Compassion as Power: Clinical Implications of Therapeutic Touch
Dolores Krieger, Ph.D., R.N.

Paper presented at the Martha E. Rogers Colloquium on Nursing Science, sponsored by Lehman College Division of Nursing, The City University of New York, April 19, 1990

Thank you very much, Dean Willie, for inviting me to present the keynote address to the 1990 Martha E. Rogers Colloquium on Nursing Science. I have always thought of Martha as one of the true heroines of nursing, for it was her indomitable courage and clarity of foresight that brought nursing squarely into the twentieth century—before that time of unique opportunity for significant growth flowed by and left us stranded among the silted dregs of outmoded ideas, even though intentions were well meaning. As her student I was proud to be counted as one of Martha’s Mavericks, and today I am honored to be her friend. You could not have picked a better model for the scholarly inquiry that is the hallmark of these colloquia on nursing science, and I applaud the perceptivity of your choice.

However, the failure to keep in touch with the times has been an unfortunate characteristic of our society as a whole. Recently Ornstein and Ehrlich summed up this sad state by noting that at this time we are foolishly functioning with a mind set fit for the 18th century, while playing with the “toys” of the 21st. Neither our society nor our profession can afford this attitude any longer. As our newspaper headlines remind us daily, history is changing every 20 minutes, and we are already caught up in the dynamism of a postmodern world that involves a new science, a new society, and a new spirituality based on the recognition...
of a mutual interdependence.

Carl Jung called this time an End Point, for we are at the end of a millenium as well as at the end of a century. It is time for a radical shift in our perceptions. It is important, perhaps even crucial, that we learn to think in new ways and strive to access the farther reaches of the mind. This realization sparked the genius of Professor Rogers in her call to recognition that the core of concern in nursing is neither with bedpans nor with thermometers but with human beings and their world, and that the appropriate context in which these constantly interacting energy fields were to be viewed was through the perspective of their unitary nature. This incisive declaration significantly engaged the conceptual frame of professional nursing with a dynamism that served to strengthen and to clarify the unique nature of its directions, scope, and depth of inquiry.

The recognition of the unitary nature of Man and environment has been variously stated throughout time by many cultures. In our own country, for instance, Luther Standing Bear, of the Lakota Sioux, in explaining the fundamental ideas of the belief system of his People said:

But very early in life the child began to realize that wisdom was all about and everywhere, and there were many things to know. Even in the sky there were no empty places. Everywhere there was life visible and invisible and every object gave us a great interest in life. Even without human companionship, one was never alone. The world teemed with life; there was no complete solitude for the Lakota.

In many other cultures, also, the message was constant: human beings and their environment are indissolubly bonded. But in our western culture this clear vision has been lost over the past 400 years of frankly slavish adherence to mechanistic cartesian models. Such modeling was an appropriate view for classical physics, which dealt with inanimate objects. History tells us that the seeming control that could be exerted through this perspective was considered phenomenal. It served as a model for chemists and then for the professionalization of physicians early in this century, and later nursing followed in lockstep. It was this latter historical error that Martha Rogers sought to correct.

Foundational to the Rogerian conceptual system is the assumption that the fundamental unit of all manifestation is based in energy fields. Eighteen years ago my colleague, Dora Kunz, and I developed a mode of healing that we designed specifically for use by persons in the health professions which we named Therapeutic Touch. Therapeutic Touch is a creative synthesis of ancient healing practices coupled with several substantive researches on the Therapeutic Touch process. This has led to a growing body of knowledge that has been tested in clinical practice by nurses, physicians, psychologists, and a wide variety of therapists. At this time, Therapeutic Touch has been taught in more than 80 colleges and universities in this country and in 59 foreign countries. It is used in hospitals and other health facilities, and enjoys a long record of safety for both practitioner and patient, or healee. It has been taught in innumerable extension courses and professional in-service programs for continuing education units. Four years ago the American Journal of Nursing, Inc., cosponsored a half-hour videotape on Therapeutic Touch with the Hospital Satellite Programs, Inc. These videotapes are bounced off a communication satellite to broadcast receivers in hospitals, which then use them in their in-service programs. In its first year the videotape on Therapeutic Touch became the company’s best-seller. Also, about 4 years ago the computer retrieval system named MEDLINE, which is a data base for literature of significance to the health field, created an individual category for written materials on Therapeutic Touch. Many of the articles cited are in foreign lan-
guages, French, Italian, German, Spanish, Dutch, Russian, Afrikans, Japanese, and Thai among them. There has also been a large amount of formal researches done on the Therapeutic Touch process, so many that in fact I myself have difficulty keeping an accurate accounting. To the best of my knowledge, at this time there are 12 doctoral dissertations written on Therapeutic Touch and 8 more in progress. Seven postdoctoral studies have been completed, and 4 more are in progress. In addition, there have been innumerable Masters’ theses and clinical studies done on Therapeutic Touch.

