A combined study exploring Nurse Lecturers’ understanding of
Holism, the Placebo and Touch in Nursing Therapy

Power, J, J. (Queen’s University Belfast)

Abstract

Objective – A combined study exploring nurse lecturers’ understanding of spirit; the medical model; holism; placebo and energy medicine

Results – There was evidence of a confused or vague idea of the nature of spirit and holism among nurse lecturers, with this possibly reflected in the nursing curriculum. There was some evidence of the disproportionate effect of the medical model within the teaching curriculum and in clinical practice. About 50% of the nurse lecturers were very positive about the placebo effect within nurse therapy, although the same proportion was dismissive of the placebo effect. There was some agreement for the incorporation of complementary and alternative medicine (CAM) within clinical nursing practice, and the use of touch therapies. There was evident ignorance and misunderstanding of CAM and touch therapies and very limited teaching of CAM.

Conclusion – To help enhance holistic practice and to balance the clinical dominance of the medical model, the teaching curriculum should address;

- The exploration, definition and teaching of spirituality and holism
- A better understanding of the role of placebo, particularly to enhance clinical therapy
- The potential for CAM to be incorporated
- The use of touch therapies in nursing practice.

Key Words

Spirit, holism, placebo, touch therapy

Acknowledgments

I would like to acknowledge the support of Dr. Anne Lazenbatt, Dr. Lyn Cree, Dr. Janice Christie and my teaching colleagues.
Introduction

Within current medical orthodoxy treatment often continues to be concentrated within a ‘medical model’ (Aldridge, 2000; Barnum, 2003; Benor, 2006) limiting the options to patients and clients and causing frustration to some healthcare professionals (Porter, 1998). Alternatively disease could be seen as a general imbalance or dysfunction, a loss of homeostasis, affecting the whole system (Tutton, 1998; Aldridge, 2000; Wilkinson et al., 2002; Burden et al., 2005). According to this more holistic model the body system is perhaps capable of recovering that balance if it is facilitated to do so (Aldridge, 2000; Buxton-King, 2004). The medical model does not address the use of touch therapies to stimulate the patient’s or client’s potential for healing (Barnum, 2003).

Nurse lecturers are integral to the delivery of new nursing theory and nursing models to undergraduate nursing students. Central to new nursing are the concepts of holistic practice and the development of the nurse as a therapist in his or her own right. There is a potential for the inclusion of touch therapies within the practice and art of nursing (Davies, 2000; Burden et al., 2005). However, there remains a potential conflict between the models of care used conventionally by healthcare professionals such as nursing (disease focused) and the philosophy underpinning touch therapies; with the professional medical world remaining skeptical of touch therapies (Benor, 2006; Chummun, 2006). Touch therapies are not a Complementary and Alternative Medical (CAM) Practice easily assimilated to the medical model, as they substantially challenge the medical model. This is perhaps reflective of the reasons why some nurses are reticent to discuss, or to incorporate elements of their own beliefs within practice, or teaching (Wright and Sayre-Adams, 2000). Core to this alternative model are issues of spirituality; holism; empowerment; engaging with the patient’s own healing potential; and the effect of the therapist as co-healer (Wilkinson et al., 2002). However, these are also all the elements that are supposed to be core to ‘new nursing’ and to
what nurse educators should understand and teach to their nurse students (Laurenson et al., 2006). The rationale for the present study was to explore nurse lecturers’ conceptualisation of holistic practice and nursing therapy by examining specifically their understanding of spirit; the medical model and holism; placebo; energy medicine and touch therapies (the core areas).

The clinical relevance of using touch therapies as part of the focus for this study are summarised in Figure 1.

| 1. Touch therapies incorporate much of the philosophy central to the concept of ‘new nursing’. |
| 2. Touch therapy in the particular form of Therapeutic Touch is a practice already exercised by some nurses in several parts of the world, and to a limited sense within the UK. |
| 3. Some nurse practitioners claim that touch therapies can have some therapeutic potential for some patients and clients, in some circumstances, and with some conditions. |
| 4. An extension of touch therapy perhaps fits more easily with some professional nurses. |
| 5. Touch therapies involve the nurse as therapist. |

Figure 1. Clinical relevance of touch therapies

Research Question

The research question is: what are the nurse lecturers’ conceptual frameworks and understanding of holism and the potential therapeutic impact of the nurse as a therapist using the model of energy medicine?

