Complementary Therapies in Clinical Practice 24 (2016) 134–138

Contents lists available at ScienceDirect

Complementary Therapies in Clinical Practice

journal homepage: www.elsevier.com/locate/ctcp

Therapeutic Touch® in a geriatric Palliative Care Unit – A retrospective review

Helen Senderovich [a, b, d, e, *], Mary Lou Ip [h], Anna Berall [a], Jurgis Karuza [a, b], Michael Gordon [a, b, e], Malcolm Binns [a, f, g], Shaira Wignarajah [a], Daphna Grossman [a, d, e], Lynda Dunal [a, c]

[a] Baycrest, Toronto, Canada
[b] Department of Medicine, University of Toronto, Canada
[c] Department of Occupational Science & Occupational Therapy, University of Toronto, Canada
[d] Department Family and Community Medicine, University of Toronto, Canada
[e] Division of Palliative Care, University of Toronto, Canada
[f] Dalla Lana School of Public Health, University of Toronto, Canada
[g] Rotman Research Institute, University of Toronto, Canada
[h] Yee Hong Center for Geriatric Care, Canada

ARTICLE INFO

Article history:
Received 24 March 2016
Accepted 8 June 2016

Keywords:
Therapy
Palliative
Complementary
Symptoms
Gerontology

ABSTRACT

Complementary therapies are increasingly used in palliative care as an adjunct to the standard management of symptoms to achieve an overall well-being for patients with malignant and non-malignant terminal illnesses. A Therapeutic Touch Program was introduced to a geriatric Palliative Care Unit (PCU) in October 2010 with two volunteer Therapeutic Touch Practitioners providing treatment.

Objective: To conduct a retrospective review of Therapeutic Touch services provided to patients in an inpatient geriatric palliative care unit in order to understand their responses to Therapeutic Touch.

Methods: A retrospective medical chart review was conducted on both patients who received Therapeutic Touch as well as a random selection of patients who did not receive Therapeutic Touch from October 2010–June 2013. Client characteristics and the Therapeutic Touch Practitioners' observations of the patients' response to treatment were collected and analyzed.

Results: Patients who did not receive Therapeutic Touch tended to have lower admitting Palliative Performance Scale scores, shorter length of stay and were older. Based on a sample of responses provided by patients and observed by the Therapeutic Touch practitioner, the majority of patients receiving treatment achieved a state of relaxation or sleep.

Conclusions: This retrospective chart review suggests that implementation of a TT program for an inpatient geriatric Palliative Care Unit is feasible, and appears to be safe, and well-tolerated. Moreover, patient responses, as recorded in the Therapeutic Touch practitioners' session notes, suggest beneficial effects of Therapeutic Touch for a significant number of participants with no evidence of negative sequelae. Therefore, the use of TT in this difficult setting appears to have potential value as an adjunct or complementary therapy to help patients relax.

1. Introduction

Complementary therapies are increasingly used in palliative care as an adjunct to the standard management of symptoms to achieve an overall well-being for patients with malignant and non-malignant terminal illnesses [1,2,3,4]. Complementary therapies are defined as "a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine" [5].

Therapeutic Touch is a complementary therapy modality based on the belief that a person and his/her illness is reflected in an imbalance of their energy field [6]. The Therapeutic Touch practitioner detects imbalance and restores balance using a technique in

* Corresponding author. 3560 Bathurst Street, Toronto, ON M6A 2E1, Canada.
E-mail address: hsenderovich@baycrest.org (H. Senderovich).

http://dx.doi.org/10.1016/j.ctcp.2016.06.002
1744-3881/

which their hands are used to direct human energy for healing purposes. There is usually no actual physical contact [6]. Therapeutic Touch is garnering attention for its potential role in ameliorating symptoms such as pain, sleep disturbances, depression, stress and anxiety in patients suffering from both malignant and non-malignant terminal illnesses [1,2,4,7,8]. Although Therapeutic Touch is already being used in palliative care settings, there is limited evidence supporting its use in the care of elderly patients at end of life [9,10,6].

The Baycrest Palliative Care Unit in Toronto is a 31 bed unit which cares for elderly adults with both malignant and non-malignant terminal illnesses. The unit admits patients with a prognosis of up to one year. Various complementary therapies are offered on this Palliative Care Unit including: recreational therapy, art therapy pet therapy, music therapy, and spiritual guidance and support.

A Therapeutic Touch program was introduced to the unit in October 2010. Two volunteer Therapeutic Touch practitioners, who have Recognized Practitioner status with the Therapeutic Touch Network of Ontario, offered the therapy to patients who had given verbal consent. Therapeutic Touch sessions were provided up to twice weekly.

This retrospective chart review aims to describe the patients on a geriatric palliative care unit who are receiving Therapeutic Touch services and to identify their response to this treatment.

