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TOWARD THERAPEUTIC TOUCH

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ATTITUDES OF WOMEN WITH BREAST CANCER TOWARD
THERAPEUTIC TOUCH

By

Donna Blanche Zambetis

A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
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ABSTRACT

ATTITUDES OF WOMEN WITH BREAST CANCER TOWARD THERAPEUTIC TOUCH

By

Donna Blanche Zambetis

Therapeutic Touch (TT) is a complementary therapy modality which has become broadly accepted and used within the nursing profession and the lay community. The purpose of this study was to describe attitudes of women with breast cancer toward a written description of TT. A self-report questionnaire, Attitudes Toward Therapeutic Touch, was used as the data collection instrument. The participants ($n = 73$) were members of four different breast cancer support groups located in Western Michigan. Using a mean scale score of Likert items, the overall attitude toward TT was positive. Responses to the open-ended questions supported the quantitative results represented by the mean scale score. Over three quarters of the participants indicated a willingness to receive TT. There was no statistical difference in attitude between those who had previous knowledge of TT or those who had previously experienced TT as compared to those without prior knowledge or experience with TT. Implications of study findings indicate a need for the Advanced Practice Nurse (APN) to be knowledgeable and experienced regarding TT and other complementary therapies.

To my parents, who have given their children roots and wings.
To Michael, who through his love has given me the gift of time.
To our children, Evan and Patra, sweet blessings from above.

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INTRODUCTION

In the 1990's, consumers are becoming more health conscious, wishing to focus on aspects of wellness and disease prevention, which contrasts to the former medical emphasis on curative actions (Murray & Rubel, 1992; Thurtle, 1994). Further, many health care consumers are demanding to be active participants and decision makers in their healthcare experiences, changing the passive role they played in the previous paternalistic medical model (Murray & Rubel, 1992). These trends may signify a consumer dissatisfaction with the present conventional medical model, and a deliberate exploration of a system of health care that has been described with many terms, such as complementary, holistic, unorthodox, natural or alternative medicine (Downer et al., 1994; Eisenberg et al., 1993; Murray & Rubel, 1992). The U.S. government responded to the authenticity of this consumer movement for alternative health care services by creating the National Institutes of Health Office for the Study of Alternative Medical Practices in the Department of Health and Human Services in 1992 (Jacobs, 1995).

Although the practice of alternative therapy or complementary therapy share many common characteristics and the terms are often used synonymously in the literature, Gates (1994) presents a distinction between the two terms. Alternative therapy is defined as the adoption and use of unorthodox treatments, which differ from

widely accepted conventional medicine practice, and which are used either totally or partially in place of the orthodox treatments. Complementary therapies on the other hand may also include unorthodox treatments, but these are used to complement traditional medical care, rather than replace it (Gates, 1994). A few examples of alternative or complementary therapies are acupuncture, chiropractice, homeopathy, aromatherapy, biofeedback and Therapeutic Touch. The study done by Eisenberg et al. (1993) revealed that respondents with a chronic condition utilized complementary therapies with greater frequency. Cancer was one of the chronic conditions identified by Eisenberg et al. (1993) along with arthritis, chronic back pain, AIDS, chronic renal failure, gastrointestinal problems and eating disorders.

The focus of this study was on attitudes of women with breast cancer toward Therapeutic Touch, one of the complementary modalities. This study was modeled after work done by Thomas-Beckett (1991).

Therapeutic Touch (TT), a complementary intervention, was introduced into the health care system by Krieger, a nurse educator, in 1972. Krieger utilized the work of nursing theorist, Martha E. Rogers, Sc.D. RN, and her conceptual model known as Rogers' Science of Unitary Human Beings as the theoretical framework for Therapeutic Touch (Lutjens, 1991). Therapeutic Touch is based upon the ancient and traditional practice of laying-on of hands. Regarding Therapeutic Touch, Krieger (1990) states "the focus of concern is with human energy, and one could say that our students are learning about the therapeutic functions of the human energy field" (p. 83). The focus of Therapeutic Touch is to act upon the client's energy field, promoting

an energy exchange, which helps restore balance to the client's energy field, that has been disrupted by illness, injury or emotional distress. As a complementary therapy modality, it has become broadly accepted and used within the nursing profession and the lay community (Krieger, 1990; Wyatt & Dimmer, 1988).

Statement of the Problem

Therapeutic Touch is a nursing based intervention that is non-invasive with no documented side effects and can be utilized as a complementary treatment in a variety of clinical settings by the Advanced Practice Nurse (APN) (Meehan, 1993; Wyatt & Dimmer, 1988). Areas demonstrating improved outcomes from Therapeutic Touch include positive effects in reducing anxiety, nausea, pain, and improving relaxation and healing rates (Keller & Bzdek, 1986; Simington & Laing, 1993; Wyatt & Dimmer, 1988). Due to the side effects of chemotherapy and living with the chronic disease of breast cancer, women with breast cancer could benefit greatly from the use of complementary therapies, such as Therapeutic Touch, to decrease anxiety, nausea, and pain, while promoting relaxation. As the provision of ongoing care for women with breast cancer is often addressed in a primary care setting, there are many clinical applications of Therapeutic Touch for the APN practicing holistically in primary care (Wyatt & Dimmer, 1988; Wytias, 1994).

The attitudes of women with breast cancer toward Therapeutic Touch were assessed in this study. The target population of women with breast cancer was chosen for several reasons. Breast cancer is a leading cause of malignancy among women. In 1996, approximately 183,000 women will be newly diagnosed with breast cancer and

46,000 women will die from the disease and for American women aged 40 to 55 years it is the leading cause of death (American Cancer Society [ACS], 1995; Baron & Walsh, 1995). For women of all ages, breast cancer is second only to lung cancer as the leading cause of cancer mortality (ACS, 1995).

Along with the biological issues experienced by any person with a diagnosis of cancer, there are unique concerns relating to the woman with breast cancer. The emotional and psychological response to breast cancer is much greater than with many other possible diseases (ACS, 1995). ACS has identified the most common psychosocial concerns as "the threatened loss of life; the threat posed by the disease to the patient's relationships with others; fears about loss of independence, job and career; and concern about the integrity of their body and its function" (p. 637). The greater needs of the client, which are biological, psychological, social and spiritual, truly require a holistic and client-centered approach to their care. Also, the woman with breast cancer is often very active in her health care and takes a participatory role with the provider in many health care decisions.

Research Purpose and Research Question

The purpose of the study was to assess the attitudes of women with breast cancer toward TT. The broad research question answered was:

What are the attitudes of women with breast cancer toward a written description of Therapeutic Touch?

Specific research questions were as follows:

1. What is the overall attitude of women with breast cancer toward TT, after

reading a written description of TT?

2. What are the affective, cognitive and behavioral components of attitudes toward TT?

3. Is there a difference in attitude toward TT between women who have had previous experience concerning TT and those women with no previous experience with TT?

4. Is there a difference in attitude toward TT between women who have had previous knowledge but no experience concerning TT and those women with no previous knowledge of TT?

Studying and understanding the concept of attitude is relevant to Advanced Practice Nurses (APN), as attitude is an integral component of human nature and has a direct impact upon health behaviors and the effectiveness of APN interventions.

Mueller (1986) states that attitude strongly influences all of our decisions. Attitude thus directly influences decisions made by women with breast cancer in choosing whether or not to utilize complementary therapies, specifically Therapeutic Touch, as provided by an APN. In the following sections, attitude is defined and then related to both advanced practice nursing in a primary care setting and also Rogers' theory.

Review of the Literature

A literature review of research and empirical findings regarding attitude toward Therapeutic Touch, public aspiration for complementary therapies, and several studies regarding the effect of Therapeutic Touch interventions on anxiety, stress, pain and healing rates will be discussed in the following section. A critique of the literature will

be included.

There is a paucity of literature regarding attitudes toward Therapeutic Touch. Only one study was found; it was a pilot study done by Thomas-Beckett (1991). The study design was a descriptive study to pilot the Attitudes Toward Therapeutic Touch (ATTT) instrument. A convenience sample of 31 women was obtained from two Midwest clinics associated with a major university. Along with the demographic information, data demonstrated that most subjects (64.5%) had not previously heard of Therapeutic Touch; 35.5% of the subjects reported having heard of Therapeutic Touch prior to the study; and 9.7% of the subjects had actually received Therapeutic Touch in the past.

Analysis of the four point Likert scale items from the second and main part of the ATTT, the Attitude Inventory, revealed a mean scale score of 2.8 (range 1-4), which demonstrated a weak, but mostly positive attitude toward Therapeutic Touch. The qualitative responses to the three open-ended questions supported these positive findings, specifically, 39% of the sample expressed a willingness to receive a TT intervention.

Limitations of this study include the small sample size, which was a convenience sample, and therefore the results were not generalizable. Only content validity of the ATTT instrument was assessed. The study piloted an untested instrument and further testing of it is needed to establish construct and criterion-related validity, and confirm reliability. As there are no other instruments to assess attitudes toward TT, replicating this study, to further validate the ATTT instrument, is a

worthwhile contribution to nursing practice and research regarding Therapeutic Touch.

Thomas-Beckett (1991) also studied the effect of previous knowledge of TT, and previous experience with TT and how the attitude toward TT of these groups may differ from those without previous knowledge of TT or previous experience with TT. A significant difference or more positive attitude toward TT was found with the group having previous knowledge of TT, but not among those who had previous experience with TT as compared to those without previous knowledge or experience with TT. Those respondents ($\underline{n} = 11$) with previous knowledge of TT had a significantly more positive attitude toward TT. It was a very small number of participants ($\underline{n} = 3$) who reported previous experience with TT, which prompted a large standard error and may have impacted the ANOVA. For both groups, those who had previous knowledge or experience, the mean scale score was higher than for those without previous knowledge or experience.

Further study of attitudes toward Therapeutic Touch is also useful considering the great public aspiration for complementary therapies. In an effort to determine the prevalence, costs and patterns of use of unconventional therapies, Eisenberg et al. (1993) conducted a random, national telephone survey, with a sample of 1539 adults, regarding their use of 16 commonly used unconventional therapies. Eisenberg refers to complementary therapy as unconventional. These 16 complementary therapies were chosen based upon pilot research, to be representative of commonly used complementary therapies in the United States.

The survey entailed a 25 minute interview which gathered responses to questions regarding the general areas of respondent's health status, interactions with medical doctors in the past 12 months, bothersome health problems, and use of complementary therapies in the preceding 12 months. The sample was considered representative of the U.S. household population based upon sample correspondence with the distribution of subjects of the National Health Interview Survey, regarding age, sex, race social class, and other sociodemographic variables. Results of this study done by Eisenberg et al. (1993) revealed that 34% of the respondents reported using at least one complementary therapy in the past year. Extrapolating these results to the entire U.S. population, the researchers calculated that in 1990, Americans made an estimated 425 million complementary therapy visits, which is a number that exceeds total visits to all U.S. primary care physicians (388 million). These statistics illustrate the strength of the complementary therapy movement in the United States and are representative of the year 1990, therefore, the numbers may actually be much higher in 1996. Although Eisenberg (1993) did not study attitudes directly, or attitudes toward complementary therapies, positive attitudes toward complementary therapies can be inferred based upon study findings and the behaviors of the participants in his study who reported using complementary therapies.

The study findings of Eisenberg et al. (1993) indicated respondents with chronic conditions utilized complementary therapies with greater frequency. These chronic conditions include: cancer, arthritis, chronic back pain, AIDS, chronic renal failure, gastrointestinal problems and eating disorders. Considering sociodemographic

characteristics, the use of complementary therapies was significantly more common among nonblack persons (35%) compared to blacks (23%), 25 to 49 years of age who had some college education (44%) compared to those with no college education (27%), and with incomes greater than \$35,000 (39%) as contrasted to those with lower incomes (31%).

Limitations of the study include a simple survey design without a theoretical conceptualization of the study variables. There was no information provided regarding reliability and validity of the survey instrument. The sampling was done only by telephone, which excluded those without telephones, or the homeless. Non-English speaking respondents were also excluded from the survey, along with those who were physically or mentally incapacitated. This exclusion by the study design of those with poor health may have resulted in an underestimation of the use of complementary therapies as those with poor health were found to have substantially higher rates of complementary therapy use than those who perceived themselves to be in better health (52% versus 33%).

