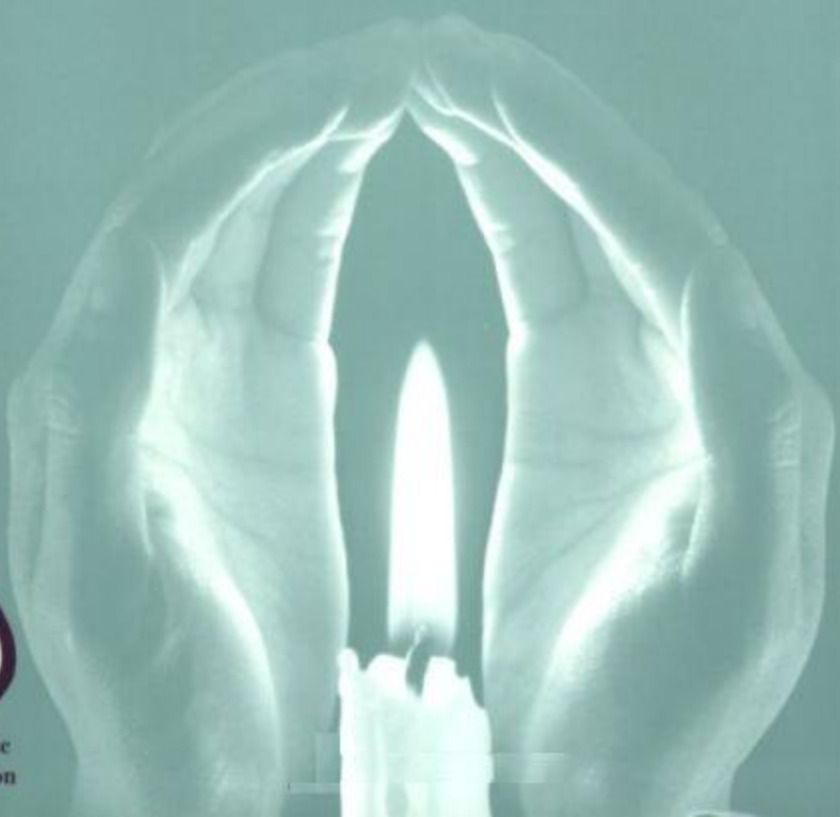
ARBARA MONTGOMERY DOSSEY • LYNN KEEGAN • CATHIE E. GUZZETTA

Holistic Nursing

A Handbook for Practice

FOURTH EDITION



American Holistic
Nurses' Association

Holistic Nursing

A Handbook for Practice

BARBARA MONTGOMERY DOSSEY
LYNN KEEGAN
CATHIE E. GUZZETTA

FOURTH EDITION

Holistic Nursing: A Handbook for Practice, Fourth Edition guides nurses in the art and science of holistic nursing and healing and offers ways of thinking, practicing, and responding both personally and professionally. It addresses one's own self-healing while also helping readers to offer new ways of healing to others. Using self-assessments, relaxation, imagery, nutrition, exercise, and aromatherapy, it presents expanded strategies for enhancing one's psychophysiology. Intended for students, clinicians, educators, and researchers who desire to expand their knowledge of holism, healing, and spirituality, ***Holistic Nursing: A Handbook for Practice*** challenges the reader to explore the inward journey toward self-transformation, to identify the growing capacity for change and healing, and to bring healing to the forefront of health care.

New Topics and Features

- Updated with the 2003 American Holistic Nurses' Association Standards of Holistic Nursing Practice
- Includes three new chapters on Aromatherapy, Relationship-Centered Care and Healing Initiatives in a Community Hospital, and Exploring Integrative Medicine and the Healing Environment in a Large Urban Acute Care Hospital
- Includes guidelines for integrating holistic interventions divided into four areas: before, at the beginning, during, and at the close of the session
- Discusses both basic and advanced strategies for integrating complementary and alternative interventions

From the Foreword

"The [fourth] edition builds upon and extends the [previous] editions by continuing to update the knowledge base with the most current, cutting-edge science and scientific-theoretical-philosophical foundation to underpin both current and [future] practices..."

Jean Watson
PhD, RN, HNC, FAAN
Distinguished Professor of Nursing
Murchinson-Scoville Chair in Caring Science
University of Colorado Health Sciences Center

Jones and Bartlett Publishers
40 Tall Pine Drive
Sudbury, MA 01776
978-443-5000
info@jbpub.com
www.jbpub.com

Holistic Nursing

A Handbook for Practice

FOURTH EDITION

Barbara Montgomery Dossey, RN, PhD, HNC, FAAN
Director
Holistic Nursing Consultants
Santa Fe, New Mexico

Lynn Keegan, RN, PhD, HNC, FAAN
Director
Holistic Nursing Consultants
Port Angeles, Washington

Cathie E. Guzzetta, RN, PhD, HNC, FAAN
Nursing Research Consultant
Children's Medical Center of Dallas
Director
Holistic Nursing Consultants
Dallas, Texas

Endorsed by the American Holistic Nurses' Association

JONES AND BARTLETT PUBLISHERS
Sudbury, Massachusetts
BOSTON TORONTO LONDON SINGAPORE

World Headquarters
Jones and Bartlett Publishers
40 Tall Pine Drive
Sudbury, MA 01776
978-443-5000
info@jbpub.com
www.jbpub.com

Jones and Bartlett Publishers
Canada
2406 Nikanna Road
Mississauga, ON L5C 2W6
CANADA

Jones and Bartlett Publishers
International
Barb House, Barb Mews
London W6 7PA
UK

Copyright © 2005 by Jones and Bartlett Publishers, Inc.
Cover image: Copyright © Comstock Images/Alamy Images

All rights reserved. No part of the material protected by this copyright may be reproduced or utilized in any form, electronic or mechanical, including photocopying, recording, or by any information storage and retrieval system, without written permission from the copyright owner.

Library of Congress Cataloging-in-Publication Data

Holistic nursing : a handbook for practice / [edited by] Barbara Montgomery Dossey, Lynn Keegan, Cathie E. Guzzetta.— 4th ed.
p. ; cm.
Rev. ed. of: Holistic nursing : a handbook for practice / Barbara Montgomery Dossey. 3rd. ed. 2000.
Includes bibliographical references and index.
ISBN 0-7637-3183-8 (pbk.)
1. Holistic nursing—Handbooks, manuals, etc.
[DNLM: 1. Holistic Nursing. WY 86.5 H732 2004] I. Dossey, Barbara Montgomery. II. Keegan, Lynn. III. Guzzetta, Cathie E.
RT42.H65 2004
610.73—dc22

2003021422

Production Credits
Acquisitions Editor: Kevin Sullivan
Production Manager: Amy Rose
Editorial Assistant: Amy Sibley
Production Assistant: Tracey Chapman
Marketing Manager: Ed McKenna
Manufacturing Buyer: Amy Bacus
Composition: Northeast Compositors, Inc.
Cover Design: Anne Spencer
Printing and Binding: Malloy, Inc.
Cover Printing: Malloy, Inc.

Printed in the United States of America
08 07 06 05 04 10 9 8 7 6 5 4 3 2 1

Nursing is an art; and if it is to be made
an art,
it requires as exclusive a devotion, as hard
a preparation, as any painter's or
sculptor's work;
for what is the having to do with dead
canvas or cold marble,
compared with having to do with the living
spirit—the temple of God's spirit?
It is one of the Fine Arts;
I had almost said,
the finest of Fine Arts.

Florence Nightingale

To Our Colleagues in Nursing:

When a nurse
Encounters another
Something happens
What occurs
Is never a neutral event

A pulse taken
Words exchanged
A touch
A healing moment
Two persons
Are never
The same

Table of Contents

Vision of Healing ..... **xvii**

Contributors ..... **xix**

Foreword ..... **xxiii**

Preface ..... **xxv**

Acknowledgments ..... **xxix**

CORE VALUE 1—HOLISTIC PHILOSOPHY, THEORIES, AND ETHICS **1**

VISION OF HEALING—Exploring Life's Meaning ***3***

Chapter 1 **Holistic Nursing Practice** **5**
Barbara Montgomery Dossey and Cathie E. Guzzetta

Nurse Healer Objectives 5
Definitions 5
Holism 7
Holistic Nursing 8
Eras of Medicine 12
Relationship-Centered Care 24
Conclusion 27
Directions for Future Research 28
Nurse Healer Reflections 28
Appendix 1-A: American Holistic Nurses' Association (AHNA) Standards of Holistic Nursing Practice (Revised 2003) 31
Guidelines 32
AHNA Holistic Nursing Description 32
Core Value 1: Holistic Philosophy, Theories, and Ethics 32
Core Value 2: Holistic Education and Research 33
Core Value 3: Holistic Nurse Self-Care 34
Core Value 4: Holistic Communication, Therapeutic Environment, and Cultural Diversity 35
Core Value 5: Holistic Caring Process 36

VISION OF HEALING—Transpersonal Self **39**

Chapter 2 **Transpersonal Human Caring and Healing** **41**
Janet F. Quinn

Nurse Healer Objectives 41
Definitions 41

Theory and Research 42
Healing: The Goal of Holistic Nursing 43
The Healer 47
A True Healing Health Care System 48
The Wounded Healer 50
Conclusion 51
Directions for Future Research 51
Nurse Healer Reflections 51

VISION OF HEALING—Reawakening the Spirit in Daily Life **55**

Chapter 3 **The Art of Holistic Nursing and the Human Health Experience** **57**
H. Lea Barbato Gaydos

Nurse Healer Objectives 57
Definitions 57
The Art of Holistic Nursing 58
Aspects of the Human Health Experience 63
Conclusion 73
Directions for Future Research 74
Nurse Healer Reflections 74

VISION OF HEALING—Active Listening **77**

Chapter 4 **Nursing Theory in Holistic Nursing Practice** **79**
Noreen Cavan Frisch

Nurse Healer Objectives 79
Definitions 79
Theory and Research 79
Selected Nursing Theories 82
A Word About Definitions of Person 86
Theory into Practice 86
Conclusion 88
Directions for Future Research 89
Nurse Healer Reflections 89

VISION OF HEALING—Ethics in Our Changing World **91**

Chapter 5 **Holistic Ethics** **93**
Lynn Keegan

Nurse Healer Objectives 93
Definitions 93
The Nature of Ethical Problems 94
Morals and Principles 94
Traditional Ethical Theories 95
The Development of Holistic Ethics 96
Development of Principled Behavior 100
Analysis of Ethical Dilemmas 101
Advance Medical Directives 102
Ethics Education and Research 102
Cultural Diversity Considerations 103

Conclusion 104
Directions for Future Research 104
Nurse Healer Reflections 104

CORE VALUE 2—HOLISTIC EDUCATION AND RESEARCH 107

***VISION OF HEALING—Web of Life* 109**
Chapter 6 The Psychophysiology of Bodymind Healing 111
Genevieve M. Bartol and Nancy F. Courts

Nurse Healer Objectives 111
Definitions 111
New Scientific Understanding of Living Systems 112
Emotions and the Neural Tripwire 118
Ultradian Rhythms 120
Mind Modulation 121
Conclusion 129
Directions for Future Research 130
Nurse Healer Reflections 130

***VISION OF HEALING—Evolving Process of Life's Dance* 135**
Chapter 7 Spirituality and Health 137
Margaret A. Burkhardt and Mary Gail Nagai-Jacobson

Nurse Healer Objectives 137
Definitions 137
Theory and Research 138
Spirituality and the Healing Process 144
Spirituality in Holistic Nursing 148
Holistic Caring Process Considerations 159
Arts and Spirituality 166
Conclusion 167
Directions for Future Research 168
Nurse Healer Reflections 168

***VISION OF HEALING—Toward Wholeness* 173**
Chapter 8 Energetic Healing 175
Victoria E. Slater

Nurse Healer Objectives 175
Definitions 175
An Overview of Energetic Healing 177
Meridians 178
Chakras 181
The Aura 190
Other Forms of Energy: Smells, Aromas, Sounds, Colors, and Touch 193
The Healer 194
The One Being Healed 196
Two Potentially Interesting Concepts for Energetic Healing 199
Research and Research Implications 201

Conclusion 203
Nurse Healer Reflections 205

VISION OF HEALING—Questioning the Rules of Science **209**
Chapter 9 Holistic Nursing Research **211**
Cathie E. Guzzetta

Nurse Healer Objectives 211
Definitions 211
Wellness Model 212
Evidence-Based Practice 212
Need to Conduct Holistic Research 214
Holistic Research Methods 215
Enhancing Holistic Research 218
Conclusion 224
Directions for Future Research 225
Nurse Healer Reflections 225

CORE VALUE 3—HOLISTIC NURSE SELF-CARE **229**

VISION OF HEALING—Toward the Inward Journey **231**
Chapter 10 The Nurse as an Instrument of Healing **233**
Maggie McKivergin

Nurse Healer Objectives 233
Definitions 233
Theory and Research 234
The Nature of Healing Relationships 239
The Nurse as a Healing Environment 244
Healing Interventions 246
Other Considerations for Integration of Concepts 249
Conclusion 251
Directions for Future Research 251
Nurse Healer Reflections 252

CORE VALUE 4—HOLISTIC COMMUNICATION, THERAPEUTIC ENVIRONMENT, AND CULTURAL DIVERSITY **255**

VISION OF HEALING—Human Care **257**
Chapter 11 Therapeutic Communication: The Art of Helping **259**
Sharon Scandrett-Hibdon

Nurse Healer Objectives 259
Definitions 259
Theory and Research 259
Therapeutic Communication 260
Therapeutic Communication Helping Model 261
Conclusion 271
Directions for Future Research 271
Nurse Healer Reflections 271

VISION OF HEALING—Building a Healthy Environment **273**

Chapter 12 **Environment** **275**
Lynn Keegan

Nurse Healer Objectives 275
Definitions 275
Theory and Research 276
Holistic Caring Process 295
Directions for Future Research 301
Nurse Healer Reflections 301

VISION OF HEALING—Sharing Our Healing Stories **305**

Chapter 13 **Cultural Diversity and Care** **307**
Joan C. Engebretson and Judith A. Headley

Nurse Healer Objectives 307
Definitions 307
Theory and Research 308
Nursing Applications for Developing Cultural Competency 325
Holistic Caring Process 327
Directions for Future Research 333
Nurse Healer Reflections 334
Resource List 334

CORE VALUE 5—HOLISTIC CARING PROCESS **337**

VISION OF HEALING—Working with Others **339**

Chapter 14 **The Holistic Caring Process** **341**
Pamela J. Potter and Cathie E. Guzzetta

Nurse Healer Objectives 341
Definitions 342
Theory and Research 342
Holistic Caring Process 347
Conclusion 370
Directions for Future Research 370
Nurse Healer Reflections 372

VISION OF HEALING—Actualization of Human Potentials **377**

Chapter 15 **Self-Assessments: Facilitating Healing in Self and Others** **379**
Lynn Keegan and Barbara Montgomery Dossey

Nurse Healer Objectives 379
Definitions 379
Circle of Human Potential 379
Self-Assessments 380
Development of Human Potentials 387
Affirmations 391
Conclusion 391
Directions for Future Research 392
Nurse Healer Reflections 392

VISION OF HEALING—Changing Outcomes **395**

Chapter 16 Cognitive Therapy **397**
Eileen M. Stuart-Shor and Carol L. Wells-Federman

Nurse Healer Objectives 397
Definitions 397
Theory and Research 398
Cognitive Therapy 402
Holistic Caring Process 418
Directions for Future Research 423
Nurse Healer Reflections 423

VISION OF HEALING—Healthy Disclosure **427**

Chapter 17 Self-Reflection: Consulting the Truth Within **429**
Lynn Rew

Nurse Healer Objectives 429
Definitions 429
Theory and Research 429
Holistic Caring Process 435
Directions for Future Research 444
Nurse Healer Reflections 445

VISION OF HEALING—Nourishing the Bodymind **449**

Chapter 18 Nutrition **451**
Susan Luck

Nurse Healer Objectives 451
Definitions 451
Theory and Research 452
Eating to Promote Health 461
Healthy Choices in Nutrition 467
Holistic Caring Process 468
Directions for Future Research 472
Nurse Healer Reflections 472

VISION OF HEALING—Moving Through Strength **477**

Chapter 19 Exercise and Movement **479**
Beryl H. Cricket Rose and Lynn Keegan

Nurse Healer Objectives 479
Definitions 479
Theory and Research 480
Holistic Caring Process 485
Directions for Future Research 491
Nurse Healer Reflections 491

VISION OF HEALING—Releasing the Energy of the Playful Child **495**

Chapter 20 **Humor, Laughter, and Play: Maintaining Balance in a Serious World** **497**
Patty Wooten

Nurse Healer Objectives 497
Definitions 497
Theory and Research 497
Holistic Caring Process 510
Directions for Future Research 516
Nurse Healer Reflections 516

VISION OF HEALING—Creating Receptive Quiet **521**

Chapter 21 **Relaxation: The First Step to Restore, Renew, and Self-Heal** **523**
Jeanne Anselmo

Nurse Healer Objectives 523
Definitions 523
Theory and Research 524
Meditation 528
Modern Relaxation Methods 536
Holistic Caring Process 553
Directions for Future Research 560
Nurse Healer Reflections 560

VISION OF HEALING—Modeling a Wellness Lifestyle **565**

Chapter 22 **Imagery: Awakening the Inner Healer** **567**
Bonney Gulino Schaub and Barbara Montgomery Dossey

Nurse Healer Objectives 567
Definitions 567
Theory and Research 568
Clinical Techniques in Imagery 575
Holistic Caring Process 581
Directions for Future Research 610
Nurse Healer Reflections 610

VISION OF HEALING—Composing the Harmony **615**

Chapter 23 **Music Therapy: Hearing the Melody of the Soul** **617**
Cathie E. Guzzetta

Nurse Healer Objectives 617
Definitions 617
Theory and Research 617
Holistic Caring Process 627
Directions for Future Research 636
Nurse Healer Reflections 636

VISION OF HEALING—Using Our Healing Hands **641**
Chapter 24 Touch: Connecting with the Healing Power **643**
Lynn Keegan and Karilee Halo Shames

Nurse Healer Objectives 643
Definitions 643
Theory and Research 644
Touch Interventions and Techniques 651
Holistic Caring Process 656
Directions for Future Research 664
Nurse Healer Reflections 665

VISION OF HEALING—Accepting Ourselves and Others **667**
Chapter 25 Relationships **669**
Dorothea Hover-Kramer

Nurse Healer Objectives 669
Definitions 670
Theory and Research 670
Holistic Caring Process 677
Conclusion 687
Directions for Future Research 687
Nurse Healer Reflections 688

VISION OF HEALING—Releasing Attachment **691**
Chapter 26 Dying in Peace **693**
Melodie Olson and Barbara Montgomery Dossey

Nurse Healer Objectives 693
Definitions 693
Theory and Research 693
Holistic Caring Process 697
Directions for Future Research 716
Nurse Healer Reflections 717

VISION OF HEALING—Nourishing Wisdom **719**
Chapter 27 Weight Management Counseling **721**
Sue Popkess-Vawter

Nurse Healer Objectives 721
Definitions 721
Theory and Research 722
Holistic Caring Process 738
Directions for Future Research 752
Nurse Healer Reflections 752

VISION OF HEALING—Acknowledging Fear **757**
Chapter 28 Smoking Cessation: Freedom from Risk **759**
Christine Anne Wynd and Barbara Montgomery Dossey

Nurse Healer Objectives 759
Definitions 759

Theory and Research 759
Holistic Caring Process 766
Directions for Future Research 776
Nurse Healer Reflections 777

VISION OF HEALING—Changing One's World View **781**
Chapter 29 Addiction and Recovery Counseling **783**
Bonney Gulino Schaub and Barbara Montgomery Dossey

Nurse Healer Objectives 783
Definitions 783
Theory and Research 784
Vulnerability Model of Recovery from Addiction 788
Holistic Caring Process 799
Directions for Future Research 807
Nurse Healer Reflections 808

VISION OF HEALING—Recovering and Maintaining the Self **811**
Chapter 30 Incest and Child Sexual Abuse Counseling **813**
E. Jane Martin

Nurse Healer Objectives 813
Definitions 813
Theory and Research 814
Holistic Caring Process 817
Directions for Future Research 825
Nurse Healer Reflections 825

VISION OF HEALING—Healing Through the Senses **827**
Chapter 31 Aromatherapy **829**
Jane Buckle

Nurse Healer Objectives 829
Definitions 829
History 830
Theory and Research 830
Conclusion 840
Holistic Caring Process 841
Directions for Future Research 848
Nurse Healer Reflections 848

VISION OF HEALING—Nursing Voices of St. Charles Medical Center **853**
Chapter 32 Relationship-Centered Care and Healing Initiative in a Community Hospital **857**
Nancy Moore

Nurse Healer Objectives 857
Definitions 857
Theory and Research 857
About St. Charles 858

Life Skills 864
Life-Death Transition 866
Arts in the Hospital 871
Healing Our Community 874
Principle-Based Care Model 876
Conclusion 877
Directions for Future Research 880
Nurse Healer Reflections 880

VISION OF HEALING—Transformation of the Acute Health Care Environment **883**

Chapter 33 Exploring Integrative Medicine and the Healing Environment: The Story of a Large Urban Acute Care Hospital **885**
Lori L. Knutson

Nurse Healer Objectives 885
Definitions 885
Introduction 885
Total Healing Environment Model: Large Urban Acute Care Hospital 886
Conclusion 896
Directions for Future Research 896
Nurse Healer Reflections 896

Index **899**

Visions of Healing

Exploring Life's Meaning 3
The Transpersonal Self 39
Reawakening the Spirit in Daily Life 55
Active Listening 77
Ethics in Our Changing World 91
The Web of Life 109
The Evolving Process of Life's Dance 135
Toward Wholeness 173
Questioning the Rules of Science 209
Toward the Inward Journey 231
Human Care 257
Building a Healthy Environment 273
Sharing Our Healing Stories 305
Working with Others 339
Actualization of Human Potentials 377
Changing Outcomes 395
Healthy Disclosure 427
Nourishing the Bodymind 449
Moving Through Strength 477
Releasing the Energy of the Playful Child 495
Creating Receptive Quiet 521
Modeling a Wellness Lifestyle 565
Composing the Harmony 615
Using Our Healing Hands 641
Accepting Ourselves and Others 667
Releasing Attachment 691
Nourishing Wisdom 719
Acknowledging Fear 757
Changing One's World View 781
Recovering and Maintaining the Self 811
Healing Through the Senses 827
Nursing Voices of St. Charles Medical Center 853
Transformation of the Acute Health Care Environment 883

Contributors

Jeanne Anselmo, RN, BSN, HNC
Holistic Nurse Consultant
Private Practice
Bayside, New York
Coordinator
Contemplative Urban Law Program
Community Legal Resource Network
City University School of Law
Queens College
Flushing, New York

Genevieve M. Bartol, RN, EdD, HNC
Professor Emeritus
University of North Carolina at Greensboro
School of Nursing
Greensboro, North Carolina

Jane Buckle, PhD, RN
Complementary and Alternative Medicine Fellow
Center for Clinical Epidemiology and Biostatistics
University of Pennsylvania
Philadelphia, Pennsylvania
Director, RJ Buckle Associates LLC
Hunter, New York

Margaret A. Burkhardt, RN, PhD, RNCS, HNC
Director
Healing Matters
Beckley, West Virginia
Family Nurse Practitioner
Gulf Family Practice
Sophia, West Virginia

Nancy F. Courts, RN, PhD, NCC
Chair and Associate Professor
Adult Health Department
School of Nursing
University of North Carolina at Greensboro
Greensboro, North Carolina

Barbara Montgomery Dossey, RN, PhD, HNC, FAAN
Director
Holistic Nursing Consultants
Santa Fe, New Mexico

Joan C. Engebretson, RN, DrPH, HNC
Associate Professor
University of Texas Health Science Center Houston
School of Nursing
Houston, Texas

Noreen Cavan Frisch, RN, PhD, HNC, FAAN
Professor and Director
School of Nursing
Cleveland State University
Cleveland, Ohio

H. Lea Barbato Gaydos, RN, PhD, CS, HNC
Assistant Professor
University of Colorado at Colorado Springs
Beth-El College of Nursing and Health Science
Colorado Springs, Colorado

Cathie E. Guzzetta, RN, PhD, HNC, FAAN
Nursing Research Consultant
Children's Medical Center of Dallas
Director
Holistic Nursing Consultants
Dallas, Texas

Judith A. Headley, RN, PhD, AOCN, CCRP
Associate Professor, Division of Oncology
Director, Clinical Research Management
School of Nursing
University of Texas Health Science Center-Houston
Houston, Texas

Dorothea Hover-Kramer, RN, EdD, CNS
Director
Behavioral Health Consultants
Cave Junction, Oregon

Lynn Keegan, RN, PhD, HNC, FAAN
Director
Holistic Nursing Consultants
Port Angeles, Washington

Lori L. Knutson, RN, BSN, HNC
Director
Integrative Medicine
The Institute for Health and Healing
Abbott Northwestern Hospital
Minneapolis, Minnesota

Susan Luck, RN, MA, HNC, CCN
Director of Nutrition Education
Biodoron Immunology Center
Hollywood, Florida
Nutrition Educator/Consultant
Special Immunology Services
Mercy Hospital
Miami, Florida

E. Jane Martin, RN, PhD, HNC, FAAN
Dean and Professor
West Virginia University
School of Nursing
Morgantown, West Virginia

Maggie McKivergin, RN, MS, CNS, HNC
Holistic Nurse Consultant
Galena, Ohio

Nancy Moore, RN, PhD
Senior Vice President
Clinical and Healing Services
St. Charles Medical Center
Bend, Oregon

Mary Gail Nagai-Jacobson, RN, MSN
Community Health Consultant
Director
Healing Matters
San Marcos, Texas

Melodie Olson, RN, PhD
Associate Professor
College of Nursing
Medical University of South Carolina
Charleston, South Carolina

Sue Popkess-Vawter, RN, PhD
Professor
University of Kansas Medical Center
School of Nursing
Kansas City, Kansas

Pamela J. Potter, APRN, DNSc (C)
Energy Oriented Psychotherapy
Wisdom Tree LLC: Resources for Healing
New Haven, Connecticut

Janet F. Quinn, RN, PhD, FAAN
Associate Professor–Adjoint
School of Nursing
University of Colorado Health Sciences Center
Denver, Colorado

Lynn Rew, RN,C, EdD, AHN-C, FAAN
Denton & Louise Cooley and Family Centennial Professor in Nursing
University of Texas at Austin
Austin, Texas

Beryl H. Cricket Rose, MSN, RN
CQI/RM/Credentialing Coordinator
Community Care Services, City of Austin
Austin, Texas

Sharon Scandrett-Hibdon, RN, PhD, CS, FNP, CHTI, CHN
Certified Psychiatric Nurse
North Texas State University Student Health Center
Denton, Texas
Family Nurse Practitioner
Pilot Point, Texas

Bonney Gulino Schaub, RN, MS, CS
Co-Director New York Psychosynthesis Institute
New York, New York
Co-Director
The Dante School for Meditative Arts
Huntington, New York
Co-Director
Holistic Nursing Associates
New York, New York

Karilee Halo Shames, RN, PhD, HNC
Director of Education
Eco Nugenics/Better Health Seminars
Santa Rosa, California

Victoria E. Slater, RN, PhD, HNC
Holistic Nurse in Private Practice
Clarksville, Tennessee

Eileen M. Stuart-Shor, RN, PhD, ANP, FAHA
Research Fellow, Cardiology
Harvard Medical School, Beth Israel Deaconess Medical Center
Cardiology Nurse Practitioner, Roxbury Health Center
Assistant Professor, College of Nursing, Northeastern University
Consultant, WellCare Associates for Integrative Medicine
Boston, Massachusetts

Jean Watson, RN, PhD, HNC, FAAN
Distinguished Professor of Nursing
Murchinson-Scoville Chair in Caring Science
University of Colorado Health Sciences Center
School of Nursing
Denver, Colorado

Carol L. Wells-Federman, RN, MEd, APRN, BC
Senior Instructor
Graduate Program, School for Health Studies, Simmons College
Visiting Scholar, William F. Connell School of Nursing, Boston College
Consultant, WellCare Associates for Integrative Health
Nurse Practitioner
Massachusetts General Hospital
Boston, Massachusetts

Patty Wooten, RN, BSN, PHN
Nurse Humorist
Jest For the Health of It!
Santa Cruz, California

Christine A. Wynd, RN, PhD, CNAA
Professor and Director of the PhD in Nursing Program
The University of Akron
College of Nursing
Akron, Ohio

Foreword

The fourth edition of *Holistic Nursing: A Handbook for Practice* attests to the success and use of previous versions, moving from theory, knowledge, and values to skills and applications that integrate personal and professional competencies of Being into Caring—Healing Practices. This edition builds upon and extends the preceding editions by continuing to update the knowledge base with the most current, cutting-edge science. The authors use a strong scientific-theoretical-philosophical foundation to underpin both current and futuristic practices, that inform and guide nursing and system directions for implementing, integrating, extending, and sustaining both basic and advanced holistic nursing modalities across setting, time, and space.

The content for this edition continues to explicate as well as incorporate comprehensive-integrative approaches to body-mind-spirit nursing and Era III nursing/medicine. These perspectives intersect and embrace biomedical developments in the field of "complementary-integrative biomedical" advances. This work is congruent with an ethical and moral foundation for transpersonal dimensions of caring and healing practices at all levels, in that it honors the wholeness of our Being and Becoming more human, humane, and spiritual in our evolution as both a profession and as an evolving humanity.

This work continues to guide this field of holistic nursing by offering an advanced orientation along with advanced knowledge and practices. It brings forth the beauty, art, and artistry of the human dimensions of holistic nursing, continually informed and deepened by the American Holistic Nurses' Association, as well as the North American Nursing Diagnosis Association. This intellectual and standardized foundational text expands the context and significance of the ethical, epistemological, and praxis dimensions. It calls forth not only the intellectual importance, but the values-guided aspects of higher-deeper levels of commitment, compassion, love, and caring that underpin this kind of advanced practice: a holistic practice that is oriented toward the betterment of human health, healing, and humankind.

The evolution of the fourth edition reflects the continuing evolution of the nursing profession. It is a seminal work that contributes to the emergence of mature holistic standards and practices within a contemporary postmodern Era III scientific phase; yet this new edition continues to ground these practices in a blueprint of timeless goals, along with the finest heritage and wisdom of Nightingale.

These new/old developments of holistic nursing guide students, faculty, and practicing nurses with breakthroughs related to expanding consciousness research, notions of internationality, energetic healing, and new views of the body, as well as spirituality through compassionate human service. These notions transcend, yet embrace, basic research in bodymind medicine, psychophysiology, human potential, and so on,

integrating values with comprehensive knowledge, clinical skills, and professional standards that inform advanced practice.

As holistic nursing experts, the authors are committed to the deepest actualization of nursing, as an ancient and pioneering, yet futuristic, profession. They practice what they teach by translating and integrating this latest thinking into pragmatic and concrete nursing actions, processes, and artistic acts of caring and healing. They help us all to comprehend the critical nature of these practices in relation to nursing and how these practices inform any "caring moment." A consequence of this important, expanded work is that the self of the nurse is invited—and even reminded—of their calling into nursing, into self-care and self-healing, as essentials for authentic living of this knowledge in their personal/professional life. As such, then, by transforming self, the holistic nurse is helping to transform systems.

In summary, this fourth edition provides a framework for all of nursing's caring—healing practices; it offers a guide for personal self-care within the holistic paradigm. The result: a major work of excellence that grounds nursing in the current demands from within and without for reform, while generating new traditions and standards of personal and professional excellence and authenticity. At another level, this work transcends nursing and has relevance for transdisciplinary education and practices, leading to greater authenticity and advancement of patient care between and among all health professionals.

Jean Watson, RN, PhD, HNC, FAAN
Distinguished Professor of Nursing
Murchinson-Scoville Chair in
Caring Science
University of Colorado Health
Sciences Center
School of Nursing
Denver, Colorado

Preface

The American Holistic Nurses' Association (AHNA) has joined with the authors and contributors of *Holistic Nursing: A Handbook for Practice*, Fourth Edition, to develop further the knowledge base for holistic nursing and delineate the essence of contemporary nursing. The purposes of this book are threefold: (1) to expand an understanding of healing and the nurse as an instrument of healing; (2) to explore the unity and relatedness of nurses, clients, and others; and (3) to develop caring-healing interventions to strengthen the whole person.

Since the third edition of this book in 2000, much has changed in the world. We are facing, as never before, unprecedented shortages of nurses, educators, and leaders. Because of the physical and emotional devastation of September 11, 2001, the fear of biological weapons such as anthrax and smallpox, the global outbreak of SARS, and the need to be prepared for biological/chemical terrorism, we all are being confronted with new challenges in nursing practice. In this time of great national and international uncertainty, self-care and self-healing are essential. But how do we respond to these challenges as responsible, caring professionals and leaders in this movement of holistic nursing and integrative health care?

This book guides nurses in the art and science of holistic nursing and healing. It offers ways of thinking, practicing, and responding, both personally and professionally. It addresses our own self-healing so that we can offer new ways of healing to others, and practice the art of healing in innovative ways in a time of great vulnerability. It presents expanded strategies for enhancing our psychophysiology using self-assessments, relaxation, imagery, nutrition, exercise, and aromatherapy. It also assists nurses in their challenging roles of bringing healing to the forefront of health care and helping to shape health care reform.

Because of public demand for alternative medicine, the National Institutes of Health (NIH) created in 1992 the Office of Alternative Medicine (OAM). In 1999, the OAM was elevated to freestanding center status, now renamed the National Center for Complementary and Alternative Medicine (NCCAM), in which it is able to fund its own research grants without partnering with other institutes. The NCCAM is evaluating strategies that capitalize dramatically on bodymind and transpersonal therapies. The consistent and cumulative research findings are revealing that these therapies not only work and are extremely safe, but are also cost-effective. At the present time, they should be considered complements to orthodox medical treatments and not a replacement for them. We advocate a "both/and" instead of an "either/or" approach in interfacing these healing modalities with contemporary medical and surgical therapies.

We challenge nurses to explore the following three questions:

1. What do you know about the meaning of healing?
2. What can you do each day to facilitate healing in yourself?

3. How can you be an instrument of healing and a nurse healer?

Healing is a lifelong journey into understanding the wholeness of human existence. Along this journey, our lives mesh with those of clients, families, and colleagues, where moments of new meaning and insight emerge in the midst of crisis. Healing occurs when we help clients, families, others, and ourselves embrace what is feared most. It occurs when we seek harmony and balance. Healing is learning how to open what has been closed, so that we can expand our inner potentials. It is the fullest expression of oneself that is demonstrated by the light and shadow and the male and female principles that reside within each of us. It is accessing what we have forgotten about connections, unity, and interdependence. With a new awareness of these interrelationships, healing becomes possible, and the experience of the nurse as an instrument of healing and as a nurse healer becomes actualized. A nurse healer is one who facilitates another person's growth toward wholeness (body-mind-spirit) or who assists another with recovery from illness or with transition to peaceful death. Healing is not just curing symptoms. Rather, it is the exquisite blending of technology with caring, love, compassion, and creativity.

This holistic approach is developed by incorporating ideas of perennial philosophy, natural systems theory, and the holistic caring process. The information presented within *Holistic Nursing: A Handbook for Practice* may be of additional interest to the nurse because it incorporates the following:

- American Holistic Nurses' Association Standards of Holistic Nursing Practice (Revised and coded, 2003)
- three new chapters on Aromatherapy, Relationship-Centered Care and Healing Initiatives in a Community Hospital, and Exploring Integrative Medicine and the Healing Environment in a Large Urban Acute Care Hospital.
- nursing diagnoses established by the North American Nursing Diagnosis Association related to the 13 domains of the newly developed Taxonomy II
- guidelines for integrating holistic interventions, divided into four areas: before, at the beginning, during, and at the close of the session
- both basic and advanced strategies for integrating complementary and alternative interventions
- client case studies in the acute care and outpatient settings
- current research and directions for future research

As we have explored new meanings of healing in our work and lives, we have interwoven the many diverse threads of knowledge from nursing, as well as from other disciplines, in this book. This integration has engendered a more vivid, dynamic, and diverse understanding about the nature of holism, healing, and its implications for nursing. Allow yourself to explore ideas of healing by reading a Vision of Healing before the start of each chapter. Each chapter then begins with Nurse Healer Objectives to direct your learning within the theoretical, clinical, and personal domains. Each chapter has a glossary of definitions for easy reference. The term *patient* is used for acute care settings, and the term *client* is used in the outpatient settings. With both the patient and the client, we view persons as co-participants in all phases of care. The challenge is to integrate all concepts in this text in clinical practice and daily life. As clinicians, authors, educators, and researchers, we have successfully used

these holistic concepts and interventions from the critical care unit and home health to the classroom.

Each chapter ends with Directions for Future Research that are specific to each topic. This section presents suggested research questions that are timely and in need of scientific exploration in nursing. In concluding each chapter, Nurse Healer Reflections are offered to nurture and spark a special self-reflective experience of body-mind-spirit and the inward journey toward self-discovery and healing.

This book is organized according to the five core values of holistic nursing contained within the newly revised *American Holistic Nurses' Association Standards of Holistic Nursing Practice*. They are as follows:

Core Value 1: Holistic Philosophy, Theories, and Ethics
Core Value 2: Holistic Education and Research
Core Value 3: Holistic Nurse Self-Care
Core Value 4: Holistic Communication, Therapeutic Environment, and Cultural Diversity
Core Value 5: Holistic Caring Process

Core Value 1 presents the philosophic concepts that explore what occurs when the nurse honors, acknowledges, and deepens the understanding of inner knowledge and wisdom. It explores relationship-centered care. It lays the foundation for transpersonal human caring, the art of holistic nursing, and provides insight into how people create change and sustain these new health behavior changes related to wellness, values clarification, and motivation theory. Holistic nursing theorists and theories are developed to guide holistic nursing practice. Holistic ethics is also addressed in both personal and professional arenas.

Core Value 2 addresses the psychophysiology of bodymind healing, spirituality, and health. Energetic healing also is developed to expand further one's understanding and practice of holism. Guidelines for holistic research also are explored to provide a framework for establishing evidence-based practice.

Core Value 3 develops and explores the concepts of therapeutic presence and the qualities and characteristics of becoming an instrument of healing. It also explores the importance of self-care.

Core Value 4 explores therapeutic communication and the art and skills of helping. The necessary steps in creating an external as well as an internal healing environment are expanded to help nurses recognize that each person's environment includes everything surrounding the individual, both the external and the internal, as well as patterns not yet understood. Concepts related to cultural diversity are presented so that the nurse can recognize each person as a whole body-mind-spirit being. Such recognition facilitates the development of a mutually cocreated plan of care that addresses the cultural background, health beliefs, sexual orientation, values, and preferences of each unique individual.

Core Value 5 expands the nursing process to the holistic caring process and includes a detailed discussion of the North American Nursing Diagnosis Association and the 13 domains of Taxonomy II. The nursing process is a six-part circular process: assessment, patterns/challenges/needs, outcomes, therapeutic care plan, implementation, and evaluation. Self-assessments and complementary and alternative strategies are developed to expand concepts relevant to healing and reaching human potential. Specific areas covered are cognitive therapy, self-reflection, nutrition counseling, exercise and movement, laughter, play and humor, relaxation, imagery, music, touch, rela-

tionships, death and grief counseling, weight management counseling, smoking cessation counseling, addictions and recovering counseling, incest/child sexual abuse counseling, aromatherapy, relationship-centered care and healing initiatives in a community hospital, and exploring integrative medicine and the healing environment in a large urban acute care hospital.

Our book is intended for students, clinicians, educators, and researchers who desire to expand their knowledge of holism, healing, and spirituality. The philosophic and conceptual frameworks are beginner, intermediate, and advanced. Therefore, the reader can approach this book as a guide for learning basic content or for exploring advanced concepts. The specific "how to" for implementing holistic interventions into clinical practice are divided into both basic and advanced levels. Some advanced interventions may require additional training, that can be obtained in practicums under mentors or in elective or continuing education courses. Each chapter also presents case studies that illustrate how to use and integrate the interventions into clinical practice.

Holistic Nursing: A Handbook for Practice challenges nurses to explore the inward journey toward self-transformation, and to identify the growing capacity for change and healing. This exploration creates the synergy and the rebirth of a compassionate power to heal ourselves and to facilitate healing within others. This inner healing allows us to return to our roots of nursing, where healer and healing always have been understood and to carry Florence Nightingale's tenets of healing, leadership, and global vision forward into the 21st century. As she said, "My work is my must." By her shining example, she invites each of us to find and know our "must" and to explore our own meaning, purpose, and spirituality.[1,2]

The radical changes necessary in health care reform are occurring rapidly. Change has always been the rule in health care. These changes provide us with a greater opportunity to integrate caring and healing into our work, research, and lives. It is up to us to help determine what these new changes will be. We challenge you to capture your essence and emerge as true healers as we navigate the rough waters in this dynamic period in health care. Best wishes to you in your healing work and life.

Barbara Montgomery Dossey
Lynn Keegan
Cathie E. Guzzetta

NOTES

1. B.M. Dossey, *Florence Nightingale: Mystic, Visionary, Healer* (Philadelphia: Lippincott, Williams & Wilkins, 2000).

2. B.M. Dossey, L.C. Selanders, D.M. Beck, & A. Attewell, *Florence Nightingale Today: Her Vision for a Healty Future* (Washington, DC: Nursesbooks.org, 2004).

For more information on the American Holistic Nurses' Association and the AHNA continuing education programs and home study courses, contact:

American Holistic Nurses' Association
P.O. Box 2130
Flagstaff, AZ 86003-2130
Telephone: (800) 278-AHNA or (520) 526-2196
Fax: (520) 526-2752
Email: http://www.info@ahna.org
Web site: www.ahna.org

For information on the holistic nursing certification examination, contact:

American Holistic Nurses' Certification Corporation
5102 Ganymede Drive
Austin, TX 78727
Email: http://www.ahncc@flash.net

Acknowledgments

Our book flows out of the larger questions that have been raised for us in the health or illness of clients/patients, the professional community with which we have worked, and our families and friends with whom we live and play.

We celebrate with our colleagues in nursing as we explore new meanings of healing in our work and life, as we acknowledge what we have done well, and as we anticipate what we must do better. We honor the work of our colleague and dear friend Leslie Kolkmeier, who was our co-author on the first and second editions of this book.

Special thanks are due to Clayton E. Jones, Chief Executive Officer, Don Jones, Jr., Chief Operating Office, and Robert W. Holland, Jr., Executive Vice President and Publisher, at Jones and Bartlett Publishers, who have provided a new home for *Holistic Nursing: A Handbook for Practice*, Fourth Edition. We thank the book team at Jones and Bartlett Publishers: Kevin Sullivan, Acquisitions Editor, Nursing, who helped us keep our goals in sight and believed in the project; Amy Sibley, for attention to editorial details; Amy Rose, Production Manager who understood the vision of this project; Tracey Chapman, Production Assistant, for her attention to production details; Anne Spencer, who captured holism in designing our book cover and logo; and Jenny Bagdigian, for her insight, enthusiasm, and expert copy edit.

Most of all, for their understanding, encouragement, and love in seeing us through one more book, we thank our families—Larry Dossey; Gerald, Catherine Keegan Michael, and Genevieve Keegan; and Philip, Angela, and Philip C. Guzzetta—who share our interconnectedness.

CORE VALUE 1

Holistic Philosophy, Theories, and Ethics

Exploring Life's Meaning

What do you tell yourself about your state of health? Is your health excellent, good, fair, or poor? Over the last few years, the answers that people give to this simple question have become better predictors of who will live or die over the next decade than in-depth physical examinations or extensive laboratory tests. This question is a way of asking what our health means to us—what it represents or symbolizes in our thoughts and imagination.[1]

What does it mean to be human? What is meaning? Why should we seek out meaning? What do we do with it? How do we keep it? Phenomenology is a philosophy that is mainly interested in these "phenomenal" questions.[2]

Meanings are individual and personal. They have relevance to the person's experiences, events, expectations, belief systems, and core values. Within each person's story are meanings about the past and present life story, as well as beliefs about future events that can be explored in a healing journey. Within the story, one looks at patterns, insights, and broad relationships to find the meanings. Only when a meaning is clear can an experience become a paradigm experience, one that is chosen to form a foundation for future reference. Meaningless experiences are seldom retained.

