

MANAGING DISCOURSE: THE THERAPEUTIC TOUCH DEBATE

**MANAGING DISCOURSE: MEDICAL HERESY, INTEGRATIVE MEDICINE,
AND THE THERAPEUTIC TOUCH DEBATE**

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Abstract

In this thesis I examine the debate surrounding Therapeutic Touch, a controversial energetic healing modality being practiced by registered nurses in biomedical institutions across North America. The debate surrounding the therapy takes place within medical journals, popular media articles, and on the internet. Within the debate, definitions of illness etiology, appropriate treatment, patient management, and alternative therapy use are contested by Therapeutic Touch proponents and critics. Through discursive analysis, interviews with local participants in the debate, and participant observation within the TT community, I present an analysis of the issues being contested and of the discursive strategies used by proponents and critics within the debate. The debate is contextualized in two ways: first, as an instance of medical heresy, in which an alternative healing group arises within the orthodox medical community and struggles to maintain itself within biomedical discourse and institutions; second, I contextualize the debate as an example of the wider trend towards integrative medicine in North America. Integrative medicine sees alternative therapies being increasingly used within health care delivery systems, either by alternative practitioners, or by biomedical practitioners who have co-opted alternative techniques. I argue that Therapeutic Touch proponents have utilized several discursive strategies in presenting and arguing for their alternative healing model. These strategies surround the issues of professional legitimacy, scientific validity, and TT's perception as religious or spiritual. Therapeutic Touch proponents manage their discourse by conforming it to orthodox biomedical discourse and by pursuing a strategy of professionalization. Through this management process, they have been able to maintain a marginal presence within biomedicine.

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Introduction

Therapeutic Touch (TT), a healing practice developed by Dolores Krieger, RN, PhD, and Dora Kunz, traditional healer and psychic, has been a topic of debate within medicine, academia, and the general public for over twenty years. TT is a form of energy healing, and was derived from the spiritual “laying on of hands”. During a therapeutic touch treatment, healers use their hands to sense “irregularities” in their patient’s human energy field (HEF) and then direct “healing energy” into them, with the intent of smoothing and balancing the field. TT was created as a therapy for use by nurses in 1972, and is now practiced by thousands of nurses North America-wide, and by a large number of lay-people in Canada.

Determining the exact number of TT practitioners is currently impossible, as consistent criteria to define practitioners, and reliable ways of determining how many people have learned TT, do not yet exist. However, estimates of the number of TT practitioners have been given by several sources. In a meta-review of TT studies in the Journal of Cardiovascular Nursing, Mulloney and Wells-Federman (1996) estimate that 20-30, 000 health professionals world-wide practice TT. Kevin

Courcey, an RN and vociferous critic of TT, estimates the level of practitioners to be around 50, 000 (Courcey 2000). Stephen Barrett, retired physician and leader of the anti health care fraud organization, Quackwatch, estimates between 20 – 22, 000 practicing health professionals (Barrett 2000). Nurse Healers-Professional Associates International, the U.S. based TT organization, claims 1200 members (Hawk 2000), while the Therapeutic Touch Network – Ontario (TTNO) claims 1200 members as well (Hawk 2000).

TT emerged amidst a general renewal of interest concerning alternative medical theories and practices. This renewal has been called a “holistic health movement” (Salmon 1984:7-9; McKee 1988; English-Leuck 1990; Saks 1997; Baer 1998), and is associated with the counter-culture, New-Age, and popular health movements of the 1960’s and 70’s (Salmon 1984:7-9; Heelas 1996:80-84; Baer 1998), although some researchers trace the movement’s history back much further (English-Leuck 1990:63-96). Salmon (1984:7-9) characterizes the holistic health movement as a “confluence of economic, social, and cultural factors” which include safe-workplace movements among organized labour, environmental activism, the women’s movement, the counter-culture, and New Age movements. He states:

Advocates of holistic health assert as a cardinal principle the notion of the fundamental and integral unity of the body, mind, and spirit...the growing popularity of these concepts...has surely ushered

in a renewed openness toward nineteenth century western medical practices, as well as towards oriental medicines and several of the traditional and indigenous therapeutic systems which are still prevalent across the globe.

As a result of the holistic health movement, conventional forms of North American medical thought and practice are being questioned, challenged, and modified (Sullivan 1996; Wolpe 1994:1133-1134). In contemporary Canadian medicine, it is no longer unusual to encounter therapies once considered alternative or marginal being practiced in biomedical institutions (Nightingale 2000). TT is an example of this phenomenon, as it is routinely used by nurses in hospitals, health clinics, and private doctors' offices. In Toronto alone, large medical institutions such as St. Joseph's Health Centre, Sick Kids Hospital, St. Michael's Hospital, Princess Margaret Lodge, and the Toronto East General Hospital have contingents of TT practicing nurses (Elton 1999).

TT's movement into conventional medical institutions has not been without opposition. In several instances, critics of the therapy have attempted to stop the acceptance of TT practice by hospitals. At times, these attempts have failed, as when the Rocky Mountain Skeptics (RMS), a Colorado based organization dedicated to fighting pseudoscience, was unable to block acceptance of TT by the Colorado Board of Nursing (RMS 1996b). At other times, these attempts have been successful – an example being RN Kevin Courcey's lobbying of the board at the Sacred

Heart Medical Center in Eugene, Oregon. After Courcey's complaints about the practice of TT at the hospital, the board decided that nurses could no longer perform the therapy, and that if requested by a patient, it would be provided by a Catholic nun instead (Courcey 1999). Another instance in which TT failed to pass a hospital review board was in the early 1990's at Grand Rapids Hospital, Michigan. A nurse at the hospital had contacted an attorney and considered filing a complaint against the board for religious intimidation should they allow TT practice. The hospital board blocked the practice, ruling that there was insufficient evidence for TT's theoretical claims and its claims for efficacy (Bishop 1999).

Some of the strongest evidence for opposition towards TT can be found within medical journals. In 1995, an editorial appearing in the journal Research in Nursing and Health entitled "Our Naked Emperor" questioned TT's lack of scientific validation and its appropriateness for clinical practice. The journal editor, Marilyn Oberst (1995:1-2), stated:

...there is no empirical evidence whatever to support the existence of a "personal energy field" capable of being transferred between persons...there is absolutely no empirical evidence demonstrating that the technique is effective in solving any of the clinical problems to which it is applied...

Oberst discusses being at a TT presentation, noting: "One colleague passed me a note during such a presentation not too long ago - it said simply, 'The emperor has no clothes'"(Ibid., p.1). In her editorial, Oberst assumes the voice of the "silent majority" of nurses who do not accept TT,

yet who have been unwilling to confront “the emperor’s obvious nakedness” (Ibid., p.1). She ends the article by stating:

We need to carefully consider the scientific and practical limits of diversity, and to set some standards for acceptable practice. At the moment we seem to have at least one naked emperor, and I think it’s time for the reputable scientists among [us] to say so – loudly, repeatedly, and in public (Ibid., p.2).

The reaction to Oberst’s editorial was considerable, with letters of response equally praising her for bringing TT’s shortcomings out into the open, and defending the practice of TT. On both sides were Ph.D. nurses and professors of nursing, indicating that the issue of TT was of interest to the profession’s elite.

Issues raised in replies to Oberst’s editorial echo those raised in similar debates about TT within the American Journal of Nursing, Journal of Advanced Nursing, Ontario Nursing Forum, and Journal of the American Medical Association (JAMA). *Critics* of TT, also referred to as *opponents* (those people who have made recorded statements opposing TT’s credibility and usefulness) point to the lack of scientific validation for its theories or purported effects, while also characterizing it as “placebo effect” (Oberst 1995), “quackery” (Rosa 1995), “folk healing” (Bullough & Bullough 1995) and even “witchcraft” (Bishop 1995). *Proponents* of the therapy (those people who have made recorded statements supporting the credibility and usefulness of TT, including TT *practitioners*, and *teachers*) retort with different (supportive) interpretations of TT research, different

views on the goals of nursing, different views on the nature of science itself, and the importance of the mind and spirit in healing.

Similar issues have arisen in debates surrounding other alternative therapies. In the Canadian Medical Association Journal (CMAJ), a series of articles entitled "Unconventional therapies for cancer" (Kaegi 1998:897-902; 1033-5; 1157-9; 1327-30; 1483-8; 1621-4) introduced information on six scientifically unproven cancer therapies. Written on behalf of the Task Force on Alternative Therapies of the Canadian Breast Cancer Research Initiative, the articles present information on essiac (an herbal tea), green tea, iscador (mistletoe), Hydrazine sulfate, vitamins A, C, and E, and 714-X. In each article, the therapy's history is introduced, along with its purported effects, the available clinical research, and potential side-effects.

In response to the article series, Ian Tannock, MD, Ph.D., and David Warr, MD (1998:801-802), wrote a letter in which they criticize the articles for only presenting supportive evidence for the treatments, and for not evaluating the quality of that evidence. Tannock and Warr mention that controlled clinical trials of both Vitamin C and Hydrazine sulphate have shown no beneficial effect, and chastise the National Cancer Institute of Canada (NCIC) for supporting the research when budgets are tight and a "surfeit of excellent proposals" exists. They characterize proponents of these therapies as irrational, stating: "One can never convince the zealots:

logic cannot win a contest with belief”, and “No amount of evidence will convince flat-earthists that the world is round!”

In the journal articles presented, proponents and critics of alternatives put forth arguments concerning the role of science in healing, the goals of healing, and the proper means of achieving these goals. From these arguments, made by medical professionals often portrayed as strongly united in value and belief, one can see the challenge which alternative therapies present to the biomedical model, and the different ways in which this challenge is interpreted by health care professionals. The increasing use of alternative therapies within health care presents an opportunity to observe how alternative healing practices contest with, and are incorporated into, the biomedical system. Therapeutic touch is a particularly appropriate example of this process, as it is based on a healing model which is fundamentally different from that of biomedicine, yet is routinely practiced amidst hospitals across North America.

Theoretical Framework

In examining therapeutic touch, I explore the ways in which an alternative model of healing is negotiated within the discourse of biomedicine. My use of the word discourse refers to the dialogue existing amongst the biomedical community in which their values and beliefs concerning illness, health, and healing are contested and defined. Most of

my analysis concerns the debate over TT, which takes place within medical journals, in popular media, on the internet, and in TT publications such as In Touch, the quarterly newsletter of the Therapeutic Touch Network – Ontario. In addition, I conducted 19 in-depth interviews with TT practitioners, critics, and recipients, and attended a TT level one training session, a practitioner support group, and a TT-based cancer support group.

In order to structure my analysis, I conceptualize biomedicine and TT as components of a larger North American Health Care System. Hahn (1995:1-4) describes health care systems as *cultural systems*, defined as “organized patterns of thinking, judging, and behaving shared by members of a society.” Within every society there are several different cultural systems which are organized around a particular group of activities or common goals. Hahn (ibid., pp. 4-5) describes the organizing element of a cultural system as its *domain*.

The common activity which binds healers within health care systems is, understandably, *healing*. Hahn (ibid., p.7) describes healing as “not only the remedy or cure of sickness – that is, the restoration of a prior healthy state – but also rehabilitation – and compensation for lack of health – and palliation – the mitigation of suffering in the sick.” From this definition, I posit a *healing narrative* which defines the role of all healers within the health care system and which contains the themes of *curing* -

the elimination of illness, and *caring* – the alleviation of suffering. The ways in which caring and curing occur in practice is dependent on culturally-determined notions of health and illness.

Health is a complex concept which is variously defined in different societies, and within different healing traditions in those societies. Salmon (1984:254-255) describes health in North America as containing notions of proper physical functioning, positive relationships in one's family, work, community, and ecological settings, and spiritual fulfillment. A term associated with health amongst members of the holistic community is *wellness*, defined by Halpert Dunn (1961:4-5) as "an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable within the environment where he is functioning." In a simplified form, wellness is feeling the best you can within your current circumstances. Murdock (1980:6) defines illness as "embracing any impairment in health serious enough to arouse concern, whether it be due to communicable disease, psychosomatic disturbance, organic failure, aggressive assault, or alleged accident or supernatural interference." From this definition then, healing can concern the treatment of physical, mental, and spiritual disturbance.

The narrative which defines the role of healer includes conceptions of health, illness, and healing found within the greater cultural system of health care. The definitions I provide for these three terms are broad, as

their interpretation varies substantially between different groups of healers. The collective view of health, illness, and healing within a group is referred to as its *healing model*. What all healing models have in common is the goal of making the sick healthy, through processes of caring and/or curing.

As pointed out by Singer & Baer (1995:181-202), the North American health care system is pluralistic, meaning that it is composed of many different health care sub-systems. These sub-systems each have their own healing model, and generally have their own institutions, or *health care delivery system*. A health care delivery system includes both the institutions in which the act of healing is carried out, and the structures which serve to socially legitimate that practice. In North America, delivery systems include professions, professional associations, medical schools, hospitals, pharmaceutical companies, medical technology producers, research institutes, medical journals, health care clinics, government administrative bodies, and the legislation which government bodies produce. All of these structures influence how a healing model is realized in practice. They also act to define and reproduce the healing model upon which they are based.

Within the North American health care system, the biomedical sub-system has achieved a position of dominance. For this reason, researchers have referred to biomedicine as an orthodoxy (an institutionalized ideology) (Wallis & Morely 1976; Kronenfeld & Wasner

1982; Armstrong 1987; Wolpe 1990; Baxx 1991; Wolpe 1994; Gillett 1994; Gursoy 1996; Stambolovic 1996; Saks 1997; Tovey 1997). A large part of medicine's present dominance can be attributed to its healing model, henceforth referred to as the *medical model*, being linked to scientific theory and method.

The association of science and medicine has a long history, but became especially prominent in the late 19th and early 20th centuries. During this period, industrialization provided the technology required for medical experimentation, and advances in biology and chemistry, primarily from laboratories in France and Germany, contributed to knowledge about disease organisms and the pharmacopoeia used to fight them (Wallis & Morely 1976:12-13). Pasteur's discovery of germs, Koch's theory of specific etiology (the cause of disease by specific micro-organisms), and Lister's discovery of antiseptic surgical procedure all had a great influence on the application of science to the healing act (Berliner 1984:30-31). As well, these breakthroughs greatly increased the prestige of scientific medicine amongst lay people of the time (Berliner 1984:36-38; Torrance 1998:12).

The 1910 Flexner report concerning medical education in North America led to an even closer association of science and medicine, as medical school curriculums were made more scientific, and medical

education was increased in length. From these early beginnings, scientific medicine has grown to the point where Wolpe (1990:913) notes:

...the ideological affinity of science and medicine is a fact of modern life, reflected in a massive medical-industrial complex. The authority of biomedicine, its singular success in the West and its rising hegemony over health care throughout the world, is predicated on its avowal of scientific means of inquiry and problem solving.

The orthodoxy can be described as exerting *discursive power*, based on the strength of its medical model, and *institutional power*, based on the health care delivery system through which members of the biomedical community apply the medical model.

The current medical model is defined by a *scientific narrative*, which holds that scientific theory and practice are the most appropriate tools for achieving the goals of healing. The scientific narrative is variously interpreted within biomedicine, yet generally contains these common elements: rationality, empiricism, reductionism, materialism, and dualism. Rationality dictates that theories underlying disease conceptions and medical treatments must be in agreement with existing scientific theories about the nature of physical reality. Empiricism holds that controlled scientific experimentation is the preferred way to assess the effectiveness of medical therapies, whether they are surgical procedures, psychotherapy techniques, or relaxation exercises. Reductionism means that wholes can be reduced to their parts, and that illnesses can be reduced to specific organic dysfunctions within the patient's body. Materialism holds that

mental events are caused by physiological processes, and that illness must be physically measured and physically treated. Materialism leads to dualism, as mental events cannot be exactly measured, and are thus seen as “less real”. Illnesses are then divided into those affecting the mind or the body, and a division is made between science and faith (spirituality). (These characteristics have been distilled from several sources: (Lee 1976:23-24; Engel 1977; Waitzkin 1983:56-58; Salmon 1984:3; Berliner 1984; Armstrong 1987; Gordon 1988; McKee 1988:776-777; Kirmayer 1988; Hahn 1995:131-172; Stambolovic 1996; Gessler & Gordon 1998).

As mentioned above, there is great variation in the way biomedical professionals interpret the scientific narrative. Part of this variation stems from the fact that the science within medicine is *applied* science, and thus is subordinate to medicine’s goals, not superior to them. The act of healing necessarily involves aspects which contradict the scientific narrative, such as attending to the psychological, emotional, social, and spiritual aspects of illness, and realizing the need to balance cure with care. Within medical professions, this balance between healing and scientific narratives is often described by the phrase “the art and science” (as in “the art and science of nursing”). As well, professions such as nursing and social work have significantly different interpretations of the biomedical model which involve what Abbott and Wallace (1990:1) term “a service ideology”, in which they are concerned with the “human qualities”

of their clients and administer caring rather than curing interventions. In this sense, professions, and different schools or specialties within professions, can be considered sub-systems within the biomedical system, operating under a *professional narrative* which delineates the particular scope of that profession or specialty's duties, and that determines their particular interpretation of biomedicine's defining narratives.

In North America other groups of healers operate outside of the biomedical system. Examples of such groups include chiropractors, acupuncturists, naturopaths, homeopaths, Traditional Chinese Medicine doctors, shiatsu therapists, and reiki healers. All of these groups are organized around their own model, which differs substantially from the medical model, yet which is still governed by the healing narrative (a general term I will use for any healing model different from that of biomedicine is *alternative model*). These groups have varying relationships with orthodox medicine depending on the closeness of their healing models to the medical model and the degree to which they represent competition for resources within the health care system. Alternative healing groups can also contain sub-discourses in which two or more schools of practice exist simultaneously, such as the *straight* and *mixer* groups in the North American chiropractic community¹.

¹ "Straight" chiropractors believe that vertebral subluxation (spinal misalignment) is the cause of most illness, and that chiropractic treatment should only involve spinal adjustment. "Mixers"

Thus, within a health care system, there are different levels of healing groups organized around different healing models, and governed by different defining narratives. The following diagram (fig. 1) is useful in sorting out how these levels interact. The diagram illustrates the levels of discourse present within the North American health care system, and helps to lay out the different defining narratives and how they influence various healing groups. Again, discourse refers to the dialogue concerning a given social group bound by common beliefs, values, and goals. Within discourses, the models of healing groups are expressed, defined, and contested by their members. For example, the discourse of therapeutic touch refers to the dialogue that takes place amongst all members of the TT community, while the discourse of biomedicine takes place amongst all members of the biomedical system, and includes several professional sub-discourses, and several specialty discourses within the professions. What the levels of the diagram show is that higher discursive levels influence all of the levels beneath them; all healers are members of the discourse of health care, and are bound by its healing narrative. Similarly, all biomedical healers are bound by the healing narrative and the narrative of science, and all TT practitioners within

hold a broader view of illness causation and provide other treatments such as ultrasound, electrical stimulation, and supplements (Caplan 1984:86-87).

Levels of Discourse Within Health Care (fig. 1)

- 1) **North American Culture** (includes norms and values found within the culture, and which influence all sub-discourses: ie. views on race, class, gender)
- 2) **Cultural System of Health Care** (Indigenous healing system, governed by the *healing narrative* which consists of all those activities designed to cure or ameliorate human illness)
- 3) **Discourses within health care** (Plural health care systems)

<p>A) <i>Biomedicine</i> (Biomedical System)</p> <p>(Biomedicine has become an orthodoxy in several indigenous health care systems: governed by the <i>scientific narrative</i> and balanced by health care as 'art', an aspect of the defining narrative of the health care discourse)</p>	<p>B) <i>Alternative Medical Systems</i> (TCM, Christian Science, Ayurveda)</p>
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- 4) **Discourses within health care systems** (primary care providers)

<p><i>Medical Profession</i>: narratives of art and science mix with professional narratives involving physician's role within health care</p> <p><i>Nursing Profession</i>: narratives of art and science mix with professional narratives involving nurse's role within health care</p>	<p><i>Alternative professions</i></p>
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- 5) **Discourses within professions**

<p><i>Therapeutic Touch practicing nurses</i>: groups which accentuate particular narratives in the professional discourse</p>	<p><i>Straights/Mixers</i> (ex. from Chiropractic)</p>
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biomedicine are bound by the narratives of health care, biomedicine, nursing, and TT.

The idea of groups being bound by narratives needs further explanation. As healing models are never held in the same way by different members of the same healing group, discourses are fluid, changing things. Within all discourses there is debate, conjecture, and even outright disagreement, as the narratives defining the discourse are often variously interpreted, and possessed of inconsistencies. However, all the members of the discourse are talking, debating, and even disagreeing, about the same basic things. They share a common language and a common set of values that serves to define their discussion, and to identify members as being part of the discourse, and legitimate participants in the group's activities. As such, discourses can control the ability of group members to practice the group's activities and to utilize the group's institutions; for this reason, disagreements within a discourse tend to be contained within its boundaries, to avoid the risk of exclusion from the group.

In the case of TT, its proponents present a healing model and practice which challenge the basic values and beliefs of orthodox medicine. Because of this, they risk exclusion from the biomedical discourse, and exclusion from the health care delivery system on which it is based. TT's relationship to biomedicine is thus different from that of

other alternative healing groups, as it is constrained by the medical model to an extent that alternative healers outside of biomedicine are not.

However, being within the biomedical system also gives TT proponents access to resources and political and economic status which they would not have as outsiders.

The relationship between TT and biomedicine can be described using the metaphorical framework of medical heresy, outlined by Paul Root Wolpe (1990; 1994). In these articles, Wolpe, drawing on the work of sociologist of religion George Zito (1983), describes alternative movements originating within medicine as *heresies* emerging within an *orthodoxy*. In Wolpe's framework, heresy is primarily a discursive phenomenon, taking place amongst a group that is united in common beliefs, values, and goals. The heretic presents ideas and/or practices which are seen as a threat to the fundamental beliefs and values of the larger group, and are thus resisted or quelled. The process of heresy is presented in the form of a drama, in which heretic and orthodoxy make competing claims concerning their visions of the discourse. This drama is resolved either by the overthrow of the orthodoxy, the occurrence of a schism between the two groups, or the conformity of the heretic.

Central to Wolpe's framework is the tension which the heretic experiences between the need to follow their novel beliefs, and their need to remain within the discourse. Should the heretic be shown to betray the

discourse's defining narratives, then they can be expelled from the orthodoxy, and lose their privileged position from which to critique it. Wolpe (1990:914) terms this expulsion from the discourse *apostasy*. In the heresy framework, the orthodoxy attempts to frame the heretic as an *apostate* by claiming that they have betrayed the fundamental values of the discourse. Conversely, the heretic attempts to defend their position within the discourse, while attempting to cast the orthodoxy as apostates.

Using Wolpe's metaphorical framework as a guide, I present TT's debate as a heretical drama in which its healing model is negotiated within orthodox medicine. In the process of negotiation, TT proponents emphasize marginal themes, and exploit inconsistencies, within biomedicine's defining narratives. These strategies are used to legitimate their healing model and avoid exclusion from the discourse. Furthermore, TT proponents utilize these same strategies to critique their opponents. In negotiating their alternative beliefs, TT proponents conform to the medical model, yet are also able to perpetuate their beliefs within biomedical discourse, and to establish their practice within biomedical institutions. In order to overcome a weakness of the heresy framework, which can make the orthodoxy appear monolithic, I present a conceptualization of the medical model which is divided into strong, soft, and fringe orthodox perspectives. This helps to show the substantial variation in the way biomedical professionals interpret the medical model.

I further contextualize TT's heretical drama as part of a larger trend towards integrative medicine within North America. This trend describes the process of alternative therapies and therapists being included, to varying degrees and in varying ways, into the biomedical health care system. In all cases of integration, alternative healing models and practices are changed due to the institutional power of biomedicine, and due to the strength of its healing model. In reaction to orthodox power, several alternative healing groups pursue a strategy of professionalization, in which they organize and standardize their practice, and seek state regulation. TT can be seen as an example of the *co-optive* aspect of integration, where alternative practices are incorporated into biomedical practice. However, TT proponents also exhibit signs of professionalization.

The thesis is divided into seven chapters. In the first chapter the research methods used for the study are described. The second chapter describes the history and practice of therapeutic touch. The next two chapters set the stage for TT's heretical drama. Chapter three looks at the problem of defining alternative therapies, and of contextualizing them in relation to orthodox medicine. Chapter four presents the orthodox medical model in strong, soft, and fringe forms, and defines each perspective with regard to definitions of illness, treatment methods, patient management, and pluralism (alternative therapy use). As well, evidence for the

integrative medicine movement is provided within North America. Chapter five introduces the healing model of TT proponents, and describes their critique of orthodox medicine. Chapter six presents the heretical drama, in which proponents and critics contest TT's healing model within the discourse of biomedicine. Chapter seven presents the current state of TT's heresy in biomedical discourse, and its incorporation into biomedical institutions. Evidence of TT's changing discourse is presented and analyzed. Finally, the conclusions present TT as an alternative healing community within medicine which has been influenced by several socio-historical and political forces. Through the agency of its members, and their management of TT's discourse, the TT community has been able to control, to a certain extent, the nature of its incorporation.

Chapter 1: Methodology

I study TT's heretical challenge to medical orthodoxy through analyzing the discourse of its proponents and the negotiation of this discourse within biomedicine. Within the heresy framework, discursive negotiation occurs between actors, yet is representative of competing models of healing, thus necessitating an analytical link between actor and belief system. The framework I use to link the statements of actors within the TT debate to the models of their representative groups is taken from the depth-hermeneutic approach described by John Thompson (1987). Thompson bases his approach on the work of Paul Ricoeur (1981), and presents it as a means for studying ideology, using the Marxist conception of ideology as a system of beliefs that serves to maintain relationships of domination. However, this approach to discourse analysis is also compatible with a more neutral conception of ideology as a system of beliefs and values held by, and serving to define, a social group.

Thompson proposes that actor and belief system are linked through *meaning*. He asserts that meaning is revealed primarily through linguistic expressions, and that it is "not a stable or invariant property of a linguistic product, but rather a fluctuating phenomenon which is constituted as much by the conditions of production as by the conditions of reception"

(Thompson 1987:520). Thompson (Ibid., p.520) further states that the meaning of a linguistic product is mediated by structural features such as “patterns of exchange, argumentation, and narrative, as well as various aspects of grammar, syntax, and style” While meaning is mediated through these features, Thompson (Ibid., pp. 520-521) notes:

A linguistic product is not only a socially and historically situated construction which displays an articulated structure, but is also an expression which claims to say something about something; and it is this claim, understood in terms of what is *asserted* by an expression and what that expression is *about*, which must be grasped by interpretation.

Thompson outlines an approach towards the interpretation of meaning, and hence of belief systems, from a given set of discursive facts. The approach involves three phases: *social-historical analysis*, *discursive analysis*, and *interpretation*. These phases are not necessarily sequential, instead, they represent contiguous analytical processes which combine within the interpretive act. Social-historical analysis aims to place the discourse being analyzed into a particular social and historical context, as meaning and its expression are dependent on such context. As well, individual discursive facts are situated with regards to whom is speaking (a Ph.D. nurse, or a TT-skeptic), and in what context the expression is made (in response to criticism, to members of a common social group, in an interview, in a medical journal). In my analysis of the TT debate, social and historical context is provided throughout the text where it is necessary

for purposes of contextualization. As well, care is taken to identify the context in which individual statements are made.

Discursive analysis involves the actual studying of linguistic products, through either syntactical or narrative approaches. In structuring my analysis of the TT debate, I utilize a narrative/content analysis framework in which utterances are seen as stories through which both the belief system of the speaker, and their motivation in speaking, can be interpreted. Interpretation involves linking discursive products with belief systems. This task involves both the “creative explication of meaning” from discursive facts, and the “synthetic demonstration” of how these meanings are representative of a given system of beliefs (Ibid., pp. 525-529). Due to the creative aspect of the interpretive process, the belief systems constructed from discursive facts, and the strategies of argument and contestation which I attribute to actors, are necessarily equivocal. My analysis of TT’s heretical challenge to biomedical orthodoxy is thus one interpretation of the discursive events involved, which could be ordered, analyzed, and interpreted in different fashion. As well, the belief systems which I construct from the discourse are not intended to be seen as static, or rigidly-defined structures - cognitive models that are held by a group are never held the same way by different members of the group.

In essence, Thompson’s framework represents a method for linking text with context, and for extracting meaning from that resulting whole.

Context, in turn, is important in justifying the resulting interpretation, with the richer context provided leading to a more accurate, or useful interpretation. In discussing an approach to discourse analysis which she calls the *ethnography of communication*, Schiffrin (1994:370-371) refers to the cultural knowledge that is required to understand, and therefore interpret, the meaning of utterances. She writes:

What we say and do has meaning only within a framework of cultural knowledge – not linguistic, but communicative, competence. The ways that we organize and conduct our lives through language are thus ways of being and doing that are deeply embedded within the particular contexts – cultural frameworks – by which we make sense out of experience

The framework of knowledge needed to be competent within the discourse of TT, and thus to produce useful interpretations of that discourse, are linked to the “culture” of TT, to the practices and forms of communicating which define that group. This type of cultural context cannot be gained through analyzing texts alone, and for this reason I conducted interviews with TT practitioners, participated in their meetings, underwent TT training, and observed and received their treatments. The knowledge thus gained helps to ground my interpretation of TT’s discourse.

Data Utilized

For my analysis, I collected examples of TT’s discourse from medical journals, TT publications, popular media articles, internet documents, edited collections, and books. Material from interviews

conducted with nurse and lay practitioners and with self-identified TT critics was also utilized, along with participant-observation experiences in which I interacted with practitioners at a TT level one training session, a practitioner support group, and a cancer support group. Texts comprised my primary source of data for the TT debate, with interviews and participant observation being used to interpret the healing model of proponents, and to provide context to the textual data.

Textual Data

Medical Journals

Information from medical journals concerning TT was obtained through searches on Med-Line, CINAHL, and Health Star Databases. From these searches a wide variety of published materials on TT were collected. These materials included controlled clinical trials, literature reviews, qualitative studies, descriptive articles, editorials, and letters to the editor. A range of materials were sampled in order to reflect the many ways in which TT discourse appears within academic publications. The different formats involved allow for analysis of the discourse from a variety of contexts. Clinical trials address issues of TT's scientific validity within a controlled, stylized rhetorical format. Conversely, editorials, descriptive articles, and letters to the editor provide examples of value-based rhetoric in which several themes within the debate are highlighted. Literature

reviews provide different interpretations of TT's considerable research base, and reveal how research is used by both proponents and critics. In order to assess the change in TT's presence within biomedical discourse, I conducted year by year searches for TT articles on MED-LINE. Using the search term *therapeutic touch*, I searched every year from 1966 to 2000, and recorded the amount of articles published each year and the type of journal in which they were published.

TT Publications

Nine issues of In Touch, The quarterly newsletter of the Therapeutic Touch Network – Ontario (TTNO), ranging from 1993 to 2000, were consulted to access dialogue taking place within the TT community. In Touch is useful in revealing how TT members speak to each other and what they speak to each other about. Different interpretations of TT practice and belief are presented, allowing one to infer the process of their social construction. This publication is invaluable in revealing the “written culture” of TT across Canada, as in every issue articles appear from all of the regional TT networks. Other TT publications used include official hand-outs given during the level one training session.

Popular Media / Internet Sites

Popular media articles provided a different contextual view of TT and were useful due to their particular narrative structure, in which “both

sides of the debate” are generally presented within the interpretive framework of the author. Articles were utilized with both positive and negative frameworks, and thus provide examples of arguments for either perspective. Internet documents provided valuable information concerning strongly pro and anti-TT groups. The major TT organizations, Nurse Healers-Professional Associates International (NH-PAI) and the TTNO, have extensive web-sites in which their corporate or “professional” image is presented. These sites are useful as examples of TT’s management of public image, as well as being useful sources of information concerning TT belief and practice. Similarly, many of the skeptics critical of TT maintain web-sites, which are equally useful in presenting their position concerning the practice.

Edited Collections

Edited collections and books were excellent sources of information concerning hard-to-find journal articles, which are often reprinted in collections. Books were also important in accessing the perspective of TT’s co-founder and chief proponent, Delores Krieger. Three volumes written by Krieger were analyzed, two concerning TT, the other concerning TT and holistic nursing.

Interviews

Interview data were used to construct the beliefs of TT proponents, critics, and recipients. Nineteen interviews were carried out over a five month period in 1999-2000. These interviews were based on a set of structured and semi-structured questions designed to elicit information concerning demographics, perception of TT, political and economic issues, and philosophy / world-view concerning health and healing. Structured questions addressed demographic issues and basic issues associated with the interviewees' experience with TT, an example being "When did you first hear about TT?" Semi-structured questions were related to certain areas of theoretical interest, but were open-ended, an example being "Have you heard any criticisms concerning TT?" A copy of the interview guide is included in appendix one.

A semi-structured interview format was chosen to account for the problem of interviewing health professionals with busy schedules and limited time. Because of these time constraints, I wanted to be sure that all important questions were asked within a given interview. Although the interview format narrowed the focus of information I was given, the semi-structured nature of several questions allowed participants to introduce information which they felt was important, so that the interview results were not over-determined at the expense of novel information (Bernard 1996:209-210).

Interviews were conducted at a place of the participant's choosing, and lasted from one half hour to an hour and fifteen minutes, with most interviews averaging around forty-five minutes. Participants were recruited through preliminary research and contact-building within the therapeutic touch community in Hamilton, Canada. In all, I interviewed 10 practitioners (6 nurses, 4 lay people), 6 recipients, and 4 critics. One recipient ended up being ineligible for the study, as it was revealed at the end of the interview that she had actually been treated by a healing touch practitioner (healing touch is a form of energy healing similar to, but separate from, TT). All interviews were tape-recorded and transcribed. As well, hand-written notes were taken during and following interviews. After the interviews were transcribed by hand, I went through each one and coded the responses for each question answered. The coded responses were then distilled into four separate groups for critics, recipients, lay practitioners, and nurse practitioners.