The studies reviewed on the intervention effects of Therapeutic Touch indicated statistically significant reductions in stress, anxiety, and pain among those who received TT as compared to the control groups. Gagne and Teye (1994) study results indicated a statistically significant reduction in subjective reports of anxiety by both TT and relaxation therapy, and the relaxation therapy resulted in statistically significant reductions in the movement measure. The control group showed only a small and statistically nonsignificant effect. Kramer's (1990) study compared the effectiveness of

TT and casual touch for stress reduction of hospitalized children aged 2 weeks to 5 years, and found that TT reduced the time needed to calm children after a stressful experience. The purpose of the study done by Keller and Bzdek (1986) was to determine the effectiveness of TT on tension headache pain as compared to a placebo simulation of TT. This study indicated that TT may be effective in reducing tension headache pain and potentially other pain as well.

TT was also found to promote healing rates. Wirth, Richardson, Erdelman and O'Malley (1993) replicated and extended an earlier study done by Wirth (1990) which analyzed the effects of TT on healing rates of full thickness dermal wounds. The study followed a randomized, double-blind, placebo controlled protocol. These results indicate TT may be beneficial to promote wound healing and supported the earlier study done by Wirth (1990). These studies also indicate that experimental, double-blind studies with random assignments are used with greater frequency to increase the power of determining a cause and effect relationship with Therapeutic Touch. The limitation of sample sizes under 100 participants was noted in all the TT studies presented. Findings from these studies on TT are all applicable to the woman with breast cancer in a primary care setting.

Critique of Literature

The Eisenberg et al. (1993) study substantiates the strength of consumer demand for complementary therapies, which infers a positive attitude toward complementary therapies, especially among those who are suffering from chronic conditions, such as cancer. Also, due to the study design, excluded were those with

physical or mental incapacities, which may have resulted in an underestimation of those with poor health who are using complementary therapies.

There is a growing body of research on the positive effects of Therapeutic Touch, yet the only research regarding people's attitudes and feelings toward Therapeutic Touch is the work conducted by Thomas-Beckett (1991). Therefore, little is known about attitudes toward Therapeutic Touch. This limitation is deemed significant based upon the effect the variable of attitude has on people's willingness to participate in a TT intervention and also how those attitudes may affect the outcome of the intervention. Therefore, participants' attitudes should be assessed before their participation in a study of TT outcomes.

Conceptual Definitions

In the following section, a review of the literature regarding attitude and Therapeutic Touch will be summarized. Conceptual definitions of attitude and Therapeutic Touch for the purposes of this study will be presented.

Attitude

The concept of attitude has been defined by various authors. Thurstone defined attitude as "the sum total of a man's inclinations and feeling, prejudice and bias, preconceived notions, ideas, fears, threats, and convictions about any specified topic" (as cited in Mueller, 1986, p. 3). Henerson, Morris and Fitz-Gibbons (1987) describe the concept of attitude as a "tool that serves the human need to see order and consistency in what people say, think and do, so that given certain behaviors, predictions can be made about future behaviors" (p. 11). Pender (1990) defines attitude

as follows, "Attitudes structure the way persons see their world and, like emotions, express persons' values and priorities" (p. 118).

Ajzen (1988) states that "an attitude is a disposition to respond favorably or unfavorably to an object, person, institution or event" (p. 4). The focus of this definition relates to the evaluative component of attitude. Attitude is defined by Ajzen (1988) within a theoretical framework of "reasoned action" developed by Ajzen and Fishbein in 1980 which includes behavioral prediction: "Just as attitudes are said to flow reasonably and spontaneously from beliefs, so are intentions and actions seen to follow reasonably from attitudes" (p. 33). This implies a causal effect of attitude upon behavior but not a direct relationship.

Ajzen (1988) cites Hovland and Rosenberg's classic work on the classification of attitude responses. Ajzen (1988) reflects, "attitude is a hypothetical construct that, being inaccessible to direct observation, must be inferred from measurable responses" (p. 4). Ajzen goes on to discuss the conceptualization of attitudes by Rosenberg and Hovland (Ajzen, 1988) who state that attitudes can be inferred from three major types of response categories. The three major response categories which Hovland and Rosenberg have designated are cognitive, affective, and conation (behavioral). Thus, attitudes must be inferred from the way a person reacts or responds to certain stimuli and are not directly observable or measurable.

Montgomery, Dossey, Keegan, Guzzetta and Kolkmeier (1995) define attitude as "feelings toward a person, object, or idea that include cognitive, affective, and behavioral elements" (p. 121). The cognitive element involves knowledge and facts,

the affective element encompasses emotions while the behavioral element refers to action and active behaviors. This definition incorporates the multidimensional response categories as discussed earlier.

Zimbardo and Leippe (1991) focus on the evaluative characteristics of attitude by defining attitude as an "evaluative disposition toward some object" (p. 31). There are three major themes of attitude cited by Zimbardo and Leippe (1991) which include: "Attitudes influence perception and thought; attitudes are easily accessible evaluative summaries; and attitudes are self-defining" (p. 35).

Champion, Austin, and Tzeng (1990) who investigated the relationship between attitudes toward health and community health indicators, did not define attitude explicitly for the purposes of their study, but a definition can be extracted. Attitude is a predictor of behavior, and involves an evaluative component to a certain stimulus.

In summary, central themes emerge from each of these definitions of attitude as cited. These common themes include: a) an evaluative or valuitive cognitive component, b) a behavioral predictive component, and c) an emotional response which is the affective component. An attitude is not directly observable and therefore must be inferred. Ajzen (1988) and Montgomery et al. (1995) similarly describe attitude as a response to a stimulus and has three components.

Having reviewed the literature, several key elements emerge critical to defining attitude. The critical elements of attitude include a response pattern to certain stimuli which involves a process of evaluating the negative or positive consequence of a certain behavior and the ability to predict group behaviors based upon attitude

assessment. Therefore, for the purpose of this study, the concept of attitude was defined utilizing the conceptualization of Hovland and Rosenberg (1960) "attitudes are predispositions to respond to some class of stimuli with certain classes of responses and designate the three major types of response as cognitive, affective, and behavioral" (p. 3).

Therapeutic Touch

Krieger (1990) who, along with Kunz (Krieger, 1990), originated the Therapeutic Touch nursing intervention, has described it as "a contemporary interpretation of several ancient healing practices" (p. 83). Wyatt (1989) has noted that Therapeutic Touch is "based on the assumption that all living things are surrounded by an energy field that can be massaged and balanced with the hands" (p. 7). The theoretical foundation for this intervention is Martha Rogers' Theory of Unitary Human Beings (Meehan, 1993). Regarding an energy field, Owens & Ehrenreich (1991) state, "The ideal energy state is characterized by a balanced flow, one with rhythm and synchronicity. Blockage or disrupted patterns of energy flow result in a degree of 'dis-ease' that may be manifested physically, mentally, emotionally, or spiritually" (p. 33). Therefore, the goal of Therapeutic Touch is to rebalance or repattern the client's energy field to promote healing and health.

Meehan (1993) describes Therapeutic Touch as "knowledgeable and purposive patterning of nurse-environmental/patient-environmental energy field process in which the nurse assumed a meditative form of awareness and used her hands as a focus for the patterning of the mutual patient-environmental energy field process" (p. 71). This

meditative state of the nurse, sometimes referred to as a centered state, and her earnest intent to heal are integral aspects of the intervention. Sagar (1990) defines Therapeutic Touch quite similarly: "TT is the transference of energy from the healer to the healee, or client. The healer is able to direct energy to the client's body" (p. 14). There are five basic steps involved in the TT technique (Owens & Ehrenreich, 1991): 1) centering; 2) assessment of the client's energy field; 3) unruffling of the energy field; 4) treatment or intervention phase; 5) balancing and evaluation of energy field.

For the purposes of this study, Therapeutic Touch was defined as a nursing intervention based on the belief that human beings do not stop at the skin, rather, they release and are surrounded by an energy field, which cannot be seen, but can be felt and described. Therapeutic Touch involves the knowledgeable and purposeful repatterning of that energy field by the nurse to promote well-being (Meehan, 1993).

Previous Knowledge or Experience of Therapeutic Touch

For the purposes of this study, previous knowledge or experience of TT is conceptually defined as a statement by the participant acknowledging having heard of TT or received TT prior to the study. Those participants with this previous knowledge or actual experience with TT would be expected to have a more positive attitude toward TT. The hypothesis of a more positive overall attitude would be especially applicable for those participants who indicate previous experience with a TT intervention, as their motivation to act reflects an attitude toward TT has already been formed which is assumed to be positive.

Conceptual Framework

The conceptual framework utilized for this study was the Theory of Unitary Human Beings as developed by Rogers (Lutjens, 1991). The four building blocks of the Rogerian model include energy field, openness, pattern and pandimensionality. These provide the foundation for the conceptual model of nursing and health. The building blocks of energy field and openness are especially relevant as a framework for the concept of attitude as defined in this study. The concept of attitude, as defined in this study, fits conceptually with Rogers' basic assumption regarding human beings. Rogers conceptualized the human being as having "the capacity for abstraction and imagery, language and thought, sensation and emotion" (Lutjens, 1991, p. 6). The concept of attitude as defined corresponds with this assumption. Language and thought could be considered the cognitive response, while sensation and emotion could be considered the affective response of attitude. The behavioral response would include the capacity to process abstraction and take action.

An energy field is described by Rogers as "the fundamental units of the living and the non-living" (Lutjens, 1991, p. 6). Human beings and the environment are energy fields according to Rogers. Rogers differentiates human energy fields from environmental fields by pattern, which "is manifested in feeling" (Fisher & Reichenbach, 1987, p. 8). Attitude is linked to this unique pattern of a person. The feelings or affective component of the concept of attitude as defined would be encompassed as part of Rogers' sentient or feeling human being.

Another important assumption is that the energy fields of the unitary human

being and the environment are open, dynamic and continuously changing in a mutual process. In defining an energy field, Rogers stresses that the environmental field is integral with the human field and both fields change continuously and creatively. This integrality of the environmental and human energy fields can be linked clearly to the concept of attitude as defined, since the environmental field of the client would include the APN and the primary care setting of the health care system. Therefore, as these fields are integral, open and continuously changing each will interact and can alter or impact the other. Recognizing the abstract abilities of a person, it is evident that these changes are made consciously and as attitude is part of the human field, the evaluation or valuation component of attitude can be potentially altered by the APN who has knowledge and experience of complementary therapies, including Therapeutic Touch.

A schematic model (see Figure 1) has been included which represents the Woman with Breast Cancer, who encompasses attitude toward TT, and may or may not have previous knowledge of TT or experience with TT. The wholeness and irreducibility of the Woman with Breast Cancer is illustrated by an inability to divide out or dissect the specific dimensions of spirituality, biological, psychological or social. The Woman with Breast Cancer is pandimensional and irreducible, with attitude incorporated into the essence of psychological, social, biological and spiritual dimensions of all Unitary Human Beings. Since attitude is incorporated as part of the substance of the psychological or social component, it can not be ignored in providing care to the whole person. The Woman with Breast Cancer may or may not have previous knowledge or experience regarding TT.



Figure 1. Schematic of Unitary Human Being.

Methods

This section will present the study design, sample, operational definition, instrument, data collection procedures, data analysis, protection of human subjects, assumptions and limitations.

Study Design

This was a descriptive study and an extension of work done by Thomas-Beckett (1991). The study design was a non-experimental survey research, with a self-report questionnaire being used as the data collection instrument. This study utilized the Attitudes Toward Therapeutic Touch (ATTT) instrument developed by Thomas-Beckett (1991).

Sample

A convenience sample of 73 women recruited from four breast cancer support groups in Western Michigan was obtained. The breast cancer support groups were located as follows: Hackley Cancer Center, Muskegon; Breast Expressions, Kent County; North Ottawa Community Hospital, Grand Haven; and Holland Community Hospital, Holland. These sites were chosen to represent predominantly rural, less populated areas of Michigan. The ATTT instrument was distributed to participants at meetings of the Holland, Grand Haven and Muskegon breast cancer support groups and mailed to 104 members of the Kent County breast cancer support group, Breast Expressions, as this breast cancer support group did not meet during June to August 1996, when the data were collected.

