

## FEATURE ARTICLE

# The Use of Biofield Therapies in Cancer Care

Beverly Pierce, MLS, MA, RN, CHTP

Biofield therapies form a subcategory of the domain of energy therapies, as defined by the National Center for Complementary and Alternative Medicine. Specific biofield therapies addressed in this article include Therapeutic Touch, Healing Touch, Polarity Therapy, Reiki, and Qigong. This article will identify core concepts in biofield therapies, review controlled trials of the use of biofield therapies with patients with cancer, describe the process of biofield therapies implementation in one cancer center, and suggest research to benefit not only patients with cancer but also family members and oncology professionals.

**B**iofield therapies form a subcategory of energy therapies, one of the five complementary medicine domains defined by the National Center for Complementary and Alternative Medicine (NCCAM). The terminology of biofield therapies is diverse because the practices that comprise the field have developed cross-culturally over thousands of years and, in recent decades, have been reformulated, taught, and practiced in a variety of ways. Terms in common use include energy healing, energy medicine, energy therapies, laying on of hands, and spiritual healing. Forms of practice found in North American healthcare systems include Healing Touch (HT), Polarity Therapy (PT), Qigong, Reiki, and Therapeutic Touch (TT) (see Figure 1). Two of the modalities were formulated specifically in the context of nursing: TT in the 1970s by Dolores Krieger, PhD, RN, at New York University, and HT in the 1980s by Janet Mentgen, BSN, RN, in Colorado. Krieger worked with healer Dora Kunz to develop and teach TT, a formal procedure for assessment and treatment of the human biofield. Mentgen compiled a range of biofield healing interventions from her own practice and from other healers and developed HT as a training program. PT was developed in the 1940s and 1950s by Randolph Stone, DO, DC, ND, who combined aspects of ancient healing practice with information from osteopathy and chiropractic. Qigong and Reiki are modalities of Japanese and Chinese origin, respectively. See Figure 2 for resources to learn more about the different types of biofield therapies.

Although the modalities have differences, they share some common assumptions.

- The human body has a subtle energy system that interpenetrates the physical anatomy and extends outward beyond it.
- The subtle energy may be conceptualized as universal energy or vital energy flowing through and available to all beings.

### At a Glance

- ◆ Biofield therapies used in the North American healthcare system have developed from a number of different sources yet share many core concepts.
- ◆ Nurses who want to implement a biofield therapies service can address skepticism with patience; published research; data on patient demand, response, and satisfaction; and physician support.
- ◆ Controlled trials of biofield therapies have pointed to improved mood and quality of life and decreased pain and fatigue. Additional well-designed studies should be undertaken to address the needs of patients with cancer, as well as the stresses affecting their families and oncology professionals.

- The normal self-healing capacity of the human body is supported by the free and balanced flow of energy through its subtle energy system.
- Disease or disorder can be detected in the energy system (perhaps before it manifests in the physical body) and can be affected therapeutically by the action of energy practitioners, in support of the self-healing capacity of the body.
- Conscious healing intent and compassion are considered essential to the effectiveness of biofield therapies.
- Practitioners' hands may or may not touch the physical body (see Figure 3). Practitioners also may carry out healing work,

Beverly Pierce, MLS, MA, RN, CHTP, is director of integrative medicine services at Suburban Hospital in Bethesda, MD, and a certified Healing Touch practitioner. No financial relationships to disclose. (Submitted August 2006. Accepted for publication September 2006.)

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**Healing Touch:** a relaxing, nurturing energy therapy; gentle touch assists in balancing physical, mental, emotional, and spiritual well-being. Healing Touch works with the energy field to support the natural ability to heal (Healing Touch International, Inc., 1998).

**Polarity Therapy:** seeks to find energy blockages, release energy to normal flow patterns, and maintain the energy field in an open, flexible condition (American Polarity Therapy Association, 2007)

**Qigong (pronounced "chee gong"):** *Qi* means air, breath of life, or vital energy of the body; *gong* means the skill of working with or cultivating self-discipline and achievement. The art of Qigong consists primarily of meditation, relaxation, physical movement, mind-body integration, and breathing exercises (Qigong Institute, 2005).