Most of the interviewees were recruited via "snowball sampling" from contacts that I made within the TT community. One interviewee was an acquaintance from school, and one other was obtained through notices which I had posted in area hospitals. These notices proved to be relatively ineffective at eliciting interviewees, as a total of five people responded to them. One respondent was a recipient who was eventually interviewed, another agreed to be interviewed and then had to cancel due to medical

reasons, and the other three respondents had all misinterpreted the poster as an invitation to either learn TT or to undergo TT treatments as part of a study.

Demographic Information

Nurse Practitioners

Of the six nurse practitioners interviewed, all are middle-aged Caucasian women. Eileen is a 48 year old obstetrics nurse with five years of experience practicing TT. She also volunteers as a therapist at the Wellwood Cancer Support Centre at Henderson Hospital and gives frequent volunteer TT treatments at the homes of cancer patients. Dora is a 44 year old member of an acute care geriatric assessment team who has been practicing TT for five years. She is also a recognized TT teacher. Cindy is a 46 year old neonatal nurse who is currently enrolled in a Masters of Nursing program. She has been practicing TT for five years and plans to do a study of the therapy for her graduate thesis. Susan is a 55 year old professor of nursing who first learned TT in the mid 1980's, although she seldom finds time to practice the therapy these days. Erica, a 52 year old RN who works in an outpatient pain clinic, learned TT about nine years ago and has practiced for four. She volunteers at the Circle of Friends cancer support group, and like Eileen, has given many treatments to cancer patients in hospital and at their homes. The final practitioner

interviewed was Alice, a 48 year old RN who works in a private doctor's office. She has been practicing TT longer than any of the other nurses in the study and gives regular treatments at hospitals, in people's homes, in her own home, and at Wellwood.

Four of the nurses took their TT instruction through the standard series of one day workshops, while Alice and Susan got their instruction before the different TT levels were established.

Lay Practitioners

Three of the lay practitioners were Caucasian women, one is a Caucasian man. Stephanie is a 46 year old clerical worker who has been practicing TT for five years; Samantha is a 61 year old retiree and community volunteer who has been practicing TT for about seven years, and Crystal is a 50-something TT instructor and lecturer who has been practicing the therapy for over 20 years. Roger is a 65 year old retired engineer who has been practicing TT for four years. Roger and Stephanie learned TT through standard one-day weekend courses, Samantha learned it from a practitioner friend, and Crystal learned it from the therapy's founder, Delores Krieger. Three of the four have consulted clinical studies of TT.

Of all the interviewees, only Crystal Hawk wanted her real name used, as she is a vocal and high profile proponent of the therapy. Crystal

is the co-founder of the Therapeutic Touch Network – Ontario, past research chair of TT's international organization, Nurse Healers – Professional Associates International, the first lay practitioner of TT recognized by NH-PAI, and a life-time member of that organization.

Recipients

Of the four TT recipients interviewed, three are women, and one is a man. Of the women, Jennifer is a 53 year old Caucasian real estate agent and director of an NGO which supplies aid to Latin America, Mary is a 38 year old Caucasian speech pathologist and cancer survivor, and Patricia is a 39 year old African Canadian nurse who was in university to complete her BscN at the time of her interview. The last recipient is Rob, a 46 year old male Caucasian cancer patient and former business executive who is a regular member of Circle of Friends, the holistic cancer support group. Mary and Rob received TT from nurses as part of their cancer treatment, while Jennifer received it from an RN friend when she badly burned her foot. Patricia received TT from another nurse working with her on a hospital ward. All of the recipients heard about TT through RN acquaintances except for Rob, who was directed towards the Circle of Friends by the Cancer Assistance Program. All of the recipients had heard of the therapy through popular or scholarly articles before being formally introduced to it.

Critics

Of the four critics, three are MD's, one is a nurse. The MD's are all Caucasian males. Dr. Steves is a 35 year old Emergency Medicine specialist, Dr. Alexander is a 46 year old professor of medical epidemiology, and Dr. Weller is a 46 year old hematologist. Sheila, the RN, is a 43 year old Caucasian female who works in a rehabilitation clinic. Only Dr. Steves had experienced a TT treatment, while the others had all seen TT in live demonstrations or on video. Two critics first encountered TT in scholarly journals, one in a popular magazine, one by observing practitioners as an intern. Two of the critics have looked over TT studies, one has not, and one, Dr. Weller, has examined several of them.

Participant Observation

The methods of participant observation used in the study were short, being similar to a "rapid-assessment" approach to field work (Bernard 1995:140). Several TT treatments were observed by myself at four different times in three different locations. The total number of treatments observed was 8. Originally, I intended to observe treatments taking place within hospitals, but due to the sensitive nature of the therapy in this setting, I was unable to do so. Treatments were given by nurses working on hospital wards on a sporadic basis, and thus could not be easily observed. In the Wellwood clinic, the directors of the TT program

would not allow me to observe treatments, as their clients were generally seriously ill cancer patients whom they did not want to make uncomfortable in any way. Instead, treatments observed took place at a cancer support group run out of a private residence and affiliated with hospital-based cancer services, a TT level one training session held at a local hospital, and a TT support group held monthly at a local church.

To further ground myself in the practice of TT, I underwent level one training in the therapy and had treatments given to me on two occasions. The training session lasted one full Saturday, and was held at a Hamilton hospital. The instructor was a long-time nurse and qualified therapeutic touch teacher and practitioner whom I had earlier interviewed for this study. The training involved a lecture on the basics of therapeutic touch, the relaxation response, and energy medicine. The other portion of the class consisted of experiential exercises in which participants experimented with feeling their own and other people's energy fields, learned the movements and stages involved in TT treatments, and gave and received treatments. Therapeutic touch training usually involves three workshops, with successive stages introducing participants to more advanced levels of theory and practice. Due to time constraints, I was only able to attend the first workshop. After all periods of participant-observation I took extensive notes of the experiences.

Chapter 2: Therapeutic Touch

History and Development

Therapeutic Touch was developed in 1972 by Delores Krieger, Ph.D., R.N., and professor of nursing at New York University, and Dora Kunz, a psychic healer, and past president of the American Theosophical society. Theosophy is a pluralistic religious organization founded in 1875 by Helena Blavatsky and Henry Olcott. Blavatsky was born in the Ukraine, and travelled widely throughout Europe, Africa, and the Middle East before coming to New York in 1873 and meeting Olcott, who at that time was a successful lawyer. Blavatsky had studied with several famous spiritualists, and performed her own seances in which she would invoke various spiritual “phenomena”. Theosophy combined European spiritualist and occult beliefs with Eastern religious traditions such as Buddhism and Hinduism (Campbell 1980). The movement spread in Europe, India, and eventually the United States, influencing many prominent New Age personalities such as Rudolph Steiner, Alice Bailey, Guy and Edna Ballard, and Edgar Cayce (Heelas 1996:44-45).

In her first book on TT, entitled The Therapeutic Touch: How to Use Your Hands to Help or to Heal (1979), Krieger describes first meeting with

Kunz as the latter was part of a research team studying the process of healing. Krieger soon became fascinated with the older woman's talents, describing Kunz as someone "born with a unique ability to perceive subtle energies around living beings" (Ibid., p.4). According to Krieger, "From the time she was a child, she [Dora] studied the function and control of these energies under the tutelage of Charles W. Leadbeater, one of the great seers of the twentieth century. Through the years she has studied these abilities in depth so that they have become like a fine instrument in her hands which she can turn on or off at will."(Ibid., p.4).

There were many healers present in the study which Kunz participated in, yet for Krieger, the most impressive results came from one healer in particular, Oskar Estebany. Estebany had been a Colonel in the Hungarian cavalry in the early 1900's, and first discovered his healing powers by attempting to save his horse, which had fallen ill. He stayed all night with the horse in its stable, massaging, caressing, stroking, and finally praying over it. In the morning, the horse was healed, and Estebany's days as a healer began. At first he worked only on horses and other animals, but soon he started treating people as well. Eventually he became quite famous. After retiring from the cavalry, Estebany began making annual trips to Canada, during which time he offered his healing talents for research purposes (Ibid., pp.4-5).

Several experiments were conducted to measure Estebany's effects on non-human organisms and organic matter. Taken as a whole, these studies show some significant effects, but are inconsistent, and in need of replication. A series of tests were performed on Estebany's healing abilities by McGill biochemist Bernard Grad. These tests studied wound healing in mice (Grad, Cadoret & Paul 1961) and the growth of barley seeds (Grad 1963; 1964). In the wound healing study, there were significant effects in mice treated by Estebany, yet the results were transient, as the mice exhibited similar rates of wound healing at the end of the study (Clark & Clark 1985:287-288). Significant effects were found in the first barley seed experiments (Grad 1963), but were more mixed in the subsequent experiment (Grad 1964). Another biochemist, Smith (1972), studied the effects of Estebany's healing ability on enzyme activity, and found that enzyme solutions treated by Estebany showed significantly more activity than control solutions (Clark & Clark. 1985:290-291).

Kunz and Otelia Bengtssen, an M.D., performed another study with Estebany, and Krieger was invited to join the research team. Her role on the team was "...to help with the case histories, to take various vital signs of the patients, and to help to collate material at the end of the study." (Krieger 1981:139). In this study Estebany treated "a large sample of medically referred patients" (Krieger 1979:5). It is at this time, Krieger relates, that she was able to see Estebany at work, and to become

intrigued with his process of healing. She describes her observations of a treatment:

During the healing sessions, Estebany was very quiet; he would sit next to the healee and do exactly what he purported to do – lay his hands on the patient...He would most frequently sit on a small stool either in front of or behind the healee and put his hands wherever he felt they were needed; occasionally Dora would suggest that he put his hands over a particular area that she could perceive in need of being energized. At times, he would make a little joke to put the healee at ease, but other than that he would remain with his hands on the healee, occasionally shifting position or placing his hands on another area, the entire treatment lasting about twenty to twenty-five minutes (Ibid., pp. 5-6).

Although at first taken aback at the simple nature of Estebany's treatments, Krieger notes "it soon became apparent to me that the postures were but gross outer expressions of what appeared to be an intense inner experience for both of them" (Ibid., p.6). When she pressed Estebany as to his inner experience of healing, he said he felt like a channel for the spirit of Jesus Christ. When questioning the people he healed, they all reported feeling heat from Estebany's hands and feeling relaxed from the treatment. Krieger also noted that "Over the course of the study, some of the patients reported that they felt better; but there were no miraculous cures except one..." (Ibid., p.6).

After this experience, Krieger decided to do post-doctoral research on the healing process, and ended up doing a small pilot study and two larger sample studies with Estebany. In these three studies, hemoglobin was used as the dependent variable, with Krieger hypothesizing that

hemoglobin levels would increase in patients following treatment by the healer. In all three studies, Krieger's hypothesis was upheld, although serious methodological criticisms have been raised by subsequent reviewers, and subsequent studies have failed to replicate the results (Clark & Clark 1985; Meehan, Mersmann, Wiseman, Wolff & Malgady 1991).

During her research with Estebany, Krieger began to wonder if the healing ability she saw in him could be learned. Despite Estebany's belief that people were born with the gift of healing, and could not be taught it, Dora Kunz disagreed, and began teaching the art of healing to several students, including Krieger. Therapeutic Touch, a healing system based on the techniques of Estebany, was created as a result of these early workshops (Krieger 1979:8). In 1975, Krieger began teaching the therapeutic touch technique at New York University in a graduate class titled "Frontiers in Nursing: The Actualization of Potential for Therapeutic Human Field Interaction" (Ibid., p.vii). Kunz, as well, decided to teach TT to nurses, as she believed that "as a group they had the dedication necessary to learn and use it most effectively." (Meehan 1998:118).

Since the "Frontiers in nursing" course, TT has grown steadily, and has also become increasingly systematized. In TT's early days there was no formalized way of teaching the therapy or becoming a practitioner. Today, TT is taught in three levels, and the time it takes to

progress through all three levels can be substantial (6 months to one year, as it is recommended that students take time to practice between levels two and three). Courses are now taught by “recognized teachers” and consist of a formalized curriculum which individual teachers can interpret to a limited extent. Each instruction level consists of a one day work-shop.

In 1977 Krieger started a non-profit organization of TT practitioners in order to formalize TT instruction and to serve as “the expert source of information on the Krieger-Kunz model (the only model) of therapeutic touch” (NH-PAI 2000:1). The organization, known as Nurse Healers – Professional Associates International, also serves as an unofficial regulatory body for TT practitioners. The NH-PAI is affiliated with other regional TT organizations. In Canada these include the Atlantic Therapeutic Touch Network (based In Halifax), the British Columbia Therapeutic Touch Network (based in Vancouver), the Manitoba Therapeutic Touch Network (based in Lockport), Quebec Therapeutic Touch (based in Montreal), the Therapeutic Touch Network of Alberta (based in Edmonton), and the Therapeutic Touch Network Ontario (TTNO) (based in Etobicoke), and founded in 1986 (TTNO 2000a).

Although there is no certification for TT recognized by any government or health care administration, NH-PAI has laid out criteria

for becoming a “recognized practitioner”. Attaining this designation is voluntary, and is not legally enforced by NH-PAI. In order to attain this status, a person needs to have taken all three levels of TT instruction, and to have taken an additional four days (32 hours) worth of recognized TT training. Candidates for recognition must also compile a practitioner workbook consisting of: “case study” documentation for a total of 72 TT sessions, 15 of which must be supervised by a recognized practitioner, 12 “reverse case-studies” in which the applicant documents treatments they received from recognized practitioners, and an open book test on basic concepts and information concerning TT. Upon submitting the workbook, and after one year of regular practice from the time of their first level three course, practitioners can apply to become recognized. Becoming recognized involves joining the local regional TT organization (if one was not already a member), and signing an ethics statement concerning practice. In the TTNO, recognition allows a practitioner to be involved in the TTNO Referral Service, through which they may be given client referrals by the organization.

Recognized Teachers must have been recognized practitioners for at least two years and must have completed the three levels of instruction a total of three times each. Prospective teachers must then submit a curriculum to their regional TT network for the courses they

propose to teach, and must receive mentoring and supervision from a recognized teacher. In order to maintain recognized teacher or practitioner status, yearly quotas of treatments must be fulfilled (72 each year) and three days of TT workshops must be attended each year. Although the increasing organization of TT practice seems to indicate professionalizing interests, NH-PAI has released a position paper which claims that there will be no official licensing required to practice TT (NH-PAI 1998).

Healing Model and Healing Practice

The TT technique taught by Kunz and Krieger ended up being substantially different from that used by the healer Oskar Estebany. Estebany would lay his hands directly on the person he was healing, and would then move them in non-systematized ways according to his intuition. In TT, much of the time the healer does not actually touch the patient; instead they make various standard movements with their hands held from between two to six inches from the patient's body. Krieger seems to have arrived at this difference in treatment technique through studying the energetic theories of Ayurvedic, Tibetan, and Chinese medicine (Krieger 1979:11). In particular, Yogic conceptions of *prajna*, or vital energy appear to have influenced her thinking (Narayananda 1960).

Krieger notes that *prajna* was an appropriate name for the energy being exchanged during healing, and remarks that “the term really pertains to the organizing factors that underlie what we call the life process” (Ibid., p.12). In Accepting Your Power to Heal: The Personal Practice of Therapeutic Touch (1993), Krieger states: “The term Therapeutic Touch may in fact be a misnomer because, in practice, the healer need not make physical contact with the patient (healee). Much of the work done by the person playing the role of healer has as its primary focus the modulation of the healee’s energy field rather than the touch or manipulation of his or her skin (Ibid., p.11).

While ancient conceptions of *prajna* were the original source of TT’s energetic theories, they were soon closely associated with the philosophy of Martha Rogers, Ph.D., R.N.. Rogers was a professor of Nursing at New York University from 1954 to 1975, during which time she developed a theory of nursing science originally termed Homeodynamics, but later known as the Science of Unitary Human Beings (Nursingworld 2000). The science of unitary human beings is based on a conception of humans as open energy systems (energy fields) in constant interaction with environmental energy systems (from other people, the physical environment, etc). The human life path is viewed as a process of continuous field interaction which is based on patterns and which is teleologically directed (evolutionary) (Rogers 1970).

In essence, Rogers' science of unitary human beings is the application of Ludwig Von Bertalanffy's general systems theory (Bertalanffy 1950) to the human life process. Von Bertalanffy's theory introduced the concept of open systems to biology, and explained how organisms maintain their systemic integrity in the face of entropic (degenerative) forces. He posited living beings as systems in constant, patterned interaction with their environment, a view which necessitated holistic study of systemic phenomena. As such, his model became a perfect vehicle for explaining TT's non-Western energy field theories in a language derived from popular Western science. To this day, Rogers' theory can be discerned in the "basic assumptions" (so named by practitioners) which TT proponents hold. These assumptions, as given to me during a recent (1999) level one TT training workshop, are:

1. Human beings are open, complex, pan-dimensional energy systems. This "field force" , or "vital energy" permeates space and becomes more concentrated within and around living organisms.
2. In a state of health energy flows freely in, through, and out of the field in an organized, balanced, symmetrical manner. B) In a state of dis-ease or injury, the field is: Obstructed, Disturbed, Disordered, Depleted, Congested, or Blocked
3. Human beings are capable of both transformation and transcendence. There is human potential for: using consciousness in new ways, integrating that knowledge into our lives.
4. "Healing" is an innate capacity or tendency and an intrinsic movement toward order that occurs within living organisms and that can be facilitated by Therapeutic Touch practitioners.

5. In Therapeutic Touch our intent is to restore order in the field, and to change the energy in the direction of wholeness and health. Life energy follows the intent to heal. (Pokoradi 2000).

The techniques TT practitioners actually use to effect changes in their clients' energy fields are generally broken down into five primary phases. Although these phases are usually present in TT treatments, practitioners may utilize other procedures as well, making the actual performance of TT a personal and variable thing. The five main phases are:

- Centering oneself.
- Making an assessment of the healee.
- "Unruffling" the field.
- The direction and modulation of energy.
- Recognizing when it is time to stop.

Centering takes place before the actual treatment, and involves the practitioner taking time to find within themselves "an inner reference of stability" (Krieger 1979:35). Krieger further defines the process:

In centering your consciousness, you go beyond the everyday stimulus and response of bodily interactions with the environment, or the world "out there". In centering, you relate to the extraordinary stillness of the personal, private world within you, and you bask in its profoundly quieting psychological and physical effects... During Therapeutic Touch, this centering process translates into a respect for the individuality of each person's dynamics. You can then bring to a moment everything in your past experience that might help meet a person's needs in a therapeutic manner (1993:17)

In practical terms, centering involves a therapist focusing their full attention on the person to be treated. Practitioners usually do this by standing quietly with their eyes closed, breathing deeply, performing

mental exercises designed to clear and focus the mind, and possibly saying a prayer. Centering is an important part of the TT treatment, as practitioners believe that one's intention is a major influence on one's effectiveness as a healer. If one's mind is cluttered or distracted, one will not be able to effectively direct compassionate intent towards one's patient.

Assessment is the next major phase in treatment and involves scanning the energy field of the patient while looking for any areas of irregularity, congestion, or imbalance. By acting on the second basic assumption of TT, that a person's energy field is bilaterally symmetrical, the practitioner then uses her hands, one on either side of a seated or prone patient, to assess the field. The practitioner generally sweeps downward from the head of the patient to their feet, with the hands held from two to six inches from their body. During the downward sweep they note any difference in sensation between their hands, picking them up through energy centers in the palms known as *chakras*.

Chakra is a Sanskrit term used in Yoga to refer to energy centers within the body. There are said to be seven main chakras aligned along the spinal column from coccyx to top of head (Narayananda 1960:56-58). The idea of chakras within the hands and feet is taken from Qi Gong, the indigenous Chinese theory of vital energy. In Qi Gong, there are several energy *gates* located in similar positions to the chakras (*ren mai*),

yet with gates along the back as well (*du mai*). There are also gates in the palms of the hands (*laogong*), and the soles of the feet (*yonquan*). Krieger (1993:23) mentions: "All human beings have and use these chakras, whether we are aware of them or not, for they are in fact centers of different levels of consciousness, ranging from the "gut level" to the sublimely spiritual. Therefore the chakra system is a natural component of human-energy-field dynamics."

Differences in the energy field found during assessment are usually perceived as differentials in temperature (*Ibid.*, p.30). However, Krieger mentions five levels of sensation, including heat & coolness, congestion or pressure, tingling or electric shocks, rhythmic pulsations, and intuitive or spontaneously gained insights (*Ibid.*, pp. 31-32). Perceived field differences are to be "tucked into the back of your mind" (*Ibid.*, p. 29) until completion of the assessment, at which time they are used to inform the remaining phases of treatment.

After assessment, practitioners proceed to *unruffle* the patient's field. The unruffling process involves sweeping the hands (held away from the body) down the patient's field and smoothing out any congestion. Krieger (1979:54) describes the technique:

I find it most useful to make the sweep downward, following the direction of the long bones of the extremities nearest the area of congestion or to make the sweep perpendicular to the body surface itself. I find that the sweep feels as though I were actually pushing a pressure front .

Unruffling “allows the healee’s field to mobilize its own resources so that self-healing can occur” (Ibid., p.55), and sets the stage for the next phase of TT treatment, the directing and modulating of energy.

The fourth phase builds on the clues and impressions generated through the assessment process. Any areas of the patient’s field that felt congested, or which sent particular energetic signals to the practitioner (heat, coolness, tingling, pulsing), are the focus of energy direction and modulation. The intent of energy directed and the type of modulation desired depends on the nature of cues which the practitioner received.

Krieger explains:

...if I felt heat during the Assessment, then I want to balance the area by “cooling” it. The qualities of the other cues are equally suggestive: If the area felt cool, it needs to be warmed; if the cue was a sense of pressure, then the area needs to be mobilized; the tingling needs to be quieted, the pulsations moderated and made rythmical, and the electric shocks dampened or “sedated” (Ibid., p.58).

There are several ways in which the direction and modulation of energy are performed. The hands might be held over the area being “rebalanced” while the practitioner intents the proper energy. Hands might be held over two different areas of the field as energy is balanced between them. Like much of the TT process, the actual performance of each phase is open to individual interpretation. Several practitioners I interviewed combine the basic phases with different forms of guided imagery; some use colours or sounds to modulate energy; some utilize touch in all or

some of the phases, leading to the integration of different modalities (shiatsu, massage) into the treatment. The final phase of TT treatment is a formal closing of the energy transfer/modulation process by the practitioner. Customarily, the patient is left to lie down quietly for 15 or 20 minutes following the final phase.

TT proponents believe the therapy to be useful for reducing pain and anxiety, producing a relaxation response, and facilitating the body's natural healing process (Krieger 1981; Krieger 1993; Bronstein 1996; Mulloney & Wells-Federman 1996; Macrae 1999; Therapeutic Touch Network Ontario 1999). Scientific research into TT's ability to produce these effects is extensive, yet generally inconclusive regarding the therapy's benefits beyond the level of placebo response. The word *placebo* means "to please", and the *placebo response* is a term used in biomedicine to describe the positive effects of medical treatment caused by the patient's belief in the treatment's efficacy (Brody 1980:9). Modern use of the word placebo comes from the discovery that pharmacologically inert substances (sugar pills), when given to patients, could produce significant curative effects. From this knowledge came the concept of controlled clinical trials, in which assessing the value of any medical technique involves comparing it with a similar, yet "inert", placebo procedure (Hahn (1995:89-94). Through numerous clinical trials, the healing power of placebos has been empirically proven for a wide range of

illnesses, with rates of effectiveness averaging around 35% (Beecher 1955:1603).

Placebos occupy an ambiguous position within modern biomedicine, partly because they have been found through research to induce both healing effects, and negative sideeffects (nocebos). Historically placebos were associated with the *Physik*, or “healing power” of physicians, which involved cultivating an aura of competence, authority, and somewhat mystical healing ability. Mary Crenshaw-Rawlinson (1985) notes that placebos were commonly used by physicians from the time of Hippocrates to the 19th century. They were considered part of a physician’s normal therapeutic armamentarium, and reflected commonly held beliefs that medicine often involved benevolent deception on behalf of the physician. In 1787, placebo’s were defined in Quincey’s Lexicon (a popular medical dictionary) as “a common place method in medicine” (Shapiro 1959).

Crenshaw-Rawlinson (1985) notes that placebos began to take on negative connotations in the 20th century for three reasons. First, scientific medicine began to emphasize a biochemical and physiological conception of disease and cure, in which procedures which cannot be explained by these processes are considered dubious and “unscientific”. Second, the use of placebo controls in drug trials led to their being associated with “ineffective treatment”. Third, a philosophical shift in medical ethics which

resulted in increased regard for patient autonomy and the importance of informed consent made the benevolent deception associated with placebos ethically suspect. For these reasons, placebos, despite their demonstrated healing power, tend to be negatively regarded by many modern medical professionals.

Krieger (1980:369), has dissociated TT from the placebo response.

In an article in the American Journal of Nursing she writes:

It can also be stated that faith on the part of the subject does not make a significant difference in the healing effect. Rather, the role of faith seems to be psychological, affecting his acceptance of his illness or consequent recovery and what this means to him.

Similarly, in her 1993 book *Accepting Your Power to Heal: The Personal Practice of Therapeutic Touch*, Krieger (1993:11) states:

Suggestion can act as an ever-present and powerful placebo in human healing interactions. However, the responses to Therapeutic Touch are not solely or overtly due to suggestion or persuasion. Some of the most startling therapeutic responses have occurred in persons not thought capable of responding to verbal command, such as premature babies, postoperative patients who have been deeply anesthetized, and persons who are in coma and unaware of their surroundings.

Krieger's and subsequent TT researchers' attempts to distance the therapy from placebo effects can be seen as attempts to distance the therapy from such "unscientific" mechanisms as "suggestion", "persuasion", and "faith". A common criticism put forth by TT opponents is that it is "nothing more than a placebo effect." As placebos have historically been associated with trickery or "fake" treatment, such

statements are pejorative, and imply that TT has no *real* (biologically based) therapeutic benefit.

In conclusion, the healing model and practice of TT are intimately linked with beliefs in a universal, vitalistic energy field. Proponents believe in the ability of practitioners to sense this field and manipulate it with healing effect; they also believe in the importance of subjective experience in assessing and treating illness. The intention of the healer is held to be of primary importance in the healing process, and is referred to as *intentionality*, the “strong motivation to help or heal – a compassionate need to heal” (Krieger 1993:45). These core beliefs can be combined with conventional medical, holistic, New Age, or religious (primarily Christian) beliefs depending on the individual practitioner, with religious and professional ideologies seeming to be the strongest influences on proponents’ views.

The question of TT’s religious and/or spiritual associations is an important aspect of its controversy within biomedicine, and helps illustrate the difference between official statements made by practitioners and their actual practice of the therapy. Although all of the practitioners I interviewed for this research mentioned that TT is not inherently religious, all of them utilized their personal religious beliefs in their practice. These beliefs were utilized in a non-demonstrative fashion (as personal religious imagery, prayers, etc), and were not conveyed to the clients on which they

worked. In Chapter Six, the impact of TT's religious and spiritual associations on its relationship to the orthodoxy is discussed in detail.

TT's mix of strongly alternative views and practice by biomedical professionals within biomedical institutions results in several apparent contradictions. It was modeled after a religious healer, yet denies religious connections; it is based on scientifically unproven theories, yet its practitioners have attempted to justify them scientifically; it is stressed that TT can be performed by anyone, yet practitioners appear to be making preliminary efforts toward professionalization. Because of these unique characteristics, it is difficult to classify and conceptualize TT in relation to biomedicine and to other alternative therapies. In the next chapter, existing models for understanding alternative therapies are examined, and their usefulness in conceptualizing TT is discussed.

Chapter 3: Alternative Therapies: an overview

In this section, I present an overview of literature concerning the definition, prevalence, and contextualization of alternative therapies. Problems associated with defining alternative therapies are discussed, and definitions of alternative, holistic, and complementary therapies are provided. Evidence for the prevalence of alternative therapy use in the United States and Canada is presented and possible reasons for the current levels of alternative therapy utilization are discussed.

I also present systems of classifying and contextualizing alternative therapies proposed by previous researchers, and assess their usefulness in contextualizing TT. In the models which I examine, alternative therapies are contextualized in relation to orthodox medicine's institutional power, and its discursive power (the power of the medical model). All of the models point to professionalization as an important factor in the changing relationships between alternative and orthodox medicine. I suggest that difficulties in the contextualization of TT and other alternatives arise due to their being defined in relation to a rapidly changing orthodoxy.

Defining Alternatives

It is first necessary to define four terms commonly used in studying alternative medicine. These are *alternative therapy*, *alternative practitioner*, *complementary therapy*, and *holistic medicine*. I use the term *alternative therapy* in reference to many of the practices listed by Hans Baer (1998:1495) as examples of the “holistic health movement”, which he describes as: “an extremely variegated assortment of alternative medical systems”. In the movement he includes humanistic medicine, parapsychology, folk medicine, herbalism, nutritional therapies, homeopathy, yoga, massage, meditation, and the martial arts. He also includes different alternative practitioners, namely psychic or spiritual healers, New Agers, holistic MD’s and at least some osteopathic physicians, chiropractors and naturopaths. According to the framework which I lay out in the introduction, alternative therapies are those therapies which developed outside of biomedical orthodoxy. As such, they reflect a different healing model, and are not governed by the dominant scientific narrative. Alternative therapies are generally also practiced outside of biomedical institutions, although this is beginning to change, as biomedical practitioners increasingly utilize alternative therapies in their own practice.

To further illustrate my definition, chiropractic would be an alternative therapy, as would reiki, or shiatsu, as all reflect healing models different from that of medicine. There are grey areas within such a

classification scheme, as certain alternative practices are becoming more “biomedicalized” and socially legitimated (practiced within biomedical institutions). Osteopathy in the United States, and Chiropractic in the United States and Canada are examples of alternative practices that have gained social and political legitimacy, and have also moved much closer to a biomedical view of illness and treatment (Biggs 1988; Wardwell 1994:1065-1066). However, these are special cases, and do not represent the majority of therapies labeled alternative under the classification scheme I put forth.

The designation of *alternative practitioner* is based on a healer's association with the biomedical clinical worldview, and also on their relationship with biomedical delivery systems. An alternative medical practitioner has generally not been educated and trained within the biomedical model. They may practice several therapies, some even utilized by biomedical professionals, but they practice them within a fundamentally different conceptual framework. As well, alternative practitioners tend to practice outside of biomedical institutions, examples being doctors of naturopathy and Traditional Chinese Medicine. However, in the United States, osteopaths and chiropractors can now utilize hospital facilities, thus providing an exception to this general rule (Wardwell 1994:1065-1066).

Other grey areas in the category of alternative practitioners emerge when considering biomedical professionals who utilize alternative therapies in their practice, such as nurses who do TT, or holistic physicians. By my definition, these practitioners would still be considered orthodox, as their clinical framework remains fundamentally biomedical. These practitioners may be labeled or treated as alternative by other members of the orthodoxy, as can be seen in the case of TT; however, they seldom see themselves in this light. Of course, there are exceptions to this rule as well, as some practitioners may completely turn their backs on previous biomedical training in order to embrace new clinical realities; Samuel Hahneman, founder of Homeopathy (Coulter 1984:58-60), and Andrew Taylor Still, founder of Osteopathy (Gevitz 1988), are famous examples of such a shift. These practitioners could then be deemed alternative.

The term *complementary therapy* is used to describe an alternative therapy being used within the biomedical system and in conjunction with orthodox techniques. It is useful in describing TT, as the therapy is alternative (based on a clinical view from outside the orthodoxy), yet is practiced by orthodox professionals in orthodox institutions. The term *complementary* does not, however, describe the political relationship between those health professionals who practice alternative therapies and their orthodox colleagues who do not. These relationships can be vastly

different depending on the type of professional, type of alternative therapy used, and type of institution it is used in. In the case of TT, its use by nurses in hospitals which are un-supportive of the therapy is quite different from its use in hospitals which have official TT clinics and training programs. Interviewed nurses also mentioned that differences in TT's acceptance can exist between different wards in the same hospital.

Nienstedt (1998:14) describes *holistic medicine* as "concepts or therapies based on the principles of prevention of disease and the interconnectedness, or wholeness, of all aspects of the patient (mental, physical, spiritual). This is similar to the definition put forth by Andrew Weil (1983:181), a prominent holistic physician, who refers to *holistic medicine* as "an informal collection of attitudes and practices, not a defined system of treatment". These attitudes and practices can be found (in different quality and quantity) both within the biomedical model and within alternative practices. Certain practices commonly included under the 'holistic health movement', like ear candling, aromatherapy, and reflexology are not inherently more holistic than standard biomedical procedures. Conversely, some multidisciplinary care teams in orthodox medical institutions can provide treatment that is highly holistic.

A local example of holism within orthodox institutions is the Chronic Pain Management Program at Chedoke Hospital in Hamilton. This program consists of an intensive month-long therapeutic regime with both

inpatient and outpatient streams. Each month, groups of approximately five to ten patients with long-term chronic pain are admitted to the inpatient and outpatient programs. During their stay they participate in exercise programs (swimming, cycling, stretching), group and individual counseling, and psycho-educational sessions regarding pain management, stress management and other psychosocial issues. From 1994-95 I conducted research there for an undergraduate psychology thesis. As part of my thesis, which was an evaluation of the program, I observed multidisciplinary team meetings with program clients. Members of the care team included a psychiatrist, a social worker, an occupational therapist, a physiotherapist, a nutritionist, a pharmacist, a psychologist, and a behavioural therapist. These therapists worked closely together in the treatment of individual patients, providing very 'holistic' treatment.

An important note to make about the definitions of alternative and complementary therapy and alternative practitioner is that they only exist in relation to biomedical orthodoxy. As Jinfeng (1987) points out, there are several countries for whom orthodox biomedicine is not the most prominent system of health care. In these countries, the therapies labeled alternative in biomedically dominated societies could very well constitute the majority of health care practices. Jinfeng refers to non-biomedical indigenous health care systems in other cultures as *traditional medicine*, as opposed to alternative medicine, examples of which are Traditional

Chinese Medicine in China, Ayurveda in India, Huna (shamanism) in Hawaii, and the Curanderos (traditional healers) in Mexico.

