

Article

Tactile Massage as Part of the Caring Act

A Qualitative Study in Short-Term Emergency Wards

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Aims and Objectives: The aim of this study was to illuminate the nursing staff's lived experiences and meaning in giving tactile massage (TM) while caring for patients in short-term emergency ward.

Method: Data were collected through individual qualitative interviews with six nurses and eight assistant nurses working with TM in short-term emergency wards in two hospitals in Sweden. The narratives were analyzed using a phenomenological hermeneutical method. **Findings:** Nurses experienced providing TM to patients as a present awareness in connection with compassion for the patient. TM provided the nurses with a tool to ease patient suffering and pain. Three dimensions were found where touch became a tool of doing, was an aware presence as a mindful being, and was embodied in a human-to-human connection with a changed caregiver. **Conclusion:** Given the current high-tech health care system with overcrowded units and a shortage of nursing staff, TM could be included as a caring tool to improve the caring in caregiving, allowing nurses to act in aware presence by touch to encourage health and well-being for both the patient and themselves.

Keywords: *caring; presence; massage therapy; emergency nursing*

Background

From a caring perspective, touching is an essential element of nursing (Barnett, 1972; Bottorff, 1993; Chang, 2001; Routasalo & Isola, 1996). Feeling at ease with touching, touching may influence nurses' work satisfaction in a positive way (Pedrazza, Minuzzo, Berlanda, & Trifiletti, 2014). Lewith (1996) claims that using a complementary method in nursing allows nurses to devote more time in caring for the patient and provide an excellent environment for the development of

compassion in the nurse–patient relationship. Might tactile massage (TM) provided in an emergency setting create such a favorable for the patient as well the nurse?

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Touch

Many scientists have shed light on the importance of touch, that is, touch involves something more than just physical contact; it is something that may create a sense of warmth, closeness, and the sense of doing good to another human being (Cronfalk, 2008; Eriksson, 1987; Estabrooks & Morse, 1992; Henricson, 2008). Touching and being touched is one of the most profound experiences a human being can have, and stress and frustration may result from not being touched (Wigforss, 2006). Montagu (1986), the “father of touch” in this tradition, emphasizes the importance of human touch, specifically dealing with the relationship between physical and mental health on the one hand and touching on the other, touching being an important form of nonverbal contact/communication.

It is hard to review the literature on human touch due to the proliferation of different concepts and terms involved, for example, patient-centered comfort touch, comforting touch, touching with intention, nonnecessary, intentional touch, instrumental, task oriented, and technical touch (Connor & Howett, 2009). Massage is a form of intentional touch that has been used for millennia (Wigforss, 2006). Rubbing the physical body was the primary form of medical treatment given until the pharmaceutical revolution in the 1940s (Field, 1998). From around 1880 and well into the 20th century, it was believed to be an important treatment for both mental and physical conditions. Historically, massage was used as a basic form of providing comfort in nursing care. By the 1930s, however, the use of massage began to decline, due to the new discipline of physical medicine (Ruffin, 2010). In the literature, there are descriptions of a multitude of techniques for touching in nursing, such as healing touch (Hover-Kramer, 2002), TM (Ardeby, 2003), tactile stimulation (Birkestad, 2001), Therapeutic Touch (Krieger, 1993), and Reiki (Sword, 1999). Today, there is a growing interest in massage. Maybe massage could be incorporated into nursing encounters, given that the application of so much medical technology may in part as a by-product have created a distance to the patient (Ruffin, 2010).

Patients' Experience of Massage in Acute or Intensive Care

For a patient, finding him- or herself in a critical care environment may be a frightening experience,

involving anxiety and stress. During those circumstances, a 6-minute back massage significantly improves the quality of sleep (Culpepper, 1998). Even a 5-minute foot massage can be an effective intervention for reducing stress, reducing anxiety, and promoting relaxation (Hayes & Cox, 1999). Relaxation brought about through massage may decrease pain and positively affect the patients' ability to deal with the challenging aspects of their health condition in an acute care setting (Adams, White, & Beckett, 2010; Hattan, King, & Griffiths, 2002; Hulme, Waterman & Hillier, 1999; Kubsch, Neveau, & Vandertie, 2000; Taylor et al., 2003).