To get to the process itself, it should be said at the onset that the only thing Therapeutic Touch has to do with is human energy. It does not have anything directly to do with medical diagnosis. Medical diagnosis is a highly sophisticated classification system that is very important within its own context, but it is an entirely different universe of discourse from Therapeutic Touch. Therapeutic Touch is a logic system that derives from basic assumptions about human energy, as we shall soon discuss. However, what is human energy?

Isaac Newton’s definition of energy was that it does work, and it is not difficult to see a place for the idea of human energy within this frame of reference. Imagine, for instance, a tennis match in which the players run from side to side of the court in a graphic display of human energy unbounded, except by the rules of the game. In our mind’s eye we can vividly see the potential energy locked up in human muscle as the tennis player crouches forward awaiting the serve of her opponent. Then comes the POW! as her racquet returns the ball, the sound reinforcing our acknowledgement of the expenditure of energy actualized. We can even touch our finger to the sweat that was a resultant of that physical energetic interaction. However, the human being is infinitely complex, and the summation of the ounces of sweat produced does not begin to give us an accurate idea of the interplay of human forces we perceived to be enacted. There are multiple human energies. For instance, one can see emotions as one form of human energy: rage, fear, joy even produce physiological correlates that can be measured. There are functions of our mind that also can be considered energetic, such as human will and the capacity for visualization, and other energy forms that are little understood, such as intuition, creativity, and compassion, which we shall explore further in this discussion.

Therapeutic Touch has to do with human energies such as these; they are, in fact, what makes the individual human. Therapeutic Touch has been called the clinical for Rogerian nursing science, for through its practice one can gain experiential knowledge of the homeodynamic principles that underlie that conceptual frame. Fundamentally, Therapeutic Touch is based in the therapeutic use of hands, a human function that goes back evidentially to depictions in cave paintings calculated to be more than 15,000 years old. Beginning with an essential act of centering, or finely focusing the consciousness in an act of interiority, the Therapeutic Touch practitioner may, but most often need not, make actual contact with the physical body. In that phase of Therapeutic Touch called the assessment, the person doing Therapeutic Touch learns to sensitively pick up cues from the healee’s energy field that will give her a sense of imbalances in that field, and then, in the treatment phase, she acts upon this information. This nontactile exploration of the human energy field is another mode of communication than most of us usually engage, a function that might be included within the Rogerian definition of evolutionary emergent. In this interaction, the Therapeutic Touch process can be viewed as an act of resonancy. As I noted before, Therapeutic Touch is a logic system based on several basic assumptions. I would like to bring to your attention a few of the major assumptions and indicate to you how we act upon these premises. The first assumption is
that Man is an open energy system in constant dynamic exchange with the environment, which is to say, the universe. It is this incessant flow that is the basis for the multiple examples of connectivity, coherence, and order that characterizes the life process. Because of this there is, therefore, no need to construct a rationale to explain "how" energy gets from the healer to the healee. In an open system energy flows not only to us but through us continually. The prime characteristic of life is animation, constant movement, flow. When the flow stops, so does life. The healer does not "create" energy; rather, from a centered state of consciousness, as previously stated, he or she learns how to specifically direct human energy or to sensitively modulate it. The important ingredient that the healer adds is intentionality within a context of compassionate concern. If the act is not motivated by compassion, then it is not Therapeutic Touch; it is something else.

A second basic assumption is that anatomically humans are bilaterally symmetrical. This can best be seen in the early development of the embryo and, in particular, in the skeletal system in the mature human being. This assumption permits a rational basis for inferring that there is also pattern in the underlying human energy field. In Therapeutic Touch this assumption is used as background for assessing the healee's energy state. A third basic assumption is derived from the world literature on healing, in which healers universally agree that what we in the West call "illness" is actually indicative of an imbalance in the healee's energy field. The implication we derive is that the charge to the healer, therefore, is to rebalance the individual's energy field. Finally, I would like to note the assumption that human beings have a natural ability to transform, or change, their conditions of living and to transcend or get beyond them. In a sense, these functions are the necessary prerequisites for healing to occur.

