

Exploring the Boundaries of Caring: Is Tellington Touch Nursing?

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Abstract

Tellington touch, or ttouch (L. Tellington-Jones, 1992, 1995), is an emerging therapeutic intervention being used by nurses and is a form of healing communication administered through the use of gentle physical touch. Anecdotal evidence (TEAM News International, n.d.) suggests that this simple intervention may be useful in a variety of patient-care situations (L. Tellington-Jones, personal communication, July 6, 1996). The purpose of this paper is to describe ttouch as an emerging modality; to compare attributes of ttouch with published criteria for caring touch; and to evaluate the appropriateness of providing ttouch to nursing clients. Diagrams of the techniques described are offered, a case exemplar is given, and implications for nursing practice and research are identified.

Nursing as an art and science is centered on the idea that caring practices influence the human health experience (Newman, Sime, & Corcoran-Perry, 1991; Watson, 1988). Human-to-human touch is a fundamental nursing intervention (Candlin, 1992; Groer et al., 1994; Snyder & Nojima, 1998; Wendler, 1999b) intertwined within the care flow, facilitating healing communication through caring (Montgomery, 1993). Often the initial interaction between person and nurse, touch provides the opportunity for an instantaneous, open connection and an essential form of communication (Butts & Janes, 1995; Hover-Kramer, 1998; Schoenhofer, 1989) that is irreplaceable in the context of caring (Montgomery).

Tellington touch, or ttouch (Tellington-Jones, 1992, 1995), an emerging therapeutic intervention being used by nurses and others, is a form of healing communication administered through the use of gentle physical touch. Arising from the physical discipline of Feldenkrais (1977/1990), this simple-to-learn and easy-to-use intervention may be useful for a variety of nursing situations. Anecdotal evidence (TEAM News International, n.d.) suggests that this intervention may be helpful for such common problems as acute and chronic pain, anxiety associated with procedures, labor pain, and

post-injury edema (L. Tellington-Jones, personal communication, July 6, 1996).

However, the state of the science is early, such that only one systematic investigation of ttouch has been completed (Wendler, 1999a). To initiate important dialogue about the appropriateness of ttouch as a nursing intervention, scholars and practitioners need to be informed about this intervention. The purpose of this paper is to describe ttouch as an emerging modality; to compare attributes of touch with published criteria for caring touch; and to evaluate the appropriateness of providing touch for nursing clients. Diagrams of the techniques described are offered, a case exemplar is given, and implications for nursing practice and research are identified.

What is Tellington Touch?

Background

Ttouch is a form of healing communication discovered by Linda Tellington-Jones, an internationally known equestrian master and teacher. Evolving from the physical therapeutic of Feldenkrais (1977/1990), and coupled with an intimate knowledge and understanding of animal composition and behavior (Tellington-Jones, 1995), ttouch began as part of an alternative training system for horses, dubbed TEAM, or

Tellington-Jones Equine Awareness Method (Tellington-Jones, 1992). In ttouch, the concept of cellular intelligence is incorporated with the Feldenkrais principle that nonhabitual movements and touches "awaken new brain cells and activate unused neural pathways" (Tellington-Jones, 1992, p. 11). Ttouch is said to have broad-reaching effects, particularly for animals with inappropriate or repetitive and destructive behaviors, or for those that have been traumatized. Tellington-Jones' work with difficult horses and, later, with domestic and exotic species, provides more than 25 years of anecdotal evidence of the usefulness of this integrative healing modality in animals (L. Tellington-Jones, personal communication, July 6, 1996).

Over the years, nurses, physicians, and other health care professionals have attended Tellington-Jones' informational workshops, learning ttouch techniques in the wider context of TEAM. When nurses were confronted with challenges in their clinical practices similar to their own animals' problems, some began using these same techniques, which were then informally reported, thus creating an anecdotal body of evidence (TEAM News International, n.d.). Spontaneously submitted narratives documented the successful management of common and diverse patient problems such as post-fracture edema, labor pain, and chronic back pain (Tellington-Jones, 1992). Thus, ttouch began to emerge as a natural healing modality (F. Reeder, personal communication, January 18, 1996), often used in addition to, or in conjunction with, conventional medical and nursing treatment.