Since the mid-1960s a form of soft tissue massage has been developed, TM (Ardeby, 2003). TM has become widespread in different clinical care settings in Sweden (Airosa, Falkenberg, Öhlén, & Arman, 2013; Cronfalk, 2008; Henricson, 2008; Ozolins, 2011). Implementing TM in emergency settings may increase well-being and create a sense of security for a patient who is suffering from the chaos and crisis of acute illness. Patients experience an existential togetherness with nurses during TM and are able to physically relax despite anxiety and pain (Airosa et al., 2013). TM is a soft tissue massage just stimulating the touch receptors without working on muscles. It consists of slow, structured movements using the palm of the hand (efflurage), during which the therapist applies massage oil (natural or with the fragrance of lavender) using gentle, circulating movements, which may be done over all of the body. The patient lies on a massage bench or in his or her bed, embedded in towels and blankets; only the part of the body that is being touched is uncovered.

Nurses Experience of Touch in Caregiving

Previous studies on health care workers touching patients in an intentional way have indicated that touch not only is an aspect of a caring relationship but also might be described as the very core of the caring relationship (Ozolins, 2011; also described by Ranheim, Kärner, Arman, Rehnsfeldt, and Bertö, 2010). These findings have showed that the act of touching can bring about an improvement of awareness that benefits the caring act for patients and caregivers alike. In a study by Chase, Jha, Brooks, and Allshouse (2013), nurses reported that time spent giving patients massages was often the most

undisturbed period of patient care allowed in a busy day. One study from dementia care states that using touch as a caring tool to decrease patient suffering requires respect and sensitivity from the nurse; experiencing how touch can make a difference to patient suffering simultaneously increases the nurse's sense of satisfaction and pride in his or her work (Edvardsson, Sandman, & Rasmussen, 2003). In the study by Cronfalk (2008), nurses expressed a positive attitude toward soft tissue massage (equivalent to TM), as a valued and important aspect of nursing care.

The transition from nurse to touch therapist was described by Henricson, Berglund, Määttä, and Segesten (2006) as a nurse's lived experience in his or her preparation before giving TM in an intensive care unit. The nurse's basic requirements entailed the following: a sense of inner balance, unconditional respect for the patient's integrity, and a relationship of trust with the patient, in addition to the need for a supportive environment. Another study on TM described the method as an energy-controlling system, requiring an inner balance and the ability to apply this balance while working. Even though the nurses and assistant nurses reported positive aspects, there seemed to be a primary concern about maintaining inner balance (Andersson, Wändell, & Törnkvist, 2007).

Most of the literature has studied TM from a patient perspective; thus inquiry into nurses' experiences are rare, and there have been no studies of nurses' experiences giving TM in short-term emergency wards, when meeting the acutely ill patients in a time of chaos and crisis. For nurses, daily work in a short-term emergency ward can be exhausting due to its technical and stressful environment with high demands (Airosa et al., 2011; Yang et al., 2001). In the medically dominated context, patients' experiences and well-being are at risk of becoming secondary, a situation potentially unnatural for both patient and nurse. Still, an ideological cornerstone of nursing practice is, and should be, holistic (Dossey & Keegan, 2013).

Aim

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

Method

Design

We used a qualitative method involving a phenomenological-hermeneutic approach developed by Lindseth and Norberg (2004). In terms of interpreting interview texts, the method is also inspired by the theory of interpretation presented by Paul Ricoeur and focuses on the meaning of people's narrated lived experiences. The interpretation of the text proceeds through dialectical movements between understanding and explanation (Lindseth & Norberg, 2004).

