

Therapeutic Touch, Quiet Time, and Dialogue: Perceptions of Women With Breast Cancer

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Purpose/Objectives: To compare the perceptions of women with breast cancer to an experimental therapeutic touch (TT) plus dialogue nursing intervention with perceptions of a control quiet time plus dialogue nursing intervention.

Design: Qualitative study based on the Science of Unitary Human Beings.

Setting: Data collected as part of a larger experimental study of the effects of TT on pre- and postoperative anxiety and mood and postoperative pain in women with breast cancer.

Sample: 18 women with early-stage breast cancer.

Methods: Telephone interviews at the completion of an experimental or control nursing intervention administered in the women's homes before and after breast cancer surgery.

Main Research Variables: Women's perceptions of participation in a study of the effects of dialogue and TT or quiet time.

Findings: Content analysis of transcribed telephone interviews revealed few differences in participants' perceptions of experimental and control interventions. Only participants who received the experimental intervention reported body sensations, and only participants in the control group inquired about the study and its purpose. Regardless of experimental or control intervention participation, women expressed feelings of calmness, relaxation, security, and comfort and a sense of awareness. The few women who commented about the nurse who administered the experimental or control intervention indicated that the nurse was empathetic, concerned, supportive, or helpful.

Conclusions: The women regarded either nursing intervention as a positive experience. Some also expressed positive regard for the research nurse.

Implications for Nursing: Nurses who are not trained in the administration of TT may use quiet time and dialogue to enhance feelings of calmness and relaxation in patients with breast cancer.

Key Points . . .

- Women's perceptions of an experimental therapeutic touch and dialogue intervention or a control quiet time and dialogue intervention were analyzed.
- Women reported feeling calm, comforted, relaxed, secure, and aware, regardless of the intervention they received.
- Some women may not perceive any specific benefit from a quiet time intervention.
- Some women reported a positive regard for the research nurses.

The purpose of the present qualitative study was to extend knowledge by comparing the perceptions of women with breast cancer about their participation in an experimental TT plus dialogue nursing intervention with those of women receiving a control quiet time plus dialogue nursing intervention. The effects of the experimental and control interventions on anxiety, mood, and pain already have been reported (Samarel, Fawcett, Davis, & Ryan, 1998). The present study was undertaken to better understand women's perceptions of their participation in the study and, thereby, amplify the findings of that study. In addition, the present study afforded the opportunity to identify implications for nursing.

Background

Conceptual Model

The Science of Unitary Human Beings (SUHB) (Rogers, 1990, 1992) guided Samarel et al.'s (1998) original

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Therapeutic touch (TT) was introduced by Dolores Krieger and Dora Kunz more than 30 years ago. It is a noninvasive nursing intervention derived from ancient forms of healing, such as laying-on of hands and energy transfer. Several studies of TT already have been conducted; some have been designed to quantitatively measure the effects of TT, others to qualitatively discover the nature of the experience of receiving TT (Easter, 1997; Madrid & Winstead-Fry, 2001; Peters, 1999). Investigators typically call for additional research about the experience of TT and its effects. Easter, for example, pointed out that "research in the use of TT to provide better, improved patient/client outcomes is still a vastly undiscovered area within the realm of nursing care" (p. 164).

experimental study and the present study. In the context of the SUHB, human beings and the environment are regarded as energy fields. The SUHB focuses specifically on the pattern of human and environmental energy field mutual process. Pattern is conceptualized as a wave that cannot be seen. Mutual process can be thought of as interactions among human and environmental energy fields. Manifestations of the pattern of human and environmental energy field mutual process, including individuals' experiences, perceptions, and expressions, can be observed and measured. The pattern manifestations of interest in the present study were women's perceptions of their participation in the experimental study conducted by Samarel et al.

The ultimate goal of SUHB nursing practice is "to promote human betterment" (Rogers, 1992, p. 33). Noninvasive modalities, such as TT, meditation, and imagery, as well as promotion of attitudes of hope, humor, and upbeat moods through nurse-patient dialogue and other forms of support, are emphasized. Contemporary SUHB practice methodology encompasses three components: assessment; intervention, called voluntary mutual patterning; and evaluation (Fawcett, 2000). Assessment focuses on the nurse's knowing—or recognition of—the patient's pattern manifestations. In particular, the nurse needs to apprehend and identify manifestations of human and energy field pattern related to the patient's current health events, including the patient's experiences, perceptions, and expressions. Voluntary mutual patterning refers to the work that the nurse and patient undertake together, using noninvasive modalities, to enhance the patient's efforts to actualize his or her desired health potential. Evaluation again focuses on the nurse's knowing—or recognition of—the patient's pattern manifestations. Here, the nurse and patient make judgments about the human and environmental energy field pattern manifestations following voluntary mutual patterning.