**Reiki:** a Japanese technique for stress reduction and relaxation that also promotes healing; administered by "laying on hands"; based on the idea that an unseen "life force energy" flows through people and causes them to be alive (International Center for Reiki Training, 2007)

**Therapeutic Touch:** an individualized intervention guided by cues gained from assessing an individual's energy field (Nurse Healers—Professional Associates International, 2006)

### Figure 1. Definitions of Biofield Therapies Used in the North American Healthcare System

mentally, from a distance. (When performed at a distance [nonlocally], such work comes under a different NCCAM-defined domain, that of mind-body medicine, which covers modalities such as mental healing and prayer.)

Subjectively, practitioners may sense connection with universal energy through meditation or visualization and connection with the recipient through compassion and healing intent. Practitioners are in a meditative frame of mind, open, focused, and caring. Recipients may take on, or synchronize with, the meditative state of practitioners. Significant relaxation usually occurs, sometimes sleep. Recipients may become increasingly aware of what is happening internally. Images and feelings may surface. They may feel a sense of comfort and connection with practitioners and may feel connection with an energy or reality beyond the physical and the day-to-day. Alternatively, sessions may be experienced simply as time and space for peace, quiet, and trustful interaction. Some research indicates that effects may be cumulative with repeated sessions.

## Biofield Therapies Research

Research in human biofield therapies began to appear in the nursing literature in the 1970s, with Krieger's (1975) study of the effects of TT on hemoglobin levels in hospitalized patients. Since then, a growing body of research in North America has examined the effects of biofield therapies (mostly, but not exclusively, TT) on stress, anxiety, mood, pain, fatigue, immune system function, vital signs, health-related quality of life (HRQOL), well-being, sense of personal growth, and other factors. Reviews and meta-analyses have found many of the studies in the emerging field to be of inadequate design (Wardell & Weymouth, 2004; Winstead-Fry & Kijek, 1999) but concluded that enough evidence of effectiveness exists to warrant further research. The book *Healing, Intention and Energy Medicine:*

*Science, Research Methods and Clinical Implications* (Jonas & Crawford, 2003) reviewed 19 reports of randomized controlled trials (RCTs) of biofield therapies. On the basis of the review, Jonas and Crawford ranked biofield therapies research as B on their A-F scale of evidence levels for healing research: "B: at least one properly randomized controlled experiment that rates high quality (> 80% of CONSORT criteria)" (p. xviii). CONSORT (Consolidated Standards of Reporting Trials) is a standard checklist of 22 items of information required for adequate reporting of RCTs (Moher, Schulz, & Altman, 2001).

Controlled trials of biofield therapies for patients with cancer began to be published in the 1990s. Samarel, Fawcett, Davis, and Ryan (1998) compared TT plus dialogue with a rest period plus dialogue pre- and postoperatively in women with breast cancer. The TT group had lower preoperative state anxiety than the rest-period group. Mood and pain did not differ between groups, nor were any differences found postoperatively. Later, Kelly, Sullivan, Fawcett, and Samarel (2004) interviewed 18 subjects from Samarel et al.'s study to compare the experimental group's perceptions of TT plus dialogue with the control group's perceptions of rest period plus dialogue. Both expressed similarly positive perceptions (e.g., calmness, relaxation, security, comfort), with only minor differences. Giasson and Bouchard (1998) compared the effects of TT with the effects of a rest period, looking at measurements of pain, nausea, depression, anxiety, shortness of breath, activity, appetite, relaxation, and inner peace. Among patients with cancer in a palliative care unit, the TT group showed higher scores of well-being than did the rest-period group. Olson, Hanson, and Michaud (2003) compared standard care plus Reiki with standard care plus rest in patients experiencing pain. Compared to controls, the Reiki group showed improved pain control and improved quality of life.

In a two-period, cross-over RCT, Post-White et al. (2003) examined 230 patients for the effects of massage therapy and HT as compared to nurse presence alone or standard care. HT lowered pain, fatigue, and total mood disturbance, as well as heart rate, respirations, and blood pressure. HT showed no effects on nausea or anxiety. Cook, Guerrerio, and Slater (2004) compared HT with mock treatment on nine measurements of HRQOL in 78 women diagnosed with cancer. The HT group had better outcomes on all measurements of HRQOL, three of which reached statistical significance (physical functioning, vitality, and pain). Roscoe, Matteson, Mustian, Padmanaban, and Morrow (2005) completed a pilot study on the effects of PT on HRQOL and cancer-related fatigue in 15 patients with breast cancer undergoing radiation therapy. Subjects were randomized into three groups, receiving one, two, or no PT treatments. The groups receiving PT showed significant improvement in HRQOL and cancer-related fatigue at one week. At two weeks, the two-treatment group showed the greatest improvement in cancer-related fatigue. Tsang, Carlson, and Olson (2007) designed a randomized, counterbalanced crossover pilot trial of Reiki versus rest, examining measures of fatigue, pain, anxiety, and quality of life in 16 patients with cancer. The Reiki group reported significant decreases in fatigue on each of seven days of treatments, whereas the rest group did not. Over a one-week washout period, the Reiki group maintained decreased levels of fatigue. In addition, the Reiki group, but not the rest group, showed significantly improved quality of life.