Participants and Setting

In Sweden there are two hospitals working with TM in short-term emergency wards (one university hospital and one smaller hospital in a minor city). Of all the staff working in those wards (the total number of nurses and assistant nurses was approximately about 120), 14 caregivers were trained in TM and gave patients TM (6 nurses and 8 assistant nurses). All nurses and assistant nurses trained in TM ($n = 14$) were invited by the first author by e-mail to participate in the study, and all of them agreed to participate. They were all female (34-62 years of age) and trained in TM described by Ardeby (2013). Most of the TM was given on the back, hands, and feet. Vegetable oil, natural oil, or oil with the fragrance of lavender was used during the treatment. Some of the treatments were performed in a special room near the short-term emergency ward and others took place in the patients' rooms at the short-term emergency ward.

Context

Short-term emergency wards receive patients directly from the emergency room, and patients stay in the ward for several reasons, with a wide array of diagnoses, from minor illnesses to severe diseases. The length of patient time spent in the ward varies from 1 day to several days. To work as a nurse in this stressful environment can be emotionally and physically exhausting (Yang et al., 2001). Patient care involving a high level of dependency and caring for patients close to death can also contribute to stress (Payne, 2001).

Table 1. Example of Structural Analysis

Meaning Unit	Condensation	Subthemes	Theme
Well, it gives so much back . . . I am so proud of what I am doing . . . I feel a pleasure of what I am doing . . . you get feed-back that you are doing something good, I am really proud of doing this. Maybe I have grown as a human and become more aware of the human being and not just the patient	To be proud and reflective of one's work	To become aware of oneself	Becoming changed by touch

Data Collection

Data were collected through individual interviews consisting of narratives, analyzed using a phenomenological-hermeneutical method with a convenience sampling approach.

The first author conducted the interviews. The participants were interviewed in a room near their workplace. The interviews took place between January 2012 and October 2012. An open-ended research interview was conducted to shed light on the meanings of giving touch (Kvale & Brinkmann, 2009). The participants were asked to narrate as freely as possible about their experiences in working with TM, with the interview opener, "Please tell me about your experience in a situation when you gave TM." Follow-up questions like "Could you explain further" or "Could you give me an example" were asked to obtain more information. The interviews were digitally recorded, lasted approximately 20 to 60 minutes, and were transcribed verbatim by the first author. The first author then compared the digitally recorded interviews with the transcribed versions of the interviews to validate the data. The interviews were conducted in Swedish.

Ethical Consideration

The participants were informed about the nature and purpose of the study and that the data would be treated in strict confidence. The research project was approved by the regional ethics committee Dnr 2010/514-31. All participation was voluntary and involved informed consent.

Data Analysis

The interviews were analyzed using a phenomenological-hermeneutic method based on Ricoeur's philosophy developed for nursing research by Lindseth and Norberg (2004). Three methodological

steps were taken in the interpretation process. The first was a naive understanding in which the text was read several times to grasp the text as a whole. The second step was a structural analysis in which the text was divided into meaning units and each meaning unit was then condensed (without losing the essential meaning) into meaning units. The condensed meaning units were then reflected on and abstracted to create subthemes and themes as presented in Table 1. In the third step, the themes were compared to the naive understanding for purposes of validation. During the interpretative process, the researchers' preunderstanding was considered. A diary of reflections and thoughts about the preunderstanding before and during the analysis phase was used by the first author. The analysis moved back and forth between the steps to capture a deeper meaning in the comprehensive understanding. Two authors performed independently a preliminary reading and then discussed the meaning of the text.

Findings

Naive Understanding

Nurses find using bodily touch as TM in short-term emergency wards to be pleasurable. In the beginning when practicing TM, the nurses concentrated on patients' bodies and physical reactions but, over time, they also became more aware of the emotions involved. In the interviews, they reflected on their encounters with the patients maintained with a sense of awareness and presence. To establish a connection with the patients, the nurses tried to center and get into a state of "here and now." Nurses practicing TM emphasized an understanding of the importance of *how* to touch another person, which in the end changed their approach to touch in terms of more caring caregiving altogether. TM became a tool to connect with another human. By giving TM, nurses experienced themselves as

Table 2. Subthemes and Themes

Subthemes	Theme
Using tactile massage as a tool to ease suffering; complement to medication	Touch as a tool in caring acts
Having time to center oneself and to give tactile massage	Being mindful in touch
To be in compassion	
To connect in presence	
To become aware of oneself	Becoming changed by touch

valuable professionals since they could ease suffering and felt they had the ability to do something good for another person. Nurses gained a sense of well-being and calm when giving TM, which could be described as increased awareness for the human being and themselves.

