Experiences of Caring Through Providing Touch Near End-of-Life

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Abstract: We analyzed interviews from participants who provided massage or simple touch to patients with advanced cancer near end of life. We employed qualitative, descriptive, content analysis to participants responding to a semistructured interview. Three themes emerged that align with a unitary caring perspective: caring relationships, pattern recognition and wholeness, and transformations and transcendence. Findings from this study are significant for human care and caring. Providing touch for those near end of life is a catalyst in developing caring relationships and essential for holistic practice.

Keywords: palliative care; touch; massage; advanced cancer; end of life; massage therapists; volunteers; unitary caring theory

Touch is a universal expression of human caring, and it is vital to human survival. Records from orphanages show that children who had been deprived of human touch/connection died of marasmus or experienced emotional, social, and intellectual sequelae (Hansen, 2007; Montagu, 1986; Montagu & Matson, 1979). Equally important is touch near end-of-life, when people often feel isolated, misunderstood, and disconnected from meaningful relationships (Kuhl, 2002).

Although empirical evidence supports the relationship of touch interventions such as massage to important health outcomes like pain (Boyd et al., 2016), anxiety (Jagan et al., 2019), and symptom distress (Lopez et al., 2017); the loss of touch as an expression of caring in nursing practice is a troubling trend (Adler, 2009). The nursing rituals of morning and evening care, accompanied by bathing and backrubs that once existed are now extinct in acute and long-term care settings. In nursing fundamentals courses, technologies and skills are emphasized, and it is rare for students to practice techniques of massage or even the intentional use of touch as an effective caring-healing modality practicing

Technology itself can create an unintended intimacy barrier between the patient, nurse, and others who care for the patient (Waters, 2010). Nurses from a caring science perspective understand and value the importance of touch, and may intentionally integrate forms of touch into their practice to provide comfort and healing. There is very little research related to the perspectives of those who provide touch. The purpose of this study explore

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was to explore how providers perceive the experience of touch in end-of-life care, with the hope that the knowledge gained can promote greater use of intentional, caring touch in nursing practice.

Background and Significance

It is common for families visiting intensive care units or settings where their loved ones are receiving care for life-threatening conditions to feel intimidated by the presence of machines; this contributes to their reluctance to touch their loved ones. In end-of-life care, the resulting distance between loved ones both exacerbates the suffering of the patient and regret in family and friends who did not follow their instincts to touch their loved one (Kuhl, 2002). Exploring the perceptions and experiences of those who provide touch to patients near the end-of-life can provide insights into the mutual benefits and barriers for those who provide touch and those who receive it. There is good evidence that touch, especially massage, reduces pain, and symptom distress among adult patients with advanced cancer (Boyd et al., 2016; Jane et al., 2011; Krohn et al., 2011; Lee et al., 2015; Toth et al., 2013). However, we do not understand the experience within and between those giving and receiving touch. More specifically, we do not understand the perceptions and experiences related to intentionally offering touch to those near the end-of-life. This understanding of the experiences of providing touch has the potential to inform and increase the integration of touch into nursing practice. In addition, these understandings can generate concepts and theories related to caring and healing near end-of-life.

Recent literature about the experiences of touching others is scarce, but points to reoccurring themes. Family and friends providing basic massage to their loved ones experienced gains in self-confidence, comfort, and the ability to give care (Collinge et al., 2013; Kozak et al., 2013). Additionally, family/friends who provided touch expressed surprise when they were able to participate in providing massage despite their own health problems. Learning to touch their loved ones evolved, too, into self-help, ameliorating pain and symptom intensity, and increasing closeness and connection (Kozak et al., 2013). Furthermore, the *skillfulness* of touch is ancillary to the fundamental relationship-signification that the act of touching represents (Leonard & Kalman, 2015).

Another study demonstrated the willingness of rural caregivers to learn and use simple Swedish massage techniques for their chronically-ill loved ones (Kempson & Conley, 2009). Caregivers were encouraged to provide gentle massage once a day for 15 minutes on parts of the body that were most easily and comfortably accessible. The researchers found most of the caregivers were willing to provide the massage to their loved ones and did not find the process burdensome. Perceived benefits to the caregivers providing massage to their loved ones included physical calming and relaxation, physical connection, and an empowered ability to do something beneficial for their loved ones.

Insight into the meaning of giving touch in the care of older patients was provided by Edvardsson et al. (2003) study of 12 healthcare workers (registered nurses, nursing students, and occupational therapists) who worked with long-term care residents suffering from dementia. Caregivers were trained in tactile massage or tactile stimulation. "Touching, according to these techniques, involves slowly and softly stroking the skin of recipients following certain patterns" (Edvardsson et al., 2003, p. 603). Using a phenomenological hermeneutic design, the researchers found two compelling themes from the experiences of these healthcare providers: (a) having touch as a tool in easing suffering (e.g., receiving the tool of touch, using the tool of touch, experiencing the good effect of the tool of touch); and (b) being within touch as a tool in easing suffering (e.g., becoming ready for touch, beginning within touch, becoming changed by touch). Participants expressed that by giving touch they were empowered as caregivers to ease suffering and be with patients in moments of relaxation.