Inclusion criteria for the study were:

1. Female with clinically diagnosed breast cancer.
2. Able to read and write English.

Operational Definition

Attitude Toward Therapeutic Touch. Operationally, attitudes were measured by the participant's response to the affective, cognitive and behavioral items on the Attitudes Toward Therapeutic Touch (ATTT) instrument (see Appendix A).

The affective component of attitude was measured by 8 items (items 16, 18, 21, 27, 28, 34, 35, and 37) of the Attitude Inventory section of the ATTT and one open-ended question, item 38. The affective items relate to the participant's feelings toward Therapeutic Touch. The wording of each item reflects a positive or negative attitude toward Therapeutic Touch. For example, question 16, "I am glad there are health care interventions such as TT" or question 21, "I feel calm when I read about TT" would be examples of positively worded items. The other positively worded affective items are 27, 35, and 37. Negatively worded affective items are 18, 28, and 34. The open-ended question, "What other feelings or reactions do you have about Therapeutic Touch?", qualitatively measured the affective component of attitude.

Similarly, behavioral components of attitude were measured by 6 items (items 19, 20, 24, 29, 32, and 36) of the Attitude Inventory section of the ATTT and one open-ended question, item 40. These items are either positively or negatively worded to elicit a behavioral response. An example of a positively worded behavioral statement is item 29, "I plan to read more about TT" or a negatively worded item 36 "I would not be willing to receive TT treatments along with my prescribed cancer

treatments". The positively worded behavioral items are 20, 29, and 32. The negatively worded items for the behavioral component are 19, 24, and 36. The open-ended question for the behavioral component was "Would you be willing to receive Therapeutic Touch? Why or why not?".

The cognitive component of attitude was measured by 8 items (items 17, 22, 23, 25, 26, 30, 31, and 33) and one open-ended question, item 39. The positively worded statements for the cognitive component are items 17, 22, 25, and 30. An example of a positively worded cognitive item is, "I believe TT can reduce unpleasant symptoms". Negatively worded items for the cognitive component are 23, 26, 31, and 33 and the weighted scoring system was applied. Item 33, "I do not believe human energy fields exist" is an example of a negatively worded cognitive statement. These items measure beliefs or values and the open-ended question asks "What further information would you like to know about Therapeutic Touch?".

All items 16 - 37 are rated on a 6-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). The negatively worded items (items 18, 19, 23, 24, 26, 28, 31, 33, 34, and 36) had the scoring reversed. A high total score for items 16 - 37 would indicate a more positive attitude toward TT. A low total score for these items would indicate a negative attitude toward TT. Specifically, a mean total scale score of greater than or equal to 3.5 would indicate a positive attitude toward TT, and a score less than 3.5 would indicate a negative attitude toward TT.

Previous Knowledge Without Experience of TT. Previous knowledge of TT without actual experience was defined as participant having knowledge of Therapeutic

Touch before reading the TT written description and completing the questionnaire. This knowledge did not include having previously received an actual TT treatment. Item 14 asked the question: "Have you ever heard of Therapeutic Touch before today?". A "yes" response delineated those participants who had previous knowledge, without experience of TT and a "no" response indicated participants with no previous knowledge. These participants with previous knowledge of TT, must also have answered "no" to item 15 which demonstrated no previous experience with TT. For those answering "yes" to item 14, they were then asked to indicate what they had heard in the space provided.

Previous Experience of TT. Previous experience of TT was defined as a participant who previously received the Therapeutic Touch intervention before reading the TT written description and completing the questionnaire. Item 15 surveyed: "Have you ever received Therapeutic Touch as described in the paragraph?". Responses were either "yes" or "no". Those who responded "yes" were included in the group of participants with previous experience of TT and were asked to complete two additional questions, "How many months ago?" and "How many times did you receive Therapeutic Touch?". Those who answered "yes" to item 15, could also have answered "yes" to item 14. Those who answered "no" to item 15 were included in group of those with no previous experience of TT.

Instrument

Attitudes Toward Therapeutic Touch (ATTT) is a three part questionnaire and takes approximately 14 minutes to complete. The instrument was assessed for level of

reading comprehension using the Flesch-Kincaid readability statistic, and found to have a sixth to tenth grade reading level (Thomas-Beckett, 1991). The first 15 items collect demographic data, such as age, race, income, level of education, year of diagnosis, stage of breast cancer, types of treatment received for the breast cancer, and if they had ever heard of or received TT prior to the day of testing.

The second and principal part of the ATTT instrument, the Attitude Inventory, measures the multicomponent responses of participants' attitudes toward TT, based upon the stimulus of reading a short, written description of TT, which is included on the instruction page of the survey (see Appendix A). This written description of TT is the stimulus for attitude toward TT and is considered part of the tool, as it must be read before participants can answer the Attitude Inventory section of the questionnaire. After reading the description, participants reacted to the statements given in items number 16 - 37 by circling the response that best represented their response to the statement. A 6-point Likert scale was used for responses. The Likert scale ranged from 1 (strongly disagree) to 6 (strongly agree). The original instrument piloted in Thomas-Beckett's (1991) study utilized a 4-point Likert scale (strongly disagree, disagree, agree or strongly agree) and 22 items. In the original study, Thomas-Beckett postulated that participants may not have responded to certain questions due to an unfamiliarity with Therapeutic Touch and therefore, missing data would occur. It was recommended that these two additional Likert scale response choices may allow a more accurate portrayal of participants' attitudes toward Therapeutic Touch. The copy of the ATTT instrument included in Appendix A incorporates the refinements proposed by Thomas-

Beckett.

Several content validity measures were undertaken by Thomas-Beckett (1991) during the development process of the ATTT instrument. The Attitude Inventory items were reviewed by a panel of three Master's prepared nurse researchers whose overall conclusion supported the placement of these items into the three categories of affective, cognitive and behavioral.

The 22 item Attitude Inventory scale, with a 4-point response scale, had a Cronbach's alpha coefficient of 0.98 indicating high inter-item correlation of the three subscales of affective, cognitive and behavioral responses of attitude. Cronbach's alpha for each subscale were reported as follows: 0.83 for affective subscale ($n = 16$); 0.92 for cognitive subscale ($n = 20$); and 0.86 for the behavioral subscale ($n = 20$). High correlations between the subscales indicated a unidimensional instrument, rather than a multidimensional scale as Beckett proposed.

Reliability testing was repeated in this study for the revised instrument. The overall Attitude Inventory scale, with a 6-point Likert, had a Cronbach's alpha coefficient of 0.94. The Cronbach's alpha coefficient reliabilities for the subscales were as follows: affective subscale ($n = 69$), 0.82; behavior subscale ($n = 72$), 0.81; and cognitive subscale ($n = 66$), 0.89. High correlations between the subscales of the revised instrument indicating a unidimensional instrument were as follows: affective subscale ($n = 58$), 0.83; behavior subscale ($n = 58$), 0.84; and cognitive subscale ($n = 58$), 0.85.

The third part of the ATTT instrument includes three open-ended questions

which are designed to continue inquiry in attitudes focusing on the affective, cognitive and behavioral aspects as defined in the conceptual definition of attitudes. The first question asks for any other feelings or reactions regarding TT. The second question asks if the participant desires any further information on TT. And the final open-ended question asks if the participant would be willing to receive TT, also why or why not? These open-ended questions are included to provide an opportunity for participants to offer information which may not have been asked for earlier in the close-ended questions.

Data Collection Procedures

Two separate Data Collection Procedures were developed as one of the breast cancer support groups, Breast Expressions of Kent County, did not hold meetings during the summer months which encompassed the data collection timeframe. The first Data Collection Procedures refer to the process for the Grand Haven, Holland and Muskegon breast cancer support groups which had meetings and on site data collection and the second set of procedures relate to the Kent County breast cancer support group which did not have a meeting and required mailing for data collection.

Data collection was done in Holland at the June 6th meeting; Grand Haven at the June 27th meeting and Muskegon on the 3rd of July. At the three Western Michigan breast cancer support groups, (Grand Haven, Holland and Muskegon) data collection procedures were reviewed and standardized as follows:

1. A Clinical Nurse Specialist or Social Worker at each site was designated as the data collector.

2. Data collector screened all women with breast cancer for eligibility using inclusion criteria.
3. Data collector explained study to potential participants.
4. Study packet was given to all potential participants during their breast cancer support group meeting.
5. Study packet contained a cover letter, explanatory letter and consent information form, and the ATTT instrument (see Appendix A). To insure anonymity, completion of the survey indicated consent and no signatures were required.
6. Those who did not wish to participate simply replaced the blank survey in the envelope and deposited the entire packet into the marked survey collection box.
7. After completion of the testing packet, participants were instructed to voluntarily deposit the envelope into the marked survey collection box.

The data collection procedures for the Kent County breast cancer support group, Breast Expressions, were standardized as follows:

1. An ATTT survey packet, which included the cover letter, explanatory letter with consent information form, and ATTT instrument was mailed to each member of the Kent County breast cancer support group. The current 1996 membership roster, with addresses, was obtained from one of the Breast Expressions' board members. To insure anonymity, completion of the survey indicated consent and no signatures were required.

2. A self-addressed, stamped envelope was included in the packet to facilitate return of the completed survey.
3. Study participants, after completing the testing packet, were instructed to voluntarily mail the envelope to the researcher.
4. Two weeks after initial mailing, a reminder card was sent to each participant requesting return of the completed survey (see Appendix B).

Data Collector Training

Before the study commenced, the data collection procedures were reviewed with the facilitator for the three breast cancer support groups, acting as the designated data collector. The data collector's chief responsibilities were to identify potential participants, distribute the testing packets, which had self-explanatory instructions, and respond to questions regarding the completion of the ATTT instrument. Data collectors were instructed to not answer questions regarding TT or how it works, but to encourage the participants to simply respond to the description of TT provided in completing the questionnaire.

Data Analysis

The descriptive demographic data elicited in the first part of the ATTT instrument were summarized utilizing frequency statistics. Demographic data included: age of participants, race, level of education, occupation, household income, year of diagnosis, stage of breast cancer, and type of treatment received for breast cancer. These indices were utilized to describe the sample.

Research Question #1: What is the overall attitude of women with breast cancer

toward TT, after reading a written description of TT?

Analysis: The scale mean score of the Attitude Inventory (items 16-37) was calculated, to quantify a positive or negative attitude toward TT. A mean total scale score of greater than or equal to 3.5 is an indicator of positive attitude toward TT. A mean scale score of less than 3.5 would be indicative of a negative attitude toward TT.

Research Question #2: What are the affective, cognitive and behavioral components of attitudes toward TT?

Analysis: Utilizing content analysis and specifically, thematic subgrouping (Beckett-Thomas, 1991; Polit & Hungler, 1995) all of the open-ended responses, found in items 38 - 40, were reviewed and grouped into either the affective, cognitive or behavioral components of attitude. For reliability and validity purposes, this qualitative content analysis was done independently by the investigator and another nursing graduate student who was knowledgeable regarding Therapeutic Touch. After reviewing the responses independently, the two analysts met to discuss their interpretation of the responses. After a discussion, consensus was met on categorizing the responses into thematic subgrouping. Specific quotes reported and listed in the analysis are a result of that consensus process.

Quantitative subscale scores of the affective, cognitive and behavioral subscales from the Likert items 16 - 37 were analyzed for mean subscale scores of the affective, cognitive and behavioral component of attitude. These scores were compared to the qualitative findings. The hypothesis was that attitudes can be assessed by responses to affective, cognitive and behavioral statements.

Research Question #3: Is there a difference in attitude toward TT between women who have had previous experience concerning TT rather than those women with no previous experience with TT?

Analysis: Item 15 which assessed experience with TT was summarized with percentage of "yes" and "no" responses. Using the total mean scale score and an independent samples, one-tailed *t*-test, this third area of analysis involved comparing the group means among those participants who reported receiving TT and those who did not. The hypothesis was that the group of participants with previous experience with TT would have a more positive overall attitude toward TT as compared to those with no previous experience with TT.

