. Data analyserades med manifest innehållsanalys av Granheim och Lundman (2004). Resultatet visar på minskad stress och smärta, samt en ökad arbetskapacitet för en del av informanterna. Ökat välbefinnande, medvetenhet om det egna jaget, och ökad egenkontroll beskrevs. En ökad medvetenhet och självreflektion gav ett förändrat beteende mot kollegor och patienter, där informanten uppgav att tålmodet och förståelsen för den andre har ökat. Det fanns mer kraft att orka med arbetet och även en ökad social samvaro efter arbetstid.

I delstudie II belystes meningen att som patient få taktil massage eller helhetsberöring under vårdtiden på en akutvårdsavdelning. Totalt deltog 25 patienter (16 kvinnor och 9 män) som intervjuades individuellt i samband med utskrivning eller under första veckan i hemmet. En öppen fråga om upplevelsen ställdes. Data analyserades med en fenomenologisk-hermeneutisk metod. Resultatet visar på fenomenet ”*existentiell samhörighet*” där informanten upplevde ett icke-verbalt möte som ingav lugn, trygghet, tröst, värdighet och välbefinnande, där informanten blev en ”människa”. Men även upplevelser av mer komplex karaktär kring intimitet, sensualitet och sexualitet antydde främst från de manliga informanterna.

Delstudie III belyste omvårdnadspersonalens upplevelse av att ge patienter taktil massage på en akutvårdsavdelning. Totalt deltog 14 undersköterskor och sjuksköterskor vid två sjukhus i Sverige. Data samlades in genom enskilda intervjuer med öppen fråga om upplevelsen av att ge taktil massage. Transkriberade data analyserades med en fenomenologisk-hermeneutisk metod. Resultaten visar på att taktil massage kan vara ett redskap för att lindra patientens lidande, det upplevdes som en

stor föremån att kunna erbjuda någonting naturligt till läkandet, än att endast ge mediciner. Taktil massage skapade även välbefinnande hos den som gav behandlingen. Det ansågs viktigt att kunna få en stund i avskildhet för att "centrera" sig, och gå in i känslan av att vilja ge från hjärtat med kärlek till sin nästa. En känsla av att vara medvetet närvarande skapades. En ökad medvetenhet om beröring i omvårdnaden beskrevs, med vikten av att förstå *hur* man berör. Den ökade medvetenheten skapade även självreflexion, upplevelsen av olika känslor som kom under behandlingen analyserades efteråt, och några av informanterna ägnade sig åt att skriva dagbok efter sina behandlingar för att öka medvetenheten om sina egna samt patientens reaktioner.

Delstudie IV beskriver den levda upplevelsen och meningen av att få taktil massage eller helhetsberöring efter att ha genomgått en trafikolycka med ingen eller lätt fysisk skada. Totalt deltog 41 patienter som inkommit akut efter en trafikolycka och som skrevs hem direkt efter undersökning. Patienterna inbjöds via post till studien, och de erbjöds taktil massage eller helhetsberöring upp till åtta gånger. Data inhämtades genom individuella intervjuer efter tre månader, samt enkäter vid inklusion och efter sex månader. Följande enkäter användes *primär*; visuell analog skala (VAS) för att mäta smärta, *sekundära*; Impact of Event Scale (IES-R) för att mäta förekomsten av post traumatisk stress, Känsla av Sammanhang (Kasam) samt EQ-5D (index samt VAS) för att mäta hälsa. Patienterna skattade sin smärta med VAS innan och efter den vårdande beröringen. Intervjuerna analyserades med en fenomenologisk metod av Malterud (2012) "strukturerad text kondensering" och resultaten visar på att vid ett trauma stängs kroppen "av", hur patienten inte känner av sin kropp och känner ingen smärta. Efter en tid, ofta när man kommit hem eller kommit in till sjukhuset sätts kroppen "på", smärta, domningar och stelhet förekommer, en rädsla för att ha blivit allvarligt skadad eller få men för livet infinner sig. Den vårdande beröringen beskriver ett uppvaknande av kroppen, upplevelsen att "ta plats", och få sin själ och kropp till en helhet beskrivs. Den vårdande beröringen minskar smärtan, eller för några låter smärtan försvinna helt under behandlingen. Omvårdnadspersonal som gav den vårdande beröringen upplevdes förmedla trygghet och kärlek. Resultaten av enkäterna visar en signifikant reduktion av smärta efter den vårdande beröringen efter varje behandlingstillfälle, men även över tid. Sekundära enkäter IES-R, EQ-5D index visar signifikanta positiva skillnader över tid, medan Kasam och EQ-5D VAS visar inga signifikanta skillnader.

Sammantaget visar de olika delstudierna att vårdande beröring, dvs. interventioner med taktil massage och helhetsberöring möter den enskilda individens olika behov. För friska, eller relativt frisk omvårdnadspersonal så ger interventionen möjligheter till vila och reflexion, till ett icke verbalt möte av samhörighet. För patienter som vårdas på en akutvårdsavdelning så ger den vårdande beröringen tröst, trygghet och en känsla av att bli bekräftad och närd. Att få uppleva sin kropp genom beröringssinnet. För trauma patienter innebär den vårdande beröringen minskad smärta över tid, trygghet, att kropp och själ integreras och kroppens gränser åter blir tydliga. Sammantaget framstår tydligt tre dimensioner som svarar an mot den enskilde individens behov: *att vara förankrad i kroppen, att uppleva kroppen, samt att vara i en existentiell samhörighet.*

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# APPENDIX 1

Interview guide:

- Relate your experience/perceptions from the health promotion project?
- What importance did the treatments have for you personally?
- Bearing in mind the working environment at the short term emergency department, what kind of health activities do you think should be provided?
- Should complementary treatments be included in the health activities provided at the hospital?
- What do you think is the most important aspect in promoting health?
- Do you think that the therapies you received helped you in any way, if so, why?
- Should the treatments have a financial bearing?
- Any ideas or reflections about health promotion?
- Have you ever used complementary treatments before the project?
- Is there anything more you would like to add?