Chen and Yeung (2002) reviewed published studies (clinical, in vitro, and in vivo) regarding the use of Qigong for patients with cancer in China. Of 21 clinical studies examined, 10 were controlled. Of those, four specified randomization, and none was blinded. Among the 10 controlled studies, results pointed to reduced physical symptoms, improved appetite and strength, weight gain, improved immune function, and higher survival rates. The authors wrote that study designs need to be improved and that replication is necessary. After surveying in vitro and in vivo work with Qigong and patients with cancer, they concluded with hope for more research: "Our review suggests that Qigong therapy may actually stop and prevent cancer growth" (p. 368).

## A Distinction Between "Healing" and "Curing"

In the literature about integrative medicine, a distinction often is made between the concepts of healing and curing. Curing has been defined as "the elimination of the signs and symptoms of disease, which may or may not correspond to the end of the patient's disease or distress" (Quinn, 2000, p. 41); whereas healing has been described as "the process of bringing together parts of oneself (e.g., physical, mental, emotional, spiritual, relational) at deeper levels of inner knowing, leading to an integration and balance" (McKivergin, 2000, p. 207). By and large, Western research and practice of biofield therapies are healing-focused and integrative, addressing physical symptoms such as pain, mental and emotional aspects of illness such as stress and mood, and spiritual and relational concepts such as personal growth. Likewise, Qigong is used to alleviate cancer-related symptoms. In addition, however, Qigong research in animal models has examined tumor cell inhibition and destruction as well as survival rates. Unusual among biofield therapies, some applications of Qigong are explicitly curative in intent. Taiji Five-Element Qigong, developed in China by Qigong Master Binhui He, is reported to have ameliorated and cured cancers without the use of other interventions (Chen & Yeung, 2002).

### Biofield Therapies

**Healing Touch:** [www.healingtouch.net](http://www.healingtouch.net)

**Polarity Therapy:** [www.polaritytherapy.org](http://www.polaritytherapy.org)

**Qigong:** [www.qigonginstitute.org](http://www.qigonginstitute.org)

**Reiki:** [www.reiki.org](http://www.reiki.org)

**Therapeutic Touch:** [www.therapeutic-touch.org](http://www.therapeutic-touch.org)

### Research Institutions

**Institute of HeartMath:** [www.heartmath.org](http://www.heartmath.org)

**Institute of Noetic Sciences:** [www.noetic.org](http://www.noetic.org)

**International Society for the Study of Subtle Energies and Energy Medicine:** [www.issseem.org](http://www.issseem.org)

**National Cancer Institute, Office of Cancer Complementary and Alternative Medicine:** [www.cancer.gov/cam](http://www.cancer.gov/cam)

**National Center for Complementary and Alternative Medicine:** <http://nccam.nih.gov>

**Samueli Institute:** [www.siib.org](http://www.siib.org)

## Figure 2. Internet Resources

## Clinical Use of Biofield Therapies

Since the 1970s, implementation of biofield therapies in clinical practice in North America has proceeded slowly, in part because, unlike Asian medicine, Western medicine lacks a theoretical framework by which to understand and integrate subtle energy work. Modern biomedicine, developed in the 19th and 20th centuries, is based on a Newtonian understanding of the physical world, which was superseded in the 20th century by theories of Einstein and quantum physics. The 21st century may see development of a new theoretical framework for biomedicine that will more easily accommodate biofield research and practice. McCraty, Atkinson, and Tomasino (2001) and Oschman (2000) described scientific research that may contribute to such integration. Advances in consciousness research also may shed light on the phenomenon of healing (Dossey, 2005; Mindell, 2004).