Purpose

This article reports the results of a qualitative descriptive study of experiences and perceptions of those providing massage and simple intentional touch to persons with advanced cancer enrolled in hospice care. The research question for the study was: What are the experiences and perceptions of providing massage and simple touch to persons with advanced cancer near the end-of-life?

Parent Study

This study was part of a larger research project, Reducing End-of-Life Symptoms with Touch (REST) (Kutner et al., 2008), a 3-year, multisite

randomized controlled trial (RCT) evaluating the efficacy of massage in decreasing pain and symptom distress and improving quality of life among patients with advanced cancer. Two types of touch were employed in the study: massage, provided by professional massage therapists (MTs); and simple touch, the control condition, provided by trained volunteers (simple touch volunteers [STVs]). MTs were licensed, qualified, and experienced, and the volunteers providing simple touch were hospice volunteers who were trained to provide the intervention. The massage intervention involved light Swedish massage with some trigger-point therapy for 30 minutes. Up to six, 30-minute treatments were administered over 2 weeks. STVs were hospice volunteers or health professional students trained to complete a simple light touch application. Simple touch consisted of light touch applied to 10 different locations on the body (base of neck, shoulders, lower back, calves, heels, clavicle, lower arms, hands, patellae, and feet) held at 3 minutes at each location. As with the massage intervention, up to six 30-minute simple touch treatments were administered over 2 weeks.

Pain and mood, using 10-point Numerical Rating Scales, were assessed before and after touch treatments. Valid and reliable measures of pain, symptom distress, and quality of life were administered at baseline and after 1 week, 2 weeks, and a month. Those receiving both massage and simple touch demonstrated statistically significant improvements in pain, physical and emotional symptom distress, and quality of life without increasing pain medication, a surprising finding for a sample with advanced cancer enrolled in hospice care. There were no clinically or statistically significant differences in pain, symptom distress, or quality of life between those receiving massage or simple touch except for the immediate measures of pain and mood, with those receiving massage demonstrating a significantly greater decrease in pain and better mood right after the treatment. In addition, the researchers conducted qualitative interviews with the MTs and volunteers providing massage and simple touch within the study to better understand their experiences.

Method

A qualitative descriptive design was used for this study, arguably the best approach when straight descriptions of phenomena are desired (Sandelowski, 2000). The study was reviewed and approved by the Colorado Multiple Institutional Review Board. The MTs and volunteers who provided the treatments in the REST study were informed about the study and invited to participate. Touch providers from all REST study sites were recruited if they had provided at least 12 treatments to the REST study participants. A total of 12 MTs and 7 STVs were recruited and signed consent forms that included agreement to tape record their interviews.

The interviews were conducted by researchers or trained research assistants. An interview guide with 10 open-ended questions invited responses related to experiences and perceptions of giving the touch therapies to patients with advanced cancer (Table 1). The interviews were audiotaped, conducted by phone or in person, and lasted up to 1 hour each. Interviews were transcribed and loaded into ATLAS.ti (Scientific Software

TABLE 1. Provider Interview Questions

Number	Question
1.	In general what was it like for you to provide the study treatments?
2.	What kinds of physical sensations did you experience as you provided the study treatment?
3.	What thoughts or perceptions did you have as you provided the study treatments?
4.	What else happened to you or what other feelings did you have during the study treatments?
5.	What are your suggestions for changing the study treatments you provided?
6.	What kind of physical sensations did the participants describe to you during or after the study treatment?
7.	What thoughts or perceptions did the participants describe to you during or after the study treatments?
8.	What other experiences did the participants describe to you during or after the study treatments?
9.	What changes if any did you notice in the participants after the study treatments?
10.	What do you think the role of the study treatment that you provided should be for the patients with advanced cancer?

Development GmbH, Berlin) for coding, annotation, and reporting. One audiotape was inaudible, leaving 18 participant interviews as data for this study. All data were de-identified; the researchers had no access to demographic information about the providers.

Qualitative content analysis was employed to produce descriptions, typologies, and overarching themes that represented the providers' experiences of touch and their perceptions of the study participants' experiences of receiving the touch therapies. This type of analysis was inductive and deductive in that there was constant discovery and constant comparisons when looking for insights in which situations, settings, style, images, meanings, and nuances were key topics (Sandelowski, 2000). The analysis was conducted through the lens of a nursing theoretical model aligned with caring science, unitary caring theories (Smith, 1999, 2010, 2015, 2020; Watson & Smith, 2002). In this way, the emerging findings of the inductive analysis were interpreted within the framework of a caring theory.