Meaning becomes apparent as differences, contrasts, novelty, and heterogeneity—and is necessary for the healthy function of human beings. We seek out meaning because our lives are fuller and richer when life means something positive for us. If you take away the meaning of our life, it is not worth living. The more we understand about meaning in life, the more we can empower ourselves to recognize more effective ways to cope with life and to learn more effective methods of working on life issues. In doing this, we create richer meaning in our daily lives. This attention to meaning allows us to be more effective with others as we guide them in searching for the meanings in their lives.

The meanings that a person attaches to symptoms or illness are probably the most important factors in the journey through a life crisis. Human beings can view illness from at least eight frames of reference: (1) illness as challenge, (2) illness as enemy, (3) illness as punishment, (4) illness as weakness, (5) illness as relief, (6) illness as strategy, (7) illness as irreparable loss or damage, and (8) illness as value.[3]

When we believe that meaning is absent, our bodies become bored; bored bodies become the spawning ground for depression, disease, and death. Failure of meaning has become a cliché. Professions, personal lives, even entire cultures are said to suffer from a breakdown of meaning. Although at times it may seem as if meaning is absent from our lives and our universe, such a thing is not possible, even in theory. Our existence is

awash with meaning, and we must choose our meanings with care. The choices are crucial. Nowhere is this more important—or apparent—than in health and illness. It is clear from the wealth of scientific data that it is impossible to separate the biologic parts from the psychologic, sociologic, and spiritual parts of our being. The importance of meaning can no longer be ignored, for it is directly linked with mind modulation of all body systems that influence states of wellness or illness. Because meanings and emotions go hand in hand, is it strange that the meanings we perceive could affect the body? Or that the body could affect our emotions and our meanings? These connections are so intimate that we must think of the body and the mind as a single integrated unit: the bodymind.

What are the lessons here? How can we put meaning in our life?[4]

- *We need simply to pay more attention to the meanings we perceive in life. This is easy to say, but difficult to do. It is much easier for us to concentrate on our cholesterol level, blood pressure, diet, vitamin intake, body weight, and annual physical examination than it is for us to concentrate on meanings in life. If we really believed that we could die not only from heart failure, but also from "meaning failure," perhaps we would be more attentive to the meanings we create in our lives.*
- *Wellness and illness are vastly more complex than we have heretofore believed. Wellness is not a matter of simply covering the bases physically, for we know that there is no clear separation of the physical and the mental. This recognition places much more responsibility for one's health on each individual and less on the physician. No prescriptions can be written for meaning; each of us has to attend to our own meanings in the way that is best for us. Routinely, we need to assess and evaluate our human potential to keep meaning in our lives.*
- *We need to be leery of anyone who proclaims that any particular problem is "all physical" or "all mental." These simplistic statements are indefensible in modern medical science. Those who make such claims cannot even tell us what they mean by "the physical" or "the mental," for the dividing line between them has become increasingly thin.*
- *We need to recognize the good news here: Positive perceptions and meanings can actually increase the level of our health, all other factors being equal. They can be as therapeutic as medication or a surgical procedure.*
- *We need to recognize science for the information that it can give us, and understand that the true meaning of wellness and life is in our evolving process of expanding our awareness and potential.*
- *We need to realize that meanings matter. When the time comes for your next annual physical examination, keep this fact in mind: It is not just your body that needs the checkup: Your personal life meanings need checkups from time to time, too.*

NOTES

1. L. Dossey, What Does Illness Mean? *Alternative Therapies* 1, no. 3 (1995): 6–10.
2. P. Munhall, *Revisioning Phenomenology: Nursing and Health Science Research* (New York: National League for Nursing Press, 1994).
3. Z.J. Lipowski, Physical Illness, the Individual and the Coping Process, *Psychiatric Medicine* 1 (1970): 90.
4. L. Dossey, *Meaning and Medicine: A Doctor's Tales of Breakthrough and Healing* (New York: Bantam Books, 1991).

Chapter 1

Holistic Nursing Practice

Barbara Montgomery Dossey and Cathie E. Guzzetta

NURSE HEALER OBJECTIVES

Theoretical

- Synthesize the concepts of natural systems theory.
- Compare and contrast the allopathic and holistic models of health care.
- Describe the components of the bio-psycho-social-spiritual model.
- Describe the practice and standards of holistic nursing.
- Compare and contrast the different eras of medicine.
- Discuss the activities of the National Center for Complementary and Alternative Medicine (NCCAM).

Clinical

- Explore two ways to integrate a natural systems view into your clinical practice.
- Determine if you use a bio-psycho-social-spiritual model to guide your clinical practice.
- Integrate the Standards of Holistic Nursing Practice established by the American Holistic Nurses' Association (AHNA) into clinical practice, education, and research.
- Integrate complementary and alternative therapies into clinical practice.

Personal

- Integrate complementary and alternative therapies into your daily life to enhance your well-being.
- Develop short- and long-term goals related to increasing your commitment to the holistic developmental process.

DEFINITIONS

Allopathic/Traditional Therapies: medical, surgery, invasive and noninvasive diagnostic treatment procedures, including medications.

Caring-Healing Interventions: nontraditional therapies that can interface with traditional medical and surgical therapies; may be used as complements to

---

Source: Definitions ©2003 American Holistic Nurses' Association (AHNA). Permission is given to duplicate this document for teaching purposes by an educational institution. Written consent is required for duplication by an author or publisher. AHNA, P.O. Box 2130, Flagstaff, AZ 86003-2130; phone (800) 278-2462, fax (928) 526-2752; *www.ahna.org*.

conventional medical and surgical treatments; also called alternative/complementary/integrative therapies or interventions. See list of interventions most frequently used in holistic nursing practice (Exhibit 1–1).

Client of Holistic Nursing: an individual, family, group, or community of persons who is engaged in interactions with a holistic nurse in a manner respectful of each client's subjective experience about health, health beliefs, values, sexual orientation, and personal preferences.

Cultural Competence: the ability to deliver health care with knowledge of and sensitivity to cultural factors that influence the health behavior of the person.

Environment: everything that surrounds the person, both the external and the internal (physical, mental, emotional, and spiritual) environment as well as patterns not yet understood.

Healing: the process of bringing together aspects of one's self, body-mind-spirit, at deeper levels of inner knowing leading toward integration and balance with each aspect having equal importance and value; can lead to more complex levels of personal understanding and meaning; may be synchronous but not synonymous with curing.

Healing Process: a continual journey of changing and evolving of one's self through life; the awareness of patterns that support or are challenges/barriers to health and healing; may be done alone or in a healing community.

Health: the state or process in which the individual (nurse, client, family, group, or community) experiences a sense of well-being, harmony, and unity where subjective experiences about health, health beliefs, and values are honored.

Health Promotion: activities and preventive measures such as immunizations, fitness/exercise programs, breast self exam, appropriate nutrition, relaxation, stress management, social support, prayer, meditation, healing rituals, cultural practices, and promoting environmental health and safety.

Holistic Caring Process: a circular process that involves six steps which may occur simultaneously. These parts are assessment, patterns/challenges/needs, outcomes, therapeutic care plan, implementation, and evaluation.

Holistic Communication: a free flow of verbal and nonverbal interchange between and among people and significant beings such as pets, nature, and God/Life Force/Absolute/Transcendent that explores meaning and ideas leading to mutual understanding and growth.

Holistic Nurse: a nurse who recognizes and integrates body-mind-spirit principles and modalities in daily life and clinical practice; one who creates a healing space within herself/himself that allows the nurse to be an instrument of healing for the purpose of helping another feel safe and more in harmony; one who shares authenticity of unconditional presence that helps to remove the barriers to the healing process.

Human Caring Process: the moral state in which the holistic nurse brings her or his whole self into relationship to the whole self of significant beings which reinforces the meaning and experience of oneness and unity.

Intention: the conscious awareness of being in the present moment to help facilitate the healing process; a volitional act of love.

Intuition: perceived knowing of things and events without the conscious use of rational processes; using all the senses to receive information.

Patterns/Challenges/Needs: a person's actual and potential life processes related to health, wellness, disease, or illness which may or may not facilitate well-being.

Person: an individual, client, patient, family member, support person, or community member who has the opportunity to engage in interaction with a holistic nurse.

Person-Centered Care: the condition of trust that is created where holistic care can be given and received; the human caring process in which the holistic nurse gives full attention and intention to the whole self of a person, not merely the current presenting symptoms, illness, crisis, or tasks to be accomplished; reinforcing the person's meaning and experience of oneness and unity.

Presence: the essential state or core in healing; approaching an individual in a way that respects and honors her/his essence; relating in a way that reflects a quality of *being with* and *in collaboration with* rather than *doing to*; entering into a shared experience (or field of consciousness) that promotes healing potentials and an experience of well-being.

Spirituality: a unifying force of a person; the essence of being that permeates all of life and is manifested in one's being, knowing, and doing; the interconnectedness with self, others, nature, and God/Life Force/Absolute/Transcendent.

Standards of Practice: a group of statements describing the expected level of care by a holistic nurse.

HOLISM

Natural Systems Theory

Derived primarily from the work of von Bertalanffy,[1] natural systems theory provides a way of comprehending the interconnectedness of natural structures in the universe. The theory is complex, but has relevance for the health care professions (Figure 1–1). In brief, natural structures vary in size from the level of subatomic particles (i.e., quarks) to the universe, but each possesses specific characteristics within a structure and is governed by similar principles of organization. Therefore, a change in any one part of the hierarchy affects all other parts. Changes are occurring in all levels simultaneously; for example, the ripple effect of a pebble thrown in a body of water changes the surface while simultaneously changing the air surface above and the water surface below. As with a kaleidoscope, a slight turn changes the whole configuration.

The traditional biomedical Western view of disease usually begins at the systems level and stops at the molecule level (see Figure 1–1). From the more precise perspective of the natural systems approach, however, disease can originate in a disturbance at any level from the subatomic to the suprapersonal, and it may result when a force disturbs or disrupts the structure of the natural systems themselves. The goal of health care is to decrease the many different disturbances and stressors caused by a per-

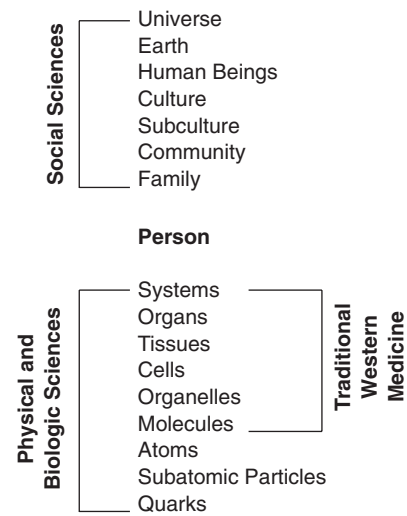


Figure 1–1 Patterns of Natural Systems Components

son's illness. These disturbances also have an impact on the family's routine. As the ill person and the family strive to reweave the social fabric of their lives and achieve more harmonious interaction, this moving balance affects all the components of the natural systems hierarchy.

A key characteristic of the hierarchy of natural systems is information flow.[2] Regardless of the point at which it originates, information spreads up and down the components of the hierarchy. Information flow has a domino effect as it affects the whole system. The magnitude of the problems that a disturbance at one level may cause and its impact on the whole hierarchy are clear in any study of the overpopulation of the planet. The result of overpopulation is depletion of natural resources and chaos associated with too many people living in disharmony.

Holism and natural systems theory have important implications for directing future research and health care education as well as for clients' and nurses' views of health and disease,[3,4] even though medicine's technologic, allopathic focus remains strong today. Those who advocate the allopathic method combat disease with techniques that produce effects different from those produced by the disease; those who advocate the holistic model assert that consciousness is real and is related to all matters of health and illness. Table 1–1 provides a comparison of the allopathic and holistic models.

Bio-Psycho-Social-Spiritual Model

The most comprehensive model available to guide mainstream health care is the bio-psycho-social-spiritual model. In this holistic model, all disease has a psychosomatic component, and biologic, psychologic, social, and spiritual factors always contribute to a patient's symptoms, disease, or illness.[5] The spiritual dimension in the bio-psycho-social-spiritual model incorporates spirituality in a broad context: values, meaning, and purpose in life. It reflects the human traits of caring, love, honesty, wisdom, and imagination. The concept of spirit implies a quality of transcendence, a guiding force, or something outside the self and beyond the individual nurse or client. It may reflect a belief in the existence of a higher power or a guiding spirit. To some, spirit may suggest a purely mystical feeling or a flowing dynamic quality of unity. It is undefinable, yet it is a vital force profoundly felt by the individual. The human spirit can make the difference between life and death, as well as wellness and illness.

As shown in Figure 1–2, each component of the bio-psycho-social-spiritual model is interdependent and interrelated. It is necessary to address all these components to achieve optimal therapeutic results. Regardless of the illness involved, the technology developed, or the therapy used, the bio-psycho-social-spiritual model provides the major overall road map in caring for the whole patient and in meeting the mandates of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). For example, the Patient Bill of Rights states that:

> care of the patient must include consideration of the psychosocial, spiritual, and cultural variables that influence the perception of illness. The provision of patient care reflects consideration of the patient as an individual with personal value and belief systems that impact upon his/her attitude and response to the care that is provided by the organization.[6]

HOLISTIC NURSING

Two major challenges in nursing have emerged in the twenty-first century. The first is to integrate the concepts of technology, mind, and spirit into nursing practice; the second is to create and integrate models for health care that guide the healing of self and others. Holistic nursing is the most complete way to conceptualize and

Table 1–1 Assumptions of Allopathic and Holistic Models of Care

Allopathic Model	*Holistic Model*
Treatment of symptoms	Search for patterns, causes
Specialized	Integrated; concerned with the whole patient
Emphasis on efficiency	Emphasis on human values
Professional should be emotionally neutral	Professional's caring is a component of healing
Pain and disease are wholly negative	Pain and disease may be valuable signals of internal conflicts
Primary intervention with drugs, surgery	Minimal intervention with appropriate technology, complemented with a range of noninvasive techniques (psychotechnologies, diet, exercise)
Body seen as a machine in good or bad repair	Body seen as a dynamic system, a complex energy field within fields (family, workplace, environment, culture, life history)
Disease or disability seen as an entity	Disease or disability seen as a process
Emphasis on eliminating symptoms and disease	Emphasis on achieving maximum bodymind health
Patient is dependent	Patient is autonomous
Professional is authority	Professional is therapeutic partner
Body and mind are separate; psychosomatic illnesses seen as mental; may refer (patient) to psychiatrist	Bodymind perspective, psychosomatic illness is the province of all health care professionals
Mind is secondary factor in organic illness	Mind is primary or co-equal factor in all illness
Placebo effect is evidence of power of suggestion	Placebo effect is evidence of mind's role in disease and healing
Primary reliance on quantitative information (charts, tests, and dates)	Primary reliance on qualitative information, including patient reports and professional's intuition; quantitative data an adjunct
"Prevention" seen as largely environmental; vitamins, rest, exercise, immunization, not smoking	"Prevention" synonymous with wholeness: in work, relationships, goals, body-mind-spirit

Source: Reprinted with permission from M. Ferguson, *Aquarian Conspiracy: Personal and Social Transformation in Our Time*, rev. ed., pp. 246–248, © 1987, J.P. Tarcher.

practice professional nursing. The AHNA description of holistic nursing and holism appears in Appendix 1–A.[7] (See the Resource List at the end of this chapter for AHNA's address.)

Standards of Holistic Nursing Practice

The AHNA Standards of Holistic Nursing Practice[8] define and establish the scope of holistic practice and describe the level of care expected from a holistic nurse. These standards were developed as a result of a sophisticated research study on the professional knowledge, activities, and skills required to practice holistic nursing on a day-to-day basis. Over a 3-year period, an AHNA Task Force gathered data from the professional literature; educational and clinical programs; academic, clinical, and research content experts; and a representative sample of AHNA's membership. The data were used to develop the Inventory of Professional Activities and Knowledge of a Holistic Nurse (IPAKHN). After the

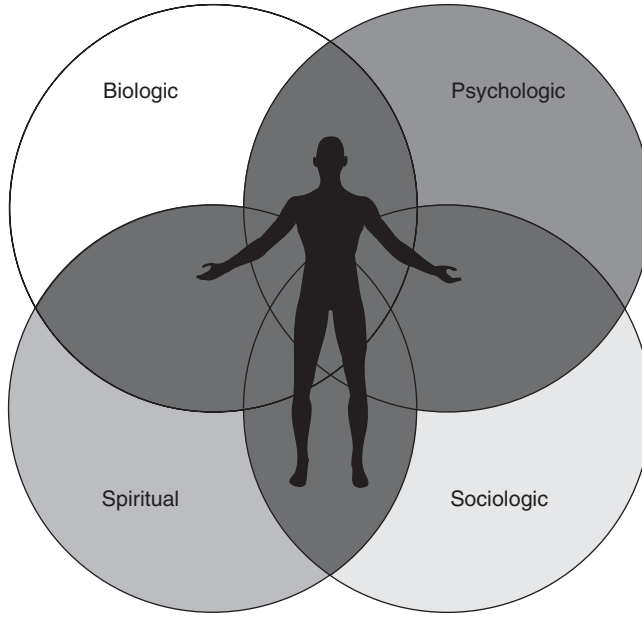


Figure 1–2 The Bio-Psycho-Social-Spiritual Model. *Source:* Reprinted with permission from C.E. Guzzetta and B.M. Dossey, *Cardiovascular Nursing: Holistic Practice*, p. 6, © 1992, Mosby Year Book.

IPAKHN was revised based on recommendations from the National League for Nursing, it was sent to the AHNA membership with a request that they prioritize holistic nursing activities and knowledge.[9] Thus, the data-gathering process captured the "real" world or the core concepts of holistic nursing based on the consensus of nearly 700 people.

The blueprint or framework of the Standards made it possible to develop the *Core Curriculum for Holistic Nursing,*[10] which delineates the fundamental knowledge, competencies, theories, and research for holistic nursing. In turn, the current edition of this book, as well as *Essential Readings in Holistic Nursing*,[11] were developed to expand and augment the knowledge provided in the *Core Curriculum*; all three can be used as major references in teaching holistic nursing as well as in preparing for the AHNA's holistic nursing certification examination. The AHNA's certification examination also originated in the blueprint of the Standards. It provides a yardstick by which to measure and confirm that certain individuals are competent to practice holistic nursing as defined by the AHNA. Nurses who pass the examination earn the distinction of certification in holistic nursing and can use the initials HNC (i.e., holistic nurse certified) after their name, along with those of their other credentials.

The AHNA *Standards of Holistic Nursing Practice,*[12] revised in 2003, reflect the five core values of holistic nursing, each of which has an accompanying description and standard-of-practice action statements (Appendix 1–A; Figure 1–3). The Standards are to be used in conjunction with the American Nurses Association *Nursing: Scope and Standards of Practice* and the standards of the specific specialty in which holistic nurses practice. They are to be implemented in one's personal life, clinical and private practice, education, research, and community service. Depending on the setting or area of practice, however, holistic nurses may or may not use all of the action statements.

Figure 1–3 The Five Core Values Embodied in the American Holistic Nurses' Association's (AHNA) the *Standards of Holistic Nursing Practice*. *Source:* Copyright © American Holistic Nurses' Association (AHNA).

The Standards describe a diversity of nursing activities in which holistic nurses are engaged. They are based on the philosophy that nursing is an art and a science for which the primary purpose is to provide services that enable individuals, families, and communities to achieve their inherent wholeness. The concepts embodied in the Standards incorporate a sensitive balance between art and science, intuitive and analytic skills, and the ability to understand the interconnectedness of the body, the mind, and the spirit. The Standards are used by nurses with expanded practice roles who do not hold graduate degrees, as well as other holistic nurses practicing at the undergraduate level of education.

In response to the growing number of graduate programs in holistic nursing, in 2003 the AHNA created the AHNA *Standards of Advanced Holistic Nursing Practice for Graduate-Prepared Nurses*[13] (hereafter referred to as the Advanced Standards). The Advanced Standards are based on the same five core values as the basic Standards, but reflect a higher level of performance, proficiency, and expertise. They apply to graduate-level nurses (i.e., those who have a master's or doctoral degree in nursing), as such preparation results in the comprehensive knowledge and skills necessary for specialization, expansion of knowledge and competencies, and the advancement of specialization. AHNA advanced practice certification in holistic nursing soon will be available to graduate-prepared holistic nurses.

When developing the Advanced Standards, the AHNA considered the *Essential of Master's Education* (published by the American Association of Colleges of Nursing[14]) and the *Standards of Advanced Practice Nursing* (from the American Nurses Association[15]). These two documents are used by nursing schools during development of

graduate nursing curricula, and aided the AHNA in defining the scope of advanced holistic nursing practice.

ERAS OF MEDICINE

Three eras of medicine currently are operational in Western biomedicine (Figure 1–4 and Table 1–2).[16] Era I medicine began to take shape in the 1860s, when medicine was striving to become increasingly scientific. The underlying assumption of this approach is that health and illness are completely physical in nature. The focus is on combining drugs, medical treatments, and technology. A person's consciousness is considered a by-product of the chemical, anatomic, and physiologic aspects of the brain and is not considered a major factor in the origins of health or disease.

In the 1950s, Era II therapies began to emerge. These therapies reflected the growing awareness that the actions of a person's mind or consciousness—thoughts, emotions, beliefs, meaning, and attitudes—exerted important effects on the behavior of the person's physical body. In both Era I and Era II, a person's consciousness is said to be "local" in nature; that is, confined to a specific location in space (the body itself) and in time (the present moment and a single lifetime).

Era III, the newest and most advanced era, originated in science. Consciousness is said to be nonlocal in that it is not bound to individual bodies. The minds of individuals are spread throughout space and time; they are infinite, immortal, omnipresent, and, ultimately, one. Era III therapies involve any therapy in which the effects of consciousness create bridges between different persons, as with distant healing, intercessory prayer, shamanic healing, so-called miracles, and certain emotions (e.g., love, empathy, compassion). Era III approaches involve transpersonal experiences of being. They raise a person above control at a day-to-day, material level to an experience outside his or her local self.

"Doing" and "Being" Therapies

Holistic nurses use both "doing" and "being" therapies (Figure 1–5). *Doing* therapies include almost all forms of modern

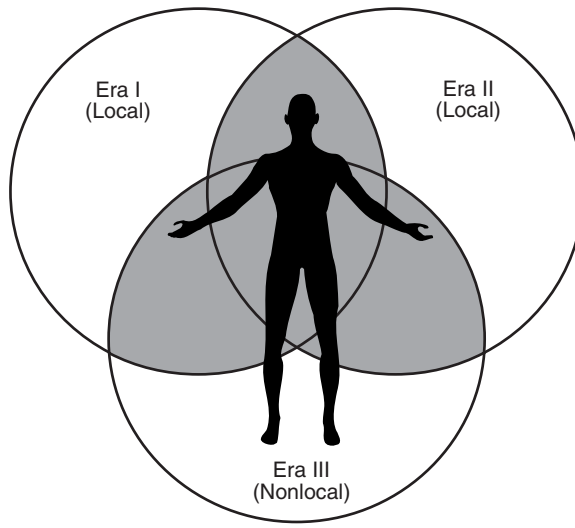


Figure 1–4 Eras of Medicine. *Source:* Adapted with permission from L. Dossey, *Reinventing Medicine: Beyond Mind-Body to a New Era of Healing*. San Francisco: HarperSanFrancisco, 1999. Copyright Larry Dossey.

Table 1–2 Eras of Medicine

	Era I	*Era II*	*Era III*
Space-Time Characteristic	Local	Local	Nonlocal
Synonym	Mechanical, material, or physical medicine	Mindbody medicine	Nonlocal or transpersonal medicine
Description	Causal, deterministic, describable by classical concepts of space-time and matter-energy. Mind not a factor; "mind" a result of brain mechanisms.	Mind a major factor in healing *within* the single person. Mind has causal power; is thus not fully explainable by classical concepts in physics. Includes but goes beyond Era I.	Mind a factor in healing both *within* and *between* persons. Mind not completely localized to points in space (brains or bodies) or time (present moment or single lifetimes). Mind is unbounded and infinite in space and time—thus omnipresent, eternal, and ultimately unitary or one. Healing at a distance is possible. Not describable by classical concepts of space-time or matter-energy.
Examples	Any form of therapy focusing solely on the effects of *things* on the body is an Era I approach—including techniques such as acupuncture and homeopathy, the use of herbs, etc. Almost all forms of "modern" medicine—drugs, surgery, irradiation, CPR, etc.—are included.	Any therapy emphasizing the effects of consciousness solely within the individual body is an Era II approach. Psychoneuroimmunology, counseling, hypnosis, biofeedback, relaxation therapies, and most types of imagery-based "alternative" therapies are included.	Any therapy in which effects of consciousness bridge between different persons is an Era III approach. All forms of distant healing, intercessory prayer, some types of shamanic healing, diagnosis at a distance, telesomatic events, and probably noncontact therapeutic touch are included.

Source: Reprinted with permission from L. Dossey, *Reinventing Medicine: Beyond Mind-Body to a New Era of Healing*. San Francisco: HarperSanFrancisco, 1999. Copyright Larry Dossey.

medicine, such as medications, procedures, dietary manipulations, radiation, and acupuncture. In contrast, *being* therapies do not employ things, but instead use states of consciousness. These include imagery, prayer, meditation, and quiet contemplation, as well as the presence and intention of the nurse. These techniques are therapeutic because of the power of the psyche to affect the body. They may be either directed or nondirected.[17] A person who uses a directed mental strategy attaches a specific outcome to the imagery, such as the regression of disease or the normalization of the blood pressure. In a nondirected approach, the person images

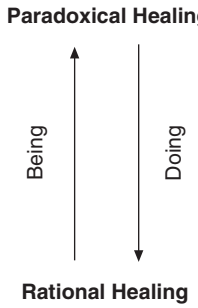


Figure 1–5 "Being" and "Doing" Therapies. *Source:* Reprinted with permission from L. Dossey, *Meaning and Medicine: A Doctor's Tales of Breakthrough and Healing,* by Larry Dossey, p. 204, New York, Bantam Books, 1991. Copyright Larry Dossey.

the best outcome for the situation, but does not try to direct the situation or assign a specific outcome to the strategy. This reliance on the inherent intelligence within one's self to come forth is a way of acknowledging the intrinsic wisdom and self-correcting capacity from within.

It is obvious that Era I medicine uses "doing" therapies that are highly directed in their approach. It employs things, such as medications, for a specific goal. Era II medicine is a classic bodymind approach that does not require the use of things, with the exception of biofeedback instrumentation to increase awareness of bodymind connections. It employs "being" therapies that can be directed or nondirected, depending on the mental strategies selected (e.g., relaxation or meditation). Era III medicine is similar in this regard. It requires a willingness to become aware, moment by moment, of what is true for our inner and outer experience. It is actually a "not doing" so that we can become conscious of releasing, emptying, trusting, and acknowledging that we have done our best, regardless of the outcome. As the therapeutic potential of the mind becomes increasingly clear, all therapies and all people are seen to have a transcendent quality. The minds of all people, including families, friends, and the health care team (both those in close proximity and those at a distance), flow together in a collective as they work to create healing and health.

Rational vs. Paradoxical Healing

All healing experiences or activities can be arranged along a continuum from the rational domain to the paradoxical domain.[18] The degree of "doing" and "being" involved determines these domains (Figure 1–6). Rational healing experiences include those therapies or events that make sense to our linear, intellectual thought processes, whereas paradoxical healing experiences include

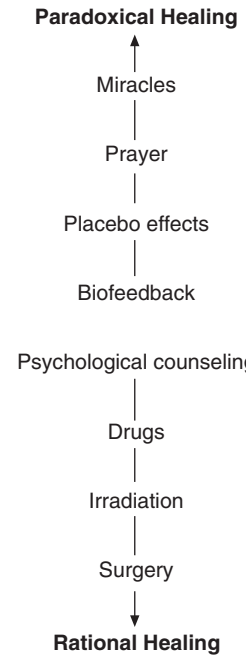


Figure 1–6 Continuum of Rational and Paradoxical Healing. *Source:* Reprinted with permission from L. Dossey, *Meaning and Medicine: A Doctor's Tales of Breakthrough and Healing,* by Larry Dossey, p. 205, New York, Bantam Books, 1991. Copyright Larry Dossey.

healing events that may seem absurd or contradictory but are, in fact, true.

"Doing" therapies fall into the rational healing category. Based on science, these strategies conform to our world view of common sense notions. Often, the professional can follow an algorithm, which dictates a step-by-step approach. Examples of rational healing include surgery, irradiation, medications, exercise, and diet. On the other hand, "being" therapies fall into the paradoxical healing category, because they frequently happen without a scientific explanation. In psychological counseling, for example, a breakthrough is a paradox. When a patient has a psychologic breakthrough, it is clear that there is a new meaning for the person. However, there were no clearly delineated steps leading to the breakthrough. Such an event is called a breakthrough for the very reason that it is unpredictable—thus, the paradox.

Biofeedback also involves a paradox. For example, the best way to reduce blood pressure or muscle tension, or to increase peripheral blood flow, is to give up trying and just learn how to *be*. Individuals can enter into a state of "being," or passive volition, in which they let these physiologic states change in the desired direction. Similarly, the phenomenon of placebo is a paradox (see Chapter 9). If an individual has just a little discomfort, a placebo does not work very well. The more pain a person has, however, the more dramatic the response to a placebo medication can be. In addition, a person who does not know that the medication is a placebo responds best. This is referred to as the "paradox of success through ignorance."

Prayer and faith fall into the domain of paradox because there is no rational scientific explanation for their effectiveness. Scientific studies are being conducted, however.[19] In a prayer study done by Byrd, for example, 5 to 7 people in Protestant and Catholic prayer groups across the United States prayed each day for each of 201 patients with acute myocardial infarction.[20] Those in a control group of 192 patients with acute myocardial infarction were not prayed for, although they received the same medical care as the prayed-for group. In this 10-month randomized, prospective double-blind study, the following significant events occurred:

1. Patients in the prayed-for group were five times less likely than were those in the control group to require antibiotics (3 patients compared to 16 patients).
2. Patients in the prayed-for group were three times less likely to develop pulmonary edema (6 patients compared to 18 patients).
3. No one in the prayed-for group required endotracheal intubation, although 12 in the control group required mechanical ventilatory support.
4. Fewer patients in the prayed-for group died (although the difference was not statistically significant).

This study is an example of a nonlocal phenomenon—an Era III approach—because it involves the conscious effort of people praying for others at a distance.

"Miracle cures" also are paradoxical, because there is no scientific mechanism to explain them.[21] Every nurse has known, heard of, or read about a patient who had a severe illness that had been confirmed by laboratory evidence, but had disappeared after the patient adopted a "being" approach. Some say that it was the natural course of the illness; some die and some live. At shrines such as Lourdes in France and Medjugorje in Yugoslavia, however, people who experience a miracle cure are said to be totally immersed in a "being" state. They do not try to make anything happen. When interviewed, these people report experiencing a different sense of space and time; the flow of time

as past, present, and future becomes an "eternal now." Birth and death take on new meaning and are not seen as a beginning and an end. These people go into the self and explore the "not I" to become empty, so that they can understand the meaning of illness or present situations.

Complementary and Alternative Therapies

Also called unconventional or integrative therapies, complementary and alternative medical (CAM) therapies traditionally have been defined as those interventions neither taught widely in medical schools nor generally available in U.S. hospitals.[22] Recently, it has been suggested that CAM therapies be defined as a broad set of health care practices (i.e., already available to the public), that are not readily integrated into the dominant health care model because they challenge diverse societal beliefs and practices (i.e., cultural, economic, scientific, medical, and educational).[23]

In 1992, the National Institutes of Health (NIH) created the Office of Alternative Medicine (OAM) to evaluate alternative therapies.[24] The 1993 OAM research budget was $2 million. In 1999, the OAM was raised to the status of a freestanding center and renamed the National Center for Complementary and Alternative Medicine (NCCAM), with a budget of $50 million (see Resource List for NCCAM's address). The estimated budget for 2004 is $116 million.

One of the reasons for the NCCAM's creation was the federal government's recognition that U.S. citizens are pursuing CAM therapies with unprecedented enthusiasm. It has been estimated that 40 percent of all U.S. adults use some form of these therapies.[25,26] Between 1990 and 1997, the total number of visits to CAM practitioners increased nearly 50 percent, from 425 million visits to 629 million visits. By 1997, visits to CAM practitioners exceeded the total number of visits to primary care physicians. Recent estimates for out-of-pocket expenditures for complementary and alternative care now range from $27 billion to $34 billion.[27] Yet one of the most disturbing trends related to CAM therapies is that patients are not disclosing to their allopathic physicians more than 60 percent of the CAM therapies used, thus creating a "don't ask, don't tell" scenario.[28] This finding also may help explain why many allopathic physicians believe that the controversy over alternative measures is a tempest in a teapot; they simply are unaware of what their patients are doing. In addition, skeptics frequently charge that persons interested in CAM therapies are poorly educated and, thus, easily misled. Researchers have found the opposite to be true. Consumers of such therapies tend to be well educated and to hold a holistic orientation, believing in the importance of body, mind, and spirit in health.[29,30]

Sierpina believes the popularity of CAM therapies can be attributed to a multifactorial phenomenon that includes the desire for individual autonomy in health care decisions, the rising cost of care, the perceived safety between alternative and conventional therapies, legislative and insurance changes, and shifts in the therapeutic relationship between patients and their health care providers.[31] The popularity of CAM therapies also has caused educators and clinicians to pay attention. The report of the White House Commission on Complementary and Alternative Medicine Policy calls for inclusion of evidence-based CAM therapies in educating health professionals.[32] In a recent survey of 125 deans or directors (of baccalaureate and higher degree nursing programs), almost 60 percent of respondents used the AHNA's definition of holistic nursing in their educational curricula and were acquainted with the Holistic Nursing Core Curriculum.[33] (See Appendix 1–A for definition.) In

addition, nearly 85 percent of the respondents included CAM therapies in their curricula.[34] These findings are supported by the results of a similar survey in which 77 percent of 105 responding deans or directors (of baccalaureate nursing programs) related that their undergraduate curricula included content and/or experiential learning related to CAM therapies.[35] Likewise, clinicians in various practice areas increasingly are using CAM therapies, recommending such therapies to their patients, and expressing interest in learning more about various therapies.[36,37] For example, in a recent survey of critical care nurses, 88 percent of the respondents were open to using or eager to use CAM therapies in their critical care practice, although to do so many desired additional training and education.[38]

The development of the NCCAM makes it possible to move beyond the testimonials, anecdotes, and skepticism surrounding complementary and alternative therapies. One of the major missions of the Center is to determine which of these therapies are safe, beneficial, and cost-effective and which are not. Because the Center charts a legitimate scientific course for the field and confirms that such research has merit, the creation of the NCCAM represents the single most important event in the evolution of the CAM therapies field. It authorizes practitioners and scientists to use the tools of rigorous science to demonstrate whether CAM therapies actually have the potential to change the clinical course and outcomes of an illness.[39] Nurses in practice have the opportunity to play a major role in the future direction and investigation of many of these complementary and alternative interventions.

NCCAM has defined five domains, or categories, of CAM therapies,[40] as outlined in Exhibit 1–1. The therapies most frequently used by holistic nurses (based on data collected from the AHNA's 3-year IPAKHN study, discussed earlier) are highlighted. The category of mind/body therapies (ranging from biofeedback, guided imagery, hypnotherapy, meditation, music therapy, and relaxation to prayer) is predominant in the holistic nursing domain, undoubtedly because these therapies have the potential to affect the body-mind-spirit. As of this writing, NCCAM has funded 138 CAM research studies leading to 355 publications in 244 journals.[41]

In addition, the NCCAM has funded 18 complementary and alternative medicine research centers[42] (Table 1–3). Each research center focuses on a specific health condition and is responsible for evaluating the effectiveness and safety of CAM treatments in their specialty area. The research centers establish mechanisms by which promising CAM research ideas can be reviewed, developed, and executed in a scientifically rigorous manner. As a result of these investigative studies, many of the so-called CAM therapies are likely to be found ineffective. Some will be shown to be worthless or actually harmful. Others, however, will almost certainly be validated as genuinely effective, safe, and relatively inexpensive when compared to conventional modalities.

The ultimate goal of the CAM therapies movement is not to supplant modern medicine with alternatives, but rather to integrate validated alternative approaches with the best of current conventional medical practices. For example, cancer treatment appears to be a particularly fertile area in which to investigate the best combination of conventional modalities (i.e., surgery, radiation, and chemotherapy) and alternative strategies (i.e., nutrition, vitamins, exercise, group support, visual imagery, and relaxation) to enhance bio-psycho-social-spiritual outcomes.[43] Thus, CAM therapies must be considered adjuncts to conventional medical and surgical treatments rather than replacements for them.

Exhibit 1–1 Complementary and Alternative Therapies

Classification of CAM Therapies Defined By the National Center for Complementary and Alternative Medicine (NCCAM)

I. Alternative Medical Systems

Alternative medical systems are built upon complete systems of theory and practice. Often, these systems have evolved apart from and earlier than the conventional medical approach used in the United States. Examples of alternative medical systems include:

- Acupuncture
- Anthroposophic medicine
- Ayurveda
- Environmental medicine
- Homeopathic medicine
- Latin American rural practices
- Native American practices
- Natural products
- Naturopathic medicine
- Past life therapy
- Shamanism
- Tibetan medicine
- Traditional Chinese medicine

II. Biologically Based Therapies

Biologically based therapies in CAM use substances found in nature, such as herbs, foods, and vitamins. Examples include:

- Antioxidizing agents
- Cell treatment
- Chelation therapy
- Metabolic therapy
- Oxidizing agents (ozone, hydrogen peroxide)
- Gerson therapy
- Macrobiotics and other therapeutic diet programs
- Megavitamins
- Nutritional supplements
- Botanical medicines

III. Manipulative and Body-Based Methods

Manipulative and body-based methods in CAM are based on manipulation and/or movement of one or more parts of the body. Examples include:

- Acupressure*
- Alexander technique
- Biofield therapeutics
- Chiropractic medicine
- Feldenkrais method
- Massage therapy*
- Osteopathic manipulation
- Reflexology*
- Trager method
- Zone therapy

IV. Energy Therapies

Energy therapies involve the use of energy fields. They are of two types: biofield therapies are intended to affect energy fields that purportedly surround and penetrate the human body. The existence of such fields has not yet been scientifically proven. Some forms of energy therapy manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. Examples include Qi gong, Reiki, Therapeutic Touch, and Healing Touch.

Bioelectromagnetic-based therapies involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating current or direct current fields.

- Electroacupuncture
- Electromagnetic fields
- Electrostimulation and neuromagnetic stimulation devices
- Magnetoresonance spectroscopy
- Magnets/magnetic fields
- Qi gong
- Reiki
- Therapeutic touch*
- Healing Touch

V. Mind-Body Interventions

Mind-body medicine uses a variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms. Some techniques that were considered CAM in the past have become mainstream (for example, patient support groups and cognitive-behavioral therapy). Other mind-body techniques are still considered CAM, including meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance.

(continued)

Exhibit 1–1 (continued)

Art therapy*
Biofeedback*
Counseling*,†
Dance therapy
Guided imagery*
Humor therapy*
Hypnotherapy
Meditation*
Music therapy*
Prayer*
Psychotherapy
Relaxation techniques*
Support groups*
Tai chi
Yoga

Additional Interventions Frequently Used by Holistic Nurses*

Aromatherapy
Autogenics
Breathing exercises
Cognitive therapy
Community-based health care practices
Exercise and movement
Goal setting and contracting
Healing presence
Healing touch modalities
Holistic self-assessments
Journaling
Nutrition counseling
Play therapy
Self-care interventions
Self-reflection
Smoking cessation
Weight management

Source: http://www.nccam.nih.gov.

*Frequently used interventions in holistic nursing practice. From B. Dossey, et al., Evolving a Blueprint for Certification: Inventory of Professional Activities and Knowledge of a Holistic Nurse, *Journal of Holistic Nursing* 16, no. 1 (1998):33–56.

†Used to provide support to those experiencing situations such as addictions, death, grief, unhealthy environments, sexual abuse, and violence; to promote wellness; and to resolve relationship and lifestyle issues.