Prevalence and Reasons for Use

Several studies have been done on the use of alternative therapies in North America. These studies generally suggest that such use is increasing, but exact levels of use and increase are difficult to determine due to differences in operationalizing the category alternative therapy. In two studies by Eisenberg et. al. (1993; 1998), use of a wide range of alternative practices was measured. They defined alternatives as “medical interventions not taught widely at U.S. medical schools or generally available at U.S. hospitals” (1993:246). This definition is based on a therapy’s exclusion from biomedical institutions, and is similar to the definition I use, although I give more weight to the healing model represented by a therapy and how it differs from the medical model. In both of Eisenberg’s studies, researchers measured the prevalence of use of relaxation techniques, chiropractic, massage, imagery, spiritual healing, commercial weight-loss programs, lifestyle diets, herbal medicine, megavitamin therapy, self-help groups, energy healing, biofeedback, hypnosis, homeopathy, acupuncture, and folk remedies.

In Eisenberg et. al.’s first study, a 1990 national survey of 1539 adults revealed that one in three respondents (34 percent), had utilized an

alternative therapy in the previous year. Estimated total expenditures on these therapies were \$13.7 billion, comparable to the \$12.8 billion spent in out-of-pocket hospitalization expenses during the same time period (Eisenberg, Kessler, Foster, Norlock, Calkins & Delbanco 1993). In the follow-up study conducted in 1997, it was found that the prevalence of alternative therapy use had risen to 42.1 percent (of 2055 survey participants), indicating that an already high level of use was increasing (Eisenberg, Roger, Davis, Ettner, Appel, Wilkey, Rompay & Kessler 1998).

In Canada, a report on the 1994-95 National Population Health Survey (NPHS) indicated that an estimated 15 percent of Canadians aged 15 and over had utilized some form of alternative health care in the previous year (Millar 1997). The question in the survey asked people whether they had contacted an alternative health practitioner, thus eliminating the self-treatment categories present in Eisenberg et. al.'s studies. This narrower operationalization could account for the differences in prevalence between Millar's NPHS data and Eisenberg et. al.'s survey data. In a more recent (1999) survey conducted by the Fraser Institute, alternative therapy utilization was found to be much higher; 73 percent of Canadians reported using at least one alternative therapy at some point in their life, and fifty percent of respondents reported using at least one in the previous year. Estimates of total expenditures on alternative medicine were \$3.8 billion dollars per annum, accounting for more than 16 percent

of all private health care expenditures in 1995 (Ramsay, Walker & Alexander 1999).

In the 1998/99 National Health Survey report, Health Care in Canada: A First Annual Report, alternative therapy use was broken down by province, and by type of therapy. It was reported that about 2.5 million Canadians visited a chiropractor, and nearly two million used the services of other alternative health care providers within the previous year. The most common therapists consulted after chiropractors were massage therapists, homeopaths, naturopaths, and acupuncturists. Western and central provinces were found to have much higher frequencies of use than eastern provinces (CIHI 2000:38).

No reliable data exists as to how many people receive therapeutic touch (TT) treatments. However, there is reason to believe that the therapy has grown in prevalence over the last ten years. In the (1993) Eisenberg et. al. study the prevalence of use of energy healing was 1.3%, which increased to 3.8% in the 1997 survey. As TT is generally classified as energy healing, these figures could indicate an increase in TT use in the U.S.; however, such a conclusion should be viewed with caution, as TT was not specifically mentioned in either study. Indications of TT's increased prevalence in Canada can be found in the growth of regional TT networks and practitioner support groups. There are now TT practitioner groups in most major cities in Canada, and regional TT organizations

covering Canada and the U.S.. In the June, 1993 edition of in touch (the TTNO's newsletter), there were 21 practitioner support groups listed, while in the May 2000 edition, there were 128 such groups listed, in locations across the country.

The prevalence of alternative therapy use has led researchers to ask who is using these therapies, and why they are using them. These questions have been addressed by several researchers. In Eisenberg, et. al's (1993; 1997) studies on the United States, people most likely to use alternative therapies were of Caucasian descent, between 25 to 49 years old, and from higher educational and income brackets. Education level and ethnicity were found to be the best predictors of use. Results of the 1997 follow-up study were similar, although significantly higher use was found among women. In both studies, use was higher among people with chronic illness (Eisenberg et. al. 1997). These findings are matched by those in Millar's Canadian study, which mentions the most likely users as post-secondary educated, of higher income, female, and between the ages of 25-64. The highest indicator of use was possession of three or more chronic medical conditions (Millar 1997).

Wolsko, et. al. (2000) recently performed a study of alternative therapy use by 536 patients admitted at three different ambulatory clinics in Denver, Colorado. The alternative therapies studied included acupuncture, chiropractic, herbal medicine/dietary or vitamin supplements,

meditation/relaxation, and massage. In their study, the three hospitals served patients from varying socioeconomic (SES) groups and ethnic backgrounds. One clinic primarily served Medicaid patients (n=208), another predominantly served employees of the hospital in which it was located (n=179), while the third clinic was in a university hospital located in an affluent community, and served employees and faculty members at the University of Colorado (n=149). Statistically significant differences in gender, SES, age, race, education level, and self-rated health status were found between the three patient groups. In terms of alternative therapy use between the groups, it was found that lower self-rated health status (adjusted odds ratio (95% CI) of 2.07) and female gender (odds ratio of 1.86) were the best predictors of use. Income level was not found to be significant (odds ratio of 1.05), however, respondents from the lowest income group showed the least willingness to pay out of pocket for the alternative therapies studied.

Surveys have also ascertained how patient attitudes towards biomedical health care, and towards health issues in general, have determined alternative therapy use. Several studies have shown that a reason for using alternative therapies is dissatisfaction with biomedical care, in particular with care of chronic illness (Cassileth, Lusk, Strouse & Bodenheimer 1984; Furnham & Bhagrath 1993; Dunfield 1996). However, this hypothesis has been questioned by Astin (1998), who found that

dissatisfaction with medicine was not a significant motivator to alternative therapy use. Astin found that sufferers of chronic illness were most likely to utilize alternative therapies, with next best indicator being classification as a “cultural creative”, defined as “those who are at the leading edge of cultural change and tend to be interested in psychology, spiritual life, self-actualization, self-expression, like the foreign and exotic, and enjoy mastering new ideas” (Ibid., p.1549). Having a holistic view of medicine (defined as mind, body, and spirit being equally important in health) was also a predictor of use. Like the findings in Wolsko (2000), socioeconomic status was not a significant predictor.

Furnham has performed a number of studies on the reasons why patients in England choose alternative or conventional medicine. In a study of the beliefs of patients who visited a homeopath and patients who visited a regular practitioner, Furnham and Smith (1988) suggested that dissatisfaction with regular practitioners, as opposed to regular medicine itself, was a prominent reason why people consulted alternative practitioners. Furnham and Forey (1994) compared various health beliefs between patients of general practitioners (GP) and alternative practitioners (AP) and found that patients of AP's believed more in the efficacy of alternative medicine and the importance of holistic (body, mind, spirit) medical care, had higher levels of health awareness, and were suspicious of the ability of GP's to cure illness. Furnham and Forey interpreted these

results as implying that some alternative therapy patients are drawn towards treatment because of their views on health and healing, not necessarily their dissatisfaction with conventional medicine.

In summary, it appears that the most robust determinant of alternative therapy use is being in possession of one or more chronic illnesses. Another prominent, yet inconsistent, predictor is high socioeconomic class. Because most alternative treatments are not covered under insurance plans (with the exception of chiropractic, and more recently, acupuncture and massage), they are more readily utilized by people able to afford the out of pocket expense. Other predictors for use include female gender, high education level, being dissatisfied with conventional medicine (linked to possession of chronic illness), or having a holistic view of health.

Classifying & Contextualizing Alternatives

Both Nienstedt (1998) and Eskinazi (1998) have addressed the haphazard ways in which alternative therapies are generally labeled and categorized, pointing out such difficulties as how to combine complex ethnomedical systems (Ayurveda, Traditional Chinese Medicine [TCM]), mechanical treatment procedures (massage, ear candling), and spiritual therapies (laying on of hands, psychic healing) into one category. Nienstedt proposes a classification system based on four quadrants, in

which alternative medicine is divided into three groups and orthodox biomedicine makes up the fourth.

Alternative medicine is classified into *Cross-Cultural Alternatives* (Yoga, Reiki, Acupuncture), *Mind/Spirit Alternatives* (Christian Science, Hypnotherapy, Faith Healing), and *Body Healing Alternatives* (Massage, Chiropractic, Reflexology). These categories represent an interesting attempt at solving a complex classificatory dilemma, yet create as much confusion as they dispel. Questionable allocations include Reiki under Cross-Cultural, when it is perhaps the archetypal example of New Age spiritual healing, and was developed in North America (although its founder was Japanese). Similarly, Zen is included as a Mind/Spirit therapy (as opposed to Cross-Cultural), while Therapeutic Touch, which works with energy fields, is presented as an External Body Healing approach along with Chiropractic, a wholly physical practice (Nienstedt 1998).

Eskinazi's (1998:3) classification system focuses on the ways in which therapies are defined in relation to orthodox medicine, and proposes that therapies are considered alternative for the following reasons: 1) *cultural* – health care practices may have developed outside of mainstream North American culture; 2) *economic* – therapies similar to conventional pharmacological approaches (herbs) can be developed outside of conventional economic systems (pharmaceutical industry,

research institutions, hospitals); 3) *scientific beliefs* – there exists no accepted scientific explanation for the therapy's effects; 4) *medical beliefs*– alternative practices often focus on preventative and therapeutic enhancement of psychosomatic systems (immune system), which is not as prominent in biomedicine; 5) *educational standards* – some practices are passed on through oral or alternative traditions, rather than through formal academic or professional training.

The usefulness of Eskinazi's classification of alternative therapies is that it points out their "sheer diversity in terms of content, practice, and institutional relationship to orthodox forms of medicine" (Sharma 1993:16). As well, it reveals how practices can be considered alternative in certain aspects, but not in others. Because of the many ways in which a therapy can be termed *alternative*, such an appellation will always refer to a changing body of theories and practices. Presently, therapies which were once considered outside of the biomedical model are now being used frequently within it - acupuncture and massage therapy being two obvious examples (Kligman 1998). In this respect, a therapy's changing relationship to the institutions of medical power can greatly influence how alternative it is perceived to be.

Several researchers have contextualized alternative therapies in relation to orthodox medical institutions, and have thus offered additional ways to classify and understand them. A system of classification is

proposed by Wardwell (1976; 1994), and organizes all health care practitioners within the United States “based on such structural characteristics as legal licensure or customary practice” (1976:62).

Wardwell orients alternative practices in relation to the orthodox medical profession, which he identifies as the “touchstone...with its broad scope of practice, rights, and privileges” (Ibid., p.62). *Ancillary practitioners* are those who practice directly under the authority of the medical profession, examples being nurses, pharmacists, and physiotherapists. *Limited practitioners* practice independent of medical supervision, but limit themselves to certain conditions and/or parts of the body. Examples include dentists, optometrists, and clinical psychologists. *Marginal, or parallel practitioners* represent those organized systems of healing “whose philosophy or theory of health and disease conflicts with that of orthodox medicine” (Ibid., p.63). Examples given include chiropractors, homeopaths, naturopaths, and osteopaths. Wardwell (Ibid., p.63) states that:

Because these professions challenge some of the basic assumptions of orthodox medicine and attract patients with a wide variety of conditions, they pose a more serious threat to organized medicine. Relations between it and them are fraught with conflict and are inherently unstable.

Finally, *quasi practitioners* include those “who reject the medical model of the doctor-patient relationship yet assist people in obtaining relief” (Ibid., p. 63). In his later article, Wardwell (1994:1063-1065) further

describes quasi practitioners as “non-medical healers that use methods that have not been or cannot be empirically verified.” Members of this category are subdivided into *folk healers* (shamans, herbalists), *magical healers* (shamans in pre-literate societies), *faith healers* (charismatic healers, Christian Scientists), and *quacks*, who “pretend to be scientific and to believe sincerely in the merits of their machines, procedures, or healing rituals” (Ibid., p.1064). Wardwell notes that quacks tend to attribute the benefits of their therapies to ‘natural’ as opposed to ‘supernatural’ effects (such as healers who use magnets, or electrical impulses).

Wardwell’s framework classifies alternative therapies based on their relationship to biomedicine, explaining this relationship in terms of the discursive and institutional power of the orthodoxy. Other health practitioners are classified in relation to the medical profession based on their institutional relationships (licensing, access to hospitals), and also based on their cognitive relationship (closeness to the biomedical model of healing). Both marginal and quasi practitioners are said to possess healing models in conflict with that of the orthodoxy, but the marginals are distinguished by their greater organization, thus proving to be a greater threat to the orthodoxy. In his framework, Wardwell (1994:1064) classifies TT as a form of New Age faith healing, writing:

Some practices shock the scientific observer. Auras remind one of Mesmer's magnetism. Therapeutic 'touch' is similar in that there is no physical touch (hence the word is in quotes). Its benefits are believed to derive from interaction between the therapist and the patient's aura. Amazingly, it has attained the respectability of being taught in workshops sponsored by university nursing schools.

There are some difficulties in TT's faith healing classification. In describing the category, Wardwell (Ibid., p. 1064) notes:

Between contemporary faith healers and empirically grounded therapists, whether physicians or limited or even marginal practitioners, there is nearly complete role segregation. A simple test would be to see what the effect would be on a patient if a physician were to intone "Let us pray", or if a religious advisor were to prescribe medicine. Because of this role segregation, faith healers pose no serious threat to orthodox medicine (as marginal practitioners may).

TT's practice by nurses within biomedical institutions makes it a prominent exception to the segregation of empirically grounded practitioners and "faith healers". It is apparent from studying TT that some of its "amazing" acceptance within biomedicine has to do with its claims for scientific validity, and its distinguishing syncretistic spirituality from religion. Nurses who practice TT attempt at all costs to distance the therapy from the category of faith healing; for this reason TT's inclusion within this category does not capture those discursive characteristics which have enabled what Wardwell terms "faith healing" to enter into biomedical practice.

TT practicing nurses are also ancillary professionals, and as such, they are legally licensed members of the orthodoxy. For this reason, their ability to challenge the biomedical model and operate within its institutions

is far more complex than Wardwell suggests by his classification. As members of the orthodoxy, TT proponents have access to research facilities, medical journals, hospitals, and nursing schools wherein their healing model and practice can be propagated to a greater extent than that of most marginal practitioners. Because Wardwell constructs the quasi-healer category based on the empirically verifiable effects of healing techniques, not their relationship to biomedical institutions or discourse, important aspects of TT's context are lost.

A prominent model of conceptualizing health care systems among anthropologists is presented by Kleinman (1980; 1984), and divides such systems (he calls them *indigenous healing or health care systems*) into popular, professional, and folk sectors. Kleinman (1980:24) views health care systems as cultural systems, writing:

In every culture, illness, the responses to it, individuals experiencing it and treating it, and the social institutions relating to it are all systematically interconnected. The totality of these interrelationships is the health care system.

Each culture has its own indigenous health care system, defined by its own particular beliefs concerning illness, and its particular socioeconomic and political structures. Kleinman (1984) also uses the term indigenous in another sense when talking about North American society. While he classifies North American health care as an indigenous system, he also uses the term indigenous to refer to non-biomedical practices within it.

This distinction occurs due to Kleinman's separation of biomedicine from other healing traditions in *all* health care systems, including the ones in which it can be legitimately considered as indigenous. As such, within North America, *indigenous medicine* is synonymous with *alternative medicine*.

In order to facilitate comparison among different indigenous health care systems, Kleinman's model focuses on the common ways in which *clinical reality* is structured across cultures. He writes:

Beliefs about sickness, the behaviours exhibited by sick persons, including their treatment expectations, and the ways in which sick persons are responded to by family and practitioners are all aspects of social reality. They, like the health care system itself, are cultural constructions, shaped distinctly in different societies and in different social structural settings within those societies. These health-related aspects of social reality – especially attitudes and norms concerning sickness, clinical relationships, and healing activities – I shall call *clinical reality* (1980:38).

Kleinman's model looks at the differences between lay, professional, and folk conceptions of clinical reality within health care systems. These three perspectives are present within most cultures, and are represented in different social groups. The popular sector consists of lay-people, the professional sector consists of culturally-legitimated professional healers, and the folk sector consists of "non-professional, non-bureaucratic, specialist" healers (Kleinman 1980:59). It is noted that in some smaller-scale societies that no professional sector exists. Kleinman (1984:142) argues that the largest sector within health care

systems is that of popular health care, in which “illness is first experienced, labeled, and treated by the individual (self-care), or more often by family members and other members of the social network”. Kleinman situates most healing within the popular sector, in which “The sick person and his family utilize beliefs and values about illness that are part of the cognitive structure of the popular culture” (1980:52). In North American health care systems the popular sector would include the booming industry of over-the-counter pharmaceuticals. Also included would be lay-people who utilize indigenous (alternative) therapies to treat themselves, family members, and friends; examples being those trained in therapeutic touch, massage, or similar healing modalities, or who utilize homeopathic or herbal remedies.

The professional sector is comprised of organized healing traditions. In North America these traditions include the many biomedical professions and other “alternative indigenous professions” such as osteopathy and chiropractic. The professional sector is distinguished by its model of clinical reality. Kleinman (1984:147) notes:

Professionalization tends to distance practitioners from patients and to prioritize concern for disease ahead of interest in illness. Western-oriented biomedicine seems to be the more extreme example of this trend, perhaps because biomedical ideology and norms are more remote from (one almost wants to say estranged from) the life world of most patients.

The clinical reality of the professional sector constitutes an expert system of knowledge concerning health care, and is thus different (more formalized) from the systems utilized in lay or folk sectors. This difference in knowledge systems can be seen between nurses and lay people who practice therapeutic touch. Nurse practitioners, the focus of this study, present a more formalized, professional view of the therapy than do lay practitioners. This was apparent when comparing interviews with each group, and statements made by both types of practitioner within in touch, the TTNO quarterly publication. Nurses provided a more standardized, consistent view of TT than did lay people, and talked about the practice and its effects in biomedical terms. This suggests that their use of an expert system of knowledge (that of the nursing profession) affects their interpretation of TT.

Kleinman (1980:52) notes that the professional sector also has greater institutional power than popular and folk sectors to define the nature of clinical reality:

...the power to create illness and treatment as social phenomena, to legitimate a certain construction of reality as the only clinical reality, is not equally distributed. The professional sector is paramount because social power is in large part a function of institutionalization, and the professional sector is heavily institutionalized whereas the popular sector is diffused.

Kleinman also talks about the discursive power utilized in maintaining professional control over norms, beliefs and values concerning health

care, noting that: “the professional sector requires that its form of clinical reality be accepted as the only clinical reality” (1980:56). In biomedicine, he argues, this professional monopolization of health care discourse is particularly apparent:

Professional socialization of modern health professionals causes them to regard their own notions as rational and to consider those of patients, the lay public, and other professional and folk practitioners as irrational and “unscientific.”

The grounding of a dominant clinical reality within institutions is synonymous with my definition of orthodoxy, in which the discursive power of a unifying biomedical model is combined with the institutional power of hospitals, medical schools, health clinics, and professional associations. These two sources of power serve to control rival healing traditions which aspire toward greater social legitimacy.

According to Kleinman (1984:148) the folk sector of health care systems is inhabited by “non-professional, non-bureaucratized ‘specialists’”. In the case of North America, he distinguishes between modern and traditional forms of folk healing. Traditional forms include Christian Science Healers, herbalists, Evangelical healers, and indigenous ethnic healers. Modern forms include hypnotherapists, family therapists, polarity therapists, and health food advisors. (Ibid., p.149). Included in the *modern* category would also be lay TT practitioners who treat non-related clients as volunteers, or for money. Kleinman characterizes folk healers

as usually being individual practitioners who practice outside institutional settings either in their homes or in the homes of patients. He also mentions that folk practitioners can be part-time and non-intensive, or full-time and in pursuit of professional status (Ibid., p.149).

Kleinman's model of health care systems has many strengths, including its identification of the important role which personal and family care play in any such system, its distinguishing of medical practitioners by their level of professionalization and their conception of healing, and the effect which professionalization, and professional dominance, have on a group's version of clinical reality. In the case of TT, the clinical reality associated with professionalization is useful in explaining differences in statements made by nurse and lay practitioners. As well, professionalization is one of the strategies used by TT proponents in their heretical challenge to the orthodoxy, and will be discussed further in chapter 6. Finally, Kleinman's view of biomedical orthodoxy as a dominant clinical perspective embedded in powerful social institutions also supports Wolpe's (1990; 1994) idea that challenges to the biomedical model can be perceived by the biomedical elite as real threats to their social legitimacy.

One difficulty with Kleinman's model is that through separating biomedicine from all other healing systems, biomedicine then appears as the standard for judging all other indigenous systems. It could be argued that the biomedical model is simply another healing model, with specific

historical, geographical, and cultural characteristics. Such a view of biomedicine has been put forth by other anthropologists. Hahn (1995:132) writes:

In describing biomedicine as a cultural system, I do not deny the knowledge or efficacy of this system. Biomedicine has made revolutionary discoveries and created powerful inventions. Rather, I claim that Biomedicine is one ethnomedicine among many others, and that, like all ethnomedicines, it is rooted in cultural presuppositions and values, associated with rules of conduct, and embedded in a larger societal and historical context.

Although Kleinman does note the complex socioeconomic and political influences on biomedicine, fundamental aspects of its clinical reality are not challenged or questioned within his model. As pointed out by such writers as Singer and Baer (1995:33-38), basic biomedical conceptions of illness and treatment can be viewed in a highly critical light, which questions their role in perpetuating social and economic inequalities.

Singer and Baer utilize a similar political-economic perspective in the conceptualization of alternative therapies contained in Critical Medical Anthropology (1995). In this book they present a model for studying health care systems which is formed around the following questions:

(1) Who has power over the agencies of biomedicine? (2) How and in what form is this power delegated? (3) How is power expressed in the social relations within the health care system? (4) What are the economic, socio-political and ideological ends and consequences of the power relations that characterize biomedicine? and (5) What are the principle contradictions of biomedicine and arenas of struggle in the medical system? (Baer, Singer & Johnsen 1986:95-96)

To answer these questions they utilize a neo-Marxist conception of what they term the “American dominative medical system” (Singer & Baer 1995:181) which identifies different levels of political and economic power, and highlights the conflicts that emerge between these levels. The resulting model of biomedicine is presented in a broad, systemic format (fig. 2), which illustrates these different levels. Macro-social, intermediate-social, micro-social, and individual tiers are delineated, allowing for the analytical integration of critiques on the level of global political economy, corporate and state sectors, professional organization, individual practice, and patient resources. Heterodox medical systems are included in this format, and are delineated from *Cosmopolitan Medicine* (which they also deem *bourgeois medicine*, and which includes licensed biomedical professionals and their associated institutions and organizations) (Ibid., p.63).

In another diagram (fig. 3), Singer and Baer (1995:181) illustrate the power differences between plural medical systems, noting: “The medical systems of complex societies are characterized by pluralism. However, these systems are hierarchical rather than adjacent in that bourgeois medicine enjoys a dominant status over heterodox and ethnomedical practices.” The table shown in figure 3 shows the dominant position of Bourgeois medicine, which Singer and Baer attribute to its close association with powerful

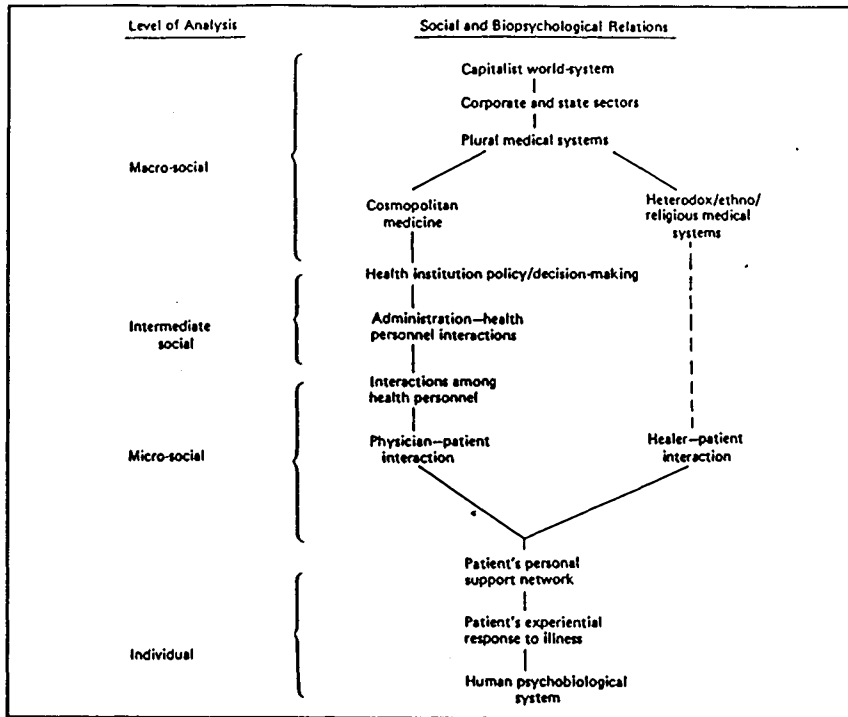


Fig. 2. Adapted from Singer & Baer (1995) *Critical Medical Anthropology*. p. 63

- A. Bourgeois Medicine
- B. Osteopathic Medicine as a Parallel Medical System Focusing on Primary Care
- C. Professionalized Heterodox Medical Systems
 1. Chiropractic
 2. Naturopathy
- D. Partially Professionalized or Lay Heterodox Medical Systems (e.g., homeopathy, acupuncture, Rolfing, reflexology, etc.)
- E. Anglo-American Religious Healing Systems (e.g., Christian Science, Seventh Day Adventism, evangelical faith healing)
- F. Ethnomedical Systems (e.g., African American ethnomedicine, *curanderismo*, *espiritismo*, *santeria*, Chinese medicine, Native American healing systems)

Fig. 3. Adapted from Singer & Baer (1995) *Critical Medical Anthropology*. p. 191

corporate interests within capitalist society. They note: "This dominative status is legitimated in many advanced capitalist countries by laws that give bourgeois medicine a monopoly over certain medical practices, and limit or prohibit the practices of other types of healers" (Ibid., p.181). Other practitioner groups are listed under Bourgeois medicine in descending order of systemic power.

Singer and Baer focus on professionalization as one of the key processes by which alternative therapies change their relationship with *bourgeois medicine*, contrasting it with unionization. They write:

Although health occupational groups (nurses, medical technologists, and technicians, etc.) which find themselves subordinate to administrators and physicians in the bourgeois medical division of labour, occasionally adopt the unionization approach, alternative medical practitioners, who often exhibit marked petty-bourgeois ambitions, almost invariably adopt professionalization as a strategy of collective social mobility (1995:191).

Professionalization is undoubtedly important within health care in North America, as evidenced by the history of such sectarian medical practitioners as Homeopaths (Coulter 1984; Kaufman 1988), Thompsonists (Rothstein 1988), Naturopaths (Mills 1966), Eclectics (Connor 1997), Osteopaths (Mills 1966; Gevitz 1988), and Chiropractors (Mills 1966; Wardwell 1976; Caplan 1984; Wardwell 1988; Biggs 1988; Coburn 1997). Each of these alternative medical systems embarked on a process of professionalization aimed at increasing the legitimacy of their practice and increasing the political autonomy and economic security of its

practitioners. As mentioned previously, TT also appears to be following this 'professionalization imperative' within the world of alternative medicine. This could also be influenced by the nursing profession which, although largely unionized, is engaged in the active process of increasing its professional status (Mulloney 1992; Canadian Nurses Association (CNA) 1993:6-8; 1996).

In terms of contextualizing TT, CMA's focus on social and class conflict is useful, as nursing has a history of political conflict with the medical profession (McPherson 1996), and as my research indicates that some power-related tensions might exist between nurse and lay TT practitioners. At a therapeutic touch practitioner support group I attended, several lay practitioners in the group complained about the standards set out by NH-PAI for becoming a recognized practitioner and for maintaining this status. The lay practitioners found the time commitment requirements unrealistically high for people with full time jobs outside of the health care field. They also found the continuing education requirements exceedingly expensive. The professionalism represented by TT's 'recognition' procedures can be interpreted as favouring its nurse practitioners, as nurses have to take continuing education credits in order to retain RN status. There are also some indications that NH-PAI is biased towards nurse over lay practitioners, as the application for recognized status still asks for proof of nursing registration (Hawk 2000).

Singer and Baer's broad conceptual model of health care systems is useful in linking macro-level political and economic aspects of health care systems to the levels of professional organization and primary and self-care. Their neo-marxist perspective leads to an emphasis on the institutional power of orthodoxy, and the ways in which it can control opposition from alternative practices through legislation. Within their model, the common social legitimation of bourgeois medical professions is balanced with an appreciation for the points of conflict which can occur between them. This view of orthodoxy as a dynamic, conflict-filled system is consistent with the view that I present in chapter five.

In examining previous attempts to define, classify and contextualize alternative therapies it is apparent that several different forms and approaches exist. However, certain common elements can be found within these diverse methods. Wardwell, Kleinman, and Singer and Baer all contextualize alternative therapies in relation to biomedicine's discursive and institutional power. Wardwell's typology of health care professions balances these two forces, as practitioners are distinguished based on their professional power within health care delivery systems, and also through their relationship to the orthodox view of health, illness, and healing. Kleinman's model of health care systems focuses more on the clinical reality put forth by practitioners, and shows how this reality differs between organized professions and lay and folk healers. Singer and Baer

emphasize the institutional power of medicine, and its relations to capitalist hegemony. They show how the monopoly on political and economic power which bourgeois medicine holds acts to marginalize heterodox healing systems and reproduce class, race, and gender inequalities present within greater capitalist society.

These three frameworks also focus on the importance of professionalization within the North American health care system. They note how gaining legitimacy through professionalization involves adopting more of the ideological and structural characteristics of orthodox biomedicine. Singer and Baer (1998:191) note:

In reality, professionalization acts as a subtle, but highly effective, hegemonic process by which alternative medical practitioners internalize some, if not many, of the philosophical premises, therapeutic approaches, and organizational structures of bourgeois medicine.

Wolpe (1990:914-915) describes a similar tension between the narrative innovations of the heretic and their need to conform to the orthodox discourse. Examining TT's heretical drama reveals similar tensions caused by proponents balancing scientific justification with innovative narratives concerning energetic healing, spirituality, and intuitive knowing.

Most researchers classify and contextualize alternative medical practices by the nature of their relationship with orthodox biomedicine. As such, these approaches can present a picture of the orthodoxy which is more monolithic than their authors might intend. Biomedical systems are

currently undergoing rapid change, and the orthodoxy, although still institutionally dominant, is no longer homogeneous in terms of theory and practice (indeed, if it ever was). This situation demands a higher level of specificity in the contextualization of medical alternatives and a greater appreciation for the heterodox nature of the biomedical model. As

Kleinman notes:

What we have learned about indigenous healing is knowledge about particular healing systems and healers in particular social contexts at particular times...Much the same sort of meaning should attend our analysis of biomedicine, of psychotherapy and of self-care. Each is plural and highly diverse. Therefore when we discuss healing we need to specify which type of healing, which healers, in which setting, under what conditions, at what time.

In light of Kleinman's words, if one is examining an alternative practice within a rapidly changing health care system, one must present a conceptualization of both orthodoxy and alternative which accounts for that change, for its current manifestations (in terms of prominent ideological narratives) and possible future effects. Through my analysis of the biomedical model in chapter five, I attempt to show both how the narrative of science binds it together in an undeniable whole, and also how that narrative is widely interpreted within contemporary medicine, leading to strong, soft, and fringe orthodox models.

Chapter 4: Biomedicine: Defining Orthodoxy

Orthodox medicine is the prototype against which heresy is defined in my analysis of therapeutic touch as medical heresy. From the discussion of orthodoxy in chapter four, orthodox medicine can be seen as an institutionalized, socially legitimated healing model. In medicine, this model concerns what Salmon (1984:1) calls “the organized activity of healing”, and consists of basic notions of illness, cure, and healing, yet also constitutes a broader framework for interpreting “ourselves, our world, and the relationships between humans, nature, self, and society.” (Gordon 1988:19).

In this chapter I present a version of the medical model which accounts both for its coherence, and for its wide interpretation amongst medical professionals. The version of the medical model I present comes from analyzing the statements of biomedical professionals, the actions of those professionals, and institutional expressions of value and belief (from medical schools, professional colleges and professional organizations). I structure this analysis by focusing on the healing and scientific narratives which define biomedicine. The first narrative is often expressed as “the art of medicine”, and represents the goals of healing and its notions of care and cure. The second narrative concerns “the science of medicine”, and

posits that science is the accepted way of achieving the goals of healing. The narrative of science contains several themes, including dualism (mind/body, science/spirit), reductionism, rationality, and objective measurement. The application of modern scientific theories and techniques to health care is the dominant characteristic of the medical model, yet its tension with the healing narrative, coupled with other ideological pressures from inside and outside of biomedicine, lead to wide variation in its interpretation.

Interpretation of the scientific narrative is influenced by the different occupational groups within medicine. Nurses constitute the largest number of health professionals and possess an interpretation of the medical model which is substantially different from that of the medical profession (being caring based, less based on diagnosis and cure) (Benjamin & Curtis 1986:179-181; Storch 1988). As well, medical administrators have conceptions of illness and treatment which are governed more by economic and utilitarian concerns (controlling costs/maximizing profits, Fordist rationalization, ensuring the universality and comprehensiveness of health care) (Bakx 1991:23-24; Burke & Stevenson 1998). Even within the medical profession there are differences in interpreting the medical model found between areas of specialization (surgery as opposed to family practice) and between general practitioners (evidence-based medicine vs. interpretive medicine).

Freidson (1970:16) has pointed out that “medicine is seen as a single profession at considerable expense of the facts. Within it are warring factions, each struggling for jurisdiction and control over various areas of work.”