Methodology of Ttouch

Tellington-Jones developed her general ideas into a systematic approach and described numerous forms of ttouch, each

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with its own reported potential for promoting healing and communication. Despite the diversity of species for which touch was used, Tellington-Jones (1992, 1995) contended that commonalities existed in these four fundamental components of touch: (a) an open mental attitude, (b) use of the hands and fingers, (c) breath awareness and control, and (d) finding the pressure scale. When used simultaneously, these components constitute touch and are described more fully below.

Mental attitude, the first component, is one of openness, a sense of oneness with the earth, best described as grounding. Tellington-Jones' description of the process is similar to that of centering, an important initial activity of therapeutic touch (Krieger, 1980) that is seen as an essential component of purposeful touching (Hover-Kramer, 1998; Snyder & Nojima, 1998). Although Tellington-Jones (1992) insists there is "not manipulation [of] energy, bone or muscle" (p. 23), the language and metaphor of choice used to describe touch imply otherwise. For example, Tellington-Jones (1992) uses the analogy of a car battery giving another a jump start: "Once the initial contact is made, that car that needed the boost can drive off . . . under its own power" (p. 23). This comparison clearly refers to possible energetic components not well explicated.

The second component, use of the hands and fingers, starts with the fundamental intervention called Clouded Leopard (see Figure 1). Clouded Leopard is a circular touch that begins by placing the palm of one hand on the body. The four fingertips are placed in a comfortable, slightly curved position, while the thumb provides stabilization for the hand. The other hand also rests on the body, usually on the opposite side from the one being touched by the touch hand, thus providing an unbroken circle of self. The practitioner then imagines the face of a clock, with the fingers resting at the six o'clock position. Forming as perfect a circle as possible (Tellington-Jones, 1992), the fingers are moved clockwise around the imaginary clock. The rotation is one and a quarter circles; the fingers are brought fully

around, from the initial six o'clock position to nine to twelve to three and back to six, passing the six o'clock position and coming to rest at the eight o'clock position. From there, the fingers are slowly returned, relaxed, back to the six o'clock position, and gently and slowly are slid along the skin surface to the next position. Each Clouded Leopard touch should take 3-6 seconds (L. Tellington-Jones, personal communication, November 2, 2000).

Using systematic or random placement of the hands and fingers (Tellington-Jones, 1995), and working from the head toward the feet, one repeats the action until there is indication (by moving away, for example) that enough touch has been received. Touches are performed smoothly and gently. Circles completed in about a second are said to "wake up," or stimulate, while slowly performed circles are said to promote relaxation and to release "the memory of pain stored in the cells themselves" (L. Tellington-Jones, personal communication, July 6, 1996). Thus, the open mental attitude, infused in the context of touch administration, includes a specific intentionality or purpose.

Tellington-Jones (1992) also presents the notion of "listening with the hands" as part of the expressive use of the practitioner's body in touch. The purpose of listening with the hands is to assist with the unfolding assessment through touch. This form of listening through touch constitutes an openness to nonverbal communication and is said to help the touch practitioner determine the way in which touch is desired. It also awakens the practitioner to subtle changes in tenseness, skin temperature, and moistness, as well as the leaning into, or moving away from, touch. This awareness supports the concept of touch as a form of communication. Finally, listening with the hands is also seen as an aesthetic way of knowing from the interactive-integrative paradigm (Newman, Sime, & Corcoran-Perry, 1991), because relationship and communication underpin the nursing situation when touch is administered.

Breath control and awareness make up the third component of touch. Practitioners are advised not to hold their breath as this "blocks a smoothly flowing connection to the world" (Tellington-Jones, 1992, p. 25) but instead to remain awake to their own breathing patterns. The being or person receiving touch "will gradually attune his/her breathing to yours, creating a mood of heightened receptivity between you [both]" (Tellington-Jones, 1992, p. 25). This attitude brings to mind the concept of breath control in yoga and the universal energy system of Qi in Chinese medicine, again lending support to the notion that touch may share similarities with other energy therapeutic interventions (Hover-Kramer, 1998; Mulloney & Wells-Federman, 1996).

Finding the pressure scale is the final critical component of touch. Tellington-Jones (1995) identified a 9-point range of pressure, with 1 being the gentlest possible touch and 9 being the heaviest, deepest possible touch. A touch of 3 would be the most touch tolerated when a person, supporting the elbow, touches the surface of the closed eyelid, forming a circular touch with one finger. A 1-level touch is the lightest possible version of this touch, while a 9 touch is three times as vigorous as the 3 touch. The experience and expertise of the practitioner, and the type of touch chosen are subjective aspects of developing this ratio-level scale as described by Tellington-Jones (1992, 1995), who now recommends that a 6 pressure be the maximum used for healthy human beings (personal communication, November 3, 2000).