CAM therapies expand the strategies that nurses can employ independently to provide holistic, body-mind-spirit care. For centuries, nurses have largely kept the spirit of caring and healing alive in Western cultures, while medical science has sought a physical answer for every question. The caring–healing paradigm is at the very root of professional nursing practice. The modern nurse healer is a hybrid of scientific skill and spiritual commitment, who understands that healing is much more than curing disease. Such nurses understand that they do not heal *disease* (i.e., the pathophysiologic breakdown of the body); rather, they facilitate healing in the *person with an illness* who not only has disease, but also is struggling with the human experience of that disease in terms of its symptoms, suffering, and consequences, to find the wholeness embodied in the experience.[44] Many complementary and alternative practitioners have been taught both to attend competently to the physical illness and suffering that accompany disease and to provide patients with the understanding, meaning, and self-care strategies that they need to deal with their condition.[45]

Although many patients cannot be—or choose not to be—cured, they all are in need of healing. Even during devastating illness, crisis, and death, healing can take place, and growth toward wholeness can occur.[46] This caring–healing paradigm opens an exciting new frontier to nurses

Table 1–3 NCCAM Research Centers To Evaluate Complementary and Alternative Therapies

Research Center	*Objectives*	*Specialty*
Center for Addiction and Alternative Medicine Research (CAAMR) Minneapolis Medical Research Foundation Minneapolis, MN 55404 URL: *www.mmrfweb.org/research/addicton&alt_med/index.html*	To support the rigorous scientific evaluation of complementary and alternative medicine (CAM) treatments for addictions and their health and psychological complications including preclinical trials of an herbal compound formulated to help prevent alcoholic relapse, preclinical trials of electroacupuncture to map the neural substrates of opioid dependence, and a clinical trial of an herbal compound for the treatment of hepatitis C symptoms.	Addictions
Center for CAM Research in Aging and Women's Health Columbia University College of Physicians and Surgeons New York, NY 10032 URL: *cpmcnet.columbia.edu/dept/rosenthal*	To investigate herbal and dietary treatments for postmenopausal women including black cohosh for the treatment of menopausal complaints, a basic science evaluation of various biological activities of a Chinese herbal preparation to help assess its safety for women with or at risk for breast cancer, and clinical studies comparing a macrobiotic diet with an American Heart Association diet to assess outcomes including hormone and phytoestrogen metabolism, cardiovascular function, and bone metabolism.	Aging and Women's Health
Center for Alternative Medicine Research on Arthritis University of Maryland School of Medicine Division of Complementary Medicine Baltimore, MD 21207-6693 URL: *www.compmed.ummc.umaryland.edu*	To investigate the cost effectiveness of and long-term outcomes following acupuncture treatment for osteoarthritis of the knee; the effectiveness of mind/body therapies for fibromyalgia; the mechanism of action and effects of electroacupuncture on persistent pain and inflammation; and the mechanism of action of an herbal combination with immunomodulatory properties.	Arthritis
Center for Frontier Medicine in Biofield Science Department of Psychology University of Arizona P.O. Box 210068 Tucson, AZ 85721-0068	To facilitate and integrate research on the effects of low energy fields including developing standardized bioassays (cellular biology) and psychophysiological and biophysical markers of biofield effects and applying the markers developed to measure outcomes in the recovery of surgical patients.	Biofield

(continued)

Table 1–3 (continued)

Research Center	*Objectives*	*Specialty*
Botanical Center for Age-Related Diseases Purdue University West Lafayette Division of Sponsored Programs West Lafayette, IN 47907-1021	To study the health effects of polyphenols (a diverse group of chemical components widely distributed in plants) including soy, grapes, green tea, and several herbs which may be clinically relevant to the two leading causes of death in the United States, heart disease and cancer, and to two leading causes of diminished quality of life, osteoporosis and cognitive decline.	Botanicals
Botanical Dietary Supplements for Women's Health University of Illinois at Chicago 809 S. Marshfield Avenue Chicago, IL 60612-7205	To focus initially on 10 herbal supplements that have implications for benefit in women's health issues, including therapies for menopause and to support research training in pharmacognosy (the study of natural products, including botanicals). The center will also provide information on botanicals to consumers and health professionals; educational activities will include an interactive website.	Botanicals
UCLA Center for Dietary Supplements Research: Botanicals University of California at Los Angeles 10945 Le Conte Avenue, Suite 1401 Box 951406 Los Angeles, CA 90095-1406	To conduct research to explore the potential mechanisms of action of yeast-fermented rice for cholesterol reduction, the implications for heart disease prevention of green tea extract and soy for inhibition of tumor growth, the use of St. John's Wort for relieving mild depression, and assess the levels of bioactive compounds in several botanicals available as dietary supplements.	Botanicals
Arizona Center for Phytomedicine Research University of Arizona College of Pharmacy 1703 E. Mabel P.O. Box 210207 Tucson, AZ 85721-0207	To focus on three botanicals (ginger, turmeric, and boswellia) widely used in Ayurvedic medicine for the treatment of inflammatory diseases including arthritis and other chronic inflammatory conditions such as asthma.	Botanicals
Johns Hopkins Center for Cancer Complementary Medicine Johns Hopkins University Baltimore, MD 21205 URL: *www.hopkins-cam.org*	To investigate complementary and alternative medicine (CAM) modalities for cancer including the antioxidant effects of herbs in cancer cells; the antioxidant and anti-inflammatory properties of soy and tart cherry on aspects of cancer pain in four animal models; the safety and efficacy of PC-SPES, a mixture of Chinese herbs, in men with prostate cancer; and the impact of spiritual practices on disease recurrence and immune and neuroendocrine function in African-American women with breast cancer.	Cancer

(continued)

Table 1–3 (continued)

Research Center	*Objectives*	*Specialty*
Specialized Center of Research in Hyperbaric Oxygen Therapy University of Pennsylvania 133 South 36th Street (6463801) Research Services, Mezzanine Philadelphia, PA 19104-3246	To examine the mechanisms of action, safety, and clinical efficacy of hyperbaric oxygen therapy for head and neck tumors; validate a model to predict who benefits from hyperbaric oxygen benefits after laryngectomy; examine the effects of hyperbaric oxygen on growth of blood vessels and tumors; characterize the effects of hyperbaric oxygen on cell adhesion and growth of metastatic tumor cells in the lung; and test the effects of elevated oxygen pressures on cellular levels of nitric oxide.	Cancer
Center for Complementary and Alternative Medicine Research in Cardiovascular Diseases Adult Cardiac Surgery/Thoracic Transplantation The University of Michigan Taubman Health Care Center Ann Arbor, MI 48109 URL: *www.med.umich.edu/camrc/index.html*	To investigate the use of complementary and alternative medicine (CAM) modalities to treat and prevent cardiovascular disease including the use of an herbal supplement, Hawthorn extract, in the treatment of congestive heart failure, the application of the Reiki biofield energy healing technique in diabetic peripheral vascular disease and autonomic neuropathy, and the influence of spirituality upon outcomes in patients having coronary artery bypass surgery, and the impact of traditional Chinese medicine techniques of Qi Gong on post-CABG pain, healing, and outcome.	Cardiovascular Diseases
Center for Natural Medicine and Prevention Maharishi University of Management Fairfield, IA 52557 URL: *www.mum.edu/CNMP*	To evaluate the use of CAM modalities for the prevention of cardiovascular disease (CVD) in high-risk older African-Americans including the effects of meditation on atherosclerotic CVD, carotid atherosclerosis, CVD risk factors, physiological mechanisms, psychosocial risk factors, and quality of life; and effects of a traditional herbal antioxidant compared to conventional vitamin supplementation on carotid atherosclerosis, endothelial function, oxidative stress, CVD risk factors, and quality of life.	Cardiovascular Disease in Aging African-Americans
Consortial Center for Chiropractic Research Palmer Center for Chiropractic Research Davenport, IA 52803 URL: *www.palmer.edu*	To provide an infrastructure to examine the effectiveness of chiropractic health care and assistance to chiropractic researchers in developing research projects as well as developing research workshops and educational materials; providing training in research methodology, bioethics, biostatistics, clinical trial design, and basic laboratory methods; establishing a network of chiropractic clinicians in specific topic areas; and prioritizing research topics related to chiropractic treatment of musculoskeletal conditions.	Chiropractic

(continued)

Table 1–3 (continued)

Research Center	*Objectives*	*Specialty*
Oregon Center for Complementary and Alternative Medicine Research in Craniofacial Disorders Center for Health Research Kaiser Foundation Hospitals 3800 N. Interstate Avenue Portland, OR 97227-1110	To conduct research on health outcomes associated with CAM practices for craniofacial disorders as well as to identify the physiological and psychological mechanisms underlying some of these practices. Phase II trials will include CAM approaches to TMD pain management; alternative medicine approaches among women with TMD; and complementary naturopathic medicine for periodontitis.	Craniofacial Disorders
Oregon Center for Complementary and Alternative Medicine in Neurological Disorders Oregon Health Sciences University 3181 SW Sam Jackson Park Road Portland, OR 97201	To investigate the use of CAM antioxidants and stress reduction as treatments for neurodegenerative and demyelinating diseases. Many of these diseases have oxidative injury as a causative or contributory factor, and several CAM approaches have direct or indirect antioxidant effects.	Neurological Disorders
Center for CAM in Neurodegenerative Diseases Department of Neurology Emory University School of Medicine Atlanta, GA 30322 URL: *www.emory.edu/WHSC/MED/NEUROLOGY/CAM/index.html*	To investigate CAM treatments for neurodegenerative diseases (e.g., Parkinson's, Alzheimer's, and Huntington's disease, MS, stroke) including repetitive transcranial magnetic stimulation to relieve the depression associated with Parkinson's disease, the use of Valerian to treat sleep disturbances in Parkinson's disease, and the effect of the Chinese mind-body modalities of Tai Chi Chuan and Qi Gong on motor disabilities associated with Parkinson's disease.	Neurodegenerative Diseases
Pediatric Center for Complementary and Alternative Medicine University of Arizona Health Sciences Center Department of Pediatrics 1501 N. Campbell Avenue P.O. Box 245073 Tucson, AZ 85724-5073	To study integrative approaches in three common pediatric problems: recurrent abdominal pain, otitis media, and cerebral palsy. The Center is also establishing a pediatric research fellowship in CAM and research methodologies.	Pediatrics
Exploratory Program Grant for Frontier Medicine University of Connecticut Center on Aging, MC 5215 University of Connecticut Health Center 263 Farmington Avenue Farmington, CT 06030-5215	To evaluate the effects of Therapeutic Touch and healing touch on several human diseases and processes including pre-clinical projects on bone metabolism and fibroblast biology and clinical projects on bone metabolism in postmenopausal women with wrist fractures and immune function in women with advanced cervical cancer.	Touch

who are willing to pursue knowledge, expertise, and research in CAM modalities. By integrating these therapies into traditional clinical environments, these nurses will bring true healing to the forefront of health care.[47]

RELATIONSHIP-CENTERED CARE

In 1994, the Pew Health Professions Commission published its report on relationship-centered care. This report serves as a guideline for addressing the bio-psychosocial-spiritual dimensions of individuals in integrating caring, healing, and holism into health care.[48] The guidelines are based on the tenet that relationships and interactions among people constitute the foundation for all therapeutic activities. The three components of relationship-centered care include the patient–practitioner relationship (Table 1–4), the community–practitioner relationship (Table 1–5), and the practitioner–practitioner relationship (Table 1–6). Each of these interrelated relationships is essential within a reformed system of health care, and each involves a unique set of tasks and responsibilities that address self-awareness, knowledge, values, and skills.

Table 1–4 Patient–Practitioner Relationship: Areas of Knowledge, Skills, and Values

Area	*Knowledge*	*Skills*	*Values*
Self-awareness	Knowledge of self Understanding self as a resource to others	Reflect on self and work	Importance of self-awareness, self-care, self-growth
Patient experience of health and illness	Role of family, culture, community in development Multiple components of health Multiple threats and contributors to health as dimensions of one reality	Recognize patient's life story and its meaning View health and illness as part of human development	Appreciation of the patient as a whole person Appreciation of the patient's life story and the meaning of the health-illness condition
Developing and maintaining caring relationships	Understanding of threats to the integrity of the relationship (e.g., power inequalities) Understanding of potential for conflict and abuse	Attend fully to the patient Accept and respond to distress in patient and self Respond to moral and ethical challenges Facilitate hope, trust, and faith	Respect for patient's dignity, uniqueness, and integrity (mind-body-spirit unity) Respect for self-determination Respect for person's own power and self-healing processes
Effective communication	Elements of effective communication	Listen Impart information Learn Facilitate the learning of others Promote and accept patient's emotions	Importance of being open and nonjudgmental

Source: Pew Health Professions Commission at the Center for the Health Professions, University of California, San Francisco, 1388 Sutter Street, Suite 805, San Francisco, California 94109, (415) 476-8181.

Table 1–5 Community–Practitioner Relationship: Areas of Knowledge, Skills, and Values

Area	*Knowledge*	*Skills*	*Values*
Meaning of community	Various models of community Myths and misperceptions about community Perspectives from the social sciences, humanities, and systems theory Dynamic change—demographic, political, industrial	Learn continuously Participate actively in community development and dialogue	Respect for the integrity of the community Respect for cultural diversity
Multiple contributors to health within the community	History of community, land use, migration, occupations, and their effect on health Physical, social, and occupational environments and their effects on health External and internal forces influencing community health	Critically assess the relationship of health care providers to community health Assess community and environmental health Assess implications of community policy affecting health	Affirmation of relevance of all determinants of health Affirmation of the value of health policy in community services Recognition of the presence of values that are destructive to health
Developing and maintaining community relationships	History of practitioner-community relationships Isolation of the health care community from the community-at-large	Communicate ideas Listen openly Empower others Learn Facilitate the learning of others Participate appropriately in community development and activism	Importance of being open-minded Honesty regarding the limits of health science Responsibility to contribute health expertise
Effective community-based care	Various types of care, both formal and informal Effects of institutional scale on care Positive effects of continuity of care	Collaborate with other individuals and organizations Work as member of a team or healing community Implement change strategies	Respect for community leadership Commitment to work for change

Source: Pew Health Professions Commission at the Center for the Health Professions, University of California, San Francisco, 1388 Sutter Street, Suite 805, San Francisco, California 94109, (415) 476-8181.

Table 1–6 Practitioner–Practitioner Relationship: Areas of Knowledge, Skills, and Values

Area	*Knowledge*	*Skills*	*Values*
Self-awareness	Knowledge of self	Reflect on self and needs Learn continuously	Importance of self-awareness
Traditions of knowledge in health professions	Healing approaches of various professions Healing approaches across cultures Historical power inequities across professions	Derive meaning from others' work Learn from experience within healing community	Affirmation and value of diversity
Building teams and communities	Perspectives on team-building from the social sciences	Communicate effectively Listen openly Learn cooperatively	Affirmation of mission Affirmation of diversity
Working dynamics of teams, groups, and organizations	Perspectives on team dynamics from the social sciences	Share responsibility responsibly Collaborate with others Work cooperatively Resolve conflicts	Openness to others' ideas Humility Mutual trust, empathy, support Capacity for grace

Source: Pew Health Professions Commission at the Center for the Health Professions, University of California, San Francisco, 1388 Sutter Street, Suite 805, San Francisco, California 94109, (415) 476-8181.

Patient–Practitioner Relationship

In a patient–practitioner relationship, the practitioner incorporates comprehensive biotechnologic care with psycho-social-spiritual care. Active collaboration with the patient and family in the decision-making process, promotion of health, and prevention of stress and illness within the family are also part of the relationship. A successful relationship involves active listening and effective communication; integration of the elements of caring, healing, values, and ethics to enhance and preserve the dignity and integrity of the patient and family; and a reduction of the power inequalities in the relationship with regard to race, sex, education, occupation, and socioeconomic status.

To work effectively within the patient–practitioner relationship, the practitioner must develop specific knowledge, skills, and values (see Table 1–4), including expanding self-awareness, understanding the patient's experience of health and illness, developing and maintaining caring relationships with patients, and communicating clearly and effectively.[49]

Community–Practitioner Relationship

The patient and his or her family simultaneously belong to many types of communities, such as the immediate family, relatives, friends, co-workers, neighborhoods, religious and community organiza-

tions, and the hospital community. Practitioners must be sensitive to the impact of these various communities on patients and foster the collaborative activities of these communities as they interact with the patient and family. The restraints or barriers within each community that block the patient's healing must be identified and improved to promote the patient's health and well-being.

The knowledge, skills, and values needed by practitioners to participate effectively in and work with various communities, as summarized in Table 1–5, include understanding the meaning of the community, recognizing the multiple contributors to health and illness within the community, developing and maintaining relationships with the community, and working collaboratively with other individuals and organizations to establish effective community-based care.[50]

Practitioner–Practitioner Relationship

Providing holistic care to patients and families can never take place in isolation; it involves many diverse practitioner–practitioner relationships. Collaborative relationships entail shared planning and action toward common goals with joint responsibility for outcomes.[51] There is a difference, though, between multidisciplinary care and interdisciplinary care. Multidisciplinary care consists of the sequential provision of discipline-specific health care by various individuals. Interdisciplinary care, however, also includes coordination, joint decision-making, communication, shared responsibility, and shared authority.[52]

Because the cornerstone of all therapeutic and healing endeavors depends on the quality of the relationships formed among the practitioners caring for the patient, it is necessary for all practitioners to understand and respect one another's roles. Conventional and alternative practitioners need to learn about the diversity of therapeutic and healing modalities that they each use. In addition, conventional practitioners must be willing to integrate complementary and alternative practitioners and their therapies in practice (i.e., acupuncture, herbs, aromatherapy, touch therapies, music therapy, folk healers). Such integration requires learning about the experiences of different healers, being open to the potential benefits of different modalities, and valuing cultural diversity. Ultimately, the effectiveness of collaboration among practitioners depends on their ability to share problem solving, goal setting, and decision making within a trusting, collegial, and caring environment. Practitioners must work interdependently rather than autonomously, with each assuming responsibility and accountability for patient care. To form a practitioner–practitioner relationship requires the knowledge, skills, and values shown in Table 1–6, including developing self-awareness; understanding the diverse knowledge base and skills of different practitioners; developing teams and communities; and understanding the working dynamics of groups, teams, and organizations that can provide resource services for the patient and family.[53]

CONCLUSION

Holism embodies the view that an individual is an integrated whole, independent of and greater than the sum of the parts. Natural systems theory provides the understanding of the interconnectedness of natural structures in the universe, while the bio-psycho-social-spiritual model serves as a guide to practice. With these

frameworks, the goal of holistic nursing is to enhance the healing of the whole person from birth to death.[54] The AHNA *Standards of Holistic Nursing Practice* define the ways to accomplish this goal, describing the scope of holistic practice and the level of care expected from a holistic nurse. Nurses can reduce the devastating effects of crisis and the illness of individuals by using these frameworks and Standards to provide care to the whole person.

DIRECTIONS FOR FUTURE RESEARCH

1. Examine complementary and alternative therapies in nursing that can facilitate healing, and determine which ones are effective for which conditions.
2. Contrast the value that patients and their families attach to healing modalities with the value that nurses attach to them.
3. Investigate anticipated or actual solutions or complications that result from complementary and alternative therapies.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or to begin a process of answering the following questions:

- How do I define holism?
- What holistic processes are in need of further development in my personal and professional life?
- When I use the words *Guiding Force*, *Higher Power*, *God*, or *Absolute*, what kind of link with a universal wholeness do I experience?

NOTES

1. L. von Bertalanffy, *General Systems Theory* (New York: George Braziller, 1972).
2. E. Lazlo, *The Systems View of the World* (New York: George Braziller, 1968).
3. J.A. Astin and A.W. Astin, An Integral Approach to Medicine, *Alternative Therapies in Health and Medicine* 8, no. 2 (2002):70–75.
4. K. Fiandt, J. Forman, M.E. Megel, R.A. Pakieser, and S. Burge, Integral Nursing, An Emerging Framework for Engaging the Evolution of the Profession, *Nursing Outlook* 51, no. 3 (2003):130–137.
5. B. Dossey, *American Holistic Nurses' Association Core Curriculum for Holistic Nursing* (Gaithersburg, MD: Aspen Publishers, 1997).
6. Patient Rights, *Accreditation Manual for Hospitals* (Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, Suppl., 1992).
7. American Holistic Nurses' Association, *AHNA Standards of Holistic Nursing Practice* (Flagstaff, AZ: AHNA, 2003).
8. American Holistic Nurses' Association, *AHNA Standards,* 2003.
9. B. Dossey et al., Evolving a Blueprint for Certification: Inventory of Professional Activities and Knowledge of a Holistic Nurse, *Journal of Holistic Nursing* 16, no. 1 (1998):33–56.
10. B. Dossey, *Core Curriculum for Holistic Nursing*.
11. C.E. Guzzetta, *Essential Readings in Holistic Nursing* (Gaithersburg, MD: Aspen Publishers, 1998).
12. American Holistic Nurses' Association, *AHNA Standards,* 2003.
13. American Holistic Nursing Association, *AHNA Standards for Advanced Holistic Nursing Practice for Graduate-Prepared Nurses* (AHNA: Flagstaff, AZ, 2003).

14. American Association of Colleges of Nursing, *The Essentials of Master's Education* (Washington, DC: AACN, 1996).

15. American Nurses Association, *Scope and Standards of Advanced Practice Registered Nursing* (Washington, DC: ANA, 1996).

16. L. Dossey, *Reinventing Medicine: Beyond Mind-Body To a New Era of Healing* (San Francisco: HarperSanFrancisco, 1999).

17. L. Dossey, *Meaning and Medicine: A Doctor's Tales of Breakthrough and Healing* (New York: Bantam Books, 1991).

18. L. Dossey, *Healing Words: The Power of Prayer and the Practice of Medicine* (San Francisco: HarperSanFrancisco, 1993).

19. L. Dossey, *Be Careful What You Pray For: You Just Might Get It* (San Francisco: HarperSanFrancisco, 1997).

20. R. Byrd, Positive Effects of Intercessory Prayer in a Coronary Care Unit Population, *Southern Medical Journal* 81 (1988):826.

21. L. Dossey, Cancelled Funerals: A Look at Miracle Cures, *Alternative Therapies in Health and Medicine* 4, no. 2 (1998):10–19.

22. D.M. Eisenberg et al., Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use, *New England Journal of Medicine* 328, no. 4 (1993):246–252.

23. D.P. Eskinazi, Factors That Shape Alternative Medicine, *Journal of the American Medical Association* 280, no. 18 (1998):1621–1623.

24. C. Marwick, Alternative Therapies Studies Move into New Phase, *Journal of the American Medical Association* 268, no. 21 (1992): 3040.

25. D.M. Eisenberg et al., Trends in Alternative Medicine Use in the United States, 1990–1997, *Journal of the American Medical Association* 280, no. 18 (1998):1569–1575.

26. J.A. Astin, Why Patients Use Alternative Medicine: Results of a National Study, *Journal of the American Medical Association* 279, no. 19 (1998):1548–1553.

27. D.M. Eisenberg et al., Trends in Alternative Medicine Use, 1573.

28. Ibid., 1575.

29. Ibid., 1571.

30. J.A. Astin, Why Patients Use Alternative Medicine, 1553.

31. V.S. Sierpina, *Integrative Health Care: Complementary and Alternative Therapies for the Whole Person* (Philadelphia: F.A. Davis, 2001).

32. J.S. Gordon, The White House Commission on Complementary and Alternative Medicine Policy: Final Report and Next Steps, *Alternative Therapies in Health and Medicine* 8, no. 3 (2002):28–31.

33. B. Dossey, *Core Curriculum for Holistic Nursing*.

34. M. Fenton and D.L. Morris, The Integration of Holistic Nursing Practices and Complementary and Alternative Modalities Into Curricula of Schools of Nursing, *Alternative Therapies in Health and Medicine* 9, no. 4 (2003):62–67.

35. S.F. Richardson, Complementary Health and Healing in Nursing Education, *Journal of Holistic Nursing* 21, no. 1 (2003):20–35.

36. M.O. King, A.C. Pettigrew, F.C. Reed, Complementary, Alternative, Integrative: Have Nurses Kept Pace with Their Clients? *Medical and Surgical Nursing* 8 (1999):249–256.

37. P.G. Brolinson, J.H. Pierce, M. Ditmyer, D. Reis, Nurses Perceptions of Complementary and Alternative Medical Therapies, *Journal of Community Health* 26 (2001):175–189.

38. M.F. Tracy, R. Lundquist, S. Watanuki, S. Sendelbach, M.J. Kreitzer, et al., Nurse Attitudes Toward the Use of Complementary and Alternative Therapies in Critical Care, *Heart & Lung* 32, no. 3 (2003):197–209.

39. P.B. Fontanarosa and G.D. Lundberg, Alternative Medicine Meets Science, *Journal of the American Medical Association* 280, no. 18 (1998):1618–1619.

40. Health Information, What is Complementary and Alternative Medicine (CAM)? *http://nccam.nih.gov*.

41. B. Block, NCCAM Prepares for a Busy Summer with Publications Database, St. John's Wort Study, Mind-Body Grants and Meetings. *Alternative Therapies in Health and Medicine* 9, no. 3 (2003):20.

42. Research, Research Centers Programs, Funded Research Centers, *http://nccam.nih.gov*.

43. C.E. Guzzetta, Alternative Therapies: What's All the Fuss? *Nurse Investigator* 3, no. 2 (Summer, 1996):1–2.

44. C.E. Guzzetta, *Essential Readings in Holistic Nursing* (Gaithersburg, MD: Aspen Publishers, 1998).

45. W.B. Jonas, Alternative Medicine—Learning from the Past, Examining the Present, Advancing the Future, *Journal of the American Medical Association* 280, no. 18 (1998):1616–1617.
46. M.A. Chulay et al., *AACN Handbook of Critical Care Nursing* (Stamford, CT: Appleton & Lange, 1997).
47. D. Milton and S.D. Benjamin, *Complementary & Alternative Therapies: An Implementation Guide to Integrative Health Care* (Chicago: AHA Press, 1999).
48. Pew–Fetzer Task Force on Advancing Psychosocial Health Education, *Health Professions Education and Relationship-Centered Care* (San Francisco: Pew Health Professions Commission and the Fetzer Institute, 1994).
49. Ibid.
50. Ibid.
51. L.L. Lindeke and D.E. Block, Maintaining Professional Integrity in the Midst of Interdisciplinary Collaboration, *Nursing Outlook* 46 (1998):213–218.
52. Pew Health Professions Commission, California Primary Care Consortium, *Interdisciplinary Collaborative Teams in Primary Care: A Model Curriculum and Resource Guide* (San Francisco: Center for the Health Professions, University of California, 1995).
53. Pew–Fetzer Task Force, *Health Professions Education and Relationship-Centered Care*.
54. B.M. Dossey, *Florence Nightingale: Mystic, Visionary, Healer* (Springhouse, PA: Springhouse Publishing, 2000).

RESOURCE LIST

American Holistic Nurses' Association
P.O. Box 2130
Flagstaff, AZ 86003-2130
Telephone: 1-800-278-2462
Website at *http://www.ahna.org*

National Center for Complementary and Alternative Medicine Clearinghouse
Website at *http://nccam.nih.gov*

NCCAM Clearinghouse (for questions about the National Center for Complementary and Alternative Medicine Clearinghouse)
P.O. Box 7923
Gaithersburg, MD 20898
Telephone: 1-888-644-6226

APPENDIX 1–A

American Holistic Nurses' Association (AHNA) Standards of Holistic Nursing Practice (Revised 2003)

Guidelines
AHNA Holistic Nursing Practice Definitions (See Definitions, Chapter 1, pp. 5–7)
AHNA Holistic Nursing Description
Interventions Most Frequently Used in Holistic Nursing Practice (See Exhibit 1–1, pp. 18–19)
Summary of AHNA Core Values (See each Core Value Statement)
AHNA Standards of Holistic Nursing Practice

Core Value 1:	Holistic Philosophy, Theories, and Ethics
Core Value 2:	Holistic Education and Research
Core Value 3:	Holistic Nurse Self-Care
Core Value 4:	Holistic Communication, Therapeutic Environment, and Cultural Diversity
Core Value 5:	Holistic Caring Process

Note: To obtain a copy of AHNA Standards of Holistic Nursing Practice in the above format, contact AHNA at the address below.

Source: ©2003 American Holistic Nurses' Association. Permission is given to duplicate this document for teaching purposes by an educational institution. Written consent is required for duplication by an author or publisher. AHNA, P.O. Box 2130, Flagstaff, AZ 86003-2130; phone (800) 278-2462, fax (928) 526-2752; *www.ahna.org*.

GUIDELINES

The AHNA Standards of Holistic Nursing Practice:

- are used in conjunction with the American Nurses Association Standards of Practice and the specific specialty standards where holistic nurses practice.
- contain 5 core values that are followed by a description and standards of practice action statements. Depending on the setting or area of practice, holistic nurses may or may not use all of these action statements.
- draw on modalities derived from a number of explanatory models, of which biomedicine is only one model.
- reflect the diverse nursing activities in which holistic nurses are engaged.
- serve holistic nurses in personal life, clinical and private practice, education, research, and community service.

AHNA HOLISTIC NURSING DESCRIPTION

Holistic nursing embraces all nursing which has enhancement of healing the whole person from birth to death as its goal. Holistic nursing recognizes that there are two views regarding holism: that holism involves identifying the interrelationships of the bio-psycho-social-spiritual dimensions of the person, recognizing that the whole is greater than the sum of its parts; and that holism involves understanding the individual as a unitary whole in mutual process with the environment. Holistic nursing responds to both views, believing that the goals of nursing can be achieved within either framework.

The holistic nurse is an instrument of healing and a facilitator in the healing process. Holistic nurses honor the individual's subjective experience about health, health beliefs, and values. To become therapeutic partners with individuals, families, and communities, holistic nursing practice draws on nursing knowledge, theories, research, expertise, intuition, and creativity. Holistic nursing practice encourages peer review of professional practice in various clinical settings and integrates knowledge of current professional standards, laws, and regulations governing nursing practice.

Practicing holistic nursing requires nurses to integrate self-care, self-responsibility, spirituality, and reflection in their lives. This may lead the nurse to greater awareness of the interconnectedness with self, others, nature, and God/Life Force/Absolute/Transcendent. This awareness may further enhance the nurses' understanding of all individuals and their relationships to the human and global community, and permits nurses to use this awareness to facilitate the healing process.

CORE VALUE 1: HOLISTIC PHILOSOPHY, THEORIES, AND ETHICS

Holistic nursing practice is based on the philosophy and theory of holism and the foundation of ethical practice.

1.1 Holistic Philosophy

Holistic nurses develop and expand their conceptual framework and overall philosophy in the art and science of holistic nursing to model, practice, teach, and conduct research in the most effective manner possible.

Standards of Practice

Holistic nurses:

1.1.1 recognize the person's capacity for self-healing and the importance of supporting the natural development and unfolding of that capacity.

1.1.2 support, share, and recognize expertise and competency in holistic nursing practice that is used in many diverse clinical and community settings.

1.1.3 participate in person-centered care by being a partner, coach, and mentor who actively listens and supports others in reaching personal goals.

1.1.4 focus on strategies to bring harmony, unity, and healing to the nursing profession.

1.1.5 communicate with traditional health care practitioners about appropriate referrals to other holistic practitioners when needed.

1.1.6 interact with professional organizations in a leadership or membership capacity at local, state, national, and international levels to further expand the knowledge and practice of holistic nursing and awareness of holistic health issues.

1.2 Holistic Theories

Nursing theories that are holistic, and other relevant theories, provide the framework for all aspects of holistic nursing practice and leadership.

Standards of Practice

Holistic nurses:

1.2.1 strive to use nursing theories to develop holistic nursing practice and transformational leadership.

1.2.2 interpret, use, and document information relevant to a person's care according to a theoretical framework.

1.3 Holistic Ethics

Holistic nurses hold to a professional ethic of caring and healing that seeks to preserve wholeness and dignity of themselves and all persons/families/communities in all practice settings.

Standards of Practice

Holistic nurses:

1.3.1 identify the ethics of caring and its contribution to unity of self, others, nature, and God/Life Force/Absolute/Transcendent as central to holistic nursing practice.

1.3.2 integrate the standards of holistic nursing practice with applicable state laws and regulations governing nursing practice.

1.3.3 engage in activities that respect, nurture, and enhance the integral relationship with the earth, and advocate for the well-being of the global community's economy, education, and social justice.

1.3.4 advocate for the rights of patients to have educated choices in their plan of care.

1.3.5 participate in peer evaluation to ensure knowledge and competency in holistic nursing practice.

1.3.6 protect the personal privacy and confidentiality of individuals, especially with health care agencies and managed care organizations.

CORE VALUE 2: HOLISTIC EDUCATION AND RESEARCH

Holistic nursing practice is guided by, and developed through, holistic education and research.

2.1 Holistic Education

Holistic nurses acquire and maintain current knowledge and competency in holistic nursing practice.

Standards of Practice

Holistic nurses:

2.1.1 participate in activities of continuing education and related fields that have relevance to holistic nursing practice.

2.1.2 identify areas of knowledge from nursing and various fields such as biomedical, epidemiology, behavioral medicine, cultural and social theories.

2.1.3 continually develop and standardize holistic nursing guidelines, protocols and practice to promote competency in holistic nursing practice and assure quality of care to individuals.

2.1.4 use the results of quality care activities to initiate change in holistic nursing practice.

2.1.5 may seek certification in holistic nursing as one means of advancing the philosophy and practice of holistic nursing.

2.2 Holistic Nursing and Related Research

Holistic nurses provide care and guidance to persons through nursing interventions and holistic therapies consistent with research findings and other sound evidence.

Standards of Practice

Holistic nurses:

2.2.1 use available research and evidence from different explanatory models to mutually create a plan of care with a person.

2.2.2 use expert clinical judgment to select appropriate interventions.

2.2.3 discuss holistic application to clinical situations where rigorous research has not been done.

2.2.4 create an environment conducive to systematic inquiry into healing and health issues by engaging in research or supporting and utilizing the research of others.

2.2.5 disseminate research findings at meetings and through publications to further develop the foundation and practice of holistic nursing.

2.2.6 provide consultation services on holistic nursing interventions to persons and communities based on research.

CORE VALUE 3: HOLISTIC NURSE SELF-CARE

Holistic nursing practice requires the integration of self-care and personal development activities into one's life.

3.1 Holistic Nurse Self-Care

Holistic nurses engage in holistic self-assessment, self-care, and personal development, aware of being instruments of healing to better serve self and others.

Standards of Practice

Holistic nurses:

3.1.1 recognize that a person's body-mind-spirit has healing capacities that can be enhanced and supported through self-care practices.

3.1.2 identify and integrate self-care strategies to enhance their physical, psychological, sociological, and spiritual well-being.

3.1.3 recognize and address at-risk health patterns and begin the process of change.

3.1.4 consciously cultivate awareness and understanding about the deeper meaning, purpose, inner strengths, and connections with self, others, nature, and God/Life Force/Absolute/Transcendent.

3.1.5 use clear intention to care for self and to seek a sense of balance, harmony, and joy in daily life.

3.1.6 participate in the evolutionary holistic process with the understanding that crisis creates opportunity in any setting.

CORE VALUE 4: HOLISTIC COMMUNICATION, THERAPEUTIC ENVIRONMENT, AND CULTURAL DIVERSITY

Holistic nursing practice honors and includes holistic communication, therapeutic environment, and cultural diversity as foundational concepts.

4.1 Holistic Communication

Holistic nurses engage in holistic communication to ensure that each person experiences the presence of the nurse as authentic and sincere; there is an atmosphere of shared humanness that includes a sense of connectedness and attention reflecting the individual's uniqueness.

Standards of Practice

Holistic nurses:

4.1.1 develop an awareness of the most frequently encountered challenges to holistic communication.

4.1.2 increase therapeutic and cultural competence skills to enhance their effectiveness through listening to themselves and others.

4.1.3 explore with each person those strategies that can assist her/him, as desired, to understand the deeper meaning, purpose, inner strengths, and connections with self, others, nature, and God/Life Force/Absolute/Transcendent.

4.1.4 recognize that holistic communication and awareness of individuals is a continuously evolving multilevel exchange that offers itself through dreams, images, symbols, sensations, meditations, and prayers.

4.1.5 respect the person's health trajectory which may be incongruent with conventional wisdom.

4.2 Therapeutic Environment

Holistic nurses recognize that each person's environment includes everything that surrounds the individual, both the external and the internal (physical, mental, emotional, and spiritual) as well as patterns not yet understood.

Standards of Practice

Holistic nurses:

4.2.1 promote environments conducive to experiencing healing, wholeness and harmony, and care for the person in as healthy an environment as possible.

4.2.2 work toward creating organizations that value sacred space and environments that enhance healing.

4.2.3 integrate holistic principles, standards, policies and procedures in relation to environmental safety and emergency preparedness.

4.2.4 recognize that the well-being of the ecosystem of the planet is a prior determining condition for the well-being of the human.

4.2.5 promote social networks and social environments where healing can take place.

4.3 Cultural Diversity

Holistic nurses recognize each person as a whole body-mind-emotion-spirit being and mutually create a plan of care consistent with cultural background, health beliefs and practices, sexual orientation, values, and preferences.

Standards of Practice

Holistic nurses:

4.3.1 assess and incorporate the person's cultural practices, values, beliefs,

meanings of health, illness, and risk behaviors in care and health education.

4.3.2 use appropriate community resources and experts to extend their understanding of different cultures.

4.3.3 assess for discriminatory practices and change as necessary.

4.3.4 identify discriminatory health care practices as they impact the person and engage in effective nondiscriminatory practices.

CORE VALUE 5: HOLISTIC CARING PROCESS

Holistic nursing practice is guided by the holistic caring process, whether used with individuals, families, population groups, or communities. This circular process involves the following six steps, which may occur simultaneously.

5.1 Assessment

Holistic nurses assess each person holistically using appropriate conventional and holistic methods while the uniqueness of the person is honored.

Standards of Practice

Holistic nurses:

5.1.1 use an assessment process including appropriate traditional and holistic methods to systematically gather information.

5.1.2 value all types of knowing including intuition when gathering data from a person and validate this intuitive knowledge with the person when appropriate.

5.2 Patterns/Challenges/Needs

Holistic nurses identify and prioritize each person's actual and potential patterns/challenges/needs and life processes related to health, wellness, disease, or illness, which may or may not facilitate well being.

Standards of Practice

Holistic nurses:

5.2.1 assist the person to access inner wisdom that can provide opportunities to enhance and support growth, development and movement towards health and well-being.

5.2.2 collect data and collaborate with the person and health care team members as appropriate to identify and record a list of actual and potential patterns/challenges/needs.

5.2.3 use collected data to formulate an etiology of the person's identified actual or potential patterns/challenges/needs.

5.2.4 make referrals to other holistic practitioners or traditional therapist when appropriate.

5.3 Outcomes

Holistic nurses specify appropriate outcomes for each person's actual or potential patterns/challenges/needs.

Standards of Practice

Holistic nurses:

5.3.1 honor the person in all phases of her/his healing process regardless of expectations or outcomes.

5.3.2 identify and partner with the person to specify measurable outcomes and realistic goals.

5.4 Therapeutic Care Plan

Holistic nurses engage each person to mutually create an appropriate plan of care that focuses on health promotion, recovery, restoration, or peaceful dying so that the person is as independent as possible.

Standards of Practice

Holistic nurses:

5.4.1 partner with the person in a mutual decision process to create a health care plan for each pattern/challenge/need or opportunity to enhance health and well-being.

5.4.2 help a person identify areas for education to make decisions about life choices in a conscious, informed manner that empowers the person to maintain her/his uniqueness and independence.

5.4.3 offer self-assessment tools, word associations, storytelling, dreams, journals as appropriate.

5.4.4 use skills of cultural competence and communicate acceptance of the person's values, belief, culture, religion, and socioeconomic background.

5.4.5 assist the person in recognizing at-risk patterns/challenges/needs for potential or existing health situations (e.g., personal habits, personal and family health history, age-related risk factors), and also assist in recognizing opportunities to enhance well-being.

5.4.6 engage the person in problem-solving dialogue in relation to living with changes secondary to illness and treatment.

5.5 Implementation

Holistic nurses prioritize each person's plan of holistic care, and holistic nursing interventions are implemented accordingly.

Standards of Practice

Holistic nurses:

5.5.1 implement the mutually created plan of care within the context of assisting the person towards the higher potential of health and well-being.

5.5.2 support and promote the person's capacity for the highest level of participation and problem-solving in the plan of care and collaborate with other health team members when appropriate.

5.5.3 use holistic nursing skills in implementing care including cultural competency and all ways of knowing.

5.5.4 advocate that the person's plan, choices, and unique healing journey be honored.

5.5.5 provide care that is clear about and respectful of the economic parameters of practice, balancing justice with compassion.

5.6 Evaluation

Holistic nurses evaluate each person's response to holistic care regularly and systematically and the continuing holistic nature of the healing process is recognized and honored.

Standards of Practice

Holistic nurses:

5.6.1 collaborate with the person and with other health care team members when appropriate in evaluating holistic outcomes.

5.6.2 explore with the person her/his understanding of the cause of any significant deviation between the responses and the expected outcomes.

5.6.3 mutually create with the person and other team members a revised plan if needed.

The Transpersonal Self

The act of synchronizing mind and body is not a random technique that someone created for self-improvement. Rather, it is a basic principle of the human experience: the integration of body, mind, and spirit. In exploring the foundations for healing self and facilitating healing in others, we nurses mature and exercise our human capacity to go beyond individual identity and evolve to our highest potential—the transpersonal self. Understanding the dimensions of the transpersonal self is a major force in our ability to enhance healing in our self and others. Yet knowing states of the transpersonal self is not an end point, but a continuing, never-ending process.

Throughout history, there has been a quest and a universal need to understand why there is human life and what happens after death. This body of knowledge is perennial philosophy—philosophia perennis. *Roots of perennial philosophy are found in all traditional lore, from the most primitive to the most highly developed cultures. The three major elements of perennial philosophy are*

1. *the metaphysics that recognize a divine reality substantial to the world of things and lives and minds.*
2. *the psychology that finds in the soul something similar to, or even identical with, divine reality.*
3. *the ethics that place the human being's final end in the knowledge of the immanent and transcendent ground of all being—the thing is immemorial and universal.*[1]

In the writings of perennial philosophy, human beings are described as part of a whole, a part of the totality of the universe. In perennial philosophy, there are many levels of human consciousness, which are referred to as the Great Chain of Being. These levels begin with a physical level and move up through emotional, mental, existential, spiritual, and other levels. In different versions of the Great Chain, the levels of consciousness range in number from 3 to 20 or more. In order to reach wholeness, humans must understand the relationship of self with the universe and their existential identity; that is, we must come to terms with the finite nature of existence, accept our ego limitations, and be willing to face things as they appear in our life without denying that they exist.

Each level in the Great Chain transcends, but includes, its predecessor(s).[2] *Each higher level contains functions, capacities, or structures not found on a lower level. The higher level does not violate the principles of the lower level; it simply is not exclusively bound to or explainable by them. All levels are available to us if we allow openness at each level. A person's wholeness and healing are determined by awareness of all levels. Absolute Spirit is that which transcends everything and includes everything.*

As nurses reflect on the inner dimension of

self and ways of being, this conscious journey toward wholeness evolves toward self-transcendence. Early in our personal ego development, self-consciousness arises as essential for healthy human development. As the self continues to develop and mature, however, different self-concepts, identities, and life experiences lead toward the conscious journey of inner understanding. The psyche has many layers of consciousness. As one continually moves inward, seeking inner knowledge along with personal understanding, one experiences the Absolute that is composed of higher ordered wholes and integrations. Basic structures of the psyche are not replaced, but become part of the larger unity. The ultimate part of the journey is awakening, or enlightenment to the knowledge that one is part of the whole.

NOTES

1. A. Huxley, *The Perennial Philosophy* (New York: Harper Colophon Books, 1945), vii.
2. K. Wilbur, *Quantum Questions* (Boston: Shambhala, 1984), 15–16.

Chapter 2

Transpersonal Human Caring and Healing

Janet F. Quinn

NURSE HEALER OBJECTIVES

Theoretical

- Define transpersonal human caring.
- Define healing.
- Compare and contrast the processes of healing and curing.
- Discuss the nature of "right relationship" as it relates to healing.

Clinical

- Apply the elements of a "caring occasion" to facilitate healing.
- Describe examples of healing at the body, mind, and spirit levels of human experience that you have observed in practice.
- Begin to imagine how your own clinical practice setting might evolve to become a true healing health care system.

Personal

- Imagine what right relationship would look like and feel like when applied to something you want to heal in yourself.
- Identify ways in which you can create your own healing environment.
- Explore and celebrate an area of personal woundedness that has healed and thus has made you a better nurse.

DEFINITIONS

Healing: the emergence of right relationship at one or more levels of the body-mind-spirit system.[1]

Healing System: a true health care system in which people can receive adequate, nontoxic, and noninvasive assistance in maintaining wellness and in healing for body, mind, and spirit, together with the most sophisticated, aggressive curing technologies available.

Human Caring: the moral ideal of nursing in which the nurse brings his or her whole self into relationship with the whole self of the patient/client, to protect the vulnerability and preserve the humanity and dignity of the one cared for.[2]

Right Relationship: a process of connection among or between parts of the whole that increases energy, coherence, and creativity in the body-mind-spirit system.

Transpersonal: that which transcends the limits and boundaries of individual ego identities and possibilities to include

Portions of this chapter have been published as: J. Quinn, Healing: A Model for an Integrative Health Care System, *Advanced Practice Nursing Quarterly* 3, no. 1 (1997):1–7, by permission of Aspen Publishers.

acknowledgment and appreciation of something greater. Transpersonal may refer to consciousness, intrapersonal dynamics, interpersonal relationships, and lived experiences of connection, unity, and oneness with the larger environment, cosmos, or Spirit.

THEORY AND RESEARCH

Within the discipline of nursing, there is widespread acceptance of the concept of caring as central to practice. However, there is no widespread consensus as to what caring *is*. Morse and her colleagues reported that five basic conceptualizations, or perspectives, on caring can be identified in the nursing literature: (1) caring as a human trait, (2) caring as a moral imperative or ideal, (3) caring as an affect, (4) caring as an interpersonal relationship, and (5) caring as a therapeutic intervention.[3]

The term *transpersonal human caring* is most often associated with Jean Watson's theory of nursing as the art and science of human caring. Watson defined human caring as the moral ideal of nursing, in which the relationship between the whole self of the nurse and the whole self of the patient/client protects the vulnerability and preserves the humanity and dignity of the patient/client.[4] This emphasis on the whole self—the whole person of both nurse and patient—requires the addition of the term *transpersonal* in Watson's framework and in the discussion of human caring as it relates to holistic nursing practice. Within a transpersonal perspective, people are more than the body physical and the mind as contained in that body. A transpersonal perspective acknowledges that all people are body, mind, and spirit or soul, and that interactions between people engage each of these aspects of the self. A nurse with a transpersonal perspective recognizes that this is a fact of human interaction, not an optional event. A holistic nurse recognizes, as Watson suggested, that there is something beyond the personal, separate selves of the nurse and the patient involved in the act of caring.