The first step toward inductive analysis began by reading aloud each of the MT and STV interviews to gain an appreciation of the depth and meaning of their experiences and perceptions. Next, two nurse researchers independently coded the transcripts of three MTs and three STVs. The researchers compared their initial coding results to ensure commonality among basic concepts, taxonomy, and coding processes. Codes were further defined, collapsed, redefined, and agreed upon. Coding of the remaining MT and STV interviews was completed by the first researcher.

Subsequently, the nurse researchers reviewed the coded data. Inconsistencies in coding were identified, and a list was compiled of key words that could link to potentially missing codes. From this list, a word search was performed on each transcript to ensure the codes were in fact included in the MT and STV interviews. Informational saturation was attained when the keyword search was exhausted and participant statements did not contribute to new codes.

Similar to ethnographic content analysis, this study applied reflexive movement between concept development, data coding, data analysis, and interpretation (Altheide, 1987). Codes were clustered into domains and shared pathways of experiences or processes (Kearney, 2001). The taxonomy of these domains was based on the latent commonalities of MT and STV experiences and their descriptive meanings. Descriptive summaries penetrating the informational contents of domains emerged, and quotes from the transcripts supported the interpretation.

Existence statements (straight-forward, simple statements) began to surface around assertion and concepts (Walker & Avant, 2019). Statements were refined, renamed, collapsed, and redefined. The existence statements began to reflect themes that were consonant with unitary caring theory (Smith, 2020; Watson, 2018). The deductive step linked transcript coding and clustering of codes into domains related to overarching themes consistent with unitary caring theories (i.e., descriptive statements demonstrating how providers of touch were deeply connected to the one being touched, connection to the environment, and acts that led to caring and have a healing presence) (Watson, 2016). Figure 1 provides an example of one theme's structure and taxonomy. A unitary caring framework was chosen for interpretation to illuminate the conceptual synthesis of Watson's transpersonal caring science and Rogers's (1970, 1992) science of

Overarching Theme	**Caring Relationship**			
Domains	**Openness**	**Mutual Goodwill**	**Consciousness**	**Relationship**
Codes	*Openness Open to touch*	*Appreciative Benefit Continuation Gratitude Honor Interesting Offer Outstanding Positive Privilege Rewarding Wonderful*	*Centering Intention*	*ConnectedI ntimate experience Looking forward Love Matching and pacing Outside sounds Patient centered Relationship Trust*

Figure 1. Supporting codes and domains for the overarching theme, caring relationships.

unitary human beings. The themes painted a holistic picture of the human experience in providing massage or simple touch to patients with advanced cancer near end-of-life.

Credibility and Trustworthiness

Creswell (1998) recommended completion of at least two procedures to establish credibility and trustworthiness in qualitative studies. In this study, three procedures were used: (a) peer debriefing, (Lincoln & Guba, 1985), (b) auditor authentication of the process for analysis and the product, (Lincoln & Guba, 1985), and (c) researcher bias clarification through reflective journaling (Merriam, 1988). Peer debriefing was completed through inter-code reliability as two researchers conducted independent analysis of six interviews, reviewed coding and agreed on the coding process, basic concepts, and taxonomy. The researchers held debriefing sessions, thereby establishing congruency of emerging findings, and tentative interpretations (Creswell, 1998; Lincoln & Guba, 1985; Merriam, 2009). An external inquiry audit authenticated the process and product of the research (Lincoln & Guba, 1985). In this study, the auditor was an outside nursing content expert in the area of oncology nursing, end-of-life, and palliative care. The auditor adapted and used guidelines set by researchers who had critically reviewed qualitative work for credibility and trustworthiness (Letts et al., 2007; Lincoln & Guba, 1985; Miller, 1997; Schwandt & Halpern, 1988).

The principal investigator (PI) for this study was prepared with a PhD in Nursing and was a certified advanced practice registered nurse in palliative care and a licensed and certified MT. The PI engaged in critical self-reflective journaling to raise awareness of any personal biases in the analysis. (Creswell, 1998; Merriam, 2009). The PI recorded past experiences, biases, prejudices, and orientation in a diary, acknowledging that these could shape the approach to this study and interpretation of the data. Entries in the journal occurred at the beginning of the coding process and throughout the data analysis. The PI's journal was evaluated by the auditor as part of the external audit.

Results

We found three overarching themes related to the experiences and perceptions of providing touch to people with advanced cancer near end-of-life: caring relationships, pattern recognition and wholeness, and transformation and transcendence. Each will be elaborated.

Theme 1: Caring Relationships

Codes associated with the interconnectedness of the provider and one being touched were clustered into four domains: openness, mutual goodwill, consciousness, and relationship. Caring is defined as the relational mutual process through which wholeness can be addressed, motivated by an ethic and intention toward new patterning and possibilities of healing (Cowling, 2000; Reed, 2010). Therefore, these domains supported the overarching theme of caring relationships (Table 2).