Thus, touch is a simple, gentle, easy-to-implement intervention. Administering touch requires no special certification and may be learned within about 30 minutes. No extraneous equipment is required; all that is needed is the conscious intention to communicate caring and respect, and a willingness to touch in a caring manner (L. Tellington-Jones, personal communication, July 6, 1996). Three forms of touch are illustrated: Clouded Leopard (see Figure 1), Python Lift (see Figure 2), and Noah's March (see Figure 3).

Figure 1



Clouded Leopard

The name describes how the hand rests on the body – as lightly as a cloud. The name came from a Clouded Leopard in the Los Angeles zoo who was worked on with the TROUGH.

HOW TO:
The weight of your hand rests lightly on the body, with fingers lightly curved.
The pads of your fingers push the skin one and a quarter circle. The middle finger leads. Feel the connection between your forefinger and thumb, which are held several inches apart. Keep your wrist straight yet flexible and off the body. Breathing in rhythm with circles helps maintain a softness in your fingers, hand, arm and shoulder. Move the skin in a circle rather than rubbing over the hair.
Watch the animal's reaction. If he/she seems uncomfortable, lighten the pressure or change the TROUGH.





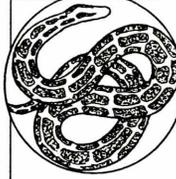

*Do this TROUGH around the tail and hindquarters and down the legs to the paws. Exercise caution with a fearful or aggressive animal.

USES/PRESSURE	
Aggression	2-5
Aloofness	2-4
Barking	3-5
Car sickness	2-4
Fear Biting*	3-5
Introducing New Animals to Household Pets	2-5
Leash Pulling	3-5
Nervousness	2-4
Preparation for Training	2-5
Reducing Stress	2-6
To Increase Self-confidence	3-5



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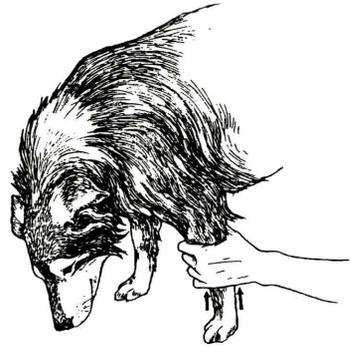
Figure 2



Python Lift

The Python Lift is used frequently to relieve and release muscular tension and spasm. It is effective on the shoulder, legs, neck, and chest areas of animals, and is great on human backs, arms, legs, and shoulders, too.
The Python Lift relaxes nervous animals and improves balance and gait problems. It also helps bring your animal into a state of mental and emotional stability.

HOW TO:
The whole hand is placed on the body or around the leg with just enough pressure to gently lift the skin and muscle. Hold for about four seconds and then slowly return the skin to the starting point. Remember to breathe with the movement. If you lift too much it causes the animal to tense or move away.



USES

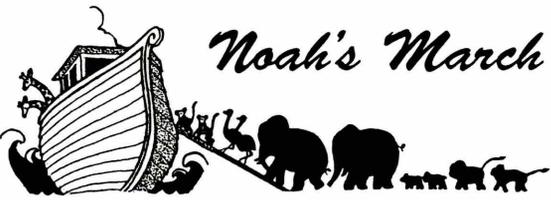
- Arthritis
- Balancing
- Hip Dysplasia
- Nervousness
- Gait Improvement
- Improving Physical, Emotion Mental Balance
- Stiffness in Back and Shoulder Areas



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Note. From TTouch Cards [cards used as training aids], Animal Ambassadors, TEAM & TTouch Training, 1992, Santa Fe, NM: Author. Copyright 1992 by Linda Tellington-Jones. Reprinted with permission.

Figure 3



Noah's March

Noah's March is the TROUGH we use to finish a session. Similar in nature to Lick of the Cows Tongue, this TROUGH is done with the intention of reintegrating the body of your pet. Thinking of the basic Troughs as "dots," these long sweeping strokes "connect the dots" after the session.

HOW TO:
Beginning at the head/neck area use long sweeping strokes with the entire hand including the fingers and palms. Cover every inch of the body and tail and all the way down the legs to the end of the paws.
Use to finish a session and provide reintegration and revitalization.





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What are the Attributes of Ttouch That Make It Nursing?