When nurses enter into caring–healing relationships with patients, bringing with them an acknowledgment and appreciation of the body, mind, and spirit dimensions of their own human existence, they are engaged in a transpersonal human caring process. In this type of relationship, they know themselves to be interconnected with the patient and with the larger environment and cosmos. They know that they are walking on sacred ground when they walk this path with their patients, and they recognize that neither one will be the same afterward. For that moment, they are joined with the other who is patient, or client, and so become part of something larger than either alone. In this transpersonal healing process, they are each changed.[5]

Watson called these healing encounters "caring occasions," and suggested that they actually transcend the bounds of space and time. The field of consciousness created in and through the caring–healing relationship has the potential to continue healing the patient long after the physical separation of nurse and patient. Moreover, the nurse, following engagement in a true caring occasion, will also continue to benefit from the mutual process. When nurses are able to engage their full, caring selves in the art of nursing, it is both energizing and satisfying.

It is often assumed that nurses burn out as a result of caring too much. However, today's nurses are far more likely to burn out for a different reason: the difficulty in finding the time to care for patients with their whole selves within health care systems that do not value caring.

HEALING: THE GOAL OF HOLISTIC NURSING

While caring is the context for holistic nursing, healing is the goal. The origin of the word *heal* is the Anglo-Saxon word *haelan*, which means to be or to become whole. Defining what it means to be or become whole is a challenging task. For example, is wholeness a goal, an end point that is something to work toward, but is rarely achieved? Is wholeness a state of perfection of body-mind-spirit? Is wholeness something that people either have or do not have, something that people can obtain and hold on to, or something that comes and goes? Is it a state or a process? Is wholeness dependent upon the structure and functioning of the body? Can one ever be *not* whole; that is, can one ever be other than wholly who/what one is at any point in space and time? If one cannot be *not* whole, then how is it possible to talk about becoming whole? Each holistic nurse should spend some time thinking about what this means to her or him, because a nurse's perspective on wholeness will influence everything that she or he does.

Healing As the Emergence of Right Relationship

Wholeness is frequently described as harmony of body, mind, and spirit, while harmony is defined as an ordered or aesthetically pleasing set of relationships among the elements of the whole. This simple definition illustrates the implications of associating harmony with healing. First, wholeness involves more than the intactness of physical structure and function, or the status of isolated parts of a person. Second, if healing is about harmony, it is necessary to expand the ways of knowing about healing to include the aesthetic as well as the scientific.

Synonyms for the word *harmony* include unity, integrity, connection, reconciliation, congruence, and cohesion. Taken together, these terms begin to suggest that wholeness is not necessarily a state of any kind, but a process that is fundamentally about relationship. Wholeness is about the relationship of the parts of a system to one another and to the larger systems of which they are a part. When the great theoretical physicist David Bohm was asked, "How can anything become more whole if everything is already part of the indivisible wholeness of the implicit order of the universe?" he responded with one word. "Coherence," he said, creating no doubt that wholeness was not about adding and subtracting parts, but about how those parts related to each other.[6] Increasing the wholeness of a system is about establishing a pattern of relationships among its elements that is more and more coherent.

Healing, if it is a process of being or becoming whole, must be an emerging pattern of relationships among the elements of the whole person that leads to greater integrity, connection, and cohesion of the whole system. This pattern of relationships can be called *right relationship*.[7] Thus, healing is the emergence of right relationship at or between or among any and all levels of the human experience. It is a process rather than a state. It is dynamic, and it always affects the whole person, no matter at what level the shift actually occurs. Key to an understanding of the effects of a shift into right relationship at any level are theories about how systems, particularly living systems, work. The new sciences are "known collectively as the sciences of complexity, including general systems theory (Bertalanffy, Weiss), cybernetics (Wiener), non-equilibrium thermodynamics (Prigogine), cellular automata theory (von Neumann), catastrophe theory (Thom), autopoietic system theory (Maturana and Varela), dynamic

systems theory (Shaw, Abraham), and chaos theories, among others."[8] Within a systems perspective, human beings are *holons*;[9] that is, simultaneously autonomous wholes and parts of larger wholes. Each holon is embedded in an "irreversible hierarchy of increasing wholeness, increasing holism, increasing unity and integration."[10]

Several principles related to the nature of systems are fundamental to all these theories and have direct implications for the understanding of healing. The first and most basic is that a system is more than and different from the sum of its parts. It is "more than" its parts because the pattern of relationships among the parts of the whole gives the system its own unique identity. "A pattern of organization [is] a configuration of relationships characteristic of a particular system."[11]

A second principle is that a change in the part always leads to a change in the whole. Because human beings are living systems governed by these principles, any shift, no matter how small or at what level it appears, will always affect the whole body-mind-spirit. Furthermore, because every person is simultaneously a part of the larger whole of family, society, the ecosystem, and the universe, a change in an individual body-mind-spirit leads to a change in all of these as well. This awareness is, of course, part of the teaching of virtually every spiritual tradition, and it affirms that nurses' individual healing work matters to far more than just the nurses.

The third principle that relates directly to healing is that the nature of the change in the whole cannot be predicted by the nature of the change in the part. "The new state [of a system] is decided neither by initial conditions in the system nor by changes in the critical values of environmental parameters; when a dynamic system is fundamentally destabilized, it acts indeterminately."[12]

Human beings as living systems are self-organizing systems, capable of—indeed, striving toward—order, self-transcendence, and transformation. "We are beginning to recognize the creative unfolding of life in forms of ever-increasing diversity and complexity as an inherent characteristic of all living systems."[13] Thus the healing process itself is inherent within the person. This urge toward healing, toward right relationship, when manifested, may be thought of as the "haelan effect."[14]

In the context of these principles, right relationship is not a moral judgment, a statement about right and wrong, good or bad. Rather, it is a way of understanding a particular quality of pattern and organization. The inherent tendency of any living system, as part of the evolutionary process, is toward actualizing its "deep structure"[15] (i.e., an acorn "wants" to actualize its inherent tree nature). The consequence of not being in right relationship is the tendency toward "self-dissolution."[16] Right relationship may be thought of as any pattern of organization within the system that supports, encourages, allows, or generates actualization and self-transcendence—at any or all levels. Thus, consistent with the tendencies inherent in all living systems healing, the emergence of right relationship at any level, body, mind, or spirit

- increases coherence of the whole body-mind-spirit.
- decreases disorder in the whole body-mind-spirit.
- maximizes free energy in the whole body-mind-spirit.
- maximizes freedom, autonomy, and choice in the whole body-mind-spirit.
- increases the capacity for creative unfolding of the whole body-mind-spirit.

Because of its inherently creative nature, true healing is always a process of emer-

gence into something new, rather than a simple return to prior states of being. Holistic nurses do not limit the focus of their care to recovery alone, but rather expand their focus to helping patients integrate their illness experience and transcend their former selves toward new patterns of self-actualization. This is the growth process of nature. Nightingale's statement that the goal is to put the patient in the best condition so that nature can act on him may refer to this natural, forward-moving tendency toward wholeness.[17]

Healing as the emergence of right relationship may occur at any level of the body-mind-spirit. For example, when an organ is transplanted, the emergence of right relationship between the new organ and the surrounding cells and tissues of the recipient's body-mind-spirit signals healing. If that right relationship does not occur, if the cells of the new organ do not become integrated into the existing body-mind-spirit, if rejection rather than acceptance happens, then the patient may die from a lack of right relationship, and thus healing, at the cellular level. When broken bones knit together, or when the edges of a wound begin to approximate, right relationship is emerging at the physical level. Each of these emerging right relationships has an impact on the whole, as noted earlier.

The effects on the whole person of a shift toward right relationship at the emotional level are evident in a moment of forgiveness, or a release of a long-held resentment. At such a time, the way in which a person stands in relationship to an event and/or a person from the past changes. The letting-go of resentment carries with it an often overwhelming release of energy for new growth and an expanded consciousness. The body-mind-spirit of one who is experiencing forgiveness moves toward integration and transcendence of previous patterns and forms. Forgiveness of one's self or another has profound effects at every level of being.

Sometimes right relationship emerges at the spiritual level before it manifests itself anywhere else. In moments of deep love—such as gratitude, or the sudden awareness that they are not alone but in fact are connected to everything and everyone else in the cosmos—individuals have come into right relationship with the transcendent dimensions of life—God, the One, Ultimate Reality, the Ground of Being. The language is not as important as the recognition of change. Those who have this experience are more whole, more coherent, more free to become who they are most deeply meant to be, more healed.

Healing vs. Curing

Healing and curing are different processes. *Curing* is the elimination of the signs and symptoms of disease, which may or may not correspond to the end of the patient's disease or distress. The diagnosis and cure of disease provide the focus of the modern health care (sickness–cure) system. This is not a wrong focus, only an incomplete one. When it is estimated that 85% of health problems are either self-limiting or chronic, it becomes clear that something in addition to a focus on the curing of diseases is required. That something is healing, which is different from curing in several key ways.

Healing may occur without curing. The person dying of acquired immune deficiency syndrome (AIDS) who reconciles with his parents after a long separation is healing. The person who has become quadriplegic and uses this as an opportunity to recommit to living a life of meaning and service is healing. The mother of young children who consents to radical, invasive surgery for an otherwise incurable cancer is healing by coming into a new relationship with the disease and making choices based on her commitment

to live for her children. The surgery may not cure her disease, but the choice to undergo the surgery is a healing choice. Curing is almost always focused on the person as a physical entity, a body. If the body cannot be fixed, if the physical disease state or state of disability cannot be cured, then there is "nothing more we can do for you." Healing is multidimensional. It can occur at the physical level, but it can also occur at each of the other levels of the human system—emotion, mind, and spirit.

Curing may or may not be possible, but healing is always possible. Many of the diseases of our time are, in fact, not curable, and people who are living with chronic illnesses of the immune system and cardiovascular systems make up a large percentage of the caseload of any primary care provider. In contrast, because healing is the emergence of right relationship at any or all levels of the human system, it can happen even when there is no possibility for physical cure. The potential for healing exists within every human being by the very fact that as humans, we have a multidimensional, self-reflective nature. Indeed, for some people, the very fact that they are facing an incurable disease or situation provides enough instability in the system to catalyze tremendous healing shifts, an "escape to a higher order" in the language of Prigogine's model of dissipative structures.[18]

Although curing follows a usual or predictable path, healing is always creative and unpredictable in both process and outcome. In textbooks on curing, the events that will be probable parts of recovery and the time line are described, and the actual progress of the patient is measured against these referents. The misapplication of this information is increasingly apparent as patients in the modern sickness–cure system are being told exactly how many days of care they are permitted for cure to occur. The nature and the direction of a healing change cannot be predicted, however. Furthermore, because the direction of healing is always toward self-transcendence, something new is emerging, and the whole that was before becomes a part of the new, larger (or deeper) whole. This unidirectional unfolding toward increasing complexity and diversity is also, of course, a fundamental premise of the Science of Unitary Human Beings first proposed by Rogers in 1970.[19] The end point of a healing process cannot be predicted ahead of time. It can only be observed as it emerges.

Death is seen as a failure in the sickness–cure system, but as a natural process in the healing system. Death is seen as the enemy, that which is to be avoided at all costs, even at the expense of the humanity and personhood of the one being treated in the sickness–cure system. The increasingly widespread use of "living wills"—formal, legal documents that are required to allow death without the heroic battle waged in sickness–cure institutions—provides abundant evidence of this observation. Rather than being a failure, however, death is part of the natural unfolding of the life process. All living systems eventually die. In some spiritual traditions, death itself is viewed as the ultimate healing, because it releases the eternal soul from the limitations, pain, and suffering of embodiment. This, of course, is a matter of individual belief.

Healing As an Outcome

Healing as a process of emergence does not lend itself to the type of outcome measurement usually applied to curing. It is one thing to evaluate whether the signs and symptoms of disease are still present. It is quite another to determine if there has been a shift at any level of this person's body-mind-spirit. Carper outlined four

"patterns of knowing" for nursing: empirics, personal, ethical, and aesthetic.[20] Each of these ways of knowing is valid, according to Carper, but only empirical knowing is widely used and accepted as such.

The knowledge about people gained through the use of empirics—the data gathered through the five senses and their extensions by technology—is unquestionably abundant and important. Tools constructed to elicit information about quality of life, lifestyle, spiritual well-being, and other aspects of life can provide glimpses into healing, to be sure, but they cannot tell the whole story, nor can they be used as "outcome" measures (e.g., what the measures "should" show, what the patient "should" be feeling by this day).

To know if healing is actually happening, more than empirical knowing is necessary. Because the nature of healing is creative and unpredictable, often the best instrument for determining whether healing is happening is the subjective knowing of both patient and nurse. Most nurses have had the experience of participating in a healing moment, a caring occasion. In these moments with patients, there is often a felt sense of awe, reverence, and wonder. Nurses intuitively know that they are standing on holy ground, that they are in the presence of something sacred. It is a body sensation, a chill or a surge of energy. The nurse looks at the patient, the patient looks at the nurse, and they both know. There may be no words, no description; just knowing. Neither may even be able to name what the healing was, or what shifted, but they trust that it is real.

Journal-keeping is a powerful way for people to keep track of their own healing. Over time, content may shift, new awareness may arise, dreams may become vivid and clear, and as patients see their own written words they realize that they have changed, that they are more whole, more themselves, perhaps expanded in consciousness. This is healing, and the nurse can participate in this process by encouraging the patient to keep a journal and to share it. Sometimes it is through the aesthetic route that healing becomes apparent. Using paper and crayon, patients may draw the shift from despair to hope or fear to peace. Music and movement may become the means through which patients/clients communicate the progress of their healing, the quality of their wholeness.

None of these indicators of healing can be predicted. They cannot be put into a formula to determine length of stay or number of office visits allowed. They are valid and important indicators nevertheless. It may be that, just as nurses have come to accept the definition of pain as being what the patient says it is, they will come to see that healing is happening when the patient (or their intuitive knowing) says it is. This, of course, presents a problem in a system that is increasingly moving to managed care and outcome prediction. It is here that holistic nurses have the opportunity, even the responsibility, to help to define outcome in a way that preserves the wholeness of patients and does not allow their "progress" to be reduced to the behavior of the body physical.[21]

THE HEALER

"It is often thought that medicine is the curative process. It is no such thing; medicine is the surgery of functions as surgery proper is that of limbs and organs. Neither can do anything but remove obstructions; neither can cure. Nature alone cures."[22] This same perspective applies to healing.

Healing is completely unique and creative, and may not be coerced, manipulated, or controlled, even by the one healing. The nurse healer is a facilitator of this process, a sort of midwife, but is not the one doing the healing. Nor is the locus of the healing an isolated part of the patient (i.e., the "mind" or the "spirit"). All healing emerges from within the totality of

the unique body-mind-spirit of the patient, sometimes with the assistance of therapeutic interventions, but not because of them. Therapeutics (drugs, surgery, complementary therapies) may be necessary for the patient to be cured or healed, but they are not sufficient causes. Every nurse has cared for patients who "should have" gotten better but did not, as well as patients who "should have" died but went on to live long, healthy lives.

The assumption that the patient accomplishes all healing and curing does not mean that the patient controls all healing and curing. The causes of illness and cure are so complex and multifaceted that no simple statement of cause and effect is appropriate to describe either. Nurses can participate knowledgeably in the healing process, formulating a healing intention and doing what they believe is best in this situation, but the outcome of that process remains a mystery. At least part of the healing process will always be an unfolding mystery. Suggesting otherwise to patients may contribute to their sense of failure when they are unable to cure themselves of disease. True caring is a moral commitment to protect the vulnerability of another, not add to it.

A TRUE HEALING HEALTH CARE SYSTEM

As noted previously, the current health care system focuses almost exclusively on the curing process, thus making it more akin to a sickness–cure system. While necessary and excellent in its own right, this system is incomplete. The use of new tools of care, including alternative, holistic, or complementary therapies, without a fundamental shift in the philosophy of care with which they are used, will *not* transform the sickness–cure system into a true, healing health care system, however. This error of confusing the tools of care with the philosophy of care may lead to serious consequences for both health care practitioners and their patients.

The fundamental orientation of a holistic practitioner is toward an appreciation of and attention to the wholeness and uniqueness of every person. Holistic nurses remember that, in effect, there is nothing that is *not* holistic. There is no intervention that does not affect the whole body-mind-spirit of the patient, because the body-mind-spirit is integral and cannot be divided. There are natural versus non-natural modalities, for example, but both affect the whole body-mind-spirit. There are invasive and noninvasive interventions, but both affect the whole body-mind-spirit. There are interventions that start in the body (e.g., medications, surgery, exercise, movement therapy), the mind (e.g., autogenic training, hypnotherapy, guided imagery), or the spirit (e.g., meditation, prayer, gratitude practice, loving kindness). None of these interventions is inherently more "holistic" than the other, however, because all roads lead to the body-mind-spirit; all interventions affect the whole.

For this reason, simply adding new tools of care will not transform the sickness–cure system. The way in which practitioners use the tools available, whether the tools are conventional or complementary, and their willingness to become a midwife to nature rather than the hero of success stories, make the care holistic or integrative. The true health care system will emerge when both curing and healing processes are equally valued, sought after, and facilitated for all, and when the full range of curing, caring, and healing modalities is available to all. Holistic nurses have a key role to play in facilitating this level of change in the existing systems.

Integration of the Masculine and the Feminine

The Western sickness–care system is characterized almost exclusively by attributes usually ascribed to the masculine principle and usually carried by men. This is a natural consequence of the fact that men have been the principal creators of that system and continue to be the dominant culture of the system. These attributes are extremely useful in the treatment of acute injury and disease, but without the attributes usually ascribed to the feminine principle, they provide an incomplete foundation for a true, integrative healing health care system.

Table 2–1 suggests another perspective on these different attributes. A perspective that sees the goal as "getting the job done" can be associated with the sickness–cure model, while one that focuses on "holding sacred space" can facilitate healing of the whole body-mind-spirit.[23]

Nurse As Healing Environment

One of the most powerful tools for healing is the presence of the nurse in the patient's environment. In fact, the nurse has the greatest impact of all the elements in the patient's environment. Simply by virtue of the role, a nurse has all the ritual power of the shaman of other cultures. The nurse is guardian of the patient's journey through illness and healing; the keeper and bestower of information, medicines, and treatments; the mediator of the system and the comings and goings of others in the system.

In a model of the universe that includes the nonlocal nature of consciousness[24] or the possibility for the existence of a human energy field that extends beyond

Table 2–1 Ways of Being with People Seeking Help

"Getting the Job Done"	*"Holding Sacred Space"*
Authority vested in the external "expert"	Authority vested in the individual client(s)
Source of healing: what the expert provides	Source of healing: the body-mind-spirit of the client(s)
Gathering, collecting, taking in information	Receiving information
Problem solving/fixing	Life unfolding/facilitating
Making "something" happen, where "something" is • defined by the external "expert" • defined ahead of time • meeting the goal	Allowing "something" to happen, where "something" is • defined mutually • defined in the moment • emergence of mystery
Directing/taking over to make it happen	Guiding/helping to allow it to happen
Doing to or for	Being with
Leading	Walking with
Power over	Power with
Expert is accountable and responsible for outcome	Facilitator is accountable and responsible for competent practice
Failure is the nonachievement of predetermined outcome	Failure is giving up on the unfolding process

the skin,[25] the nurse is not simply part of the patient's environment, but rather the nurse *is* the patient's environment.[26] As Newman noted, "In the case of a nurse interacting with a patient, the energy fields of the two interact and form a new pattern of inter-penetration, spirit within spirit." [27]

The healing environment of the patient may increase to the maximum when the nurse intentionally shifts consciousness into a centered or meditative state. The interconnectedness of the energy fields of the nurse and the patient can facilitate relaxation, rest, or healing in the patient.[28] When a nurse is centered in the present moment and has the intention to be a healing environment, he or she may carry this intention in the energy field and manifest it in the voice, the eyes, and the quality of touching. Nurses should ask themselves:

- Do patients hear in my voice that I care? That I have time for them? That they are safe with me?
- What is the quality of my facial expression? Of my eyes? Do they communicate care and compassion, or are they perfunctory and distant? Does the patient feel seen by me, or overlooked? If the eyes are the windows of the soul, what is my soul saying to the soul of my patient? What is the patient's soul saying?
- Am I focused on the task at hand and simply touching the patient to get the job done? Or does my touch convey care, support, nurture, and competence? Does my touch communicate that I know I am touching this person's spirit as I contact his or her skin, because where else is the spirit located but in the body? Do I speak of love and kindness and respect through my hands?

Learning how to shift consciousness into a healing state is a basic skill for the holistic nurse. Nurses are not simply separate selves "doing to" the patient, but an integral part of the patient's environment, "being with" them on the healing journey. The quality of the energy with which the patient is interacting is part of what nurses attend to, and this means attending to their own state of consciousness and well-being before, during, and after their interactions with patients. Thus, taking time for themselves to learn and practice relaxation, meditation, centering, or other self-care strategies becomes essential in this model. Nurses are not being selfish by taking this time. They are recognizing that unless they are energized, relaxed, and centered, they will be trying to give what they do not have to give. This results in less than optimal care for the patients and burnout for the nurses.

THE WOUNDED HEALER

Everyone is wounded. Life does not allow anyone to slide under its radar and escape its trials. Thus, being wounded is not optional. What individuals *do* with their wounding is optional, though. When nurses do the work of healing that their own woundedness requires, they have the capacity to become "wounded healers" for others. The wounded healer is not a healer because he or she is perfect, whole, and finished with life's growing pains. No, the wounded healer is a healer precisely because he or she knows deeply and personally the need for ongoing healing, caring, and wholeness. Having undertaken to become healed themselves, wounded healers are unafraid of the healing journey and are courageous companions on the healing journey of others. They know the territory of healing from the inside, and can guide others at one moment and

console them the next, for the journey is always shifting.

Conversely, wounded healers know their limitations and can identify when a given patient is touching them in a place that is still unhealed. Instead of rejecting the patient because they are unconscious of this reality, wounded healers make sure that another staff member is assigned to the patient so that the patient's care will not be compromised by their inability to provide a caring presence.

The more nurses become healed and whole themselves, the more they have to offer their patients. As they grow and develop in self-love and compassion, their well of compassion and mercy for others expands. Frances Vaughan, a transpersonal psychologist, put it this way: "Healing happens more easily through us when we allow it to happen in us. In this way the wounded healer who, at the existential level, identifies with the pain and suffering of those he or she attempts to heal, becomes the healed healer who, being grounded in emptiness and compassion, can facilitate healing more effectively."[29]

As nurses heal, they become increasingly aware of the sacred trust that is granted to them when they are privileged to participate in another person's healing journey. They accept the privilege and its demands and responsibilities willingly, because the wounded healer always wants to give something back.

CONCLUSION

Transpersonal human caring provides the context for holistic nurses to facilitate healing—the emergence of right relationship—in patients and clients. Through the use of centering and intentionality, the holistic nurse may become a healing environment and participate in the creation of a true, healing health care system that integrates both masculine and feminine attributes. "Holding sacred space" for healing is an additional skill of the holistic nurse. This skill does not replace "getting the job (of curing) done;" but it *enhances* it. The nurse, as a wounded healer, recognizes that people are on their own healing journeys, but they may assist each other as personal healing evolves.

DIRECTIONS FOR FUTURE RESEARCH

1. Collect personal stories and narratives that provide exemplars of "caring occasions."
2. Conduct interviews with patients who see themselves as healing, even in the absence of curing, to search for patterns that may facilitate this shift for other patients.
3. Explore the relationship between job satisfaction in nurses and the practice of centering and holding sacred space.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer, or begin a process of answering, the following questions:

- How do I feel when I am engaged in a "caring occasion"?
- How do I know when healing is happening in my patients? In myself?
- What gives me true joy and peace in my practice as a holistic nurse, and how can I create more of that?
- What wounds have I consciously healed in my life, and what are the gifts of those wounds that help to make me a better nurse?

NOTES

1. J. Watson, *Nursing: Human Science and Human Care* (New York: National League for Nursing Press, 1988), 54.
2. J. Quinn, On Healing, Wholeness and the Haelan Effect, *Nursing and Health Care* 10, no. 10 (1989):553–556.
3. J. Morse et al., Concepts of Caring and Caring as a Concept, *Advances in Nursing Science* 13, no. 1 (1990):1–14.
4. Watson, *Nursing: Human Science and Human Care*, 59.
5. J. Ercums, Nursing's Caring Paradigm: A Story of Mutuality and Transcendent Healing, *Alternative and Complementary Therapies* 4, no. 1 (1998):68–72.
6. D. Bohm, response to a question raised at the International Transpersonal Association meeting, Prague, Czechoslovakia, 1992.
7. Quinn, On Healing, Wholeness and the Haelan Effect, 553.
8. K. Wilber, *Sex, Ecology and Spirituality: The Spirit of Evolution* (Boston: Shambhala, 1996), 14.
9. A. Koestler, *The Ghost in the Machine* (New York: Random House, 1976).
10. K. Wilber, *The Marriage of Sense and Soul* (New York: Random House, 1998), 67.
11. F. Capra, *The Web of Life* (New York: Anchor Books, 1996), 80.
12. E. Lazlo, *Evolution, the Grand Synthesis* (Boston: Shambhala, 1987), 36.
13. Capra, *The Web of Life*, 222.
14. Quinn, On Healing, Wholeness and the Haelan Effect, 554.
15. Wilber, *Sex, Ecology and Spirituality*, 40.
16. Ibid., 44.
17. D. Wardell and J. Engebretson, Professional Evolution, *Journal of Holistic Nursing* 16, no. 1 (1998):64.
18. I. Prigogine, *Order Out of Chaos* (New York: Bantam Books, 1984).
19. M. Rogers, *An Introduction to the Theoretical Basis of Nursing* (Philadelphia: F.A. Davis, 1970).
20. B. Carper, Fundamental Patterns of Knowing, *Advances in Nursing Science* 1, no. 1 (1978): 13–23.
21. Wardell and Engebretson, Professional Evolution.
22. F. Nightingale, *Notes on Nursing: What It Is and What It Is Not* (New York: Dover Press, 1969), 133.
23. J. Quinn, Holding Sacred Space: The Nurse as Healing Environment, *Holistic Nursing Practice* 6, no. 4 (1992):26–36.
24. L. Dossey, *Healing Words* (San Francisco: HarperSanFrancisco, 1993), 43.
25. M. Rogers, Nursing: Science of Unitary, Irreducible, Human Beings: Update 1990, in *Visions of Rogers Science-based Nursing*, ed. E.A.M. Barrett (New York: National League for Nursing, 1990).
26. Quinn, Holding Sacred Space.
27. M. Newman, The Spirit of Nursing, *Holistic Nursing Practice* 3, no. 3 (1989):6.
28. Quinn, Holding Sacred Space.
29. F. Vaughan, *The Inward Arc* (Boston: Shambhala, 1985), 70.

SUGGESTED READINGS

Kreitzer, M.J., Jensen, D. Healing practices: trends, challenges, and opportunities for nurses in acute and critical care. *AACN Clinical Issues* 11, no. 1 (2000):7–16.

Kreitzer, M.J., Snyder, M. Healing the heart: integrating complementary therapies and healing practices into the care of cardiovascular patients. *Progress in Cardiovascular Nursing* 17, no. 2 (2002):73–80.

Lewis, S.M. Practice applications. Caring as being in nursing: unique or ubiquitous? *Nursing Science Quarterly* 16, no. 1 (2003):37–43.

Locsin, R.C. Culture perspectives: holistic healing: a practice of nursing. *Holistic Nursing Practice* 16, no. 5 (2002):ix–xii.

Quinn, J.F., Smith, M., Ritenbaugh, C., Swanson, K., Watson, M.J. Research Guidelines for Assessing the Impact of the Healing Relationship in Nursing. *Alternative Therapies in Health and Medicine* 9, no. 3 (2003):A65–A79, special supplement.

Quinn, J.F. Revisioning the nursing shortage: a call to caring for healing the healthcare system. *Frontiers of Health Services Management* 19, no. 2 (2002):3–21.

Quinn, J.F. The self as healer: reflections from a nurse's journey. *AACN Clinical Issues* 11, no.1 (2000):17–26.

Quinn, J.F. Healing: a model for an integrative health care system. *Advanced Practice Nursing Quarterly* 3, no. 1 (1997):1–7.

Rombalski, J.J. A personal journey in understanding physical touch as a nursing intervention. *Journal of Holistic Nursing* 21, no. 1 (2003):73–80.

Stichler, J.F. Creating healing environments in critical care units. *Critical Care Nursing Quarterly* 24, no. 3 (2001):1–20.

Stickley, T., Freshwater, D. The art of loving and the therapeutic relationship. *Nursing Inquiry* 9, no. 4 (2002):250–256,

Updike, P., Cleaveland, M.J., Nyberg, J. Case reports. Complementary caring–healing practices of nurses caring for children with life-challenging illnesses and their families: a pilot project with case reports. *Alternative Therapies in Health & Medicine* 6, no. 4 (2000):108–112.

Ward, S. Caring and healing in the 21st century. *MCN, American Journal of Maternal Child Nursing* 23, no. 4 (1998):210–215.

Watson, J., Foster, R. The Attending Nurse Caring Model: integrating theory, evidence and advanced caring–healing therapeutics for transforming professional practice. *Journal of Clinical Nursing* 12, no. 3 (2003):360–365.

Watson, J., Smith, M.C. Caring science and the science of unitary human beings: a trans-theoretical discourse for nursing knowledge development. *Journal of Advanced Nursing* 37, no. 5 (2002):452–461.

Watson, J. Intentionality and caring–healing consciousness: a practice of transpersonal nursing. *Holistic Nursing Practice* 16, no. 4 (2002):12–19.

Watson, J. Leading via caring–healing: the fourfold way toward transformative leadership. *Nursing Administration Quarterly* 25, no. 1 (2000):1–6.

Reawakening the Spirit in Daily Life

Individuals who are said to possess "psychologic hardiness" have certain characteristics referred to as the three Cs.[1] *First, these individuals feel open to* change *and are willing to take risks. They see life as a series of challenges rather than problems, and they seem to thrive on challenges. Second, these individuals feel a* commitment *to family, friends, and goals. Third, they have a sense of personal power and* control *over life, and perceive their body-mind-spirit as an integrative unit. Hardiness characteristics not only apply to staying healthy, but also have tremendous potential for adapting to more effective health promotion strategies if chronic illness is present.*

These hardiness characteristics assist us in learning more about our human potentials. Change implies flexibility and suggests that lifestyle habits do not have to be permanent. It is wise to experiment with new, healthier behaviors, and to try new ways of relating with friends, family, and colleagues. Changing detrimental or risky habits is essential for well-being. The more we choose effective lifestyle patterns, the better we learn the process of change. Changing and taking risks are important parts of life. Often, when people do not change, they conclude that they do not have the willpower to change. Rather than willpower, we should think in terms of "skillpower," which implies new information and skills that lead to long-lasting changes in lifestyle patterns. The more we risk when changing lifestyle, the more consistently we select positive changes because the fear of changing is lessened.[2]

Hardiness characteristics help us experience a sense of meaning and purpose in our work. "Work spirit" is related to increased effectiveness, productivity, and individual satisfaction, which contribute to positive results in the workplace. It is also directly related to the degree of responsibility that one is willing to take to change the course of one's life. Work spirit grows when one understands and appreciates the benefits of maximizing his or her potential through self-care modalities such as exercise, nutrition, play, relaxation, and stress management strategies. Work spirit also involves selflessness; that is, being unself-consciously engrossed in the outcome of work tasks and projects rather than worrying about others' perceptions of the way those tasks and projects are being done. People with work spirit have abundant energy and always appear to be "on a roll" or "in a flow state." They feel a sense of purpose and are creative and nurturing. They experience a different sense of time. These individuals have a sense of higher order and oneness. Their state of mind is positive and open to new ideas, and a full sense of self is manifest.

Individuals with work spirit exhibit synergy; they discover common threads in situations when there appear to be none. They work

with self and others to produce greater results. These people exhibit hardiness. They can make frequent shifts in thinking and can release old mindsets. They understand that patterns and processes in any project create the whole, rather than focusing on isolated parts. They value input from colleagues, seek meaningful relationships, and also praise co-workers' talents and resources. They focus on win–win situations.

Individuals who have low levels of work spirit can create dysergy in the workplace. They focus on an isolated action that promotes one function, but impedes the progress of another person or the group working together. These individuals tend to work alone or evoke unnecessary competition among colleagues. They exhibit poor communication skills, aggressiveness, and insecurity, emphasize win–lose outcomes, and reject meaningful interaction from co-workers.

Organizations can increase individual work spirit by having an identified purpose that workers can share and articulate. When this purpose is clearly communicated, supervisors (or managers) recognize individual strengths and talents and channel creative energy toward the organizational goal. Organizations that offer praise and rewards that encourage risk taking and problem solving, without imposing punishment for mistakes, also increase individual work spirit.

NOTES

1. S. Kobasa et al., Hardiness and Health: A Prospective Study, *Journal of Personality and Social Psychology* 42 (1982):168–177.
2. J.F. Wane (Issue Editor), Hardiness and Health, *Holistic Nursing Practice* 13, no. 3 (April 1999). [This entire issue focuses on many aspects of hardiness and health.]

Chapter 3

The Art of Holistic Nursing and the Human Health Experience

H. Lea Barbato Gaydos

NURSE HEALER OBJECTIVES

Theoretical

- Describe aesthetic knowing.
- Explore the art of holistic nursing.
- Discuss the dynamic, dialectic relationship of health-wellness–disease-illness that comprises the human health experience.
- Discuss the facilitation of healing through the processes of engagement, values clarification, and change.
- Discuss the workplace and the human health experience.

Clinical

- Describe the ways in which you are an artist in your practice.
- Identify the relationship of health-wellness–disease-illness in at least two patients.
- Identify the stages of change with a patient, and cocreate a plan to implement appropriate strategies for motivation and sustained changed behaviors.
- Explore with a colleague the ways in which cultural variations in values affect the responses of patients.
- Explore workplace wellness in your clinical setting.

Personal

- Reflect on ways that aesthetics enhance your health and well-being.
- Write down two action steps that will move you toward a more artful and healthful life.

DEFINITIONS

Art of Nursing: the creative mediation and expression of all patterns of knowing in nursing in transformative, aesthetic, and caring holistic nursing actions.

Attitudes: feelings arising out of thoughts, emotions, and behaviors associated with a particular person, idea, or object.

Beliefs: a subset of attitudes that indicate faith in a particular person, idea, or object.

Cocreative Aesthetic Process: an example of when nursing is art; includes four aspects: Engagement, Mutuality, Movement, and New Form.

Culture: a pattern of learned behaviors and values that are socially reinforced and transmitted from generation to generation.

Dialectic: the art of discourse, implying a relationship in which there is a synthesis of objective and subjective perspectives.[1,2]

Disease: a discrete entity causing specific symptoms; more broadly, a phenomenon causing a deviation from normal.[3]

Engagement: the process of commitment, involvement, and performance of value-consistent health behaviors.[4]

Health: an individually defined experience of well-being, harmony, and unity; a process of becoming; an expanding of consciousness.[5]

Human Health Experience: that totality of human experience that encompasses health-wellness–disease-illness.[6]

Illness: a subjective experience of symptoms and suffering to which the individual ascribes meaning and significance; not synonymous with disease.

Motivation: the internal spark or desire necessary for a person to be committed to change, set goals, and succeed.

Self-Responsibility: the ability to choose behaviors that are congruent with personal values.

Values: endowment of a particular person, idea, object, or behavior with worth, truth, or beauty.

Values Clarification: a process whereby one becomes more aware of how life values are established and how these values influence one's life.

Wellness: integrated, congruent functioning aimed toward reaching one's highest potential.

THE ART OF HOLISTIC NURSING

Nursing is a science, and it is also an art. Those in the field of nursing have made many advances in describing the *science* of nursing. Exactly what constitutes the *art* of nursing is less clear. Interpreting the art of nursing as the "nursing arts" places the emphasis on the proper techniques employed in the tasks of nursing, such as bathing the patient, making the bed, and administering medication. In 1860, however, Florence Nightingale defined the art of nursing as a fine art having to do with the spirit: "Nursing is an art; and if it is to be made an art it requires as exclusive a devotion, as hard a preparation as any painter's or sculptor's work; for what is the having to do with dead canvas or cold marble, compared with having to do with the living body."[7]

Aesthetic Knowing

Carper's landmark study identified the fundamental patterns of knowing in nursing as empirical, ethical, personal, and aesthetic.[8] Since that study, efforts have been made to develop knowledge in all four of the patterns of knowing. Of the four, the aesthetic pattern remains the least studied.[9] This may be a result of both the inadequacy of many methods of inquiry to capture the knowing in this pattern, and the fact that the language of aesthetics in nursing is still evolving. Nevertheless, the aesthetic pattern of knowing is the basis for practice because it mediates and expresses all of the others.[10] Aesthetic knowing is the direct perception of that which is significant in nursing situations.[11]

Watson provides a compelling reason to turn scholarly attention to aesthetics when she declares that, "Beauty and art are part of the ushering in of a transpersonal caring–healing perspective."[12] She further asserts: "In transpersonal caring and healing, we will need to create and sustain the existence of a community of healers which is committed to the domain of art, beauty, and soul care to accompany and transform the usual ways of doing medicine."[13] Furthermore, failure to reengage with aesthetics in practice and in life will lead to mindless conformity and a lack of vision.[14]

Chinn and Kramer have done a great deal to provide a theoretical understanding of the aesthetic pattern of knowing. They describe aesthetics as a whole experience that is both intuitive and expansive. *Aesthetic knowing* is said to have two components: "knowledge of the experience toward which the art form is directed and knowledge of the art form itself."[15] Thus, the artful nurse has knowledge of the patient and the human health experience as well as knowledge of nursing. This suggestion is consistent with the human predisposition to aesthetic knowing.

Predisposition to Aesthetic Knowing

Human beings are predisposed to aesthetic knowing because of three innate capacities that enable aesthetic appreciation. Dissanayake[16] summarizes these: (1) *Spatial thinking*; (2) *binary thinking*, the mind's organizing principles of thinking in contrasting pairs and using prototype recognition; and (3) *anagogic-metaphoric thinking* are all abilities that enable an aesthetic response. Spatial thinking locates the position of the physical body in space. It indicates the amount of space occupied and the spatial distance between the body and other objects. Spatial thinking places us physically in relation to everything else. It is a pervasive and largely unconscious kind of thinking. Binary thinking allows categorization of qualities and social phenomena into contrasting pairs. Dissanayake uses the examples of: large/small, good/bad, and parent/child to illustrate this idea. This capacity makes human beings responsive to polarities, dualities, and oppositions, which has value in creating analogy and metaphor. Prototype recognition is the capacity to categorize perceptions into types. That is, if enough of the essential features of a phenomenon are present, the mind categorizes it according to a general category based on similar features. Though at times errors are made, on the whole this ability is an economical and fairly accurate way to handle a huge amount of information. The ability to recognize figure-ground relationships, insidedness-outsidedness, and division by the use of lines, squiggles, and angles, are important features of visual perception that contribute to the aesthetic response. The ability to recognize the salient, repetitive, and similar enables the distinction of something that is special or out-of-the-ordinary. Thus, things that are "special" may also be recognized as anomalous. The experience of discovery so nourishing to the creative imagination emerges out of the ability to recognize anomalies of various kinds. Anomalies may appear as the presence of an unexpected factor, the noticing of a necessary factor as missing, or the presence of the necessary and expected factors arranged in an innovative or unexpected way.[17]

"Making Special"

In employing the capacities that predispose people to an aesthetic response, Dissanayake argues that human beings exhibit a core behavioral tendency (e.g., core behavioral tendencies to attachment and aggression) to "make special" and that this "making special" is the wellspring of ritual and art, both of which have survival value.[18] "Making special" is a behavior that is as important to survival as are other core behavioral tendencies, such as aggression and attachment. Thinking of art as having survival value and as the effort to "make special" suggests the reason that nursing may be considered an art. In art-filled nursing, practitioners "make special" the relationship between nurse and patient. Through this specialness,

they cocreate the circumstances for healing and sometimes for survival.

The Art of Nursing

Though investigations into the art of nursing are few and lack consensus on definitions, Gramling has suggested that the studies available can be categorized as either philosophical or experiential.[19] Philosophical studies have been done by Rhodes, Burke, Johnson, and LeVasseur. Rhodes described the art of nursing as a creative interaction that is the core of nursing. Burke studied how a nurse develops nursing artistry. She said that nurses have a "perceptual palette" that is derived from the nurses' imaginations and sensitive spirits. Johnson did a comprehensive dialectic examination of 41 writings on the art of nursing. Her work identified five abilities of the artful nurse: 1) grasping meanings in patient encounters, 2) connecting meaningfully with patients, 3) performing nursing functions with skill, 4) rationally choosing appropriate nursing actions, and 5) behaving morally in nursing practice. LeVasseur believes that much work needs to be done theoretically to describe the art of nursing. She examined many theories on aesthetics and noted that the tendency to separate art from craft in most aesthetic theories is not relevant for the practice component of nursing.

Experiential studies have been done by Appleton, Skillman-Hull, and Gramling. Appleton associated the art of nursing with caring and described it as a "gift of self." Skillman-Hull examined the lives of nurses who were also artists and discovered that participants linked nursing as art with caring. The participants also found different ways of dealing with the struggle to be both nurses and artists. Gramling's study yielded themes from critically ill patient's stories of nursing art. These themes were: 1) perpetual presence, 2) knowing the other, 3) intimacy in agony, 4) deep detail, and 5) honoring the body.

Watson and Chinn suggest that the art in nursing may be understood as a particular kind of asking (research) and knowing, learning, practice, and reflective experience.[20] They believe that the characteristics of art are apparent in the language of nursing, stories of nursing, nursing education, and nursing research. Chinn and Kramer describe the art of nursing as an embodied synchronous movement with patients.[21] Synchronous means that rhythm and coordination exist between the nurse and patient. They define the aesthetic experience as a transformative art–act, and assert that "the focus for defining the artform that is nursing is the intuitive use of creative resources to form experience." Thus, the art of nursing is a performance art. It happens in the moment and is full of dance-like movement. The quality of movement suggests that the art of nursing is fluid, flexible, and responsive. Newman calls this dancing the rhythm of relating and says that effective communication is unlikely without it.[22]

Art is compelling and out of the ordinary; it uses symbols and has meanings beyond those that are readily apparent. Art, like ritual, is a container for feelings.[23] When nurses are artful, they are able to receive another's feelings and to hold them. "The art of nursing is the capacity of a human being to receive another human being's expression of feelings and to experience those feelings for oneself."[24] Nurses and other health care professionals have appropriated the term *empathy* to mean that special kind of relating that allows them to feel the suffering of another without losing their professional bearings. Patients describing the art of nursing noted that artful

nurses develop a deep connection characterized by empathy and intuition.[25]

Intuition

Art arises out of the imagination, that realm of the mind that relies on intuitive judgment. Intuitive judgment has six aspects[26] that are not sequential, but are used in various combinations.

1. **Pattern recognition:** the ability to see a pattern without analyzing the separate components.
2. **Similarity recognition:** the ability to relate one pattern to another, even if there are significant differences in the objective components.
3. **Common sense understanding:** a deep understanding of culture and language that allows the nurse to understand the experience of the patient and not just the disorder or the disease.
4. **Skilled know-how:** the combination of knowledge, expertise, and experience that allows flexibility in actions and judgment.
5. **A sense of salience:** the ability to discern what is significant in a situation.
6. **Deliberate rationality:** the use of past experience and analysis to generate multiple interpretations of a clinical situation.

Creativity

Both science and art are creative and aesthetic. In truth, the most creative solutions to problems in both science and art are often the most aesthetic ones.[27] Because holistic nursing is both science and art, the holistic nurse is obligated to uncover or recover, support, and celebrate the creative self. Awakening and cultivating the imaginative mind requires uncovering the heart, opening the mind, letting loose the imagination, creating an environment conducive to creativity, working to master a form, and demonstrating the courage to take risks and be vulnerable.[28] Vulnerability is a key to authenticity,[29] which is requisite because the creative process is a manifestation of the spirit. In the creative process, artists touch their innermost selves and the source of their being through the mastery of a physical form.[30] The physical form of nursing is manifested in acts of caring.