Openness referred to the willingness of the one being touched to remain open to new experiences. Those being touched felt ready to open up and share intimate, private things about themselves. "Very often they will open up to me and give me thoughts about their situations, about their husbands or wives, or whatever . . . [things] that they would not express just casually to . . . family members" (MT8).

TABLE 2. Four Domains of Caring Relationships: Additional Supportive Quotes

Domain	Selected Quote
Openness	"People are allowing the intimacy to touch their body at a time in their life when they are dying, it sort of opens up this other avenue of communication [. . .] because it is trust, you know." (STV5)
Mutual Goodwill	"For me, making the home calls, being with the families, feeling like the little bit I was doing, was doing something for them, just made me feel good." (MT4)
Consciousness	"I personally pray while I work because that is my belief system that I ask for the ability to help them with their pain or their anxiety or their emotional issues. So that's usually how I keep my focus on the patient is actively praying while I'm working" (MT4)
Relationship	"The fact that these two total strangers can just get together [and] develop a certain intimacy that you don't normally have in your day to day." (STV1)

Note. MT = massage therapist; STV = simple touch volunteer.

Mutual goodwill referred to a sense of satisfaction through reciprocity (e.g., response to and awareness of in-kind gestures and actions, such as participation in this study). "It was very rewarding for me to be able to meet people on this very different level, this very personal, private level that you just don't get to, or that I don't get to with most people" (STV7). Having the opportunity to offer and provide touch to patients with advanced cancer near the end-of-life was mutually beneficial.

> I felt like it was a wonderful opportunity to help these cancer patients. Give them a little bit of, you know, the touch and a little bit of compassion . . . having the touch therapy, I know they enjoyed it. I felt really good about being a part of it and doing it for them. (MT12)

Consciousness referred to the awareness of engaging in a continuous, mutual process with the one being touched, characterized by genuine focus and authentic presence with intention to shape the experience (Cowling et al., 2008; Reed, 2010). MTs reported they would often center themselves prior to the beginning of the treatment. This ritual allowed the therapist to shift their consciousness and focus entirely on the ones being touched, their needs and their patterns. The ritual manifests an intention to heal and becomes part of the massage treatment.

> When I [. . .] go in I put my hands on them for a few minutes without even moving my hands and I think about what I hope to accomplish with my touch, my heart and my mind [. . .] I center myself, basically is what I do and I think positive thoughts and I only think about that client or patient when I'm working on them. (MT4)

Relationship referred to the spirit-to-spirit unitary connection during a caring moment (Reed, 2010; Watson & Smith, 2002) and the trusting bond that was established between the provider and one being touched.

> It's a very trusting thing. I mean, they tell you things that they wouldn't normally tell other people or they can't. And you just create a tremendous bond and a trust with these people in order to [be] able to work on them. I mean, working on someone's body is, you know, that's about as close as you get. And, they have to trust what you're doing and what you put through and the energy that you put into it, they need to be able to feel that. (MT11)

Both the MTs and those providing simple touch spoke about touch as the catalyst toward relationships, yet the emphasis was not on the mechanical action of touch. The providers did not talk specifically about the objective quality of touch, but rather the intersubjective relationship and the profound gifts touch could offer those giving and those receiving touch. Developing a connection with the one being touched appeared to be an imperative for those giving simple touch. Those providing simple touch spoke of creating connections with the one being touched, and this allowed the one being touched to become more open. "I would say the thing that stands out is that I did not . . . expect the connection that adding touch to a visit seems to bring. And, it seems to bring a depth of . . . connection" (STV3).

Families looked forward to seeing the provider of touch and shared how one being touched would anticipate their visits. In some cases, the one receiving touch reported to providers they wanted to continue the treatment even after the REST study protocol was complete. As one STV stated "[. . .] they seemed disappointed when our six sessions were over . . . did I have to stop after six treatments? Could we work [out] something that I could keep coming?" (STV6). The personal attachment to the one being touched invoked a sense of deep affection.

The descriptions in the provider interviews regarding caring relationships reveal the emergence of feelings of unconditional love among providers for one being touched. Unconditional love is the essence and totality of the caring relationship as described by both provider groups. One STV shared this statement, which may encompass and summarize the theme of caring relationships: "I've got four patients, let me see . . . four folks that I can recall who said, I love you" (STV3).

Theme 2: Pattern Recognition and Wholeness

Pattern recognition is the ensemble of information received from sensory and pandimensional awareness that reveals a compelling sense of wholeness amidst the variety of phenomena of life (Cowling, 2000). Pattern manifestations or phenomena that are facets labeled by participants as physical, emotional, mental, social, and spiritual are included as pattern information (Cowling, 2000). A facet implies an aspect of something that is whole rather than something that is divisible into separate parts. For this reason, participant

interview statements pointing to the physical, psycho/social, and spiritual/cultural aspects of perceptions and experiences represented the theme of pattern recognition.