The attributes of caring touch in nursing, which derived from prior work, are defined thus:

In nursing, a caring touch is a contact- or energy-based form of healing communication that begins with a desire, on a human-to-human level, to connect, combined with the creation of a sacred space for healing and involving a conscious intention to care, help or, especially, to promote healing, which creates an opportunity for healing communication to unfold. By using body, spirit or energy, a human-to-human connection is made, which results in a

sense of balance, wholeness, or transformation as an expression of health as expanding consciousness. (Note. This definition originally appeared as a figure in "Using Metaphor to Explore Concept Synthesis," by M. C. Wendler, 1999b, *International Journal for Human Caring*, 3(1), p. 34. Copyright 1999 by International Journal for Human Caring. Adapted with permission.)

This definition has embedded within it a set of evaluative criteria for determining the appropriateness of any form of touch in nursing practice. In examining the criteria, one can see that ttouch is a form of contact-based touch that is initiated with the desire to connect for the

purpose of communicating caring and respect. In the case of touch in nursing, then, the touch of animals is excluded, while human-to-human touch is not. This human focus is what places touch within the domain of nursing (Newman, Sime, & Corcoran-Perry, 1991).

Sacred space allows not only for the idea that the nurse is in the environment with the client but also for the idea that the nurse is the environment for the client (Quinn, 1992). The nurse both creates and becomes sacred space in touch when the mental attitude reflects openness, and the nurse is grounded and centered. Touch itself is intended to initiate a healing dialogue. By enhancing touch with the intention to connect (Hover-Kramer, 1998) through communication, any touch in nursing has the potential to become a caring touch (Buttorff, 1993) if a caring occasion (Watson, 1988) occurs. The act of caring through touch may create a change in the "sensation experienced by the recipient" (Hover-Kramer, 1998, p. 103). When this occurs in touch, it is sometimes experienced as a tingling sensation (L. Tellington-Jones, personal communication, July 6, 1996), and is thought to be evidence of use of new or unused neural pathways (Tellington-Jones, 1992).

The openness experienced by the practitioner during touch may also contribute to "heightened receptivity" (Tellington-Jones, 1992, p. 25). It is important to note that the concept of open-minded presencing is similar to the process of centering, an important pre-activity of energy-based caring touches that include Reiki, therapeutic touch, and healing touch (Mulloney & Wells-Federman, 1996). The intent to promote healing is also important in energetic healing modalities (Quinn, 1992).

As touch uses both body and the spirit (and, arguably, energy) to promote a connection between humans, these aspects fit the evaluative criteria listed in the definition of caring touch in nursing. Further, persons experiencing touch often comment about how deeply they feel cared for when receiving this form of touch. Thus, touch may provide the nurse with an opportunity to

create a caring occasion (Watson, 1988) toward the goal of promoting health as expanding consciousness (Newman, 1994; Quinn, 1992). The following case exemplar of the implementation and outcome of touch for a critically ill patient supports somewhat the idea of health experienced here as expanding consciousness (Newman, 1994) through transformation (Wendler, 1996) as a result of changed sleep patterning during and following touch.

Exemplar

Mrs. T. was experiencing pelvic cancer and was admitted to the surgical intensive care unit (SICU) following a radical pelvic exenteration. In this surgical procedure, the surgeons removed all the cancerous tissues and rebuilt internal organs. As a result, Mrs. T. had her uterus, ovaries, bladder, and part of her bowel and her vagina removed. At the same time, the surgeons crafted a neobladder, a neo-vagina, and a colostomy for her. Because of the extensive surgical work completed, it is common for these patients to experience a very high level of pain.

When she returned to the SICU for treatment of sepsis and peritonitis following a bowel obstruction, Mrs. T. was critically ill and highly unstable physiologically. However, several days later, she was successfully weaned from the ventilator, and her condition slowly began to stabilize. Upon my arrival at 11 p.m., she was sleepy, but still wearing the "mask of pain." When I asked her what was wrong, she said she was still experiencing excruciating pain and stated, "All I want to do is sleep."

Her family confirmed that Mrs. T. had not slept, uninterrupted, for more than an hour in about 10 days. Every touch, even the most gentle, increased her discomfort. When I arrived, her linen was soiled, her skin was damp, and she was in need of skin care. She remained on life-support drips, and was receiving morphine 10 mg per hour via continuous IV drip and lorazepam 1 mg every 2 hours via intermittent intravenous push. She weighed approximately 100 pounds.