Related Literature

TT is practiced as a "direct subjective experience of patterning" (Meehan, 1990, p. 69). TT, which involves "knowledgeable and purposive patterning of nurse-environmental/patient-environmental energy field [mutual] process" (Meehan, 1993, p. 71), encompasses all three components of the SUHB practice methodology. TT has been taught in at least 100 colleges and universities and has been used by nurses in many situations and settings in more than 75 countries (Glazer, 2000; Madrid & Winstead-Fry, 2001). Literature reviews, which collectively encompass hand and computer-assisted searches for studies published from 1974–2001, have been undertaken to determine the effectiveness of TT (Easter, 1997; Hughes, Meize-Grochowski, & Harris, 1996; Kelly & Sullivan, 2001; Madrid & Winstead-Fry; Peters, 1999; Quinn, 1988; Smyth, 1995). The reviews revealed that study samples collectively have included well and ill male and female participants ranging in age from two weeks to more than 80 years. The effectiveness of TT has been evaluated in individuals with various clinical conditions, including cardiac disease, degenerative arthritis, burns, psychiatric disorders, HIV infection, chemical dependency, wounds, and breast cancer, as well as in individuals experiencing symptoms such as stress, anxiety, and pain. The findings of Peters' meta-analysis indicated that TT had a positive, medium-

size effect on physiologic and psychological variables within participants in studies that used pretests and posttests. Although a similar effect was found for physiologic variables (e.g., pain, wound healing, immune status) when TT was compared with control treatments, Peters concluded that an insufficient number of studies have been done to support a claim of TT being more effective than control treatments for psychological variables (various measures of anxiety). Samarel et al. (1998) reported a medium-sized effect for preoperative state anxiety in their study of the effects of an experimental TT and dialogue nursing intervention and a control quiet time and dialogue nursing intervention; the women who received the experimental intervention prior to breast cancer surgery had lower state anxiety, controlling for trait anxiety, than did their counterparts who received the control intervention. However, no evidence existed of an effect of the interventions on preoperative or postoperative mood, postoperative state anxiety, or postoperative pain.

Some investigators have studied individuals' experiences or perceptions of receiving TT, rather than the effectiveness of TT. Smyth (1996) found that the patients in her study regarded TT as "a gentle, helpful, caring, pleasant, noninvasive treatment" (p. 24); the researcher, however, did not provide any information about the patients studied. Samarel (1992) found that 20 adults who had received TT for varying periods of time (range = 2 days–7 years) outside the context of participation in research projects reported a fulfilling and multidimensional experience that facilitated personal growth. More specifically, Samarel described the lived experience of TT as "a dynamic, multidimensional experience of developing awareness and personal change leading to resonating fulfillment" (p. 655). Hughes et al. (1996) reported that adolescent psychiatric patients (N = 7) described TT as an experience that engendered feelings of calmness and relaxation and expanded awareness of body sensations, such as feeling heat or cold and relief from headache or leg pain. Green (1996, 1998) reported that two women declared the experience of TT a "powerful force that radiated inner peace, harmony, and tranquility" (Green, 1996, p. 124).

Two investigations concluded that children (France, 1993) and adolescents (Hughes et al., 1996) experienced the human energy field during TT treatments; however, the researchers did not explain what they meant by the experience of the human energy field. Smyth (1996) concluded that the experience of TT is "being-in-another-world" (p. 18). She explained, "It was discovered that experiencing therapeutic touch leaves a patient momentarily situated in another world—a world of the invisibility of being" (p. 23). Heidt (1990) found that TT is experienced by nurses who practice it (n = 7) and their patients (n = 7) as "opening to the flow of universal life energy" (p. 182).

Smyth (1996) noted that patients regarded TT as an integral part of an "unconditional" relationship with the nurse that is "central to the healing relationship" (p. 24). Hughes et al. (1996) reported that although some patients felt uncomfortable with TT treatment, all felt safe with the nurse who administered it.