Cowling (1997) describes appreciating pattern as "seeing underneath all that is fragmented to the real existence of wholeness and acknowledging that with awe" (as cited in Smith, 2020, p. 496). The approach to appreciating pattern contrasts with a clinical problem-solving approach and " [. . .] moves away from the assessment and diagnosis of disease/illness and disorders and into a nonjudgmental approach to the human experience of health, illness, death, and dying" (Reed, 2010, p. 26).

Wholeness is the ontological viewing of the person as irreducible, unable to be known through examining parts or dimensions of human existence (Rogers, 1992). The approach to the person being touched involved the whole person, and their environment (i.e., their family, their home) as a unified whole being. For this reason, the term wholeness, as a response to the human experience was used to refer to the manifestations in bodily feelings, sensations, memories, family relationships, and meanings.

Codes associated with pattern recognition and wholeness were clustered into eight domains (Tables 3 and 4): body, physical symptom relief, nonphysical symptom relief, empathy, sensing, memories, family, and meaning. Body referred to the anatomical location of the one being touched (i.e., neck, shoulder, arm, etc.).

Physical symptom relief referred to the alleviation of physical pain or discomfort. Nonphysical symptom relief referred to alleviation of discomfort other than physical symptoms, such as emotional relief, changes in mood, or anxiety/nervousness. It is "just the idea of providing comfort to people who are at the end of their lives and experiencing pain, anxiety, sleeplessness, or some other type of discomfort and providing some relief to them" (MT6).

> I noticed a real relaxation from when I come in and begin to after I finish . . . the patients often appear calmer. They say they have less pain sometimes. They said that their mood improved sometimes. And, I can see they are calming. (STV6)

Those providing touch described their experiences in counting pulses, respirations, and matching and pacing to the one being touched. Those simply touching the person were sensitive to physical changes that occurred during the sessions "Pulses have definitely on the whole gone down . . . a lot of people were responding with lower respirations as well [. . .]" (STV3).

Empathy implied an attempt to understand an experience from the perspective of the other. "My thoughts were primarily of their situation and rather than anything on my situation. I was just sort of imagining that or trying to empathize with their situation more so than anything" (STV5). Sensing referenced physical and nonphysical feelings that emanated from touch (e.g., warmth, tingles).

> I would get very warm sometimes, overly so. Generally, my hands are warm but sometimes my body would feel a sensation of warmth just flowing right through, patients sense it and I certainly sense it, and I don't analyze it a whole lot. I'm just present with it. (MT5)

Another said, "I felt my hands tingling the whole time. I guess you would call that perhaps an

TABLE 3. Five of Eight Domains of Pattern Recognition and Wholeness: Additional Supportive Quotes

Domain	Selected Quote
Body	"He was having pain [. . .] and he looked at me with some surprise and he said, you know my hips don't hurt and my hands hurt a lot less and he said well, I can see why people like this stuff." (MT7)
Physical and Nonphysical Symptom Relief	"She just smiled and held my hand and thanked me and said how big a difference it had made for her, calming her down and relieving her pain. I was very grateful to be able to be here and to provide that help for her." (MT7)
Empathy	"I've had thoughts that it's sad that the first time they're getting their massage [. . .] in their lives is when they're dying [. . .] I think about how hard it must be for them and their family to be going through this time." (MT6)
Sensing	"I know I definitely felt heat at different times." (STV3)

Note. MT = massage therapist; STV = simple touch volunteer

TABLE 4. Three of Eight Domains of Pattern Recognition and Wholeness: Additional Supportive Quotes

Domain	Selected Quote
Memories	"He proceeded to let me know all the details of his life that made him that angry and he had a very, very, sad story about a son who died and a daughter who was raped and murdered, so it had nothing to do with his illness." (STV6)
Family	"The family members said, she looks so much forward to this. We are so happy that you are here. I got comments like that all the time." (MT2)
Meaning	"I feel that the clients are really benefiting, I feel that it is such a positive part of their end of their life." (STV4)

Note. MT = massage therapist; STV = simple touch volunteer

interchange of energy or something, I don't know" (STV7).

Memories referred to the sharing of stories, reminiscing, or recalling an event or moment from the past while being touched. As an example, one therapist told the story of how rubbing the person's feet seemed to open up a space of intimacy where meaningful details of the person's life situation were shared.

> You know, one man told me a story about how he sat . . . one night with a loaded.38 and he had to decide whether he was going to leave his life or kill himself . . . he sat all through the night, and when dawn came, he decided to leave. He got in his truck and he was on the road for eight years after that. And I thought, he is only telling me this because I am massaging his feet. (MT5)

Family referred to any aspect of family responses, involvement, observations, and internal family dynamics. One massage provider shared "I had one patient, his wife told me: you know he got out of bed and he wanted to go and sit outside today, and he hasn't done that in months" (MT4).