Structural Analyses

Based on the naive reading, three questions emerged: How is TM useful for nurses? What happens when nurses experience a connection with the patient? How does TM affect the caregiver? From these questions, three main themes emerged: touch as a tool in caring acts, being mindful in touch, and becoming changed by touch (Table 2).

Touch as a Tool in Caring Acts

Tool to ease suffering. When touching in the context of TM to patients in short-term emergency wards, nurses were given an opportunity to act in a caring way. TM implied taking time for the patient and is a manual tool to alleviate patient suffering. Using *touch as a tool in caring acts* was viewed as something of a luxury. To provide this little extra bit of care created a great sense of well-being and relaxation for the patient as well as the nurse. For nurses, the experience of connecting and being truly present with the patient to ease suffering may have provided a deeper understanding of the naturalness of caring and an awareness of the importance of touching the patient in a certain way.

I know two occasions when I managed to stop panic attacks, in two patients they completely stopped with TM, I started to ask if I could give hand massage, and I was allowed, and it took just about 5 minutes and I had stopped the attack, yes,

this panic attack, yes, and then I continued for about 20 minutes and she was nearly asleep. (IP 106)

Working with TM introduced into the caring act an awareness of the importance of giving the patient enough time and of working more unhurriedly.

Complement to medication. Having TM as a tool may decrease suffering in a more natural way. Many of the acutely ill patients are in pain, which TM helps ease using fewer drugs. Applying TM in the caring act is a way of showing compassion without any other tools than the hands.

I think I accomplish a greater achievement if I do TM, than just going and getting a drug, because that's become so impersonal. . . . I feel that I am doing more for the patient if I take the time, because I think many patients feel that you are always in such a hurry . . . but if you sit down and take the time . . . (IP 111)

There seems to be a desire on the part of the nurses interviewed to strive for naturalness in the healing process and to support the patient's own resources.

Being Mindful in Touch. The caregiver needs to be able to center themselves in a state of peace, love, and compassion when starting to use TM with a patient. It takes time and an aware presence to create this moment of nonverbal communication. TM allows nurses to be *caring* caregivers, which brings a feeling of satisfaction. They are human beings doing something out of compassion for other human beings.

To center oneself and provide TM. There is a need for nurses to consciously set aside time to prepare themselves to provide TM given their stressful work in short-term emergency wards. They might find a quiet place to concentrate on their breathing, or just sit down and let all their thoughts slip away. Yoga was seen as a means to center oneself.

I noticed that it is easier to focus on what I am doing, when I begin, to focus, and then the feeling will appear, but it is very important that I am not stressed when I start. I need time to prepare, to sit in a yoga position, and let everything fade away, just for 10 minutes. (IP 106)

There is a need for supportive colleagues to get time to perform TM. Most of the nurses reported that their colleagues valued their work with TM and helped them make time for providing TM, since they saw that TM might reduce anxiety and pain for their patients. Some nurses had scheduled time to give TM, which they appreciated a lot, since they felt they did valuable work.

To be compassionate. To do good for other people is the deep core of TM, and the intention of compassion, love, and willingness in the TM is significant.

You feel that you are very considerate . . . you give . . . you think that you don't give so much of yourself, but you do . . . it becomes, what should you say, an act of love . . . of some kind. You get warm feelings and thoughts. You are in this bubble of care, consideration, warmth, love . . . I think . . . Yes warmth. (IP 110)

Doing something good for another generates feelings of compassion, and self-confidence grows, providing a feeling of having a value.

To connect in presence. TM may deepen the relationship with an acutely ill patient. When connecting in presence it may be possible to meet the human being and not just a patient. It is a meeting beyond borders. A nonverbal encounter in aware presence takes place where the patient's feelings and emotions can be acknowledged and have an impact on the nurse when feelings of sadness, loneliness, or other kinds appear.