Quiet time, with or without controlled environmental noise, such as background music, is a noninvasive nursing intervention that typically is used to induce a state of relaxation

or maintain a resting state (Thomas, Liehr, DeKeyser, Frazier, & Friedmann, 2002). The findings of some studies suggest that relaxation or music (or a combination of relaxation and music) is an equally effective means of reducing postoperative pain (Good, Anderson, Stanton-Hicks, Grass, & Makii, 2002; Good et al., 2001). The findings of another study, in contrast, indicated that music was a more effective means of reducing state anxiety than uninterrupted rest (Wong, Lopez-Nahas, & Molassiotis, 2001). Available research has focused primarily on the effects of the interventions, rather than study participants' perceptions of the interventions.

Dialogue is a noninvasive nursing intervention that is regarded as an essential aspect of nursing practice (Caris-Verhallen, Kerkstra, & Bensing, 1997; Hartrick, Lindsey, & Hills, 1994). Nurses have used dialogue for many years to provide support to patients experiencing pain, distress, and anxiety (Anderson, Mertz, & Leonard, 1965; Elms, 1964). Although studies have revealed that talking with patients can reduce their pain and enhance their mood (Diers, Schmidt, McBride, & Davis, 1972; Moss & Meyer, 1966), previous research has not focused on patients' perceptions of spending a specific amount of time in dialogue with a nurse.

All studies to date have focused on the effects or experience of TT, the effects of rest or relaxation and music, or the effects of dialogue. No study has included a description of perceptions of participation in a non-TT control treatment that includes quiet time and dialogue. This study extends knowledge by comparing answers to questions about participating in a TT experimental nursing intervention with answers to questions about participating in a non-TT control nursing intervention.

Methods

Study Design and Sample

Data for this study were collected as part of a larger experimental study of the effects of TT on pre- and postoperative anxiety and mood and postoperative pain with a sample of 31 women with early-stage breast cancer (Samarel et al., 1998). The experimental nursing intervention consisted of 10 minutes of TT and 20 minutes of dialogue, and the control nursing intervention consisted of 10 minutes of quiet time and 20 minutes of dialogue. An audiotape of music was played for all participants to control background noise. Selection of the length of time for the TT treatments was in keeping with the typical length of treatment (Quinn, 1989). Experimental and control interventions were administered both pre- and postoperatively. Figure 1 outlines the study protocol.

The women were blinded to the hypotheses of the larger experimental study, although they were informed of the essential nature of the experimental and control nursing interventions before agreeing to participate. The research nurses also were blinded to the study hypotheses. As women completed the postoperative experimental or control intervention, they were contacted by one of the investigators to determine their willingness to participate in a telephone interview. Recruitment of study participants for the interview ceased when no novel answers to questions were noted. Although constant comparative analysis (Polit &

Recruitment and Informed Consent

Each woman who was referred by her surgeon received an explanation of the study during an initial recruitment telephone call. The explanation indicated that each woman would receive two home visits, when she would talk about her concerns, questions, and feelings, as well as be assigned to receive a 10-minute nursing treatment consisting of sitting quietly with a nurse or having a nurse move her hands two to four inches from the surface of the woman's skin. After agreeing to participate, each woman was assigned randomly to the experimental or control nursing intervention, using the sealed opaque envelope technique. The research nurse who administered the experimental or control nursing intervention then contacted the woman by telephone to arrange for the preoperative home visit. At the beginning of the preoperative home visit, each woman received a written explanation of the study and signed a consent form.

Experimental Nursing Intervention: Therapeutic Touch (TT)

Each woman who received the experimental TT nursing intervention was informed that she would listen to restful music and receive a 10-minute nursing treatment, during which the nurse would move her hands around the woman's body but not touch her body.

To provide a TT treatment, the research nurse

1. Suggested that the patient sit quietly in a chair with her eyes closed.
2. Played an audiotape of the piano solo "Lokus: Spheres of Peace," recorded by Doug Cutler, Ontario, Canada, 1982, to provide relaxing background music for the duration of TT treatment.
3. Assumed a meditative state of awareness by shifting the focus from the external environment to an inner focus through which the nurse attends to the patient in a relaxed and gentle manner (about one minute).
4. Mentally made a specific intention to therapeutically assist the patient (about one minute).
5. Moved hands two to four inches over the patient's body from head to feet using the hands as sensors or scanners to assess the patient's energy field pattern (i.e., pattern manifestation appraisal) (about two minutes).
6. Focused intent on the specific direction of the patient's energy field pattern manifestation, using the hands as focal points (about four minutes).
7. Placed hands over the patient's solar plexus to pattern energy, that is, focus the flow of energy between the patient and environment (about two minutes).