In order to more accurately portray the competing interpretations of the orthodox model, I have divided the orthodoxy into strong, soft, and fringe categories. These categories are loosely based on *pharmaceutical*, *integrational*, and *holistic* medical models presented by Aakster (1986). They are not to be taken as empirically valid categories which can be used for classification purposes, but rather as analytical tools to structure my discussion of different streams of biomedical thought. The intention of the categories is to account both for the common elements which define the orthodox model, and for the diversity which exists within medicine concerning its interpretation. Although TT proponents *are* challenging an orthodox model of healing, it is a model which is already changing, with ‘holistic’ and ‘integrational’ viewpoints becoming more prominent among biomedical practitioners.

I examine the three orthodox perspectives in relation to four areas of medicine: 1) definitions of illness; 2) treatment methods; 3) patient management; and 4) medical pluralism (fig. 4). The area of medical pluralism concerns the use of alternative therapies within health care, either by orthodox practitioners, or by alternative practitioners working

Degrees of Orthodoxy in Biomedicine (fig. 4)

	Strong Orthodox (elite)	Soft Orthodox (reformer)	Fringe Orthodox (heretic)
Definition of Illness (etiology)	Disease is biologically based and reductively defined; mental events are identical to their material equivalents, somatopsychic etiology	Disease is largely influenced by social and physical environment and psychological factors, balanced somatic/psychological etiology	Illness can involve spiritual or subtle energies; diseased physiology is an indicator of disrupted psychosocial or spiritual aspects
Treatment Methods	Interventions have a direct physiological impact – surgery, drugs, transplants, implants, all must be scientifically proven	Interventions on physiological, psychological, and social levels – counseling, nutrition, exercise, must be scientifically proven	Some interventions have only a psychological or spiritual effect; can be based on scientifically unproven theories, but must be effective
Patient Management	Curative interventions are the most important aspect of treatment; social and psychological realms are not medical territory – science	Care of patients is as important as curative treatment, talking, explaining to patients, balance between art and science of medicine	Healing is the goal, involves creating ‘wellness’, integrating spiritual and emotional aspects; more attention to the art of medicine
Pluralism	Only biomedically sanctioned professionals should be involved in health care provision	Can refer to complementary therapists who are licensed or reputable; can use complementary therapies in own	Full pluralism in health care, alternative therapists should be legal members of the health care system, included in health

within the cultural system of health care. I provide examples of the different orthodox views for each area, and demonstrate how certain themes run throughout each orthodox perspective in given areas of medicine. In definitions of illness, treatment methods, and patient management, all brands of orthodoxy fall along an etiological and therapeutic continuum between biological, psychosocial, and spiritual factors. This continuum reflects the changes taking place in biomedical practitioners' views regarding mind/body and science/spirit dualism, and reductionism. Dualism is most apparent within the strong orthodox position, and least apparent within the fringe perspective.

With regards to pluralism, the orthodox perspectives range from a patent disavowal of alternative medicine's efficacy, to a willingness to incorporate proven alternative therapies into biomedical practice, to an enthusiastic endorsement of alternative therapies, and of alternative practitioners. Evidence for biomedicine's acceptance of alternative therapies is discussed after the orthodox model is presented. This discussion focuses on the ways in which alternative therapies are being integrated into the biomedical system, and the difficulties that arise from combining different healing models.

Strong Orthodoxy (elite)

The strong orthodoxy represents the most conservative ideological element within biomedicine. This perspective is associated with Wolpe's "professional elite": those members of biomedical systems who are in positions of greatest power and who thus have the most vested interest in maintaining the orthodoxy intact (1994:1136). The core around which the biomedical elite are assembled is science. Wolpe states:

Insofar as there is a modern orthodoxy that has usurped the place traditionally held by religion, it is science...The alliance of Western medicine with modern science...is so intimate that it is almost inconceivable to imagine a successful heretical challenge to biomedicine without a concurrent crisis in science as a whole (p. 1133).

As such, those medical professionals who are most closely linked with science – the academic physicians, medical researchers, journal editors, and medical association executive - tend to have strongly orthodox views.

Having said this, there are some important exceptions to this rule. In Canada, CMAJ Editor-in-Chief John Hoey is a cautious supporter of alternative therapies. Likewise, John Reudy, Dean of Medicine at Dalhousie University, is a supporter of integrating alternative therapies into orthodox practice.

Orthodox biomedical definitions of illness have been studied extensively, with several researchers agreeing that notions of experimental science are central to their formulation (Burns 1975; Salmon

1984:3; Berliner 1984:30; Hahn 1995:133). Engel (1977:130) describes the biomedical definition of illness:

It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioural dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behaviour, it also demands that behavioural aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes. Thus the biomedical model embraces both reductionism, the philosophic view that complex phenomena are ultimately derived from a single primary principle, and mind-body dualism, the doctrine that separates the mental from the somatic.

Gordon (1988:24) discusses the 'naturalist' philosophy which underlies biomedical ideology, agreeing with Engel's view of reductionism (which she terms atomism) in illness definition. Kirmayer (1988:59) concurs with Engel's claim for mind-body dualism within the biomedical model, yet more accurately describes this dualism in terms of the types of disease definitions and classifications used in medicine (either physical or psychological), and the importance given to direct observation of physiological pathology over subjective experiences of disease. Strict mind-body dualism, originating with Descartes' division of man into a material body and an immaterial mind, is a position that few, if any biomedical practitioners would defend. Today's orthodox scientists and medical practitioners subscribe to a monistic materialism which sees 'mental events' as being identical to physical events (Clark 1985), yet

which leads to primacy of the physical in mind-body interactions (somatopsychic etiology – Engel 1975:667).

The influence of Cartesian dualism can also be seen in the split between science and spirituality. For, as French (1969:127-128) notes, the Cartesian separation of mind and body was a separation of body from “rational soul”, and thus man’s spiritual essence was also separated from his extended (material) being. It has also been argued that the split between spirituality and medicine began in 400 B.C. when Hippocrates first denied the supernatural origin of epilepsy. Barton (1958:4) remarks that: “Hippocrates made a pertinent observation, saying, ‘It seems to me that the disease is no more divine than any other. It has a natural cause just as other diseases have. Men think it divine only because they do not understand it.’”

In spite of these early fissions between the worlds of spirit and medicine, they retained a close relationship until fairly recently. In colonial North America, diseases were interpreted in Biblical terms and associated with sin. Many doctors of the time were also ministers (Ibid., p. 5). Lella and Pawluch (1988:136-137), in recounting the history of medical anatomy, note that from the 16th to the early 19th centuries, dissection of the human body was bracketed by religious context. When working on the cadaver, anatomy instructors and students were engaged in a process of discovering the nature of God through his material creation. This close

relationship between science and spirit began to change in the 19th century, as can be seen in a remark to medical students from Sir William Osler (1903:26):

One and all of you will have to face the ordeal of every student of this generation who sooner or later tries to mix the waters of science with the oil of faith. You can have a great deal of both, if you only keep them separate. The wrong comes from the attempt at mixture (Quoted in Lella & Pawluch 1988:138).

Today, the strong and soft orthodox perspectives on spirituality are characterized by the issue's general absence from discourse. As such, spirituality is not included in definitions of disease, nor does it play a role in treatment.

Methods of treatment advocated by the strong orthodoxy derive from the biological basis of disease definitions. Therapeutic procedures should have a direct physiological impact on the biologically determined disease organism or structure, what Berliner (1984:30) refers to as "invasive manipulation". Therapies derived from this view include surgery, pharmacotherapy, transplants, implants, and radiation therapy. These therapies are based on an idea of bodies as machines wherein 'parts' can be 'replaced' or 'modified' (Williams 1997). The method for evaluating such therapies is the scientific method, and amongst the strong orthodox this equates to randomized, controlled, double-blind experiments of efficacy, combined with an understanding of the biological pathway involved in the treatment (Margolin, Avants & Kleber 1998). The extensive

use of technology in diagnosis and treatment is also a hallmark of strong orthodoxy, and said to be the result of a “technological imperative” in medicine (Koenig 1988).

Philosophers of science Clark Glymour, Ph.D. and Douglas Stalker, Ph. D. provide an example of strong orthodox ideology concerning treatment:

Medicine in industrialized nations is scientific medicine. The claim tacitly made by American or European physicians, and tacitly relied on by their patients, is that their palliatives and procedures have been shown by science to be effective. Although the physician’s medical practice is not itself science, it is based on science and on training that is supposed to teach physicians to apply scientific knowledge to people in a rational way (1985:21).

A similar strong orthodox view of medical practice is given in an editorial on alternative medicine by the senior editor and editor of JAMA, Phil Fontarossa, MD, and George Lundberg, MD:

There is no alternative medicine. There is only scientifically proven, evidence-based medicine supported by solid data or unproven medicine, for which scientific evidence is lacking (Fontarossa & Lundberg 1998:1618).

Patient management is viewed by the strong orthodoxy primarily as the application of curative interventions. Glymour and Stalker describe the therapeutic relationship in these terms:

The practice of medicine in the United States and in other industrialized nations is a form of consultant engineering. The subjects are people rather than bridges, but in many respects the professions of medicine and engineering are alike...If physicians learn relatively fewer generalizations that are entirely psychological or social in nature or that posit psychological mechanisms for

physical effects, the reason is not that such generalizations are alien to the “medical model” but that relatively few of them are applicable and scientifically warranted (1985:21-22).

In the strong orthodox model, psychological and social causes of illness are rarely “applicable and scientifically warranted”. This ideological conception of illness and treatment shows up in biomedical patient management in which emphasis is placed on laboratory and technology-assisted diagnosis and invasive biological intervention (Batt 1998). In today’s North American health care systems, the strong orthodox view of patient management is epitomized by the evidence based medicine movement, in which physicians determine the best course of treatment for their patients by combining individual clinical expertise and experience with research data gathered and synthesized through systematic reviews and meta-analyses (Sackett, Richardson, Rosenberg & Haynes 1997). Evidence-based medicine has its critics among the orthodoxy, though, as some doctors claim it to be “nothing but the thinly disguised worship of statistical methods and techniques” (Boba 1998:758). Criticisms of evidence-based medicine stem from the perceived limits of epidemiological data in treating individual patients, and the devaluing of clinical experience (Goodman 1999).

Advocates of a strong orthodox perspective on pluralism see a very minor role for alternative therapies or practitioners, if they are conceded a role at all. Stephen Barrett (1998:38-39), retired MD and leader of

Quackwatch, gives an example of a strong orthodox view of alternative practitioners:

“Alternative medicine” has become a politically correct term for questionable practices formerly labeled quack and fraudulent. The science-based medical community is committed to testing its theories and practices and developing a coherent body of knowledge. The “alternative” community is not. The scientific community is willing to examine new ideas but gives priority to those that appear most promising. However, this openmindedness of science is not emptyheadedness. Enough is known to conclude that many “alternative” practices are worthless.

In response to a recent article in the Canadian Medical Association Journal (CMAJ) which reviewed six common unconventional treatments for cancer, doctors Ian Tannock & David Warr (1998:802) state:

The publication of “A patient’s guide to choosing unconventional therapies” is a low point for both CMAJ and the Canadian Cancer Society (who allowed its logo to appear with the article). Here we have a major medical journal helping patients to access treatments for which there is no scientific basis or clinical evidence of efficacy. What shall we look for next? The CMAJ guide to Canadian witch doctors?... The series on unconventional therapies for cancer provides some useful background information, but it is a pity that it does not provide an evidence-based assessment of their clinical effects. The message is loud and clear: they don’t work.

Soft Orthodoxy (reformer)

Soft orthodox ideology concerning illness can be described by the biopsychosocial model of George Engels (1977). In this model, the tendencies toward reductionism and materialism of strong orthodox illness definitions are countered with a systemic view of disease etiology which takes into account social, psychological, and behavioural dimensions.

Many medical professionals have endorsed such a view of disease definition (Duhl 1980; Weil 1983; Gillett 1994; Stambolovic 1996; Lewinson 1998). Donald Fink (1980:327), MD, maintains:

With the developments in cell biology, psychosomatic medicine, and through more sophisticated clinical epidemiological investigations, it is now commonly recognized that no diseases have a single cause, and for the major health problems of our country, it is often hard to find even a dominant cause. Rather, illness is being seen as developing out of a subtle interaction between multiple forces within the host and external environment which together result in what comes to be recognized as a health problem, or even a "disease".

It is important to point out that the soft orthodox view of illness etiology contains all of the biological factors acknowledged by strong orthodox adherents; it is different in deliberately expanding the scope of factors involved in disease causation, and in giving substantially more weight to social, psychological, and environmental forces.

Proponents of soft orthodoxy view all illnesses as psychosomatic, in the sense that all disease processes are affected by psychological processes. (Weil 1983:56-57). As such, they are more likely to utilize therapeutic interventions on the psychological and social levels (Rabkin 1980). Such interventions are combined with conventional biological procedures, and their evaluation is still undertaken through scientific research (Gillett 1994). The soft orthodox approach to illness and treatment can be seen in the field of psychosomatic medicine.

Psychosomatic medicine deals with illnesses that "are characterized by

physical symptoms or dysfunctions in various bodily organs and systems that are intimately linked with psychosocial factors” (Gatchel 1993:1). Gatchel (Ibid., pp.4-6) traces the origins of this field to the early 19th century, when the work of physicians such as Benjamin Rush (1745-1813), and Claude Bernard (1813-1878) began to suggest that psychological states were the possible causes for many physical illnesses. Sigmund Freud (1856-1939) also contributed substantially to the field through his description of conversion hysteria, in which a psychological process was directly linked to a physiological state.

Later investigations of psychosomatic illness have focused on the impact of certain personality types or psychological conflicts (eg. repressed anger) on physical illness. Alexander (1950) studies the psychological influences on seven physiological disorders: peptic ulcer, ulcerative colitis, hyperthyroidism, regional enteritis, rheumatoid arthritis, essential hypertension, and bronchial asthma. Other important research focuses on “multifactorial” conceptions of infectious disease and the importance of environmental stress, psychological coping patterns, and disease dose (how much of a pathogen one is exposed to) have on etiology. Such conceptions have been put forth by Engel (1954), Dubos (1955), and Sternbach (1966), among others.

Recent advances in psychosomatic medicine have enabled researchers to posit the mechanisms by which psychology impacts on

illness. One of the most promising areas of study is psychoneuroimmunology, which focuses on interactions between the immune system, the central nervous system, psychological states, and disease processes. The immune system is a complex web of physiological processes designed to recognize foreign organisms within the body and to kill those invading organisms. The system functions through the activity of specialized cells produced in the bone marrow (*phagocytes, lymphocytes, antibodies*). Normally these cells kill foreign organisms, but in the case of *autoimmune* dysfunction, the immune cells begin attacking the body itself, as seen in multiple sclerosis (Palmbald 1981:230).

Research in psychoneuroimmunology involves both animal and human subjects. Generally, a stressor is applied to a subject group, and the effects of the stressor on immune function, and/or disease progression, is measured. From this research, it has been proven that psychological stressors affect immune functioning, and hence disease processes, via the central nervous system. From these results, researchers have demonstrated that there are two-way causal links between brain and immune system, and have thus dispelled a long-held scientific belief that immune function was autonomous from neural influence (Reilley, Fitzmaurice & Spackman 1981; Ader 1996). Robert Ader (1996:18), who coined the term psychoneuroimmunology in 1980,

feels that discoveries concerning the relationships between nervous and immune systems have gone a long way towards establishing the link between mental and physical processes. He writes:

Collectively, these relationships provide the foundation for previously observed behaviourally-induced alterations in immune function and for immunologically based changes in behaviour. They may also provide the means by which psychosocial factors and the emotional states that accompany the perception and response to stressful life experiences influence the development and progression of infectious, autoimmune, and neoplastic disease (cancer).

Other researchers also see a direct connection between the results of psychoneuroimmunologic research and medical practice. As Plaut and Friedman (1981:7) argue, many of the clinicians working in the field of psychosomatic medicine:

have expressed the hope that this multifactorial approach to disease would lead to changes in the attitudes of health care workers towards patients, so they would be seen less as objects and diseases and more as people living in a social context.

The patient management style of soft orthodox practitioners is generally based upon a multifactorial approach to illness in which patients are dealt with as individuals and their life circumstances taken account of in treatment and follow-up. Proper communication between physician and patient is central to this style, as is the caring aspect, or 'art' of medicine. An example of patient management from a soft orthodox perspective can be found in this talk given in 1927 by Francis Wald Peabody, a famous lecturer at Harvard Medical School:

Disease in man is never exactly the same as disease in an experimental animal, for in man the disease at once affects and is affected by what we call the emotional life. Thus, the physician who attempts to take care of a patient while he neglects this factor is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment... One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient (1980:67).

Peabody's words express several important aspects of soft orthodox views concerning illness, treatment, and patient management. All of these things are still based on the paradigm of science, yet the realms of psyche and emotion are included within the paradigm. As well, humanistic commitment on the part of the physician is held to be an important factor. Such humanistic concern is also a major ideological characteristic of the nursing profession, in which it has a long history and strong place among current professionals (Boutilier 1994; Watson 1980; McPherson 1996:254-255). Holistic patient management is one aspect of the soft orthodoxy which is spreading rapidly throughout North American biomedicine as a whole (Neufeld 1998), as studies continue to link more egalitarian patient-doctor relationships and increased physician communication with greater patient satisfaction (Wiggington-Cecil & Killeen 1997).

With regards to pluralism, soft orthodox ideology sees a definite role for alternative therapies and/or practitioners within health care. In an article on alternative therapies, Doris Milton, Ph.D., RN (1998), advises nurses to include alternative therapies in their practice either through

getting personal instruction in them, or by integrating alternative practitioners into referral networks. She encourages nurses to “explore alternative and complementary therapies both as a service to clients and as therapies they may incorporate into their personal health care” (1998:460). Similarly, CMAJ editor-in-chief John Hoey (1998:804), in response to an article attacking alternative therapy use in cancer treatment, states “What we need in Canada not a war between conventional and alternative medicine, but a collaboration”.

In 1996, the CMA annual meeting’s symposium on alternative medicine drew standing room only crowds. During the symposium Dr. John Reudy, dean of medicine at Dalhousie University, remarked that “the biomedical system is presumptuous in its denial of the validity of other treatments”. He also spoke about the changes in medical education which will need to occur as alternatives become more prevalent (Sullivan 1996:1330). The soft orthodox ideology concerning alternative practices and practitioners has been called *integrative medicine* (Kent 1997:1428) and constitutes a growing ideological narrative within biomedicine today.

Fringe Orthodoxy (heretic)

Members of the ideological fringe in medicine hold varied beliefs concerning illness, treatment and patient management. In general, they are similar to that of the medical reformers, yet more inclusive of spiritual

factors in illness etiology and treatment. The concept of *psychogenesis* (the belief that psychological factors can cause illness) (Gatchel 1993:4) is prominent amongst the fringe. In addition, they may also grant illness causing power to 'subtle' or spiritual energies. A major difference between the fringe perspective and the strong and soft positions is that the former maintain the etiological and therapeutic importance of factors which mainstream science has yet to explain. Thus, the healing powers of mind, spirit, and energy are invoked, even though there is no widely-accepted basis for their effects.

It is important to note that proponents of the fringe perspective generally utilize the standards of empirical science to evaluate therapies based on unexplained theories. (although the definition of such standards can vary widely) (Pelletier 1980). The continued importance of science in fringe orthodox perspectives can also be seen in books by holistic MD's Deepak Chopra (1988) and Larry Dossey (1988), in which they frequently cite research in psychosomatic medicine and quantum mechanics to support their alternative arguments. This combination of alternative theory and science can be seen In James Gordon's (1996:198) Manifesto for a New Medicine, where he ends his section on Traditional Chinese Medicine by stating: "We are living out the next step in the evolution of Chinese medicine, working to find new and useful ways to marry ancient therapeutic wisdom and modern scientific medicine."

Conceptions of subtle energy are common in fringe beliefs concerning illness and health. The belief that a vital energy underlies all matter is expressed by Richard Moss, MD, in the Black Butterfly (1987), and Shakti Gawain (1985), author of the popular psychology book Creative Visualization. Gawain describes this modern version of vital force:

The scientific world is beginning to discover what metaphysical and spiritual teachers have known for centuries. Our physical Universe is not really composed of any 'matter' at all; its basic component is a kind of force or essence which we can call *energy*.

Things appear to be solid and separate from one another on the level at which our physical senses normally perceive them. On finer levels, however, atomic and sub-atomic levels, seemingly solid matter is seen to be smaller and smaller particles within particles, which eventually turn out to be just pure energy. (1985:5)

Gawain's description of energy reveals a sense of radical connection between things, including human beings, which we normally consider physically distinct. This notion of fundamental unity is also echoed by Larry Dossey (1982:80), who utilizes the concept of the "biodance" when describing physical reality:

From the level of the electron to that of the stars and galaxies, modern physics points to a unity of matter and its environment. This interaction is so intimate that matter and its surrounding environment cannot any longer be considered separate entities.

Man, in his in-between world, situated in size between the electrons and the galaxies, also cannot be considered separate from his environment. Our oneness with the universe is manifested in the biodance, the endless flow of chemical elements between the human body and its environment.

Some members of the orthodox fringe also believe that illness and health are completely personal, a much stronger version of the soft orthodox view of “treating patients as people”. Holistic medicine advocate James Gordon, MD, (1996:58) states:

Maybe every person’s illness is different from everyone else’s. Perhaps my gallbladder problems, even my pneumonia, are different from yours. Not in the sense simply that my interpretation of my condition or my reaction to it is different, but that in some radical, deeply biological way, it is different enough to make a real difference. Not only that, it can be different from one hour to the next, and different depending on who assesses it.

This individualism has implications for treatment, as Gordon reveals:

The diagnostic entities and statistical norms that dominated my medical education were indeed only relative truths based on statistical averages. The excessive reliance on tests and lab values might be subversive not only of a close doctor-patient relationship and of clinical judgement, as I had suspected, but also of a precise scientific understanding of the person a doctor is supposed to help (Ibid., p.62).

Such strong views of patient individuality are often matched by therapeutic regimes which are oriented towards individuals, not diseases. These regimes can be quite similar to those advocated by soft orthodox practitioners, with behavioural, psychological, and physical interventions combined, but differ in the use of metaphysical or spiritual treatment methods. Goldstein, et. al. (1987) found that members of the American Holistic Medical Association (AHMA) reported use of mainstream therapies like physical exercise and counseling at comparable levels with family practitioners; however, AHMA’s reported using significantly more

spiritual healing and meditation therapy in their practice. Wolpe (1990:919) refers to spiritual treatments as rituals, and notes that: "Some holistic MD's pursue these rituals in pure form, abandoning biomedical treatment altogether and becoming spiritual or psychotherapeutic healers". Belief in the healing powers of spirituality leads some fringe practitioners to posit cures which occur entirely via spiritual means. An example of such a cure is described by Richard Moss (1987:1-2):

It was the second day of the conference. For several hours Laura had been singing a childhood hymn, repeating it over and over. Suddenly the quality of her singing changed. She felt as though she were no longer singing. She was the song. She found herself lifted to her feet, her arms raised towards the sky, her head arched upwards. She said her hands did not end at her fingertips, but continued into the air and sky. The air and sky were alive, and she and they were the same. Her feet seemed to disappear into the earth. Earth, feet, body, arms, sky, song, singer – all were one living being. Laura did not consider what was happening, it just took over her. She was the experience.

The next day her terminal liver cancer was gone. The grapefruit sized bowel metastasis that she had supported with her hand was gone...In the ensuing weeks, all the secondary complications of her diabetes and cancer – kidney failure, fluid in her lungs, tumor-ridden lymph nodes, partial blindness, loss of sensation in her hands and feet, addiction to pain medication – healed.

Patient management in fringe orthodoxy often involves establishing a state of "wellness" as opposed to simply curing disease (Fink 1980).

Jerry Johnson, occupational therapist and author of *Wellness: A Context For Living* (1986:10-11) describes a "wellness model":

Within the perspective of the wellness model, a person is viewed as an integral part of a system (ie., is influenced by and in turn influences the environment in which he or she lives, works, and

plays). A breakdown requires examination by both the health professional and the patient of the patient's problems and goals, of the systems within which the patient functions, and of the interrelationships between the patient and these systems.

Movement from a state of illness to a state of wellness is usually referred to as *healing* or *caring*, and distinguished from *curing*, which is the job of orthodox medical practice (Watson 1980; Myss 1988:130-132).

A controversial aspect of fringe orthodoxy concerns the notion of personal responsibility for health. MD Tom Ferguson(1980:393) outlines a "self-care movement", and relates it to holistic health:

If holistic health represents a change in the philosophical basis of health care, self-care represents a change in the basic patterns of responsibility and decision making... But while self-care and holistic health are not identical, it is important to note that they are not antithetical. Holistic health proposes that our health system needs a new map. Self care suggests that the wrong person has been holding the map.

The importance of taking responsibility for one's health is a theme raised by other holistic medical practitioners. In discussing nutrition, James Fadiman (1980:252) states: "The goal within the holistic model is not to come up with an ideal diet but to encourage persons to gain control over their eating...". MD James Gordon (1980:xi) writes that "a holistic approach views the patient as an individual person, not as a symptom-bearing organism. This attitude emphasizes the self-responsibility of the person for his or her health and the importance of mobilizing the person's own health capacities...".

The notion of taking personal responsibility for one's health has been criticized on two grounds. First, critics have argued that the ideas of personal responsibility put forth by holists fail to take into account those circumstances which are beyond individual control. Daniel Wikler (1985:143) writes: "In the context of holistic medicine, the difficulty is that the notion of personal responsibility for health will be understood as grounds for blaming the victim, exonerating the environmental factors that made him sick, and excusing medical intervention that failed to restore health." The other criticism is that exhortations toward increased personal responsibility for health can be used by governments as an excuse to cut back on publicly funded health care provision. Salmon (1984:258) makes such an argument:

To the extent that the populace believes health problems result mainly from personal behaviours, demands for health care as a basic right can be, and in fact are being, undermined in this period of economic contraction. This ideological notion serves a political use in justifying federal cutbacks and instituting greater cost-sharing. In other words, why should public monies be used to provide medical care to people who are not taking better care of themselves?

Fringe ideology concerning pluralism sees alternative therapists as full members of the health care system and advocates for their legality and coverage under medical insurance plans. However, many nurses and doctors appear to be advocating the use of alternative therapies more than the equal recognition of alternative therapists (Baer, et. al. 1998:536). As

a result, those espousing truly fringe views of medical pluralism are probably a minority within the minority of holistically-minded professionals.

The Trend Towards Integrative Medicine

Examining the perspectives present within orthodox medicine serves to highlight the different ways in which medical values and beliefs are interpreted by medical professionals. However, the narrative of science which defines the medical model is present throughout its discourse, in strong, soft, and fringe groups. Although medical professionals with strong and fringe orthodox perspectives might argue about what is the most important defining characteristic of illness, or what constitutes the most efficacious method of treatment, they share a set of common assumptions and a common language that serves to define their argument.

Professional divisions and specialties within professions both have a great impact on interpretations of the medical model. George Engel's biopsychosocial model is less radical coming from a psychiatrist than it would be coming from a professor of internal medicine or surgery. Within the fields of psychiatry, psychology, and psychosomatic medicine (which bridges several disciplines), medical professionals have been working with concepts of holism and psychosocial etiology for many years. Conversely,

the field of internal medicine is seen as more concerned with strong orthodox conceptions of illness and treatment (Hahn 1995:174).

Differences in value and belief concerning alternative therapies are also apparent between medical specialties and between different health care professions. Tovey (1997), performed a study involving 546 unorthodox medical practitioners (homeopaths, chiropractors, herbalists, reflexologists) in the U.K., in which the practitioners were asked to report on the nature of their encounters with various biomedical professionals. The professional groups used were medical consultants, general practitioners, hospital doctors, nurses, occupational therapists, and pharmacists. Tovey found that 78% of alternative therapists encountered either a significant level of interest or genuine enthusiasm towards their practice by nurses. Conversely, only 17.6% of medical consultants and 13% of hospital doctors showed the same levels of interest. General practitioners were in the middle, with 43.6% showing significant interest or genuine enthusiasm. Tovey interprets this data as suggesting that a status related schism exists within the orthodoxy in its relation to alternative therapists. Higher status professions are less inclined to work with alternative practitioners, while lower status professions (general practitioners, nurses) are more inclined to.

Tovey also had the alternative therapists in his study report on whether they noticed an increased or decreased willingness in medical

professionals to work with alternative practitioners. In response to this question, the alternative therapists reported an increased level of acceptance across all of the biomedical professions listed in the study. This result provides some evidence of alternative medicine's growing acceptance within biomedicine, and is echoed by a Canadian study by Verhoef and Sutherland (1995). In this study, attitudes towards alternative practitioners (AP's) were measured in 82 Ontario and 118 Alberta general practitioners (GP's). The researchers found that fully 56% of GP's believed that alternative medicine has ideas and methods from which conventional medicine could benefit. As well, 54% referred to AP's, and 16% practiced some form of alternative therapy themselves.

Increasing acceptance of alternative therapies is leading to their integration into biomedical institutions. This integration can take four forms. In the first, the AP becomes a legitimated member of the health care system in that they have access to biomedical institutions and are covered under government or private insurance plans. Chiropractors in Canada and the U.S. are an example of this first form of integration. In the second form, termed *association*, AP's are brought within the biomedical system through referrals. In these situations the AP's retain their professional autonomy from biomedicine and are not brought fully within its legitimating institutions (hospitals, insurance plans). Examples of this form include such practitioners as naturopaths, homeopaths, and polarity

therapists. In the third form, alternative practitioners are *absorbed* into the biomedical system in a legitimate, yet subordinate position. An example of the third form of integration is midwifery. Finally, the fourth form of integration, more accurately termed *incorporation*, sees the alternative therapy co-opted by biomedical practitioners. An example of incorporation is the growing use of acupuncture by biomedical GP's in North America.

Different forms of integration are currently taking place in the North American biomedical system, and encountering varying degrees of resistance and acceptance on the part of the orthodoxy. Alternative practitioners are being integrated into educational institutions, as seen in the Canadian Memorial Chiropractic College's affiliation with York University (Johnson 1999). Other such mergers have failed, though, as when the British Columbia Institute of Technology attempted to teach degree courses in naturopathy and Traditional Chinese Medicine. Their proposal met with strong resistance from the British Columbia Medical Association (BCMA), causing the Institute to back down (Johnson 1999a). In British Columbia, Traditional Chinese Medicine has become a regulated health profession, and might soon be included under the province's health insurance plan (Johnson 1999b). Naturopaths are already covered under provincial insurance (Johnson 1999b).

A large amount of integrative efforts concern the incorporation of alternative techniques by biomedical practitioners. The growth of this

incorporation can be seen in the many holistic professional associations which have emerged across North America. The American Holistic Medical Association (AHMA), formed in 1978, consists of doctors who embrace holistic principles and utilize alternative therapies in their practice. The organization has a regulatory body, the American Board of Holistic Medicine, which certifies physicians as holistic practitioners. In 1996 the AHMA claimed 600 members (Caplan & Gessler 1998:190). These figures do not approach the total number of U.S. physicians practicing alternative medicine, though, as it has been estimated that there are between 3000 and 5000 MD's practicing acupuncture alone (Greene 2000).

In Canada, the Canadian Complementary Medical Association (CCMA) was formed in 1996 by Nova Scotia MD William LaValley (Gray 1997). Today, the association has approximately 200 members. As well, the Ontario Medical Association has a complementary medicine section which also claims 200 members (Ibid 1997). Nurses have also formed holistic associations. The American Holistic Nurses Association (AHNA) was formed in 1981, and now claims 3000 members (AHNA 2000). In Canada, the Canadian Holistic Nurses Association (CHNA) was formed in Vancouver in 1986, and claims a membership of 100 nurses (Petersen 1996:30).

In Canada, alternative therapies are being increasingly utilized in hospital settings (Elash 1997), and in private practices (Swanson 2000; Kent 2000). In 1996, the Tzu Chi Institute, Canada's first centre for evaluating alternative therapies, opened in Vancouver. The institute was primarily funded by a Buddhist charitable organization, but also receives annual funding from the University of British Columbia, the BC Women's Hospital and Health Centre, and the Vancouver Hospital Foundation (Kent 1997). In the U.S., the National Institute of Health opened an Office of Alternative Medicine in 1993. The OAM started with a yearly budget of 2 million dollars and a mandate to scientifically evaluate alternative therapies so that those proven effective could be incorporated into mainstream medicine. Today, renamed the National Council on Complementary and Alternative Medicine, its yearly budget has risen to 68.7 million dollars (NCCAM 2000).

Alternative therapy use by biomedical practitioners has also come to the attention of government licensing and regulatory bodies and medical schools. In the U.S., the Federation of State Medical Boards is developing country-wide guidelines for the practice of alternative therapies by physicians. More than 20 states have already approved laws which allow such practice (Greene 2000). In Canada, an Office of Natural Health Products is being formed by the Federal Government in order to regulate herbal remedies and other natural health products (Sibbald 1999). In the

U.S., herbs are regulated under the Food and Drug Administration (Niendstedt 1998:34-35).

Medical schools in both Canada and the U.S. are beginning to include information courses on alternative therapies in their undergraduate curricula. Ruedy, Kaufman & MacLeod (1999) interviewed representatives of all 16 Canadian medical schools. They found that 13 of the schools had undergraduate courses in alternative medicine, while two schools actually taught the practice of alternative therapies. In the U.S., Wetzel, Eisenberg & Kaptchuk (1998) surveyed all 125 of the country's medical schools to assess the prevalence of courses on alternative medicine. Out of 117 responding schools, 75 reported offering elective courses in alternative medicine. According to the Rosenthal Center For Complementary and Alternative Medicine (RCCAM:1999) at the University of Columbia, 36 U.S. medical schools teach courses in how to utilize alternative techniques.

The number of medical journals dealing with alternative and complementary medicine is another indicator of integrative medicine's growing presence within biomedicine. Journals focusing specifically on alternative therapies include: Alternative Therapies in Health and Medicine, the Journal of Alternative and Complementary Medicine, the Journal of Holistic Nursing, Holistic Nurse Practitioner, Complementary Therapies in Medicine, the Journal of Integrative Medicine, the Journal of

Complementary Therapies and Nurse Midwifery, and the Scientific Review of Alternative Medicine.