Objectives of the study

1. To explore nurse lecturers’ understanding of the nature of spirit, holism and the nurse as therapist within the placebo
2. To explore nurse lecturers’ understanding of touch therapies and their potential role within nursing therapy and the possible implications for nurse education
Methodology

This study employed a mixed methodology using both qualitative and quantitative research methods in order to better address the research objectives. The first phase of the study used a quantitative method, and the second phase employed qualitative methods. The Phase I questionnaire was developed from the evidence-based literature and piloted with six nurse lecturers. Phase II of the study provided a depth of understanding of the personal philosophy and experiences of the nurse lecturers within the core areas. A personal interview format was used.

The researcher obtained consent for the research from the Research Ethics Committee on the 21st January 2004. All of the participants in the study were given a full description of what the study involved and their informed consent was obtained. They were entitled to withdraw from the study at any time. The study ensured the protection of the respondents’ anonymity with regards to the questionnaire data. Material from all participants interviewed was treated with confidentiality.

The convenience sample for the Phase I questionnaire survey represented all of the undergraduate nurse lectures teaching within the school of nursing and midwifery. The study population for the Phase II interviews was drawn from those nurse lecturers indicating willingness to undertake interview in their responses to the Phase I questionnaire (25). From this number fifteen participants were interviewed (selected against a sampling matrix) proportionally representing the nursing branches of adult, child, mental health and learning disability within undergraduate teaching.

The pilot study helped to improve the validity and reliability of the questionnaire by generating constructive comment and critique from tutors and academics involved within
research [n=6]. The survey questionnaire was developed and validated using exploratory factor analysis techniques in an attempt to enhance the reliability of the research instrument and to elicit information of a factual and objective nature.

With regards to Phase II of the study the researcher sought to maintain credibility and rigour (Cormack, 2000; Parahoo, 2006). The researcher demonstrated evidence of integrity and good practice and that the work fairly reflected the ‘social world’ that was being explored (Cormack, 2000). The researcher sought to be rigorous, reflected in the quality of field notes and details of data collection giving greater ‘context’ to the methods of analysis. In addition the researcher attempted to enhance credibility through triangulating the fieldwork data with the use of supportive questionnaires to compare with interview data, and through the inclusion of ‘disconfirming evidence’ (Green and Thorogood, 2004). The researcher also sought to be reflexive and to bracket pre-existing values and beliefs (Green and Thorogood, 2004).

Data Collection and Analysis

Phase I: Survey Questionnaire

A 16 item attitudinal scale was revised and enhanced after pilot testing on lecturers in nursing (n=6). The scale used a five-point Likert format. Questionnaires were sent to all 106 nursing lecturers (n=106). This figure represented the total of nurse lecturers then teaching within the school. Sixty-one questionnaires were completed and returned; a response rate of 57%. The questionnaire was submitted to the nurse lecturers on the 13th Sept 2005.

The data from coded questionnaires were entered into a database. Statistical analysis was undertaken using ‘SPSS for Windows (version 15)’ software. Analysis addressed descriptive statistics, frequencies, exploratory factor analysis and cross-tabulation analyses.
Phase II: Semi-structured Interviews

Interviews were undertaken until saturation of data was achieved (Cormack, 2000). A phenomenological approach to data analysis was used to achieve a depth of understanding of personal cosmologies (Speziale and Carpenter, 2002; Parahoo, 2006). The data were subjected to thematic analysis against a form of conceptual or analytical framework (Figure 2) to aid analysis of large volumes of data (Cormack, 2000). This framework was developed by the researcher from the literature addressing nursing theory.