Total treatment time: 10 minutes

Control Nursing Intervention: Quiet Time

Each woman who received the control quiet time nursing intervention was informed that she would listen to restful music and sit quietly with the nurse for 10 minutes.

To provide quiet time, the research nurse

1. Suggested that the woman and nurse sit quietly with their eyes closed.
2. Played an audiotape of the piano solo "Lokus: Spheres of Peace," recorded by Doug Cutler, Ontario, Canada, 1982, to provide restful background music for the duration of the quiet period.

Total treatment time: 10 minutes

Dialogue (same for both groups)

All women were informed that they also would engage in a 20-minute period of talking with the nurse.

To engage in dialogue with the woman, the research nurse

1. Suggested that the woman and nurse sit in comfortable chairs for a relaxed chat.
2. Initiated dialogue about the woman's experiences with breast cancer and how she may have been feeling.
3. Encouraged continued communication and provided support through use of a focused, caring attitude, using therapeutic communication techniques.
4. Provided reassurance and reinforcement for treatment decisions.
5. Answered general questions related to breast cancer and did not discuss specific treatment protocols or advise which protocols to choose.

Total dialogue time: 20 minutes

Figure 1. Treatment Protocols

Note. Based on information from Samarel et al., 1998.

Hungler, 1999) was not used formally, two of the investigators reviewed the tape recordings and transcripts of the telephone interviews periodically during data collection and determined that no novel answers were being generated by the time 15 study participants had been interviewed. Consequently, the decision was made to stop data collection after 18 telephone interviews. Thus, the data-generating sample for the present study was the first 18 (58%) of the 31 women who completed the larger study. Nine women had received the experimental nursing intervention, and nine had received the control nursing intervention. The typical study participant was 55 years of age, was white, was college educated, lived with a significant other, was employed outside the home, and had had mastectomy with axillary node dissection.

Instrument

The **Telephone Interview Guide** (see Figure 2) consisted of six open-ended questions. The purpose of the interview was to determine the women's perceptions of their participation in the experimental study. Open-ended questions were used to avoid leading the women to particular answers. One question was directed to only the participants who received the experimental intervention, and one was directed to only the participants who received the control intervention; all other questions were directed to all of the participants. The use of the terms "physically" and "emotionally," although not in keeping with the SUHB, were used because they are understandable to the lay public and facilitated comprehensive expression of the women's perceptions of study participation.

Procedure

Study procedures, including those for the larger experimental study and the present study, were approved by a university institutional review board, and the women signed informed consent forms. The experimental and control interventions were administered by trained research nurses in the women's homes an average of 1.6 days (range = 1–7 days) prior to definitive surgery for breast cancer and within 1.0 day of hospital discharge, an average of 3.3 days after surgery (range = 1–7 days) (Samarel et al., 1998). The telephone interview was conducted an average of 5.1 days after the postoperative home visit (mode = 4 days, range = 2–9 days). The researchers decided not to interview the women immediately after the completion of the postoperative intervention to allow the women time to reflect on their experience of participating in the experimental study. Telephone interviews, rather than face-to-face interviews, controlled study costs and were con-

sidered less disruptive to the women than another home visit would have been. The telephone interviews were done by an investigator who had not been directly involved in recruitment of study participants or the administration of the nursing interventions to minimize the possibility of socially desirable answers to the questions. The interviews, which lasted 2–28 minutes (mode = 3 minutes), were recorded to audiotape with the women's oral permission and then transcribed verbatim by the study's administrative assistant. Two of the investigators read and listened to the transcripts at the same time to verify their accuracy.