Clinical implementation of biofield therapies is occurring, in part because the modalities of TT and HT developed specifically within the field of nursing. Since the 1970s, an estimated 200,000 individuals have been trained in TT, about 60% of whom are nurses (D. May, personal communication, February 16, 2006). With regard to HT, about 80,000 trainings (15–30 hours each) have been completed since 1990. (Because the HT program offers six sequential trainings, that figure includes many participants more than once.) An estimated half of HT class participants are nurses (C. Hutchison, personal communication, May 15, 2006). In addition, many nurses have studied Reiki or other biofield therapies. How many nurses currently are using biofield therapies in conventional oncology settings is unknown. Some do so in the context of well-established integrative medicine programs. At Place of Wellness at the University of Texas M.D. Anderson Cancer Center in Houston, a nurse teaches a twice-monthly introductory class, "Healing Touch for Self and Others" and provides individual sessions as requested by those who have taken the class (L. Baynham Fletcher, personal communication, February 6, 2006). In other facilities, nurses may use biofield therapies in ways not fully acknowledged by their institutions, as in a case study that follows.

Yet another unrecognized level of energy work may be occurring in conventional oncology settings. Some biofield therapists believe that when the work is practiced and becomes a familiar part of their professional repertoire, almost inevitably, any opportunity for therapeutic presence or contact carries with it an element of energy healing. In other words, for nurses who study and practice biofield therapies, any instance of care that includes healing intent and compassion also may be operating at the level of energy healing. Although theoretical, this is consistent with the well-accepted concept of nurses' therapeutic use of self.

In the remainder of this article, a case study will be used to describe some challenges in implementing a biofield therapies service in a cancer center. Finally, the article will propose a research agenda to explore the value of biofield therapies in clinical practice for the benefit of patients, their families, and oncology teams as a whole.

## Implementation of Biofield Therapies: A Case Study

A Midwestern cancer center had a philanthropically supported complementary care program staffed by a nurse director, a chap-



**Figure 3. Woman Receiving a Reiki Treatment**

lain, an integrative care counselor (a healing coach or cancer guide), an arts and humanities coordinator, and a nurse coordinator of a resource center. The resource center coordinator, who was experienced in HT, guided imagery, and other modalities, initially provided therapies to staff members on request but not to patients. Then, when a patient facing lumpectomy asked for biofield therapy pre- and postoperatively, the chaplain relayed the request to the practitioner, who complied. Subsequently, the medical director of the cancer center denied permission for biofield therapies to be used in the facility, reasoning that the work had no scientific basis and had been discredited by a study published in *JAMA* (Rosa, Rosa, Sarner, & Barrett, 1998). The study examined whether TT practitioners could sense the energy field around the hand of an investigator held behind a screen. Practitioners did not identify the field more frequently than chance. The investigators concluded “that the claims of TT are groundless and that further professional use is unjustified” (Rosa et al., p. 1005). The research has been critiqued on a variety of grounds (e.g., that effective use of TT does not require practitioners to be able to sense an energy field [Freinkel, 1998]). Some at the cancer center believed that the use of biofield therapies might reflect poorly on the institution. Nevertheless, upon considering patient choice and patient support, the medical director modified the decision, permitting biofield therapies only when requests were initiated by patients.

During the following year, the HT practitioner collaborated with an oncology nurse to submit two versions of a proposal to add HT to the complementary care program, citing published research on biofield therapies. The practitioner provided HT sessions for a small number of patients as requested, mostly those who were receiving chemotherapy or radiation. In two cases, patients were experiencing high levels of treatment-related anxiety.

They requested HT to help them moderate their emotional responses so that they would be able to go forward with treatment protocols. In one case, a family member asked to be taught a basic energy healing practice so that she could carry out the work at home. One patient was a respected physician who took an opportunity to let the medical director know the nature of the benefits she felt she was receiving from HT. Soon thereafter, the medical director gave permission for the work to go forward openly and be listed in the complementary care program brochure.

Overall, the program saw steadily increasing demand for HT sessions, going from zero in the first month to 24 in the fifth month. During that period, the practitioner worked with 32 patients for a total of 72 sessions. They were mostly in an outpatient setting, although a few were inpatient pre- and postoperative and palliative sessions. As appropriate, guided imagery, sound, music, and breath work were integrated with HT sessions. Volunteers in the resource center covered the hours when the HT practitioner was with individual patients. When she left her position at the cancer center, biofield therapies were unstaffed until a nurse cancer guide with many years of experience in TT was hired. Biofield therapies continue to be offered in the context of a hospitalwide integrative care program. (For a description of biofield therapies implementation in another hospital setting, see King [2005].)