Research Question #4: Is there a difference in attitude toward TT between women who have had previous knowledge but no experience concerning TT rather than those women with no previous knowledge of TT?

Analysis: Item 14 which assessed prior knowledge of TT was summarized with percentage of "yes" and "no" responses. Using the total mean scale score and an independent samples, one-tailed *t*-test, this fourth area of analysis involved comparing the group means among those participants who reported knowledge of TT and those who did not. The hypothesis was that the group of participants with previous knowledge, but no experience, regarding TT would have a more positive overall attitude than those participants with no previous knowledge of TT.

The SPSS software program was utilized for data analyses, with a significance level set at 0.05.

Protection of Human Rights

The anonymity of the respondent was guaranteed as no name was written on the instrument. For on site data collection, all questionnaires were placed in a manila envelope whether it was completed or not completed. This procedure protected the anonymity of those participants who had declined to participate in the study.

Organizational protocol were followed to obtain permission from each breast cancer support group facilitator to conduct the research project. The Michigan State University Committee on Research Involving Human Subjects (UCRIHS) approved the study (see Appendix C).

Assumptions

The assumptions presented by Thomas-Beckett (1991) were utilized for this study.

1. Subjects were able to read the TT written description and honestly answered the questions in the survey.

2. Women with breast cancer who attended the breast cancer support groups in this study had adequate judgement capabilities to complete the questionnaire.

3. The ATTT instrument is sensitive enough to measure participant attitudes by measuring feelings, thoughts and intentions for behavior.

Limitations

Other extraneous variables which may affect the outcome variable, but were not measured are personality characteristics of the subjects, cultural influences and potential social pressures, or quality of facilitator-client relationship present in the

testing environment. An additional limitation was the necessity to have two different data collection methods, on site data collection and mailing of questionnaires, in this study.

This was a nonprobability approach and therefore the results are not representative or generalizable. Also, as the ATTT instrument was developed by Thomas-Beckett in 1991, and as this study is only the second utilization of the instrument, there is a lack of extensive validity and reliability testing of the instrument.

Results

The purpose of this section is to present the study results. This section will include description of the sample and answers to research questions.

Description of Sample

The sample consisted of 73 women, almost three quarters (73%, $n = 53$) of whom were from the Kent County Breast Expressions support group. The 104 mailings to the Kent County group with 53 surveys returned yielded a response rate of 51%. The remaining three support groups each provided approximately 10% of the remaining sample as follows: the Holland group 8% ($n = 6$) from a meeting attendance of 12; the Grand Haven group 8% ($n = 6$) from a meeting attendance of 19; and the Muskegon group 11% ($n = 8$) from a meeting attendance of 10. The smaller groups average attendance at meetings was 12-25 women, but group facilitators commented that during the summer months, attendance was less predictable.

This sample was an average 51 years of age ($SD = 8.1$), predominantly Caucasian (97%, $n = 70$), well educated, with average reported annual household

income greater than \$36,000 (Table 1). The majority of the participants were employed (62%, $\underline{n} = 40$), with 14% ($\underline{n} = 9$) retired.

Almost three-quarters (72%, $\underline{n} = 52$) of the participants have been diagnosed with breast cancer since 1990 with a mean length of time since diagnosis of 5.11 years ($\underline{SD} = 4.46$). The distribution of the participants according to year of diagnosis is summarized in Table 2. Of those who were knowledgeable regarding their stage of breast cancer at diagnosis, the majority were either Stage 1 (29%, $\underline{n} = 21$) or Stage 2 (33%, $\underline{n} = 24$). Sixty-four of the 73 participants responded to the question of stage of breast cancer upon diagnosis (Table 2).

Participants were asked to respond to which types of treatments they had received for breast cancer by reporting yes, no, or do not know for the following: radical mastectomy, modified mastectomy, lumpectomy, radiation and chemotherapy or other drugs. A response of Tamoxifen was considered a positive response to chemotherapy or other drugs. Regarding treatment modalities for breast cancer, almost three quarters of the sample (72%, $\underline{n} = 51$) had a modified radical mastectomy, and indicated receiving chemotherapy (70%, $\underline{n} = 51$) (see Table 3). Responses for other

TABLE 1

Frequency and Percent of Sample Demographic Variables

| Demographic variable | n | % |
|--------------------------------|----|-------|
| Race | | |
| White | 70 | 97.2% |
| Native American | 1 | 1.4% |
| Other | 1 | 1.4% |
| Education | | |
| 1st - 11th grade | 2 | 2.8% |
| H.S. Diploma | 18 | 25.0% |
| Some college | 21 | 29.2% |
| College degree | 13 | 18.1% |
| Master's or above | 18 | 25.0% |
| Annual household income | | |
| 0-\$12,000 | 4 | 6.3% |
| \$12,001-24,000 | 9 | 14.1% |
| \$24,001-36,000 | 6 | 9.4% |
| \$36,001-48,000 | 8 | 12.5% |
| \$48,001-60,000 | 8 | 12.5% |
| \$60,001+ | 29 | 45.3% |
| Occupation | | |
| Homemaker | 15 | 23.1% |
| Teacher | 11 | 16.9% |
| Self-Employed | 9 | 13.8% |
| Retired | 9 | 13.8% |
| Health Care | 6 | 9.2% |
| Secretary | 6 | 8.2% |
| Bookkeeper | 4 | 6.2% |
| Childcare | 2 | 3.1% |
| Unemployed | 1 | 1.5% |
| Executive | 1 | 1.5% |
| Machine Operator | 1 | 1.4% |

TABLE 2

Frequency and Percent of Sample Breast Cancer Variables

| Breast cancer variable | n | % |
|------------------------------|----|-------|
| Year of diagnosis | | |
| 1964 - 1985 | 4 | 5.6% |
| 1986 - 1990 | 24 | 33.4% |
| 1991 - 1996 | 44 | 61.0% |
| Stage of cancer at diagnosis | | |
| Stage 0 | 4 | 5.5% |
| Stage 1 | 21 | 28.8% |
| Stage 2 | 24 | 32.9% |
| Stage 3 | 5 | 6.8% |
| Stage 4 | 3 | 4.1% |
| Don't know | 15 | 20.5% |
| Missing | 1 | -- |

treatments not listed included: touch healing, hands on healing, reconstructive surgery, intercessory prayer, visualization, meditation, stem cell transplant, therapeutic massage and Therapeutic Touch. Of the 73 participants, it was quite evenly divided among those who had heard of TT previously and those who had no prior knowledge of TT. There were 39 participants (53%) had heard of TT before participating in the study and 32 (44%) who had not. For this item, there were only 2 missing cases (3%). Of those who had heard of TT previously, the majority indicated hearing about TT from a speaker who gave a presentation to a meeting of the Kent County Breast Expressions' support group.

TABLE 3

Frequency and Percent of Sample Treatment Modalities

| Treatment modality | n | % |
|-----------------------------|----|-------|
| Radical mastectomy | | |
| No | 64 | 90.1% |
| Yes | 7 | 9.9% |
| Modified radical mastectomy | | |
| No | 20 | 28.2% |
| Yes | 51 | 71.8% |
| Lumpectomy | | |
| No | 43 | 61.4% |
| Yes | 27 | 38.6% |
| Radiation | | |
| No | 43 | 59.7% |
| Yes | 29 | 40.3% |
| Chemotherapy or other drugs | | |
| No | 22 | 30.1% |
| Yes | 51 | 69.9% |
| Other treatment not listed | | |
| No | 63 | 91.3% |
| Yes | 6 | 8.7% |

Others responded hearing about TT from a friend or reading a magazine article. Only 14% ($n = 10$) participants had ever received TT, compared to 82% ($n = 60$) who had never received TT.

Answers to Research Questions

1. What is the overall attitude of women with breast cancer toward TT, after reading a written description of TT?

The overall attitude of women with breast cancer toward TT, after reading a written description of TT was positive ($M = 4.49$, $SD = 1.26$, $n = 73$). The range for the mean total scale score is 1 - 6, with a score of 3.5 or greater an indicator of positive attitude toward TT.

2. What are the affective, cognitive and behavioral components of attitude toward TT?

There were 57 (78%) participants who responded to the open-ended questions. Based upon these responses to the open-ended items, the attitude toward TT was positive and supported the quantitative results represented by the mean subscale scores. Utilizing thematic subgrouping, responses were grouped into either affective, cognitive or behavioral components. A complete list of the responses to the open-ended questions can be found in Appendix D.

Affective Component. The affective component of attitude was assessed both qualitatively and quantitatively. The qualitative assessment involved responses to the open-ended question, "What other feelings or reactions do you have about Therapeutic Touch?". The responses were classified as either a positive or negative reaction. There

were 33 affective open-ended responses of which 19 (58%) reflected positive attitudes toward TT and 14 (42%) presenting a negative affective response. The affective component of attitude was also analyzed by the quantitative affective subscale ($n = 60$) and found to be consistent with the qualitative findings ($M = 4.33$, $SD = .918$).

Examples of affective responses which indicate a positive reaction are as follows:

"I would like to see more information made available to lay people and patients."

"Sounds great, where do I get more information."

"I wish more doctors would recognize TT can help a patient to get well, and not be afraid of it. More hospitals should allow their nurses, who can do TT, to treat patients."

"That we as Western medicine participants need to be familiarized with the mind-body connection and need a better understanding of the molecular structure of the body."

"I feel warm and relaxed and free of pain when I have my treatments."

"I have searched for a calming influence ever since my diagnosis. This would have contributed greatly. Hope it gets put into practice."

Another term for the prevailing theme of the negative reactions to the affective open-ended questions could be skepticism. Examples of affective responses which indicate a negative reaction are given below:

"Skeptical, but interesting."

"I believe other methods of treatment can help breast cancer patients, however I am skeptical of TT. There are patients in my support group who attend the sessions regularly and feel better because of it they say."

"Unfortunately the demonstrations I've seen done by nursing staff make it out to be more than it is. It has been presented as a 'healing' process and I've seen it misrepresented to cancer patients. It has been sold to some as 'faith healing' and I find that pretty pathetic and unprofessional."

"I feel very skeptical about this actually working."

"This technique doesn't sound very scientific or medical to me. It verges on religious or 'witch doctor' type treatment."

"Somehow I feel uncomfortable that by just placing your hands over my body will help anything. I feel its a way doctors can make more money off people without the cost of medicines - very profitable for the doctor. And very expensive for the patient. Treatment already costs enough to the survivor. TT is

not going to cost the doctor much."

Cognitive Component. The cognitive component of attitude was assessed in two ways, quantitatively and qualitatively. The qualitative assessment included responses to the open-ended question, "What further information would you like to know about TT?". Again, these cognitive responses were grouped into either a positive or negative category. There were 32 responses, 28 (88%) of which overwhelmingly expressed a positive attitude toward TT with only 4 (12%) displaying a negative reaction. The overwhelming theme of the positive reactions to the cognitive question was a desire for more information regarding TT. For the cognitive component, the quantitative results for the cognitive subscale also supported the qualitative findings. The mean score for the cognitive subscale ($n = 62$) was $M = 4.22$ with a $SD = 1.08$ which is consistent with a positive attitude toward TT.

Examples of positive reactions to the cognitive component of attitude are provided:

"Anything about it."

"I would like to hear from cancer patients who received TT, and would like to know what they thought about it."

"Where, when and how much is the cost?"

"Blind study research on control groups. Physiological results on tested patients."

"How it works?"

Behavioral Component. The behavioral component of attitude was assessed quantitatively and qualitatively. The qualitative assessment involved responses to the open-ended question, "Would you be willing to receive TT? Why or why not". Nine responses to the behavioral component of attitude were identified, which were

grouped into either a positive or negative category, 8 (89%) of the 9 presented a positive attitude toward TT. Further indication of an overall positive attitude toward TT, $n = 42$ (78%) stated a willingness to receive TT. The predominant theme for this component of attitude was a stated openness and willingness to try a new option. For the behavioral component, the quantitative results for the behavioral subscale also supported the qualitative findings. The score for the behavioral subscale ($n = 62$) was $M = 4.11$ with a $SD = 1.10$ which is consistent with a positive attitude toward TT.