2. Method

In order to describe the patients who received Therapeutic Touch and their response to treatment, a retrospective chart review of a subset of patients admitted to the Palliative care unit at Baycrest Health Sciences from October 2010–June 2013 was performed. There were 733 patients admitted to the Palliative Care Unit during the study period. Of these, 114 (15%) received Therapeutic Touch therapy. Approximately 1 in 5 of the remaining patients who had not received Therapeutic Touch were randomly sampled to represent a comparator group (n = 123). Observations on 101 patients were recorded by the Therapeutic Touch practitioner during the first treatment session offered - thirteen patients declined the first session offered but later accepted treatment. This study was approved by Baycrest's Research Ethics Board.

Each session of Therapeutic Touch was 5–7 min long. If the patient was awake, there would be a touch option available, defined as a very light touch over the feet, hands and shoulders. The practitioner places their hands over the body of the patient and starting from either the head or the shoulder, make their way to the feet. The sessions were broken down into 4 phases. The assessment phase assesses the patient's energy field symmetry, since the purpose of Therapeutic Touch is to equalize the field. The clearing phase is about rebalancing the energy field. During the modulation phase, the volunteer checks to see if there are any more imbalances and then focuses directly on those. Lastly, the reassessment phase is to see if the body feels different in any way than it did originally.

Referrals for Therapeutic Touch for relaxation purposes were predominantly made by the unit's Occupational Therapist (OT). On admission, the OT would explain the Therapeutic Touch program if the patient or their Substitute Decision Maker (SDM) spoke English and were capable of understanding and appreciating the information and were not actively dying. If the patient and/or SDM expressed interest in Therapeutic Touch they would then be referred to the program. It is important to note that many of the patients in this population are approaching EOL and thus are not expected to be discharged. However, if a patient stabilizes and is able to go home, the patient can contact a trained and registered Therapeutic Touch Network practitioner who provides this modality in the community.

Data were extracted from electronic medical records as well as the Therapeutic Touch practitioners' documentation records by one of the research assistants (JT). Demographic and clinical data collected from the patients' Electronic Health Record included gender, age, diagnosis, Palliative Performance Scale (PPS) score on admission and length of stay on the Palliative Care Unit. Palliative Performance Scale scores are reliable measures for assessing a patient's functional status in the palliative care setting [11–13]. Because the Palliative Performance Scale score is helpful in determining prognosis, it is used in establishing eligibility for admission to the Palliative Care Unit and is administered to all patients prior to admission. Lower Palliative Performance Scale scores indicate lower functional status. The Palliative Performance Scale scores were not completed for all patients admitted to the Palliative Care Unit until late 2010, which explains why some patients did not have a score assigned.

Information collected regarding the Therapeutic Touch treatment session included the session date, patient's goals for the treatment, patient feedback, and practitioner observations. Two of the co-authors (LD & DG) clustered the multiple observations made by the Therapeutic Touch practitioners into four categories which included: appeared to relax, drifted to sleep during session, expressed gratitude and no response.

Patients' clinical and demographic characteristics were described using summary statistics including mean, standard deviation and range for continuous variables and percentages for categorical variables. Differences between patients who received Therapeutic Touch and those who did not were evaluated using either two sample *t*-test for continuous variables and chi-square test for categorical variables.

Hypothesis tests were performed at an alpha level of 5%. Statistical computation was performed using IBM SPSS Statistics version 21.0 (SPSS Inc., Chicago).

3. Results

3.1. Patient characteristics

During the period from October 2010 to June 2013 a total of 733 patients were admitted to the Palliative Care Unit. One hundred and fourteen patients received Therapeutic Touch during the course of their stay on the unit. Observations on 101 patients were recorded by the Therapeutic Touch practitioner during the first session offered. Some of the reasons that 13 patients declined the first session offered included having visitors, not being available, family requesting the Therapeutic Touch practitioner to return and sleeping with no consent to provide Therapeutic Touch while sleeping.

Referrals to Therapeutic Touch were made by the OT for 15% of the patients admitted to the Palliative Care Unit. The Therapeutic Touch practitioners recorded that all patients they saw requested Therapeutic Touch for the purpose of relaxation.

Demographic and clinical characteristics for patients who received Therapeutic Touch during the study period as well as a random sample of patients who did not receive Therapeutic Touch during this period are summarized in Table 1.

In the Therapeutic Touch group there were 114 patients, and 105 (92%) of whom had a primary malignant diagnosis. In the non-Therapeutic Touch group there were 123 patients, and 97 (79%) of whom had a primary malignant diagnosis. The proportion of malignant diagnoses relative to the non-malignant diagnoses was significantly greater ($\chi^2_1 = 8.24$, $p = 0.004$) in the Therapeutic Touch group compared to the non-Therapeutic Touch group. Patients in the Therapeutic Touch group had a higher Palliative Performance