Although the capacity for creativity is universal, there appear to be gender differences in the actualization of the creative impulse.[31] Firestone suggested that women tend to define creativity as a response to life—a way of living. In contrast, many studies on creativity that have been done with men emphasize the *products* of creativity, such as exceptional scientific or artistic innovations. It may be that creativity in the art of nursing (an essentially feminine art, whether it is performed by women or men) has something to do with a characteristic way of responding or living in which the nurse expresses creativity through the mastery of acts of caring.

Gramling has suggested that rather than asking, "What is the art of nursing?" a better question would be, "When is the art of nursing?"[32] The cocreative aesthetic process may be considered as one example of *when* nursing is art.

The Cocreative Aesthetic Process[33]

The cocreative aesthetic process may be understood as having four aspects—engagement, mutuality, movement, and new form. These aspects are accurately imagined, not as *parts* of a process but as *facets*, in which each facet is present at all times, but more brilliant when the light of

attention is turned on it. These aspects constitute a process that is neither linear nor sequential. Rather, the process has the qualities of skillful improvisation: creativity, spontaneity, integrity, rhythm, and unpredictability. Furthermore, improvisation is unique to the moment and to the people involved—it cannot be recreated or revised. Good improvisation requires excellent intuitive judgment and mature technical skills. Though the process is not linear, it has a discernible beginning and end. It begins with engagement and ends with the creation of a new form. A brief description of each aspect follows:

1. **Engagement** initiates the relationship of one with another and is possible because the participants value each other and the process.
2. **Mutuality** is characterized by the interpenetration of the experience of one person with another. Empathy is essential to this interpenetration. Caring pervades this aspect and is its ethic. The characteristics of the healing relationship are evident in mutuality and include trust, warmth, confidence, credibility, honesty, expectation, courtesy, and respect.[34]
3. **Movement Within and Movement Through** are the two modes of movement experienced in cocreation. Movement within creates rhythm, and movement through creates pattern. Both the rhythm and the pattern are unique to the relationship and to the moment. Movement within (rhythm) is created by a syncopated going back and forth between the self and other. Movement through (pattern) has the characteristic temporal pattern of all human experience: beginning, middle, and end. As the cocreators move through, they go from unknowing to knowing and from unforming to forming. The pattern also refers to the recursive nature of the experience as the cocreators move through and back into engagement and through again from unknowing to knowing and unforming to forming. Unknowing creates space for the other and for new forms. If one or the other of the cocreators already knows, then there is no space to hear or make something new.
4. **New Forms** are cocreated in a process that may be physical, psycho-social-linguistic, intellectual, or transpersonal. Typically, new forms are recognized with relief, gratitude, and sometimes awe. The forms deepen the experience by being the evidence of it and by allowing a reopening of the cocreative experience through reengagement. The process may be recognized by the cocreators as healing, in the sense of revealing or creating a sense of wholeness.

In the cocreative aesthetic process, aesthetics refers to the wholeness of the experience and to its beauty. Grudin says that "beauty oddly resembles gravity: like gravity beauty is a force whose existence is inferred from its apparent effects. You might even call beauty a kind of spiritual gravity, a natural force of attraction, cohesion . . . beauty is a necessary dimension of wholeness . . ."[35] He goes on to say that the effects of beauty are pleasure and love. The cocreative aesthetic process is a holistic relatedness that produces feelings of pleasure and love and a desire for more such experiences.

Nursing is art when the nurse and the other person(s) cocreate aesthetically the circumstances for healing. The cocreative aesthetic process demonstrates that when nursing is art, the experience is both caring and holistic and directed toward *healing with*. As such the cocreative aesthetic process has therapeutic value for both cocreators. It reinvigorates both and cre-

ates a transforming bond between the cocreators.

Technology

The increase of technology in nursing may at first appear to preclude an artistic approach, but it actually enables the nurse to be more present (and thus more artful) to the patient. "Technology reduces the time spent in 'having to do things' and provides the means to carry out the care with less effort . . . . Technologies can shorten the time spent in completing a task and make procedures less invasive, more comfortable, and more private."[36] In art of any sort, it is important to master the needed technology so that skill development is no longer the focus, but a means to the aesthetic end. When technology is used with beauty, grace, and the intent to "make special," it enhances rather than decreases an act of aesthetic caring.

Ethics

Art as practice has a moral dimension. It reflects the moral consciousness of the artist and informs the moral consciousness of the spectator, observer, or participant.[37] In nursing as art, the patient relies on the integrity of the nurse, and the nurse supports the patient's integrity. The nurse's moral sense lies in his or her awareness of the vulnerability of patients.[38] In other words, the morality demonstrated by the art of holistic nursing has integrity that is derived from an acute sense of responsibility and an awareness of the vulnerability of patients. Because nursing occurs when people are at their most vulnerable, there is no art that has a greater need for moral awareness. The ethic that supports this position is care; it arises out of the moral development of women and is based in the feminine value of the primacy of relationship.[39]

The art of holistic nursing arises from aesthetic knowing, and it is about the "making special" of the relationship between patient and nurse. Grounded in science and in aesthetics, the art of holistic nursing is fluid, cocreative, beautiful, creative, compelling, and moral. Its aim is healing, and it is fundamentally a spiritual process that "manifests in the physical, mental and emotional realms."[40] As Stewart said, "The real essence of nursing, as of any fine art, lies not in the mechanical details of execution, nor yet in the dexterity of the performer, but in the creative imagination, the sensitive spirit and the intelligent understanding lying back of these techniques and skills."[41]

ASPECTS OF THE HUMAN HEALTH EXPERIENCE

Holistic nurses practice their art within the human health experience—the totality of the human condition that contains and reveals the dynamic relationships among health-wellness–disease-illness.[42] Wellness and illness, like health and disease, are often thought of as mutually exclusive and opposite outcomes. In holistic nursing, however, wellness–illness and health–disease are neither mutually exclusive, nor polar opposites, but are part of a process and part of the whole. Events of wellness-illness–health-disease within the human health experience unfold in a dynamic, dialectic relationship that makes it easier to understand that the individual is a changing person in a changing world.

All aspects of the human health experience have both cognitive and affective dimensions.[43] Cognitive dimensions of health–disease can be seen as comprehensible/incomprehensible, manageable/ unmanageable, and meaningful/meaningless. Affective themes that appear are joy /despair, acceptance/resentment, power/ fear, and anticipation/confusion.

In the practice of artful nursing, the nurse acknowledges the meaning of the health experience for patients.[44] Therefore, developing a more artful practice requires exploration of the dynamics of health-wellness–disease-illness to gain a deeper understanding of the patterns, meanings, and patient responses. Through greater understanding of the range of meanings in general, and the meaning for individual patients in particular, nurses can facilitate the healing process.

Caring

Newman and her colleagues identified that the proper focus of nursing is caring in the human health experience.[45] She describes caring in the human health experience as unitary, whole, and transformative. She further asserts that neither caring nor human health experience alone can describe the focus of nursing. Many disciplines claim caring, but only nursing has both caring and health as its mission. Further, Newman states that nurses who practice without caring are not really practicing nursing.

Culture

Culture is "a pattern of learned behavior and values reinforced through social interactions, shared by members of a particular group and transmitted from one generation to the next."[46] Cultural beliefs deeply influence the perceived meaning of health and illness for patients and family members, and a nurse's understanding of the cultural context of the human health experience can facilitate the development of the transcendent togetherness. The development of empathy, the artful use of intuitive judgment and creativity, truth telling, competent care, and the facilitation of the expression of the patient's true self are more likely to occur when the nurse understands the cultural context of the patient's health experience. Furthermore, care that has integrity is culturally congruent. Therefore, nurses must be sensitive to cultural factors to ensure that patients receive care within the context of their cultural backgrounds, health beliefs, and values.

Cultural competence implies that the nurse "understands and attends to the total context of the patient's situation."[47] Care is culturally appropriate when it applies all of the necessary underlying background knowledge about the culture. Being culturally sensitive implies that nurses possess at least basic knowledge of and "constructive attitudes toward the health traditions observed among diverse cultural groups found in the settings in which they are practicing."[48]

One way of gaining insight into a client's dominant cultural values is to answer the following five questions regarding the culture under consideration:

1. What is the inherent nature of humans? Are they good, evil, or a combination?
2. What is the relationship of humans to nature? Does nature dominate humans, do humans dominate nature, or do humans co-exist in harmony with nature?
3. What is the temporal focus of human experience? Is the perception of time predominantly focused on the past, present, or future?
4. What is the human mode of activity? Is human potential found in being (spontaneity is valued), growing (personal control and self-actualization are valued), or in doing (action is valued)?
5. What is the pattern of human relationships? Are significant relationships linear and hereditary, collateral and group-oriented, or individual-oriented with an emphasis on independence and autonomy?[49]

Nurses can gain cultural competency by reading and studying the literature of, or about, the culture under consideration.[50]

Reading this literature provides a window through which a nurse can participate through his or her imagination in the dramas, joys, values, and experiences unique to the culture. In addition, nurses who become familiar with studies on healing beliefs and practices of other cultures can base culturally congruent care on an assessment of the client's health–illness beliefs, attitudes, and values; the beliefs about causative agents of symptoms and illness; the way in which healers within the culture diagnose the symptoms or illness; and the treatments recommended by the healers. Knowledge of general response patterns for specific cultural and ethnic groups is essential in order to provide a foundation for further assessment and individualized care (see Chapter 13, Table 13–1).[51] This information serves as a guideline for individualized care. *It should never be used as the basis for ethnocentric or stereotypic responses by health care providers.* The art of nursing depends on recognizing the uniqueness of each person and developing a unique relationship with the client.

Values Clarification and the Human Health Experience

The pioneering work of Raths and colleagues regarding values is widely used in health care settings. This work explores the complexity and differences in values, attitudes, and beliefs.[52] *Values* are affective dispositions about the worth, truth, or beauty of a thought, object, person, or behavior. Values influence decisions, behavior, and nursing practice. *Attitudes* and beliefs are closely related to values. Attitudes are feelings toward a person, object, or idea that include cognitive, affective, and behavioral elements. *Beliefs* are a subclass of attitudes. The cognitive factors involved in beliefs have less to do with facts and more to do with feelings; they represent a personal confidence, or faith, in the validity of some person, object, or idea.

Values are more dynamic than attitudes because, in addition to the cognitive, affective, and behavioral elements, they possess motivational characteristics. They provide direction and meaning to life and guide behavior. They provide both a personal and a professional frame of reference by which to integrate, explain, and evaluate new thoughts, experiences, and relationships. Values are transmitted by moralizing, modeling, adopting a laissez-faire attitude, explaining, manipulating, and using a reward/punishment approach.

Personal values are not always consistent with professional values. A direct conflict between a strong personal value and a professional value may lead to confusion, frustration, and dissatisfaction. Sometimes, the stories of nursing—a valuable source of understanding about the art of nursing—reveal confusion, doubt, and ambiguities regarding values.[53] A nurse has the right not to participate in any activity or experience that violates personal values. Usually, when confronted with a situation that requires action, individuals have a variety of alternatives. When choosing among alternative actions, it is important to focus on values in order to choose the best alternative. Nurses need to clarify their own values in order to help others make value-congruent choices.

Values clarification is a dynamic process that emphasizes an individual's capacity for intelligent, self-directed behavior. By taking the time to deliberate about values, individuals find their own answers to a variety of questions or concerns. There is no "correct" set of values, because no one set of values is appropriate for everyone. Rather, the process of values clarification establishes a closer fit between what a person *does* and what that person *says*.

The process of values clarification has three steps: choosing, prizing, and acting.[54] In the first step, the person chooses the value freely and willingly, although only after evaluating each alternative and

its consequences. The second step is to prize and cherish the decision and to affirm or communicate the choice publicly. The last step in the process is to incorporate the choice into behavior. These steps translate a value into a consistent, repeated behavioral change that confirms the adoption of the particular value. A true value passes through all steps, but not necessarily in the order discussed. Value indicators are beliefs that do not meet all the criteria of true values and tend to be more numerous than actual values. If the individual is motivated to undergo the values clarification process, a value indicator may become a true value.

Within the human health experience, people make choices that have significant effects on the relationships of health-wellness–disease-illness. Some choices are oriented toward changing behaviors in order to have healthier and longer lives. However, patients sometimes exhibit behaviors that demonstrate unclear values, such as ignoring professional advice regarding health choices, inconsistent communication or behavior, numerous admissions to health care agencies for the same health problem, and confusion about which course of action to take.[55]

The following is an example of a nurse helping a patient to clarify his values.

> Mr. B.Z. is a 49-year-old man who was admitted to the coronary care unit with a diagnosis of acute myocardial infarction. He was executive vice president of a large company. Following admission, his condition was stable, and no major complications developed. On the second day of his hospital stay, he was found lying in the hospital bed with his briefcase open, surrounded by papers. He was writing a report and requested a telephone in his room. The nurse handled the situation as follows:
>
> **Nurse:** It sure looks like you have a lot of work.
>
> **Patient:** Yes, I have so many deadlines this week, I cannot believe it. I really do not have time to be here. I sure hope my wife brings my fax machine soon.
>
> **Nurse:** It seems that your work is very important to you. I certainly can understand deadline problems. Could we take just a minute to discuss some other things that are important to you right now?
>
> **Patient:** Sure. Getting better and getting out of here are important to me, and having the energy to deal with the demands of my job. This better not happen to me again.
>
> **Nurse:** Tell me what you know about preventing another heart attack.
>
> **Patient:** Well, I know I am going to have to lose some weight and get some regular exercise. I'm not sure how I will fit that into my schedule, though.
>
> **Nurse:** Do you think that the heavy demands of work had anything to do with this illness?
>
> **Patient:** Well, I know a lot of stress can make people sick. I've got to admit that I have had a stressful couple of months at work. Yes, I suppose all of that didn't help.
>
> **Nurse:** You've told me that your work is important to you. You've also told me that preventing another heart attack is important. You have said that it will be important to lose weight, exercise, and perhaps reduce some of your daily stress. If you could begin to work on one of these areas, which area would you choose?
>
> **Patient:** I guess learning to deal with stress.
>
> **Nurse:** That is a great place to start. Many techniques can be used to reduce stress levels. They can have a profound impact on your mind, as well as a positive effect on your body. If you are willing, I'd like to take a few minutes now and guide

you in a relaxation technique that can be of help to you right now and later after your discharge. Would you be willing to try this with me?

Patient: Sounds good. I'm willing to try. I suppose I should have thought about this stuff a long time ago.

Health Behaviors and the Human Health Experience

People usually adopt preventive behaviors when they are asymptomatic, but wish to enhance their lifestyles. Changing may or may not be independent of the health care system. Illness behaviors often accompany symptoms and involve the health care system for evaluation and any necessary treatment. People who do not adhere to recommended health behaviors are often labeled *noncompliant*. *Noncompliance* is a term that implies patient failure in meeting professional expectations and is inconsistent with holistic nursing philosophy and ethics. Terms such as *engagement* and *lack of engagement* in recommended health behaviors are less paternalistic and judgmental.[56]

The Health Belief Model

Three factors that significantly influence a patient's motivation to change are his or her health attitudes, beliefs, and social support. The health belief model identifies the specific attitudes and beliefs that influence people to choose preventive health care and to engage in recommended medical regimens. According to this model, the motivation to change behavior comes from the perception that the reward is greater than the perceived cost and the perceived barriers. The major factors in determining engagement include

- the health and willingness of the patient to accept medical recommendations.
- the patient's subjective estimate of his or her susceptibility, vulnerability, and extent of bodily harm.
- the extent to which engagement interferes with the patient's social roles.
- the patient's perception of the efficacy and safety of the proposed regimen.[57]

Criticisms of this model are that it focuses primarily on cognition and does not explicitly integrate affect. This model also places the burden of action entirely on the patient and does not address the larger issues impinging on patients, such as the range of choices available as a result of organizational and governmental policy and funding.[58] These criticisms suggest that this model is somewhat incongruent with the philosophical and ethical foundations of holistic nursing. The model emphasizes the personal context of decision making, however, and understanding personal context is essential to the practice of artful nursing. Furthermore, because the model is widely used in health care as the basis for research studies on patient motivation,[59] it may serve as a starting point for understanding patient choices. An especially positive aspect of the model is that it highlights the differences between professional and lay beliefs and expectations and provides the basis for forging a link between the two.[60]

The Health Belief Model focuses on the perceptions of the patient rather than those of the provider. It does not predict or screen persons who are at risk for nonengagement. It is possible, however, to identify four categories that describe individuals according to the relationship of health beliefs, attitudes, and social support to facilitate engagement. Categorization of patient characteristics is inconsistent with the art of nursing, because that art demands unique responses within a unique relationship. Even so, if used judiciously as a starting place for understanding and potential intervention and not as a model for labeling or otherwise objectifying people, categorization can be a helpful

cognitive device. The four engagement categories are:

1. Positive health beliefs and attitudes, as well as adequate social support
2. Negative health beliefs and attitudes, but adequate social support
3. Positive health beliefs and attitudes, but little or inadequate social support
4. Negative health beliefs and attitudes, and little or inadequate social support[61]

Exploring with the patient his or her values regarding the following facilitates the use of this cognitive device:

- general beliefs regarding health
- willingness to seek health care advice
- willingness to accept health care advice
- perception of the seriousness of the high-risk behavior and its consequences
- perception of susceptibility and vulnerability to the consequences of the behavior
- perception of the risks, benefits, and degree of interference that the new behavior will have on current roles[62]

The category that best describes the patient's attitudes and circumstances determines the choice of strategies to facilitate engagement. When they become ill, individuals described by Category 1 believe that their illnesses are serious and that their therapy will be helpful. Nurses will be more effective with these individuals if their teaching efforts facilitate affective, cognitive, and psychomotor learning. Matching the information presented to the patient's coping style and locus of control demonstrates caring. To accommodate different coping styles, those persons who use denial receive basic survival information, whereas those who cope by focusing on the problem receive detailed information. Those persons who are internally controlled (i.e., who believe that what they do will affect the outcome of the illness) receive specific instructions on ways to manage or control the situation. Those who are externally controlled (i.e., who believe that others or fate will determine the outcome of the illness) will benefit if an authority figure presents the information to them. For individuals with an external locus of control, a caring response is to discuss the most important points first and then repeat them.

In caring for individuals described by Category 2 (i.e., those who have negative health beliefs and attitudes, but adequate social support), focusing on consciousness-raising techniques can be effective. If the patient desires, the nurse can arrange or facilitate the patient's efforts to arrange self-help group meetings. In this way, the patient can talk with other individuals who have similar problems and concerns. They can share effective strategies and perhaps resources. The social support network of the patient can strengthen and facilitate healthy patient choices. Values clarification is useful in exploring alternatives for healthy behaviors. Behavior modification techniques are also helpful with people who demonstrate the characteristics of this category. If the patient desires, cues can be recommended that stimulate healthy behavior. Small rewards can be suggested to support healthy behaviors of the patient's choice. The rewards should follow the behaviors and should be as small as possible, yet still be rewarding (e.g., taking 30 minutes off to read a good book following the daily exercise program). Before attempting the behavior change, patients may find that keeping a diary for several days to identify the cues and consequences of a particular behavior is helpful in identifying a list of rewards.

Increased social support and cognitive strengthening are likely to benefit individuals described by Category 3. Providing family and friends with important information, and encouraging their involve-

ment with recommended therapy, discussion, or values clarification sessions, increase and strengthen social support. Patient involvement with community agencies and self-help groups may also be appropriate. Cognitive strengthening through training in assertiveness, relaxation, imagery, problem solving, and goal setting may enhance coping skills.

A "foot-in-the-door" strategy that requires minimal behavioral change may be effective with patients described by Category 4. Even small changes can produce positive outcomes. Mutually establishing basic goals and simple ways to meet these goals will support patient choices and self-esteem. As with any behavior change, rewards and reinforcement may be effective. Breaking down complex behaviors into more easily accomplished steps will facilitate mastery and, thus, self-esteem. Written rather than verbal contracts may serve to remind patients of the nurse's support, concern, and of a mutual commitment.

Stages of Change in Addictive Behavior Patterns

Nurses frequently come into contact with patients because of the health or social consequences of addictive behaviors. New studies into the genetics of addiction reveal that one possible explanation for substance abuse may lie in dopamine and serotonin dysfunctions.[63] However, not all people who carry a genetic predisposition will exhibit addictive behaviors if their lifestyle choices minimize the risk of genetic endowment. Once the addiction is present, however, complex approaches involving both pharmacological and behavioral interventions may be needed to change behavior. Whether nurses are designing programs for population groups or cocreating individual care plans with patients, it is helpful to realize that the modification of addictive behavior is complex and involves a progression through five stages of change: (1) precontemplation, (2) contemplation, (3) preparation, (4) action, and (5) maintenance.[64]

In the *precontemplation stage*, individuals have no intention of changing behavior in the near future. They are usually unaware of their problems, although their family, friends, employers, and neighbors are very aware of the problems. If people in this stage agree to therapy, it is usually under pressure from others. Most often, they feel coerced into changing and will demonstrate change only as long as the pressure continues.

At the *contemplation stage*, an individual is aware of the problem and is thinking seriously about overcoming it, but has not yet made a commitment to take action. Serious consideration of the problem solution is the central feature of contemplation. The individual knows what action to take, but weighs the pros and cons of the problem and its solution. The struggle to cope with the effort, energy, and perceived loss required to overcome the addiction can last two years or longer.

The *preparation stage* combines both intention and behavioral criteria. In this stage, individuals who have unsuccessfully taken action within the past year plan to take action again within the next month. Although previous action may have reduced the addictive behavior somewhat, the criterion for effective action has not been reached.

During the *action stage*, individuals modify their behaviors, experiences, or environment in order to overcome their addictions. The hallmarks of this stage are significant overt efforts and modification of target behaviors to an acceptable criterion. In this stage, individuals receive the most external recognition from others. An enormous amount of time, energy, and commitment are required in this stage. Individuals are in the action stage if they have successfully altered the addictive behaviors for a period of one day to six months.

The *maintenance stage*, in which individuals work to prevent relapse, represents a continuation of change rather than a stop and start of addictive behaviors. The criterion for this stage is that healthy behaviors replace addictive behaviors for longer than six months. In reality, this stage extends from six months to an indeterminate period past the initial action.

Each stage of change represents a period of time, as well as a set of tasks needed for movement to the next stage. Regardless of whether individuals try to change on their own or seek professional help in changing, they typically move through these stages several times before termination of the addiction. Figure 3–1 illustrates the spiral pattern in which most people actually move through the stages of change. Individuals may progress from contemplation to preparation to action to maintenance, but most will relapse. The spiral model suggests that most people who relapse do not revolve endlessly in circles, nor do they regress all the way back to where they began. Rather, they learn from their mistakes and try different behaviors the next time. The number of successes continues to increase over time; thus, the more action taken, the better the prognosis for success.[65]

To assist individuals with changes in addictive behaviors, the nurse first helps them to identify clearly their stage of change. Each stage suggests treatment choices. For example, action-oriented therapies may be effective with individuals in the preparation or action stages, but very ineffective, or even detrimental, to those in the precontemplation or contemplation stages. The stages of change represent a temporal dimension that guides nurses in understanding when particular shifts in attitudes, intentions, and behaviors occur. Professionals who counsel individuals with addictions use a transtheoretical approach: They examine recommended change techniques across different theories and then integrate them.[66] Exhibit 3–1 presents ten processes with definitions and examples of interventions for each process. These processes are potent predictors of

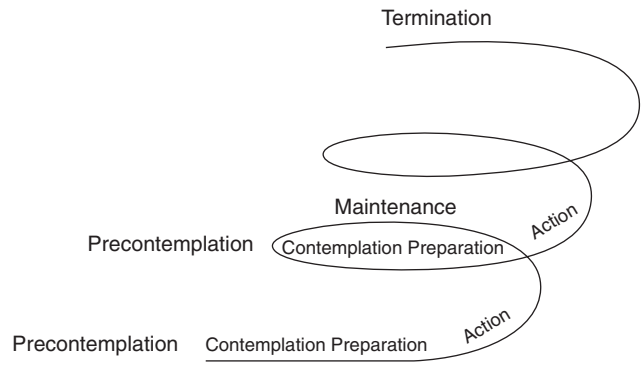


Figure 3–1 A Spiral Model of the Stages of Change. *Source:* Reprinted from Prochaska, J., et al., In Search of How People Change, *American Psychologist*, Vol. 47, No. 9, pp. 1102–1114. Copyright © 1992 by the American Psychological Association. Reprinted with permission.

Exhibit 3–1 Titles, Definitions, and Representative Interventions of the Processes of Change

Process	*Definitions: Interventions*
Consciousness raising	Increasing information about self and problem: observations, confrontations, interpretations, bibliotherapy
Self-reevaluation	Assessing how one feels and thinks about oneself with respect to a problem: value clarification, imagery, corrective emotional experience
Self-liberation	Choosing and making a commitment to act or belief in ability to change: decision-making therapy, New Year's resolutions, logotherapy techniques, commitment-enhancing techniques
Counterconditioning	Substituting alternatives for problem behaviors: relaxation, desensitization, assertion, positive self-statements
Stimulus control	Avoiding or countering stimuli that elicit problem behaviors: restructuring one's environment (e.g., removing alcohol or fattening foods), avoiding high-risk cues, fading techniques
Reinforcement management	Rewarding one's self or being rewarded by others for making changes: contingency contracts, overt and covert reinforcement, self-reward
Helping relationships	Being open and trusting about problems with someone who cares: therapeutic alliance, social support, self-help groups
Dramatic relief	Experiencing and expressing feelings about one's problems and solutions: psychodrama, grieving losses, role playing
Environmental reevaluation	Assessing how one's problem affects physical environment: empathy training, documentaries
Social liberation	Increasing alternatives for nonproblem behaviors available in society: advocating for rights of repressed, empowering, policy interventions

Source: Reprinted from Prochaska, J., et al., In Search of How People Change, *American Psychologist*, Vol. 47, No. 9, 1102–1114. Copyright © 1992 by the American Psychological Association. Reprinted with permission.

change both for patients who make changes on their own and for patients who change with professional therapy.

One of the most important findings to emerge from the self-change in addictive behaviors research of Prochaska and colleagues is the integration between the processes and stages of change.[67] Exhibit 3–2 represents this integration from cross-sectional research involving thousands of people who changed on their own at each of the stages of change for smoking cessation and weight loss.[68–73] This research indicates that people in the precontemplation stage process less information about the problem, devote less time and energy to it, and experience fewer negative reactions to it. People in the contemplation stage are more receptive to consciousness-raising techniques, such as confrontation, observation, and interpretation. As people in the precontemplation stage become more aware of the problem, they evaluate the effect of their behaviors on the people to whom they are the closest. Thus, moving from the precontemplation

Exhibit 3–2 Stages of Change in Which Particular Processes of Change Are Emphasized

Precontemplation	*Contemplation*	*Preparation*	*Action*	*Maintenance*
Consciousness raising Dramatic relief Environmental reevaluation				
	Self-reevaluation			
		Self-liberation		
			Reinforcement management Helping relationships Counterconditioning Stimulus control	

Source: Reprinted from Prochaska, J., et al., In Search of How People Change, *American Psychologist*, Vol. 47, No. 9, 1102–1114. Copyright © 1992 by the American Psychological Association. Reprinted with permission.

stage to the contemplation stage increases the use of cognitive, affective, and evaluative processes of change. The research also shows that, during the action stage, people begin to believe that they have the autonomy to change their lives. Like the maintenance stage, the action stage involves high degrees of preparation. In these stages, patients consider what leads to relapse, how to avoid relapse, and what alternative responses are available for effective coping. The important key here for change is the individual's conviction that to maintain change means to operate from a sense of self-value.

The underlying structure for change of addictive behaviors is neither technique-oriented nor problem-specific. It is a performance art that demands a perfect match between process and stage. In other words, efficient self-change or therapy change depends on doing the right things (processes) at the right time (stages). In artful caring practice, the nurse and patient work together to cocreate the circumstances that will facilitate successful change.

The Workplace and the Human Health Experience

At times, nurses encounter people who are seeking changes in their health experience in the context of their work environment. Many workplace wellness programs are now being developed throughout the United States because of the escalating health care costs for employees, cumulative research findings that document the rising health care costs associated with unhealthy employee behaviors, and employer support of these programs. Generally, workplace wellness programs focus on stress management, nutritional education, weight control, exercise/physical fitness, smoking cessation, management of hypertension, alcohol and drug control, accident prevention, and early cancer detection.

Violence in the workplace has become a significant issue. The National Institutes for Safety and Occupational Health estimates that each year in the United States two million workers experience actual violence, and another six million are threatened with harm.[74] Therefore, workplace wellness programs may also address the issue of workplace aggression and the syndrome of traumatic stress.[75]

Because of their education and holistic focus, nurses are in an ideal position to develop wellness programs within businesses and all areas of the community.[76] Ideally, nurses should have leadership skills and a knowledge of current health care practices, existing workplace wellness programs, marketing, and health care reimbursement. Community health nursing theory can provide specific guidance for nurses seeking to develop community wellness programs.

Effective wellness programs help individuals identify their motivation for change; that is, the spark or desire to improve their present situation. Imagination is a prerequisite of motivation, for it is necessary to answer the question, What do I really want? Discipline and determination also must be engaged. Some of the circumstances that may block motivated behavior are:

- self-doubts and fears of unknown consequences that can override a person's desire to learn new health behaviors.
- belief that prior commitments or high-priority projects leave little time for learning or implementing new behaviors.
- perception that the new behaviors are distasteful.
- previous failures in changing behavior.
- lack of confidence in the ability to implement new strategies.
- cultural beliefs that discourage the new behavior.
- lack of support from family, co-workers, or other groups.[77]

Whether in the workplace, the hospital, or other health care environment, the wise nurse recognizes that some people do not perceive the degree to which culture conditions their beliefs, attitudes, and values. Though wellness may be desired, people sometimes feel helpless under the burden of their role responsibilities and have a pervasive sense that they can do nothing to resolve existing problems. Artful caring helps people clarify their values and beliefs, identify obstacles to change, and rename these obstacles as challenges. Naturally, nurses will be more effective in motivating patients if they model wellness themselves. More than ever, nurses are placing an emphasis on wellness in their own lives. They are teaching self-care, self-responsibility, and choices that lead toward health, and are becoming powerful role models for the message of health that they bring.

CONCLUSION

Nursing is an art as well as a science. The artistry of nursing is embodied in the nurse's gift of self in a cocreative relationship with the patient. The intent of artistic nursing is healing, which is an essentially spiritual process. Understanding the human health experience as a complex and dynamic dialectic relationship of health-wellness–disease-illness can facilitate the finding of meaning in the experience and, thus, the process of healing. Caring in the human health experience is the focus of the discipline. Understanding the role of perceptions, values, beliefs, attitudes, the stages of change in addictive behavior patterns, and blocks to motivation helps to

explain the complexities that people confront when making health choices.

DIRECTIONS FOR FUTURE RESEARCH

1. Clarify when nursing is art.
2. Determine whether nurses who understand the health-wellness–disease-illness dialectic relationship, and who use this understanding with patients, use holistic therapies more often than nurses who do not understand or use this model of the human health experience.
3. Evaluate the influence of culture in selecting choices for health interventions.
4. Evaluate to what degree matching nursing interventions to the patient's stage of change enhances patient outcomes.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- When am I artful in my nursing practice?
- How do my values influence my practice?
- How would I describe my experience of health–wellness? Of disease–illness?
- What motivates me to change?
- What is my self-image?
- What is my current quality of life?

NOTES

1. R. Barnhart, ed., *The Barnhart Concise Dictionary of Etymology* (New York: HarperCollins Publishers, 1995).
2. L. Jensen and M. Allen, Wellness: The Dialect of Illness, *Image* 25, no. 3 (1993): 220–224.
3. Ibid.
4. S. Leddy and J.M. Pepper, *Conceptual Bases of Professional Nursing Practice*, 3rd ed. (Philadelphia: J.B. Lippincott, 1995).
5. Ibid.
6. Jensen and Allen, Wellness: The Dialect of Illness.
7. J. Watson, Introduction: Art and Aesthetics as Passage between the Centuries, in *Art and Aesthetics in Nursing*, eds. J. Watson and P. Chinn (New York: National League for Nursing, 1994), xv.
8. B. Carper, Fundamental Patterns of Knowing in Nursing, Advances *in Nursing Science*, 1 (1978):13–28.
9. K. Gramling, When is Nursing Art? in *The HeART of Nursing: Expressions of the Creative Art in Nursing*, ed. C. Wendler (Indianapolis: Sigma Theta Tau, 2002).
10. C. Appleton, The Gift of Self: A Paradigm for Originating Art in Nursing, in *Art and Aesthetics in Nursing,* eds. J. Watson and P. Chinn (New York: National League for Nursing, 1994), 91–116.
11. Carper, Fundamental Patterns of Knowing in Nursing.
12. Watson, *Post Modern Nursing and Beyond* (London: Harcourt Brace, 1999).
13. Ibid.
14. Ibid.
15. Gramling, When is Nursing Art?
16. E. Dissanayake, *Homo Aestheticus: Where Art Comes From and Why* (Seattle: University of Washington Press, 1992).
17. R. Grudin, *The Grace of Great Things* (New York: Tichnor & Fields, 1990).
18. Dissanayake, *Homo Aestheticus: Where Art Comes From and Why*.
19. Gramling, When is Nursing Art?
20. J. Watson and P. Chinn, eds., *Art and Aesthetics in Nursing* (New York: National League for Nursing, 1994).
21. P. Chinn and M.K. Kramer, *Theory and Nursing: Integrated Knowledge Development*, 5th ed. (St. Louis: Mosby, 1999).
22. M.A. Newman, Caring in the Human Health Experience, *International Journal of Human Caring* 6, no. 2 (2002):8–11.
23. Dissanayake, *Homo Aestheticus: Where Art Comes From and Why*.

24. Watson, Introduction: Art and Aesthetics as Passage between the Centuries.
25. Appleton, The Gift of Self.
26. P. Benner and C. Tanner, Clinical Judgement: How Expert Nurses Use Intuition, *American Journal of Nursing* 87 (1987):23–31.
27. F. Barron et al., *Creators on Creating* (New York: Tarcher/Putnam, 1997).
28. Ibid.
29. L.E. Daniel, Vulnerability as a Key to Authenticity, *Image* 30, no. 2 (1998):191–192.
30. B. Willis, *The Tao of Art* (London: Century Paperbacks, 1987).
31. L.A. Firestone, *Awakening Minerva: The Power of Creativity in Women's Lives* (New York: Time Warner, 1997).
32. Gramling, When is Nursing Art?
33. H.L. Gaydos, Illuminated Lives: Cocreated Portraits of Contemporary Women Healers. Doctoral Dissertation, The Union Institute, Cincinnati, OH, 1999.
34. L. Dossey, Samueli Conference on Definitions and Standards in Healing Research: Working Definitions and Terms, *Alternative Therapies* 9, no.3 (2003):A10–A13.
35. Grudin, *The Grace of Great Things*, 57–58.
36. A. Bernado, Technology and True Presence in Nursing, *Journal of Holistic Nursing Practice* 12, no. 4 (1998):42.
37. K. Maeve, Coming to Moral Consciousness through the Art of Nursing Narratives, in *Art and Aesthetics in Nursing*, eds. J. Watson and P. Chinn (New York: National League for Nursing, 1994), 67–90.
38. S. Gadow, Existential Advocacy: Philosophical Foundation of Nursing, in *Nursing Images and Ideals*, eds. S. Spicker and S. Gadow (New York: Springer, 1980), 79–101.
39. K. K. Blais, J.S. Hayes, B. Kozier, and G. Erb, *Professional Nursing Practice*, 4th ed. (New Jersey, Prentice-Hall, 2002).
40. M.A. Burkhardt, Reflections: Awakening Spirit and Purpose, *Journal of Holistic Nursing* 16, no. 2 (1998):165.
41. P. Donahue, *Nursing: The Finest Art* (St. Louis, MO: Mosby, 1985), 467.
42. Jensen and Allen, Wellness: The Dialect of Illness.
43. Ibid.
44. Appleton, The Gift of Self.
45. Newman, Caring in the Human Health Experience.
46. K.K. Chitty, *Professional Nursing Concepts: Concepts and Challenges*, 3rd ed. (Philadelphia: W.B. Saunders, 2001).
47. R.E. Spector, *Cultural Diversity in Health and Illness*, 6th ed. (New Jersey: Prentice-Hall, 2004).
48. Spector, *Cultural Diversity in Health and Illness*, 8.
49. M.M. Andrews, Cultural Diversity and Community Health Nursing, in *Community Health Nursing: Promoting the Health of Aggregates*, eds. J.M. Swanson and M. Albrecht (Philadelphia: W.B. Saunders, 1993), 371–403.
50. G.M. Bartol and L. Richardson, Using Literature to Create Cultural Competency, *Image* 30, no. 1 (1998):75–78.
51. K. Shadick, A Practice Model for Promoting Cultural Diversity (Paper presented at the American Nephrology Nurses Association Annual Conference, Dallas, TX, 1994).
52. L. Raths et al., *Values and Teaching: Working with Values in the Classroom* (Columbus, OH: Charles E. Merrill, 1978).
53. Maeve, Coming to Moral Consciousness through the Art of Nursing Narratives.
54. Raths et al., *Values and Teaching: Working with Values in the Classroom*.
55. K.K. Blais, J.S. Hayes, B. Kozier, and G. Erb, *Professional Nursing Practice*, 4th ed. (New Jersey: Prentice-Hall, 2002).
56. D. Lauver, A Theory of Care-Seeking Behavior, *Image* 24, no. 4 (1992):281–287.
57. I. Rosenstock, The Health Belief Model: Explaining Health Behavior through Expectancies, in *Health Behavior and Health Education*, eds. K. Glanz and B. Rimer (San Francisco: Jossey-Bass Publishers, 1990), 39–62.
58. Lauver, A Theory of Care-Seeking Behavior.
59. J. Mirotznik et al., Using the Health Belief Model To Explain Clinic Appointment-Keeping for the Management of a Chronic Disease Condition, *Journal Of Community Health* 23, no. 9 (1992):1102–1114.
60. Spector, *Cultural Diversity in Health and Illness*.
61. I. Rosenstock, The Health Belief Model: Explaining Health Behavior through Expectancies, in *Health Behavior and Health Education*, eds. K. Glanz and B. Rimer (San Francisco: Jossey-Bass Publishers, 1990), 39–62.

62. J. Prochaska et al., In Search of How People Change, *American Psychologist* 47, no. 9 (1992):1102–1114.

63. D. Antai-Otong, *Psychiatric Nursing: Biological and Behavioral Concepts* (New York: Delmar, 2003).

64. Prochaska et al., In Search of How People Change.

65. Ibid.

66. Ibid.

67. Ibid.

68. R. Kaplan and H. Simon, Compliance in Medical Care: Reconsideration of Self-Prediction, *Annals of Behavioral Medicine* 12 (1990):66–71.

69. L. Beutler and J. Clarkin, *Systematic Treatment Selection* (New York: Brunner/Mazel, 1990).

70. C. DiClemente, Motivational Interviewing and the Stages of Change, in *Motivational Interviewing: Preparing People for Change*, eds. E. Miller and S. Rollnick (New York: Guilford Press, 1991), 191–202.

71. C. DiClemente and S. Hughes, Stages of Change Profiles in Alcoholism Treatment, *Journal of Substance Abuse* 2 (1990):217–235.

72. C. DiClemente et al., The Process of Smoking Cessation: An Analysis of Precontemplation, Contemplation, and Preparation Stages of Change, *Journal of Consulting and Clinical Psychology* 59 (1991):295–304.

73. T. Glynn et al., Essential Elements of Self-Help/Minimal Intervention Strategies for Smoking Cessation, *Health Education Quarterly* 17 (1990):329–345.

74. B. Cherry and S. Jacob, *Contemporary Nursing: Issues, Trends, and Management*, 2nd ed. (St. Louis: Mosby, 2002).

75. J. Dish, Creating Healthy Work Environments for Nursing Practice, in *The Nursing Profession: Tomorrow and Beyond,* ed. N. Chaska (Thousand Oaks, CA: Sage, 2001).

76. J. Dunham-Taylor, Nurses Cut Health Care Costs, *Journal of Holistic Nursing* 11, no. 4 (1993):398–411.

77. J. Achterberg et al., *Rituals of Healing* (New York: Bantam Books, 1994).

Active Listening

To achieve good listening, it is necessary to quiet the inner dialogue. Good listening has an enormous quality of nowness, *the ability to set aside intellectualizations when a client goes off in an unexpected direction. Sometimes, because of a personal inner dialogue of analysis and intellectualization, a nurse will stop the flow of a client's story and bring the client back to a certain point, which then may block the client's insight. As nurses increase the process of nowness, clients also will move to a state of nowness that allows a place of inner wisdom to emerge. Questioning and listening that structures a client's answers only minimally is a great art.*

Any communication process has three components. They are (1) a sender of the message, (2) a receiver of the message, and (3) the content of the material. In order to understand others, it is essential to listen actively. Being quiet while someone else is talking is not equivalent to real listening. The key to real listening is intention, which occurs when we focus with someone in order to move with purpose in our responses and interventions. This can lead others, and ourselves, toward effective actions or forward in personal growth. Real listening occurs when we have the intention to learn something, or want to understand, enjoy, or help someone.

At times we all lapse into pseudolistening when we try to meet the needs of others. Some signs of pseudolistening are

- *silence to buy time preparing your next remark*
- *listening to others so that they will listen to you*
- *listening only to specific information while ignoring the rest*
- *acting interested when you are not*
- *partially listening because you do not want to disappoint the other person*
- *listening in order not to be rejected*
- *searching for a person's weaknesses in order to take advantage of them*
- *identifying weak points in dialogue so that you can be stronger in your response*

We must continue to learn how to be with others. Active listening skills promote effective communication in several ways: They clarify the message. The receiver of the message can verify nonverbal messages communicated through body language or by silence. The receiver is also able to gather additional information that can help with interventions. Active listening facilitates a greater acceptance of the sender's thoughts and emotions. Thus, the receiver of the message may be in a better situation to choose the most effective behaviors that lead toward health and wholeness.

Chapter 4

Nursing Theory in Holistic Nursing Practice

Noreen Cavan Frisch

NURSE HEALER OBJECTIVES

Theoretical

- Describe the elements of holistic nursing and explain why the use of theory is one of the elements.
- Compare and contrast the following nursing theories: Nightingale's Theory of Environmental Adaptation Model; the Roy Adaptation Model; the Modeling and Role-Modeling Theory, Watson's Theory of Transpersonal Caring; Rogers' Theory of Unitary Human Beings; Newman's Theory of Expanding Consciousness; and Parse's Theory of Human Becoming.

Clinical

- Apply the nursing theories discussed in the clinical setting.
- Determine how the perspective of each theory influences the nursing care and the evaluation of that care.

Personal

- Select a nursing theory(ies) that provides a framework and philosophy consistent with your own view.
- Use the theory(ies) and evaluate its effect on your personal world view.

DEFINITIONS

Concept: an abstract idea or notion.
Conceptual Model: a group of interrelated concepts described to suggest relationships among them.
Framework: a basic structure; the context in which theory is developed; the structure that permits theory to be understood.
Metaparadigm: concepts that identify the domain of a discipline.
Model: a representation of interactions between and among concepts.
Nursing Theory: a framework; a set of interrelated concepts that are testable; a way of seeing the factors that contribute to nursing practice and nursing thought.
World View: a perspective; a way of viewing, perceiving, and interpreting one's experience.

THEORY AND RESEARCH

By definition and by history, nursing is a holistic practice. Nursing's work is concerned with the restoration and promotion of health, the prevention of disease, and the supports necessary to help the client gain a subjective sense of peace and harmony. As a profession, nursing has never focused solely on the physical body or the disease entity. Rather, taking into account the holistic nature of all persons, nursing is concerned with the client's experience

of the condition. In addition, nurses attend to the environmental influences that promote recovery as well as the social and spiritual supports that promote a sense of well-being for clients. Nurses have found that nursing theories help to articulate the nature of nursing practice and guide nursing interventions to meet client needs.