From these examples, it is apparent that integrative medicine is a growing trend in the North American health care system. While holistic MD's and nurses continue to form a minority within their professions, their numbers are increasing, as are the numbers of institutions taking an interest in alternative therapies. The probable reasons for this growth can be attributed to three important trends. First, there is the holistic health movement, which has gained momentum in North America since the 1960's and 70's, and has influenced many biomedical professionals and many more lay people (Molgaard & Byerly 1981:153-154; Salmon 1984:252-258; Gordon 1984). As Salmon (1984:8-9) notes, the holistic health movement heralded a renewed interest in unconventional therapies that included sectarian practices (naturopathy, homeopathy), traditional medicines (native American, shamanistic healing), and Eastern practices (TCM, Ayurveda). As well, through its focus on taking personal responsibility for health, the movement has led to a greater interest in self-treatment among the lay community.

Another major trend influencing the integrative medicine movement is the perceived "crisis in medicine" (Waitzkin 1983; Rachlis & Kushner 1994; Armstrong, et. al. 1994) which concerns the rising costs and decreasing health returns of biomedicine. In Canada and the U.S., health

care expenditures as a proportion of gross domestic product (GDP) have been rising steadily over the past forty years. In 1960, both countries allocated about 5.3% of their GDP towards health care, whereas in 1991, Canada's health care spending had increased to 9%, while the U.S.'s had increased to 13.3% of GDP. In comparison to other Organization for Economic Cooperation and Development member countries, in 1991 the U.S. spent the most on health care, with Canada in second place (Angus 1998). These numbers indicate a substantial increase in financial investment in health care, leading governments in both countries to advocate for cost-control measurements. In the U.S., cost-control initiatives have included legislating the creation of health maintenance organizations (HMO's), prepaid group practices (PGP's), and professional standards review organizations (PRSO's). These three structural innovations are intended to control costs through coordinating health resources, changing the medical fee structure to a fixed yearly amount paid per patient, and encouraging peer cost – control amongst health care providers (Waitzkin 1983:220-222).

In Canada, the development of a publicly administered health insurance system has allowed governments to enact more direct cost-control measurements. Due to public administration, bureaucratic control has increased over health care policy, as financial analysts have taken the place of medical professionals in management positions. (Blishen

1991:129-131). Federal control over health care costs has taken the form of changes to health care funding, in which open-ended funding of provincial insurance plans was replaced by block payments linked to the GDP. As well, with passing 1984's Canada Health Act, the government made extra-billing by physicians (charging fees above those covered by provincial health insurance) illegal (Crichton, Tsu & Tsang 1994:218).

Provincial governments have control over how federal funding is applied to health care, and have enacted rationalization measures concerning hospital funding and human resources management (*Ibid.*, p.220). In Ontario, these measures are being coordinated through government committees on health services restructuring, which are concerned with ways of integrating health delivery systems for greater cost control and effectiveness (Skelton-Green & Singer 1997).

In Canada, through the perceived fiscal crisis in medicine, and government attempts at cost control, the self-regulatory powers of health care professions have been substantially decreased. Conversely, the policy-determining power of patient's rights movements has been made much stronger, as governments are more directly influenced by public advocacy groups (Blishen 1991:145-154). Blishen (*Ibid.*, pp. 145-154) also refers to an increased awareness of medical issues amongst lay people, which has led to the de-mystification of medicine, and the further destabilization of professional authority. The greater power of lay people

to determine health policy, at a time when they are increasingly turning to alternative therapies, can lead to significant pressures towards integrating alternatives into medicine.

The second aspect of a perceived medical crisis, the decrease in health returns, can be attributed to two causes. Ironically, the first cause relates to the substantial successes of modern medicine, and its creation of unrealistic expectations within Western societies. Vaccines and antibiotics have led to virtual elimination of most infectious diseases, including smallpox, diphtheria, poliomyelitis and tuberculosis. As well, improved surgical techniques and advances in medical technology have led to such “heroic” life-saving procedures as coronary bypasses, heart transplants, and kidney transplants (Lewinshon 1987: 1264-1265; Crichton, et al. 1994:67). Lewinshon (Ibid., p.1265) remarks: “There is no denying...that the advances of medical science in the past hundred-odd years, in terms of basic knowledge as well as practical benefits, have been prodigious.” However, with the modern prevalence of chronic illnesses, and medicine’s inability to combat the spread of AIDS, the ability of biomedicine to “solve most, if not all, the problems of disease”, has been shaken (Ibid., p. 1266).

The changing disease profile in industrialized nations has seen life-style related illness, particularly cardiovascular disease and cancer, become the leading causes of morbidity and mortality (Burkitt 1978). In

Canada, heart disease remains the leading cause of death, but has been declining since the 1960's. Cancer is the second leading cause of death, and has been slowly rising since the 1960's, with variable patterns for specific cancers. Deaths from lung cancer in men and women, breast cancer in women, and skin cancers for both sexes have been the fastest growing (D'Arcy 1998:43-46; National Cancer Institute of Canada 2000). These conditions are less easily cured by biomedical means, thus leaving room for alternative therapies to be utilized in illness management. Evidence for this exists in pediatric oncology in Canada; a recent study involved surveying the families of 583 pediatric patients concerning their use of a broad range of alternative therapies (naturopathy, homeopathy, herbal medicine, TCM, relaxation, imagery, massage). Out of 366 respondents, 42% used some form of alternative or complementary therapy for either curative or symptom-management purposes (Fernandez, Stutzer, MacWilliam & Fryer 1998).

The large numbers of lay people who utilize alternative therapies, in particular the money being spent on such use, can be seen as a third major force driving integration. With considerable amounts of money being spent out of pocket on alternative treatments – an estimated 13.7 billion dollars in the U.S. in 1997 (Eisenberg, et. al. 1998), and an estimated 3.8 billion dollars in Canada in 1995 (Ramsay, Walker & Alexander 1999) – the incentive for biomedical professionals to

incorporate alternative practices is economically compelling. Dr. Wah Jun Tze, founder of the Tzu Chi Institute, had an Angus Reid poll done of Vancouver residents in which 89% of respondents said they would use an alternative medical centre. Remarked Tze “physicians cannot afford to ignore this level of interest” (Kent 1997:1427).

Despite high levels of alternative therapy use among lay people, and their increasing acceptance among medical professionals, there is still resistance to integration on behalf of the orthodoxy. Much of this resistance focuses on the “unscientific” nature of alternative healing models, their ineffectiveness, and their incompatibility with the medical model. In a 1997 policy document the AMA states:

(1) There is little evidence to confirm the safety or effectiveness of alternative therapies. Much of the information currently known about these therapies makes it clear they have not been shown to be efficacious. Well-designed, stringently controlled research should be done to assess the efficacy of alternative therapies. (2) Physicians should routinely inquire about the use of alternative or unconventional therapy by their patients, and educate themselves and their patients about the state of knowledge with regard to alternative therapy that may be used or contemplated. (3) Patients who use such therapies should be educated as to the hazards that might result from postponing or stopping conventional treatment.

A similar perspective is put forth by Dr. Arnold Relman, editor-in-chief of the New England Journal of Medicine, during a 1999 debate with Dr. Andrew Weil, director of the University of Arizona Program on Integrative Medicine. Relman states:

In my view, integrating alternative medicine with mainstream medicine would not be an advance but a return to the past, an interruption of the remarkable progress achieved by science-based medicine over the past century. I can't see how such integration, even if it were possible, would improve medical care or further the cause of human health. What is more, considering all the dubious and disparate theories and practices gathered under the banner of alternative medicine, I don't see how our medical schools could make sense of such a hodgepodge, much less unify it with conventional medicine. Most alternative systems of treatment are based on irrational or fanciful thinking and false or unproven factual claims. Their theories often violate basic scientific principles and are at odds not only with each other, but with current knowledge of the structure and function of the human body as now taught in our medical schools (Dalen 1999:2).

The AMA policy statement and Relman's comments on integration reveal the difficulties inherent in combining different models of healing. Within these two statements can be seen the defining narratives of the medical model – science and healing, and the ways in which they are inextricably linked. In both statements, the lack of scientifically-proven effectiveness for alternatives not only makes them useless in the act of healing, but also potentially harmful if used in place of genuinely “efficacious” treatment. As well, Relman points out the impossibility of combining the medical model with “irrational”, “fanciful” beliefs that “violate basic scientific principles”. In the face of such strong resistance, one might ask how alternative healing models become integrated at all?

Therapeutic touch practitioners posit a healing model which appears wholly on the alternative side of what Relman terms the “wide philosophical gulf between alternative and conventional medicine” (Ibid.,

p.2). Yet in spite of this, TT has managed to create a foothold within biomedical discourse and institutions. As an alternative healing group originating within biomedicine, TT has been particularly confronted by the problems of combining disparate belief systems put forth by Relman. In the language of Wolpe's (1990:914) heresy model, the heretic "faces a difficult challenge. Though he challenges the orthodoxy, his allegiance to the discourse must not be impugned, or he loses his privileged position from which to dispute the orthodox ideology." Despite the incentives towards integration occurring from outside of biomedicine, alternatives must still find their way into the medical model in order to become accepted. In the next two chapters, I examine how TT proponents and critics have negotiated this acceptance. Through the heretical drama of the TT debate, the process by which alternative and medical models are defined, challenged, and defended is revealed.

Section 2: The TT debate as heretical drama

Chapter 5: Setting the Stage

“Heresy”, Wolpe (1994:1136) states “in a profession as in a church, is a dramaturgical phenomenon. It takes place at a moment in a profession’s history, builds in a series of claims in a moment of crisis, and then fades into long-term resolution.” In the case of TT, the values and beliefs of its proponents constitute a challenge to the medical model which cuts across professional boundaries. TT originated as a heresy within the discourse of nursing, yet claims for and against TT are made by nurses and doctors, and lay people play roles on both sides of the debate. As well, the healing model of TT proponents directly challenges the biomedical narratives concerning the centrality of science in healing and the separation of science from spirituality. For these reasons, the heretical drama of TT plays on a wider stage than that of the nursing or medical professions. It plays against the entire discourse of biomedicine.

As mentioned in the introduction, a challenge must come from within the ranks of the orthodoxy to be labeled heretical; a criterion which TT fulfills due to its origins in nursing. Wolpe (1994) also gives two other

necessary conditions for heresy, that it must not be an act of the discourse's elite, and that it must draw from the same language base as the orthodoxy. The first condition emerges because, as Wolpe states "when the elite makes claims (or accepts claims made by others) against the traditional ideology, it is not considered heresy, but revelation" (1994:1135). By definition, heresy is a challenge from an area of little power within the orthodoxy. This challenge seeks to either usurp the power of the elite to define the discourse, or to modify this definition in a direction favourable to the heretic.

TT is more prominent in the elite within nursing than it is in the elite of the entire discourse of biomedicine. Evidence for this comes from the fact that TT studies are frequently published in nursing journals by nurse researchers with advanced degrees, and several nursing organizations (Canadian Nurses Association, College of Nurses of Ontario, Registered Nurses Association of British Columbia, National League of Nurses, North American Nursing Diagnosis Association) recognize TT as a nursing therapy (although they do not officially endorse or promote the practice and its attendant theories).

It is important to note that although TT has more presence among the elite in nursing, practitioners do not make up a majority of nurses. According to the Canadian Institute of Health Information (2000) there were 228,450 practicing registered nurses in Canada in 1999. As

mentioned in the introduction, exact numbers of TT practitioners are impossible to determine. However, the number of practitioners claimed by Canada's regional TT networks (by network estimates approximately 1500, 1200 in Ontario, half of which are lay practitioners), suggests that nurses who regularly practice TT represent a small minority within the profession. Accurate practitioner numbers in the United States are equally unknown, but as NH-PAI claims only 1200 members, it can be assumed that TT practicing nurses represent a similar minority of the professional population. For these reasons, TT fits Wolpe's first criteria both within nursing and within the larger realm of biomedical discourse.

The second criterion for an ideological challenge being heretical, that it must draw on the same language base as the orthodoxy, refers to a particular problem which the heretic faces. As part of a discourse, the heretic cannot betray the defining narratives of that discourse, to do so is to risk being labeled an *apostate*. Apostasy leads to exclusion from the discourse, and in the case of biomedicine would entail a healing model which departed from the primary goals of healing (curing and/or caring for illness in human beings), or which denied the importance of science in achieving these goals. Other beliefs which might invite accusations of apostasy would be those that stress the importance of spirituality in healing. Due to the rigid definition between science and religion within most strong and soft orthodox perspectives, a belief system that is

perceived as spiritual or religious can be excluded from the medical community – deemed to be a matter of *faith*, rather than of *medicine*. The concept of apostasy is important in understanding the process of heretical challenge, as each side accuses the other of betraying the ideals of the discourse, while attempting to avoid such characterization at the same time. In essence, each is committed to a process of justifying that they hold the true nature of the discourse within their belief system, while attempting to portray the other as betrayer of the discourse.

The problem which apostasy presents to the heretic is that the orthodoxy, by its institutional dominance, controls the language, concepts, and practices of the discourse. Thus, in order to avoid the charge of apostasy, the heretic must present their challenge using the language of the orthodoxy. They usually attempt to do this by drawing on the orthodoxy's own history in order to support their claim. Similarly, they tend to utilize minor narratives already present within the orthodox model, or to capitalize on tensions or inconsistencies present within it (Wolpe 1994:1135). In the case of TT, proponents utilize the narratives of larger discursive levels (the primary goals of healing, biomedical beliefs in the importance of science), yet also use narratives particular to the discourse of nursing (conceptions of the science/art balance in nursing, professional ideology), and to their own discourse (energetic healing, spirituality in health care). The process of legitimation generally involves presenting

narratives of the heretical discourse as aspects of narratives from greater discursive tiers. This can be seen in claims by practitioners that TT represents the “essence” of nursing or healing.

As will be seen in the drama’s unfolding, statements made by TT proponents meet Wolpe’s third criteria for heresy. Proponents express and defend their healing model using strategies of legitimation that draw heavily on the language and authority figures of the orthodoxy. As well, they make claims concerning the true nature of the discourses of nursing, biomedicine, and health care that utilize marginal themes within the orthodoxy’s defining narratives. These marginal themes mainly concern the idea of health care as art (healing, caring) and the importance of spirituality in healing.

Integration

The heretical characteristics of TT’s healing model can be explained through its integration of alternative and biomedical world-views. Through examining the historical circumstances surrounding TT’s creation, I intend to contextualize the therapy’s heretical character and to reveal the origin of some of its alternative influences. TT emerged during a period in which many North Americans began to question the way in which medicine was practiced and structured. The counter-culture which emerged during the 1960’s and 70’s also gave birth to the holistic health

movement (Molgaard & Byerly 1981; English-Leuck 1990:111-118). As mentioned in the introduction, this movement took a much broader view of health that involves economic, social, psychological, environmental, and spiritual components (Salmon 1984:254-257). Along with a broadening of health definitions, the holistic healing movement also included elements of distrust for authority prominent within the counter-culture (Molgaard & Byerly 1981:153-155; English-Leuck 1990:111).

New Age thought also had a large impact on healing practices during this period, as spiritual and healing focused “growth centers” began to appear across the U.S., beginning with the Esalen Institute in 1962, and leading to an estimated 300 such center’s in 1974 (Heelas 1996:53-54). The influence which New Age thought had on healing was to focus it more on internal, spiritual transformations, and the responsibility of individuals for their own health. Heelas (1996:82) describes ‘classic’ New Age healing as “anti-authoritarian self-spirituality.” He notes:

The basic idea is simple. The spiritual realm is intrinsically healing. Healing comes from within, from one’s own bodility-as-spirituality / energy; from one’s own experience of the natural order as a whole... The crux of the matter, it then follows, lies with getting in touch with the spiritual realm. One works to remove those ‘blocks’ which are disrupting energy flows; or one practices affirmations. Whatever the method, though, the dis-eased person is primarily responsible for the process of healing. The Self has a key role in healing the self.

Heelas describes the role of the New Age healer as being a guide, or facilitator of another’s inner healing. He states: “In the detraditionalized

and anti-authoritarian world of the New Age, the healer clearly cannot have the same kind of authority exercised by the conventional, science-informed doctor, the person who draws on an established body of knowledge.”; instead, he argues:

the authority of many healers rests on their claims to be spiritual. Their spirituality entitles them to make judgements, the entitlement logic running ‘at heart, we are all spiritual beings; I am in closer contact with my spirituality than you (I am healthy, you are diseased); since we both belong to the same spiritual realm, I speak with your inner self when I suggest that you do this and that; instead of speaking as an external voice of judgement I speak as your guide (Ibid., pp. 82-83).

There is evidence from the claims made by TT practitioners that the New Age conceptions of healing described by Heelas play a large role in the TT healing model; this evidence is presented in the following section.

Other evidence for New Age influences on TT’s healing model comes from Krieger’s writing. In The Therapeutic Touch: How to Use Your Hands to Help or to Heal (1979:10), she notes:

Dora and I were invited to a conference in Council Grove, Kansas, that was sponsored by the Menninger Foundation and the Association for Transpersonal Psychology. It happened that about eight or nine of us were into healing of one kind or another, and so Elmer Green, Ph.D., Director of Research at Menninger’s and the prime mover in the Council Grove Conferences, asked us if we would be willing to take part in a small study. Dora, Jack Schwartz, who is a well-known psychic, and I volunteered...

The transpersonal psychology movement was founded on the work of such thinkers as C.G. Jung, Fritz Perls (the developer of Gestalt therapy) , Wilhelm Reich (the developer of Orgone therapy, in which the body’s

inherent wisdom is utilized in healing), and Carl Rogers (Rogerian psychotherapy), and is described as a manifestation of New Age thought by Heelas (1996:53). Krieger's association with the transpersonal psychology movement, as well as her study participation with a "well-known psychic", indicates involvement with holistic/New Age communities.

A direct source of New Age influence on Krieger came from Dora Kunz, a prominent Theosophist, who first instructed Krieger in the laying on of hands. Kunz, in turn, was said to have been tutored by Charles W. Leadbeater, whom Krieger (1979:4) describes as "one of the great seers of the 20th century." In his book on Theosophy, Bruce Campbell (1980:191-192) gives an account of Leadbeater's beliefs concerning spiritual energy:

Leadbeater had taught that higher beings are pouring down streams of force on the world. He claimed that one of the chief ways in which this force reaches the world is by being poured through individuals who are willing to act as passive channels, or 'pipes.'

As will be seen in the upcoming discussion of TT's healing model, Leadbeater's account of accepting higher forces is very similar to descriptions of channeling "universal healing energy" given by several TT proponents.

Krieger's integration of New Age influences into biomedical practice is indicative of heresies. Wolpe (1994:1137) notes that "Heretics tend to be people who have affiliations or adopt ideologies outside of the

orthodoxy, and then attempt to reconcile or blend the two". Often, this integration involves an experience of dissonance on behalf of the heretic, in which personal experience of a alternative model or practice contradicts previously held conceptions. Evidence for such a process can be seen in Krieger's description of her encounters with Kunz and Estebany. In speaking about Kunz, Krieger (1999:3) writes:

In my own background I had taught research at the graduate level in a university, and so my observations of her had a certain rigid marshalling of "facts", from which I expected logical answers. And so, imagine my surprise when, time after time, I had to admit to myself that Dora's way of problem-solving or of perceiving states of illness, for which science has no answer or understanding, were as purposefully under control as any I knew how to devise.

Similarly, in describing her first experience studying Estebany, she remarks:

To a casual observer it might have appeared that nothing was happening. However, a significant number of these patients got better. Most of them had verified medical histories and had been referred by physicians who, when the patients returned for follow-up examination, confirmed their improvement. Nothing in my previous experience had prepared me for these findings, so I decided to study therapeutic touch in considerable detail (Krieger 1980:367).

In this sense, Therapeutic Touch can be perceived as Delores Krieger's attempt to reconcile the practice of spiritual healing with the profession of nursing, and with biomedicine as a whole. Other proponents claim that personal anomalous experience precipitated their practice of TT. For some, they learned the therapy after receiving TT treatments and experiencing benefits from it. One lay practitioner that I interviewed for the

study, Stephanie, has TMD (a painful disease affecting the muscles of the jaw). TT treatments by a friend helped reduce her pain and prompted her to begin practicing. RN Linda Woznica began practicing TT after a neck injury she sustained in a car accident was helped by the therapy (Elabdi 1997:18). Several other of the interviewed practitioners, while starting TT courses out of curiosity, remarked that they became convinced of the therapy's validity because of their experience with it. A common statement was "you could just see that it works".

The importance of personal transformative experience in the belief systems of TT proponents suggests the influence of New Age conceptions of self-transformation and self-healing. The importance of personal experience in relation to TT is also apparent in the "conversion stories" which practitioners tell. Amongst the practitioners I interviewed for the research, most of them described experiences where they had given treatments to skeptics in which the skeptics emerged as "believers" of TT's effects. These stories reflect the privileging of personal experience over "rational" knowledge which is a central characteristic of TT's healing model.

Crisis and Critique

Wolpe (1990) states that the heretical drama generally begins with the occurrence of a *theodicy* within a given discourse. Nelson (1972:66 –

cited in Wolpe 1990:916) defines theodicy as “the problem that arises within a belief system when the individual’s experience involves suffering which the system fails to accommodate”. Essentially, the theodicy represents a “crisis of faith”, in which one’s current model of reality ceases to account for one’s experience. Within biomedicine such a crisis of faith would involve questioning the usefulness or appropriateness of the medical model in the act of healing. Theodicy in the discourse of science can be described by Kuhn’s (1970:92) notion of shifting paradigms, in that “scientific revolutions are inaugurated by a growing sense...that an existing paradigm has ceased to function adequately in the exploration of an aspect of nature to which that paradigm itself had previously led the way.” This “growing sense” is precipitated by anomalous events experienced by individual members of the discourse (such as experimental results that defy explanation by the current paradigm, or that contradict its fundamental laws). As a result of the paradigm’s deficiency, Kuhn writes “In both political and scientific development the sense of malfunction that can lead to crisis is prerequisite to revolution.” (Ibid., p.92).

Kuhn’s “revolution” occurs when the existing paradigm is replaced by a new paradigm which resolves some or most of the areas of dissonance within the discourse (Ibid., pp.11-12). In the case of heresy, such a paradigmatic revolution has yet to occur within the greater

discourse in which they participate, although the heretic does claim that the discourse is in a state of “crisis” which necessitates revolution. Wolpe characterizes this attempt as the *heretical critique*, in which the current orthodoxy is charged with responsibility for the paradigmatic crisis. Through analyzing the rhetoric of TT proponents and other holistic health advocates, their attempts to portray a “crisis in health care” are apparent. In addition to arguing for this perceived crisis, they also blame orthodox medicine for its inception.

The TT movement evolved amidst a wider critique of biomedicine being made by holistic health advocates. In 1978, a year before Krieger’s first book on TT, the American Holistic Medical Association was formed, composed of physicians critical of the orthodox paradigm and committed to ideas of holistic care (Caplan & Gessler 01998:190-191). Three years later, the American Holistic Nurses Association (AHNA) was formed (AHNA 2000). Around the same time, two collections on holistic medicine were published: Hastings, Fadiman & Gordon’s (1980) Health for the Whole Person: The Complete Guide to Holistic Medicine, and Randolph Flynn’s (1980) The Healing Continuum: Journeys in the Philosophy of Holistic Health.

Gordon (1980:3-27) opens Health for the Whole Person... with a strong polemic against biomedicine’s dangerous use of drugs, inability to treat chronic illness, and denial of social, psychological, and spiritual

aspects of illness and health. TT proponents can be seen to engage in a similar *heretical critique*, as they argue for a crisis within health care and blame the orthodoxy for it. The critique put forth by proponents is similar to what Stambolovic (1996:601) terms “the heresy of Modernity”, which he characterizes as “a comprehension that the limits of science, the official dogma of Modernity, are too narrow to encompass the totality of human experience”. The critique is also similar to the more medicocentric “holistic heresy” posited by Wolpe (1990:915) and defined as:

...a philosophy of practice that generally emphasizes the primacy of the doctor-patient [healer-patient] relationship, the importance of psychological, social, and spiritual factors in health and illness, the acceptability of nonconventional modalities of treatment, and the responsibility of the patient for participation in the health process.

Krieger (1979:16) asserts that “the therapeutic use of hands...appears to be a human act; however, it is an act that we have all but forgotten in this scientific age in our adulation of things mechanical, synthetic, and, frequently, inhuman.” Similarly, in 1981, she writes:

Human beings have always found meaning in their personal interactions (their oneness) with the universe. The exception to this is found within the rigid, dualistic world view of Cartesian philosophy...the Cartesian philosophy and a mechanistic view of the world have been routinely accepted in the Western world until recently. That this Cartesian view of a dichotomy of mind and body is not appropriate to the study of human beings can be inferred by the increasing reluctance of contemporary scientists to continue in that mold (Krieger 1981:ix).

Krieger further attacks the model of materialist, reductionist science:

The dramatic advances in technology that characterize the twentieth century have enabled us to conceive beyond the level of mere organized common sense...However, as scientists now delve in depth into previously unexplored and unquestioned territories of research, their findings throw a veil of doubt over traditional materialistic methods of scientific inquiry. In an increasingly sharp shift we now begin to recognize that we 'forgot' to include a living context for all our logical discernments. We forgot that in living nature it is the *plan of the whole* to which its subsystems relate (1981:3).

Krieger states that the conventional theories and methods of science are "not appropriate" for studying human beings. She links this limitation of science to limitations in scientific medicine, as in 1993 when she writes: "Why so much interest in Therapeutic Touch? Part of the answer, I believe, lies in our continuing ignorance about the causes of many human illnesses in spite of our high-tech expertise" (Krieger 1993:6). The statements made by Krieger and other holistic health proponents argue for a crisis within the discourse of health care (people are not being cured or healed of their illness, or illnesses are not being prevented), while blaming this crisis on the biomedical orthodoxy (their scientific, dualistic, reductionist tendencies). Other TT proponents have launched similar polemics against orthodox medicine. The president of the Canadian Holistic Nurses Association (CHNA), Betty Petersen, opens her article "The Mind-Body Connection" by stating: "Fed up with a system oriented more to illness than to wellness and with quick fixes like popping pills, a growing number of health care consumers are turning to non-invasive

complementary therapies to help achieve personal wellness” (1996:29).

Peterson finishes her introduction by noting:

The late Dr. Norman Cousins indicated that “...up to 90% of patients who reach out for medical help are suffering from self-limiting disorders well within the range of the body’s own healing powers.”...Writes Larry Dossey in his book *Healing Words*: “Physicians inadvertently kill tens of thousands of people annually via the unanticipated side effects of drugs and surgical procedures” (Ibid:30).

Although TT proponents engage in an heretical critique of orthodox medicine, the critique of TT is different from that proposed by Wolpe (1990:916), who maintains that “a heretical movement rarely paints its opponents in terms of benign neglect. As Louis Feuer has suggested, movements must choose an opponent that is branded as ‘evil’, that justifies extreme measures, against which the movement’s goals are seen as just and good.” The critiques presented by TT proponents, while constituting attacks on its legitimacy, are different in that they also stress the complementarity of their practice with orthodox medicine. This position labels the orthodoxy *deficient*, not *evil*, and calls for the *modification* of orthodoxy, as opposed to its complete overthrow. Examples of the complementarity inherent in TT’s critique can be found in In Touch, the official publication of the TTNO.

In one issue, a nurse discussing TT use in geriatric settings states:

I am not claiming that medications are useless, but they definitely can’t give a person a feeling of “self worth”. I am not intending to infer that only we [TT practitioners] do it right. The great majority of

people who work with the elderly are dedicated and caring (Malec 1999:14).

The In Touch editor in 1997, May Bant, describes TT's healing potential:

When our body's healing system is overwhelmed by illness, we are not able to protect ourselves and we display symptoms of 'dis-ease'. We need help to reactivate our immune system and unblock our natural healing process. We have the Power to Heal within ourselves. Frequently, a combination of conventional methods (eg. Drug therapy or surgery with complementary practices) will return our systems to improved health. Then preventative methods (relaxation and stress management) can stimulate our healing response and increase our quality of life (Bant 1997:2).

A particularly clear example of TT's complementary position is a discussion between practitioners concerning a woman who was treating her daughter's abdominal pain with TT, only to find that the therapy's analgesic effects were covering up acute appendicitis. The doctors had ruled out appendicitis due to a lack of discomfort in the girl, but upon the urging of the mother, they examined her again, identified the problem, and performed life-saving surgery. One of the practitioners commenting on this situation said:

I think that our situation is an excellent example that TT is to be used complimentary to the medical community, and not as an alternative. The ending, for Tamara [the daughter], could have been unfortunate. Be proud of your expertise, but keep the lines of communication open (Will 1999).

TT's complementarity was also a common theme presented by the nurse practitioners whom I interviewed. A long-time TT practitioner and associate professor of nursing at McMaster University, when asked how

she would envision a reformed health care system, replied:

I would still have the traditional, by the North American meaning of traditional, health care workers. I think we need that. Each person contributes a piece, but I would love to see all of the different practitioners working together with the client.

Another nurse practitioner mentioned:

When we learn TT, we're always taught that TT doesn't replace traditional medicine. If we were treating a person with cancer, we would encourage them to keep on with their chemo, or radiation, or drug therapy, or whatever it is that they're taking. This is a compliment to it. So, I wouldn't say.... it compliments traditional medicine, it would never replace it.

TT's combination of critiquing biomedical orthodoxy while at the same time acknowledging its benefits can be interpreted in different ways.

In one sense TT's complementary stance can be seen as an astute strategy designed to propagate its heresy without engendering too much hostility from the discourse's elite. In fact, there is some evidence that proponents think this way, and the strategies that they use to manage the language of TT's challenge are examined in Chapter Six.

Another reason for the stance of TT practitioners towards the orthodoxy is simply because they are *of* the orthodoxy. In the biomedical system, TT is largely practiced by nurses, who, as mentioned in the introduction, have much less professional freedom than do physicians. There are signs that this is changing. In the United States, the role of nurse practitioner has led to more control over practice (Moloney 1992:183-206), and in Canada similar changes to the nursing role are

being contemplated (Thompson 1997), but have yet to be realized.

Despite these changes, nurses continue to occupy a position of lesser power within the biomedical system than does the medical profession.

Crichton, Tsu & Tsang (1994:78) discuss nursing's position within the Canadian health care delivery system, noting: "Unlike physicians, who determine to a large degree their own working conditions as fee-for-service practitioners, nurses have to cope with working conditions set by hospitals and other employers." Similarly, Armstrong (1993:46) asserts: "Nurses remain subordinate to doctors. Doctors' authority is justified on the basis of their responsibility for patients and their superior knowledge. Yet nurses are held accountable, in spite of having little control over patient care or their own working conditions." TT practitioners who are also active nurses are bound by these same institutional relationships, which could influence their complementary stance towards biomedicine.

Another factor influencing TT's complementary views arises from the education of nurse practitioners within biomedical schools. Although the relationship between the discourses of nursing and biomedicine is complex, and involves different visions of health care (nurses as 'carers', doctors as 'curers')(Wicks 1995), nurses have also gained from this relationship, and recognize both the political and practical utility of scientific medicine (Lynn Smith 1988:99-101; Moloney 1992:45-70). For

these reasons, the narratives of biomedicine permeate the discourses of nursing and TT.

The Heretical Model

Wolpe (1990:917) mentions that an heretical critique “paves the way for the introduction of an ideology to replace the orthodoxy’s.” He further asserts that: “The heretical ideology is drawn as much as possible from existing strains in the discourse, strains usually ignored, slighted, or marginalized in the orthodox ideology” (Ibid., p.917). In examining the healing model of TT’s proponents, it is apparent that their definitions of illness, treatment of illness, and approach to patient-healer interaction fall within the biomedical fringe. In some cases, these ideas border on apostasy, as the importance of science in medicine is fundamentally challenged, and spirituality is given a primary role in health care. In the area of pluralism, TT’s model is a blend of fringe and soft orthodoxy, as alternative therapies are embraced by proponents, but approached with a co-optive intent, rather than a truly pluralistic intent.

The discursive themes which TT practitioners emphasize in their healing model focus on the ‘art’ of health care, and as such represent an interpretation of the fundamental healing narrative. What makes the interpretation of TT different from that of the biomedical orthodoxy is the importance they give to the amelioration of suffering and its concomitant

humanist aspects, such as caring, compassion, and spirituality. As can be seen in the presentation of TT's model, and the analysis of strategies used to argue it, proponents also utilize the narrative of science. However, their interpretation of the narrative is different from that of the orthodoxy in that it renders prominent marginal themes and subordinates the rational theory behind healing processes to measures of their empirical effectiveness.

Definition of Illness

Definitions of illness given by TT proponents constitute one of the areas of intense variation in language and interpretation within this group. Some practitioners put forth statements which equate illness with disturbed energy fields and seemingly indicate a belief in 'energetic etiology' – illness caused by energy imbalance. In her first article on TT in the American Journal of Nursing (AJN), Delores Krieger (1980:368) argues for TT's effects based on the Yogic concept of *prana*. She remarks: "Eastern literature states that the healthy person has an overabundance of prana and that the ill person has a deficit. Indeed, the deficit is the illness." She relates similar views in her first book on TT:

The consensus concerning why the person is ill is most frequently stated in terms of there being an imbalance of energies; some say that the ill person is in disharmony with the universe or with a God or Gods; others say that there is a disequilibrium between the *yin* and the *yang* factors in the individual, and so on. My next step is simply to accept these statements as valid, both on the basis of general concurrence of opinion and because these same reasons have been

stated by many people of authority who come from far-flung corners of the Earth (Krieger 1979:57).