The case study suggests a number of observations. In moving toward integration of biofield therapies, educating decision makers about peer-reviewed research is important but possibly not sufficient. Patient requests and a physician advocate may be more decisive factors. In early stages of implementation, philanthropic support is essential. As a program matures, additional kinds of support, including out-of-pocket payment, may need to be examined.

One way to begin implementation is to identify one or more trained biofield practitioners already on staff who can find time to offer services at no additional cost to the institution or patients. A useful first step is to survey existing staff to learn what expertise already is present and then find a way to set aside time for biofield therapies, even if on a very limited scale.

Making time to offer biofield therapies creates an opportunity to integrate further healing modalities, including but not limited to guided imagery, aromatherapy, and music, according to need and interest. Healing sessions thus become an arena for patient choice, an opportunity for freedom, even creativity. This may have great value when the cancer experience is perceived as a time of restricted personal choice.

The process of bringing biofield therapies into conventional cancer institutions may be slow. Because of the potential for long-term benefit, nurses may want to be persistent.

## Biofield Therapies in Oncology: Not for Patients Only

The cancer experience is profoundly challenging on all levels—physical, mental, emotional, spiritual, and relational—for all involved—patients, family, and friends. Not least among those affected are the professionals who make cancer their life’s work. Medland, Howard-Ruben, and Whitaker (2004) cited the need for oncology nurses to recognize signs of stress and burnout, relax and renew themselves, foster a community of care, and attend to that which is spiritually meaningful. They stated

that professional burnout can lead to high rates of staff turnover. As a result, nurse recruitment, retention, and training become pressing issues for oncology administrators. Given a community of care that is stressed and actively seeking healing resources, institutions should consider making biofield therapies available not only to patients with cancer but also to those who care for them. Mackereth, White, Cawthorn, and Lynch (2005) developed a successful complementary therapies program specifically to support oncology and palliative care professionals.

In "Burnout: Caring for the Caregivers," Penson, Dignan, Canellos, Picard, and Lynch (2000) identified a range of needs for oncology professionals, such as taking time for themselves, engaging in self-care and restorative practices such as meditation, and drawing multidisciplinary members into the team for support. Biofield practitioners as team members are a resource for direct care of patients. Viewing patients as people in relationships, practitioners also can teach family members simple biofield techniques, allowing them new ways to be with and comfort their loved ones. Beyond that, the potential value of biofield therapies for oncology nurses themselves is an area for exploration. Given the challenges of oncology nursing and the need to support and retain experienced nurses, studying the use of biofield therapies for oncology nurses in the workplace may be timely.

Outcomes from controlled trials provide rationale for the use of biofield therapies with patients, but little research has been done in applying the therapies to family members or professionals. However, many early TT studies were conducted with healthy volunteers, which may be relevant to those in oncology settings who are not diagnosed with cancer. Quinn and Strelkauskas (1993) examined the effects of TT on a small group of recently bereaved individuals. Outcomes included strong increases in joy, contentment, vigor, and affection and significant decreases in anxiety, depression, guilt, and hostility. Focusing on TT responses of individuals experiencing grief, the study appears to be relevant to the families of patients with cancer and to oncology professionals. Lafreniere et al. (1999) reported an RCT showing an association among three monthly TT sessions, significant decreases in mood disturbance, and significant increases in vigor in healthy female volunteers. Redesigning and carrying out studies such as these would be useful, specifically with family and professional caregivers of patients with cancer.

## Conclusion

Biofield therapies based in ancient, cross-cultural healing practices are being integrated into conventional cancer care. Recent studies suggest that they have the potential to alleviate symptoms in all human dimensions of physical, mental, emotional, spiritual, and relational well-being. Further research and implementation may support the healing of patients and the community of care as a whole.

**Author Contact:** Beverly Pierce, MLS, MA, RN, CHTP, can be reached at [bpierce@suburbanhospital.org](mailto:bpierce@suburbanhospital.org), with copy to editor at [CJONEditor@ons.org](mailto:CJONEditor@ons.org).

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