Examples of positive statements regarding the behavioral component of attitude are as follows:

"Sure, I don't see that it could harm anything -- only help."

"Sure, sounds interesting."

"Yes, willing to try!"

"Yes, it can't hurt and I'll try most anything."

"Yes, anything that will help without drugs would be wonderful."

"Yes, if it was covered by insurance and combined with more conventional treatment."

The negative reactions to this open-ended question generally included the theme of skepticism along with the rejection of receiving a TT treatment. Examples of these responses include:

"No, waste of time."

"No, not until I know more about it."

"Not sure. I might want to observe it first."

"I'm not really against it per se, but feel it is not a necessary means, too ethereal, superstitious or new age type identification. For me it is not an option, and in the category of yoga, meditation, etc."

"I don't think I would be a good candidate because I am doubtful of it's benefits."

No. I do not believe in it."

In summary, the overall analysis of the open-ended responses revealed a

positive attitude toward TT and supported by the quantitative findings. The most common qualitative response themes of general attitude toward TT reflected an interest in receiving more information about TT and a willingness to try the intervention.

3. Is there a difference in attitude toward TT between women who have had previous experience concerning TT and those women with no previous experience with TT?

The attitude of participants with previous experience with TT was positive ($n = 10$, $M = 4.68$, $SD = .89$). This compares quite similarly with the attitude toward TT of the group with no previous experience with TT, which was also positive ($n = 60$, $M = 4.44$, $SD = .89$). The difference in attitude toward TT between women who have had previous experience concerning TT compared to those women with no previous experience with TT was not statistically significant, $t(68) = -0.57$, $p = 0.57$. The hypothesis that the group of participants with previous experience with TT would have a more positive attitude than those with no previous experience with TT was not supported.

4. Is there a difference in attitude toward TT between women who have had previous knowledge but no experience concerning TT and women with no previous knowledge of TT?

The attitude of participants with previous knowledge but no experience with TT was positive ($n = 28$, $M = 4.28$, $SD = 1.07$). This also compares quite similarly with the attitude toward TT of the group with no previous knowledge or experience with TT, which was also positive ($n = 32$, $M = 4.58$, $SD = 1.48$). The difference in attitude

toward TT between women who have had previous knowledge but no experience concerning TT compared to women with no previous knowledge of TT was not statistically significant, $t(58) = -0.89$, $p = 0.38$. The hypothesis that the group of participants with previous knowledge but no experience with TT would have a more positive attitude toward TT than those with no previous knowledge was not supported.

Discussion

Sample

The overall sample consisted mainly of Caucasian women, with an age range of 31-73 years with a mean age of 51 years. This average participant age compares to Thomas-Beckett's (1991) study which had a sample mean of 56.7 ($SD = 12.7$) years. The educational and annual household income levels of the sample was quite high with one-fourth having a Master's degree or higher and almost half having incomes greater than \$60,001. These demographic indices, other than age, also corresponded to results of the study by Downer et al. (1994) which found that participants using complementary therapies tended to be younger, of higher social class and female.

Of those who knew their stage of cancer upon diagnosis, half of the sample was in either Stage 1 or Stage 2 at time of diagnosis, which corresponds with the sample of Thomas-Beckett (1991). Based upon this early detection, this also indicates that the majority of these women will be breast cancer survivors, dealing with the impact of breast cancer on a longterm and chronic basis. As early detection technology advances, and treatment modalities for breast cancer become more effective this population will continue to expand.

One of the interesting findings of this study was that the mean length of time since diagnosis was greater than 5 years. It was surprising that a large number of women were still participating in a breast cancer support group 5 years after their diagnosis and surgery. The women's continued participation in a breast cancer support group may indicate the impact the disease still has on their lives and the continued support they desire. These findings are supported by Wyatt & Friedman (1996) who have studied the long-term female cancer survivor, and found that the issues of most importance to this population revolve around spiritual, psychological and social concerns. In Wyatt & Friedman's study, quality of life was found to be poor in the areas of spiritual/philosophical, diet and exercise habits, with the lowest score identified in social/emotional support.

One out of five participants, were unable to report the stage of their breast cancer when it was diagnosed. In this study, the percentage of women who did not know the stage of their breast cancer at diagnosis was smaller than Thomas-Beckett (1991) study (21%; 39%) respectively.

The majority of the women had a modified radical mastectomy with chemotherapy as a treatment modality. Although this finding parallels the previous pattern of treatment recommended for breast cancer Stage 1 or 2 by the ACS (1995), the latest treatment recommendations include lumpectomy with irradiation followed by adjuvant therapy, versus the modified mastectomy with irradiation and adjuvant therapy.

Overall Attitude Toward TT

Quantitative analysis of the Attitude Inventory items revealed an overall positive attitude toward TT by the participants. This finding was supported by the qualitative responses. These findings support the previous findings by Thomas-Beckett (1991) who found a positive attitude toward TT. Further indication of a overall positive attitude toward TT was expressed by over 75% of the sample who responded to item 40 stated a willingness to receive TT, as compared to Thomas-Beckett's findings of 54.5% willing to receive a TT treatment. Although only a limited number of participants had ever received TT, the overwhelming majority were willing to try this particular complementary therapy. In this study, the number of participants who had actually received the complementary therapy of TT, i.e., one of seven, were less than the percentage found in the study by Eisenberg et al. (1993), which was approximately one of three. But study results, one of seven who had actually received the complementary therapy of TT, were very consistent to the findings of Downer et al. (1994) which surveyed practice of complementary therapies by cancer patients and presented a final result of one out of six using a complementary therapy.

Some of the reasons for this positive attitude toward TT were reflected in the open-ended responses which indicated ideas such as an acceptance of the mind-body connection, desire for non-invasive and non-pharmacologic therapy and also recognition of the stress in their lives resulting from the diagnosis and treatment of breast cancer and the potential value of TT in easing that stress and anxiety. All positive responses regarding TT referred to the use of the intervention to complement

the medical care they received. No participant stated a desire for TT in place of, or as an alternative to medical treatment.

The open-ended questions reflected the individual's rationale for a positive attitude toward TT and clearly illustrated the ability to categorize responses as either affective, cognitive or behavioral components of attitude. The Likert items were necessary and essential to quantify the attitude toward TT, and the open-ended questions contributed data for a more broad description of attitude. This indicates a clear advantage of the methodological design of the ATTT instrument which incorporates both quantitative and qualitative items to increase the interpretability of the study findings.

Previous Knowledge Without Experience of TT

There was a greater percentage of participants in this study who had heard of TT previously (53%) compared to the study done by Thomas-Beckett (1991) which had only 33% of sample with previous knowledge of TT. The majority of those who had previous knowledge of TT indicated that they had learned of TT through a presentation and demonstration by a group of nurses at the Kent County breast cancer support group. Sources of information regarding TT were either a health care professional or friend. There was no indication of lay sources of information regarding TT. Receiving information on TT from a health professional or acquaintance may increase the positive attitude of TT and willingness to learn more about the intervention. Also, many participants commented that they were aware of others who had received TT and had a beneficial response.

Unexpectedly, there was no significant difference in attitude toward TT among those who had previous knowledge without experience of TT, as compared to women with no previous knowledge of TT ($\underline{M} = 4.28$, $\underline{SD} = 1.07$ and $\underline{M} = 4.58$, $\underline{SD} = 1.48$) respectively, with a possible range of 1 - 6, and a total mean scale score greater than 3.5 indicative of a positive attitude toward TT. These values do not demonstrate as much actual variability when comparing the two groups of those with and without previous knowledge of TT. This differed from the Thomas-Beckett's (1991) study which found a significant difference and more positive attitude toward TT among those women who had previous knowledge without experience of TT as compared to those with no previous knowledge. In this study, previous knowledge regarding TT, does not equate with acceptance of TT or positive attitude toward TT. This is supported by the qualitative findings which reflect an interest in TT but moderated by major skepticism themes.

There are several possible reasons for this finding. For participants, stating that they have knowledge regarding TT does not mean that they believe the accuracy of that knowledge or have accepted the information. Definite gaps may exist on the continuum of knowledge progressing to attitudes advancing on to behaviors. Also, considering the sample characteristics, the information participants had previously received on TT may not have conformed culturally with their value system. Kent and Ottawa counties are predominantly conservative, Dutch, and Christian Reformed. Many responses to the open-ended questions expressed skepticism and concern of a link with the New Age ideology which would not conform with their religious value system.

Another possibility to consider is the orientation of the provider of information regarding TT, was it presented positively or negatively which would have impacted upon attitudes.

Previous Experience with TT

While the frequency of previous knowledge of TT among participants was quite high, the number of those who actually experienced a TT treatment was quite small, only one out of seven. Possible reasons for this low number were also provided by participants. Many indicated that they did not know where TT treatments might be available, how to locate complementary services, or the cost involved in receiving TT. Cost may have been a barrier for some, as several responses included a wish that TT or similar complementary therapies would be covered by their insurance policies. Participants expressed a wish that their present physician or health care provider would offer TT. The small number (14%) of participants who had received TT was similar to Thomas-Beckett's (1991) finding, which was approximately 10% of her study sample. Interestingly, Thomas-Beckett's study was done in a university community and the majority of the respondents in this study were from Kent County, which includes a larger city, yet there was a lower number of participants who received TT possibly due to lack of available TT providers. This lack of providers of complementary therapy may be even more marked in a smaller populated, rural community.

This outcome was similar when comparing for any differences in attitude toward TT between the groups of those with previous experience of TT, having actually received a TT treatment, and those with no previous experience of TT. Again

there was no significant difference in attitude toward TT between these two groups (\underline{M} = 4.68 and \underline{M} = 4.44) respectively. Results by Thomas-Beckett (1991) did not indicate a significant difference in attitude toward TT between those with previous experience as compared to those without previous experience with TT. For Thomas-Beckett (1991) the \underline{n} = 31, only 3 of which received TT previously, so it was a very small group with a large standard error which may have had an impact.

Although the group who had received TT previously was larger in this study (\underline{n} = 10) than Thomas-Beckett's study, it still was small in comparison to the group of those with no previous experience of TT (\underline{n} = 60). Such a small group size does not statistically create an ideal situation for this type of comparison. There is less chance for significant findings when such a large sampling variability exists between the two groups. Also, receiving a TT intervention may not have been a pleasant or positive experience for those participants, which would have impacted negatively their attitude toward TT.

Discussion of Results with the Conceptual Framework

The results of this study partially support the conceptual model as proposed. The responses to the close-ended and open-ended questions demonstrate the affective, behavioral, and cognitive components of attitude as conceptually defined. Based upon participants' written statements, these components can be analyzed and an attitude toward TT was inferred and found to be positive. These statements support the schematic which represents The Woman with Breast Cancer as irreducible and pandimensional with attitude incorporated into the essence of the psychological, social,

biological and spiritual dimensions.

Findings from this study also indicated that for those 44% of participants with no previous knowledge of TT, a large number were able to develop a positive attitude toward TT ($M = 4.03$, $SD = .92$) based upon the information provided by the written description of TT. This willingness to learn about TT and develop a positive attitude toward TT based upon the written description of the ATTT, reflects the openness of the Unitary Human Being to the environmental field which includes the APN, who has knowledge and experience regarding complementary therapies, including TT. Many participants expressed a positive attitude toward TT and interest to learn more about TT, based upon this written description of TT, which for many was their first exposure to the intervention of TT.

The attitude toward TT was not significantly different among those with previous experience or knowledge regarding TT as compared to those with no prior experience or knowledge. This is the component of the model which needs to be altered based upon study findings. If the present model was used in future replications of this study, the following changes would be recommended. For the Unitary Human Being, as illustrated in the schematic, in place of the concept previous knowledge or experience regarding TT, would be inserted the concept of pattern. Pattern is one of the four building blocks of the Rogerian model, and is the unique quality which differentiates a human energy field from an environmental energy field. Pattern is manifested in feelings and emotions, and is therefore linked to attitude. The introduction of knowledge or experience regarding TT by an APN would alter or

expand a person's pattern, as the the environmental and human energy fields are both open and continuously changing.