Meaning referred to providers of touch giving back to others, spirituality, and helping to improve the quality of life for those who were near the end-of-life. "It's a very close spiritual feeling as though what you are doing is very important even though it is the end-of-life, that you are making a difference. I think that working with people who are ill makes you gentle" (MT7).

Theme 3: Transformations and Transcendence

Codes referring to the domains of comfort, calmness, and escaping (Table 5) informed the theme, transformations, Transformation referred to the outcome of the caring connection between the provider and one being touched. "Transformation implies a changing of form in a literal sense, as in seeing things from a different angle" (Cowling et al., 2008, p. E43). Transcendence advances beyond transformation and involves a timely shift to another dimension (Cowling et al., 2008; Reed, 2010) occurring when the MT or STV and one being touched engages in a caring moment, beyond the limits of time, space, and physicality.

Comfort referenced the one being touched as positive response to treatment and the human-to-human feeling of touch. "And it is an intimate experience . . . I am thankful that I gave her that space in the beginning to come to that comfort on her own" (STV4).

Calmness referred to the treatment outcomes of feeling fewer burdens, less hardship, and less stress. "It was a calm for me and calm for the situation too because the family members who were around kinda watching, everyone kind of sat, and they watched, and they took a breath I guess too" (MT1). Another commented,

> [. . .] a kid or an animal would sneak back in and be quiet, you know and lay beside us and not cause any distraction. And we were working in silence. There was no music or any additional noise in the room and as she settled, I settled and the whole room settles. (MT10)

Escaping referred to the outcome of feeling apart from the body or having received permission to let go. Those offering touch shared in an experience of witnessing the one being touched become calm and drift into a different space. They often spoke about this "space" being not a physical location but rather a state of consciousness in which the one being touched could pause and dwell: "They are usually quiet, sometimes they dose off a little bit. Not asleep completely, but maybe just for a little bit . . . when they're awake we move and that's how I've seen them to be" (STV 6).

TABLE 5. Three of Domains of Transformations and Transcendence: Additional Supportive Quotes

Domain	Selected Quote
Comfort	"She just needed some comforting and I was the person that she shared that with me." (STV7)
Calmness	"I think that they are so fragmented by all of the treatments that they go through that to have someone come in and kind of go over their body and kind of connect it so that they can relax while it's happening and touch their body in such a way that for the first . . . you're not poking or prodding or putting any kind of toxic stuff into it, so it is really uplifting for them. He proceeded to let me know all the details of his life that made him that angry and he had a very, very, sad story about a son who died and a daughter who was raped and murdered, so it had nothing to do with his illness." (MT11)
Escaping	"Mostly they just wanted to kind of drift off." (MT2)

Note. MT = massage therapist; STV = simple touch volunteer

Discussion

Caring Relationships

The most salient theme woven into the interviews was caring relationships. The vignettes that emerged from the interviews illustrated transpersonal caring moments (Watson, 1999). According to Watson (1999), transpersonal refers to an intersubjective, human-to-human relationship, which encompasses two individuals in a given moment. This moment involves action and choice by both the one-caring and the one-being-cared-for. The one-caring can enter into the experience of another, and the other can enter into the experience of the one-caring. As reflected in their interviews, stories from the one being touched about their life history emerged, suggesting both the provider and one being touched were co-creating an historical lived experience during their shared moments of giving and receiving touch.

During transpersonal caring moments, sharing of the past life history of both persons presents both with new opportunities (Watson, 1999). Transpersonal caring moments occurred during the touch session. Although touch creates a physical pathway for human-to-human connections, it can also be a type of catalyst for the caring relationship. Those providing touch shared a common belief that it was an honor to work with this population. This theme is common with healthcare providers in hospice and palliative care. Openness, intentionality, trust, connection, and the ability to match and pace with one another are reflected within excerpts from the interviews. This attuning to the dynamic flow of relating is a concept in the middle range theory of unitary caring (Smith, 2020).

Beyond the surface of physical touch resides a spirit-to-spirit connection through which those providing touch and the one being touched experience compassion, reverence, grace, and humility. The providers had compassion toward the one being touched and their families. Moments of sadness and empathy are described in reference to the journey the one being touched was going through, and a sense of deep honor and respect materialized. This feeling of reverence extended to the one being touched through contributing to something meaningful like the study. Those sharing these intimate moments through touch experienced spiritual realizations about the end-of-life and were attuned to the journey of the one being touched, which was humbling.

The Caring Relationships theme has also been described in the literature. Kempson and Conley (2009) found massage was a unique mechanism for the establishment of a personal physical connection between the caregiver (family member) and care recipient. Reflections of feeling special (Billhult & Dahlberg, 2001) and the desire to see the same friendly face (Rodeheaver et al., 2003) were also incorporated into this study's theme of caring relationships.