Data Analysis

Attention was given to criteria for establishing the trustworthiness of qualitative data, including credibility, dependability, confirmability, and transferability (Polit & Hungler, 1999). Credibility of the data was supported by the investigator's attentive listening to each woman's answers to the interview questions. Although the interviews were short, the investigator provided prompts to ensure that each woman had an opportunity to answer each question completely. Content analysis was used to identify answers to the interview questions as expressed in words, phrases, and sentences (Polit & Hungler; Weber, 1990). The unit of analysis, then, was each answer to each interview question. Dependability and confirmability of the data were supported by having two of the investigators who did not recruit study participants, administer the nursing interventions, or conduct the telephone interviews independently review the transcripts and make lists of frequently used words and phrases. They then compared their separate lists to find commonalities and developed a coding tool. Both of the investigators then independently coded all transcripts, examining the women's answers to each interview question separately. The investigators compared and discussed their codes until they reached agreement for the code assigned to each answer. The frequency of each answer was calculated, and recurring themes were identified. Dependability and confirmability of the data were supported further by the other two investigators' careful scrutiny of codes and themes. Transferability of the data is limited because of the small sample size. However, the results provide a comprehensive description of the women's answers to the interview questions.

Results

A total of 101 answers was identified from the analysis of the transcripts: 52 answers were from participants who received the experimental nursing intervention, and 49 were from participants who received the control nursing intervention. No evidence was found that the women's answers to the questions were influenced by the varying amount of elapsed time between the postoperative intervention and the telephone interview, which ranged from two to nine days.

Thirty-two answers were given to the first question asked of all study participants: "How did you feel physically and emotionally during the home visits?" Many of the answers (n = 26, 81%) indicated a feeling of calmness. Examples include "comfortable," "calm," "at peace," "good to have someone to talk to," and "fine, okay." The other answers (n = 6, 19%) reflected a sense of awareness, exemplified by the words "interesting," "stimulating," and "enlightened."

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1. How did you feel physically and emotionally during the home visits?
 2. How did you feel physically and emotionally while the nurse talked with you?
 3. How did you feel physically and emotionally when you received the nursing treatment? (experimental intervention participants only)
 4. How did you feel physically and emotionally when you sat quietly with the nurse? (control intervention participants only)
 5. How have you felt physically and emotionally since the home visits?
 6. Is there anything more you would like to tell me about your feelings or the home visits?
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Figure 2. Telephone Interview Guide

Eight answers were given to the second question asked of all participants: "How did you feel physically and emotionally while the nurse talked with you?" Slightly more than half ($n = 5$, 63%) of those answers reflected feelings of calmness and relaxation. Answers exemplifying those feelings were "calm," "relaxed," "fine," and "like a friend sitting there." The other answers ($n = 3$, 37%) indicated a sense of awareness. For example, an answer provided by a woman who had received the experimental intervention was, "As far as the touch thing, I don't know that I am as open to that as I should be for it to give benefit."

Eleven answers were given to the question asked only of the participants receiving the experimental intervention: "How did you feel physically and emotionally when you received the nursing treatment?" Almost all of those answers ($n = 10$, 91%) reflected body sensations and feelings of calmness and safety. Answers reflecting body sensations included, "I could feel something," "strange feeling," "tingling through the body," "like someone touching me," "magnetic field," and "whatever was in me drained out." Answers reflecting feelings of calmness and safety included "calm," "relaxed," "secure," "liked it," and "secure/euphoric." The one (9%) additional answer—"I have been through this before and understand the treatment"—indicated a sense of awareness.

Thirteen answers were given to the question asked only of the control group: "How did you feel physically and emotionally when you sat quietly with the nurse?" The majority of those answers ($n = 10$, 77%) indicated feelings of comfort and relaxation. Examples were "relaxed," "comfortable," and "soothing." The other answers ($n = 3$, 23%), including "gave information," "not used to sitting quietly," and "different music," reflected a sense of awareness.

Twenty-three answers were given to another question asked of all study participants: "How have you felt physically and emotionally since the home visits?" Most of those answers ($n = 20$, 87%) indicated feelings of comfort and relaxation: "comfortable," "content," "relaxed," and "fine." The three (13%) additional answers, including "fortunate" and "good to talk," reflected a sense of awareness.