Sometimes I feel it is very heavy, I feel like I want to cry. If I allow myself to enter the other person's energy field, I feel I can hardly breathe, then you just want to breathe and go away, just go, because you feel you are going to cry, and I know that is not coming from inside me because I did not have that feeling before meeting this patient. . . . You enter the other person's aura or sphere, and you take part in those feelings . . . the one who is depressed or sad . . . sometimes I imagine a bubble before I start TM, [and] inside that bubble no feelings will/can reach me unless I allow them to. (IP 103)

It creates a feeling of humility to connect on a deeper level with a patient where this nonverbal connection in presence takes place.

Becoming Changed by Touch. Becoming changed by touch illustrates an awareness of oneself and the patients and how to deal with emotions and reflections. There is a change from being unaware of touch and of how to use one's hands in daily work, to an awareness of the importance of *how* to touch.

To become aware of oneself is to deal with the different kind of emotions and feelings arising during TM, for which one needs different strategies. One of the strategies is journaling. For example, every day after working with TM, some nurses wrote down all their feelings and emotions and tried to understand their origin. This self-reflection could start after a while when the nurses felt secure and safe giving TM, since in the beginning they were still just concentrating on the patient's body. Sometimes, TM took energy from them and they felt exhausted afterward. To deal with this, they "shut off" during TM, meaning they cut the connection in presence with the patient, and focused on the body of the patient during TM. But most of the time, the TM was experienced as something energy giving.

If a patient is very sad, very sad, and tears are falling heavily, but he or she still wants to have TM, afterward I get very, very tired, and sad, not that I cry, but I don't feel any joy, maybe for the rest of the day, until I realize that I am not sad because I am sad. . . . It took time before I learned to leave the thoughts about the job, just at the job. I took her tears home with me, and it used to take some time before it faded away. . . . Nowadays, I come home, sit in my sofa, and try to create an awareness of whose feelings am I sensing. . . . I use journaling; it clarifies what is happening for me, it is a relief. . . . I have many diaries back home . . . (IP 101)

One might say that you care for yourself at the same time as you care for another. Depending on the workload that day, your tiredness quickly goes away when you give TM. When you are in the bubble, your tiredness disappears after a while. There is energy . . . well I won't say you get alert, but get energy. (IP 110)

Becoming aware of oneself strengthens self-esteem and one becomes more aware of one's own boundaries and learns how to say no to the demands of others. The nurses felt valued. Many of the nurses described having become calmer as a person over time as their self-esteem grew.

Comprehensive Interpretation

The grasp of the phenomena in the comprehensive understanding is an *aware presence in connection* with the patient that leads to an experience of the core of caring.

Nurses live in a double and paradoxical environment where the external tasks and medical details are important for patients' whole lives and destinies. In an emergency ward context, decisive life-changing moments are frequently played out in front of caregivers' eyes. Everyday life can therefore mean a constant struggle among choices: to be a present fellow human being or to close one's eyes and just get on with the task at hand. This may also include a lack of knowledge or of opportunities for nurses to do something more for the patient than their routine tasks. When nurses offer TM, the opportunity to approach patients in a new way opens up a world of knowledge and experience that both satisfies the moment and can be transferred into all their professional work and connections to patients. To be present, to really be there for someone else, is an underrated ability that has healing potential. By using and experiencing TM, the nurses changed into the *caring* and compassionate caregivers they wanted to be. The sensibility to enter another human being's sphere had the power to transform the nurse into a fellow human being and to express an awareness of presence when touching the patient.

Discussion

Method Discussion

The choice of a phenomenological-hermeneutic approach is based on our focus on nurses' lived experience. This approach requires an open-ended question to have the participants narrate as freely as possible. Less experienced nurses seemed to find the open-ended questions difficult to handle, as they reported that they did not have a lot of experience in giving TM and that they were insecure about what they might contribute.