Implications for Advanced Practice Nursing in Primary Care

Based upon the study findings of a positive attitude toward TT there are many implications for the APN providing holistic care in a primary care setting. This section will review these implications for the APN in primary care and recommendations for further research based upon the study findings. These implications for the APN in primary care, will be reviewed within the framework of clinical, educational and research applications.

The major findings of the study include an overall positive attitude toward TT. Seventy-eight percent of the participants expressed a willingness to receive TT. Fifty-three percent had heard of TT previously, but only 14% had received a TT intervention. There were no significant differences in attitude toward TT for those who had previous knowledge or experience with TT as compared to those with no previous knowledge or experience.

Characteristics of the sample population, which include a mean length of time since diagnosis of over 5 years reflect the need for clinical consideration of the woman with breast cancer who is a long-term survivor. This population of women who are long-term survivors of breast cancer, along with other cancers, is increasing and will be seen with greater frequency by the APN in the primary care setting. As is evidenced by their continued participation in a breast cancer support group, even after many years have lapsed since their initial diagnosis and as reflected in the responses to

the open-ended questions, these women are still dealing with issues that are very psychologically and emotionally stressful for them. The APN as assessor and clinician must continue to collect subjective data from women with breast cancer to identify their perceptions of emotional or psychological stress, even though the treatment may have been completed years ago. The APN must foster a holistic caring relationship, which encourages openness and communication and recognizes the psychological, social and spiritual needs along with the physical. Wyatt & Friedman (1996) have suggested that providers must become more educated, more tolerant and accepting of a wider variety of spiritual, existential and philosophical issues to be effective in caring for these long-term cancer survivors who may have many non-physical needs. The first step in this process is the APN recognizing their own beliefs and value system.

Many women with breast cancer also expressed a recognition of the mind-body connection and the effect of their emotional or psychological stress upon their physical well-being. A desire for their providers to also recognize this connection was voiced. The APN's role as a leader of the health care team can be very instrumental in shaping this change in the orientation of health care services which the woman with breast cancer desires. New models of health care delivery systems are being created, the APN can guide this process to ensure that client-centered and holistic care is established as a standard of care.

The APN who is community based as a primary care provider is especially suited to impact upon enhancing the standards of care provided to women with breast cancer. The community presence of the APN allows for development of networks and

linkages with other community systems such as health providers, healthcare facilities, agencies, and families to promote holistic healthcare which includes complementary therapies. The APN as change agent can affect care not only at the individual or community level, but also would be able to have an impact at the state or national level to further increase political and legislative awareness of healthcare consumers' demand for holistic health care. Health care policies and pathways of care can be developed and designed with this objective of holistic health care in mind, which includes complementary therapies, such as Therapeutic Touch.

Many of the respondents indicated that they wished they had a non-pharmacologic intervention such as TT available to help with relaxation and possibly decreasing their stress. Along with the non-pharmacologic properties, the complementary therapy modality offers a cost-effective strategy to alleviate stress, ease pain while also promoting healing and relaxation. Cost-effective strategies such as this are becoming crucial in today's managed care environment. With the utilization of TT and other complementary therapies, cost savings to a practice may be achieved through reductions in complications or secondary infection, fewer costly prescriptions may be required, and provider time may be reduced by a decrease in repeat office visits or telephone calls to manage chronic problems.

New models of care, which are cost-effective and have positive outcomes are sought after in the managed care arena. Therefore, education regarding TT and complementary therapies must also be extended to other health care providers and agencies. Keeping in mind the limitations of this study regarding generalizability,

studies such as this support the trend that women with breast cancer have a positive attitude toward TT. If the goal of providers or institutions is to provide holistic care, which is consumer-driven, these interests in complementary therapies need to be addressed.

Three quarters of the sample expressed an interest in receiving TT. In contrast to this considerable desire to receive TT, only 14% had ever received TT. Most women did not know where to locate a provider of TT, which has a definite implication for primary care. Ideally, the APN would possess the knowledge regarding complementary therapies and could provide TT and incorporate the intervention into the management plan for the client. But, if an APN had not learned the skills of TT, implications of this study indicate that the APN must act as a coordinator of care to find a practitioner who has expertise in this complementary therapy. Sometimes, this may even necessitate the APN to act as an advocate and leader in either the healthcare or political arenas, to ensure that complementary therapies are available to the client. This study established that a positive attitude toward TT and solid interest in receiving this nursing intervention existed among this sample.

Recognizing the positive attitude in TT and other complementary therapies the APN must act as an educator to assist the client in making informed choices regarding complementary therapies to increase potential benefits and limit risks to the client. This role of the APN as an educator was also well illustrated by the study results. For many of the participants, they had no previous knowledge or experience with TT and expressed an appreciation of the information obtained in the written description of TT.

This supports the APN acting as a resource of knowledge and experience regarding TT for the woman with breast cancer. But in order to provide the client with this information, the APN must be very knowledgeable regarding available complementary therapies. To promote acceptance and use of TT by clients in a primary care setting, an APN may utilize several marketing strategies. Examples of these strategies may include offering a free trial of a TT intervention, which would allow clients to experience TT and promote dissemination of information on TT by word of mouth to the client's acquaintances and advertisement of TT services provided by the APN, through office postings, newspaper ads or public seminars. If TT proved beneficial for the client, the APN could teach family members how to provide TT, which would empower the family and decrease the dependence upon the APN, further encouraging the active participation of the client in their own health care.

As proposed by Rogers, there is an openness and integrality of the woman with breast cancer with the greater environmental field, which includes the APN. This openness and integrality allows the APN, who has knowledge and experience of complementary therapies, including Therapeutic Touch, to act as a resource of information regarding TT and thereby affect the attitude toward TT of the woman with breast cancer. Through this openness of the energy fields, the APN, as educator and collaborator may have an effect on women's use of TT and/or other complementary therapies.

The integrality of the client and the client's environment must always be recognized, as the environmental or social context of a client will influence his or her

attitudes. The APN and the healthcare system are part of this environmental context. Utilizing experience and knowledge, the APN is able to be an effective change agent and educator for the client, and influence the client's attitudes. This was evidenced by participants who had no prior knowledge of TT before receiving the study packet and expressed appreciation and desire to learn more about the TT intervention, which they previously did not know existed. Based upon study findings, the APN practicing in a primary care setting, must be aware of this desire by clients for further education of complementary health care strategies and continue to educate clients regarding complementary therapy options. This requires that the APN has a knowledge base regarding TT and complementary therapies. TT is only one of many known complementary therapies. Before APNs can educate clients, they must educate themselves.

The knowledge base available to APNs needs to be continuously updated and refined by research-based data. The APN, as a leader and role model for nursing, can further these research activities. As Wyatt (1988) states: "The current research base of Therapeutic Touch is expanding, as the practice area continues to generate further questions for study" (p. 42). The APN, as researcher, can fully explore TT and other holistic nursing interventions. Henerson, Morris, & Fitzgibbon (1987) assert the importance of assessing attitudes: "It is necessary to assess attitudes in order to determine if interventions brought about an attitude change which will eventually lead to new behaviors" (p. 8). According to this statement, it is productive to research attitude along with complementary therapies. This study was built upon and supports

the previous research on attitudes toward TT (Thomas-Beckett, 1991). Based upon study findings, that a positive attitude toward TT and interest in TT exist, the next progression would be to expand the research into the actual intervention and outcomes, to answer questions relating to how attitudes are affected by the TT intervention and vice versa, how the outcomes of the TT interventions affect attitudes. The scientific data to support the TT intervention must exist for the APN to be an effective change agent in increasing the acceptance of TT and other complementary therapies by the health community and securing financial measures such as health insurance reimbursement for TT, which was specified by many participants as an important consideration.

Recommendations for Further Research

The literature review, as discussed earlier, revealed a paucity of research regarding attitude toward TT. Further research is suggested as follows:

1. Further tool refinement and testing of the reliability and validity of the ATTT instrument, as this is the only instrument identified to specifically assess attitude toward TT. Several suggestions for future tool refinements were made by the tool developer, Thomas-Beckett (1991), some of which were accomplished with the present study. For this study, it was noted that for many participants, especially the older women, their initial reaction was that the survey was too lengthy and overwhelming. It is recommended to modify the format to overcome this perception and potentially increase the response rate for future studies. For the Attitude Inventory section, rather than having each

question with Likert items placed underneath, have the Likert items positioned to the right side of the questions in a column format. With this type of format, all of the Attitude Inventory items could easily be placed on 1 page, as compared to the 3 required at present.

2. Since the components of attitude were not found to be very distinct, and the ATTT instrument is unidimensional, factor analysis of discussions from focus groups of women with breast cancer could be analyzed to further refine the ATTT instrument and improve the quality of the subscales. The themes obtained from the focal group could then be utilized to develop new quantitative items. These new Likert items would be piloted with a large sample and factor scores could be computed to identify any distinct dimensions or measures of the construct of attitude.
3. If this study is replicated with a similar population, it is recommended that the data collection occur during spring or fall months. This is advisable as some groups do not meet during the summer months and some do not meet during the winter months. Also, for those groups who may meet year round, the attendance rates fall markedly during the summer according to group facilitators.
4. Regarding data collection procedures, it was noted that the most complete surveys, especially regarding the open-ended questions were from the Kent County participants, who received their surveys by mail. Apparently, having the opportunity to complete the surveys at their convenience facilitated more

complete responses. Also, the meeting agenda was quite full for some of the groups and it was difficult for enough time to be allotted to complete the survey. Future research designs could incorporate mailing the surveys.

5. Design a more powerful study utilizing the ATTT instrument, which has a larger sample to increase the generalizability of the findings and allow for inferential statistics. If the design was altered to have surveys mailed, a random selection of potential participants could be made from the Tumor Registry which would also increase the heterogeneity of the sample and expand the generalizability of the study findings.
6. Develop a randomized, double-blind, pretest-posttest experimental design, utilizing the ATTT instrument and the actual intervention of TT to determine if receiving TT affected the outcome of a more positive or negative attitude toward TT.
7. Include questions in the ATTT instrument to assess why participants had either started or stopped TT. It would also be interesting to study what subjective response to a TT treatment was experienced by participants and how that might affect their attitude toward TT.
8. Add a Locus of Control (LOC) scale to the ATTT instrument to study if those participants with an internal LOC would have a more positive attitude toward TT than those with an external LOC. A study done by Furnham and Forey (1994) indicated that clients with an internal LOC were more receptive to complementary therapies.

Summary

This study assessed the attitude toward TT of women with breast cancer after participants read a written description of Therapeutic Touch. Findings support the earlier study done by Thomas-Beckett (1991) of an overall positive attitude of women with breast cancer toward TT. The responses by the participants also supported the literature which indicates a significant interest by health care consumers regarding complementary therapies.

The message of health care consumers of the 1990's is clear, the health care system can no longer provide only conventional and dualistic care, which are both traditionally based upon the medical model approach. This study supports the literature which indicates a heightened interest and demand for holistic care, that includes the component of complementary therapies. The APN who understands that no separation or clear boundary exists between a person's psychosocial, spiritual, or physical health, and is knowledgeable and experienced regarding complementary therapies will be prepared to meet this demand for holistic health care.

APPENDICES

APPENDIX A

APPENDIX A

ATTITUDES TOWARD THERAPEUTIC TOUCH INSTRUMENT

Dear Potential Participant,

I am a graduate student in the College of Nursing at Michigan State University. My studies include the completion of my master's thesis.

I am utilizing a questionnaire to assess attitudes toward Therapeutic Touch. Women who have been diagnosed with breast cancer will be asked to complete the written questionnaire. As a nurse, I am interested in providing quality care to people and the community. Research such as this will hopefully provide information for treatment options for all patients.

An explanatory letter with consent information immediately follows this letter. The questionnaire is located inside the manila envelope. Your help and assistance is greatly appreciated.

Once again, thank you for considering participation in this study.

Sincerely,

Donna Zambetis, R.N., B.S.N.