Fourteen answers were given to the final question asked of all participants: "Is there anything more you would like to tell me about your feelings or the home visits?" Some answers ($n = 6$, 43%) revealed feelings of calmness and relaxation, as exemplified by the words "calm," "relaxed," "supported," and "peaceful." Another answer ($n = 1$, 7%) went beyond feeling calm and relaxed to a broad sense of awareness of the experience of receiving TT. The woman who provided that answer said, "I thought [TT] was kind of a strange procedure, but for some reason or other, there was something very calming about it, very unusually protective about it, like building a shield against the outer world kind of thing. I felt somehow very strangely protected." A few other answers ($n = 4$, 29%) to the final question pertained to participants' perceptions of the nurse. Answers included, "She was empathetic and concerned," "supportive person," "nice to talk to," and "very helpful." The three (21%) additional answers, given by participants who received the control intervention, focused on the purpose of the study, which reflected a sense of awareness. For example, one answer was, "If I had known it [the control intervention] was going to be the way it was, I would not have done it."

Within the context of the SUHB, the answers of the women who participated in this study are interpreted as their perceptions of manifestations of the pattern of the mutual process occurring between the nurse and the woman during a noninvasive nursing intervention. Collectively, the study findings indicate that the women regarded the nursing intervention as a positive experience that included feeling calm, comforted, relaxed, secure, and aware.

Feelings of calmness and relaxation were evident in the answers to all questions. The women's perceptions of either the experimental TT plus dialogue nursing intervention or the control quiet time plus dialogue nursing intervention were similar to descriptions of TT alone reported by other investigators. For example, adolescent psychiatric patients who received TT also reported feelings of calmness and relaxation (Hughes et al., 1996), and the description of TT as an experience of inner peace, harmony, and tranquility (Green, 1996, 1998) is similar to feelings of calmness and relaxation.

A sense of awareness also was evident in the women's answers to all questions. Those answers focused primarily on evaluation of the nursing intervention received, rather than the more personalized awareness described by Samarel (1992). The difference could be attributed to the length of time that the participants in the two studies received the intervention—just twice in the present study compared with multiple times over a period of years for many in Samarel's study.

Some women's comments about their interactions with the research nurse reflected positive regard, such as "supportive," "helpful," "empathetic," and "concerned." Hughes et al. (1996) and Smyth (1996) also noted the positive regard their study participants had for the nurses. In those studies, a nurse administered only a TT treatment; in the present study, no differences were noted in comments about the nurse from the women who received TT and dialogue and those who received quiet time and dialogue.

The essentially similar answers of the experimental and control intervention participants in this study echo the lack of substantial group differences in the quantitative data collected for the larger experimental study (Samarel et al., 1998). Although the sample for the present study was small, which mandates caution when drawing conclusions, the noninvasive nursing intervention of quiet time plus dialogue may be as effective as the noninvasive nursing intervention of TT plus dialogue. However, of some concern is the finding that one-third of the women who received the control intervention questioned the purpose of the study, whereas none of the women who received the experimental intervention did so. This finding may indicate a lack of benefit from a nursing intervention consisting of quiet time and dialogue for at least some women with breast cancer.

Although the typical length of time for a TT treatment is 10 minutes, treatments have ranged from 5–32 minutes (Heidt, 1981; Keller & Bzdek, 1986; Meehan, 1993; Quinn, 1989). Investigators may want to consider studying the differential effects of various lengths of time for TT treatments and control treatments in future studies.

Because the dialogue component of the nursing interventions was twice as long (20 minutes) as the TT or quiet time component (10 minutes), the women's perceptions may have been more influenced by dialogue than by TT or quiet time. Future studies should be designed to test the specific effects of TT and dialogue or quiet time and dialogue. Moreover, given that Ekwall, Ternstedt, and Sorbe (2003) found that women with gynecologic cancer preferred that health care be based on their perceptions of their need for information and dialogue, future studies should be designed to control for the amount of dialogue desired by each participant.

Noteworthy is that the participants who received the experimental intervention experienced body sensations that were not experienced by their control intervention counterparts. Inasmuch as TT does not involve actual touching of the recipient by the practitioner, the researchers are not sure whether the women's knowledge that the nurse's hands would be near their bodies or TT accounted for the reports of bodily sensations. They believe, however, that participants' openness to TT does not influence their perception of TT. Indeed, patients are not required to have an *a priori* belief in the efficacy of TT to obtain beneficial effects or to perceive TT as a positive experience (Samarel, 1992; Samarel et al., 1998).