All participating nurses and assistant nurses were female. It would have been interesting to have narratives from male participants and to see if they shared the same experiences. All nurses and assistant nurses had worked in their profession for at least 3 years and most of them were older than 40 and consequently had many life experiences. Most

of the nurses and assistant nurses working with TM at the university hospital ($n = 7$) were colleagues of the first author, which may have influenced their answers in the direction of trying to satisfy the first author. However, one strength is that all the narratives from both hospitals were similar, which may suggest that they had narrated freely.

Results Discussion

Shedding light on the nurse as caregiver may be perceived as setting the patient aside, but as Dahlberg and Segesten (2010) claim, it is important to keep in mind that, in the end, the development of nurses' competencies always aims at what is best for the patient.

One could discuss the possible outcomes of the narratives if nurses who had stopped working with TM for different reasons had participated in the study. Perhaps being aware and present in connection with the patient might have been experienced as too demanding or too close for some staff. However, all nurses in this study were actively working with TM, which may mean that they had a positive attitude toward TM.

With an aware presence, nurses reported suddenly feeling sad or lonely or experiencing other feelings as a result of them taking on board the feelings and emotions of their patients. During their training in TM, those experiences were not discussed. Over time the nurses felt safer in their feelings and dared to be *in* the feelings of others, they started to feel more self-confident, and they narrated feelings of daring to meet the whole of human kind. This emphasizes the importance of training nurses in TM, to become aware of what may happen during treatment, since for some this was a frightening experience in the beginning.

Ranheim et al. (2010) found in a previous study how participating nurses, while giving touch, become more "aware" and described an expansion in their senses when they become more vulnerable and open in their encounters with their patients. This awareness of the patients' bodies as well as their moods and expressions of relaxation, happiness, or anxiety opened up new dimensions of the caring experience. Hover-Kramer (1998) argues that personal preparation and intent are essential; that the presence of a balanced caregiver can provide a sense of security, protection, and comfort; and that if nursing staff are burdened with emotional tension, that heaviness

may be conveyed to the patient. This idea of conveyed emotional tension was also found in our study where the nurses thought that their emotional well-being could be assimilated by the patient. The importance of an emotional association in the encounter as an essence of caring was also described by Ranheim et al. (2010). Arman and Rehnsfeldt (2011) reported that the caregivers need to act out of the goodness of love, caritas, and that one needs to come to terms with one's own existence, which involves presence and acceptance of everything in life.

Our findings also support the results of Edvardsson et al. (2003), who describe that "I" and "thou" merge together in the concepts of body and self, doing and being, where two dimensions arise: using the tool of touch as *doing* and being within touch as *being*. In our study, touch became a tool of *doing*, and an aware presence as a mindful *being*, embodied in a human-to-human connection with a changed caregiver as *becoming*. The participants in Edvardsson et al.'s study were health care workers working with patients with dementia, while in our study, the nurses were working with acutely ill patients. In both cases, the outcome is a change in the nurses as they start to see the person behind the disease as a human being, like themselves.

According to our findings, nurses experienced having TM as a tool deepens their relationships with patients when connected in an aware presence by touch. Centering and connecting led to self-reflection, and moments of giving TM gave the nurses a sense of well-being in an otherwise stressful environment that encouraged the nurses to comfort the suffering patient.

Still, even if the majority of the nurses in our study shared a positive attitude against TM, one needs to be aware that some nurses less trained in TM experiences said that TM drained them of energy and they felt exhausted afterward. They also found the lack of time to give TM as an obstacle for implementing TM in their daily caregiving routine. This indicates the need of a mentorship system for helping with tools to handling emotions and feelings that arise and are experienced during TM, and how to protect oneself so as not to become drained of energy but instead take advantage of even brief moments to connect with the patient. In a previous study by Pedrazza et al (2014), findings indicate that helping nurses establish a positive and warm

relationship with patients through touch without being overwhelmed by patients suffering could improve nurses' quality of care and well-being.