The essence of the participants' caring relationships was not solely on the corporeality of touch but also on the life-giving, biogenic mode of being with another (Halldorsdottir, 1991). Halldorsdottir defines biogenic as a mode where one affirms the personhood of the other by connecting with the true center of the other in a life-giving way. This biogenic mode thus relieves the vulnerability of the other, making the other stronger, enhancing growth, restoring, reforming, and potentiating learning and healing. This study suggests that massage and the simple act of touching are biogenic.

MTs recognized the contributions of the participant receiving massage to others. They saw

themselves and the participant co-creating history, if not a legacy, by being part of a research study that might help others. MTs described end-of-life as a spiritual time and space for the recipient of massage and shared in their legacy, life-review, and reminiscence. MTs also talked about the creation of openness and presence, listening to the stories of the person receiving massage and providing no judgment. A sense of being with the other with authentic presence was part of the caring relationship.

Pattern Recognition and Wholeness

Providers of the touch therapies described the pattern of those being touched. Pattern is the characteristic of a human field providing identity, and it distinguishes one person from another (Cowling, 2000; Malinski & Manhart Barrett, 1994; Rogers, 1970, 1992). Rogers (1970) indicated that patterning is a dynamic process with continuous change. Cowling (2000) described pattern as the essence of being. Pattern appreciation is the reaching for essence in each individual and seeing wholeness within the pattern (Cowling, 2000).

The codes and domains supporting pattern recognition and wholeness have also been reported. Rodeheaver et al. (2003) reported similar instances of physical symptom relief from stress and pain. From a nonphysical symptom perspective, Billhult and Määttä (2009) found participants had reduced anxiety, while Cronfalk et al. (2009) found massage provided a general feeling of peace of mind.

Johns (2013) described a phenomenon called connected knowing, which he defines as the ability to connect with the experiences of others through empathy. Although the domain of empathy was not widely emphasized in this study, similar meanings were noted in the thoughts, reflections, and disclosures of those giving and receiving touch. The connected knowing between those giving and receiving touch was the genesis of heightened sensitivity to the steady pulse of relating. "Through this attuning, there is a knowing of when and how to move, be still, speak, be silent, laugh, cry, touch or withdraw" (Smith, 1999, pp. 23–24). Being engaged and attuning to dynamic flow allowed the one giving touch to become sensitive to the wholeness through pattern recognition.

Those giving simple touch described their observations and impressions of the environment and family dynamics. They discovered that the recipient experienced touch deprivation and found the need to teach family members and significant others how to touch. Those giving simple touch appeared to spend more time than the MTs with family members and they taught the family members how to provide the simple touch treatment after the study ended. Simple touch was designed to be a control intervention, but it was found to have therapeutic value in itself.

Transformation and Transcendence

Providers reflected on the moments when the one being touched experienced transformation and transcendence, starting with a change of perspective in a literal sense, as in seeing things from a different lens (Cowling et al., 2008; Newman, 2003; Reed, 2010). Commonly reported by the providers were metaphors that evoke images of transcendence (e.g., drifting, fading, floating, and letting go). Touch created an opportunity to pause and suspend time in the everyday business of life.

Agren and Berg (2006) found time and space would disappear during touching occasions. Øien et al. (2007) found themes of being detached from the body and being in touch with the body. These concepts are akin to the domains comfort, calmness, and escaping, supporting the theme transformations and transcendence. However, as Coward and Reed (1996) shared, investing oneself in a relationship with others and the surrounding environment manifests self-transcendence. In this study, transformations and transcendence occurred while providers and those being touched were in each other's presence during touching occasions. None of those providing touch suggested transformations and transcendence occurred in isolation.

Watson and Smith (2002) indicated that healing modalities such as touch help to connect with a universal caring field to access the inner healer. In this study, the providers of touch opened a window of potential for the one being touched. The concepts of relaxation and calmness are common and expected during MT. Those providing touch therapies were sensitive to verbal and nonverbal feedback to gauge the response and transformation of the recipient towards relaxation and calmness.

Limitations

Several limitations are identified in this study. First, there was no ability to have member checks (Creswell, 1998; Lincoln & Guba, 1985; Merriam, 2009), since this was an analysis of existing data and the researchers did not have direct access to the participants. Second, the researchers conducting the analysis were limited by the parameters of the original dataset. For example, demographic information was unavailable for the touch providers and there was no access to field notes, facial expressions, gestures, and comments that may have occurred after the official interviews (e.g., after the tape recorder was turned off). Third, transferability of the findings describing the experiences and perceptions of those providing touch are limited to the population, in this case persons with advanced cancer receiving hospice care. Fourth, the PI is a both a nurse scientist and a MT. Although the PI performed research bias clarification through self-reflective journaling, there still remains a possibility of bias in the interpretation of data. Finally, the providers of touch in this study had previous access to and experience with chronic and end-of-life care; most of those giving simple touch were hospice volunteers, which may predispose study participants to a particular worldview. Hospice volunteers commonly have experiences with loved ones previously in hospice and make a deliberate choice to do this type of work (Weeks et al., 2008). The unique sensitivity and expertise as a hospice volunteer may have influenced the approach, development, and relationship towards the receiving simple touch. The hospice volunteer is likely to be a social, caring, and empathetic communicator who works to build a trusting relationship with the hospice patient, and while the volunteer is neither a hospice professional nor naturally occurring friend; the volunteer often bridges the gap between these two roles (Savery & Egbert, 2010).