Nursing Theory Defined

A nursing theory is a framework from which professional nurses can think about their work. Theory is a means of interpreting one's observations of the world, and is an abstraction of reality. For example, most nurses have studied developmental theory, which provides a framework for viewing childhood behaviors expected with various ages and phases of child growth. Consequently, when nurses observe a toddler crying when his mother must leave him alone with nurses in the hospital, nurses interpret the child's crying as separation anxiety—an expected and predicted toddler behavior according to developmental theory. The theory provides a means of understanding behavior that otherwise might seem random and, thus, is a framework from which to understand the child's actions. Thus, "a theory suggests a direction in how to view facts and events."[1] In nursing, there are four basic ideas (or concepts) that are common to all nursing theories—the concepts of nursing, person, health, and environment. These concepts comprise the core content of the discipline—the 'metaparadigm' of nursing. In recent years, some have suggested that the four concepts are too restrictive for development of nursing knowledge,[2] while others have suggested additions to the four. Discussion of this debate is outside the scope of this chapter; however, one should note that as different theories present differing definitions of these four basic concepts, each theory suggests new concepts that must also be developed. Consider that one theory may define the environment in direct, concrete terms, referring to the physical environment, while another theory may define the environment as an energy field. Each of these theories would have a different perspective on the effect of the environment on a client's health, and the concept of 'energy field' could become a concept in nursing's metaparadigm to those who ascribe exclusively to a worldview that incorporates such a notion. The way that a nurse defines concepts basic to nursing care, and the way that a nurse thinks about the relationship of these concepts, affects the practice and, presumably, the outcome of nursing care.

Since the writings of Florence Nightingale,[3] who is considered to be the first nursing theorist and the founder of "modern secular nursing," nurses have had theories about how to practice nursing. Most of these theories, however, have been developed since the 1960s. Several nurses have put forth their ideas of what nursing is and how nursing care can be delivered to assist clients in achieving health. Many practicing nurses are unaware that the care they give is based on a specific theory. They have learned what nursing is by going to nursing school and working with a set of beliefs or assumptions about nursing and the outcomes of nursing care. Nursing curricula are based on nursing theories—in some schools, theory is taught as an assumption; in others, it is more explicitly taught as a theory. Nonetheless, all nurses have learned what nursing is from a viewpoint that includes definitions of the major concepts of nursing theory, and have learned to practice nursing in a manner consistent with that viewpoint. When nurses study nursing theory, they have an opportunity to consider carefully the assumptions on which they base their practice. Knowledge of several theories gives nurses more choices in thinking about the situations in which they find themselves and their clients. Theory gives nurses tools to guide

practice and, because nursing theory is grounded in research, theory provides a scientific basis for nursing care.

The Need for Theory

Whenever the topic of nursing theory comes up, some nurses ask, Why do I need a theory? Isn't being holistic enough? These are very important questions. Nurses committed to holism are kind and compassionate nurses who share a philosophy that emphasizes a "sensitive balance between art and science, analytic and intuitive skills, self-care skills, and the ability to care for patients using the interconnectedness of body, mind, and spirit."[4] Theory suggests, in fact *demands*, that nurses reflect on this philosophy and consider how their practice is working (or not working) to achieve holistic ideals.

The Description of Holistic Nursing developed by the American Holistic Nurses' Association (AHNA) states that "holistic nursing practice draws on knowledge, theories, expertise, intuition, and creativity."[5] All five elements are necessary for the nurse to function in an ideal way: Nursing *knowledge* is essential for the understanding of health and disease states and the various regimens required to achieve health. *Theories* enable one to reflect on practice, and to consider carefully all alternatives of care. *Expertise* is necessary to perform nursing skills, and for the ability to make accurate assessments and decisions about care. *Intuition* is needed to understand the client, and to appreciate the subjective experiences of others. *Creativity* is helpful in solving care problems that seem insurmountable; it provides the nurse with novel ideas and ways of being with clients. Each one of these elements is as important as the others. Knowledge and theory are cognitive tools that help the nurse understand and reflect upon practice. Expertise is an experiential tool that comes from practice and a significant number of encounters in nurse–client situations. Intuition and creativity are affective tools that lead the nurse to feel, experience, and follow inner guidance when working with clients.

Professional practice requires that nurses use these five elements to achieve the best possible results. A holistic nurse can move back and forth between intuitive knowing and logical reasoning; between a creative approach to care and a standard care protocol; and between a hunch of what to do and a considered direction grounded in the predictions of a theory. All of the elements of practice come only by learning how to use them. Table 4–1 presents a summary of the five elements of holistic nursing practice.

Theory Development

Theories develop over time as a theorist defines concepts, suggests relationships between concepts, tests and evaluates the relationships, and modifies the theory

Table 4–1 Five Elements of Holistic Nursing Practice

Element	*Domain*	*Use in Practice*
Knowledge	Cognitive	Understanding health and disease states; interpreting regimens of care
Theory	Cognitive	Reflection; considered judgments
Expertise	Experiential	Skilled performance
Intuition	Affective	Subjective knowing
Creativity	Affective	Spontaneity; solving problems or challenges

based on research findings. When the theorist provides definitions of the concepts and suggests possible relationships, the work is called a "conceptual model." The concepts of a conceptual model are abstract and cannot be tested readily.[6] More concrete and testable relationships must be derived from the model to develop a theory. Some writers find the distinction between a theory and a conceptual model irrelevant,[7] and for purposes of this chapter, all works will be called theories. It is important, however, for nurses to understand that theories develop and mature, and that they pass through various stages serving increasingly complex purposes:

1. **Description.** The theory provides definitions of concepts, suggests a way of looking at the world, and provides a framework for describing the phenomena of nursing.
2. **Explanation.** The theory suggests relationships between and among various concepts and gives the nurse a means of explaining observed events.
3. **Prediction.** The theory has research findings that establish clear relationships between aspects of nursing, and the nurse is able to predict outcomes.
4. **Prescription.** The theory is well developed and permits a nurse to prescribe nurse or client actions with confidence in the outcomes.

Most nursing theories are developed to the stage of description and explanation, and theorists and researchers are currently developing nursing theories to the stages of prediction and prescription. Any aspect of a theory can be validated through research. For example, if a theory states that a person is a human energy field and suggests that there is an exchange of energy between two persons, research that evaluates such an exchange serves to validate the theory.

SELECTED NURSING THEORIES

There are several recognized nursing theories; a standard text on nursing theory covers more than 25 theories.[8] The following are those most commonly used by holistic nurses.

The Theory of Environmental Adaptation

Florence Nightingale gave nursing the first published theory by which to reflect on nursing. She presented views on the major concepts important to nursing and directed nurses in the provision of care. To Nightingale, *Nursing* is putting patients in the best condition for nature to act upon them; *Nursing*, as a profession, is a calling. *Person* is described in relation to the environment; the person is the recipient of nursing care. *Health* is the "positive of which pathology is the negative."[9] *Environment* is stressed in relation to healing properties of the physical environment, such as fresh air, light, warmth, and cleanliness. In relation to healing, Nightingale wrote, "Nature alone cures."[10]

For Nightingale, the focus of nursing care was the creation of an environmental space so that natural healing may take place. Cleanliness, fresh air, and order are emphasized, as are the patient's needs for nutrition. While not stated as such in her writings, Nightingale and her nurses regularly provided emotional and interpersonal supports. The images of Nightingale with her lamp attending to patients' needs at night, writing letters for them, and being present as a caring nurse are as much a part of her theory of practice as preparing food and cleaning the sick room. Although Nightingale's theory has not been developed in the same sophisticated manner as more modern theories, her work stands as a remarkable treatise on reflective and thoughtful practice. Nurses today

often are surprised by the accuracy of her directions in guiding current practice. The theory has been studied and "modernized" by nurse scholars who have described it in terms of theory development used today. Selanders noted that "the principle of environmental alteration has served as a framework for research studies."[11] Nightingale's theory is clearly a wonderful heritage for holistic nurses. A definitive statement on Nightingale's life and work is available in a recent biography.[12]

The Roy Adaptation Model

Sr. Callista Roy began work on her theory in 1964 and its development continues today.[13,14] Her theory is based on the idea that it is necessary to adapt to stressors and to achieve health as a state of balance or homeostasis. *Nursing* is defined in terms of the roles and activities of nurses to promote adaptive responses in support of a client's health. *Person* is defined as a holistic, adaptive system; individual aspects or parts of an individual act together to form a unified being. *Health* is a state or process of being and becoming an integrated, whole person; it is a state of balance. *Environment* includes any condition, circumstance, and/or influence that affects the development and behavior of persons or groups. Stimuli in the environment can be focal (the immediate situation), contextual (other current stimuli in the person's environment that provide the context for adapting to the current situation), or residual (all other internal factors).

Because the theory is based on the idea of adaptation, the nurse is directed to evaluate the stressors in the client's environment and determine the client's ability to adapt or cope with current stressors. Health is achieved when the client is able to adapt or cope to create a sense of balance and a physiologic state of homeostasis. Nursing care involves taking actions to promote healthy adaptation. This theory has been strongly influenced by systems theory—changes in one or any part of the system affect other parts of the system. For example, emotional stress produces stress for the physical body and requires adaptation. The theory has been used to guide curriculum and nursing practice. Recent studies using the theory as a framework have investigated the application of the concepts to women's health in relation to stressors of menopause[15] and social supports for women with breast cancer.[16]

The Modeling and Role-Modeling Theory

In 1983, Helen Erickson and her colleagues published a theory and paradigm for nursing called the Modeling and Role-Modeling theory.[17] The theory draws on work from many theoretical perspectives, including Maslow's Basic Needs, Erikson's Stages of Development, Piaget's Theory of Cognitive Development, and Selye's Stress Theory. The work of the psychiatrist Milton Erickson, the father-in-law of the theory's senior author, provided a perspective of the mind-body connection in health, healing, and disease. His work also supported the belief that the most important thing a professional can do is understand the world from the client's perspective.

According to this theory, *Nursing* is a process that demands an interpersonal and interactive relationship with the client. Facilitation, nurturance, and unconditional acceptance should characterize the nurse's caregiving. *Person* is seen as a holistic being with interacting subsystems (biologic, psychologic, social, and cognitive), and with inherent genetic bases and spiritual drives; the whole is greater than the sum of its parts. *Health* is a dynamic equilibrium between subsystems. *Environment* is seen as both internal and external;

environment includes stressors as well as resources for adapting to them.

The client is seen as an individual with strengths that can and should be used to mobilize resources to adapt to stress. Adaptation potential is a theory-specific term used to describe conditions of adaptation—equilibrium (which can be adaptive or maladaptive), arousal, or impoverishment. The theory presents five aims of all nursing interventions: (1) to build trust, (2) to promote positive orientation, (3) to promote perceived control, (4) to promote strengths, and (5) to set mutual goals that are health-directed. The nurse uses this theory by creating a model of the client's world (Modeling) and using that model to plan interventions and to demonstrate and support health-producing behaviors from within the client's world view (Role Modeling). An excellent case study applying the theory to a client with diabetes mellitus illustrates how the perspective can help the client develop strengths.[18] Some of the current research on the theory has focused on understanding the self-care actions and autonomy among specific populations of patients.[19,20]

The Theory of Transpersonal Caring

First presented as a philosophy and science of caring in 1979,[21] Jean Watson's theory of Transpersonal Caring emphasizes the humanistic aspects of nursing, combined with scientific knowledge. Within this framework, *Nursing* is mediated by "professional, personal, scientific, esthetic, and ethical human care transactions."[22] *Person* is seen holistically with the knowledge that the whole is greater than, and different from, the sum of the parts; every person is a valued individual to be cared for, cared about, and understood. *Health* is a subjective state that has to do with unity and harmony; illness can be understood as disharmony. Caring is achieved through the *environment*. Although environment is not defined explicitly, Watson stated that the environment provides social, cultural, and spiritual influences that may be perceived as caring.

In using the theory of Transpersonal Caring, the foremost role of the nurse is to establish an intimate, caring relationship with the client. The nurse must be able to understand the client's subjective experiences and interact with the client in a meaningful relationship. For Watson, the 'caring occasion' or the 'caring moment' are situations where nurses and clients come together in unique ways such that there is a truly transformational encounter, leaving both the nurse and the client changed. Watson drew significant attention to the fact that the nurse must never "objectify" another human being (treat the client as an object), as every human being must be approached with unconditional acceptance and positive regard. The strength of the theory relies on the nurse's ability to provide quality, caring interactions with the client while simultaneously promoting health through nursing knowledge and interventions. Watson's theory gave rise to numerous qualitative research studies that documented the lived experiences of clients as they received care within a health care system. In recent writings, Watson advocates a postmodern view of nursing, and of science, that comprises multiple Truths, physical and nonphysical realities, and the relativity of time and space.[23] Postmodernism is characterized by ideas of balance, interconnectedness, and a holographic context,[24] that clearly bring nursing thought into a new dimension. Current research on the theory suggests that the perceived 'actual caring occasion' is a significant factor in the persistence in treatment for patients with depression.[25]

The Science of Unitary Human Beings

Martha Rogers was the first theorist to describe nursing in relation to the view that a person is an energy field. In addition, she believed that nursing is a "humanistic science dedicated to compassionate concern for maintaining and promoting health, preventing illness, and caring for and rehabilitating the sick and disabled."[26] Rogers' theory, which is an abstract system, is the basis for the Science of Unitary Human Beings. Within this theory, *Nursing* is the scientific study of human and environmental energy fields. *Person* is a unified whole, defined as a human energy field; human beings evolve irreversibly and unidirectionally in space and time. *Health* is understood in terms of culture and, according to Rogers, individually defined by the subjective values of each person. *Environment* is the environmental energy field that is in constant interaction with the human energy field. There are no boundaries to the environmental or human energy fields. Many studies have tested concepts of this theory, and several authors have suggested research methodologies specifically appropriate to the Science of Unitary Human Beings. These include the Unitary Field Pattern Portrait Research Method described by Butcher,[27] rational hermeneutics described by Alligood and Fawcett,[28] and case study approaches described by Cowling.[29]

The Theory of Expanding Consciousness

Margaret Newman included Rogers' concepts of energy patterns and unitary human beings in developing her own theory.[30] Newman viewed *Nursing* as a profession that is moving to an integrated role; nursing is caring, and caring is a moral imperative for nursing. *Person* is a dynamic energy field; humans are identified by their field patterns. *Health* is expanding consciousness that includes an individual's total pattern; pathologic conditions are manifestations of the individual's total pattern. *Environment* is the wholeness of the universe; there are no boundaries. For Newman, people are not separate entities, but instead are "open energy systems constantly interacting and evolving with each other."[31] Health and illness are paired as a unitary process—complementary forces of order and disorder that are essential in each person's continuing development. Newman notes that experiencing a significant illness often results in a turning point (a *choice* point) for a person where he/she sees him-/herself differently. Thus a person can expand consciousness after transcending limitations of disease and other life events. Research on Newman's theory has focused on the meaning/purpose of living with illness and the effects of disruptive processes on the patterns, change and growth of the whole.

The Theory of Human Becoming

Rosemarie Rizzo Parse further developed the idea of the person as a unitary whole and suggested that the person can only be viewed as a unity.[32] *Nursing* is seen as a scientific discipline, but the practice of nursing is an art in which nurses serve as guides to assist others in making choices affecting health. *Person* is a unified, whole being. *Health* is a process of becoming; it is a personal commitment, an unfolding, a process related to lived experiences. *Environment* is the universe. The human–universe is inseparable and evolving as one. Research on the Theory of Human Becoming has documented the importance of

intersubjective dialogue in assisting clients to move toward different meanings and choices in their lives[33] and has described the sense of caring that clients perceive from nurses guided by the theory.[34] The concept of 'presence' is critically important for this theory, as the nurse offers authentic presence to each client in the process of becoming and living experiences. One author has explored the meaning of 'lingering presence' from within the theory, and has identified meanings such as living within the familiar–unfamiliar while moving beyond, the surfacing of presence in the remembered moment, and the private experience of presence.[35]

A WORD ABOUT DEFINITIONS OF PERSON

Since the emergence of Rogers' theory, the definition of person as a unitary whole has challenged nurses to reflect on the meaning of *whole*. Parse suggests that there are two world views in nursing: a summative paradigm in which the person is viewed as a combination of component parts (with the belief that the whole or the essence of the person is greater than the sum of the parts) and the simultaneity paradigm in which a person can be viewed only as a unity; that is, the person is a holistic energy field and cannot be broken into parts.[36] For Rogers, Newman, and Parse, the only appropriate definition of the person is in terms of the unitary whole. Adherents of their theories insist that it is impossible to think of persons as having component parts (e.g., bio-psycho-social-spiritual components) and that any discussion of a "part" is improper. Other theorists (e.g., Roy, Erickson, and Watson) have concluded that discussion of the "part" is helpful in considering the various ways in which a person functions, feels, and reacts to the environment.

Throughout the years of this debate, the AHNA has been asked to take a stand on the meaning of *whole* in holistic nursing practice. The official AHNA Description of Holistic Nursing states that holistic nursing is defined primarily as all nursing practice that has the enhancement of healing of the whole person as its goal.[37] The AHNA recognizes that there are two views of holism, and has publicly stated that "holistic nursing responds to both views, believing that the goals of nursing can be achieved within either framework."[38] The important aspect of nursing practice is that the nurse and the client believe that the care received is assisting the client to enhance healing and achieve a state of health. Any nurse who believes that a particular theory is helping to reach the goals mutually set between nurse and client should use the theory and reflect on how the theory's world view changed and assisted nursing practice.

THEORY INTO PRACTICE

The theories previously discussed are not the only theories in use today, and most certainly other theories will be suggested in the future. Nurses use these and others in making assessments and in interpreting assessment data. The interpretation of data based on the theory's world view leads the nurse to establish goals for care and to design interventions to achieve the best outcome. To illustrate the use of theory in a clinical situation, Exhibit 4–1 outlines the view of the following client situation according to each of the theories.

> Mr. S. is a 50-year-old man who comes to the emergency department with his wife. He is suffering from severe chest pain and is short of breath. He has never experienced this before, and he tells his nurse

that he is very much afraid of having a heart attack because his partner at work had a heart attack just last year. His wife is supportive and, under the circumstances, appears relatively calm. She asks the nurse to help provide assurance and treatment, if needed.

Reflection on the use of nursing theory demands that the nurse think about practice in new and critical ways. For practice to be consistent, nursing interventions should be derived from the theory; that is, there should be a congruence between the "thinking" about the nurse–client interactions and the "doing" of the nursing care. For example, the Modeling and Role-Modeling theory requires that the nurse create a model of the client's world and step into that world before planning interventions. It is important for the nurse to consider the timing and pacing of his or her actions so that they are consistent with the client's. Thus, nurses acquainted with this theory frequently use the modalities of guided imagery and hypnosis because these techniques require the nurse's pacing interactions, breathing, and speech to be like the client's. One of the benefits of theory-based practice is that nurses are challenged to make their practice consistent. Further, the focus of the nurse's thought is on the theory, the world view, and the client rather than on the modality or the nursing activities and tasks. Table 4–2 presents common complementary modalities that are consistent with the nursing theories described in this chapter.

Exhibit 4–1 Interpretation of Case, Mr. S., According to Selected Theories

Nightengale's Theory of Environmental Adaptation

The environment of care for Mr. S. should include order, light, air. Activities and actions must be carried out efficiently with minimal disturbance to others. Nursing actions should be professional and unobtrusive.

Roy Adaptation Model

Stressors for Mr. S. are to be assessed. The immediate (focal) stimuli are the experience of chest pain and Mr. S.'s fear of having a myocardial infarction; the contextual stimuli are the choice to come to the hospital for care and the fact that Mr. S. has a partner who experienced a myocardial infarction a few months ago. Residual stimuli are other factors unknown to the nurse at present that may affect Mr. S.'s feelings and ability to cope. Interventions are directed to reestablish physiological homeostasis and equilibrium.

Modeling and Role-Modeling

Mr. S. is currently in a state of arousal related to his pain and call for help. He needs to feel safe and secure in the hospital environment. His wife is one of the resources that he is using to help him to cope and adapt to his immediate condition. Care should be directed toward supporting Mr. S. to receive the treatments or care he wishes and to help him reestablish equilibrium. To promote perceived control, Mr. S. should be given choices about his care whenever possible.

Watson's Theory of Transpersonal Caring

Both Mr. S. and his wife require the presence of a compassionate and caring human being to offer them unconditional acceptance and support throughout the evaluation and treatment in the hospital.

Energy Field Theories

The emergency department is part of the environmental energy field, in interaction with the client's energy field. Assessment of balance of the client's field is to be done; actions to reestablish balance are needed while other treatments and evaluations are being carried out. The pain and fear that brought Mr. S. to the hospital are part of the energy pattern. The art of nursing permits the nurse to guide Mr. S. in making choices about care; however, the nurse recognizes that by coming to the emergency department, Mr. S. has chosen to receive evaluation and treatment.

Table 4–2 Nursing Interventions Most Consistent with Specific Nursing Theories

Theory	*Interventions*	*Rationale*
Nightingale's Theory of Environmental Adaptation	Care of the environment to promote order, fresh air, and light	Nursing care to the environment puts the patient in the best condition for nature to act upon him/her and promotes healing.
Roy Adaptation Model	Progressive relaxation Coping enhancement	The nurse evaluates stressors, assists the client to eliminate immediate stress (when possible), and enhances coping strategies in order to adapt to stressors.
Modeling and Role Modeling	Guided imagery Hypnotherapy	To "model the client's world," the nurse must focus on timing and pacing of nursing actions. To assist the client to mobilize resources to cope with stress, the modalities of imagery and hypnosis help the client to uncover inherent strengths.
Watson's Theory of Transpersonal Caring	Therapeutic presence Healing presence	To establish a meaningful nurse–client relationship based on caring and the demand for authentic person-to-person exchange, presence is the most important and basic nursing action.
Energy Field Theories	Therapeutic touch (TT) Healing touch modalities	Interventions based on the concepts of the human and environmental energy field are clearly consistent with theories that describe this as their world view.

CONCLUSION

A theory provides a means of interpreting and organizing information. Nursing theories give nurses a tool to ensure that nursing assessments are comprehensive and systematic, and that care is meaningful. Holistic nurses use several theories, and each nurse must decide which theory to use and when to use an alternative perspective. In selecting a theory, a nurse should ask two questions: What theory is most comfortable for me? and, What theory is most comfortable for my client? The perspective selected must be comfortable for both. Many clients, as well as nurses, have strong feelings and opinions about what nursing is and what type of care they wish to receive. If the theory's perspective is not comfortable for the client, the nurse is ethically obligated to change her or his perspective and adopt a framework that is compatible with the client's needs.

DIRECTIONS FOR FUTURE RESEARCH

1. Holistic nurses should consider what is and is not known about any theory being applied to practice and evaluate the next steps needed to develop the theory in their own area of practice.
2. Evaluate theories related to the identification of specific outcomes of care.

NURSE HEALER REFLECTIONS

After reading this chapter, the holistic nurse will be able to answer or to begin a process of answering the following questions:

- What definition of the concept of *person* is a good fit with my own view of myself and others?
- Which of the nursing theories described can I use in my practice?
- Which of the nursing theories would be uncomfortable for me to use? Can I openly explore why a particular theory(ies) would be uncomfortable for me to use?
- How will I determine if the theory I am using is acceptable to my clients?
- In what ways am I able and willing to make a contribution to the use and development of nursing theory?

NOTES

1. J.S. Hickman, An Introduction to Nursing Theory, in *Nursing Theories: A Base for Professional Practice*, 5th ed., ed. J. George (Upper Saddle River, NJ: Prentice Hall, 2002):1 –20.
2. V.M. Malinksi, Response: notes on book review of *Analysis and Evaluation of Nursing Theories, Nursing Science Quarterly* 8 (1995):59.
3. F. Nightingale, *Notes on Nursing* (London: Harrison, 1860).
4. B.M. Dossey, ed., *Core Curriculum for Holistic Nursing* (Gaithersburg, MD: Aspen Publishers, 1997):5–6.
5. American Holistic Nurses' Association (AHNA), *Description of Holistic Nursing* (Flagstaff, AZ: AHNA, 1998).
6. J. Fawcett, *Contemporary Nursing Knowledge* (Philadelphia: F.A. Davis, 2000).
7. J. George, *Nursing Theories: The Base for Professional Practice,* 5th ed. (Upper Saddle River, NJ: Prentice Hall, 2002).
8. J. George, *Nursing Theories*.
9. Nightingale, *Notes on Nursing*, 74.
10. Ibid.
11. L.C. Selanders, The Power of Environmental Adaptation: Florence Nightingale's Original Theory for Nursing Practice, *Journal of Holistic Nursing* 16 (1998):247–263.
12. B.M. Dossey, *Florence Nightingale, Mystic, Visionary, Healer*. (Springhouse, PA: Springhouse, 2000).
13. C. Roy and H.A. Andrews, *The Roy Adaptation Model: The Definitive Statement* (Stamford, CT: Appleton & Lange, 1991).
14. C. Roy and H. Andrews. *The Roy Adaptation Model*, 2nd ed., (Stamford, CT: Appleton & Lange, 1999).
15. D.A. Cunningham. Application of Roy's Adaptation Model When Caring for a Group of Women Coping With Menopause, *Journal of Community Health Nursing* 19 (2002):49–60.
16. S. Melda, L. Tulman, and J. Fawcett. Effects of Two Types of Social Support and Education on Adaptation to Early-Stage Breast Cancer, *Research in Nursing and Health* 25 (2002):459–470.
17. H. Erickson et al., *Modeling and Role-Modeling: A Theory and Paradigm for Nursing* (Lexington, KY: Pine Press, 1983).
18. J. Sappington and J. Kelley, Modeling and Role-Modeling: A Case Study of Holistic Care, *Journal of Holistic Nursing* 14 (1996):130–141.
19. J.E. Hertz and C.A. Anschutz, Relationships Among Perceived Enactment of Autonomy, Self-Care, and Holistic Health in Community-Dwelling Older Adults, *Journal of Holistic Nursing* 20 (2002):166–186.

20. C.W. Baldwin, J. Hibbein, S. Herr, L. Lohner, and D. Core. Self-care as Defined By Members of the Amish Community Utilizing the Theory of Modeling and Role-Modeling, *Journal of Multicultural Nursing and Health* 8 (2002):60–64.
21. J. Watson, *Human Science and Human Care* (New York: National League for Nursing, 1988).
22. Ibid.
23. J. Watson, *Postmodern Nursing* (London: Churchhill Livingstone, 1999).
24. J. Kelley and B. Johnson, Theory of Transpersonal Caring, in *Nursing Theories: The Base for Professional Practice*, 5th ed., ed. J. George (Upper Saddle River, NJ: Prentice Hall, 2002):405–426.
25. J. Mullaney, The Lived Experience of Using Watson's Actual Caring Occasion to Treat Depressed Women, *Journal of Holistic Nursing* 18 (2000):129–142.
26. M. Rogers, *The Theoretical Basis for Nursing* (Philadelphia: F.A. Davis, 1970), vii.
27. H.K. Butcher, Crystallizing the Process of the Unitary Field Pattern Portrait Research Method, *Visions: The Journal of Rogerian Nursing Science* 6 (1998):13–26.
28. M.E. Alligood and J. Fawcett, Acceptance of the Invitation to Dialogue: Examination of an Interpretive Approach for the Science of Unitary Human Beings, *Visions: The Journal of Rogerian Nursing Science* 8 (1999):5–13.
29. W.R. Cowling, Unitary Case Inquiry, *Nursing Science Quarterly* 12 (1998):139–141.
30. M. Newman, *Health as Expanding Consciousness*, 2nd ed. (New York: National League for Nursing, 1994).
31. M. Newman. *Health as Expanding Consciousness,* 3rd ed. (Boston: Jones and Bartlett Publishers, 1999), 25.
32. R.R. Parse, Human Becoming: Parse's Theory of Nursing, *Nursing Science Quarterly* 5 (1992):35–42.
33. S. Baumann, Contrasting Two Approaches in a Community-Based Nursing Practice with Older Adults: The Medical Model and Parse's Nursing Theory, *Nursing Science Quarterly* 10 (1997):124–130.
34. N. Janes and D. Wells, Elderly Patients' Experiences with Nurses Guided by Parse's Theory of Human Becoming, *Clinical Nursing Research* 6 (1997):205–222.
35. M.R. Ortiz, Lingering Presence: A Study Using the Human Becoming Hermeneutic Method, *Nursing Science Quarterly* 16 (2003):146–154.
36. R.R. Parse, *The Human Becoming School of Thought* (Thousand Oaks, CA: Sage, 1998).
37. AHNA, *Description of Holistic Nursing.*
38. Ibid.

VISION OF HEALING

Ethics in Our Changing World

Albert Einstein believed that the most important human endeavor is striving for morality in our actions. Our inner balance and even our very existence depend on it. Only morality in our actions can give beauty and dignity to life. Ralph Waldo Emerson relayed a similar message when he said that character is a natural power—light and heat and all nature cooperate with it.

For healing modalities to operate in a natural environment, the disposition of the intellect, will, emotions, and spirit of the healer must be balanced and centered. Such balancing and centering effects are enhanced by knowledge of self. Belief structures, and the reasoning behind such belief structures, place the individual healer's spirit in a dynamic equilibrium or cybernetic relationship with the powers in the cosmos. It is in this way that conscious evolution proceeds. It is a give and take process—a continuous ongoing dialogue between the healer and the cosmic environment that empowers the healer to heal. Healing is a psychophysiologic psychospiritual experience that enables the healer to cooperate with nature and, indeed, exigently coerce nature to cooperate with the healer.

Holistic ethics provides guidelines for the development of the healer's spirit and spells out the steps needed to develop the healing attitude. Ethics thus serves as a guide to tap into the wisdom of the cosmos, teaching the individual strategies to release the self to become more participatory in the Greater Self. The participation in the Greater Self forms the linkages between the powers of the cosmos, the healer, and the one to be healed.

Nursing and ethics have been intertwined since the inception of modern nursing. The ethics of nursing comprises both a bedside ethic and a social ethic, as nurses have always concerned themselves in such matters of public policy as urban slums and tenements, war and disaster, and the special needs of the underserved. Recently, the ethics of public policy has also addressed environmental concerns, population issues, human rights, health care delivery, and health promotion. Nurses, both individually and collectively, are directly in the forefront not only of ethical decision making, but also of public policy formation. Many aspects of future health care delivery will be based on the ethical decisions that we make now. Thus, nurses must examine current and future healing activities from ethical perspectives. All of us must strive to understand the concept and application of ethics.

Chapter 5

Holistic Ethics

Lynn Keegan

NURSE HEALER OBJECTIVES

Theoretical

- Review the classic principles of ethics.
- Synthesize the basic tenets from the work of traditional ethical theorists.
- Explore the new concept of holistic ethics.

Clinical

- Relate ethical theory to clinical situations.
- Gain the knowledge necessary to serve on institutional ethics committees.

Personal

- Begin to see daily choices as opportunities to make a positive impact on the world.
- Clarify your own values and ideas.

DEFINITIONS

Being: the state of existing or living.

Consciousness: a state of knowing or awareness.

Ethical Code: a written list of a profession's values and standards of conduct.

Ethics: the study or discipline concerned with judgments of approval or disapproval, rightness or wrongness, goodness or badness, virtue or vice, and desirability or wisdom of actions, dispositions, ends, objects, or states of affairs; disciplined reflection on the moral choices that people make.

Holistic: concerned with the interrelationship of body, mind, and spirit in an ever-changing environment.

Holistic Ethics: the basic underlying concept of the unity and integral wholeness of all people and of all nature, that is identified and pursued by finding unity and wholeness within the self and within humanity. In this framework, acts are not performed for the sake of law, precedent, or social norms, but rather from a desire to do good freely in order to witness, identify, and contribute to unity.

Morals: standards of right and wrong that are learned through socialization.

Nursing Ethics: a code of behavior that influences the way nurses work with those in their care, with one another, and with society.

Personal Ethics: an individual code of thought and behavior that governs each person's actions.

Planetary Ethics: a code of behavior that influences the way in which we individually and collectively interact with the environment and other peoples and animals of the earth.

Values: concepts or ideals that give meaning to life and provide a framework for decisions and actions.

THE NATURE OF ETHICAL PROBLEMS

Because ethical issues consist of diverse values and perspectives, they are extremely complex. Ethical questions arise from all areas of life. The ramifications of the population explosion, euthanasia, genetic engineering, and allocation of resources are only a few examples of a host of controversial ethical issues. Furthermore, four specific recent developments in our society have dramatically increased ethical awareness: (1) advances in medical technology, (2) greater recognition of patients' rights, (3) malpractice cases and court-ordered treatment, and (4) scarcity of resources.[1] Jonsen noted the element of mystery intertwined with ethics when he stated that no matter how much is revealed about antibodies, osmolality, immunoglobulins, or any of the other mysteries of the body, mystery remains at the heart of the science of medicine. The patient also participates in the mystery, for the patient knows himself or herself intimately.[2] Naturally then, mystery adds to the element of complexity.

Unfortunately, ethical dilemmas are usually characterized by the fact that there is no right answer. There are often two or more unsatisfactory answers or conflicting responses. In addition, nurses often find that the expectations of employers, physicians, patients, or other nurses themselves are sources of conflict.[3]

Changes in the knowledge that forms the basis of our values are changing the sources of some of our ethical dilemmas. For example, technologies related to computers and communication have affected patient confidentiality. Improved life support technology has been used to keep patients alive against their wishes. Sophisticated technology has the clear disadvantage of being able to reduce persons to objects.[4] Thus, advances in procedures (e.g., organ transplantation, amniocentesis) and equipment (e.g., respirators, dialysis machines) have opened the doors to new possibilities for extending or prolonging life, but they also prompt the critical ethical question: Does the fact that it *can* be done mean that it *should* be done?[5]

MORALS AND PRINCIPLES

Over the past two decades, biomedical ethicists have identified several moral principles. Three primary principles are (1) respect for persons, (2) beneficence, and (3) justice. Sometimes these principles are stated as obligations; sometimes, as rules. Whether primary or secondary, these principles represent many obligations: to respect the wishes of competent persons, to not harm others, to take actions that benefit others, to produce a net balance of benefits over harm, to distribute benefits and harms fairly, to keep promises and contracts, to be truthful, to disclose information, and to respect privacy and protect confidential information.[6]

Orentlicher, a physician, lawyer, and ethicist, thinks that there are, at root, only two ways to guide proper behavior: rules and precedents. He notes that rules are designed to support underlying values; e.g., speed limits are set to promote public safety. Rules are attractive because they provide seemingly clear lines of conduct that prevent slides down slippery slopes. They also can help to avoid the capriciousness of personal discretion and the obtrusiveness of governmental intrusion in decision making. However, Orentlicher is concerned with the unintended consequences of rules, and cites as an example the case of mandating pregnant women to undergo medical procedures to prevent

harm to their fetuses. A third moral concern is the political difficulty of having explicit rules where life-and-death decisions are being made, such as allocation of scarce organs. Here, society tends to adopt a system of vague precedents that operates under the guise of rules. The appearance of objectivity, which is inherent to general rules, can hide the vagueness of the processes that actually are being used.[7]

Orentlicher argues that rules sometimes work to the detriment of the value that prompted implementation of the rule in the first place. In fact, this phenomenon is widely considered a sort of natural law: the law of unintended consequences. For example, a medicolegal question might be, should pregnant women be forced to undergo treatment to help their fetuses? If forced treatments were endorsed, then some women might avoid prenatal care, thus—and here is the unintended consequence—harming their fetuses. The answer might depend on whether forced treatment would help more fetuses than would be harmed by women who would be driven away from prenatal care. This is but one example of the complexity of ethical decision making.[8]

Within natural law ethics, the principle of *double effect* has special importance for nurses. Often, nurses are involved in actions that have untoward consequences. For example, administering a drug to relieve a cancer patient's pain may shorten the patient's life. In double effect situations, four conditions must be met before an act can be justified:

1. The act itself must be morally good, or at least indifferent.
2. The good effect must not be achieved by means of the bad effect.
3. Only the good effect must be intended, even though the bad effect is foreseen and known.
4. The good effect intended must be equal to or greater than the bad effect.[9]

Ethics addresses three types of moral problems: *moral uncertainty* (unsureness about moral principles or rules that may apply, or the nature of the ethical problem itself); *moral dilemma* (conflict of moral principles that support different courses of action); and *moral distress* (inability to take the action known to be right because of external constraints). Ethical debate helps to relieve moral uncertainty by clarifying questions and illuminating the ethical features of the situation. Discussion helps to clarify moral dilemmas by revealing general and specific obligations and values.[10] Milner urged nurses to use principles and theory to deal with issues of relationships as well as health care concerns, as following principles rather than emotions or feelings in conflicting situations may reduce moral distress. Basic ethics that involves how we treat each other as human beings is a necessary first step before we can appropriately deal with broader issues.[11]

TRADITIONAL ETHICAL THEORIES

Many nurse clinicians turn away in frustration when confronted with the details of ethical theories. Perhaps this is because in the past it has been difficult to see how these historical philosophical theories relate to contemporary clinical situations. In order to make these theories meaningful to the work setting, it is helpful to think of situations in which they may apply to current clinical practice.

A number of ethical theories have played a role in Western civilization, and have laid the foundation for the development of modern ethics. Aristotelian theory is based on the individual's manifesting specific virtues and developing his or her own character. Aristotle (384–322 BC) believed that an individual who practices the virtues of courage, temperance,

integrity, justice, honesty, and truthfulness will know almost intuitively what to do in a particular situation or conflict.[12] The system of Emmanuel Kant (1724–1804) formulated the historical Christian idea of the Golden Rule. "So act in such a way as your act becomes a universal for all mankind." [13] Kant was very much concerned with the "personhood" of human beings and "persons" as moral agents.

Other theories that are helpful in understanding a holistic approach to ethics include the utilitarianism theory of Jeremy Bentham (1748–1832) and John Stuart Mill (1806–1873), the natural rights theory of John Locke (1632–1714), and the contractarian theory of Thomas Hobbes (1588–1679). Briefly stated, the consequentialist, or utilitarian, view of Bentham and Mill is that the consequences of our actions are the primary concern, the means justify the ends, and that every human being has a personal concept of good and bad. The natural rights theory of Locke was the forerunner of the U.S. Declaration of Independence, as it included the tenet that individuals have inalienable rights and that other individuals have an obligation to respect those rights. The contractarian theory of Hobbes contends that all morality involves a social contract indicating what individuals can and cannot do.[14]

Another way of viewing ethics is in terms of the two traditional forms: the deontologic (from a Greek root meaning knowledge of that which is binding and proper) style and the teleologic (from a Greek root meaning knowledge of the ends) style. The former assigns duty or obligation based on the intrinsic aspects of an act rather than its outcome: action is morally defensible on the basis of its intrinsic nature. The latter assigns duty or obligation based on the consequences of the act: action is morally defensible on the basis of its extrinsic value or outcome.

THE DEVELOPMENT OF HOLISTIC ETHICS

The holistic view of reality reopens vistas of thought that were dominant in the pretechnologic era, when people were generally closer to their environment and the earth. The allure of new science and technology sidetracked many of us into primarily linear, rational, unidirectional thought. Furthermore, while technology has provided conveniences and easy solutions, it has also contributed to a tendency to objectify the universe.

Holistic ethics is a philosophy that couples both reemerging and rapidly evolving concepts of holism and ethics. It involves a basic underlying concept of the unity and integral wholeness of all people, and of all nature, that is identified and pursued by finding unity and wholeness within the self and within humanity. Within the framework of holistic ethics, acts are not performed for the sake of law, precedent, or social norms; they are performed from a desire to do good freely in order to witness, identify, and contribute to unity of the self and of the universe, of which the individual is a part. Encompassing traditional ethical views, the holistic view is characterized by the Eastern monad in the yin–yang mode and the Western concept of masculine and feminine. Holistic ethics is not grounded or judged in the act performed or in the distant consequences of the act, but rather in the conscious evolution of an enlightened individual of raised consciousness who performs the act. The primary concern is the effect of the act on the involved individual and his or her larger self.[15]

Presuppositions

Ethics is the study of the paths of practical wisdom. It is concerned with judgments of goodness and badness, and rightness and

wrongness, based on a philosophic view of the nature of the universe. All ethical theories have presuppositions. The following are some of the presuppositions of holistic ethics:

- There is a Being or Spirit who is actively involved with humanity and with the universe, in whose image we are created.
- There is a divine plan. Although modeled on it, the material universe is but an infinitesimal part of the overall plan.
- The Spirit is active in the inner life of individuals.
- Persons (personalities) have a dual existence. One existence is on the material plane (body, mind, and spirit); the other is on the divine plane (soul).
- Humankind has a purpose or task—the evolution of itself and the universe into a more perfect image of its Creator.
- The concept of unity is the key to the path of critical wisdom.
- The matter of which our entire universe (body, mind, and spirit) is comprised is subject to dynamic development under the influence of dialectic laws. These principles operate on both psychologic and physical planes.
- The Spirit is operative in the universe. This cosmic view embraces two paths: The first is the scientific or phenomenologic path, which has as its by-product holistic ethics; the other is the theologic path. The two paths intersect at a point called Omega, the apex both of the scientific and of the religious views of nature. According to this concept of time and space, Omega is not only present in the universe, but also represents a different and much larger reality. The symbol of Omega transcends matter.
- There is purposefulness in the universe. All occurrences—the entire range from good to bad, from complex to simple—are in some way part of the divine plan. There is purpose and reason, although oftentimes consciously incomprehensible, for things that happen.[16]

Holistic ethics originates in the individual's own character and in the individual's relationship to the universe. In some way, the universe is present totally in each individual; paradoxically, the person is just a small part of that same universe. Gregorios believed that wisdom is a condition in which the self and the world are in communion with each other and within the larger communion, with the infinite totality of Being in its integrity.[17] A holistic view takes into account the relationship of unity of all being. Albert Einstein, in the course of a serious illness, was asked if he feared death. He replied, "I feel such a sense of solidarity with all living things that it does not matter to me where the individual begins and ends."[18]

An a priori belief for a holistic person is probably "I believe in being," or even more simply, "I am." In this belief system no act, principle, or person is independent, but all are interrelated; all are "I." Each and every action is a moral action, either contributing to the unity of being or diminishing it. It is the enlightened and totally expanded "I" that creates a holistic view of ethics.

Moral acts may be judged not solely in terms of their intrinsic nature nor solely in terms of their ends, but in both ways. The act may affect the nature of the person performing the act (the "I") and his or her relationships, as well as affect the object

of the act and the object's relationships. In addition, it can be helpful to explore the relationship of the act to the present and future of humanity. Through use of this construct, holistic ethics is both deontologic and teleologic. Holistic ethics is specifically teleologic in questioning the meaning and quality of life.

As a philosophic design for living, holistic ethics is a system for the individual. It appeals to the emotions, senses, aesthetic appreciation, and the inner self as revealed by meditative techniques. Such techniques may be active (e.g., the body movements of Tai Chi or jogging), passive (e.g., a sitting meditative posture), or traditional prayer.

The educative process of holistic ethics is not a matter of memorizing facts or historical perspectives, but is instead a process of developing an attitude of awareness of the sacredness of ourselves and all of nature. It is a process in which there is an expanded view that, for both internal and external transformation, our inner self and the collective greater self have stewardship not only of our bodies, minds, and spirits, but also of our planet and the total universe.[19]

Based on this emergent ethical theory, the American Holistic Nurses' Association (AHNA) has developed a position statement on holistic nursing ethics (Exhibit 5–1).

Holistic Ethics and Consciousness

The underlying principle in a holistic ethical view is being, and its corollary is consciousness. Being and consciousness can further be defined as having their origin in the spirit.[20] Not only is consciousness accepted in the holistic system as the product of an evolutionary process, but it is also believed to become operative through the effect of the spirit. Our personal will becomes the motivator for continued evolution. In the holistic concept of ethics, moral decisions affect both the spirit of humankind as a whole and our own individual spirits.[21] As each of us evolves our own individual consciousness, we assess and direct the evolution of the consciousness of our species and contemplatively examine our relationship with the universal Being.