The need for awareness of the risks involved regarding compassion fatigue is pivotal. Compassion fatigue is a concept that emerged during the early 1990s and includes burnout in nurses. The concept is associated with exposure to suffering as well as the absence of emotional support within the workplace, and nurses are open to a great extent of suffering (Sabo, 2006). There is an assumption that compassion fatigue may reduce productivity and increase sick leave as well as staff turnover (Hegney et al., 2013). As the nurse–patient relationship is at the core of caring TM, this may be one way of strengthening this relationship, working with compassion but being aware of the risk of compassion fatigue. Halldorsdottir (2012) highlights, from a patient perspective, how presence makes the caregiver more attentive to the patient and increases the ability to listen and respond. TM can thus be seen as a way to use experience for development of a "compassionate competence" that can be the core of good professional nursing.

Theoretical Discussion

Halldorsdottir (2008) offers a synthesized theory of the dynamics of a nurse–patient relationship introduced from the patient's perspective. It is described as lived reality with a sense of spiritual connection involving a bond of energy. This connection is the *life-giving* nurse–patient relationship. The concepts in this theory are the following. *The bridge*, the perceived openness in communication and connectedness in a nurse–patient relationship: In our study the sense of connection in presence with the patient where a nonverbal encounter took place may be the bridge in a nurse–patient relationship. *Empowerment*, a sense of well-being and health: In our findings the nurses said that giving TM gave them a great sense of well-being and being privileged. *Health*, the lived experience of health is when the person has the ability to achieve his or her vital goals: Giving TM, nurses felt that they could alleviate the patients suffering with their hands and reflected on the impact the TM had on themselves. *The wall*, the perceived disconnect between the nurse and the patient, which could be due to being unwilling or unable to connect with the patient,

working with TM where a nonverbal encounter takes place may increase the intuition of the patients mood or feelings. Sometimes the nurse felt a need to cut off the mental connection with the patient for self-protection. *Disempowerment*, a subjective sense of being broken down in some way: This concept may be due to the sense of carrying the patient's burden, feel sad or lonely when giving TM. *Vulnerability*, the lived experience of being easily hurt and set off-balance: One way of dealing with all the emotions and thoughts appearing when giving TM was journaling, helping nurses feel empowered instead of disempowered.

From this point of view one could say that working with TM is a journey toward oneself. The difference between the training levels of different nurses in TM is evident from the interviews, with the less trained nurses being more focused on the patient's physical body. In our study, five of the staff were certified touch therapists (Level 3), and all the other staff ($n = 9$) were trained in Level 1. The TM described by Ardeby (2013) consists of three levels. At Level 1, the participant learns how to practice TM on the back, hands, and feet during a weekend course; certification (Level 3) includes whole body training and requires 1 week (total) of theory and practice and an additional 60 hours of documented practice.

Our findings indicate that working with TM over time may give the nurse skills and a professional wisdom to work in light with a heart of compassion knowing themselves and being comfortable with themselves as well with others.

Relevance to Practice

Integrating bodily touch and massage such as TM in the caring act may create a connectedness with the patient and give nurses an opportunity to become *caring* caregivers. In today's high-tech health care world with overcrowded units and a shortage of nursing staff, providing TM may give nurses a moment of an aware presence in touch. Little time is required to incorporate this technique, as even a 5-minute massage may create a moment of connectedness in the patient–nurse relationship. The increased interest in TM among patients and nursing staff illuminates the importance of training that is meaningful to the nurses. Currently available courses do not specifically focus on TM in relation to nursing. Since this study illustrates a changed

caregiver, perhaps a modified course for nurses might generate new skills in the caring act. One could discuss whether TM should be integrated in the nursing curricula.

Conclusion

Using TM may give nurses a tool in their work, may change their caregiving practice, and may increase their and their patients' well-being in a stressful environment. With TM, nurses can ease patient suffering, and an aware presence puts them in touch with the importance of *how* to touch the patient, and thus become a *caring* caregiver. However, introducing a complementary treatment, such as TM, requires a supportive environment, structure, and time for nurses to maintain their inner balance, which in turn, requires organizational support and economic and political commitment.

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