A similar view of illness as energetic imbalance is given by RN Rochelle Mackey (1995:27). In an article in AJN, she states: "For practitioners of therapeutic touch, illness is an imbalance in this energy field or a disruption in the energy flow." TTNO recognized teacher Barbara Janelle (2000:11), in an issue of In-Touch, writes: "Congested energy reduces flow through the field and adversely affects field function. From an energetic standpoint, physical problems are primarily the result of an energy deficit." Similarly, RN Barbara Daley (1997:1125) writes in the Journal of Advanced Nursing: "The TT perspective postulates that a healthy person has a balance between inward and outward energy flow, with illness being the result of an imbalance or disruption in this energy field or flow." One of the nurse practitioners I interviewed, when asked to define illness, replied "Being imbalanced. Being ill is having an imbalance in the body's energy, or an imbalance in your well-being". The concept of energetic etiology can also be found in the North American Nursing Diagnosis Association (NANDA) who have included "energy field disturbance" as a recognized nursing diagnosis. They define the diagnosis as "a disruption of the flow of energy surrounding a person's being which results in disharmony of the body, mind, and/or spirit" (NANDA 1994:37).

Definitions of illness which equate it with energetic imbalances and which postulate physical pathology arising from such imbalances are firmly within the orthodox fringe, as they give disease-causing power to unseen, un-measurable forces. Such claims invite comparisons to Mesmerism by the strong orthodoxy (Rosa, Rosa, Sarnier & Barrett 1998:1006; Courcey 2000:2); because they lack scientific support, they also skirt apostasy. However, not all proponents equate illness with energy imbalance. Some make statements which indicate that disease *leads* to an imbalance in the energy field, an example being RN Jane Simington's (1993:23-24) description of the field: "When a person is in a state of wellness, the waves emitted are smooth and warm. During times when the physical, psychological, or spiritual well-being is threatened, the wave-like emissions become "ruffled", "hot", or "cold". Several proponents leave out discussions of energy entirely when discussing illness, instead describing it as an imbalance in one's body, mind, or spirit. Such views were common amongst the TT practitioners I interviewed for this research, and fit into common fringe or even soft orthodox conceptions of illness.

Treatment Methods

The ambiguity concerning proponents' definitions of illness and their conception of how illness relates to energy fields also extends to conceptions of the healing act. In discussing two explanatory paradigms

for TT's effects, proponent and researcher Therese Meehan (1998:119) notes: "In neither framework is the concept of 'energy field' precisely defined." Meehan also notes that there are discrepancies between proponents concerning the exact mechanism by which practitioners use energy to heal:

Some writers state that TT involves direction of the practitioner's own excess energies for use by the person who is being treated, seeming to imply that the healing energy is a human characteristic alone. However, according to Kunz and most other literature, the practitioner's role as an instrument for a universal healing energy is a fundamental and inviolable assumption (Ibid., p.119).

These differences in interpreting the mechanism of TT's effect lead to differences in how practitioners describe the treatment process.

Statements seem to fall into the categories suggested by Meehan, with nurses either maintaining that healing takes place by an interaction between two personal energy fields, or saying that healing involves being a channel for external energy sources. The discrepancy between beliefs in how TT operates may come from statements made by Krieger (1993:46) which seem to integrate both perspectives:

To heal another person, in one sense the healer interposes his or her own energy field between the healee and the illness. From another point of view, however, the healer sensitively draws upon the universal energies that are the backdrop to all living events and within which both healer and healee are figures sharing a unitary nature..

Examples of statements which fall into Meehan's first category describe TT strictly in terms of the energy fields of patient and healer.

Simmington (1993:24) states: "Another human being can restore balance [in the field] by intentionally smoothing the ruffling that is felt just beyond the skin and by directing energy to areas of depletion (cold) and away from areas of congestion (hot)." In a study of TT on post-operative pain

Meehan (1993:71) describes treatment as :

...a knowledgeable and purposive patterning of nurse-environmental / patient-environmental energy field process in which the nurse assume(s) a meditative form of awareness and use(s) her hands as a focus for the patterning of the mutual patient-environmental energy field process.

An Example of a practitioner who focuses more on being "an instrument for a universal healing energy" is TT instructor Chery Ann Hoffmeyer, who states that the intent of TT is to "act as a conduit for beneficial energy" (Elabdi 1997:18). Similarly, Mackey (1995:28) explains "when you use Therapeutic Touch, you're not using your energy. You're simply the conduit through which a healing universal energy is directed toward the recipient." For many practitioners in this category, TT's practice takes on definite spiritual, and often religious significance.

Recognized teacher Barbara Janelle (2000:20) suggests:

...our primary role as Practitioners in TT [is] to ask as clearly as possible for help from the Infinite Source of Love for the receiver. For me, it is becoming very clear that TT is a form of prayer.

Regular in touch columnist Grant Hallman (1999:6) describes his experience of the treatment process:

To Center is to open within oneself a direct channel to God; this channel having infinite width and zero length. It is all the prayers I have ever said or will ever say, expressed in silent and complete understanding. It is like coming home.

The conceptualization of TT treatment as a process of asking help from, or opening up to, a universal, spiritual, and all-pervasive energy source has led some practitioners to argue for its effectiveness in treating people who are unconscious, or who are not in the presence of the practitioner. Janelle (1999:7) writes:

With centering, comes the acknowledgment of the spiritual essence of the receiver, and on some level, the receiver remembers the magnificent spiritual self. This call to remember who they are and why they have come to live this life is most profound in the cases of comatose patients where TT has nudged many patients to return to consciousness and to living life.

Similarly, in a 1993 talk by Delores Krieger at the University of Toronto she instructs:

To perform TT on unconscious people ... you need to reach them with your mind and the emotions. Align your *chakras* with the patient – try each one and if you make contact on one level then go to the next one... Once you reach the highest level of awareness, then stop at that place and use that as the place where you do TT. (summarized by Kaszuba 1993:6)

Although Krieger talks about reaching out to the unconscious patient with “mind and the emotions”, she then directs the healer to align their *chakra*’s with those of the patient - a process of linking subtle energy centers with definite spiritual qualities.

Distance healing is described in an [In Touch](#) article:

Living out in the country and many miles from family and friends I practice Therapeutic Touch through distance healing. Through my clear intent and visualization, I bring forward an image of the person sitting in front of me, and then do an assessment of their energy field. I have been amazed by the results and how I can actually feel where the energy is blocked in their field. On many occasions, I send Distance Healing Therapeutic Touch while I am lying in a tub full of very warm water; that is when I feel the other person's energy so much stronger (Ethier 2000:13).

Barbara Janelle, in discussing distance healing in In Touch, mentions its advantage as being able to offer TT to a group of people simultaneously, or to a place or an event. She also mentions "that because we enter a timeless and spaceless realm in doing TT, I believe it is possible to offer long-distance treatments to the past as well as to the future, simply by setting that as an intent" (1999:17)².

The energetic and spiritual practices of TT which take place at great distances, defy accepted conceptions of linear time, or which affect people who are not aware of treatment, are arguably outside the realm of even fringe orthodoxy. These aspects rule out any possibility of currently known placebo or psychoneuroimmunologic effects and thus rely completely on TT's energy field theories. Because it is almost universally acknowledged by proponents and critics that these theories have not been proven scientifically, this enables critics to seize on these aspects as signs of TT's apostasy. However, there is a demonstrated effort on behalf of several

² There has been some research to support distance healing effects – see Astin, Harkness & Ernst (2000).

proponents to validate TT's effects scientifically. This is attested to by the large amount of research that has been done on the therapy by nurses and other proponents, beginning with Delores Krieger's initial studies on hemoglobin (Krieger 1972; 1974a; 1974b), and continuing with research performed by Quinn (1984; 1989), Quinn & Strelkauskas 1989), Meehan (1993), Meehan, Mersman, Wiseman, Wolff & Malgady (1991), and Heidt (1981; 1990; 1991).

A full review of the therapeutic touch literature is beyond the scope of this thesis, however it is useful to point out that research results concerning the therapy's efficacy remain equivocal. Reviewers of the literature have interpreted it widely. Clark and Clark (1985) critique early studies of TT, including Krieger's hemoglobin studies, and Heidt's 1981 study on anxiety, concluding: "In the final analysis, the current research base supporting continued nursing practice of therapeutic touch is, at best, weak" (p. 294). Meehan (1998), a cautious proponent of TT, reviews literature including all of the above-mentioned nurse studies and concludes that TT's effectiveness in reducing anxiety and relieving pain is inconclusive. She argues that "it seems clear that TT is intrinsically interrelated with the powerful placebo effect.", a statement which contrasts with TT's energetic hypotheses.

Mulloney and Wells-Federman (1996) performed an extensive review and conclude that evidence for TT's effects on reducing stress,

pain, and anxiety are equivocal, but that the therapy can be effective for wound healing. Ramnarine-Singh (1999), in a limited review of six TT studies measuring pain, anxiety, and the relaxation response, concludes that there is evidence of the therapy's effectiveness in these areas, with a need for further research. Linda Rosa and Larry Sarner (1998), members of anti-TT organization The National Therapeutic Touch Study Group, performed an extensive search of TT literature and concluded "no well-designed study demonstrates any health benefit from TT" (Rosa, et. al. 1998:1009). In a recent systematic review of prayer, distance healing, and non-contact therapeutic touch studies, it was shown that 13 out of 23 moderate to well controlled studies showed positive treatment effects, including 7 out of 11 TT studies examined (Astin, Harkness & Ernst 2000)³.

While the large number of published TT studies have not provided unequivocal evidence of its clinical effectiveness, or of its energetic theories, the research produced by TT proponents can be interpreted as an attempt at scientific legitimation on behalf of proponents. Other evidence for proponents seeking to scientifically validate TT come from the structure of TT organizations, almost all of which have a "research

³ One of the most extensive reviews of TT research to date was conducted by Larry Sarner and Linda Rosa (Rosa, et. al. 1998), in which they accumulated 853 published reports on TT from between 1972 and 1996. Out of these reports, 83 concerned clinical research of TT's effectiveness.

chair” whose job it is to keep abreast of current scientific studies on the therapy and make them available to network members (NH-PAI 2000; TTNO 2000). In Touch has a research section in each issue where summaries of TT and related research are given. Proponents’ efforts to justify TT through science are also seen in the public debates over the therapy, and will be discussed further in chapter 6.

Part of the difficulty in coming up with coherent and accurate descriptions of TT proponents’ beliefs concerning illness and treatment arises from the very real differences which exist in their interpretation of the therapy. From spending time with TT practitioners in a level one training workshop, a practitioners’ support group, and a TT-based cancer support group, I found that the differences exhibited in statements concerning TT translated into differences in its practice. Moreover, these differences appear to be tolerated, to a point, by TT’s ‘elite’ - its founding members, network executives, and recognized teachers. Delores Krieger, in a 1993 talk in Toronto, advises TT practitioners that “one will learn more from oneself than from any teacher as the individual is actualizing the self’s resources” (summarized by Baker 1993:7).

Tolerating, and even encouraging personalized interpretations of the therapy seems to be an important part of TT’s ideology, which relies almost completely on subjective, intuitive sensation in assessing and treating illness, and which values personal ‘knowing’ over formalized

knowledge. However, as mentioned in chapter one, there are elements within TT that are moving towards standardizing and organizing the practice. These elements act to curb the variation within TT's ideology through censoring inappropriate statements made by members. The attempt of TT proponents to regulate their own ideology and practice is also discussed in chapter 6.

There is much less variation in the claims for treatment that TT proponents make. The majority are psychological or psychosomatic in nature, with relaxation being the most common effect mentioned. A nurse practitioner I interviewed says of her patients "it relaxes them"; another describes her patients experiencing "Feeling more relaxed, decreased pain, more positive emotion". A nurse practitioner working in a neonatal unit describes using it on her niece when she was an infant: "I always got a real nice relaxation response from her. She would be crying and we would be unable to settle her and then I would come and give her a few moments of TT and she would just go limp." Other effects of treatment are claimed; one lay practitioner I interviewed said that her clients "feel that they can have control over their treatment". Easing of anxiety and opening of communication channels are also effects attributed to TT. In her article in AJN nurse practitioner Rochelle Mackey (1995) describes TT's usefulness in several situations, including helping a dying patient come to terms with his illness, helping a mother bond with her premature infant,

and helping a patient recently diagnosed with cancer to overcome his anger and fear. The predominantly psychological and psychosomatic nature of TT's claimed effects are consistent with fringe orthodoxy.

Patient Management

In terms of patient management, which includes the goals of treatment and the nature of the therapeutic relationship, TT's healing model again places it within the orthodox fringe. TT practitioners claim to be pursuing a goal of *wellness* or *well-being* in their patients, expressed as a balance in their body, mind, and spirit, and gained through a process of *healing*, as opposed to *curing*. The therapeutic relationship created to facilitate these goals is quite different from that of the strong or soft orthodoxy, and involves the formation of an intimate spiritual and emotional bond between practitioner and patient.

Many proponents make a distinction between the processes of healing and curing. As described by TT practitioners and recipients, two major effects are said to result from the healing process. One, mentioned by all official TT sources (NH-PAI 2000; TTNO 2000; Pokoradi 1999), is that the body's natural healing forces are bolstered, leading to more effective physiological responses to wounds or diseases. A second effect was mentioned by interviewed practitioners who work in palliative care, gerontology, and oncology, and consisted of the ability to be mentally,

emotionally, and spiritually healthy in the face of intractable physical illness. Curing is said to be the domain of traditional biomedical interventions, and is often associated with the medical profession.

Two nurse practitioners whom I interviewed gave examples of the distinction between healing and curing. One nurse's view of the two processes emerged during a discussion of her TT practice:

...I work with a lot of cancer patients, and they're more relaxed and more comfortable after the practitioner has worked with them. We're healing them, we're actually not curing them. That's what our goal is, is to give them relaxation which will reduce their pain level if they're having pain. They're coping better with what's going on. And I think that's what some of the problem is with people who are the critics, is that they think we're trying to cure them, but we're not. That's not our aim.

Is this a distinction between healing and curing?

Yeah, curing is what medical people want to do.

How would you define that?

Free of disease. They can cut it out, they can burn it out, or whatever. Healing, the person can die...but they're healed. Y'know, they're at peace with what's going on."

Another nurse practitioner and recognized TT teacher describes the TT process:

...it's not illness-based. You're not looking at the organ in particular. You're looking at the overall well-being of the person, so you have to remember your outcome. It's healing, not curative. If you've got cancer and you're looking for TT treatment, you're not out to cure the person's cancer. You're out to relax them, to maybe help with their nausea, maybe to help them sleep better, just to sort of be the best they can be within their given situation. So to say that that works less well, than a headache that you can fix and make it be gone, I think is misleading. I don't think that one is better than the other or more effective than the other. Which one made a difference to the person's wellness? Both did. Which one is of more value? Well, maybe the guy that has the cancer who can sleep tonight

without puking, maybe that's a bigger improvement than someone who had a headache, but who's going to be fine tomorrow. You can't really base it on disease.

Recognized teacher and cofounder of the TTNO, Crystal Hawk (2000), describes the concept of wellness, and further distinguishes between the goals of TT and those of biomedical interventions:

Now you see, wellness is just not on the same continuum as disease. TT practitioners are not on the continuum of disease. We're on a continuum of wellness. When someone is very sick and goes to the doctor, you try to get them back to just where they were, whereas the continuum of wellness involves more consciousness, conscious behaviour. We can go in to see someone who is dying and who has some spiritual aspect to them and ask: how are you feeling, and they can feel very well... TT demands such a different point of view, such a different shift that I don't see how it integrates, how it functions at all with definitive medical practice as it's practiced today with drugs, with cutting.

From the above statements, a picture emerges of the goals of TT treatment. From them, we can see how these those goals compare to those of conventional medicine. RN Mary Simpson (1997:21) states: "In Therapeutic Touch recovery is viewed as "whole person healing" that involves the client from a holistic perspective – body, mind, emotions, spirit, and his/her environment." Healing does not attempt to eliminate disease organisms or processes, rather it attempts to engender a positive psychological, emotional, and spiritual state (well-being) within the ill person. In the case of treatable illness, such a state is said to facilitate the curative process. In the case of terminal illness, well-being can mean a peaceful death.

When Crystal Hawk contrasts the continuum of wellness with the continuum of disease, she is highlighting the way in which proponents appeal to narratives within the greater discourse of health care to explain and legitimate their practices. The state of wellness and the process of healing represent aspects of narratives within the health care discourse, and which are present, yet marginal within biomedical discourse. By postulating a “continuum of disease”, or a process of biologically-based “curing”, proponents are showing how the orthodoxy only represents a portion of the entire domain of health care. This use of narratives concerning health care to simultaneously legitimize TT and criticize biomedicine is explored in greater detail in chapter 6.

The healer-patient relationship in TT is considerably different from that found in most orthodox medicine, where the focus is on diagnosing diseases and administering curative therapies in a context of expert-client relations. In TT, patient and healer are seen more as equal partners in an intimate, spiritual act. One of the nurse practitioners I interviewed describes a “typical” treatment:

There’s always this feeling of calm. It’s a very special time...And there’s this real connection between me and the client. Even if you’re not talking or not touching, you’re just really working together, and you feel this...There’s very little distraction because you really get into it, the client and you, and everything...you work so together.

Barbara Janelle (1999:7) describes the centering phase in TT:

Centering with compassion for another leads to unexpected and wondrous things. Both feel connected. This touches the sacred truth that "All is One". I frequently hear TT students and practitioners say, "I will never see that person (the receiver) the same way again. I will never be able to feel separate from, hostile towards or superior to that person again.

Similarly, practitioner Jim Prudhom (1998:7) relates his experience of centering:

The visualization of my centering started to change. I would still begin with a point inside me, but with the concept of an infinitely expanding sphere growing outward from my initial centre, and the same thing happening to the receiver, our centres would become the same. In fact, this would also be happening with every point in the universe. In this visualization, every centre becomes the same centre: every point becomes the same point. The receiver, the universe...and I, become one.

Finally, Delores Krieger, in an address given to the Green Mountain Oncology Group in 1994, notes:

As a healer you will find that you have stepped into another, often unrealized dimension of yourself. This realm, however, is a real world of personal exploration, with its own sense of quietude, timelessness and implicate order: a domain that permits a profound level of communication between healer and healee (Krieger 1998:13).

The healer-patient interactions described by proponents appear mystical in nature and indicate the development of a strong emotional connection between the practitioner and the client. The strength of this connection seems greater for the practitioner; however, proponents also claim that TT creates intense bonding on the side of the patient. Crystal Hawk (2000) states:

This bonding between people, I mean, its incredible. A mother does TT for her baby, or people in a family do TT with each other, there is a bond that is so incredible. My grandchildren run to me, they might love me, but they don't even know why they run to me, that bond has been created so young by doing TT over and over again. It is incredible, incredible sensing communion at some level which people don't even understand. When I do TT with somebody at a workshop, I mean they kind of follow me around the whole time afterwards (laughs).

Strong emotional bonds are also developed in clinical encounters involving orthodox biomedical practitioners. Miller (1992) studied visits to two family practitioners and classified them as either "routines", "dramas", or "ceremonies". Visits classified as "dramas" were defined as "those clinical encounters occurring over time and involving conflict(s) or intense emotion, or both" (Ibid., p.291). These visits included "bad news" diagnoses and visits involving family discord, and often led to *ceremonies* in which "The physician sometimes invoked the covenantal and parental image of priest". However, Miller also points out that dramas and ceremonies, those clinical encounters which involved intense emotional interaction between physician and patient, are a small portion of the cases seen by family physicians. Most of the cases are *routines* characterized by "the rapid use of a presumed mutually acceptable biomedical protocol applied in prescriptive fashion to an everyday primary care problem" (Ibid., p.291). The relationship between TT practitioner and patient is different in that strong spiritual and emotional bonding is the goal of every encounter.

Pluralism

Practitioners of TT take a view of pluralism which can be viewed as fringe orthodox in some ways, and soft orthodox in others. TT nurse practitioners are open to alternative or complementary therapies in that they will incorporate them willingly into their nursing practice. Lay practitioners are similar in their enthusiasm for alternative therapies, as evidenced by the many lay people I encountered at the TT training session, practitioner support group and cancer support group who also took classes in Reiki, acupuncture, Jin Shin Do, Yoga, and Qi Gong. In this sense, TT proponents are great campaigners for alternative therapy use within biomedicine. However, it is unclear how proponents view the more politically loaded side of pluralistic health care, in which fully licensed alternative practitioners would provide competition to nurses and other biomedical professionals. From the nurse practitioners I interviewed for this research, and from the written statements and actions of proponents, it appears that TT might actually encourage a soft orthodox view of pluralism, wherein alternative therapies are co-opted by biomedical practitioners. This approach to alternative therapies has been termed *integrative medicine* (Clark 2000; Weil 2000:4-7).

The openness of TT proponents to all manner of alternative therapies is readily apparent. Therapeutic Touch itself was created by Dolores Krieger's co-opting of spiritual healing and meditation into nursing

practice. She has proven to be a supporter of other alternative modalities as well, publishing a book Foundations for Holistic Nursing Practices (1981) in which she assesses healing practices drawn from shamanism, Traditional Chinese Medicine, and Ayurveda, along with several modern practices such as hypnosis, biofeedback, iridology, and chiropractic. In the book, the application of these practices to nursing are discussed in articles written by such prominent TT proponents as Janet Macrae, Patricia Heidt, and Janet Quinn.

A willingness to incorporate alternative therapies remains a characteristic of TT practitioners today. The practitioners I interviewed and interacted with regularly use visualization, hypnosis, reiki, shiatsu, and acupressure in their treatments. The Nurse Healers – Professional Associates International describes its mission as “to lead, inspire, and advance Therapeutic Touch, *other healing modalities* and healing life ways for the world community.” (NH-PAI 2000, emphasis mine). In the pages of In Touch can be found advertisements for workshops in Thought Field Therapy, Yoga, Huna (Hawaiian shamanism), and healing sounds (from Yoga and Qi Gong), all taught by TTNO members.

The pluralism of TT proponents appears to have limits though. In the case of nurse practitioners, openness to alternative therapies seems to be limited to their incorporation into nursing, as opposed to giving greater recognition to alternative practitioners outside of the biomedical system.

In Foundations for Holistic Nursing Practices (1981:132) Krieger describes a “renaissance nurse” who “teaches the client appropriate techniques for centering, meditation, relaxation, or imagery...and punctuates the client’s rehabilitation with shared teaching-learning experiences on body awareness, yoga, neuro-linguistics, or biofeedback.” In an article in the Advanced Journal of Nursing, Krieger (1999:9) states:

Since the early 1970’s, professional nurses have made up the largest segment of audiences at workshops and conferences on alternative healing methods. During the 1980’s and 1990’s, holistic modalities firmly captured the public’s attention. In states that foster independent nursing practice acts, nurses have increasingly turned away from workplaces that don’t support creative nursing and have set up independent practices.

From these statements, a picture emerges of nurses trained in alternative healing techniques (which Krieger terms ‘creative nursing’) entering the pluralistic health care market in direct competition with non-biomedical alternative practitioners. This is similar to the perspective put forward by other proponents of holistic nursing, such as the American Holistic Nurses’ Association (AHNA) which “believes that nurses have the unique ability to provide services which facilitate wholeness” (AHNA 2000). Similarly, in their introduction to the edited volume Complementary/Alternative Therapies in Nursing – 3rd Edition (1998:xiii), editors Mariah Snyder and Ruth Lundquist state:

Times have changed, and there is a greater demand by individuals and health professionals for this kind of information [on alternative therapies] than ever. It is the premise of this book that nurses are

natural providers of these kinds of holistic services, and this book provides accessible, practical, research-based descriptions of the techniques that they need in twenty-eight alternative/complementary interventions ... Now is the opportune time for nurses to deliver to society the type of health care society desires.

The view of pluralism suggested by Krieger and other holistic nurses is indicative of an incorporative approach to integrative medicine, in which sanctioned biomedical practitioners integrate alternative therapies into their own practice. Clark (2000:9-10), in his Integrating

Complementary Health Procedures into Practice, states :

One of the myths held by some allopaths is that unqualified and unlicensed individuals practice complementary methods. However, the majority of those providing such treatment are allopathically educated. Practitioners educated in both approaches are uniquely qualified to recognize the limitations of both systems. They are able to decide which therapeutic approach will most likely be most effective...

In this passage, Clark is suggesting that the best people to provide alternative therapies are those who are "allopathically educated", indicating the acceptance of the therapy, but rejection of the non-biomedical therapist, which is typical of the integrative perspective.

The beliefs, values, and practices of TT proponents constitute an heretical model due to their challenge of orthodox biomedical narratives concerning healing, science, and the separation of science and spirituality. In their definitions of illness, conceptions of the healing act, and approach to patient management, proponents are characteristic of the biomedical fringe. As such, they accentuate the 'art' of healing and the importance of

spirituality in health care, yet still utilize the narrative of science to validate their healing model. Proponent attitudes toward alternative therapies are fringe in that they readily accept alternatives into their practice, yet more soft orthodox in that this acceptance is co-optive, rather than co-operative. This stance towards alternative therapies is consistent with that of the *integrative medicine* movement. In the following chapter, I discuss the discursive strategies used by proponents and opponents during the *heretical drama*. In the claims and counter-claims of actors within the drama TT's heretical model is legitimated, criticized, and modified in response to criticism.

Chapter 6: Strategies used by Actors in the Debate

In the public debate over TT, proponents present and argue for their healing model in the face of criticism from other members of the biomedical discourse. As mentioned at the beginning of Chapter Five, heretics must present their model in a form that does not betray their allegiance to the discourse. In doing this, they utilize the language of the discourse but try to emphasize marginal narratives and exploit inherent inconsistencies within it. They also try to recast the history of the discourse in a light favourable to their cause, accomplishing this through “appealing to charismatic founders, historical examples, and basic values to show the historical primacy of their ideology” (Wolpe 1990:915). Both the heretics and their critics attempt to cast each other in the role of *apostate* to the ideals of the discourse.

In the TT debate, it can be seen that proponents and critics utilize narratives and narrative themes from the discourses of nursing, biomedicine, and health care as a whole; these narratives and themes concern the following areas:

- 1) the essence of nursing: wherein proponents use strategies of *professional legitimation*, arguing that TT represents the “true” goals of nursing, and where critics claim that it betrays those goals.

- 2) science: in which proponents use strategies of *scientific legitimation*, arguing for TT's scientific validity or contesting the orthodox definition of science, and critics accuse TT of being unscientific.
- 3) spirituality in health care: in which proponents and opponents argue about the role of spirituality in healing, and the importance of caring and compassion in health care.
- 4) professionalization: in which proponents utilize a strategy of *professionalization* to consolidate and manage their discourse in response to orthodox criticism

TT proponents also use authoritative evidence to support their claims. This is discussed within each section as applicable.

The Essence of Nursing

A strategy used by proponents and critics of TT concerns defining the therapy in relation to the "true" goals of nursing – an idealized vision of what the discourse of nursing should be about. Proponents argue that TT represents nursing as it always has been – holistic, intuitive, caring-based, spiritual - and encourage further movement in this direction. Critics argue that nursing is a scientific profession whose status within biomedicine depends on developing sound scientific theory and practice; they see TT as hindering this development and de-legitimizing the profession as a result.

In Delores Krieger's (1980:365) first article on Therapeutic Touch, she states "one can hardly imagine the most basic of nursing skills being performed without the act of touch. Indeed, touch is, so to speak, the imprimatur of nursing". Similarly, she writes: "One of the uniquely human acts that permeates almost every phase of nursing is characterized by the touching of another in an act that incorporates an intent to help or to heal the person so touched" (Krieger 1981:138). In these passages, Krieger is associating TT with the basic goals of nursing practice, which she equates with "the deeply human qualities of empathy, compassion, and a desire to lift a little the veil of pain and suffering that seems to clothe the human condition" (Ibid., p.137). She adds: "These altruistic characteristics, frequently spoken of as *caritas* and *agape*, help provide dosages of what Pitrim A. Sorokin has called "the vitamin of love" to persons who are ill and in need. This act of transpersonal love has been a hallmark of nursing, a tradition that goes back to the medieval days of the hospice" (Ibid., p.138).

Several other proponents have defined TT as the "true expression" of nursing. Elabdi (1997:19) writes: "TT is viewed by its proponents as the full extension of the trusting and caring relationship between nurse and client." Therese Meehan (1998:117) begins a review article on TT by stating: "The nurturance of human life, the therapeutic use of self and the specialized use of the hands have long been recognized as central characteristics of nursing practice." Barbara Mackey (1995:32)

characterizes TT as “a renewal of the art of nursing.” Mulloney and Wells-Federman (1996:46) write: “The practice of TT is intrinsic to the holistic nature of professional nursing. For many nurses, TT embodies the spirit of nursing practice...”

Opponents of TT also utilize narratives concerning the defining qualities of nursing, in their case to accuse TT practitioners of betraying the nursing discourse. In the June 1997 issue of In Touch, a letter to the editor of the Hospital News was reprinted, along with replies to the letter by members of the TTNO. The letter was written by an RN who identified himself as MR. D., and criticized a positive article on TT which had appeared in the Hospital News. Mr D. (1997:8) wrote:

In my view, the movement to introduce such medical “alternatives” into hospitals simply serves to make nurses look bad. For a news article such as this to appear, at a time when nurses are having to compete with cafeteria workers for professional respect, is especially unwelcome.

I ask that in the future you refrain from such lapses in critical thinking when selecting items to include in your paper. The credibility of my profession and of your publication depends on it.

Two replies to Mr. D.’s letter were printed as well. The first was written by a clinical educator, who pointed out:

...Mr. D.’s own professional association, the College of Nurses of Ontario (CNO) has noted “that Therapeutic Touch is a recognized approach in providing nursing care”. Therapeutic Touch falls under RN Standard 5, Section 7.3 which identifies that nursing practice “Promotes comfort and hygiene by using touch, massage, and stress reducing techniques.” (Nault 1997:8)

The second printed response was from TTNO executive Helen Will (1997:9), who defended the article on TT and countered Mr. D.'s accusation of TT's making nursing "look bad". She again asserts TT's embodiment of the true vision of nursing:

Many nurses and other professionals incorporate Therapeutic Touch in their practices and view it as an essential tool which they use to improve the quality of patient care in both the hospital and the community. We have many reports from practitioners who find Therapeutic Touch effective in situations where other medical and nursing measures have failed to give relief. We have heard over and over how Therapeutic Touch has brought the "art" back into nursing, and with it, the heart

The exchange between Mr. D. and the two TT proponents illustrates two ways in which TT proponents respond to criticisms based on professional legitimation: appeals to professional authority, and appeals to professional values. The clinical educator responds with an appeal to professional authority by reminding Mr. D. of TT's legal recognition by the CNO. Helen Will appeals to TT's abilities to provide patient care and to its representation of the "art" and "heart" of nursing.

Mr. D's critique of the Hospital News article centers on TT's potential to undermine the "professional respect" and authority of nursing in relation to other hospital workers or members of the public. Similar criticisms have been leveled by other nurses, yet focus more on nursing's image as a scientifically based profession. Through their "unscientific" practices, TT proponents are thought to threaten the status of nursing

within biomedicine. One example of such a critique comes from nursing theorist Myra Levine, in response to Krieger's first TT article. Writes

Levine (1975:1383):

The pretense of the healers that they perform scientific therapies is unconscionable. In our struggle to achieve academic recognition as a profession, we simply cannot afford to indulge in this kind of charlatanism. TT challenges the validity of modern nursing research, teaching, and practice.

Marilyn Oberst (1995:1), in the Research in Nursing and Health editorial mentioned in the Introduction asserts "unchallenged promulgation of scientifically unsubstantiated practice weakens the confidence of both the public and practitioners in the quality of nursing care and the science that undergirds it." In a comment on Oberst's article and replies to it, RN's and professors of nursing Bullough and Bullough (1995:377) write that TT "has long been an embarrassment to us", adding "We have even had the embarrassment of trying to explain to a group of colleagues how we could claim nursing belonged in the university if this was our level of sophistication." In another comment, RN Linda Rosa responds to a TT proponent's question of why people are upset about TT if it can't do any harm. States Rosa (1995:575): "The old 'what's the harm' argument is indeed weak and reprehensible. There's lots of harm, such as losing public trust, graduating nurses unable to think straight, and looting public coffers."

The strategy of professional legitimation is primarily directed by proponents toward other members of the nursing discourse. It emphasizes traditional nursing values involving caring and compassion and portrays TT as an embodiment of those values. Critics tend to accuse TT of delegitimizing the nursing profession, not through emphasizing caring and compassion, but by ignoring other important narratives within the discourse, namely professionalism and the primacy of science in achieving nursing's goals. Geriatric nurse Jack Stahlman, in a critical comment on Barbara Mackey's 1995 pro TT article in the American Journal of Nursing, states: "One of the basic tenets of nursing is that all interventions are to be based on sound scientific principles" (Stahlman 1995:17). Stahlman's criticism concerns the nursing profession, but arguments surrounding TT's scientific validity also reach outside of the discourse of nursing and into the wider biomedical discourse. Because of this, I will examine all of the science-based arguments concerning TT in the following section, as those made within and without of the realm of nursing utilize the same discursive strategies.

Scientific Legitimation

Wolpe (1994:1133) argues that science is the true orthodoxy in biomedicine, and my analysis of the biomedical model in chapter Four supports this claim. Although the narrative of science is interpreted widely within biomedicine, even members of the orthodox fringe recognize the power of science and the critical importance of its use in validating healing modalities. In the TT debate, the therapy's origins within nursing ensured that it would be infused with scientific values and beliefs. Proponents utilize science to legitimate TT through claiming the practice is scientific and through defining science in a form that is more amenable to their goals. They exploit the inherent tension between narratives of science and healing within biomedicine, appealing to both narratives to deflect criticisms. Both proponents and critics argue that the other group is "unscientific", and therefore a betrayer of the entire biomedical discourse. Proponents do this either through pointing out the unscientific motivations behind criticisms made of TT, or by presenting definitions of science which exclude their critics. Opponents accuse proponents of apostasy by contesting the theory underlying TT, and its clinical effectiveness.

One form of scientific legitimation used by TT proponents involves making direct claims for the therapy's scientific status. On a TTNO handout given to students at the level one training workshop, entitled *16 Reasons to Learn Therapeutic Touch*, reason four is:

4. TT is being thoroughly researched.

Over 20 doctoral and post-doctoral dissertations and innumerable masters theses have been done on TT...