<table>
<thead>
<tr>
<th>Nursing Theory</th>
<th>Themes</th>
<th>Conceptual Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>The nature of Spirit</td>
<td>Spirituality</td>
<td></td>
</tr>
<tr>
<td>Unitary Human Beings</td>
<td>Medical Dominance</td>
<td>The Medical Model</td>
</tr>
<tr>
<td>Human Wholeness</td>
<td>Holistic Practice</td>
<td>Holism</td>
</tr>
<tr>
<td>Nurse Therapist</td>
<td>The Role of Nurse as Therapist</td>
<td>Nursing Therapy and the Placebo</td>
</tr>
<tr>
<td>Energy Field Medicine</td>
<td>CAM and Touch Therapies</td>
<td></td>
</tr>
</tbody>
</table>

Figure 2: Conceptual Framework

Discussion of Results

Spiritual health is widely believed to be an essential component of general health (Aldridge, 2000; Long and Baxter, 2001; Barnum, 2003), and this was evident from Phase II qualitative interviews with the study sample of nurse lecturers. The spiritual dimensions of health are apparently important to the greater majority of the nurse lecturers, as 77% of the (Phase I) nurse lectures identified ‘spirit’ as a dynamic force central to positive health and wellbeing. Greenstreet (1999) suggests that within the western model of health, ‘spirit’ is normally
associated with individual consciousness, or with an individual personal meaning to life that does not address the nature of the transpersonal (Scott Webster, 2004). Indeed, Barnum (2003) suggests that within a religious model spirituality is to some extent proscribed and limited in its attempt to comprehend the spiritual. Malinski (1994) in discussing Rogers’s energy fields suggests that they are effectively patterns of spirituality. Perkins (2003) in exploring the nursing theory of Unitary Human Beings suggests a transpersonal dimension to life to be explored and used therapeutically. The majority of the nurse lecturers interpreted spirituality within either an existential, or a faith belief and proscribed model and not within in a transpersonal model.

In addition the majority of the nurse lectures have a confused or vague idea of the nature of ‘spirit’. This uncertainty possibly reflects the Phase I data suggesting an undecided response to the nature of spirit. Aldridge (2000) discusses the development of dualism with the rise of scientific medicine, with ‘spirit’ and matter functioning separately. Phase II interviews with a number of the nurse lecturers suggested a separation of spiritual belief, and indeed spiritual experience from the teaching of health and nursing. This separation of belief and experience from concrete thinking could be viewed as a form of dualism. Again for a number of the nurse lecturers’ ‘spirit’ was something separate; private; a ‘religious’ experience, and not capable of rational interpretation for teaching purposes. Corresponding to the current study findings Dyson et al (1997); Martsolf and Mickly (1998); Narayanasamy (2006); and Ross (2006) all address the lack of teaching to spirituality within the nursing curriculum. Indeed, the present study suggests that spirituality is not an area that is addressed in any depth within the nursing curriculum.

Ross (2006) argues that spiritual care is expected of nursing and that holism is better promoted when nurses are aware of their own spirituality. Dyson et al (1997) suggest that spirituality is an important area of nursing care and intrinsic to a model of holism. New
nursing is essentially holistic (Martsolf and Mickly, 1998), almost all of the nurse lecturers talked to a holistic model. This was evident within the questionnaire data, with some 96% of responses defining health within a bio-psychosocial model (Chummun, 2006). This is in agreement with Phase II data that show that all nurse lecturers talked to a bio-psychosocial model, and interestingly, more than 50% of the nurse lecturers in Phase II talked to a bio-psycho-socio and spiritual model.

This belief in either a bio-psychosocial, or a bio-psycho-socio-spiritual model, as the basis for health contrasts with the belief expressed by some of the nurse lectures in Phase II; they suggested that the medical model had a disproportionate influence within the teaching curriculum. The Phase I analysis illustrated some agreement for a biological basis for health, and for its greater emphasis within nurse education, rather than a focus upon a more holistic bio-psychosocial model of health. Some 20% of the respondents favoured a greater emphasis upon the biological basis of disease. Whether this reflected in a significant medical model focus within some of the curriculum teaching, it would not be possible to conclude from this study, although a significant number of the nurse lecturers perceived a medical model focus within the teaching curriculum. This finding would be worthy of further investigation. Benor (1996); Aldridge (2000); and Salvage (2002) all suggest that scientific models of medicine continue to dominate global health care. Chummun (2006) identifies a reductionist and symptom-based approach to the medical model. Millenson (1995) argues that western models of medicine set the framework for other health disciplines. The majority of the nurse lecturers in Phase II suggested that in their clinical experience, the medical model tended to dominate the clinical areas.