The study findings suggest that the women felt comfortable with the home visits and the nurse. Being comfortable refers to "a state of physical and material well-being, with freedom from pain and trouble, and satisfaction of bodily needs" (Oxford English Dictionary Online, 2002b). Nurses who provide comfort lend support and a sense of security; they provide relief and assistance in times of sickness and soothe in times of trouble (Oxford English Dictionary Online, 2002a). Kolcaba and Kolcaba (1991) identified three types of comfort: relief, ease, and transcendence. Relief, according to Kolcaba (2003), is "the experience of a patient who has had a specific comfort need met" (p. 258). Ease refers to "a state of calm or contentment" (Kolcaba, p. 253), and transcendence is "the state in which one rises above problems or pain" (Kolcaba, p. 259). These definitions suggest that ease, rather than relief or transcendence, is the type of comfort reflected in the answers of most participants in the present study.

The argument could be made that quiet time is so different from TT that it does not represent an adequate control intervention. The use of quiet time is, however, similar to rest periods as the control condition in a study of the effect of TT on the well-being of individuals with terminal cancer (Giasson & Bouchard, 1998). The larger experimental study was deliberately designed to compare TT and a noninvasive control nursing intervention that did not require the nurse to have knowledge of TT. Consequently, "sham" or "mimic" TT (Quinn, 1988) was not employed as the control intervention. Moreover, although quiet time may be in keeping with the notion of "presence," one could argue that TT also is a form of presence, which Parse (1998) defined as "a special way of 'being with' in which the nurse is attentive to moment-to-moment changes in meaning" (p. 71). Perhaps the similarity in many answers given by the women who received TT and those who received quiet time reflects their perception of the nurse's presence and both the experimental and control research nurses' expectations of beneficial outcomes from their presence with the women.

Labeling the control treatment as "quiet time" may be misleading in that music was played throughout the 10 minutes of that component of the control nursing intervention. Music also was played during the TT component of the experimental nursing intervention so that the background for both components would be equivalent. The music, which was an audiotape of a restful piano solo, may have contributed as much or more to the women's perceptions of their study participation than TT or quiet time. Future studies of TT should be designed to determine the specific effects of background music.

The one-on-one home visits by a nurse, as well as the women's willingness to be part of an experimental study, could have led to a Hawthorne effect, accounting for some of the findings (Polit & Hungler, 1999). Of continuing concern is the answer "fine" to some questions. The women's use of that word could be interpreted as a neutral or polite, not necessarily meaningful, answer that was used to avoid a negative answer.

Asking about both physical and emotional feelings made interpretation of answers difficult. In some instances, whether the answer was to the physical or emotional aspect of the question was unclear. Perhaps each question should be divided into two distinct parts (physical feelings and emotional feelings) in future studies. Yet differentiating between physical and emotional experiences is not consistent with the SUHB. Consistency with the SUHB may require questions to be more open-ended and general (e.g., "How did you feel?"). Pretesting of such open-ended and general questions for the telephone interview, however, indicated that answers were more limited than when the question encompassed both physical and emotional aspects. An ongoing challenge for SUHB researchers is the selection of the most appropriate approach to elicit pattern manifestations. Researchers are encouraged to continue to seek ways to ask questions about SUHB-based nursing interventions that are consistent with the SUHB and, at the same time, understandable to the lay public.

Implications for Nursing

The study findings indicate that women with breast cancer could be offered a choice of TT, quiet time, or dialogue when feelings of calmness and relaxation are desired. Unlike participation in an experimental study, where assignment to interventions typically is done using a random procedure, women who seek nurses in the practice setting are able to select the intervention they most prefer. The advantage of quiet time or dialogue as a nursing intervention is that training in the theory and practice of TT would not be required to assist women to experience pattern manifestations they regard as positive. Thus, nurses who are not trained in TT may offer an essentially equivalent intervention to enhance feelings of calmness and relaxation in women with breast cancer. Nurses should, however, remain sensitive to women who may not value a period of quiet time with a nurse as a legitimate intervention. Clearly, nurses are responsible for thoroughly explaining the nursing interventions that they are prepared to offer to women with breast cancer and encouraging each woman to select the intervention she regards as most congruent with her expectations for nursing care.

TT, quiet time, and dialogue all involve the nurse's therapeutic use of self. Preparation for TT, which includes centering, or assumption of a meditative state, and adoption of an intention to help the TT recipient (Samarel, 1992), also could become standard preparation for quiet time and dialogue interventions, which could enhance the nurse's therapeutic use of self.

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- National Alliance of Breast Cancer Organizations
www.nabco.org
- Susan G. Komen Breast Cancer Foundation
www.komen.org

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