Reason five is:

5. TT is backed by physics.

The smallest particle of which an atom is composed is pure energy, hence the TT assumption that "humans are open, complex, and pan-dimensional energy systems (Rogers)". It is based on "Quantum Physics."

(Pokoradi 2000)

In a review of five studies of TT conducted by Wirth and colleagues⁴, RN Barbara Daley (1996:1126) states: "The five double-blind, randomized experiments to be discussed in this article provide critical scientific support for the field because they indicate that TT can significantly increase the patient's physiological wound-healing response."

RN Marilyn Bronstein (1996:32) writes in The Canadian Nurse :

"Therapeutic Touch is also gaining acceptance because it now fulfills the criterion of the Western world's scientific philosophy. It has met the rigorous replication of research findings that science demands." The NH-PAI web-site states that "Therapeutic Touch is a scientifically based practice founded on the premise that the human body, mind, emotions and intuition form a complex, dynamic energy field" (NH-PAI 2000). Crystal

⁴ Wirth (1992); Wirth, Richardson, Eidelman & O'Malley (1993); Wirth, Barrett & Eidelman

Hawk (1998:1), in her web-site on TT, asserts: "Health professionals today stand firmly on its [TT's] 25 years of effective clinical practice and the solid Therapeutic Touch research that has resulted in its wide acceptance."

Physiotherapist Susan Ramsey (1997:779) describes the energetic theory which underlies TT:

Energy field theory is based on quantum physics law, which assumes that matter is energy and all living things generate vibratory fields interconnected by mathematical laws. In therapeutic touch we can postulate that the energy fields practitioners perceive can be described by these laws.

From these statements it can be seen that TT proponents present the therapy as being based on scientific theories and being supported by scientific research. These statements represent the most straightforward strategy for legitimating TT within the biomedical discourse - if TT is science, then it can't possibly represent a betrayal of biomedicine's defining narrative. As well, maintaining scientific proof of TT's effectiveness underscores its allegiance to the goals of health care – it *does* heal. This use of science to substantiate claims of healing effectiveness reveals the strength of the science narrative, and the extent to which heresies are bound by it. However, proponents do attempt to modify the narrative to make it more amenable to their model, and to challenge their critics. This process becomes apparent when examining their replies to scientific criticisms on behalf of the orthodoxy.

Critics of TT provide a much different view of its scientific basis, arguing, in effect, that it has none, and thus represents apostasy to the discourses of nursing, biomedicine, and health care. Many health care professionals have accused TT of being unscientific. In response to Marilyn Oberst's (1995) RINAH editorial in which she claimed TT had absolutely no scientific evidence to back it up, Mark Keller, Diane Lauver, Donna McCarthy, and Sandra Ward (1995:286), all Ph.D. nurses, wrote:

We applaud your analysis of the effectiveness of therapeutic touch and your insightful discussion of our unwillingness as a discipline to publicly acknowledge the evidence that this technique does not work. Thank you for taking on this sacred cow.

Similar replies were given by Baun (1995:287), and Bullough and Bullough (1995:377).

Some of the strongest criticisms of TT's scientific basis have come from members of the skeptic community. Skeptics are joined by their mutual distrust of all things paranormal and "unscientific", and constitute a sub-discourse which exists partly within the discourse of biomedicine. One prominent skeptic organization, the Rocky Mountain Skeptics (RMS), describe themselves as "an organization whose objective is to advocate for and demonstrate the use of scientific inquiry into any activity that claims to be scientific or that presents itself as an alternative to science" (RMS 1998). Founder of the Community for the Scientific Investigation of Claims of the Paranormal (CSICOP) James Randi is fond of quoting David

Hume: "Extraordinary claims require extraordinary evidence." (Randi 2000). Both RMS and CSICOP have taken an interest in TT, and join a host of other organizations opposed to the practice. Prominent groups include the National Council Against Health Fraud (NCAHF), and its subgroup the Questionable Nurse Practices Task Force (QNPTF), the National Therapeutic Touch Study Group (NTTSG), and Quackwatch.

Skeptical organizations figure prominently in the TT debate not only due to their organized opposition to the practice, but because several TT critics within biomedicine are members, and leaders, of these organizations. RN Linda Rosa, mother of Emily Rosa, the girl who conducted a "science fair project" on TT which ended up in JAMA and claimed to disprove the practice, is a member of the QNPTF. Her father, Larry Sarner, and MD Stephen Barrett, both co-authors of the JAMA article, are members of the NTTSG. Barrett is also the president and founder of Quackwatch (Quackwatch 1999:1). Two of the TT critics I interviewed for this research, both MD's, are members of skeptical organizations, and claimed to know of several other medical professionals who belonged as well.

The criticisms of TT made by skeptics represent the strongest of strong orthodox positions, which holds science as the ultimate judge of a medical theory or procedure. In an address to the Colorado Board of Nursing, an RMS spokesperson claimed that the board "must rely upon

science and only upon science and the scientific method to provide you with the standards to judge proposed treatments and techniques” (RMS 1996b:2). In this same address, TT proponents were described as “purveyors of unproven, ineffective, and unscientific pseudomedical techniques – some even identifiable as health care fraud or quackery” (Ibid., p.1). Skeptics also portray TT proponents as people who don’t or refuse to understand science, accusing them of “scientific illiteracy” (RMS 1996a:2), and of using “less-than-scientific and extremely imprecise language” (Selby & Scheiber 1998).

Although skeptics do claim that TT’s effectiveness is not scientifically proven (RMS 1996b:4), or is nothing more than a placebo (Coursey 2000:7), their main complaints against TT concern the unscientific nature of its underlying theories. An example of such a critique which gained considerable attention within the nursing, medical, and lay communities is Emily Rosa’s TT experiment (Rosa, Rosa, Sarner & Barrett 1998). The debate which followed the publication of the experiment in JAMA again illustrates the intersection of biomedicine’s primary narratives within the TT debate, and reveals the ways in which tensions between them are utilized by proponents and critics. At the end of their article in JAMA, Rosa, et. al. (Ibid., p.1009) conclude:

Therapeutic Touch is grounded on the concept that people have an energy field that is readily detectable (and modifiable) by TT practitioners. However, this study found that 21 experienced

practitioners, when blinded, were unable to tell which of their hands was in the experimenter's energy field... To our knowledge, no other objective, quantitative study involving more than a few TT practitioners has been published, and no well-designed study demonstrates any health benefit from TT. These facts, together with our experimental findings, suggest that TT claims are groundless and that further use of TT by health professionals is unjustified.

The experiment performed by Rosa et. al. represents an attack on TT's theoretical assumptions concerning the presence of human energy fields and the ability of practitioners to sense them. The argument present in their concluding statement rests on two clear assertions: first, that practitioners can't feel an energy field, and second, that no published research has shown a health benefit from TT. From these supporting clauses they conclude that use of TT by health professionals is unjustified, in effect, that it constitutes apostasy.

Responses to the experiment in the form of letters to JAMA both supported and challenged the assertions of Rosa et. al. All respondents cannot be easily identified as proponents or opponents, as several commented specifically on the study design alone, and did not make explicit statements concerning TT's efficacy. There were some respondents who were obviously proponents (made direct statements concerning TT's value or efficacy in their comment), and who will be identified as such. Letters which only criticized the study will be designated as coming from "respondents." In this dialogue it can be seen that proponents and other respondents use different strategies to counter

the article's criticism of TT, including arguing that science in biomedicine must be in service to the goals of health care, and using orthodox definitions of science to critique the critics.

From letters criticizing the JAMA article, the scientific narrative within biomedicine is both limited, and strengthened. Several letters point out science's role in *service* of the dominant healing narrative. Proponent and MD Andrew Freinkel (1998:2005) states:

Therapeutic Touch is not a parlor trick and should not be investigated as such. Rather, it is a therapeutic technique that may be discovered to require active involvement by a genuinely ill patient, as the author's themselves convolutedly acknowledge in their citation of Krieger's work... It is not yet clear if TT will be proven to be effective and for which, if any, indications. A serious and appropriately designed clinical study is needed to determine its efficacy, not an elementary-school science project.

Freinkel makes a clear distinction between the science used by Rosa, et. al., and that used in medicine. In his letter, TT is described as "a therapeutic technique", "a clinical issue", and "a clinical phenomenon" deserving "serious and appropriately designed clinical study." The methods used in the study are described as an "artificial demonstration", "methodologically flawed", and "a magic trick". The distinction being made here is between good science (which realizes the goals of health care), and bad science (which loses sight of the primacy of those goals). As such, the letter represents a defence of the biomedical discourse and a differentiation between the science used within it, and that used without.

Science which takes place outside the goals of healing is deemed inappropriate in judging “clinical phenomena”, therefore limiting the scientific narrative; however, the narrative is strengthened in that science remains the accepted way of evaluating these goals.

Several proponents argued for the subordination of science to the goals of healing. RN Susan Collins (1998:1) writes “ I care very little whether a practitioner can feel energetic exchange successfully in a contrived situation such as the experiment set up when I see outcomes that the TT process as a whole works.” Lay respondent Jesse Lee (1998:2) writes: “The definitive test of a healing practice is whether healing takes place, not whether the practitioners have a flawless grasp of the natural forces at work.” Proponent Mary Ireland, RN, Ph.D. (1998:3-4) states:

In the interest of scientific exploration of the efficacy of TT and its mechanism of action and the advancement of quality patient care, which is never mentioned in the article, we should be cautious in following the recommendations of the authors to discard an intervention that many patients throughout several decades tell us “works.”

Respondent Joel Howell, MD, Ph.D. (1998:6) identifies himself as skeptical of TT’s efficacy, but nevertheless writes: “When we wish to definitively assess the efficacy of a therapeutic intervention today, we must await studies of its effectiveness (or lack thereof) in treatment, whether or not we can demonstrate a theoretical basis for its effect.”

Letters also criticized the basic science used by Rosa et. al., and implied that the study was a vehicle for the anti-TT bias of its authors. Members of the Kansas City NH-PAI chapter argue that the experiment “clearly fails to meet the criteria of randomization, control, and valid intervention”, and conclude that: “It is unfortunate that JAMA would publish articles that deliberately fragment the TT process to achieve erroneous results to further the author’s own biases” (Carpenter, Hagermaster & Joiner 1998:2). Ireland (1998:3) writes:

Research design flaws in the study by Ms. Rosa and colleagues are disturbing given the serious nature of study results and the suggestion that TT should no longer be offered to patients. First, the authors are not neutral and unbiased, nor is the senior author representative of nurse scientists with advanced degrees currently conducting research.

In these responses, the strategy is not to subordinate biomedicine’s scientific narrative to its healing narrative, but to question the validity of the basic science used by the experimenters. This critique portrays Rosa, et. al. as apostates to the discourse of science itself - as betraying its principles in pursuit of personal bias. In using this strategy, proponents are utilizing the language and concepts of the orthodoxy to criticize the orthodoxy.

There is evidence to suggest that proponents criticize the Rosa, et.al. (1998) study on legitimate scientific grounds. Prominent TT critic and Vice President of the RMS, Carla Selby (1998), published a review of

the JAMA article in the Rocky Mountain Skeptic. In her article Selby harshly criticizes the experiment on several counts, including the obvious anti-TT bias of its authors, the suggestive language they use to refer to TT (“laying on of hands”, “metaphysical ideas”), the improper sampling techniques used, the use of an unclear and inconsistent research protocol, and the improper use of controls. She finishes her critique by stating:

It is therefore, doubly egregious, indeed, completely irresponsible, for JAMA editors to give space to work that, at the very best, can be described as competent for a 4th grade science project. As shown above, the quality of the research is exemplary of either very bad science or adequate school work. No matter how desperate we in the skeptical community are for a win in our column, JAMA, as a respected member of this community, did us no service by either the publication of a school-girl’s project or the subsequent over-promotion of the results and pronouncements about the work’s significance and policy implications.

In several public debates over TT, proponents have also attempted to alter the definition of science when critiqued on scientific bases. They do this either through presenting different interpretations of TT research, or by postulating broadened definitions of science which account for TT’s theories and effects.

In response to Marilyn Oberst’s critical editorial on TT in Research in Nursing and Health, RN Mary Anne Bright (1995:285) responds: “Contrary to your assertion that therapeutic touch is a ‘scientifically unsubstantiated practice’, there has been well-controlled research which has offered “scientific” support for the efficacy of therapeutic touch.” Such positive

interpretations of research by proponents are common (Manhart-Barrett 1995:379; Stravena 1995:379; Mackey 1995:18; Daley 1997). However, some proponents have exercised more caution in interpreting the research in light of criticism. Therese Meehan (1995:17) writes in response to Mackey's (1995) article in AJN:

What current research about TT tells us, according to Popper's principles of refutation and verification, is that there is no convincing evidence that TT promotes relaxation and decreases anxiety beyond a placebo response, that the effects of TT on pain are unclear and replication studies are needed before any conclusions can be drawn. Other claims about outcomes are, in fact, speculation.

Wolpe (1994:1139) discusses the place of research within a discourse, and in relation to heresy. He characterizes scientific research as one of the "knowledge products" of a discourse. In describing professional discourses he writes: "Knowledge products are what a profession 'sells' to the public, whether those products are disease prognoses, legal maneuvers, explanations of quarks, theoretical interpretations, or military strategies". According to Wolpe, knowledge products must conform to the orthodox ideology. Those that don't are examples of *dissent*, and are either "self-censored, suppressed by the orthodoxy, or become the subjects of controversy and are used for boundary clarification" (ibid., p.1139).

Dissent is a challenge to the knowledge products of a discourse, yet is only considered heresy when the dissenting research challenges the

basic ideology of the discourse (the framework in which knowledge products are produced). Wolpe characterizes these instances as *challenges to value*. Thus, research which shows TT to be efficacious, yet which follows accepted scientific protocols and explains its results in terms of existing medical and scientific theories, is an example of dissent, although Wolpe notes that it might be interpreted as heresy by the orthodoxy. Research which questions the basic assumptions of scientific method or theories clearly constitutes heresy (Ibid., p.1139-1140). TT proponents make challenges of both kinds through their research and through their claims for TT's effects. Their more heretical claims concern the definition of science.

TT proponents attempt to legitimate their ideology through expanding or modifying definitions of science to accommodate energetic theories. At the same time, these definitions often characterize the science of their critics as narrow, outdated, and inappropriate. In some instances they imply that the science used by critics represents apostasy.

In an In Touch article, recognized teacher Grant Hallman (1999:6) criticizes the Rosa et. al. (1998) article for basing its methodology on reductionist theories:

The idea that one can snip out the Assessment part of a TT treatment and test it in isolation, depends on the assumption that Assessment works exactly the same in isolation as it does as part of a TT treatment. This assumption is based on a "deconstructionist" viewpoint, which is that the whole is no larger than the sum of its

parts. If that assumption is not true, the test will produce a negative result which will then be (falsely) applied to TT as a treatment. This is exactly how a preconceived idea (that TT can't work) prejudices an experiment. It is simply bad science.

Hallman makes the same distinction between good and bad science which other respondents to the JAMA article make, yet also critiques a fundamental tenet of scientific method, that of reductionism, from an holistic perspective. TT can't be reduced into its constituent elements, and to attempt to do so is "bad science".

Hallman (2000:15) also argues the need for greater intuition in science in

In Touch:

...scientific, provable knowledge and intuitive, subjective knowledge form opposite ends of a paradox. Within a paradox, there is value in both parts; indeed, to focus exclusively on one side of the paradox leads to error, because it neglects the truth of the other end. Thus I believe it is necessary to hold simultaneously to the value of intuition and to the value of evidence.

The addition of holism and intuition into science and medicine represent mild changes to the orthodox paradigm, yet proponents also question its more fundamental aspects, and its applicability in healing.

Several proponents posit that the science used to justify critiques of TT is being replaced by a new science which validates the therapy's assumptions. Claims of this sort also imply that TT represents a leading edge application of the new science, and that those who criticize the therapy do not accept it due to bias. The web-site of the TTNO (2000:3),

in its Information section, contains a paragraph under the heading

“Paradigm Shift” which states:

We are on the verge of a major paradigm shift that extends across the sciences from physics to medicine and biology. It involves a transition from the mechanistic Newtonian model to the acceptance of the Einsteinian paradigm of a complex, yet interconnected, energetic field-like universe. Therapeutic Touch fits into this model and is perceived to be on the leading edge of 21st century “Vibrational Medicine”.

RN Helen Will (1997:8-9) writes this response to a critic on behalf of the

TTNO:

Therapeutic Touch is based on a conceptual framework. These quantum mechanics theories are not new, but society has been so entrenched in the Newtonian principles, they have largely been ignored. Therapeutic Touch is based on the General Systems Theory, Einstein’s Theory of Relativity, The Quantum Field Theory, The Human Energy Field Model, and Roger’s Theory of Unitary Human Beings. The scientific community shielded itself from new possibilities with skepticism.

How the improved function and healing actually “scientifically” happens within the human organism is still not clearly understood. However, it took many years before the germ theory was proven. Many people died painfully and needlessly because the mainstream, highly respected scientific and medical community adamantly refused to wash their hands. Eventually, research caught up with the concept. In the case of biofield therapeutics, innovative and creative research will eventually catch up to this concept as well.

Will’s letter displays a masterful re-directing of scientific critique towards itself, as, similar to respondents to the JAMA article, she accuses critics of not being scientific, or in this case, of resisting a claimed revolution in scientific paradigms. It is the scientific community that is “shielding itself” from the truth – an accusation often made by TT critics

concerning the therapy's practitioners. In Will's letter, the TT critics are also accused of apostasy to the discourse of healing by being associated with the "mainstream, highly respected scientific and medical community" which "killed people painfully and needlessly" due to their refusal to accept germ theory. Through re-defining science and TT's role within it, the scientific narrative becomes a base for critiquing the orthodoxy.

Not all TT proponents cite the physics-based paradigm shift implied in the TTNO statement and Helen Will's letter. Others question its application to the healing process itself, implying that there are equally valuable alternative narratives. In response to Oberst's (1995:1-2) Research in Nursing and Health editorial, Patricia Heidt (1995:377-378), RN, Ph.D., and noted TT researcher, writes:

It is interesting that nursing is defining itself as a science (using all the requisite models of the past century) at a time when most traditional societal and cultural structures are breaking down. We are caught in this transition with one foot in the past and one in the future. I feel that because we are primarily a woman's profession we can never be content with using reasoning mind alone in our scientific research. That is why most practitioners, even if they disregard the scientific studies because of their flaws, believe in the essence of TT. They know from a personal experience, from an instinct, from an intuition, that we are able to influence one another and communicate with one another and the environment that surrounds us.

Violet Malinski, RN, Ph.D. (1995:286) argues that notions of science are relative and based on different worldviews. She claims that: "When we fail to acknowledge the existence of more than one worldview, we talk in

terms of science and method, singular, failing to recognize that there is more than one way to view science and certainly more than one scientific method.” She argues that TT:

is best understood in the simultaneity, unitary-transformative, and simultaneous-action worldviews based on concepts of unitary fields in continuous mutual process identified by pattern; where change is continuous, unpredictable, and diverse; and personal knowledge, feelings, values, and pattern recognition are primary sources of information.

The perspectives on science given by Heidt and Malinski are strongly heretical within the discourse of biomedicine. Heidt characterizes the science of orthodox biomedicine as a crumbling institution which lacks evaluative power in the realm of TT practice. In place of science she introduces personal knowledge and intuition, linking these qualities to the feminine character of nursing. Malinski, as well, presents a view of science based on “personal knowledge” and “feelings”, yet does not so much suggest that orthodox science is crumbling and being replaced, but rather that it is only one way of viewing the world. In both cases, the orthodox model of science debated in the JAMA article and responses is presented as limited, relative, and inappropriate for studying TT.

Spirituality in Healing

As demonstrated in Section II, TT proponents routinely make comments that demonstrate spiritual or religious beliefs. These beliefs

concern the importance of spirituality in healing and the inherent spirituality of the TT process. Critics of the therapy characterize the practice of TT as mystical, religious, New Age, or occult, arguing that this separates the practice from biomedicine. Historically, the relationship between healing and spirituality (predominantly Christian) in the West has been close (Barton 1958:3-5; Lella & Pawluch 1988:136-137). This association is especially apparent within the profession of nursing, which in Canada originated with Christian nursing orders (Ross-Kerr 1988:3-21; Boutilier 1994:24-31). However, as advances in science began to lead the practice of healing away from the realm of spirituality, the two became occupationally separate within Western biomedical institutions (with the exception of the remaining Christian nursing orders).

From a strong orthodox perspective, the spirituality professed by TT proponents has no place within biomedicine. Glymour and Stalker (1985:22) explain the distinction between modern physicians and holistic proponents: "A physician engineer cannot honestly claim powers of magic or occult knowledge. The principles governing scientific reasoning and belief are negative as well as positive, and they imply that occult doctrines are not worthy of belief." Critics of TT have characterized the therapy in terms which suggest occult associations. The RMS, in particular, consistently refer to TT as either a "ceremony" or a "ritual." Members Carla Selby and Bela Scheiber (1998:2) describe the theory behind TT as

having “far more in common with revealed wisdom than with a scientific hypothesis.” RMS member William Aldorfer (RMS 1996b:5), in closing his address on TT to the Colorado State Board of Nursing, states:

The State Board of Nursing has credentialed the teaching, training, and instruction of a ceremony, a system of belief. In so doing, the State Board of Nursing has proactively advocated, promoted, legitimized, and underwritten the introduction of ceremony, ritual, and fakery into the honourable profession of nursing.”

Proponents try to counter such criticisms by utilizing two strategies.

The first is attempting to separate the spirituality of TT from the idea of religion. Proponents argue that spirituality is a universal human phenomenon, linked with energy field dynamics, and not requiring a religious framework to be experienced or articulated. The second strategy they use is to appeal to themes concerning spirituality within the defining narratives of the health care discourse. These themes are made more prominent, and TT is portrayed as an example of their direct application.

Apart from debates over science, arguments over TT's spiritual beliefs are the most widely and hotly contested. Most of the TT practitioners I interviewed for my research had encountered opposition to their practice based on it's being perceived as “the Devil's work” by Christian health professionals and lay people. Christian nurses, in particular, have spoken out about TT. An article by Valerie Bailey (1993) in the Journal of Christian Nursing (JCN), describes a Christian nursing student named Janice who was uncomfortable when TT was taught to her.

Writes Bailey (Ibid., pp.4-6): "Although concerned that religious beliefs were being taught as scientific practices, she did not formally complain before she graduated last year." Sharon Fish (1996), a vocal critic of TT's spiritual aspects, notes the therapy's origination with Dora Kunz, and stresses her status as a "self-proclaimed psychic" and "past president of the American Theosophical Society" (Ibid., p.6). Fish goes on to compare TT to Eastern mysticism, Satanic energy, psychic and occult science, witchcraft, spiritual mediumship, and Mesmerism, before concluding:

Therapeutic Touch is ... helping to birth in nursing a host of spiritually illegitimate and dangerous practices that include mediumship and more. Those who say they can practice the technique of TT and divorce themselves from its occult associations need to be reminded that apart from the occult, TT would not exist. It is rooted and grounded in psychic soil, and it bears related fruit (Ibid., p.10).

The criticisms of overtly religious health care professionals arise from conflicts between religious, or spiritual, views, and imply the "wrongness" of TT's beliefs in relation to their own. Other critics of TT's spirituality, including skeptics and health professionals who do not identify as religious, try to characterize the practice as religious or mystical in order to prove that it has no place in science or scientific medicine. Their argument is not that TT is the wrong kind of religion, but that TT is religion, and therefore separate from biomedicine. RN and skeptic Kevin Courcay (2000:7), in an article posted on the Quackwatch web-site, writes of proponents:

In their attempt to create a non-disproveable theory of TT, they have instead created a religion; and they expect nurses to believe on faith that this method works despite its lack of scientific credibility. Their fundamentalist stance encourages disdain for science and rationalism, and betrays the basic tenets of modern nursing. They have used their positions of power in the nursing profession to spread their religion, and have craftily used the political dynamics of the late 20th century to stage their holy war...

Coursey presents the spread of TT as a religious jihad against science and rationality, conjuring images of the reasons why church and state became separated in the western world – fundamentalism, abuse of power, holy war. Consistent with the skeptical rhetoric, it leaves no role for TT amongst the “modern” profession of nursing, or in the modern world.

Jack Stahlman (1995:17), GN, in reply to a pro-TT article in AJN, questions whether nurses should take over religious functions, and recommends that requests for TT should be met by clergy or other outside support groups. He further characterizes TT as “fuzzy metaphysics” and “outdated parapsychological mumbo-jumbo.” Bullough and Bullough (1998), in an article in the Journal of Professional Nursing, argue “that therapeutic touch be regarded as a religious practice similar to prayer or to other healing techniques advocated by adherents of Christian Science. By labeling therapeutic touch a religious practice, a matter of faith rather than science, it changes the nature of the discussion...” (p. 254). They end their article with several recommendations, including that TT should not be

taught in any publicly funded institution, and that treatments should only be offered to those patients who believe in TT, or who request it after it is explained to them (Ibid:256-257).

The interpretations of TT presented by Bailey, Fish, Courcay, Stahlman, and Bullough and Bullough represent a serious threat to proponents of TT seeking to maintain the practice within biomedicine. One of the ways in which practitioners attempt to diffuse such threats is to define TT as a non-sectarian spiritual practice. Delores Krieger (1999a:200), in response to Bullough and Bullough (1998) states: "I have consistently noted in my writings that therapeutic touch has no religious context whatever. Spiritual, yes; however, there never has been any religious adherence required for the practice of therapeutic touch." In her reply Krieger characterizes TT as "a contemporary interpretation of several ancient, transcultural healing practices" (Ibid., p.200), and recommends that therapeutic touch is an appropriate area of study for professional nurses.

In response to a letter by Bishop (1999) in AJN, in which she describes threatening her hospital with a religious intimidation lawsuit should TT be taught there, Krieger (1999c:14) states: "Therapeutic touch does not now have, and has never had, a religious context or orientation". I received a similar response in an interview with Crystal Hawk (2000), in

which I questioned her about criticisms of TT based on its religious qualities. She replied:

It's always been very secular. Everyone can do whatever they want with it. People do TT, they see Jesus, Mary, Buddha, whatever they want; but because it's secular, anyone can take it on because it doesn't have a religious flavour to it. It's not like religious laying on of hands. It's a phenomenon in the universe that we tap into or we don't tap into.

In claiming that TT is representative of non-exclusive, syncretistic spirituality, proponents are still left open to attack by critics who feel that even spirituality has no place within biomedicine. However, TT proponents also stress the importance of spirituality within the discourse of healing, arguing that it has both historical legitimacy and healing effect.

A common source of historical authority invoked by TT proponents is the figure of Florence Nightingale, generally recognized as the woman who made nursing into a profession. Nightingale was an English nurse who won renown for revolutionizing the treatment of soldiers during the Crimean War. She founded the first professional school of nursing in 1860 at St. Thomas' Hospital in London, England (Ross-Kerr 1988:237-258). A complex person, she organized and standardized nursing practice, establishing its importance in medicine, yet also held socially progressive views, and was quite spiritual (Macrae 1995). This complexity of character makes Nightingale a potent authority figure for TT proponents, as she is associated with the practical, scientific aspects of nursing, with the

founding of the profession, and with the more spiritual beliefs of proponents.

RN Mary Anne Bright (1995:285), in response to Oberst's (1995) editorial "Our naked emperor", mentions Nightingale in her response:

Whether or not the emperor has no clothes is irrelevant to therapeutic touch practitioners. We are not looking at surface phenomena, nor at current fashion; rather, we are attempting to encounter the force to which Florence Nightingale referred when she asserted that "Only nature heals..."

Rochelle Mackey (1995:18) defends TT's use of "healing energy" by asserting:

The idea of a universal healing energy is not new to nursing. Florence Nightingale was an intensely spiritual woman. She wrote that "nature alone cures" and that what nursing has to do "is put the patient in the best condition for nature to act upon him"

In these statements, the presence of Nightingale is invoked to lend credence to TT's use of a mysterious healing force or "universal healing energy." It is also mentioned that Nightingale herself was "intensely spiritual". In the TT level one workshop I attended, the instructor quoted Nightingale's "Only nature heals." dictum in describing how TT supports the body's natural healing process. As well, three of the nurse practitioners I interviewed mentioned Nightingale, and cited her book Notes on Nursing (1969) as an influence. These nurses made it clear that they read Nightingale within her historical context, and did not endorse the patriarchal aspects of her nursing philosophy

Nightingale's spirituality is the focus of an article by noted TT proponent Janet Macrae, RN, Ph.D. (1995) in Image: Journal of Nursing Scholarship. The article comments on Nightingale's Suggestions for Thought, a collection of letters and personal notes she had privately printed in 1860. Macrae describes how Suggestions For Thought outlines a view of spirituality quite close to that proposed by TT practitioners. She notes that Nightingale believed "spirituality is a much broader, more intuitive concept than that of religion", and that "spirituality is intrinsic to human nature and is our deepest and most potent resource for healing" (Ibid., p.8). These statements build a legitimating bridge between spirituality and healing; such a bridge is also built between spirituality and science, as Macrae states: "Nightingale held that even the development of spirituality is subject to law. She viewed spirituality as a science..." (Ibid., p.10). To close out her article, Macrae puts forth the idea that nursing "can be transformed into a spiritual discipline" (Ibid., p.10).

Attempts by TT proponents to separate spirituality from religion, and to broaden the definitions of nursing and healing to include spirituality, are made difficult by two main factors. First, TT's syncretistic spirituality is often interpreted as an offensive religious doctrine by adherents of exclusionary faiths, or by atheists. Issues of religious freedom then come into play, and TT opponents have successfully blocked its practice through characterizing it as an affront to their religious beliefs (what Bishop (1999)

terms “religious intimidation”). Second, the division between science and faith in biomedical discourse, although being broken down to some extent, is still apparent. If TT is seen, in the words of Bullough and Bullough (1998) “as a matter of faith rather than science”, then the practice could cease to be a ‘nursing intervention’ and instead become a support service offered by chaplains or nuns. For these reasons, managing their spiritual beliefs is of concern to proponents.

Professionalism

From the strategies discussed so far it is argued that TT proponents have legitimated their model and challenged that of the orthodoxy through exploiting the inherent tensions between major narratives within biomedicine, and through emphasizing marginal themes within those narratives. Another strategy that proponents have used is to consolidate and constrain their discourse in reaction to the power of the orthodoxy. In this pursuit, they undertake a pro-active approach to discourse management consistent with professionalization, and similar to strategies used by other alternative healing traditions in their ideological struggles with biomedical orthodoxy.

From Kleinman (1980; 1984), Wardwell (1976; 1994), and Singer & Baer’s (1995) conceptualization of alternative therapies it can be argued that there is a “professionalization imperative” within the discourse of

biomedicine, and that TT proponents are pursuing the status of profession. Larson (1977) links the rise of modern professionalism to state control and capitalist social structures, embedding professions within a framework of political and economic power. He argues that professions represent “monopolies of competence” combining pre-capitalist ideals of vocation (profession as an intrinsically rewarding *calling*), universal service (social responsibility), and obligation (a sense of duty which comes with elite status), with capitalist notions of “professional commodity” (control over a certain economic market) (Ibid., p.220). The medical profession in North America is generally held up as an “ideal type”, as it most closely embodies the goals which professionalization strives for: control of the profession over its education, its regulation, the content of its work, and the market in which the work is performed (Freidson 1970).

Professionalization, then, is the pursuit of professional attributes in occupations that aspire to the status and power which professions enjoy. Notes Johnson (1972:32), “professionalism is a successful ideology and as such has entered the political vocabulary of a wide range of occupational groups who compete for status and income”. He lists attributes commonly associated with professions as: “1) skill based on theoretical knowledge; 2) the provision of training and education; 3) testing the competence of members; 4) organization; 5) adherence to a professional code of conduct; and 6) altruistic service” (Ibid., p.23). In

addition, Larson (1977:41) identifies the standardization and formalization of knowledge as being a strong component of professionalization.

TT appears to be undergoing a professionalization process involving the management and standardization of their discourse, and the cultivation of a professional ideology. Discourse management takes the form of 'editing' and 'censoring' the statements of proponents, with the twin effects of formalizing knowledge and controlling elements within the discourse that are perceived as too radical, and dangerous to TT's status within biomedicine. Several examples of this process can be found in In Touch. First, the newsletter itself serves as a discourse-management tool, as when RN and recognized teacher Mary Simpson (1999:2), then editor of In Touch, writes:

A word about submissions to the newsletter. I have received several, which, although they were very interesting, were not Therapeutic Touch! Of concern is the fact that the writers obviously do not know that what they are doing is not TT. If you intend to submit your experience please use TT terminology. It could be beneficial to all concerned if you have the article reviewed by a Recognized Teacher. I do not intend this to restrict discussion on the way we do TT, but we cannot publish material that goes against the concepts of Kreiger-Kunz.

Similarly, in reviewing a book on TT, Julie Benkofsky-Webb (1997:24, 28) chastises the book's author for utilizing "improper" terminology concerning the practice. In the June, 1997 issue of In Touch, the TTNO executive state in a memorandum that: "Many of us think it is not a good idea to have TT at Psychic Fairs, because of the implications"

(TTNO 1997:30). At the end of the same issue, the following statement appears:

You have some concerns about the way a person is doing/teaching TT.

This is a situation in which our Quality Assurance committee can be of assistance. Your concern/complaint must be in writing. All recognized practitioners are required to sign the Statement of Ethics and Conduct. If a practitioner is not adhering to this, the Network should know. It is important to protect the public.

In Touch also serves as a forum for those nurses who have experienced censoring or editing to speak out. In the May, 2000 edition, recognized teacher Barbara Janelle (2000:20) writes:

Now as I look at the state of Therapeutic Touch, I am dismayed to find that there are many in TT who would treat it as a static technique too. Too often the terms, "pure TT" and "That's not TT!" imply that we are not to think beyond the bounds of rigidly defined steps. These terms are loaded with controlling intentions.