I think it is important at this point to clearly differentiate between the term "cure" and the concept of healing, so that you understand clearly the context within which I speak to you this evening. The word cure comes from the Latin and has the connotation, to care for. Early in the Christian church history the curate was concerned with the preservation of the soul. In more recent times the term "cure" has come to be associated with a system or method of medical treatment, so that the phrase "to be cured for five years" I take to mean that, under a particular system or method of medical treatment or care, the patient will live for five years. On the contrary, the word "heal" derives from the Middle English helen, to make whole, to care about (rather than to care for) the whole or total individual. The term heal, therefore, has to do with how one thinks of oneself, ones worldview or philosophy of life. Consequently, healing is concerned with the quality of life across its whole spectrum which, of course, includes the process of dying from that time of livingness. It is for this reason that I say that the distinguishing features of healing are concerned with transformation and transcendence. These are subjective qualities, of course; however, one only need look to current studies in psychoneuroimmunology to recognize the importance of subjective mood on the neuropeptides stationed throughout the body and the resultant functioning of endorphins—not only in reference to the alleviation of pain, but also in reference to the high sense of well being that follows. In healing, therefore, one could say that the feasible objectives are:

*To bolster the healee's own potential for self protection; that is, to strengthen the healee's immunological defenses,

*To support the natural intelligence of the physical body towards self healing; so that, in effect, the healer becomes a human support system as s/he actively creates a healing milieu, and

*To educate the healee in preventive techniques, particularly in reference to stress, so that the healee may maintain a state of high caliber,
vibrant well being and thereby be awakened to the realization of his or her own potential.

The healing process itself is awesome to witness. There is elegance, beauty, and an indescribable grace in the harmonic regularity and specificity of the healing process in action. However, one finds oneself wondering: How can healing be so selective that it inhibits chaotic growth of tissues in malignancies, on the one hand, and yet vigorously stimulates the precise laying-down of new tissue in wound healing? In the end one must admit that healing is, indeed, a profound mystery.

How does one get to understand the mystery? As I mentioned before, the essential state of consciousness in healing is one of a compassionate nature. I also said that if there is no compassion, then the person is doing something else. Unfortunately, today compassion is indeed a “non-ordinary” state of consciousness, in that it is so rare as a lifeway. I have been called a “soft sell,” and I must admit that I encourage the term for, as a teacher I will do anything to capture the student’s attention and to challenge him or her to think for oneself. Therefore, let me share with you that the reaches of compassion do, in fact, give one access to other states of consciousness, other realms of perception; that is, for a moment you see the healee and circumstances differently. Compassion can open the gates to an experience in Rogerian-defined four-dimensionality.

If that compassionate state of consciousness can be sustained, or if it is in frequent use, its dynamics can carry perception into the sweep of the higher orders of self. Then, there is the possibility that compassion can become an act of conscious power. It is toward attaining this conscious power of compassion that practitioners of Therapeutic Touch strive.

Therapeutic Touch is transcultural, and so is compassion. No particular school of philosophical thought can claim an exclusivity clause to its definition, nor can any one religion delimit its practice. Compassion is constellated as a universal archetype that transcends all boundaries. We know this archetype as the Mother of the World, the feminine principle. It is when compassion becomes a conscious process that it holds the possibility of becoming a volitionally directed power. Such a person knows how to participate knowingly in change, and change is the keystone of the healing process. The wielder of conscious compassion thus can become a change agent whose perspective encompasses more than the events of the immediate moment. Such a person envisions positive possibilities, the potential that awaits expression, and he or she may be fortunate enough to engage in foresight, although it be tinged with altruism.

Compassion is implicit in the code of Florence Nightingale, who was perhaps the first nurse scientist. My message to you tonight is that it is our charge to make compassion explicit in our time; that is, to make compassion a conscious act of our commitment to nursing. To do so is to participate knowledgeably in the evolution of nursing. Those of you who look forward to being the nurse scientists of a newer Age know that there is no other way. Nursing without compassion is simply something else. Sentimentality is inappropriate, and there are times when mere love is not enough. The nurse of the newer Age must be knowledgeable, mindful, and willing to engage the powers of intelligent, conscious compassion to help those who are in need. Conscious compassion is a natural potential in all of us; it needs but be actualized by each of us.