Explanatory Letter and Consent Information

This study is a Michigan State University graduate student thesis. It is designed to obtain information about a particular nursing intervention; Therapeutic Touch. Information from this study may be used to develop research plans for further testing of Therapeutic Touch as a nursing intervention. Participation in the study requires the completion of a short questionnaire. The amount of time needed is about 15 minutes.

If you wish to participate, open the envelope and follow the directions for completing the questionnaire. Once completed, place the questionnaire in the envelope and deposit it in the designated collection box. By completing and returning the questionnaire, you are voluntarily agreeing to participate in the study. Participation in the study consists only of completing the questionnaire. If you have any questions about how to complete the questionnaire, ask the staff member.

Your participation is voluntary; you may refuse to participate or stop your participation at any time without penalty. There are no known risks of harm either physically, psychologically, socially, or economically from filling out the questionnaire. Benefits of your participation include providing information which would be used to further test the intervention of Therapeutic Touch.

Your response to the questionnaire will be held strictly confidential. Answers to the questionnaire will be shared with the principal investigator, Donna Zambetis, R.N., and her thesis committee only for purposes of this study. No names will be used, and subjects will remain anonymous in all reports of the research findings.

If you do not wish to participate, replace the questionnaire in the envelope and deposit it in the collection box. Because all questionnaires are returned in an envelope and no names appear anywhere on the questionnaire, you are guaranteed anonymity.

If you have any questions or concerns about this study, please contact the principal investigator for assistance:

Donna Zambetis
404 Leggatt
Grand Haven, MI 49417

Phone: (616)847-6437

Thank you for your time and participation in this research project!

If you would like a report of the research findings, whether you complete the questionnaire or not, please write your address only at the bottom of this paper. Keep the top portion of this letter, and separately place this portion, with your address, in the study result request envelope. Results of the study will be addressed to "Potential Participant".

address_____state_____zipcode_____

INSTRUCTIONS: Please read the following description of Therapeutic Touch;

Since your diagnosis of breast cancer, you may have been introduced to many methods of medical treatment such as surgery, chemotherapy, or radiation. Some women take an active role in their health care by seeking medical, as well as non-medical treatments to improve their well-being. There are many non-medical treatments which can be used for achieving well-being, such as imagery, biofeedback, and relaxation techniques. Another example of a non-medical treatment is Therapeutic Touch.

Therapeutic Touch is a nursing intervention. It is based on the belief that human beings do not stop at the skin, rather, we release and are surrounded by an energy field. Imagine sitting close to someone. You can feel the warmth of their body even though you are not physically touching them. You are interacting with their energy field, which cannot be seen, but it can be felt and described.

There are studies being done on the effects of Therapeutic Touch in order to understand how it can help people such as you. Some studies have found that Therapeutic Touch can reduce tension headache pain, promote relaxation, accelerate the healing process, relieve nausea, reduce anxiety, and increase hemoglobin levels, while other studies have found no results from Therapeutic Touch. More information is needed about Therapeutic Touch, so it can be used for the promotion of health and well-being of all patients who wish to participate in their care.

***After reading the description below of Therapeutic Touch, please turn the page and answer the questions on the Study Questionnaire.

Thank You.

If you were to receive Therapeutic Touch, you would be placed in a quiet room, sitting in a comfortable chair with comfortable clothing. Your feet are on the ground and your arms are at your sides. You could close your eyes, and allow your body to relax. The nurse would then move his/her hands over your body, leaving the hands about three to five inches away from your skin. She/he is massaging the field of energy that surrounds you and is a part of you. Moving from your head to your toes in a gentle sweeping motion, the nurse is massaging you without having to physically touch you. You may experience a sensation of warmth or tingling on your skin, and an overall feeling of relaxation.

The Therapeutic Touch treatment usually lasts about fifteen minutes. After the treatment is over, you may sit in the chair, relaxed and quiet. The goal of the Therapeutic Touch treatment has been to create balance in your energy field, in order to allow your own healing energies to work.

Questionnaire

For the following questions, please fill in the blank or place a checkmark by the answer which applies to you:

1. What year were you diagnosed with breast cancer?_____,
do not know_____.
2. Have you had a radical mastectomy for breast cancer treatment? yes___ no___
do not know_____.
3. Have you had a modified mastectomy for breast cancer treatment? yes___ no___
do not know_____.
4. Have you had a lumpectomy for breast cancer treatment?
yes___ no___ do not know_____.
5. Have you had radiation for breast cancer treatment?
yes___ no___ do not know_____.
6. Have you had chemotherapy or other drugs for breast cancer treatment? yes___ no___
do not know_____.
7. Have you had any other treatment for breast cancer not listed? yes___ no___ . If yes,
please list_____, do not know_____.
8. What stage was the cancer in your breasts upon diagnosis?
Stage 0___, Stage 1___, Stage 2___, Stage 3___, Stage 4___, do not know_____.
9. What is your age? _____
10. What is the highest level of education that you have completed?
1st - 11th grade _____
High School Diploma _____
Some college _____
Baccalaureate Degree _____
Post-Graduate _____
Master's Degree _____
11. What is your primary race or ethnic group?
Asian or Pacific Islander _____
Black or African American _____
Hispanic _____
Native American _____
White or Caucasian _____
Other _____

12. What is your occupation? _____
13. Please indicate the appropriate category for your annual household income.
- | | |
|---------------------|-------|
| 0 - \$12,000 | _____ |
| \$12,001 - \$24,000 | _____ |
| \$24,001 - \$36,000 | _____ |
| \$36,001 - \$48,000 | _____ |
| \$48,001 - \$60,000 | _____ |
| \$60,001+ | _____ |
14. Have you ever heard of Therapeutic Touch before today?
yes___ no___
If yes, what have you heard? _____
15. Have you ever received Therapeutic Touch as described in the paragraph? yes___ no___
If no, then go to question #12.
If yes, how many months ago? _____
If yes, how many times did you receive Therapeutic Touch? _____

Go to the next page when completed with the above questions.

Attitude Inventory

For the following questions, read each item and circle the response which best describes your reaction to the statement about Therapeutic Touch:

16. I am glad there are health care interventions such as Therapeutic Touch.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

17. I believe Therapeutic Touch can reduce unpleasant symptoms.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

18. I am not happy that there are health care interventions such as Therapeutic Touch.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

19. I will not seek further information about Therapeutic Touch.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

20. I intend to tell family and/or friends about Therapeutic Touch.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

21. I feel calm when I read about Therapeutic Touch.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

Please continue on the next page

22. I believe human energy fields can be felt and massaged.

| | | | | | |
|----------------------|----------|----------------------|-------------------|-------|-------------------|
| STRONGLY DISAGREE | DISAGREE | SLIGHTLY DISAGREE | SLIGHTLY AGREE | AGREE | STRONGLY AGREE |
|----------------------|----------|----------------------|-------------------|-------|-------------------|

23. I do not think Therapeutic Touch could help me.

| | | | | | |
|----------------------|----------|----------------------|-------------------|-------|-------------------|
| STRONGLY DISAGREE | DISAGREE | SLIGHTLY DISAGREE | SLIGHTLY AGREE | AGREE | STRONGLY AGREE |
|----------------------|----------|----------------------|-------------------|-------|-------------------|

24. I will not tell anyone about what I've read about Therapeutic Touch.

| | | | | | |
|----------------------|----------|----------------------|-------------------|-------|-------------------|
| STRONGLY DISAGREE | DISAGREE | SLIGHTLY DISAGREE | SLIGHTLY AGREE | AGREE | STRONGLY AGREE |
|----------------------|----------|----------------------|-------------------|-------|-------------------|

25. I think Therapeutic Touch could have beneficial effects.

| | | | | | |
|----------------------|----------|----------------------|-------------------|-------|-------------------|
| STRONGLY DISAGREE | DISAGREE | SLIGHTLY DISAGREE | SLIGHTLY AGREE | AGREE | STRONGLY AGREE |
|----------------------|----------|----------------------|-------------------|-------|-------------------|

26. I do not believe Therapeutic Touch can reduce unpleasant symptoms.

| | | | | | |
|----------------------|----------|----------------------|-------------------|-------|-------------------|
| STRONGLY DISAGREE | DISAGREE | SLIGHTLY DISAGREE | SLIGHTLY AGREE | AGREE | STRONGLY AGREE |
|----------------------|----------|----------------------|-------------------|-------|-------------------|

27. I am excited about Therapeutic Touch.

| | | | | | |
|----------------------|----------|----------------------|-------------------|-------|-------------------|
| STRONGLY DISAGREE | DISAGREE | SLIGHTLY DISAGREE | SLIGHTLY AGREE | AGREE | STRONGLY AGREE |
|----------------------|----------|----------------------|-------------------|-------|-------------------|

28. I am afraid to receive Therapeutic Touch.

| | | | | | |
|----------------------|----------|----------------------|-------------------|-------|-------------------|
| STRONGLY DISAGREE | DISAGREE | SLIGHTLY DISAGREE | SLIGHTLY AGREE | AGREE | STRONGLY AGREE |
|----------------------|----------|----------------------|-------------------|-------|-------------------|

29. I plan to read more about Therapeutic Touch.

| | | | | | |
|----------------------|----------|----------------------|-------------------|-------|-------------------|
| STRONGLY DISAGREE | DISAGREE | SLIGHTLY DISAGREE | SLIGHTLY AGREE | AGREE | STRONGLY AGREE |
|----------------------|----------|----------------------|-------------------|-------|-------------------|

Please continue on the next page

30. I think Therapeutic Touch could help me.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

31. I do not believe human energy fields can be felt and massaged.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

32. I would be willing to receive Therapeutic Touch treatments along with my prescribed cancer treatments.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

33. I do not believe human energy fields exist.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

34. I have unpleasant feelings when I read about Therapeutic Touch.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

35. I feel reassured when I read about Therapeutic Touch.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

36. I would not be willing to receive Therapeutic Touch treatments along with my prescribed cancer treatments.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

37. I have pleasant feelings when I read about Therapeutic Touch.

| | | | | | |
|----------|----------|----------|----------|-------|----------|
| STRONGLY | DISAGREE | SLIGHTLY | SLIGHTLY | AGREE | STRONGLY |
| DISAGREE | | DISAGREE | AGREE | | AGREE |

Please go on to the next page when you have completed the above questions.

For the following questions, please write any additional information you were unable to share in the previous questions. Please be specific.

38. What other feelings or reactions do you have about Therapeutic Touch?
39. What further information would you like to know about Therapeutic Touch?
40. Would you be willing to receive Therapeutic Touch? Why or why not?

Whether or not you completed the questionnaire, place it in the envelope and deposit it in the collection box.

****Thank you for your participation in this study*****

APPENDIX B

APPENDIX B

REMINDER POSTCARD

Reminder Postcard

Just a reminder to send in your Therapeutic Touch Survey. If you have already done so, I would like to thank you for your participation. If you need another questionnaire, please call (616) 847-6437, leave your address, and one will be sent to you.

Thank you,

**Donna Zambetis R.N., B.S.N.
MSU Graduate Program**

APPENDIX C

APPENDIX C

UNIVERSITY COMMITTEE ON RESEARCH INVOLVING
MICHIGAN STATE UNIVERSITY
 ANIMAL OR ANIMAL SUBJECTS
 UNIVERSITY

June 3, 1996

TO: Donna Zambetis
 404 Leggatt
 Grand Haven, MI 49417

RE: IRB#: 96-303
 TITLE: ATTITUDES OF WOMEN WITH BREAST CANCER TOWARD
 THERAPEUTIC TOUCH
 REVISION REQUESTED: 05/30/96
 CATEGORY: 1-C
 APPROVAL DATE: 05/28/96

The University Committee on Research Involving Human Subjects' (UCRIHS) review of this project is complete. I am pleased to advise that the rights and welfare of the human subjects appear to be adequately protected and methods to obtain informed consent are appropriate. Therefore, the UCRIHS approved this project and any revisions listed above.

RENEWAL: UCRIHS approval is valid for one calendar year, beginning with the approval date shown above. Investigators planning to continue a project beyond one year must use the green renewal form (enclosed with the original approval letter or when a project is renewed) to seek updated certification. There is a maximum of four such expedited renewals possible. Investigators wishing to continue a project beyond that time need to submit it again for complete review.