Holistic ethics is not grounded or judged either in the act performed or in the distant consequences of the act, but rather in the conscious evolution of an enlightened individual who performs the act. The primary concern is the effect of the act on the individual and his or her larger self (that unity of which the individual is a part). Unethical acts are those that degrade or brutalize the individual who performs the act, and that detract from his or her conscious evolution. The effect of an unethical act is to make us aware of the deprivation of divinity within humanity and of humanity itself. The unethical act dissolves the unity of matter and takes away wholeness. Acts must be judged in this setting to determine whether they promote wholeness and integration of either an individual or the collective whole.[22]

Clearly, it is within the emergence of consciousness that the evolution of ethical action begins. Anthropologist Richard Leakey suggested that consciousness supplied primitive human beings with their first capacity for empathy. For example, when the early human recognized that a particular action would injure the self, that human inferred that a particular action would cause injury to another person (another self). Leakey contended that the mechanism of consciousness (i.e., the recognition of self) provided the rudiments of a kind of Golden Rule: "Do not do unto others what you would not have done unto you."[23]

Seshachar described three levels of consciousness:

1. Knowledge and awareness of the external world by exoceptors (e.g., organs of sight, hearing).

Exhibit 5–1 American Holistic Nurses' Association Position Statement on Holistic Nursing Ethics

Code of Ethics for Holistic Nurses

We believe that the fundamental responsibilities of the nurse are to promote health, facilitate healing and alleviate suffering. The need for nursing is universal. Inherent in nursing is the respect for life, dignity and right of all persons. Nursing care is given in a context mindful of the holistic nature of humans, understanding the body-mind-spirit. Nursing care is unrestricted by considerations of nationality, race, creed, color, age, sex, sexual preferences, politics or social status. Given that nurses practice in culturally diverse settings, professional nurses must have an understanding of the cultural background of clients in order to provide culturally appropriate interventions.

Nurses render services to clients who can be individuals, families, groups or communities. The client is an active participant in health care and should be included in all nursing care planning decisions.

In order to provide services to others, each nurse has a responsibility toward him/herself. In addition, nurses have defined responsibilities towards the client, co-workers, nursing practice, the profession of nursing, society and the environment.

Nurses and Self

The nurse has a responsibility to model health behaviors. Holistic nurses strive to achieve harmony in their own lives and assist others striving to do the same.

Nurses and the Client

The nurse's primary responsibility is to the client needing nursing care. The nurse strives to see the client as a whole, and provides care that is professionally appropriate and culturally consonant. The nurse holds in confidence all information obtained in professional practice, and uses professional judgment in disclosing such information. The nurse enters into a relationship with the client that is guided by mutual respect and a desire for growth and development.

Nurses and Co-Workers

The nurse maintains cooperative relationships with co-workers in nursing and other fields. Nurses have a responsibility to nurture each other, and to assist nurses to work as a team in the interest of client care. If a client's care is endangered by a co-worker, the nurse must take appropriate action on behalf of the client.

Nurses and Nursing Practice

The nurse carries personal responsibility for practice and for maintaining continued competence. Nurses have the right to utilize all appropriate nursing interventions, and have the obligation to determine the efficacy and safety of all nursing actions. Wherever applicable, nurses utilize research findings in directing practice.

Nurses and the Profession

The nurse plays a role in determining and implementing desirable standards of nursing practice and education. Holistic nurses may assume a leadership position to guide the profession toward holism. Nurses support nursing research and the development of holistically oriented nursing theories. The nurse participates in establishing and maintaining equitable social and economic working conditions in nursing.

Nurses and Society

The nurse, along with other citizens, has responsibility for initiating and supporting actions to meet the health and social needs of the public.

Nurses and the Environment

The nurse strives to manipulate the client's environment to become one of peace, harmony, and nurturance so that healing may take place. The nurse considers the health of the ecosystem in relation to the need for health, safety and peach of all persons.

Source: Courtesy of the American Holistic Nurses' Association, Flagstaff, Arizona.

2. Inner sensing, not directly derived from sensory data, but triggered by them (e.g., emotions, intentions, memories, dreams, imagination).
3. Knowledge of one's self (other than body) characterized by the ability to recognize the present from the information of the past and to project the future, establishing a continuity in one's lifetime. The belief that there is an "I," a self who does the perceiving, makes possible the creation of aesthetic, ethical, and spiritual values that are unique to persons.[24]

Of these three levels, it is possible that only the first is present in lower animals. In some higher mammals, there may be an element of the second. The absence of language in animals, however, makes it difficult for them to express, to compare, and to evaluate these experiences, and for humans to make a valid assessment of the extent to which this inner sensing has been developed. There is little doubt that the third level of consciousness is exclusive to human beings. Seshachar continued to explain that a fusion of the totality of impressions and experiences makes the consciousness an attribute unique to humans.

Holistic ethics embraces and strives for the fusion between self and others. In the process, it becomes a cosmic ecology, a flowing with the universal tide of events and a co-creator of celestial harmony. All events and ethical decisions become part of the unfolding of a harmonious order and a realization of potentials. Even tragic events can be analyzed within this harmonious spectrum with full realization of the fusion of relationships. One's own actions can become courageous, truth-full, being-full, beauty-full, assured, detached, and virtuous.[25]

DEVELOPMENT OF PRINCIPLED BEHAVIOR

Health care providers with a holistic ethics perspective and high standards of principled behavior are best prepared to analyze clinical dilemmas. Burkhardt and Nathaniel asserted that principled behavior flows from personal values that guide and inform one's responses, behaviors, and decisions in all areas of one's life.[26]

Values Clarification

Values develop over time and have cultural, familial, environmental, and educational components. Values clarification is a never-ending process in which an individual becomes increasingly aware of what is important and just—and why. Understanding the truth of a situation is usually more accurate, however, if people appreciate different views and openly share these perspectives.[27] At times organizations must clarify their values. They may begin by determining what staff, board members, management, and workers value about the elements of the organization's philosophy, and identifying specific expectations for each group. In selected groups, under the direction of a guide, the members can do focus exercises on self-awareness, clinical priorities, and opinions about value-laden issues.[28]

Often, patients must clarify their values in order to participate fully in ethical decision making. One such approach involves asking individuals to identify ten health-related behaviors that they do, and to explain why they do those behaviors. Doyle noted that the reasons given for practicing a behavior provide insight into the values surrounding the behavior, such as choosing not to exercise in order to have more time, or choosing to exercise because it helps in weight control.[29]

Legal Aspects

Health care providers must adhere to the law. All nurses are responsible and accountable to comply with the Nursing Practice Act and Rules and Regulations of the Board of Nurse Examiners in the state where they are licensed and work. Standards of professional nursing practice require that each nurse practice to the level of his or her knowledge and skills. This means that, whatever an individual nurse's personal ethic, he or she must still adhere to the standards of practice and to the law.

ANALYSIS OF ETHICAL DILEMMAS

We are all confronted daily with the need to make personal and professional ethical decisions. Some decisions are minor, but others are fraught with long-term multifaceted ramifications. In order to make decisions appropriately, it is necessary, first, to operate from a set of principles and, second, to have some sort of analytical method to help sort out and classify the elements of the problem. When the cases are institutional and patient care–oriented, there are well-established guidelines for analyzing individual cases in ethics that may be helpful.[30,31] Jonsen and colleagues divided the case analysis process into four components: (1) medical indications, (2) patient preferences, (3) quality of life, and (4) contextual issues. Present in every clinical ethical case, these four topics are necessary for a thorough analysis. The holistic approach adds questions of relationships: Who am I? What is my relationship to others? What other factors are contributing to my decisions? Am I wise and courageous enough to perceive and respect others' differences and honor them as I would honor my own beliefs?

Medical Indications

The underlying ethical principle in considering medical indications is beneficence: Be of benefit and do no harm. Discussion should focus on discerning the relationship between the pathophysiology and the diagnostic and therapeutic interventions available to remedy the patient's pathologic condition. Questions to be considered in this component are, What is the overall goal in this case? and, What should be the goal in cases such as this one?[32] For example, for the patient who is terminally ill there may be discussions about the futility of further treatment.

Patient Preferences

In all interventions, the preferences of the patient are relevant. The questions to be asked are, What does the patient want? Does the patient comprehend his or her choices? Is the patient being coerced? In some cases, there is no certainty because the patient is incapable of self-expression. Whenever possible, it is essential to ensure the patient's right to self-determination, based on his or her personal values and evaluation of risks and benefits. It is necessary, however, to be clear about what is realistically feasible before considering the patient's wishes.

In the case of a child, nurses must ask the questions, Do the parents understand the situation? Do the parents appear to have the best interests of the child at heart? Are the parents in agreement or discord?

Quality of Life

A patient enters a health crisis situation with an actual or potential reduction in quality of life, manifested by the signs and symptoms of the illness. The objective of health care interventions is to improve

quality of life. In each case, multiple questions surround quality-of-life issues: What does quality of life mean, in general? In particular? How are others responding to their perceptions of it? What levels of quality impose what obligations on providers? This component may be a difficult component of the analysis of clinical problems, but it is indispensable.

Contextual Issues

Every case has a patient at its center. The patient exists in a social, psychologic, economic, and relational environment. To be relevant, all decisions must be considered in the light of this expanded conceptual and holistic view of personhood and personality. The major impacts are psychologic, emotional, financial, legal, scientific, educational, and religious.

ADVANCE MEDICAL DIRECTIVES

The Patient Self-Determination Act, effective December 1, 1991, requires that all individuals receiving medical care also receive written information about their right to accept or refuse medical or surgical treatment, and their right to initiate advance directives, such as living wills and durable powers of attorney. Advance medical directives are of two types: treatment directives (often referred to as living wills), and appointment directives (often referred to as powers of attorney or health proxies). A living will specifies the medical treatment that a patient wishes to refuse in the event that he or she is terminally ill and cannot make those decisions. A durable power of attorney for health care appoints a proxy, usually a relative or trusted friend, to make medical decisions on behalf of the patient if he or she can no longer make such decisions. It has broader applications than a living will and can apply to any illness or injury that could leave the patient incapacitated.

An advance directive applies only if a patient is incapacitated. It may not apply if, in the opinion of two physicians, the patient can make decisions. Individuals can cancel advance directives at any time. An advance directive may be simple or complex. Individuals should give a copy of the advance directive to their family members and physician, and should carry a copy if and when hospital admission is necessary.

As part of patient assessment, a nurse may consider asking the following questions:

- Have you discussed your end-of-life choices with your family and/or designated surrogate and health care team workers?
- Do you have basic information about advance medical directives, including living wills and durable powers of attorney?
- Do you wish to initiate an advance medical directive?
- If you have already prepared an advance medical directive, can you provide it now?

ETHICS EDUCATION AND RESEARCH

Nurses are engaged in moral endeavors, and thus confront many challenges in making the right decision and taking the right action.[33] Both nursing research and nursing practice rest upon an ethic of helping whole people, rather than simply amounting to a technical undertaking. This suggests that the relationship between the ethical and the technical should be a more explicit feature in education, practice, and research.[34]

The use of classroom debates can be helpful in teaching ethical content that is often nebulous and difficult for students to comprehend and apply. Debates enhance critical thinking skills through researching

issues and developing a stance that can be supported in scientific literature. At one university, a student debate project involving ethical issues with chronically ill clients led to many students changing their views during the debates. At the conclusion, many students evaluated the ethical debates as a positive learning experience.[35]

In one study, practicing nurses rated behaviors reflecting values in the American Nurses Association (ANA) Code for Nurses as more important than did senior students, thereby supporting the notion that practice contributes to value formation. The ongoing development and internalization of the nursing professions' values requires active involvement by staff development educators and nurse leaders. The phenomena of value formation and development of professional values appear to mirror the novice-to-expert model.[36]

In a qualitative study of nurses' ethical decision making, focus groups of nurses in diverse practice contexts were used as a means to explore the meaning of ethics and the enactment of ethical practice. The findings center on the metaphor of a moral horizon—the horizon representing "the good" toward which the nurses were navigating. The findings suggest that currents within the moral climate of nurses' work significantly influence nurses' progress toward their moral horizon. All too often, the nurses found themselves navigating against a current characterized by the privileging of biomedicine and a corporate ethos. Conversely, a current of supportive colleagues, as well as professional guidelines and standards and ethics education, helped them to move toward their moral horizon.[37]

CULTURAL DIVERSITY CONSIDERATIONS

The increasing cultural diversity in modern society creates difficulties in cross-cultural ethical decision making for health care workers. Nurses who are sensitive and knowledgeable about the cultural background of individual patients acknowledge an individual's cultural background and consider the characteristics of different cultures when planning the patient's care. This facilitates the process of ethical decision making. The social, economical, political, technological, and cultural changes in industrial countries during the 20th century encouraged mobilization of people between countries. For example, in anticipation of the transfer of control of Hong Kong from British to Chinese governance in 1997, large numbers of Hong Kong citizens immigrated to other developed countries such as Australia, the United States, and Canada in the 1980s and 1990s. In Canada, the number of Hong Kong immigrants increased from 7,611 in 1968 to 31,309 in 1992. In this multicultural environment, many health care providers still adhere to the myth that all individuals from different cultures are transformed into the Western culture and its associated values and perceptions. Many people from different countries retain their culture, beliefs, and values after they move to a new country.[38]

Ethical issues in international nursing research and the perspectives of an International Center for Nursing Ethics are needed to develop an international consensus of ethical behavior in research. Suggested broad guiding principles for designing and reviewing international research are: (1) respect for persons; (2) beneficence; (3) justice; (4) respect for community; and (5) contextual caring.[39] Nurse researchers from the School of Nursing in Hong Kong surveyed different cultural settings to reveal their perceptions of ethical role responsibilities relevant to nursing practice. Drawing on the Confucian theory of ethics, the objective was to understand nursing ethics in the context of multiple role relationships. The Role Responsibilities Questionnaire (RRQ) was given to a

sample of nurses in China (n = 413), the U.S. (n = 163), and Japan (n = 667). Multidimensional preference analysis revealed the patterns of rankings given by the nurses to the statements they considered as important ethical responsibilities:

- Chinese nurses were more virtue-based in their perception of ethical responsibilities.
- American nurses were more principle-based.
- Japanese nurses were more care-based.

The findings indicate that the RRQ is a sensitive instrument for outlining the embedded sociocultural factors that influence nurses' perceptions of ethical responsibilities vis-à-vis the realities of nursing practice. This information could be important in the fostering of partnerships in international nursing ethics.[40]

CONCLUSION

Holistic ethics embraces both the traditional and the masculine–feminine historical perspectives, but transcends both by taking into account the unity of being. The holistic view of human beings is one of self-actualization, as it places the highest value on the development of the individual to attain higher levels of human awareness and, thus, advances the whole of humanity. Within this framework, a unique moral viewpoint takes its origin. The cybernetic relationship of an act to the universal "I" becomes the new categorical imperative of the holistic person. Evolution and consciousness should be directed toward positive ends. They should be directed toward the "good" of people perceived by a contemplation of the reality of being. The process begins with the individual and his or her own self-realization within a universal context. It is the development of total personality where consciousness shines through with self-luminosity.[31] The best utilization of this theory is to internalize these principles and begin to apply them practically within our own settings.

Many hospitals are developing ethics committees, and soon there may be legislation requiring the participation of these committees in decision-making processes. Ethically knowledgeable nurses are poised to become active participants in ethics committees and decision-making discussions. When those opportunities arise, nurses can begin to articulate a holistic approach that supports the very essence of a comprehensive world ethical view.

DIRECTIONS FOR FUTURE RESEARCH

1. Determine how and where the new theory of holistic ethics fits into the continuum of emerging ethical theories.
2. Develop a process of clinical case analysis based on the process of holistic ethics.
3. Examine specific clinical situations through a process of holistic ethics.
4. Analyze the application of holistic ethics to planetary ethical issues.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- What new insights do I have about the process of ethics?
- How does ethics fit into my clinical practice?
- Do I have the interest and beginning ability to become involved in an institutional ethics committee?
- What role does ethics play in my day-to-day personal life?
- Am I ready to look at planetary issues from a holistic ethical perspective?

NOTES

1. F. Hendrickson and G.L. Deloughery, Ethical Influences on Nursing, in *Issues and Trends in Nursing*, ed. G.L. Deloughery (St. Louis: C.V. Mosby, 1991), 180.
2. A. Jonsen, *The New Medicine and the Old Ethics* (Cambridge, MA: Harvard University Press, 1990), 138.
3. M. Corley and D. Raines, An Ethical Practice Environment as a Caring Environment, *Nursing Administration Quarterly* 17, no. 2 (1993):68–74.
4. Corley and Raines, An Ethical Practice Environment.
5. Hendrickson and Deloughery, Ethical Influences on Nursing, 180.
6. R.M. Veatch, ed., *Medical Ethics* (Prentice Hall, 2002).
7. D. Orentlicher, *Matters of Life and Death: Making Moral Theory Work in Medicine and the Law* (Princeton, NJ: Princeton University Press, 2001).
8. Ibid.
9. Hendrickson and Deloughery, Ethical Influences on Nursing, 187.
10. M. Fowler, Ethical Decision Making in Clinical Practice, *Nursing Clinics of North America* 24, no. 4 (1989):955–965.
11. S. Milner, An Ethical Practice Model, *Journal of Nursing Administration* 23, no. 3 (1993):22–25.
12. H. Sidgwick, *Ethics* (Boston: Beacon Press, 1960), 59–63.
13. Ibid., 273.
14. Ibid., 163–169.
15. L. Keegan and G. Keegan, A Concept of Holistic Ethics for the Health Professional, *Journal of Holistic Nursing* 10, no. 3 (1992):205–217.
16. L. Keegan and G. Keegan, Holistic Ethics, unpublished manuscript, 1994.
17. P.M. Gregorios, *Science for Sane Societies* (New York: Paragon House, 1987).
18. M. Born, *Born–Einstein Letters* (New York: Walker, 1971).
19. Keegan and Keegan, A Concept of Holistic Ethics for the Health Professional.
20. L. Keegan and G. Keegan, Spirituality and the Technological Crisis, *Healing Currents* 11, no. 2 (1987):26–28.
21. D. Singh, The Psychology of Consciousness, in *The Evolution of Consciousness*, ed. K. Gandi (New York: Paragon House, 1983), 68–86.
22. Keegan and Keegan, A Concept of Holistic Ethics for the Health Professional.
23. Singh, The Psychology of Consciousness.
24. B.R. Seshachar, Biological Foundations of Human Evolution and Consciousness, in *The Evolution of Consciousness*, ed. K. Gandi (New York: Paragon House, 1983), 28.
25. Keegan and Keegan, A Concept of Holistic Ethics for the Health Professional.
26. M.A. Burkhardt and A.K. Nathaniel, *Ethics and Issues in Contemporary Nursing* (Albany, NY: Delmar Publishers, 1998).
27. B.C. Banois, Principled Behavior Applied to Everyday Life, unpublished manuscript, 1997.
28. B.S. Gingerich and D.A. Ondeck, Values Incorporated Throughout the Organization, *Caring* 12 (1993):18–23.
29. E.I. Doyle, Recognizing the Value–Health Behavior Connection: "What I do and why I do it," *Journal of Health Education* 25 (1994): 116–118.
30. A.R. Jonsen, Case Analysis in Clinical Ethics, *Journal of Clinical Ethics* 1, no. 1 (1990):63–65.
31. A.R. Jonsen et al., *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 5th ed. (McGraw Hill/Appleton Lange, 2002).
32. S.E. Shannon, Living Your Ethics, in *Critical Care: Body-Mind-Spirit*, ed. B.M. Dossey et al. (Philadelphia: J.B. Lippincott, 1992), 135–141.
33. M.C. Corley, Nurse Moral Distress: A Proposed Theory and Research Agenda, *Nursing Ethics* 9, no. 6 (2002 Nov):636–650.
34. A.M. Carson and G.J. Fairbairn, The Whole Story: Towards an Ethical Research Methodology, *Nursing Research* 10, no. 1 (2002):15–29.
35. L. Candela, S.R. Michael, and S. Mitchell, Ethical Debates: Enhancing Critical Thinking in Nursing Students, *Nurse Educator* 28, no. 1 (2003 Jan–Feb):37–39.
36. M.J. Schank and D. Weis, Service and Education Share Responsibility for Nurses' Value Development, *Journal of Nursing Staff Development* 17, no. 5 (2001 Sep–Oct):226–231.
37. P. Rodney, C. Varcoe, J.L. Storch, G. McPherson, K. Mahoney, H. Brown, B. Pauly, G. Hartrick, and R. Starzomski, Navigating Towards a Moral Horizon: A Multisite Qualitative Study

of Ethical Practice in Nursing, *Canadian Journal of Nursing Research* 34, no. 3 (2002 Oct):75–102.

38. F. Wong and S.M. Anderson, Team Approach in Cross-Cultural Ethical Decision Making: A Case Study, *Progress in Transplantation* 17, no. 1 (2003):38–41.
39. Working Group for the Study of Ethical Issues in International Nursing Research, Ethical Considerations in International Nursing Research: A Report from the International Center for Nursing Ethics, *Nursing Ethics* 10, no. 2 (2003 Mar):122–137.
40. S.M. Pang, A. Sawada, E. Konishi, D.P. Olsen, P.L. Yu, M.F. Chan, and N. Mayumi, A Comparative Study of Chinese, American, and Japanese Nurses' Perceptions of Ethical Role Responsibilities, *Nursing Ethics* 10, no. 3 (2003 May):295–311.
41. Seshachar, Biological Foundations of Human Evolution and Consciousness.

CORE VALUE 2

Holistic Education and Research

VISION OF HEALING

The Web of Life

Human beings are embedded in the web of life.[1] We are part of a highly complex, integrative living system consisting of cyclic processes in which we participate and on which we depend. What we call objects are actually networks of relationships. What we call parts are, in fact, patterns in networks of relationships. All networks, with their patterns, contain or are nested in other networks, and are inseparable. As humans, we are engaged in an evolving process that affects—and is affected by—the patterns and rhythms that we support and in which we dwell. We are interconnected and interdependent with each other, as well as with the objects and parts that we try to view as "other." We are engaged in an ongoing dance that proceeds through a subtle interaction of competition and cooperation, creation and mutual adaptation.[2]

As nurses, we need to de-emphasize the classification and categorization of objects and parts. We need to shift our thinking to take into account configurations, connections, and contexts, rather than just attending to affected parts of wholes. Our thinking needs to expand to a holistic and ecologic perspective that is grounded in a natural and social environment. We need to shed the common notion of hierarchical structures, which too often are seen in terms of domination and control. Instead, we need to consider the multileveled order found in nature that comprises the web of life. Our models need to allow the creation of new structures and modes of behavior absorbed in the process of development, learning, and coevolution. We need to recognize that we are engaged with open systems that operate far from equilibrium, and need to appreciate the nonlinear interconnectedness of all the components of the network(s).

It is especially important to remember that nurses are networks within other network(s), and that nurses are wounded healers. As nurses, we are often tempted to ignore our own woundedness. We must learn to acknowledge our wounds, as well as to recognize our strengths. When a nurse and a client who come together embrace their woundedness, healing occurs for both. Healing does not simply flow from the nurse to the client, for the potential to heal already exists within the client. The nurse encourages the client's process of inner healing. Healing occurs as the client and the nurse both acknowledge their life processes and cooperate to promote growth.[3]

As the best of traditional practices continue to merge with the best of holistic practices, the art of healing will likewise progress. Creativity and spontaneity will be released as we admit our own weaknesses in order to open creatively to our clients. Only then will we know the pow-

erful part of our being, and fully realize our interconnections. The use of self, directed by intention and with presence, provides us with wondrous possibilities for healing.

NOTES

1. F. Capra, *The Web of Life* (New York: Doubleday, 1996), 46.
2. Ibid., 36.
3. M.S. Burkhardt and M.G. Nagai-Jacobson, Nurturing and Caring for Self, in *Holistic Nursing Care*, eds. J.D. Colbath and P.M. Prawlocki, Holistic Clinics of North America 36(1) (Philadelphia: Saunders, 2001).

Chapter 6

The Psychophysiology of Bodymind Healing

Genevieve M. Bartol and Nancy F. Courts

NURSE HEALER OBJECTIVES

Theoretical

- Articulate a comprehensive conceptual model of bodymind interactions.
- Interpret the application of selected models, theories, and research in the field of psychoneuroimmunology.
- Explain the interconnections of mind modulation and the autonomic, endocrine, immune, and neuropeptide systems.

Clinical

- Recognize the implications of bodymind interactions for clinical practice.
- Incorporate the knowledge of bodymind interactions in planning nursing interventions.

Personal

- Identify one's own patterns of bodymind interactions as expressed in attitudes, tensions, and images.
- Recognize the implications of one's own bodymind patterns for self-care and self-healing.

DEFINITIONS

Autopoiesis: the self-organizing force in living systems.

Bifurcation: a point at which transformational change occurs in a complex system; the point at a fork in the road of life.

Chaos: the stable and orderly, but irregular, unpredictable behavior of a complex system.

Cycles: one of the simplest nonlinear behaviors that is periodic and recurrent.

Bodymind: a state of integration that includes body, mind, and spirit.

Information Theory: a mathematical model that helps explain the connections between consciousness and bodymind healing.

Limbic-Hypothalamic System: the major anatomic modulating link connecting the brain/mind and the autonomic, endocrine, immune, and neuropeptide systems.

Mind Modulation: the bidirectional interrelationships of thoughts and feelings with neurohormonal messengers of the nervous, endocrine, immune, and neuropeptide systems that support bodymind connections.

Network: an interconnected and interrelated system.

Neuropeptides: messenger molecules produced at various sites throughout the body to transmit bodymind patterns of communication.

Neurotransmitters: chemicals that facilitate the transmission of impulses through nerves in the body.

Psychoneuroimmunology: a branch of science that strives to show the connections among psychology, neuroendocrinology, and immunology.

Receptors: sites on cell surfaces that serve as points of attachment for various types of messenger molecules.

Self-Regulation Theory: a person's ability to learn cognitive processing of information to bring involuntary body responses under voluntary control.

Ultradian Performance Rhythm: rhythmic repetition of certain phenomena in living organisms, such as varying patterns of activity and rejuvenation, that occur in less than 24 hours.

NEW SCIENTIFIC UNDERSTANDING OF LIVING SYSTEMS

Recent developments in science reveal human beings in a new light. The mechanistic view of the world of Descartes and Newton is giving way to a holistic and ecologic view. The habit of looking at persons from the perspective of the body, mind, or spirit is misleading and creates problems of its own. The body can no longer be considered a machine powered by the mind or spirit, to which health care practitioners apply assorted therapies to effect healing. Rather, humans are now understood to be complex, highly integrative systems that are embedded in and supporting other systems. As we free the scientific imagination and increase our knowledge of laws that are the opposite of mechanistic, such as the concepts of nonlocality and superposition of states in quantum physics, our understanding of living systems will continue to change.[1,2] The term *bodymind* includes the body, mind, and spirit as a unified whole.

Quantum Theory

In the 1920s, discoveries in quantum physics shocked the scientific community. The old way of viewing phenomena no longer fit. Heisenberg described the changed world as a complicated tissue of events, in which connections of different kinds alternate, overlap, or combine, and thereby determine the texture of the whole.[3] In the past, the properties and behavior of the parts were believed to determine those of the whole. The advances in quantum physics made it clear that the relationship is reciprocal: The whole also defines the behavior of the parts.

The realization that systems are integrated wholes that cannot be understood simply by analysis shattered scientific certitude. No longer was it possible to believe that, given enough time, effort, and money, all questions would have answers. Rather, there was a fundamental shift to accepting that all scientific concepts and theories have limitations. Scientific explanations do not provide complete and conclusive answers, but instead generate other questions.[4] The more we learn, the more we discover how much we do not know. Even one additional piece of data will change the entire configuration. It is important to remain open to all possibilities, because absolute certainty is an illusion.[5]

Increasingly, scientific findings demonstrate a changing world. Planck found that radiant energy was emitted from light sources in discrete amounts, or "quanta," and that changes in the amount of radiant energy occurred in leaps, not sequential steps.[6] Bohr extended Planck's discovery to the field of subatomic particles and argued that electrons could move from one orbit of energy to another. The behavior of light does not follow one set of rules. Light possesses the qualities of both waves and particles. It is not as if one explanation is correct and the other is wrong; both inter-

pretations are useful in explaining the behavior of light in different situations.

The world is complex and unified; parts complement one another and participate in the whole. Similarly, all parts of the body work together. Health and illness are indivisible; both are natural and necessary. Hyperpyrexia (fever) may be seen as a sign of illness, as well as a sign of the body's healthy response to a threat. Fever indicates that the hypothalamic set point of the body has changed.[7] Such an alteration occurs in the presence of pyrogens (e.g., bacteria, viruses). A mild temperature elevation up to 39°C (102.2°F) stimulates the body's immune system, increases white blood cell production, and reduces the concentration of iron in blood plasma, thereby suppressing the growth of bacteria. Fever also stimulates the production of interferon, which protects the body against viruses. Fever can be beneficial because it helps to defend the body against pyrogens. Using medications to lower the body temperature prematurely, particularly in the first 24 hours of fever, may actually interfere with this important defense mechanism.

Systems Theory

The major traits of systems thinking appeared concurrently in several disciplines during the first half of the twentieth century, but it was von Bertalanffy's concept of the open system and his general systems theory that established systems thinking as a predominant scientific movement.[8] The resultant theories and models of living systems initiated a radical shift in perceptions of human beings. It is now believed that persons and their environments make up an interconnected dynamic system in which a change at any point may effect changes at other points. The idea that the world is hierarchical, with each level organized separately, has been replaced with a new understanding of relatedness and context.

Human beings are living systems, organizationally closed and structurally open, embedded within the web of life.[9] They are "organizationally closed" because they are self-organizing; that is, they establish their own order and behavior rather than submitting to those imposed by the environment. They are "structurally open" because they engage in a continual exchange of energy and matter with their environment. Words like *feedback*, *integration*, *rhythm*, and *dynamic equilibrium* account for the continually changing components of living systems.[10] These components do not operate in isolation from each other. A dysfunction in any one system of the body reverberates through the others. For example, a dysfunction of the endocrine system referred to as hypothryroidism may manifest itself by thinning hair or clinical depression.[11] Hypothyroidism, in fact, may be secondary to a dysfunction in another organ system and may not represent primary failure of the thyroid gland.[12] Thyroid deficiency may occur when the pituitary gland is malfunctioning or when there is damage to the hypothalamus. It is not possible to identify conclusively a single cause of what was formerly named a primary dysfunction. All body systems participate in the biodance: Changes in one system result in changes in the other systems and, in circular fashion, a system may initiate changes within itself, just as the pituitary gland will increase its secretion of thyroid-stimulating hormone (TSH) when the thyroid gland is underproducing thyroid hormone.

Theory of Relativity

Early in the twentieth century, Einstein developed a system of mechanics that acknowledges the relative character of

motion, velocity, and mass, as well as the interdependence of matter, time, and space.[13] The theory is based on the principle that there is no absolute frame of reference independent of the observer. Each person views others from his or her own perspective, including his or her particular biases. Einstein characterized his feelings about this scientific revelation as having the ground pulled out from under him.[14]

Scientists can no longer describe their work as finding a piece to one gigantic puzzle, or as adding a building stone to a firm foundation of knowledge. Rather, it has become increasingly apparent that scientific knowledge is a network of concepts and models, none of which is any more fundamental than the other. All things (objects) and events (happenings) in one's life are connected and relative within the whole. The mind and body are inseparably intertwined. Whatever happens in one's life is interconnected. Thoughts, feelings, and actions influence a person's state of health and illness.

Even religious beliefs have an impact, though it is not clear in what way. Koenig and associates reported that Christian persons who attend religious services at least once per week, and who read the Bible or pray regularly, have consistently lower diastolic blood pressure readings than those who do not.[15,16] A lower diastolic reading, which indicates the blood pressure when the heart relaxes, is associated with improved health. It is not known whether these religious activities influence blood pressure, or if a specific spiritual orientation accompanies these activities and thus accounts for the difference.

Studies using imaging devices show that mindfulness meditation strengthens the neurological circuits that calm a part of the brain that acts as a trigger for fear and anger. Studies using electroencephalographs found that the brains of people who practiced mindfulness increased the amount of activity in the brain associated with positive emotions. Happiness and inner balance are crucial to survival. The tragedy of September 11, 2001 demonstrated that modern technology and human intelligence informed with hatred can lead to immense havoc and suffering. We need to cultivate our inner development if we are to keep our destructive emotions in control.[17]

Principles of Self-Organization

During the 1970s and 1980s, the key ideas of current models of self-organizing systems were refined and extended, and a unified theory of living systems emerged.[18] These models encompassed the creation of structures and modes of behavior in the processes of development, learning, and co-evolution. In the past, living systems were viewed from two perspectives: in terms of physical matter (structure) and the configuration of relationships (pattern). *Structure* is concerned with quantities—things weighed and measured. *Pattern* is concerned with qualities and is expressed by a map of the configuration of relationships. Qualities, such as color or size, were considered accidental characteristics. For example, a bicycle may be red or green; may stand 24 or 26 inches high; may have a light or heavy frame, and remains a bicycle as long as it has the configuration of relationships consistent with a bicycle.

Systems, whether nonliving or living, are configurations of ordered relationships whose attributes are the properties of pattern. The bicycle, a nonliving system, consists of a number of components arranged to perform a particular function. The various kinds of bicycles (e.g., mountain bicycles, touring bicycles) embody the essential characteristics known as a bicycle. In brief, bicycles have a structure with specific components and operate as bicycles as long as the pattern of relationships that defines it as a bicycle remains.[19] Liv-

ing systems, however, are fundamentally different from nonliving systems. Living systems do not function mechanically and are not explained just by physical principles. The components of living systems are interconnected by internal feedback loops in a nonlinear fashion and are capable of self-organization.

The activity of living systems not only is purposeful, but also appears to be under the direction of an overall design or purpose.[20] The pattern of organization of living systems includes a fundamental self-organizing force known as autopoiesis.[21] Yet, if the pattern of a living system is destroyed, the system dies even though all the components of the system remain intact. The living system cannot be restored simply by recreating the pattern; however, a nonliving system, such as a bicycle, will regain function if the parts are reassembled correctly. Living systems do not rest in a steady state of balance as do nonliving systems; they operate far from equilibrium.[22] Stability in living systems embodies change. Relationships are not linear, but extend in all directions. Bifurcation occurs and generates new feedback loops.[23] Thus, living systems regulate and recreate themselves.

Life process (cognition) is the link between pattern and structure in a living system.[24] Life process is "the activity involved in the continual embodiment of the system's pattern of organization."[25] It is related to autopoiesis, and may be considered two distinct facets of the same phenomenon of life. All living systems are cognitive systems, and cognition indicates the existence of an autopoietic network.[26] Structure, pattern, and process are inextricably intertwined in a living system.

Organisms appear to be under the direction of an overall design or purpose and do not just function mechanically. For example, the symptoms experienced by humans represent attempts to gain health and, therefore, are signals of stability, not breakdown. The human immune system recognizes an invading organism as dangerous and quickly reacts to counter the threat. Symptoms are really signs of the inherent organization and adaptability of a living system. We cannot unerringly predict the outcome of these complex relationships among organisms—one person may become sick and die while another is seemingly unaffected and yet infects others with whom he has contact. Even invading organisms, which are also living systems, learn and adapt. The ability of pathogens to modify themselves and develop resistance to antibiotics is a striking example of a living system's ability to reorganize.

Bell's Theorem

Cause-and-effect thinking with its before, after, now, and later sequence is no longer acceptable. According to Bell's theorem, the whole determines the actions of the parts, and changes occur instantaneously.[27] Experience teaches us that not all people respond in the same way to the same treatment. Peptic ulcers, for example, were once considered the result of excessive production of stomach acid stemming from stress. Treatment was directed toward reducing the stress with rest and counteracting the acid with a Sippy diet (beginning with milk and cream, with gradual addition of other foods, the amounts increasing until on day 28 the patient is placed on a regular diet). Some patients recovered after submitting to this regimen; others did not. Did those who recovered do so because of the treatment of diet and rest, or did some other intervening factor bring about this change? For some patients, it is likely that the enforced rest increased their stress and the restrictive diet exacerbated the ulcer. We have since learned that peptic ulcers are associated with a common bacterium and may be healed with an antibiotic. In addition, we have learned that we

can prevent the development of peptic ulcer in patients who have experienced major injury (a not uncommon consequence of trauma) by the prophylactic administration of ranitidine hydrochloride (Zantac™). Even a fleeting thought or a passing feeling can hasten—or hinder—recovery. Changes do not happen in an orderly, stepwise sequence. Healing does not take time, but is dependent on hope and belief beyond time. Beliefs, thoughts, and feelings are part of the configuration, and each affects the human states of wellness and illness. People, for example, have personal preferences for coping with adverse events. Miller classifies people as monitors and blunters.[28] Monitors need information to reduce their stress while blunters prefer distraction. Explaining the details of upcoming surgery to a monitor can be expected to reduce stress and promote healing; not so for blunters. Blunters prefer to trust in the skills of the caregiver and do not even want to hear how the surgery will be accomplished.

Personality and Wellness

Researchers have unsuccessfully tried to link specific illnesses with particular personality constellations.[29] It has been found, for example, that individuals with peptic ulcers have as many personality configurations as does the general population. Several researchers, however, have uncovered particular personality traits associated with wellness.[30] Schwartz discovered that persons who attend to symptoms, sensations, and feelings; who connect those signals to events in their lives; and who express what is occurring have a stronger immune profile and healthier cardiovascular system than those who do not.[31] This capacity became known as the Attend, Connect, Express (ACE) Factor. Kabat-Zinn developed a training program in mindfulness (healthy attention) to help persons cope with a variety of chronic illness and intractable pain.[32]

Pennebaker found that persons who admit their feelings to themselves and others have healthier psychologic profiles and fewer illnesses than those who do not.[33] After observing that criminals seemed to relax and experience relief after confession, despite the fact that their confessions also brought certain punishment and loss, Pennebaker devised an experiment to test if disclosure of sexual and other traumas would bring similar relief. On five successive days, he asked 46 male and female students to go into a room and to write continuously for 20 minutes about the most upsetting or traumatic experience of their lives. Many students wrote about experiences that they had never mentioned to others and had even tried deliberately to erase from their memories. Students reported that the first day was disturbing and painful, but by the fifth day, they experienced resolution and calm. Later, Pennebaker teamed up with Kiecolt-Glaser to study the effect of disclosure through writing on health.[34] Students who wrote about traumas had improved immune systems and fewer reports of illness, even though they had no other therapeutic intervention.

Ouellette discovered that individuals who have a sense of control over their quality of life, health, and social conditions; have a strong commitment to work (or creative activity) and relationships; and view stress as a challenge, not a threat, have stronger immune systems.[35] Ouellette collaborated with Maddi to show that this combination of qualities, known as the "hardiness factor," is not simply a reflection of well-being that comes from good health practices. Even after these researchers established controls for good health practices, including exercise, diet, relaxation regimens, and social support, hardiness emerged as the most powerful protector of health.

Solomon showed that persons who assert their needs and feelings have more balanced immune responses.[36] McClelland argued that persons who are strongly motivated to form relationships with others based on unconditional love and trust have more vigorous immune systems and fewer illnesses.[37] Luks discovered that altruistic persons suffer fewer illnesses than others.[38] Linville found that persons who explore many facets of their personalities can more effectively withstand stressful life circumstances.[39] Although a direct cause-and-effect relationship between any personality factor and health or illness cannot be determined, this research indicates that developing personality strengths to protect one from the stresses of living seems also to bolster one's defense against illness.

Information Theory

Patterns of communication and patterns of organization in organisms can be viewed analogously.[40] Information theory, a mathematical model, was developed to define and measure amounts of information transmitted through telegraph and telephone lines. The theory was used to explain how to get a message coded as a signal in order to determine what to charge customers for messages. A coded message (signal) is essentially a pattern of organization. Information flow (i.e., the patterns of communication and organization) in human beings is able to unify physiologic, psychologic, sociologic, and spiritual phenomena in a holistic framework. Information flow is the missing piece that makes it possible to transcend the bodymind split, because information resides in both the body and the mind.[41] According to Damasio, even our emotions and feelings are sources of vital information. Emotions-proper are life-regulating phenomena that help maintain our health by making adaptive changes in our body states and form the basis for feelings. The information generated by these processes is designed to be protective and is more complex than reflexes.[42]

Santiago Theory of Cognition

Derived from the study of neural networks, the Santiago theory of cognition is linked to the concept of autopoiesis (continual embodiment of the system's pattern of organization).[43] Cognition is generally defined as the process of knowing or perceiving; it is associated with the mind, implicitly with the brain and nervous system. Yet, the Santiago theory offers a radical expansion of the traditional concept of cognition. In this new view, cognition involves the whole process of life, including perception, emotion, and behavior. Even the cells that make up the immune system perceive the characteristics of their environment and will, for example, move to the site of a wound and increase in numbers to deal with an invading organism. Despite the absence of a brain, cognition is present; in this event, it can be described as "embodied action."[44] Perception and action in these cells are inseparable.

A living organism is an interconnected network (system) that undergoes structural change while preserving its pattern of organization as it interacts with other systems.[45] Actually, changes in both autopoietic networks take place. In other words, one living system may trigger an autopoietic network response in the other, but it does not direct or control the response. A living organism chooses which stimuli from the environment will trigger structural changes. Moreover, not all changes in an organism are acts of cognition. For example, a person who is injured in an accident does not specify and direct those structural changes. However, other structural changes (e.g., perception and response of the circulatory system) that accompany the imposed changes are acts of cognition.

The Santiago theory helps explain how humans receive, generate, and transduce information. New ideas and events evoke bodymind changes; that is, neural pathways and consciousness couple to enable information transduction.[46] For example, a client with severe episodes of asthma that increasingly interfere with her activities may remember that her mother's asthma also became more severe as she aged, and the client may begin to become despondent at what she views as an inevitable decline in her own health. After a nurse teaches her how to monitor her asthma with the help of a flow meter, the client begins to see a pattern to her attacks and identifies potential triggers. She gains a new understanding of bodymind connections and uses both traditional and holistic interventions to interrupt the triggers. These interventions not only lead to, or result in a change in, the pattern of her attacks; they also provide her with a greater sense of control over her asthma. The asthma attacks decrease in severity and frequency. The client has a personal experience of information transduction and acquires a new understanding of the interconnectedness of body-mind-spirit.

The extent of the interactions that a living system can have with its environment outlines its "cognitive domain."[47] Emotions are not just an accompaniment of perception and behavior; they are an inherent part of this domain. For example, a fear response to a situation initiates an entire pattern of physiologic processes: Blood goes to the large skeletal muscles, making it easier to run, while the face blanches. Freezing for a moment allows time to assess the situation and determine if hiding may be a wiser choice. Circuits in the brain's emotional centers trigger a flood of hormones that sounds a general alert. Although experience and culture modify responses, emotions occur simultaneously with, and are part of, every cognitive act.

EMOTIONS AND THE NEURAL TRIPWIRE

The traditional view in neuroscience has been that the sensory organs transmit signals to the thalamus and from there to the sensory process areas of the neocortex,[48] which translates the signals into perceptions and attaches meanings. The signals then move to the limbic system, which sends the appropriate response to the body. This has all changed, however, with the discovery of a separate, smaller bundle of neurons that leads directly from the thalamus to the amygdala (Figure 6–1). Sensory impulses go directly from the sensory organs to the amygdala, allowing for a faster response. The amygdala triggers an emotional response even before the person fully understands what is happening. Taking immediate action, the amygdala sends impulses through the brain to the body. If the stimulus is traumatic, the amygdala responds with extra strength. Key changes take place in the locus ceruleus, which regulates catecholamines; adrenaline and noradrenaline are released. Other limbic structures such as the hippocampus and the hypothalamus respond, and the main stress hormones bring about the typical body responses labeled fight or flight, faint or freeze. Changes in the brain's opioid system that secretes endorphins prepare the person to meet the danger. Meanwhile, the neocortex processes the impulse, and a more considered response follows. Emotions are not dispensable, but rather an integral part of the whole.