A quick call to the resident revealed an unwillingness to increase the baseline order for pain medication, because of a respira-

tory rate of 10 breaths per minute. I was allowed to give small additional doses of 1-2 mg of morphine each hour. I pre-medicated Mrs. T with 2 mg of morphine for a bed bath after my initial assessment, all the while using presencing and a healing intention with each touch. Although moving in bed was difficult for her, she was able to cooperate with her care.

When I had positioned her on her side with her final turn from her bath, I asked in a quiet and gentle voice if I might offer a backrub. She nodded slowly in agreement. I began ever so gently to administer a routine back massage, using warmed lotion and a very light touch. I used this time to become fully centered and to listen with my hands to her body. After about 5 minutes, I asked her if I could use the gentle stokes and touches of touch, and she nodded her assent.

I used Clouded Leopard touch (see Figure 1) while she remained in the side-lying position. Placing the palm of my hand on her back and stabilizing my touch with my thumb and little finger, I placed the three middle fingers on her slender frame and moved them in a circular motion, as if around the face of a clock. Because of her pain level, and as a result of the pain that I could sense when I listened with my hands, I administered the Clouded Leopard touch using a 3 pressure. After 10 of these touches, I chose the Python Lift (see Figure 2). The Python Lift is frequently identified as a favorite form of touch among my patients in the ICU. I alternated hands, delivering some with my left hand and some with my right. My other hand remained placed on her shoulder, back, or hip, creating a continuous, circular connection between my body and hers.

Following about eight repetitions of the Python lift touch over her back, shoulders, and upper arms, I completed the intervention with the long, reintegrating strokes of Noah's March (see Figure 3). For this touch, I also used a light level of pressure, which I documented as a 3 on a scale of 1-9. I chose this pressure because of her prior response to other forms of touch, which in almost every case had been painful to her.

During this entire process, I maintained an internal dialogue of caring and healing, thinking, Here is peace. Here is relaxation. Here is a place to be safe. Be safe, be relaxed, and feel free to drift to sleep. You are here, safe with me. Peace is with you. I want you to start to heal. Begin your healing journey now.

After about a total of 5 minutes of touch, I noticed that her breathing was slow and easy. I left my hands, quiet and still, on her body for about another minute and then slowly removed myself from her side. I pulled the covers up to her shoulders and noticed that Mrs. T. was deeply and completely asleep. She remained asleep for 3 full hours, after which she requested to be turned, and then quickly fell asleep for another 2 hours. When she awoke, she said that her pain was "okay," and she appeared rested and relaxed. She was able to be transferred from the ICU that day.

Questions That Arise From the Exemplar

1. What is the impact of Tellington touch for patients who may have been dismembered as a result of their surgery or treatment (Schroeder, 1992)?
2. What was the information I received through my hands that told me Mrs. T. needed only a very light pressure in touch?
3. What was the effect of the traditional backrub versus that of the backrub and touch or touch alone? Are several modalities used all at once more effective than the use of a single intervention?
4. What is the effect, if any, of touch on hospital length-of-stay?
5. What is the effect of touch on a patient's ability to feel whole and connected? What is the effect of touch on wholeness and healing for patients who have experienced highly technical, medical, and nursing interventions?

Implications for Nursing Practice and Research

Determining the attributes of caring touch and comparing these to the published criteria has assisted in understanding whether this animal-based communication and training technique belongs in nursing practice (Smith, 1994). By using the evaluative

criteria embedded within the definition of caring touch and carefully comparing these attributes to a description of touch, one can determine that touch is, indeed, an appropriate nursing intervention. Because touch requires an open-minded attitude, an intention to connect, and a contact-based physical touch to promote healing communication (Montgomery, 1993), it is a form of caring touch appropriate as an intervention for nursing.

Touch is a form of contact-based caring touch that does fit within the constellation of caring touch in nursing practice, based on a comparison to published evaluative criteria. As a result of this thoughtful assessment, practicing nurses may choose to include touch within their repertoire of caring interventions. However, without a solid foundation of evidence-based practice, the effect of this natural healing modality on patients, family members, and nurses is not yet known. Rigorously designed and executed research studies may increase understanding of touch in a variety of situations, and may promote dialogue among nurses and scientists of the usefulness of this emerging intervention. Foundational research exploring the influence of touch is ongoing and may provide evidence of the potential for this new nursing intervention.

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