REVISIONS: UCRIHS must review any changes in procedures involving human subjects, prior to initiation of the change. If this is done at the time of renewal, please use the green renewal form. To revise an approved protocol at any other time during the year, send your written request to the UCRIHS Chair, requesting revised approval and referencing the project's IRB # and title. Include in your request a description of the change and any revised instruments, consent forms or advertisements that are applicable.



OFFICE OF
 RESEARCH
 AND
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 STUDIES

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PROBLEMS/
 CHANGES:

Should either of the following arise during the course of the work, investigators must notify UCRIHS promptly: (1) problems (unexpected side effects, complaints, etc.) involving human subjects or (2) changes in the research environment or new information indicating greater risk to the human subjects than existed when the protocol was previously reviewed and approved.

If we can be of any future help, please do not hesitate to contact us at (517)355-2180 or FAX (517)432-1171.

Sincerely,

David E. Wright
 David E. Wright, Ph.D.
 UCRIHS Chair

DEW:bed

cc: Gwen Wyatt

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 Excerpts in Action

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APPENDIX D

APPENDIX D

RESPONSES TO OPEN-ENDED QUESTIONS

Item 38: What other feelings or reactions do you have about TT?

"What kind of training is needed? Does it require a nurse? Would a significant other in patient's life be just or more effective in giving TT?"

"Skeptical, but interesting."

"That we as Western medicine participants need to be familiarized with the mind-body connection and need a better understanding of the molecular structure of the body."

"Fear of the unknown."

"I'm kind of neutral regarding it - sounds a little far out to me - but I am open minded about it to."

"Did not know it wasn't touching. I thought it was along the lines of a massage."

"I believe it works - I have seen it work! However, I also think that health care systems have not seen the positive results. This is a difficult treatment to have endorsed - especially in hospitals. Nurses do not have the experience to do this either. it would be wonderful to include in a BSN curriculum."

"I'd like to see conventional medicine incorporate traditional methods in teaching. This survey is encouraging."

"This is the first time I heard about TT. I would like to know much more. When I first read, my reaction was yea! Right! another quack treatment to practice on women who are emotionally and physically vulnerable."

"If it works for others, fine."

"Reading about Therapeutic Touch makes me want to explore therapeutic massage, which I've never done."

"It sounds interesting and wanted to know more when I read the enclosed information."

"I have searched for a calming influence ever since my diagnosis. This would have contributed greatly. Hope it gets put into practice."

"Anything that can reduce the anxiety and side effects of cancer treatment is beneficial."

"I think it probably would be a very positive thing to do."

"I'm open to learning about any healing treatment especially if it can reduce stress or fear, associated with breast cancer."

"I can't answer well being uninformed."

"I would be interested in knowing more about it."

"I believe its a little unbelievable and I feel its a way Drs. can make more money off people without the cost of medicines - very profitable for the Dr. and very expensive for the patient. Treatment already costs enough to the survivor. T. Touch is not going to cost the Dr. much."

"Stress relief is beneficial to health. I know. We've moved 13 times and I get/catch something every time so am always alert to listening to my body. That's how I found my cancer in stage 0, by having a physical shortly after a move. Dr. found it on mammogram."

"Sounds interesting - worth further investigation."

"I get concern that it could be 'used' in place of more traditional treatment, and result in a person hitching their 'cure' to the wrong star. Once diagnosed, you can become desperate and willing to do almost anything. Where is the documentation and outcomes. I tend to be very accepting of alternative forms of medicine and do believe that it someone believes a treatment works, then it just may."

"I always am curious and do believe if you strongly believe something would work, it will."

"I believe this therapy should be given without charge to the patient; without compensation (monetary) to the provider. I believe some people are natural 'healers'. I also believe in prayer by the patient in conjunction with those around her."

"I wish that I had TT when I was having my cancer treatment."

"Since there is no guaranteed prescription/treatment/cure for breast cancer I do not and will not rule out any kind of treatment which may help at least one person. If therapeutic therapy can relieve any anxiety or can relax a person with any additional therapy then I am all for it."

"This technique doesn't sound very scientific or medical to me. It verges on religious or 'witch doctor' type treatment."

"I do not know enough about it."

"It's such a interesting venture anyone would like to test it."

"I'd like to know more, and I'd like to try it."

"Unfortunately the demonstrations I've seen done by nursing staff make it out to be more than it is - it has been presented as a 'healing' process and I've seen it misrepresented to cancer patients."

"Since I have never experienced it, I think it would be a great thing if it worked but am not sure that it does."

"I'm curious about it as I've never heard about it before."

"I believe we as humans stop at the skin. I have no desire to pursue any other belief."

"I have known about this for years and practiced this for years. Therapeutic Touch is only the tip of the iceberg in what can be done with energy and healing. Therapeutic Touch is a beginning for the masses to become accustomed to the idea of touch, energy, and total healing. I say its about time."

"I know nothing about it."

"I believe that touch and presence are very important in the accepting and healing process - much more so because they are visible and real. I believe in God as the healer either through the means of healing the body by means of medical surgeries, medicine or death when we are healed forever and given new bodies."

"I feel they could really be helpful for some people. It just doesn't really interest me."

"Mixed emotions."

"I feel very skeptical about this actually working."

"I think its a wonderful idea. I also believe its important to have alternative methods of healing and am interested in hearing about them."

"What will they think of next?"

"When I heard my friend Karen talk about receiving daily Joh Re treatments for her MS, I thought it sounded very 'new age' and hokey. I mean . . . the light of the universe coming through someone's hands? Give me a break! So I was skeptical. She asked me if I'd like to try it, so I was game. I sat quietly and meditated and prayed. I'm probably leaning more toward believing that if the individual receiving TT or Joh RE believes the therapy helps her, then it will. How can you prove that energy fields can be modified or altered simply by having someone pass his/her hands over one's body? It sounds like hocus-pocus. But if the individual believes it helps, it will. . . sort of like hypnosis."

"I believe it can be very beneficial in releasing areas blocked by illness or injury. It is also very relaxing and has been beneficial to me. I am very interested in learning more about Reiki."

"I feel warm and relaxed and free of pain when I have my treatments."

"I don't think it's for everybody. Your mind must be open and receptive. I happen to think the mind can work wonders!"

"I would like to see more info made available to lay people and patients."

"Sounds great, where do I get more info."

"I have not formed any concrete opinion presently because I have not consciously investigated its possibilities. Logically it seems impossible that this could be effective in the healing process. Why not simply massage the skin, direct contact would seemingly be MORE effective if touching can help heal. Therefore why is TT more effective than actual touch?"

"I believe other methods of treatment can help breast cancer patients, however I am skeptical of TT. There are patients in my support group who attend the sessions regularly and feel better because of it they say."

"Don't know."

Item 39: What further information would you like to know about TT?

"None at this time."

"Anything about it."

"Cost. Where is it available?"

"How it works?"

"Names of teachers, practitioners."

"At the moment no. I'm doing very well right now."

"Is there any proof this works?"

"Where is it done?"

"Reading or someone who used this."

"None."

"I would like to talk to someone who has experienced TT themselves."

"Nothing."

"I would like to hear from cancer patients who received TT, and would like to know what they thought of it."

"None."

"Anything available."

"Where is it being done. And who is doing it. How has it helped."

"As you stated the nurses are the care givers in this area. Where can one receive it?"

"Do you have to be involved with treatments to experience TT?"

"Nothing."

"How to find out where its available when needed. Do doctors have info that they could be giving out when talking to a person about treatments."

"Where, when and how much is the cost?"

"What current research shows scientifically and spiritually. What generated this method. Why and how has it evolved."

"I guess I would like to know about the percentage it's helped and what conditions the patients were in."

"I would need to know what specifically the 'balance in your energy field' has to do with 'allowing your healing powers to work'. What's the theory, etc."

"Where is it being used? Some personal stories about the effect on the patient - nurse."

"Why does it work, in specific biological (vs. psychological) terms."

"How do they know about the energy field of another person is going to help the patient? Somehow I feel uncomfortable that by just placing your hands over my body will help anything."

"Is this associated with kinesiology?"

"Is it in the massage family?"

"How long must a person be involved in doing this?"

"Anything that is available."

"How long has it been around. What are the statistics on it. What are the additional steps or what does each session do. Is there a list of steps?"

"None."

"I would like to see in person or on video with qualified personnel."

"Who does it in Traverse City?"

"Probably would not be able to afford on a regular basis."

"Blind study research on control groups. Physiological results on tested patients."

"Scientific and psychological basis or information on TT."

Item 40: Would you be willing to receive TT? Why or why not?

"Yes, it can't hurt and I'll try most anything. I've had my 'aura' brushed and my chakras balanced and know that this at least felt good when done by someone who cared and believed, at least a little, in what they were doing."

"I'm always willing to receive any therapy."

"Perhaps for relaxation. Not having any cancer treatments right now. It would depend on the cost."

"Yes, willing to try!"

"Yes, I believe it works along with other complementary therapies."

"Yes. I'm still alive because I became my own physician and have educated myself on what works. And I have a positive attitude. I'm open to trying this."

"Yes. I would want anything that would promote the fight against cancer."

"Yes. I am always interested in any non destructive treatment programs that could be beneficial either physically or mentally."

"Sure, just for curiosity purposes."

"I'd be willing to try."

"I am not sure. 1) I don't feel I have enough information. 2) I am involved and very active in support groups, exercise, vitamins, and I also have a family who needs me. 3) Schedule problems."

"Yes."

"Yes, I'd be willing to receive it."

"Yes."

"Depending on reason."

"Sure, sounds interesting."

"I would not receive this treatment because something happened to me years ago."

"Yes, I would if something can make you feel better without drugs it is worth a try."

"Yes, but I don't think I would benefit by it. I believe its mind over matter. I don't believe I will benefit from it but if there is a slightest chance that I'm wrong, I don't want to rule out the benefit. I don't want a recurrence and if there's even the slightest chance that it could help, I'd be willing to give it a try."

"Yes, why not, yeh?"

"Yes, I strongly believe in nurturing the inner life force to be well. I also believe that this nurturance improves the quality of life."

"Yes, if it were covered by insurance and combined with more conventional treatment."

"I'd be willing to try it."

"Yes, because I believe we have only just discovered the tip of the iceberg as to human abilities to heal with our minds and souls; the energy field given off by our being (soul). I feel humans have great capabilities."

"Yes."

"Yes. I need all the balance I can find in my life."

"No."

"Yes, very much so. State of mind over matter."

"Yes, I'd love to try it. I belong to Expressions and the women in our group are very receptive to any Therapeutic touch program."

"Yes, anything that will help without drugs would be wonderful."

"Yes, massage therapy works well, so why not try Therapeutic Touch?"

"For reasons cited above, I've seen it misrepresented by the nursing profession to cancer patients. I have been sold to some as 'faith healing' and I find that pretty pathetic and unprofessional."

"I would be willing to try it if I was in pain."

"Yes. If I was still undergoing treatment I would definitely try this approach."

"No, I do not believe in it."

"Yes, mostly out of curiosity."

"I have and I believe in it totally!"

"No, not till I know more about it."

"I'm not really against it per se but feel it is not a necessary means - too ethereal, superstitious or new age type identification. For me it is not an option and in the category of yoga, meditation, etc. I would be interested in hearing the results of your study."

"I may try it sometime, but its not something I'm really interested in doing. I just don't feel like it would do that much for me."

"Not sure. I might want to observe it first."

"I don't think I would be a good candidate because I am doubtful of its benefits."

"It might be interesting. I'm always open to new things."

"No, waste of time."

"Absolutely. I have already utilized this technique on a limited basis and would like to do more."

"I go to touch healing 3 or 4 times a month. It has helped my cancer."

"Yes, to see if it really works."

"Sure, I don't see that it could harm anything - only help."

"Yes, its great stuff!"

"I wish more drs. would recognize TT can help a patient to get well, and not be afraid of it. More hospitals should allow their nurses, who can do TT to treat patients."

"Yes, it couldn't possibly harm and I believe it may help, to reduce stress if nothing else."

"Not sure at this time."

"Not sure at this time."

"Not at the present time. I am a 6 yr. survivor and don't feel I would benefit by it."

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