Implications: Practice, Education, Research, and Policy

Nurses practicing from a caring science perspective regard the establishment of caring relationships with patients as the essence of their work. They are often skillful in the intentional use of touch to convey support, to provide comfort, and to co-create healing. These nurses can be a resource to other nurses through sharing the importance of touch and being a role model. Nurses can be encouraged to seek out additional, accredited education for massage techniques or ways to provide a comforting experience through touch that might enhance their practice. In this study, the simple act of touch was a catalyst of engagement which resulted in caring relationships between those who provided and received touch. Touch, including holding of the patient while crying over the fate of their disease process or holding their hand until they sleep, demonstrates the nurses' abilities to create the space for healing (Taranto-Garnis, 2011). Providing back rubs during morning and evening care or after providing a patient bath can aid in providing comfort and distress from symptoms. What if the nursing care plan included *simple touch* treatment for 30 minutes for persons experiencing distress from symptoms?

Patient and family teaching is a hallmark of nursing practice. This study suggests nurses could actively engage family members in learning basic massage or at a minimum the power of simply touching their loved ones. In particular, nurses practicing in palliative care and hospice can teach family members how touching their seriously ill loved one can be a way for them to provide comfort and relief from symptoms. Touch, as an intervention may be a powerful remedy for family members to employ during those moments when patients near the end-of-life need reassurance that they are not alone.

As Ruffin (2011) pointed out, nursing has a long history and roots in the art and science of massage and compassionate touch. Is it possible to create curricular units dedicated to learning how to provide comforting touch to co-create a high-touch with a high-tech environment (Ruffin, 2011)? Prelicensure undergraduate and graduate nursing education programs have an opportunity to teach students how to use touch as a therapeutic and compassionate intervention.

Cook and Robinson (2006) studied the effectiveness and value of massage skills with nursing students. Their data demonstrated that when students had massage preparation in their coursework, students reported the skills contributed to the development of an enhanced nurse–patient interaction and achieved a greater sense of providing holistic patient care. Similarly, Adler (2009) engaged nursing students in an active learning project aimed at teaching students how to provide basic massage techniques. The students provided massage to residents of a secured, assisted-living

dementia unit. The massage was provided in a common room with all participates in view of each other, fully clothed, and seated at the table or in a circle of peers. Although no empirical data were collected, the researcher found residents showing more relaxed postures, relaxed facial expressions, slower breathing, and noticeable eye contact. Curricula for nursing students at all levels should involve these caring-healing modalities and competencies surrounding touch in all practice settings, especially in palliative and end-of-life care.

The findings suggest the need for continued research and theory testing and development in unitary caring science. Research expanding knowledge development and literacy in unitary caring science may further explain the overarching themes from this study: pattern recognition and wholeness, caring relationships, and transformations and transcendence.

Although the findings of this study may be applicable to those receiving palliative and hospice care, the study could be replicated in other practice settings. Simple touch being systematically developed as a nursing intervention could demonstrate benefits for nurses and patients. Simple touch grounded in unitary caring theory would be a practice niche within nursing and this topic deserves focused inquiry in application and associated impact on patient centered outcomes.

Integrative therapies including massage and simple touch should be reimbursed at the professional and advanced practice registered nurse level. However, at this time Medicare (Centers for Medicare & Medicaid Services, n.d.) does not provide a benefit to cover massage or simple touch therapies (Lee et al., 2015). As systems of care become less hospital-centric, the home health nurse becomes more valuable in the delivery of care at the patient's home. Home healthcare agencies are currently reimbursed for education of patient care and nurses trained in massage or simple touch can provide education to family members to enhance symptom management. Yet, there is no reimbursement for this type of education. Policy changes are necessary to provide massage and other holistic/integrative therapies as a reimbursable healthcare service through fee for service, capitated, or bundled payment models. As demonstrated in this study, there is value to massage and simple touch for palliative and end-of-life care, and the seriously-ill should have access to these modalities for relief of symptoms.

Conclusion

The findings of this study suggest the mutual benefit of touch for those giving and receiving it. The providers of both massage and simple touch described how touch enhanced caring relationships, pattern recognition and wholeness, and transformation and transcendence for persons near end-of-life. These finding support the importance of integrating touch into nursing practice.

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