Tutton (1998) believes that the physical presence of the nurse provides a unique opportunity to provide therapy or as therapist in their own right. Research suggests that the placebo can be viewed as an ally in therapy (Yawar, 2001; Helman, 2006) with possibly a
wide range of conditions responding to placebos (Chvetzoff and Tannock, 2003). Helman (2006) suggests that far from being inert, or an attempt to fraudulently mislead the patient the placebo was an integral and potentially valuable part of any treatment. In discussion about half of the nurse lecturers were very positive about the placebo effect as an integral part of nursing therapy. Nelson (1998) suggests that often the placebo is viewed as a sham treatment. Approximately 50% of the nurse lecturers appeared dismissive of the placebo effect, seeing it as a sham and unethical, and associating it more with double-blind pharmaceutical and experimental trials (Nelson, 1998). This negative view of the placebo was advanced by seven of the NLs in Phase II and contrasted with other research findings (Yawar, 2001; Chvetzoff and Tannock, 2003); indeed there was little evidence of a clear understanding of the nature of a placebo, or its therapeutic potential and they associated the placebo more with the medical model.

The findings from the Exploratory Factor Analysis suggested general agreement for the incorporation of CAM within the clinical areas of nursing, with some evidence supporting the specific use of touch therapies within clinical practice. There was also some evidence supporting the development of CAM within nurse education. This acknowledgement of the potential role of alternative medicine, and of touch therapies was even more marked within the descriptive analysis of Phase I, with some 70% of the study respondents agreeing, or strongly agreeing, that CAM should be incorporated as part of any pre-registration undergraduate programme of nurse education. Again this finding is positive and although touch therapies are not commonly practised within the UK’s conventional clinical areas, energy field techniques are used increasingly in areas of nursing and health care (Dennison, 2004; Laurenson et al., 2006). Rogers (1970), Parse (1987), Tutton (1998) all talk of the potential use of touch therapies within professional nursing practice.
Notwithstanding there was evidence of ignorance and misunderstanding amongst the nurse lecturers in relation to a particular type of CAM in the form of energy field therapy. Touch therapies have been used within clinical practice with some degree of success, suggesting benefits for both the client, the patient and for the therapist (Davies, 2000; Gallob, 2003; Wilkinson et al., 2002). Touch therapies are essentially holistic and can be used as a vehicle to both enhance nurses’ understanding of holism and to enhance their holistic clinical practice (Davies, 2000; Buxton-King, 2004).

Although there is evidence of increasing development of complementary and alternative therapies within areas of clinical practice (Buxton-King, 2004; Burden et al., 2005), there was evidence from the present study of very limited teaching to CAM within the curriculum. In all, four nurse lecturers from Phase II interviews highlighted how their teaching included CAM principles. However, two of these nurse lectures who were teaching to CAM were dismissive of energy field theory, or demonstrated a poor understanding of its principles. This contrasted to some extent with the questionnaire data suggesting a majority of respondents in favour of alternative medicine and touch therapies being developed within clinical practice. Burden et al (2005) outline the continuing development of supportive touch therapies and Laurenson et al (2006) discuss the development of a teaching programme within the UK for nurses in CAM therapies. Nursing theory incorporating human energy fields and their therapeutic use by nurses has existed for some 40 years (Rogers, 1970; Parse, 1987). In line with this the descriptive statistical results suggest general agreement for CAM to be incorporated within clinical teaching with 70% of the respondents agreeing or strongly agreeing.

The Limitations of the Findings

The use semi-structured interview
While every effort was made to ensure a rigorous and systematic study there are important limitations to this study:

1. Phase I data
   a. Was based on a non-random, purposive sample of university lecturers and the findings may not be generalisable to similar groups of participants outside this setting.
   b. The overall response rate was 57%, thus limiting the ability to extrapolate the results of this study to those who did not respond, such as those from Learning Disability and Midwifery.
   c. The existing data do not permit adequate analyses of subgroups, and more validation work is needed.