Janelle also mentions the "controlling intentions" present within the TT discourse when discussing her view of centering, the opening stage of TT treatment, as a prayer. She writes: "We do not speak of this in Therapeutic Touch because we try so hard not to be associated with religion" (Ibid:20). That In Touch fulfills a role in both constraining TT dialogue and opening it to criticism reflects the tensions inherent in attempts to standardize TT's highly individualized discourse.

TT's attempts at management also concern its image outside of the discourse. In the following interview I had with recognized teacher Crystal Hawk (2000), the idea of TT putting on a deliberate public face emerged:

Crystal: One of the reasons that we are being accepted in hospitals now... We say publicly that TT delivers a relaxation response, it alters your perception of pain, it heals tissues, bones and tissues, and creates a sense of bonding between people. You've probably heard that a dozen times.

Kevin: It's the party line?

Crystal: That's exactly what it is, and it keeps us out of trouble

TT's public image management also involves delineating the discourse boundaries with regard to competing therapies. On the NH-PAI (2000) web-site, the organization claims to serve "as the expert source for information on the Krieger/Kunz model (the only model) of Therapeutic Touch." Reference to being the "only model" is likely to distinguish TT from Healing Touch (HT), a competing system of energy healing in which TT techniques are taught along with other healing modalities. In a position statement on the NH-PAI site, the organization clearly states that TT and Healing Touch are separate modalities, that training in HT is not recognized by NH-PAI, and that "separate policies and procedures" should be used for each practice within institutions (NH-PAI 2000).

TT's movements towards organization and knowledge standardization are outlined in Chapter Two. In addition to creating organizations, proponents have standardized methods of teaching TT, and have established guidelines for the "recognition" of practitioners and teachers. Recognition is not certification, yet serves similar functions; recognized practitioners and teachers receive the support of TT's official

organizations through referral services and the ability to teach 'official' TT classes.

However, a poll of TT organization members conducted by NH-PAI indicated that the majority of them did not want certification. Resistance of some practitioners towards TT's professionalizing tendencies was also apparent at a TT practitioners' support group I attended. At the meeting, several women mentioned that the criteria for becoming recognized were too exclusive, and some wondered if the practice was not "losing its roots" and becoming "too organized." Such sentiments are similar to those expressed by alternative practitioners described in Baer (1998:1498), and indicate that TT's professionalizing tendencies are disputed amongst its members. In response to anti professionalization sentiment, past TTNO coordinator Diane May (2000:4-5) argues that pressure from sources outside of TT is responsible for the practices' standardization and regulation. She writes:

The credibility of Holistic Practices in general, and Therapeutic Touch, more specifically, has become much more of an issue over the past 5 years. Hence the need for standards, criteria for Recognition, etc. If we hadn't moved forward on these issues, the standards would have been set by others who knew nothing about Therapeutic Touch. Not everyone wants or needs to go 'through the hoops' required to become a Recognized Practitioner...If volunteer work is how you see using TT, then it will depend on the policies of the organization or institution where you volunteer. If you foresee a private practice in TT, Recognized Practitioner status is recommended to provide you with more credibility in your community. The Ontario Hospital Association is also suggesting to

their members that Holistic Practitioners going into hospitals have 'errors and omissions' (malpractice) insurance.

In conclusion, the processes of discourse management, knowledge standardization, public image maintenance, and regulation being undertaken by TT practitioners can be interpreted in terms of a 'professionalization imperative' which serves to distinguish them from competing discourses and protect them from orthodox criticism. Resistance towards professionalization is apparent amongst TT proponents, as members of TT organizations have voted against requiring certification, and practitioners speak out against efforts by the elite to control the TT discourse. This resistance to professionalization is balanced by claims for regulatory necessity by the discourse's elite. The elite generally characterize regulation as being imposed by forces outside of the discourse.

Chapter 7: Synthesis and Outcomes

In this chapter I provide a synthesis of the discursive strategies used by actors within the TT debate. Through managing their discourse, TT proponents have maintained their presence within biomedical discourse and institutions. However, the position of TT within medicine remains precarious due to its being perceived as “unscientific” or “religious”. Evidence is provided concerning the extent of TT’s presence within biomedical discourse and institutions. In addition, evidence is provided for a shift in TT discourse away from areas of scientific and religious contention, and towards biomedically accepted terminology and theory.

In analyzing instances of the TT *heretical drama* I have attempted to show how proponents and critics both utilize the narratives of several different discursive levels in legitimating their positions within the debate. Both sides utilize the defining narratives of the biomedical discourse and those of the discourse of nursing. In accusations of apostasy, both sides attempt to show how the other betrays different discursive realms. In these critiques, narratives of the art and science of healing are contested and negotiated in medical journals, popular media, and specialty publications such as In Touch.

Wolpe's conception of heresy provides a useful framework in analyzing the discursive strategies that proponents use in pursuit of legitimation. He describes the heretic as balanced between challenge and deference in their relationship to the orthodoxy. In order to be heretical, a challenge "must be framed as a direct attack on the orthodoxy's linguistic constructs" (1994:1142). However, he also notes: "Many potentially heretical ideas can be introduced into an ideology like biomedicine without eliciting a backlash if they are carefully formulated to conform to the orthodoxy's 'institutionalized way of speaking about the world'" (Ibid:1142). TT proponents appear to be following these dual processes, as they challenge the orthodoxy through a *heretical critique* that emphasizes the shortcomings of orthodox biomedicine, yet propose a complementary or adjunctive role for themselves within the discourse.

Similar processes of challenge and deference infuse debates over TT's relationship to nursing, its scientific validity, and its spiritual character. These debates reveal how the defining narratives within a discourse both restrict and empower heresy. Heretics must frame their healing model in terms of the discourse's master narratives, forcing them to constrain their more radical beliefs. However, these narratives also give them power, as heretics exploit inherent tensions and inconsistencies within the discourse and redefine its narratives to legitimate their claims. Through utilizing these strategies, TT proponents have been able to successfully defend

their healing model and to challenge the ability of biomedicine's elite to monopolize discursive power.

Tensions do remain within the debate over TT though, and the position of its proponents is precarious in several areas. Criticisms concerning the science underlying TT's theories do not appear to be overly threatening, but criticisms concerning the scientific basis for its effectiveness are. As seen in the discussion over Rosa, et. al. (1998) in JAMA, many of those who defended TT did so by mentioning that its efficacy must be measured in clinical trials. The strength of the scientific narrative within the orthodoxy, and even within the fringe, is strong enough to link the future of TT's heresy to its performance in these trials. Although it was noted that interpretations of research vary greatly, a stronger body of studies either proving or disproving the effectiveness of TT would have a large impact on its place within biomedical discourse. Negative results would impact significantly on strategies of scientific legitimation, causing proponents to rely more on themes within the narrative of healing, such as compassion, and spirituality, to justify the practice.

However, the fact that TT is perceived as spiritual by its critics is also problematic for its proponents, perhaps presenting as great a risk to its place within biomedical discourse as does its contested scientific validity. Essentially, these issues are two sides of the same problem. If TT is not science, then it is faith-healing, or religion, and therefore not

suitable for biomedicine. The strategies which TT proponents are using in dealing with this dilemma have their risks. In attempting to characterize it as syncretistic “spirituality” as opposed to religion, proponents seek to avoid issues of religious freedom argued by such critics as Fish (1996) and Bullough and Bullough (1998). As was pointed out in the Introduction, arguments against TT based on religious freedom can have substantial consequences, as Bishop (1999) reveals through her successful blocking of TT instruction in a Michigan hospital. She threatened the hospital board with a religious intimidation lawsuit.

It seems unlikely that TT’s self-description as spirituality will deter nurses like Bishop, Fish (1993; 1996) and other Christian nurses (Bailey 1993; Miller 1993) who perceive it as an example of New Age or Eastern Mysticism. The other strategy of proponents, which involves expanding the discourses of nursing and biomedicine to include spirituality, has some backing within the orthodox fringe. Holistic nursing is a prominent movement in both Canada (Petersen 1996; Crellin, Andersen & Connor 1997) and the U.S. (Barnum 1998; AHNA 2000), and holistic medicine is also prominent within North America (Goldstein, Jaffe, Sutherland & Wilson 1987; Caplan & Gessler 1998).

These movements within the discourses of nursing and medicine include conceptions of spirituality in health and illness. Examples include holistic physician James Gordon’s (1996:70) definition of holism as

“deeply psychological and spiritual”, or holistic RN’s Barbara Montgomery Dossey and Lynn Keegan’s (1988:4) description of healing as “a process of bringing parts of oneself (physical, mental, emotions, spirit, relationships, and choices) together at deep levels of inner knowing leading toward an integration and balance.” As such, TT proponents are not alone in their attempts to broaden the biomedical discourse to include spirituality, and this might partly explain the extent to which TT has managed to perpetuate its heresy.

Professionalization is another strategy which TT proponents use to simultaneously protect themselves from the power of the orthodoxy and from competing marginal discourses. The discourse management performed by TT’s elite acts to silence statements perceived as dangerous to the practice’s status within biomedicine. Standardization of teaching and practice criteria allow for even greater control over the discourse, and also enable TT to distance itself from competing healing modalities such as Healing Touch, Reiki, faith-healing, and Polarity.

Outcome of the Drama

Wolpe (1994) divides heresy as a dramaturgical event into an opening heretical critique and attack, and a corresponding response by the orthodoxy intended to counter the growth of the heresy or to silence it completely. If, however, the heresy manages to develop a strong enough

base within the discourse and enough institutional power to maintain itself, the drama moves into a state of *competition* in which the heretics engage in claims-making and the orthodoxy implements strategies of response and critique. The eventual outcome of the competition is described as either a type of conformity, or a schism.

Wolpe (Ibid:1143) describes the state of competition, stating that it "is a time of great tension, of political stratagems and potential change. The orthodoxy perceives itself as under attack, sees a set of basic values and assumptions called into question, and tries to defend itself" He then notes:

The nature of competition will, in part, depend on the ideological structure of both the heretics and the orthodoxy. Heretical movements may be ideologically rigid, believing their way is the only way, or flexible, believing that their way is the best, perhaps, but willing to negotiate compromises. The orthodoxy may also be flexible, willing to accommodate certain heretical ideas, or it may be inflexible, unwilling to even consider straying from its holy writ.

If both groups agree to operate in different areas within the same discourse, then a truce has been reached. Such an accommodation can be seen in psychiatry, in which psychoanalytic and biological psychiatry exist together in the same schools (Ibid., p.1143). However, if such an arrangement can't be made, then either conformity – in which heretics conform to the orthodoxy to some degree, or schism – in which "the heretical group is powerful, unyielding, and radical", and breaks off on its own (Ibid., p.1142-1145), ensue.

Through examining the present state of TT's discourse, it can be seen as a moderately successful heresy within the greater discourses of nursing and biomedicine. There is also evidence that the therapy has achieved a marginal niche within biomedical institutions. As mentioned in Chapter Five, TT's healing model is representative of the biomedical fringe, as it includes beliefs that challenge the narrative of science in the realms of illness definitions, treatment methods, and patient management. Through utilizing strategies of legitimation and through conforming their discourse, proponents have defended their beliefs from orthodox criticisms, and have perpetuated their heresy within biomedicine.

An analysis of articles published in medical journals and listed in the Med-Line data-base gives an indication of the extent of TT's heresy within academic biomedical discourse. I performed year by year searches on Med-Line, using the keywords "therapeutic touch", in order to ascertain the evolution of TT's *heretical drama*. When searching all languages and all article types from 1966 to 2000 (the oldest year of the 'new' data-base), a total of 313 articles on TT register.

The first TT articles appear in 1975, when Delores Krieger published two, both in nursing journals. Up to 1980, the total number of TT articles that appear is ten, including the first from a skeptical perspective (Sandroff 1980). From the twenty year period between 1975 and 1994, a total of 98 articles register. From 1995 on, the number of

articles for each year jumps drastically, with 215 articles registering from that point until 2000. Interpreting the increase in articles is difficult due to possible changes in the types of journals catalogued by the Med-Line database over the past five years. Another factor contributing to the rise in citations is the increase in published letters concerning the therapy. A large amount of letters are associated with three articles in particular, written by Rochelle Mackey (1995), Marilyn Oberst (1995), and Rosa, et. al. (1998). In addition, as mentioned in Chapter Four, the past ten years have seen several new journals emerge which deal specifically with complementary and alternative therapies. These journals have published several articles on TT. For these reasons, the Med-Line numbers cannot be seen as direct evidence of an increase in the total amount of articles published from year to year. However, when looked at as a twenty year trend, they do describe an increase in TT discourse within biomedicine.

The Med-line numbers support the idea that for most of its history TT existed as a heresy limited to the discourse of nursing, but that it has recently begun to spread beyond the profession into other areas of medicine. The first TT article from a non-nursing journal does not appear until 1992, by which point there are 69 total articles on the therapy, 68 of them from nursing journals. However, from 1993 onward, there are 70 articles on TT in non-nursing journals. Most of the non-nursing articles appear in journals devoted specifically to alternative medicine, with

journals concerning cancer, family practice, and psychosomatic medicine being the next most represented.

There has also been a change in the ways in which TT is being researched and talked about within medical journals, supporting the idea that proponents have acted to conform their discourse to that of the orthodoxy. TT researchers have begun to look at ways in which the therapy can be explained in non-energetic terms, either as a facilitation of the placebo response (Meehan 1998), or as a psychoneuroimmunological effect. Measures of TT's effects on the cellular immune system have become more common, beginning with a pilot study by Quinn and Strelkhaus (1993), in which TT was given by two practitioners to four bereaved patients (each of which had recently lost an immediate family member). In this study, which had no control groups and which did not test results for significance, a decrease was found in suppressor T-lymphocytes in both practitioners and recipients. In a study involving HIV infected men that involved a sham TT control group, Garrard (1995) reported significantly higher CD4+T-lymphocyte count amongst the TT group than amongst the controls. In a study of TT's effects on 99 burn patients, Turner, Clark, Gauthier, and Williams (1998), found TT to be effective in relieving pain and anxiety, and reported a decrease in suppressor T-lymphocytes in 11 subjects from whom blood was analyzed.

A noticeable difference in the language used to describe TT can also be seen from examining journal articles and other public TT material.

In early articles on TT, the concept of prajna was used to describe the energetic theory underlying the practice. In Delores Krieger's (1975) article in the *American Journal of Nursing*, she writes:

The basis for this interaction between healer and subject is thought to be a state of matter for which we in the West have neither a word nor a concept. In Sanskrit it is called *prana*...Prana can be activated by will and can be transferred to another person if one has the intent to do so.

Similarly, in her 1981 book Foundations for Holistic Health Nursing Practices, she recalls arriving at her theories about TT through

"literature...derived from the East, particularly from India and Tibet.

Briefly, it states that life energies in humans, which we in the West call animation, or vigor, are an expression of an energy system called prana"

(Krieger 1981:140). Similarly, Heidt (1990:180) writes: "Influenced by Eastern views of health, Krieger posited that the healing relationship is based on a transfer of 'life energy'." As late as 1995, RN Rochelle Mackey (1995:27) writes: "The field of human energy extends beyond the skin and is visible through Kirlian photography. In India, it's called prana. Good health is said to be an abundance of prana, illness, a deficiency."

In the last five years I have only located one article published by a TT proponent in a mainstream medical journal which refers to prana or to Eastern philosophy (Mulloney & Wells-Federman 1996). Other

mainstream letters and articles have mentioned neither concept. In a recent reply to an article in the Journal of Professional Nursing, which suggested that TT was religious, Krieger (1999:200) did not mention prana, but described the therapy as: “a contemporary interpretation of several ancient, trans-cultural healing practices.” In replying to a similar letter in the American Journal of Nursing, Krieger (1999:14) described the therapy as “a contemporary interpretation of several enduring ancient healing practices”, and mentioned that it has “a broad, transcultural perspective.” In describing the therapy, most current articles simply mention that TT supposes that there is a human energy field, or else contextualizes TT in terms of Martha Rogers’ science of unitary human beings (Simington 1993; Biley 1995; Bronstein 1996; Elabdi 1997; Samarel 1997; Katora 1997; Ramsey 1997; Daley 1997; Gordon et. al. 1998; Egan 1998; Peck 1998; Turner, et. al. 1998; Dalglish 1999).

Other evidence of TT’s discourse within biomedicine can be found in writings on holistic nursing and alternative medicine. Renee Weber, Ph.D. (1988:xi), writes in the introduction to Dossey, Keegan, Guzzetta, and Kolkmeier’s Holistic Nursing: A Handbook for Practice: “In 1979, a few years after the emergence of Kunz and Krieger’s concept of Therapeutic Touch – when this revolution in human self-image first surfaced in a serious way among health professionals – I published “Philosophical Foundations and Frameworks for Healing.” In her introduction, Weber

cites TT as a major influence on her writings in holistic medicine. Similar signs of TT's influence can be found in Guzzetta's (1998) collection Essential Readings in Holistic Nursing, in which articles by TT proponents Janet Quinn, RN, Ph.D., Carol Wells-Federman, RN, and Stephanie Mulloney, MS, RN, appear. TT is also found in complementary therapy collections such as Snyder and Lundquist's (1998) Complementary/Alternative Therapies in Nursing, 3rd Edition, and Eliopoulos' (1999) Integrating Conventional and Alternative Therapies: Holistic Health Care for Chronic Conditions.

TT has established a presence within biomedical institutions. The therapy is currently practiced within biomedicine by nurses, lay volunteers, and to a lesser extent, other health professionals (doctors, social workers, physiotherapists). These people practice in various hospital situations, such as pain or rehabilitation clinics, special complementary therapy or TT clinics, and regular hospital wards (oncology, obstetrics, cardiology, etc.). TT is also practiced outside of hospitals in hospital-affiliated support groups, in public and private health clinics, in doctor's offices, and in patient's homes, as homecare. In the United states, TT is also performed by nurse practitioners in private practice. Outside of biomedicine, TT is practiced privately by nurses, laypeople, and a host of other alternative health practitioners (chiropractors, massage therapists, reiki therapists, etc.)

An example of TT's local incorporation into biomedicine is the Wellwood Resource Centre of Hamilton, a privately funded alternative health clinic for patients with cancer. Wellwood is located within Henderson Hospital, a prominent institution for cancer research and treatment in Southwestern Ontario. The centre is endorsed by the Hamilton Health Science Corporation, which runs the McMaster University Medical Centre (MUMC), and Chedoke, Hamilton General, and Henderson hospitals. Wellwood provides: "Supportive care programs in a compassionate and healing environment. The care process emphasizes the uniqueness of each person and is conducive to exploring the physical, psychological, and spiritual dimensions of a life-threatening illness" (Wellwood 1999). Programs include classes in tai chi, yoga, and meditation, as well as a thrice-weekly TT clinic staffed by volunteer nurses. Two of the nurses I interviewed for this research volunteer in the TT clinic at Wellwood.

TT is also regularly practiced in two areas of MUMC. Both areas are run by an anesthetist, with one located in a general outpatient clinic, and the other located in a fracture clinic. The general outpatient clinic offers acupuncture for pain control, and also has a staff nurse provide TT treatments on Tuesdays. In the fracture clinic, the same staff nurse provides TT treatments on Fridays. The nurse providing these treatments has been doing so at the clinics for ten years.

In Toronto, several medical institutions provide TT services, including St. Joseph's Health Centre, St. Michael's Hospital, and Princess Margaret Lodge for cancer patients (Elton 1999). In 1993 the Toronto East General Hospital opened a full-time TT clinic with two permanent nursing staff and several volunteers. It is estimated by the clinic director that 160 nurses at the hospital have learned the therapy to date (Dalglish 1999). TT is being practiced along with other alternative therapies at Sunnybrook Health Science Centre, where 75 employees, 50 of them nurses, are trained in the therapy (Elash 1997). TT is also being practiced within several hospitals and health care centers in British Columbia. The British Columbia Cancer Agency in Vancouver has had a therapeutic touch program since 1992 (Semple 2000:5). At Royal Columbian Hospital, over 150 staff members have been trained in TT, and the therapy is used in several hospital departments. Burnaby Hospital has been utilizing touch therapies since 1982 (Nightingale 2000).

There are several examples of TT's local, "unofficial" practice within biomedical institutions. The six nurse practitioners I interviewed for the research all performed TT treatments in their workplace. Five of them worked in hospitals and one worked in a private doctors' office. As well, Therapeutic Touch courses are taught locally by one of the recognized teachers I interviewed, with these courses taking place within local hospitals (although not officially endorsed by the hospitals). In Hamilton

there are two TT practitioner support groups, with one group solely for nurses who practice in hospitals. Other hospital practitioner groups are located in Markham, Orillia, and Stratford, with three such groups located in Toronto (for nurses at Sick Kids, St. Michael's, and Toronto East General hospitals). As well, there is a large community of TT and related therapists (reiki, shiatsu) who practice at Circle of Friends, a community-based cancer support group. Both nurse and lay TT practitioners perform treatments at the Circle twice a week.

The form which TT's integration into biomedical institutions has taken is consistent with the greater integrative medicine movement discussed in Chapter Four. TT is best described as an incorporated therapy, which is used by biomedical professionals in biomedical institutions. There is some evidence that TT is also engaged in a process of professionalization, which could be designed to distinguish the practice from other, similar therapies such as reiki and healing touch. In addition, professionalization can be seen as a means by which TT's elite can both manage their discourse in response to criticisms, and conform to increasing licensing requirements demanded by governments and medical institutions.

Although there is significant evidence of TT's incorporation within Hamilton and Toronto, it is impossible to determine its prevalence in other communities. An avenue of future research would be to determine the

number of nurses practicing TT within biomedical institutions in Ontario. Without data on the number of practitioners, and the different conditions under which they practice, it is difficult to determine the extent of TT's incorporation into health care delivery systems.

Conclusions

The story of Therapeutic Touch's integration into biomedicine is a complex one, in which greater socio-historical, political, economic, and scientific processes play a significant role. The current TT community is a product of these greater forces, yet it is also a reflection of the agency of its members, and of the ways in which they responded to, and influenced, the larger processes of which they were a part. This agency is evident in the strategies of discursive negotiation and adaptation that proponents have utilized within the TT debate.

Historically, the first major influences on TT were the holistic health, New Age, and counter-culture movements, which in the 1960's and 70's began exposing Westerners to the religious traditions of the East, and opening up a broad critique of Western institutions and ways of thought. Krieger was immersed in the alternative medical culture of the time, as her association with Kunz and the American Theosophists, and later with such organizations as the Meninger Foundation and the Association for Transpersonal Psychology, indicates. Through participating in the holistic health movement, Krieger was exposed to both the laying on of hands, and to the Yogic philosophies through which she explained its healing mechanism. As such, first and foremost, TT represents an incorporation

of those alternative healing ideas into the world of biomedical nursing. This act of incorporation was both co-optive and creative, as Krieger took the healing techniques of Oskar Estebany, the Theosophical philosophy of Kunz, and Eastern conceptions of vital energy, and fused them with her own views of nursing and the healing act.

The resulting practice of therapeutic touch was a blend of alternative and establishment, as Krieger (1980:366-368) immediately began to scientifically study the practice, and to search for, as she put it “the modus operandi of this healing process.” It was through the process of confirmatory scientific research that Krieger claims she “became convinced that healing by the laying on of hands is a natural potential in man.” As well, Krieger was able to research this alternative phenomena due to her position as a professor of nursing within the biomedical system. This combination of biomedical associations and alternative healing philosophies served to mold TT’s heretical character.

From the point of TT’s emergence, the agency of Krieger and of other early TT proponents such as Janet Macrae, Janet Quinn, and Patricia Heidt, led to the therapy’s spread, first through the graduate nursing course at New York University, then into other nursing and lay communities through a widening network of teachers and practitioners. That TT began within nursing likely facilitated this spread, as the profession’s view of healing as a primarily carative process fit well with

TT's goals of facilitating the healing powers of nature through relaxing and calming the patient. Within the claims of proponents, there is a strong association made between the goals of nursing and the goals of TT, such that, for Krieger, TT represented "the imprimatur of nursing" (Krieger 1980).

TT's spread within biomedical discourse and institutions led to immediate criticisms from other members of the nursing community, who saw the New-Age inspired and scientifically implausible theories of TT as a threat to the profession's status within medicine. The TT debate within nursing discourse led to considerable flaws in the therapy's research being revealed and critiqued. As the therapy spread further within the discourse, the "untestability" of its assumptions were also strongly critiqued, and its proponents held to more demanding standards of evidence to prove TT's effectiveness. At this stage of evolution, the "TT debate" spread beyond the discourse of nursing into biomedical discourse, as the therapy's alternative healing model became increasingly known to other biomedical practitioners.

As described in chapter's five and six, the TT debate within biomedical discourse involved a meeting of fundamentally different conceptions of science and healing. The healing model of TT proponents postulated a deeply spiritual healing act based on internal, subjective knowledge, and proposed mechanisms of action that are hypothetical at

best, and unfalsifiable at worst. Reaction to TT reveals the variation within orthodoxy concerning the medical model. Fringe orthodox professionals espoused views similar to those of TT proponents and defended the therapy, while soft and strong orthodox professionals generally dismissed the therapy as scientifically implausible and therapeutically unproven. These rejections were predicated on rationalist, materialist, and dualist, assumptions. As the mechanism for TT's functioning is scientifically unproven, and seems to contradict accepted laws of physics, then the therapy is unscientific. Since the therapy cannot be adequately controlled, and shows inconsistent effects beyond a placebo, then it is a placebo effect, and therefore not effective treatment. As well, since the therapy is similar to religious healing practices, and involves spiritual elements, then it is a matter of faith (mental) rather than medicine (material).

Biomedical discourse is linked to biomedical institutions in several ways. The editorial boards on mainstream medical journals have certain criteria for accepting articles which are based on commonly held notions of appropriate medical science. Funding agencies and medical institutions (hospitals, professional schools) are also guided by similar conceptions, as are professional colleges. Within biomedical discourse, healing models and healing procedures are tested, debated, and eventually determined to be either useful parts of the biomedical system, or to be among the many unsupported hypotheses which are commonly produced within discourse

amongst scientific, and applied scientific, communities. The process of labeling things as either science, or not science, and therefore not medicine, is the *discursive power* of the orthodoxy. If TT was labeled as “unscientific”, either through its failure to establish therapeutic effectiveness, its failure to identify a plausible mechanism of action, or its being labeled as religious, then its subsequent exclusion from the discourse would have strong repercussions concerning its place within the health delivery system.

TT proponents respond to discursive criticisms in several ways, which I characterized as *strategies* for the purpose of this study. The most prominent strategy utilized is scientific justification, in which proponents produce research on TT in the pursuit of scientifically validating its effectiveness. This process involves several different elements; first, proponents produce scientific research, second, they produce interpretations of TT research which casts it in a favourable light, third, they refine their research procedures in response to criticism, fourth, they use the rules of the scientific narrative to critique their opponent’s research (as seen in the Rosa, et. al. (1998) article), finally, they modify their hypothesis concerning TT’s mechanism of effect. Other strategies used by proponents include appealing to the narrative of nursing to legitimate their model, attempting to distance TT from religious associations by representing it as syncretistic spirituality and arguing for the role of

spirituality in healing, and undergoing a process of professionalization, in which they consolidate their discourse and differentiate it from other alternative healing communities.

TT's efforts at discursive negotiation have so far been successful in that they have enabled the movement to maintain its presence within the biomedical discourse, and hence within biomedical institutions. Their need to maintain discursive legitimacy is very real, as at several hospital boards the inclusion of TT practice has been contested by critics of the therapy, and has resulted in reviews of literature to judge the therapy's effectiveness. These reviews have led to decisions for and against the therapy's incorporation, indicating both how precarious TT's standing within biomedical discourse is, and how important that standing can be in terms of institutional access.

The stage of TT's debate within medicine, which continues at the present time, has been influenced by several recent trends within the health care system as a whole. First, there is the perception of a crisis in medicine within the industrialized world, based on the twin factors of escalating health care costs and decreasing health returns from biomedicine. The rising financial burden of health care has led governments to seek ways of containing costs. The result of cost-containment imperatives appears in rationalization movements within Canada and the U.S., and serves to destabilize traditional medical

hierarchies. Bureaucrats and health care administrators now exert more control over the working conditions of health care professionals, and public concerns about health care provision now carry more weight in determining policies of delivery.

The decreasing health returns of medicine are also contributing to the perception of a health care crisis. Chronic illnesses such as heart disease and cancer are now the leading health problems in the industrialized world. As biomedicine is less effective at curing these diseases, its perceived effectiveness can also diminish, leading people to utilize alternative forms of treatment. There is evidence that alternative therapy use is much greater than was once thought, and that significant amounts of money are being spent on such therapies by the North American public. At least partly due to these influences, a movement to integrate alternative practices has arisen within biomedicine. The extent of this movement, which has been deemed "integrative medicine", is difficult to determine with any precision. However, as discussed in chapter four, there *is* substantial evidence of such a movement, and of its impact on the type of primary care provided, the type of research being funded by governments, the licensing and regulation of alternative practitioners, and the content of biomedical education.

The impact which the perceived crisis in health care and the emergence of an integrative medicine movement are having on TT's place

within medicine is unclear. In one sense, an increase in openness to alternative therapies on behalf of the orthodoxy is of benefit to the TT community. Because TT retains a presence (however marginal) within biomedical discourse, and because it is practiced by nurses, it could benefit from being a “known quantity” amongst a host of similar, yet less institutionally legitimated, practices. This, in turn could lead to its increased incorporation. However, with an increased openness to alternative therapies comes increased threats of competition. It has been noted that competition for “market share” in the realm of hospital delivered energy therapies has already emerged between TT and Healing Touch. In this sense, professionalizing behaviour on behalf of TT proponents can be seen as an attempt to define the community’s boundaries and distinguish it from competitors.

A further result of TT’s ability to maintain its presence within biomedical discourse is that recent developments in medical science are providing tentative explanatory mechanisms for TT’s effects. Researchers in the field of psychosomatic medicine and the sub-field of psychoneuroimmunology are beginning to elucidate the processes by which mind and body are bicausally connected (able to affect one-another). Although the science is still immature, these fields of medial research could provide invaluable insights into the nature of mind/body interactions once concealed under the catch-all title of “placebo effects”.

As shown in the first part of the conclusions, there is evidence that some TT proponents are moving towards integrating the findings of psychosomatic medicine and psychoneuroimmunology into their explanatory frameworks.

The willingness of some researchers (Therese Meehan, for example) to accept conceptions of TT's effects which include testable, physiologically plausible mechanisms, is indicative of the extent to which proponents have conformed their discourse to that of biomedicine. There are many more examples. As mentioned previously, Krieger and other proponents no longer discuss TT's effects in terms of prana, or Eastern religious concepts. As Crystal Hawk mentioned to me in our interview, the "party line" of TT providing a relaxation response and facilitating natural healing processes has become the face which TT presents to the medical community. That TT practitioners within biomedicine have conformed their discourse is also apparent when contrasting it with TT dialogue outside of medicine. If leading TT researchers wrote articles about the practice as a profoundly religious experience, or attempted to study such hypotheses as the potentiating effects on "distance healing" gained from soaking in a warm bath, the practice of TT would have long since been excluded from biomedicine.

The future of therapeutic touch within medicine, like its past, will be determined by the ability of its practitioners to find a legitimate place within

a rapidly changing health care system. As long as the scientific narrative serves to define the orthodoxy, TT's legitimacy within it will hinge on its scientific status. If the body of TT research eventually disproves its clinical effectiveness, then the therapy will likely be relegated to a position outside of medicine. Similarly, if TT is labeled religious within the orthodoxy, then its role again will be limited, either to chaplains within biomedicine, or to the lay community without. However, if the recent trend towards incorporating alternatives into biomedicine continues, and if TT research is able to further elucidate its mechanism of action and its clinical effectiveness, then the therapy could play a significant role within an integrative medical system.

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Appendix A –Interview Schedule

Questions for all Interviewees

1. What is your age?
2. What is your educational background?
3. What is your occupation?
4. How long have you been working in this occupation?
5. How did you first hear about therapeutic touch?
6. Do you think that practice of therapeutic touch involves gender issues? If so, what issues are they?
7. Do you think that practice of therapeutic touch involves political / economic issues? If so, what issues are they?
8. Have you heard any criticisms about therapeutic touch?
9. How do you think that therapeutic touch works?
10. Do you think that therapeutic touch should be a part of regular biomedical practice in Canada?
11. What do you think about alternative or holistic therapies? Should they be covered under government health insurance?
12. What does the term “holistic medicine” mean to you?
13. How would you define health?
14. How would you define illness?

Therapeutic Touch Practitioners

1. How long have you been practicing therapeutic touch?
2. How did you learn the therapeutic touch technique?
3. What made you decide to start practicing therapeutic touch?
4. Have you ever experienced a therapeutic touch treatment?
5. Is your practice of therapeutic touch known to your colleagues?
6. How do you feel your practice of therapeutic touch is perceived by your colleagues?
7. How do you feel your practice of therapeutic touch is perceived by your clients/patients?
8. How accepted do you think therapeutic touch is within the biomedical community?
9. How accepted do you think therapeutic touch is within the lay community?
10. How accepted do you think therapeutic touch is within the nursing community?
11. Are there cases in which therapeutic touch works better / worse?
12. How is competency in therapeutic touch different from competency in traditional biomedical interventions such as surgery or pharmacotherapy?
13. How do you feel therapeutic touch differs from other traditional biomedical interventions?
14. Describe a typical therapeutic touch treatment, including your perceptions of it.
15. Have you consulted any clinical studies of therapeutic touch?

Therapeutic Touch Recipients

1. When did you experience therapeutic touch?
2. Where did you receive the therapy?
3. Who administered the therapy (no names - nurse, friend, etc.)?
4. Had you heard about therapeutic touch before you received a treatment?
5. Describe the treatment.
6. Was the treatment beneficial?
7. Would you get another therapeutic touch treatment?

Therapeutic Touch Critics

1. Have you ever received a therapeutic touch treatment?
2. What takes place in a therapeutic touch treatment?
3. What do you find objectionable about therapeutic touch?
4. What place do you feel therapeutic touch has within biomedicine?
5. How do you think therapeutic touch reflects upon biomedicine and other health professionals?
6. Have you consulted any clinical studies of therapeutic touch?