Thank you very much for having me tonight. I enjoyed your company immensely.
MISSION STATEMENT OF THE SOCIETY OF ROGERIAN SCHOLARS

The mission of the Society of Rogerian Scholars, Inc., is to advance nursing science through an emphasis on the Science of Unitary Human Beings. The focus of the Society is education, research, and practice in service to humankind.

PURPOSES

1. Advance nursing as a basic science.
2. Explore the meaning of a philosophy of wholeness for nursing.
3. Foster the understanding and the use of the Science of Unitary Human Beings as a basis for theory development, research, education, and practice.
5. Foster a network for communicating the Science of Unitary Human Beings.
6. Create forums for scholarly debate.

PHILOSOPHY

Since its advent as a profession heralded by the work of Nightingale, nursing has been responsible for the development of a body of scientific knowledge specific to nursing and for the imaginative and creative use of this knowledge in the art of practice. The nurturance of human beings is the ever-present and age-old concern of the nursing profession.

The Science of Unitary Human Beings provides a distinctive nursing frame of reference for viewing the human being, the mutual human-environmental process, and nursing practice. Nurses who are concerned with the Science of Unitary Human Beings are challenged to contribute to its conceptual, theoretical, and practice development. Nurses are responsible for the logical analysis of the framework and the generation and testing of theories. How nurses use knowledge derived from the framework to provide a service to society is as important as the knowledge itself. The thoughtful synthesis of the science and art of nursing is essential if the framework is to contribute to the fulfillment of the profession's mandate to provide nursing service to society. All nurses concerned with the development and use of the framework are responsible for engaging in open communication of ideas, questions, challenges, and refutations generated by the framework, and reporting scholarly work and practice in the nursing literature.

The Society of Rogerian Scholars is committed to fostering the development of the Science of Unitary Human Beings by providing a formal, organized structure for the stimulation, development, and exchange of ideas. The formation of the Society is predicated upon the belief that all nurses around the world should have a forum where questions, ideas, insights, and opinions related to the framework's concepts, theories, and use in practice are discussed. The Society provides a structure to ensure open and speedy communication of current work and thinking within the framework and the most recent developments and revisions of its concepts, principles, and theories. The fulfillment of the mission and purposes of the Society will help to advance nursing as a science and thereby contribute significantly to the knowledgeable nursing of human beings.

One of the long-term goals of SRS is to establish a reference library for Rogerian scholars. Toward this end, we are asking members to send copies of their work written in the Rogerian framework, pub-
lished or unpublished, so that we can begin setting up reference files. We can then begin compiling annotated bibliographies of work focusing on practice, research, theory development, etc., to share with members. Copies of members' work would not be circulated but maintained in a central location in the hope of establishing a reference library in the future.

We have circulated our first list of members and their particular interests within the framework. Remember, if you want to be included in the next list, send your name, address, phone number, and areas of interest to V. Malinski at the SRS address.

Books, dissertations, articles, abstracts, etc., signed and dated by the author(s), can be sent to

The Society of Rogerian Scholars
Prince Street Station
P.O. Box 362
New York, NY 10012-0007

SRS

Election Results:

PRESIDENT:
SARAH H. GUELDNER, DSN

VICE-PRESIDENT:
KATHERINE RAPACZ, MSN

RECORDING SECRETARY:
ANGELA RACOLIN, M.A., R.N.

CORRESPONDING SECRETARY:
V. LOIS ALLEN, PH.D., R.N.

TREASURER:
MARY MADRID, M.A., R.N.

NOMINATING COMMITTEE:
JUDITH CHODIL
NANCY SHARTS ENGEL
KATHY PIKE PARKER
JOHN R. PHILLIPS
CAROLINE SCHODT

The proposed By-Laws change was approved.

Congratulations to those newly elected!
Society of Rogerian Scholars

MEMBERSHIP APPLICATION

Name:

Address:

Phone Numbers

Home: Work:

Affiliation:

ANNUAL FEE STRUCTURE

Please check:

PATRON $250
SUPPORTING MEMBER $150
INSTITUTIONAL MEMBER $150
REGULAR MEMBERSHIP $45
STUDENT (with copy of ID), RETIREE $25

Make checks payable (U.S. funds only please) to:

Society of Rogerian Scholars
Prince St. Station
PO Box 362
New York, NY 10012-0007