2. Phase II data
   a. The potential for interviews to merely reproduce the assumptions of the questionnaire
   b. The limited reproducibility or transferability of the study
   c. The researcher’s influence upon the participant and their responses and the tendency for the researcher’s pre-existing values and beliefs to influence data analysis. The researcher sought to limit this with the use of reflexivity and bracketing.

Nonetheless, these findings mirror those of other international research studies on this topic (Mitchell and Bennett, 2006)

The Educational Recommendations from the Study
The topic of ‘Spirituality’ should be addressed and explored at an undergraduate level, at both an existential and a transpersonal level. However, introducing a faith-belief model of spirituality could be challenging and controversial. Further, the faith-belief model is rather restrictive in terms of its interpretation of the nature of the spirit (Dyson et al., 1997; Barnum, 2003). The nature of the spirit is not essentially vague and indefinable (McNutt, 1999; Aldridge, 2000; Barnum, 2003) and models for the teaching of spirituality to nursing students have been developed (McSherry, 2006). Although not immediately evident within Rogers’ original nursing theory of the Unitary Human Being (Rogers, 1970; Parse, 1987) there is evidence that this model incorporates the transpersonal or spiritual dimensions of human health as key areas for nursing therapy (Tutton, 1998; Gunther, 2006; Leddy, 2003; Perkins, 2003) and these should be explored with a view to incorporation within the undergraduate teaching curriculum. To facilitate this, the exploration of spirituality as a topic area would have first to be undertaken with the teaching staff.

Whilst there was almost universal acceptance of the principle of health, and holism within the data set, and substantial agreement about its importance in teaching and practice, holism cannot be taught as a key principle of new nursing if there is not an agreement upon its constituents. The subject area that defines ‘Holism’ needs to be effectively defined as a precursor to effective teaching. The teaching curriculum should clearly identify a model of holistic care rather than a medical model as the focus of care teaching. This could clearly link with an exploration of the nature and definition of both spirit and spirituality. In addition nurse lecturers should be encouraged to develop a better understanding of the potential role of placebo as part of nursing therapy, particularly as a tool of real potential to enhance therapy. The effective use of placebo would seem to enhance the practice of new nursing within a holistic model.
Nurse lecturers should also be encouraged to study nursing theory incorporating Unitary Human Beings, human energy fields and to explore the research material relating to CAM practice with a view to incorporating a module within the teaching curriculum. The teaching of an alternative medical model should be based in nursing theory (Rogers, 1970; Parse, 1987; Malinski, 1994; Perkins, 2003) to include some elements of energy field therapy, and particularly touch therapies. Touch therapy has been used across time, and it is present already in parts of nursing practice (Wang and Herman, 2006; Aldridge, 2000; Wright and Sayre–Adams, 2000; Burden et al., 2005). Touch therapies fit well within nursing practice and evidently have some potential as a healing modality for some patients with some conditions in some contexts (Gordon et al., 1998; Wilkinson et al., 2002; Post-White et al., 2003; Dennison, 2004; Kemper and Kelly, 2004; Doherty et al., 2006).

Conclusion
Clinical holism could be enhanced by both a greater awareness of the function and potential of the human spirit; the important therapeutic role of the therapist and the potentially positive effect of developing touch therapies within the teaching curriculum. These could all add to nurses’ caring skills and act as a counterweight to the clinical dominance of medicine. The research findings suggest several potential directions for educational and clinical practice change. In particular, they emphasize the importance of establishing a systematic holistic approach to teaching and learning for all student nurses to allow them to deliver evidence-based nursing therapy in a complementary and alternative way.

Bibliography


Scott Webster, R. 2004. ‘An Existential framework of Spirituality.’ *International Journal of


Speziale, H., Carpenter, D. 2002. *Qualitative Research in Nursing. Advancing the Humanistic

perspective*. New York: Lippincott Williams & Wilkins.


Clinical Effectiveness of Healing Touch.’ *The Journal of Alternative and


Yawar, A. 2001. ‘Spirituality in Medicine: what is to be done.’ *Journal of the Royal Society

of Medicine*, 94: pp.529-533.