State-Dependent Memory and Recall

What people learn depends on their mood or feelings at the time of the experience.[49] Feelings are integral to human living; they are not just an extravagance or an annoyance. The emotion-carrying molecules, or

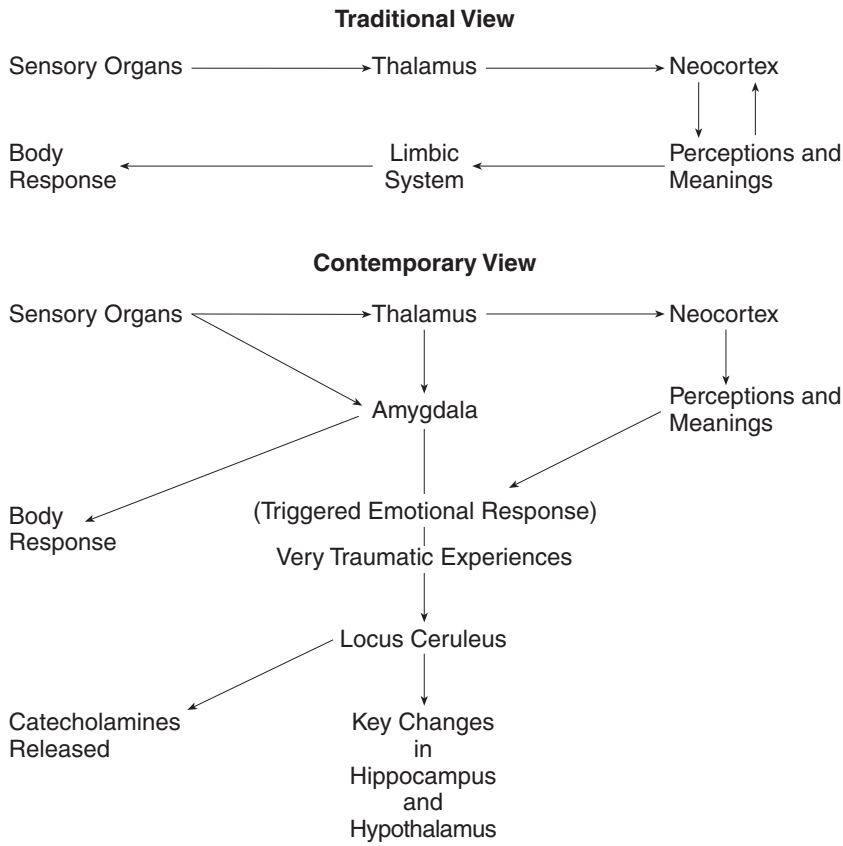


Figure 6–1 Emotions and the Neural Tripwire. *Source:* Copyright © Genevieve Bartol.

ligands, which accompany all human activity, bind to cellular receptors and send an informational message to the cell where they can be stored as memories.

Feelings and actions are intertwined. People are more likely to help others when they are in a good mood and more likely to hurt others when they are in a bad mood. Likewise, feelings and memories are intertwined. Thoughts that occur throughout daily routines are repeated patterns of memories and their associative emotional connections. Memories are accompanied by emotions that, in turn, are influenced and affected by the context in which they were acquired. A particularly traumatic experience is stamped in the memory with special strength. Subsequent stimuli in new situations and emotional experiences can attach to and reawaken past memories. These reactivated thoughts and emotions direct and shape our actions in the present.

Feelings or mood also play a major role in bodymind healing. Recent work with persons suffering from post-traumatic stress disorder (PTSD) has revealed that relearning is the route to healing. Writing therapy, bibliotherapy, art therapy, and even traditional talk therapies are all ways of unfreezing a picture frozen in

the amygdala that is capable of triggering the fight or flight, freeze or faint response provoked by seemingly benign stimuli. At the same time, body work is often used to release these pockets of energy that are frozen in the body. Because people have network responses with the systems that they contain and those with which they nest, healing can occur from multiple directions.[50]

Location of the Brain Centers

Old models for brain functioning were the telegraph or telephone by which messages were sent from one point to another. Another model compared brain functioning to that of a computer. A more accurate way of understanding brain function, however, is to use the model of a hologram. A hologram is a specially processed photographic record that provides a three-dimensional image when a light from a laser is beamed through it. If a part of the hologram is destroyed, any one of the remaining parts is capable of reconstructing the entire image. The brain operates like a hologram. This holographic model does not negate the earlier models, but is congruent with the new understanding of the way in which information is transmitted, received, and stored (learned). Current data on brain functioning modify the following elements of the traditional model:

- Memories are not stored in any specific part of the brain, but rather in multiple overlapping areas. They can be retrieved in their entirety by a stimulus to more than one area of the brain. Loss of specific memory is related more to the amount of brain damage than to the site of the injury.
- The ability to recall what was lost when the brain was first injured by gunshot wound or cardiovascular accident (stroke) often returns, even though regeneration of neurons is not generally believed to be possible.
- Paranormal events, including the transpersonal healing associated with shamanism and other approaches to metaphysical healing, involve communicating information in ways that do not conform to the current understanding of receiving, processing, and sending energy.
- Phenomena such as phantom limb sensations and auras that extend beyond the corpus challenge traditional perceptions of body image, as well as the understanding of the physical boundaries of the body.
- Mechanisms of consciousness, such as the ability of a person to reflect on the self or create and retrieve images, cannot be explained simply in terms of the structure and function of current anatomic models.

Viewing the brain in a holographic manner reveals its influence on psychophysiologic functioning. People who believe that they do not have the conscious ability to effect a physical change with their imagination do not try to do so. They will not explore memories and patterns formed of past experiences and will continue to respond unconsciously as they always have in the past. Cognitive therapy is an example of an attempt to modify the negative irrational thinking that leads to emotional distress. People are taught strategies for evaluating, challenging, and replacing their thoughts with more rational responses, thereby reducing the negative consequences of stress and enhancing health.[51]

ULTRADIAN RHYTHMS

Humans have various natural, biologic rhythms that mirror those found in nature.[52] Infradian rhythms are those that recur in a period longer than a day, such as a

woman's menstrual cycle. Circadian rhythms are those that rise and fall, usually within a 24-hour period, such as sleep and wake patterns. Ultradian rhythms refer to the cyclic patterns of rhythmic repetition that occur in cycles of less than 24 hours, such as varying levels of energy associated with activity and rest. These rhythmic patterns vary for each person, and individuals can shift them with changing demands and daily circumstances.

The body periodically offers important physiologic and psychologic information about keeping healthy, energetic, creative, and productive. This information comes from the circadian and ultradian rhythms experienced throughout the day. For example, the general pattern of the ultradian rhythm is 90 to 120 minutes of activity, followed by a 20-minute recovery period (Figure 6–2). Periods of high energy regularly alternate with signals suggesting a need for rest. Ignoring those signals and continuing to work disturbs the ultradian rhythms and leads to stress. Responding appropriately to these signals with a rest period allows the ultradian rhythms to regain their normal pattern and relieves the stress. Thus, heeding this natural call promotes rejuvenation and recovery. Nurses can use their knowledge of natural cycles to help themselves and their clients optimize their level of wellness.

MIND MODULATION

Indirect and direct anatomic and biochemical pathways connect the nervous, endocrine, and immune regulatory systems. Communication among these systems is multidirectional, with signal molecules and their receptors regulating the cellular outcomes.[53]

Stress Response

The biochemical functions of the major organ systems are modulated by the mind.[54] Thoughts and feelings are transduced into chemicals (i.e., neurotransmitters, neurohormones, and peptides) that circulate throughout the body and convey messages via cells to various systems within the body. The stress response is a good example of

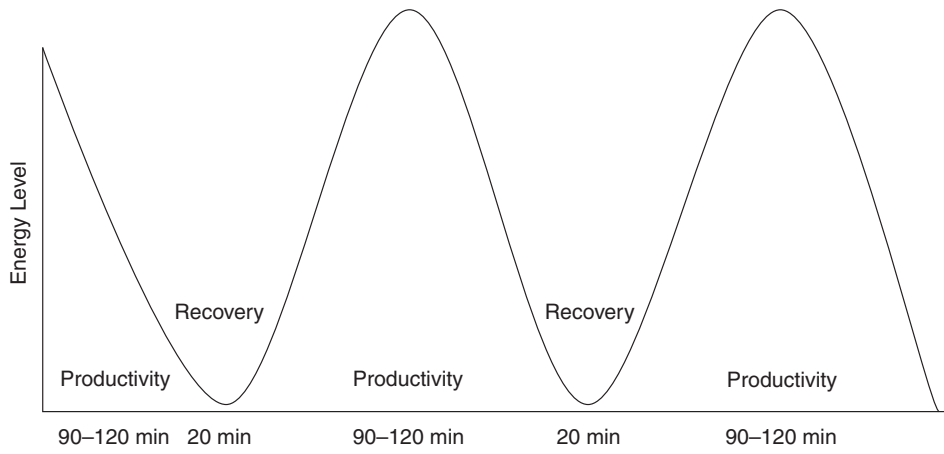


Figure 6–2 General Pattern of Ultradian Rhythms. *Source:* Copyright © Genevieve Bartol.

the way in which systems cooperate to protect an individual from harm:

> A young man is walking to his car alone late at night when a stranger grabs his arm and attempts to rob him. His immediate response is one of fear, and his body prepares him to manage the danger by preparing him physically. The locus ceruleus with nerve endings in the forebrain instantaneously secretes norepinephrine directly into the cortex. Not only does the sympathetic nervous system (SNS) secrete norepinephrine, but the SNS fibers also extend into the adrenal medulla, stimulating medulla secretion of norepinephrine. The young man's body is now full of norepinephrine, and he feels the effects. In addition, muscular tension occurs from neural messages and stimulation of the SNS to prepare him for physical challenges.[55] All of this happens even before he is fully aware of the danger.
>
> Quickly, the young man registers what is happening. The hypothalamus secretes corticotropin-releasing factor (CRF) into the hypothalamic-pituitary circulation in the brain. Within approximately 15 seconds, CRF triggers the release of the pituitary hormone adrenocorticotropic hormone (ACTH). In a matter of minutes, the adrenal cortex releases glucocorticoids.[56] Hypothalamic, pituitary, and adrenal neuropeptides and other substances interact with the immune response, completing the multidirectional circle of communication among the nervous, endocrine, and immune systems. The young man has now experienced a full-blown psychophysiologic stress reaction to the fear of being robbed and possibly hurt.

Physiologically, the cascade of changes associated with the stress response appears as tightened muscles; increased heart, respiratory, and metabolic rates; a general sense of foreboding, fear, nervousness, and irritability; and a negative mood. Other physiologic responses include elevated blood pressure, dilated pupils, stronger cardiac contractions, and increased levels of blood glucose, serum cholesterol, circulating free fatty acids, and triglycerides. Although these responses prepare a person for short-term stress, the effects on the body of long-term stress responses can include structure damage and chronic illness. The memory of this experience, stored in the brain and other body cells, has psychologic and spiritual outcomes. The individual may experience the same reaction in future similar events with less intense stress, such as having a friend touch his arm as they walk toward the car. Indeed, just thinking about this experience can initiate a stress response. Table 6–1 contains a review of the effects of sympathetic and parasympathetic stimulation.

The stress response is designed to meet the demands of stressful stimuli, including experiences such as surgery, burns, and infections. Long-term and unremitting stress can exacerbate angina, tension headaches, cardiac arrhythmias, and pain.[57] The long-term presence of high levels of cortisol over an extended period of time promotes lipolysis in the extremities and lipogenesis in the face and back, suppresses the inflammatory process, increases the risk of osteoporosis and ulcers, and leads to atrophy of immune system organs. Levels of various reproductive hormones (e.g., progesterone, estrogen, testosterone), growth and thyroid hormones, and insulin decline during stress, probably to conserve energy.[58] For example, Hippocrates recognized the stress–spontaneous abortion link when he recommended that pregnant women avoid emotional disturbances.[59] The stress of compulsive marathon running can lead to amenorrhea in women. Steps to reduce stress may promote a positive neuroendocrine milieu.[60]

Nervous System

The interconnectedness of the central nervous system (CNS) means that frontal

Table 6–1 Effects of Sympathetic and Parasympathetic Stimulation

Structure	*Sympathetic Stimulation*	*Parasympathetic Stimulation*
Pupil of eye	Dilates	Contracts
Ciliary muscle	Relaxes, accommodates for distance vision	Contracts, accommodates for close-up vision
Bronchial tubes	Dilates	Constricts
Heart	Accelerates and strengthens actions	Depresses and slows actions
Stomach muscles	Depresses activity	Increases activity
Glands	Alters secretion	Increases secretion
Liver	Stimulates glycogenolysis	
Visceral muscle of intestine	Depresses peristalsis	Increases peristalsis
Adrenal medulla	Causes secretion of epinephrine	
Sweat glands	Increases activity	Decreases activity
Coronary arteries	Dilates	Constricts
Abdominal and pelvic viscera	Constricts	
Peripheral blood vessels	Constricts	
External genitalia	Constricts blood vessels	Dilates blood vessels, causing erection

Source: Copyright © Genevieve Bartol.

cortex thoughts and images are in intimate communication with the emotion-related limbic center. As the biochemicals transduced from thoughts and ideas circulate through the limbic-hypothalamic system, memory cells from past experiences affect their structure. The hypothalamus—the central control center—coordinates the biochemical cascade, integrating neuroendocrine functions by secreting inhibiting hormones, and stimulating the autonomic nervous system (ANS). The sympathetic branch of the ANS is connected to the limbic system, has fibers extending into the adrenal medulla, and has a pathway of nerves to the thymus, lymph nodes, spleen, and bone marrow. Hence, the connections are both biochemical and anatomic.

Understanding the psychophysiologic stress response as it affects the nervous system helps to clarify how the different holistic therapies work. It is possible to interrupt feelings of anxiety by using a relaxation technique to calm oneself, or a cognitive restructuring technique to change thought patterns. When patients learn to use relaxation, imagery, music therapy, or certain types of meditation training, their sympathetic response to stress decreases, and the calming effect of the parasympathetic system takes over, leading to bodymind healing. Benson described two phases of the relaxation response:[61] The first phase includes the physiologic responses of the relaxation response; that is, decreased sympathetic nervous system activity. Encouraging patients to breathe deeply and slowly, breathing with patients, or instructing patients to synchronize their breathing with the nurse's own can help them to become calmer. In the second phase, when they are relaxed and calm, patients are more receptive and open to new information, and able to solve problems and make decisions. This is a good time to use visual imagery to heal from

stress. In addition, the body is protected because the regular practice of relaxation exercises serves to block the potency of stress hormones.[62] Other interventions, such as imagery or drumming in music therapy, demonstrate positive immunologic and neuroendocrine changes.[63]

Biofeedback, which is often used in conjunction with relaxation techniques, can also reduce arousal and tension.[64] It is so effective that it has become a common intervention for a number of conditions induced or exacerbated by uncontrolled stimulation of the stress response. To illustrate, warming the fingers decreases the discomfort that accompanies Raynaud's disease.[65] Connecting the patients' images, emotions, feelings, and spirit with their physiology is the basis for these major changes.[66] Physiologic changes flow in a circular pattern with feedback loops to the frontal cortex and limbic system, affecting thoughts and feelings. Conversely, physiologic changes affect the frontal cortex and limbic system, which in turn modify thoughts and feelings as well as the ability to make decisions and learn.

Medications are used to treat conditions, such as panic attacks, that consist of a hyperreaction of the SNS (Sympathetic Nervous System). Beta blockers, for example, block the alpha adrenergic receptors, producing lower heart rate and blood pressure. Patients who are taking beta blockers may not exhibit the normal reactions to threat. Also, older people often have decreased psychophysiologic stress responses, as their reactions to SNS stimulation are blunted. In severe panic attacks, medications may be required, but they sometimes have troublesome side effects. The use of mind-body interventions may reduce or eliminate the need for medication.

Endocrine System

Hormones are the specialized chemical messengers that act to modulate both cellular and systemic responses.[67] They are always present in body fluids, but their concentrations vary. They produce both localized and generalized effects. Furthermore, one hormone can stimulate a variety of effects in different tissues, and a single function may be subject to regulation by more than one hormone. Hormones include amines and amino acids (e.g., norepinephrine, epinephrine, and dopamine), peptides, polypeptides, proteins, and steroids.[68]

Each cell has a multitude of receptor molecules that can be modified or altered, and hormones act by binding to their specific receptor on target cell surfaces. For example, treatment with methadone is effective for heroin addicts because the methadone binds to the opioid receptor sites. A decrease in hormone levels can increase the number of receptor sites available. This is *up-regulation*. Conversely, an elevated hormone level leads to a decrease in receptors, or *down-regulation*.[69] In addition, many hormones have a negative feedback loop that maintains the balance in serum hormonal levels.

Stimuli such as circadian rhythms, the environment, and emotional and physical stressors influence the secretion of hypothalamic hormones. The opioids (i.e., endorphins, enkephalins) are synthesized in the pituitary and other parts of the CNS. They have a morphinelike effect with receptors throughout the body. These naturally occurring hormones produce the "runner's high," increase a person's pain threshold, and explain how someone can "ignore" his or her own serious injury to save a loved one.

Immune System

The immune system shares anatomic connections and signal molecules with the nervous and endocrine systems.[70] Anatomically, the nervous system has direct connections to the immune system organs (thymus, bone marrow, lymph nodes, and

spleen).[71] There are receptors on the immune system cells for the neurotransmitters such as the opioid peptides, dopamine, and the catecholamines.[72] All of the neuropeptide receptors found in the brain are also found on monocytes.[73] The SNS pathways of norepinephrine and epinephrine secretion and the hypothalamus-pituitary-adrenal axis with glucocorticoid secretion have direct effects on immune system cells. It has long been known that glucocorticoids suppress the immune system. Cortisol, for example, suppresses white blood cells; it is even administered to suppress the immune system in people with autoimmune diseases.

Recent findings indicate that CNS and ANS neuropeptides and endocrine hormones stimulated by the nervous system directly affect immune system cells. Receptor sites located on the surfaces of the T and B lymphocytes have the ability to activate, direct, and modify immune function. For example, CRF suppresses monocytic macrophages and T helper lymphocytes. Lymphocytes produce the stress hormone ACTH and the brain peptide endorphin.[74] Endorphins have both enhancing and suppressing effects on immune system cells, depending on their concentration. Immune system cells also have receptors for ACTH and other endocrine hormones.[75] In turn, cytokines, secretions of immune system cells, affect the nervous and endocrine systems.

Cytokines such as the interleukins can stimulate the hypothalamus-pituitary-adrenal axis, thus increasing the levels of glucocorticoids.[76] Cytokines stimulate white blood cell proliferation, phagocytosis, and antibody production. They also induce fever, initiate the inflammatory process, and repair tissue as a healing influence. New evidence suggests that interleukin-2, or cell growth factor, is able to up-regulate ACTH from the pituitary.[77] In other words, no system functions in isolation; all are interconnected, thus demonstrating a vital, bidirectional communication among the systems.

Interventions to reduce the stress response can have a positive effect on the immune system. Some of the direct effects of stress and holistic interventions on immunity include the following:

- Wound healing takes significantly longer in women caregivers of relatives with dementia.[78]
- The response of T lymphocytes improves following writing about traumatic experiences.[79]
- Significant increases of natural killer (NK) cells and NK cell cytotoxic activity occur following a structured psychiatric intervention with cancer patients.[80]
- Significant immunologic changes are evident in students during examination periods; NK cell cytotoxicity decreases significantly, and there are increases in polymorphonuclear superoxide release and lymphocyte proliferative responses.[81]

Interventions that induce the parasympathetic response have healing effects on the body. Because all systems are interconnected, holistic interventions contribute to health and healing.

Neuropeptides

With their receptors, neuropeptides help explain bodymind interconnections and the way that emotions are experienced in the body.[82] Circulating throughout the body, neuropeptides are considered the messengers that connect body and mind. The first neuropeptides were discovered in the intestine, which has many receptors; this explains those "gut feelings." Neuropeptides are secreted in the cortex, hypothalamus, limbic system, and pituitary,[83,84] with the limbic brain containing most of the 88 neuropeptides identified to date.[85] The frontal lobes of the cerebral

cortex have the greatest number of opiate receptors.[86] High concentrations of neuropeptides are also found in the spinal cord, accounting for the connection of body sensations and emotions.[87] This open network of neuropeptides with their receptors allows messages to enter and/or be changed at any point.

The limbic system and hippocampus are rich with neuropeptide receptors, containing almost all of them and connecting emotions and learning. The concept of emotions as neuropeptides explains why people have trouble remembering and learning when they are experiencing psychophysiologic stress. Performance is affected as well. Those who experience severe anxiety and panic before speaking in public or performing a violin concert benefit from relaxation techniques and cognitive restructuring. This ability to alter biochemicals and the consequent effects on memory and learning occur when the unconscious mind is brought into consciousness with hypnosis.[88] Pert wrote that "peptides serve to weave the body's organs and systems into a single web that reacts to both internal and external environmental changes with complex, subtly orchestrated responses."[89]

Emotions cannot be separated from the body. Nurses who attend to the body without also attending to emotions are not providing holistic care. Referrals to chaplains or therapists provide a false sense of reassurance but may leave patients and families feeling unattended, unheard, and lonely. Medical issues cannot be separated from psychosocial issues; patients and families require understanding in the context of their relationships.[90] Furthermore, because the immune system cells produce the biochemicals that affect mood, emotional expressions may be the first sign of physiologic changes.[91] Holistic interventions prepare the physiologic environment that promotes healing and has great potential for healing and wholeness.

Pain Response

Pain and suffering are universal and multidimensional experiences. Pain has physical interconnections and physiologic outcomes. As a stressor, pain stimulates the same physiologic responses as other stressors that affect the nervous, endocrine, and immune systems, and pain memories produce the same psychologic and spiritual outcomes. As stress is designed to meet demands, so pain is designed to alert people to problems. The significance of the pain shapes the experience. The more threatening the diagnosis, the more intense the suffering. For example, a woman who suspects that she may have cancer when she discovers a lump in her breast reacts with the psychophysiologic stress response. Throughout diagnosis and treatment, she must face uncertainty, fear, and pain. Any new pains are forever after interpreted as a return of the cancer, thus stimulating psychophysiologic responses. Talking with patients and their families, and especially listening to them, may not only reduce pain and suffering but also enable them to tap into their own personal resources. At the very least, listening supports their "spiritual consciousness."[92]

Somatic pain or cutaneous pain results from the stimulation of nociceptors in superficial structures such as skin and mucosa. Superficial somatic pain is sharp and prickly, such as that associated with a superficial paper cut on the finger. Deep somatic pain begins in the deep body tissues and is more diffuse than superficial somatic pain. Visceral pain results from damage to visceral organs. It is mediated by the SNS. The pain is diffuse, not easily localized, and is often referred.

Acute and chronic pain differ in several ways. First, acute pain is time-limited, because it occurs with an identifiable problem that generally responds to diagnosis and treatment. Surgery, injury, and trauma result in acute pain. Healing of tissue damage usually eliminates the pain. If untreated for 24 hours or longer, however, severe, acute pain can cause neuroplastic changes that lead to "incurable chronic pain syndromes."[93] Neuroplasticity refers to alterations in neuron structure and function resulting from stimulation. Learning and memory produce both chemical and physical neuroplastic changes.

Chronic pain is prolonged, lasting longer than anticipated based on the etiology of the pain. It may be ongoing or may be cyclic, with remissions and exacerbations (such as pain associated with sickle cell anemia, lupus, arthritis, or migraines). Prolonged chronic pain may progress to the point that it becomes the disease or condition. If this occurs, lifestyle changes affecting the person and the family and/or the system of support are common. As coping resources and sympathoadrenal responses are depleted, patients become depressed and irritable. Well-established chronic pain patterns can be changed with nonpharmacologic holistic interventions such as cognitive restructuring, biofeedback, and mental imagery.

Neuroanatomic Pain Pathways

Pain perception is shaped by afferent pathways, the CNS, and efferent pathways. Nociceptors—pain receptors located in tissues—carry signals to the dorsal horn of the spinal cord. Large, myelinated A-delta fibers transmit pain quickly and localize it precisely. The smaller, unmyelinated or lightly myelinated C fibers not only are slower to transmit pain impulses, but also localize it poorly. In addition, there are millions of sensory nerve endings in tissues and organs that, when injured, release pain-producing substances such as serotonin, histamine, bradykinin, prostaglandins, and substance P.[94] Painful stimuli can stimulate post-traumatic stress in the spinal cord, leading to a hypersensitive state that persists after cessation of the stimuli. Interruption of the afferent pain pathways before surgery is preemptive analgesia.[95]

From the dorsal horn, pain messages travel to the CNS, where they pass to the reticular formation, limbic system, thalamus, hypothalamus, medulla, and cortex. Awareness of the pain occurs in the thalamus. Pain discrimination is dependent on the interconnections between the thalamus and the somatosensory cortex. The meaning of the pain, based on past experiences, is identified in the cortex. If only the thalamus is functional, an individual can experience pain in the leg; however, an intact sensory cortex is necessary for the individual to identify that it is the lower part of the anterior leg that is hurting.[96] Other CNS cortical interconnections of the thalamus and limbic cortex determine hurtfulness, mood, and attention abilities.

Efferent fibers in the periaqueductal gray (PAG) area in the midbrain can stimulate or block pain. This area receives information from the spinal cord, reticular formation, hypothalamus, and cortex, and is associated with the limbic system. Moreover, descending fibers connect this area with the dorsal horn of the spinal cord. Stimulation of the PAG region produces analgesia. In addition, this area is rich with the opioids, so naturally occurring endorphins serve to mediate pain.

Pharmacologic approaches to pain management include anti-inflammatory medications, analgesics such as nonsteroidal anti-inflammatory drugs (NSAIDs), acetaminophen, and aspirin. The NSAIDs and

aspirin block pain transmission centrally and peripherally. They also inhibit prostaglandins, making tissues less sensitive to the damage that can be caused by chemicals such as bradykinin. The opioid analgesics work by binding to the same receptor sites as the endogenous opioids. Morphine and endorphins act at the receptor level to produce analgesia. Adjuvant analgesics include antidepressants and antiseizure medications, which can produce analgesia in some patients and some pain conditions. These medications are especially effective after nerve damage, as they suppress neuronal firing.[97]

Psychosocial Pain Pathways

Past experiences with pain, emotional state at the time of the pain, and interpretation of the meaning of the pain affect the degree to which the pain is experienced. Both pain recollection and pain anticipation elicit the pain response, just as the recollection of a stressful experience can elicit the stress response (i.e., state-dependent learning). The patient with leukemia who has experienced a number of bone marrow aspirations may begin to cry when the physician orders yet another bone marrow aspiration even before being prepared for the procedure. Thus, both cognitive and affective factors influence pain perception.

Cognitive factors affect pain interpretation. Changes in the way that a person thinks about the pain, reframing self-talk, thinking about other things (distraction), or anything that takes the focus off the pain, tends to increase the person's tolerance for the pain. Increased tolerance, in turn, increases the person's sense of control over the pain by diminishing feelings of helplessness. Opportunities to make decisions about care and to solve problems lead to a greater sense of control, increasing pain tolerance and decreasing pain perception (i.e., mind modulation). Remember the man who was robbed.

Affective factors such as emotional state, beliefs, values, and goals affect the meaning of the pain and influence the pain experience. When the pain experience leads to loss of hope or interferes with goals, the intensity of the pain is worse. For example, a sprained ankle may be uncomfortable and a nuisance to someone who tends to be sedentary, but it can be viewed as a disaster for someone who planned to run a 5-mile road race. Fear of the unknown, anxiety resulting from psychophysiologic reactions to stress, and pain are circuitous, as each intensifies the others.

Psychologic coping factors also modulate pain.[98] The depletion of coping resources leads to feelings of helplessness, loss of control, and pain anticipation that worsen pain perception. In addition, the inability to cope leads to counterproductive behaviors that exacerbate the pain. It is necessary to design individualized, supportive nursing interventions to reduce the sense of helplessness and increase the sense of control, thus strengthening coping abilities. It is important to identify the needs of patients who get secondary gains from the attention for their pain so that they can learn more effective ways to get their needs met. Pain modulation, then, becomes increasingly challenging.

Pain can reactivate repressed or unresolved past, painful, physical and emotional experiences, such as physical or sexual abuse.[99] For example, adults expressing multiple complaints of pain and seeking medical care from a variety of physicians without a definitive diagnosis may be victims of childhood abuse. When issues associated with such abuse remain repressed and unresolved, they tend to

aggravate other problems, psychologic and/or physical, often leading to "acting out" behaviors. Unresolved grief experiences can also affect the pain experience, as individuals may be coping well until they have an experience with pain. Nurses, too, carry the burdens of unresolved grief and emotional wounds. As witnesses to patients' pain and suffering, nurses may come to a bifurcation, or cross-roads, where they can either deny their wounds and withdraw from patients or experience a "transformational change."[100] When sensitive, caring nurses tolerate uncomfortable emotions and allow patients to grieve and express their pain, pain medication requests often decrease. The nurse's ability to model acceptance of grief and pain in appropriate ways encourages patients to decrease behaviors that intensify pain.[101]

Pain and suffering are different phenomena. Each can occur without the other, but they can also occur simultaneously. Suffering results when self-image is threatened. Suffering includes spiritual and/or psychosocial anguish,[102] which may be identified through sensitive assessment or by the fact that the pain reaction is greater than expected from the injury. Pain and suffering may appear indistinguishable.[103] A distraught, weeping cancer patient may be complaining of pain, for example, but assessment reveals that her physician has just told her about new metastatic lesions. As she talks, she begins to calm down, and her complaints of pain diminish. Suffering, then, can intensify pain. Patients who experience high levels of suffering have low levels of pain tolerance and often "act out" behaviorally.

The pain response is also shaped by gender, culture, current health states, coping strategies, support, and other issues, such as feelings of control and helplessness. In some cultures, both men and women are taught to be stoic about their pain. These people tend to deny pain when questioned about hurting and often refuse pain medication. In other cultures, little boys learn at an early age that "big boys don't cry." Such "killer statements" are emotionally damaging.[104] Even though there is some evidence that this is changing, many men in these cultures find it difficult to admit to pain.

CONCLUSION

New scientific understandings of living systems, such as principles of self-organization and mind modulation of the body-mind systems, provide a theoretical base for holistic healing interventions. Understanding the physiologic principles involved in nursing interventions helps nurses to design individualized and appropriate holistic care for clients. Nurses, aware of their own wounds and sensitive to the wounds of clients, are strategically placed to lead clients in facilitating health and healing. The adage "physician, heal thyself" also applies to nurses. Walking the talk is about being authentic and congruent, and allows nurses to relate to patients in authentic and congruent ways. Caring for oneself is essential for nurses to model wholeness.[105] The following story is a good illustration.

> A mother came to the Hindu leader, Mahatma Gandhi, and said, "Gandhiji, tell my child to stop eating sugar." Gandhi responded, "Come back in three days." The mother was puzzled but she went away for three days. She returned and once again pleaded, "Gandhiji, please tell my child to stop eating sugar." He looked at the child and said, "Stop eating sugar." Then the

> mother asked why it took him three days to give this instruction to her child. He replied, "Three days ago I was still eating sugar."[106]

For, if truth be known, nurses who do not care for themselves are unable to provide holistic care for their patients. The process of becoming authentic makes one sensitive to the needs of others. Modeling is, perhaps, the strongest teaching strategy.

Holistic interventions are science-based.[107] Clients often know more about these interventions than those who care for them. It is essential, therefore, to educate nurses to empower themselves as well as clients. Knowledge of the communication of the nervous, endocrine, and immune systems is necessary, but it is insufficient for holistic nursing; it does not explain all aspects of illness. New scientific information invalidates the idea of the dualism of mind and body. Thoughts, emotions, and consciousness do not reside solely in the brain, but are projected to various body parts—the brain, the glands, and the immune, enteric, and sexual systems.

The research data overwhelmingly document the bodymind interrelationships. There are still many unanswered questions, though. Does the mind exist after the physical death? Does the soul survive the death of the body? Why do some people experience phantom pain after an amputation? Nurses must continue to incorporate wholeness into their own lives while exploring effective ways to integrate care and document the effectiveness of holistic interventions. The meaning of an illness, the method of giving the diagnosis, the tone of voice and the touch of the nurse, and the relationships to family and friends, must all be investigated. The goal is to integrate the human spirit with physiologic interventions. As L. Dossey wrote:

> We will never achieve the validation of our spiritual intuitions by scrutinizing monocytes, neuropeptides, and receptor sites. What we will achieve is an expanded view of what it means to be human. The point that we will continue to emphasize is that the physiological and the spiritual are not equivalent, and if we ignore the difference between these two domains it will be at the risk of our spiritual impoverishment. These scientific insights are important signposts pointing to the nonlocal nature of consciousness. They get the mind out of the brain and into the body at large. Any science that helps us toward this understanding that is contained in the sublimest of the most acute seers of our race deserves, I would submit, our deepest respects.[108]

DIRECTIONS FOR FUTURE RESEARCH

1. Develop instruments that accurately measure psychophysiologic responses to particular holistic nursing interventions.
2. Explore the effectiveness of holistic interventions in preventing illness and promoting health.
3. Investigate the effects of holistic nursing practice on nurses.
4. Carry out longitudinal studies to examine the effects of the regular use of holistic nursing interventions.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- Do I attend to my own bodymind communication?
- Do I provide time for self-reflection?
- How do I heighten my awareness of who I am?

NOTES

1. F. Capra, *The Web of Life* (New York: Doubleday, 1996), 30.
2. F. Capra, *The Tao of Physics* (Boston: Shambhala, 1999), 67.
3. G.M. Bartol and N.F. Courts, Psychophysiology of Bodymind Healing, in *Holistic Nursing: A Handbook for Practice*, 3rd ed., eds. B.M. Dossey et al. (Gaithersburg, MD: Aspen Publishers, 2000), 71.
4. B. Haisch, Freeing the Scientific Imagination, *IONS Noetic Science Review* (Sept–Nov, 2001): 24–29.
5. L. Dossey, *Healing Words* (San Francisco: HarperSanFrancisco, 1997), 203.
6. B.M. Dossey et al., eds., *Holistic Nursing: A Handbook for Practice*, 3rd ed. (Gaithersburg, MD: Aspen Publishers, 2000), 71.
7. M.A. Boyd and M.A. Nihart, *Psychiatric Nursing* (Philadelphia: Lippincott-Raven Publishers, 1998), 197–198.
8. L. von Bertalanffy, *General Systems Theory* (New York: George Braziller, 1968).
9. Capra, *The Web of Life*, 167.
10. G.M. Bartol and N.F. Courts, Psychoneuroimmunological Aspects of Nursing, *Journal of Holistic Nursing* 11, no. 4 (1993):332–340.
11. Boyd and Nihart, *Psychiatric Nursing*, 197–198.
12. Bartol and Courts, Psychophysiology of Bodymind Healing, 71.
13. Capra, *The Tao of Physics*, 131–132.
14. Capra, *The Web of Life*, 39.
15. H.G. Koenig et al., The Relationship Between Religious Activity and Blood Pressure in Older Adults, *International Journal of Psychiatry in Medicine* 28, no. 2 (1998):189–213.
16. H.G. Koenig, An 83-year-old Woman with Chronic Illness and Strong Religious Beliefs, *Journal of the American Medical Association* 288, no. 4 (July 2002): 488–489.
17. T. Gyatsp, The Monk in the Lab, *New York Times*, 2003, 04/06, Opinion.
18. I. Prigogine, *The End of Certainty* (New York: The Free Press, 1997), 9–56.
19. Ibid., 85.
20. Bartol and Courts, Psychophysiology of Bodymind Healing, 35.
21. Capra, *The Web of Life*, 158–159.
22. Bartol and Courts, Psychophysiology of Bodymind Healing, 71, 73.
23. R. Larter, Life Lessons from the Newest Science, *IONS Noetic Science Review* (Mar–May, 2002), 22–27.
24. Capra, *The Web of Life*, 150–161.
25. Ibid., 162.
26. Ibid., 160.
27. Bartol and Courts, Psychophysiology of Bodymind Healing, 35.
28. G.M. Bartol, Creating a Healing Environment, *Seminars in Perioperative Nursing* 92, no. 7 (1998).
29. G.M. Bartol and G.G. Eakes, A Study of the Meanings Assigned to the Term Psychosomatic Among Health Professionals, *Perspectives in Psychiatric Care* 31, no. 1 (1995):24–29.
30. H. Dreher, *The Immune Power Personality* (New York: Plume, 1996), 2–4.
31. Ibid., 48–74.
32. J. Kabat-Zinn, *Wherever You Go, There You Are* (New York: Hyperion, 1994), xiii–xxiv.
33. J.W. Pennebaker, *Opening Up: The Healing Power of Confiding in Others* (New York: William Morrow, 1990), 46–48, 202–206.
34. Dreher, *The Immune Power Personality*, 104.
35. Ibid., 125–146.
36. Ibid., 137–138.
37. Ibid., 230–239.
38. A. Luks, *The Healing Power of Doing Good* (New York: Fawcett Columbine, 1991), 16–18, 27–34, 80–130.
39. Capra, *The Web of Life*, 267.
40. Ibid., 64–65.
41. C.B. Pert, *Molecules of Emotion: Why You Feel the Way You Feel* (New York: Charles Scribner's Sons, 1997), 261.
42. A. Damasio, *Looking for Spinosa* (New York: Harcourt, 2003), 139.
43. Capra, *The Web of Life*, 266–267.
44. Ibid., 268.
45. Ibid., 160–161.
46. Ibid., 269.
47. Ibid., 175.
48. Pert, *Molecules of Emotion: Why You Feel the Way You Feel*, 350.
49. D. Goleman, *Emotional Intelligence* (New York: Bantam Books, 1995), 6–7, 206–206.
50. N.C. Frisch and L.E. Frisch, *Psychiatric Mental Health Nursing* (New York: Delmar, 1998), 59, 188.

51. C.L. Wells-Federman, E. Stuart-Shor, and A. Webster, Cognitive Therapy: Applications for Health Promotion, Disease Prevention, and Disease Management, in *Holistic Nursing Care, The Nursing Clinics of North America* series 36, no. 1, eds. J.D. Colbath and P.M. Prawlucki (Philadelphia: Saunders, 2001).
52. F. Capra, *The Web of Life,* 193.
53. J. Shelby and K.L. McCance, Stress and Disease, in *Pathophysiology: The Biologic Basis for Disease in Adults and Children*, eds. K.L. McCance and S.E. Heuther (St. Louis: Mosby, 1998), 298.
54. Dossey et al., *Holistic Nursing: A Handbook for Practice*, 95.
55. C.L. Wells-Federman et al., The Mind-Body Connection: The Psychophysiology of Many Traditional Nursing Interventions, *Clinical Nurse Specialist* 9 (1995):59–66.
56. R.M. Sapolsky, *Why Zebras Don't Get Ulcers* (New York: W.H. Freeman, 1998), 33.
57. Wells-Federman et al., The Mind-Body Connection, 61.
58. Shelby and McCance, Stress and Disease, 290.
59. Sapolsky, *Why Zebras Don't Get Ulcers*, 120.
60. P. Robinson et al., Stress Reduction and HIV Disease: A Review of Intervention Studies Using a Psychoneuroimmunology Framework, *The Journal of the Association of Nurses in AIDS Care* 11, no. 2 (2000): 87–96.
61. H. Benson, The Relaxation Response, in *Mind Body Medicine: How to Use Your Mind for Better Health*, eds. K. Boleman and J. Gurin (Yonkers, NY: Consumer Reports Books, 1993), 253.
62. Benson, The Relaxation Response, 255.
63. B.B. Bittman et al., Composite Effects of Group Drumming Music Therapy on Modulatin of Neuroendocrine-Immune Parameters in Normal Subjects, *Alternative Therapies in Health and Medicine* 7, no. 1 (2001):38–47.
63. M.S. Schwartz and M.A. Schwartz, Biofeedback: Using the Body's Signals, in *Mind Body Medicine: How to Use Your Mind for Better Health*, eds. K. Boleman and J. Gurin (Yonkers, NY: Consumer Reports Books, 1993), 306.
65. Schwartz and Schwartz, Biofeedback: Using the Body's Signals, 307–308.
66. Dossey et al., *Holistic Nursing: A Handbook for Practice*, 99.
67. C.M. Porth, *Pathophysiology Concepts of Altered Health Status* (Philadelphia: Lippincott-Raven, 1998), 775.
68. Ibid., 776.
69. Ibid., 778.
70. Ibid., 1239.
71. K.L. McCance and S.E. Heuther, eds., *Pathophysiology: The Biologic Basis for Disease in Adults and Children* (St. Louis: Mosby, 1998), 297.
72. M. Jenny, Psychoneuroimmunology, in *Comprehensive Human Physiology from Cellular Mechanism to Integration*, eds. R. Greger and U. Windharst (New York: Springer, 1996), 1735.
73. J. Pert, *Molecules of Emotion*, 182.
74. Ibid., 161.
75. Shelby and McCance, *Stress and Disease*, 297.
76. J. Post-White, The Immune System, *Seminars in Oncology Nursing* 12 (1996):89.
77. McCance and Heuther, *Pathophysiology*, 297.
78. J.K. Kiecolt-Glasser et al., Slowing of Wound Healing by Psychological Stress, *Lancet* 346 (1995):1194–1196.
79. J.W. Pennebaker et al., Disclosure of Traumas and Immune Function: Health Implications for Psychotherapy, *Journal of Consulting and Clinical Psychology* 56 (1998):239–245.
80. F.I. Fawzy et al., A Structured Psychiatric Intervention for Cancer Patients: 2. Changes over Time in Immunological Measures, *Archives of General Psychiatry* 47, no. 8 (1990):729–735.
81. D.H. Kang et al., Immune Responses to Final Exams in Healthy and Asthmatic Adolescents, *Nursing Research* 46 (1997):12–19.
82. Dossey et al., *Holistic Nursing: A Handbook for Practice*, 104–105.
83. Ibid., 105.
84. Pert, *Molecules of Emotion*, 133.
85. Ibid., 67.
86. Ibid., 134.
87. Ibid., 141.
88. Ibid., 147.
89. Ibid., 148.
90. G.W. Sabe, Preparing Healthcare Professionals for the 21st Century: Lessons from Chiron's Cave, *Families, Systems and Health: The Journal of Collaborative Family HealthCare* 18, no. 3 (2002): 354.
91. Pert, *Molecules of Emotion*, 183.
92. G.B. Holland, Returning Soul to Medicine, *Noetic Sciences Review* 6, (2002), 18.
93. P. Arnstein, The Neuroplastic Phenomenon: A Physiologic Link between Chronic Pain and Learning, *Journal of Neuroscience Nursing* 29, no. 2 (1997):179–186.

94. L. Jonathan and S. Heuther, Pain, Temperature Regulation, Sleep, and Sensory Function, in *Pathophysiology: The Biologic Basis for Disease in Adults and Children*, eds. K.L. McCance and S.E. Heuther (St. Louis: Mosby, 1998), 428.

95. D. Carr, Preempting the Memory of Pain, *Journal of the American Medical Association* 279, no. 14 (1998):1114–1115.

96. S. Curtis et al., Somatosensory Function and Pain, in *Pathophysiology Concepts of Altered Health Status*, ed. C.M. Porth (Philadelphia: Lippincott-Raven, 1998), 970.

97. Porth, *Pathophysiology Concepts of Altered Health Status*, 980.

98. N. Frisch and L. Frisch, *Psychiatric Mental Health Nursing: Understanding the Client as Well as the Condition* (New York: Delmar Publishers, 1998), 452.

99. Ibid., 593.

100. R. Larater, Life Lessons from the New Science, *Noetic Sciences Review* 59 (2002): 24.

101. N.F. Courts, Nonpharmacologic Approaches to Pain, in *Pain Management Handbook*, eds. E. Salerno and J. Willens (New York: Mosby, 1996), 143.

102. E.J. Cassell, Recognizing Suffering, *Hastings Center Report* 21, no. 3 (1991):24–31.

103. P.H. Coluzzi, A Model for Pain Management in Terminal Illness and Cancer Care, *Journal of Care Management*, no. 4 (1996):45–46, 64, 68, 70, 72, 74–76.

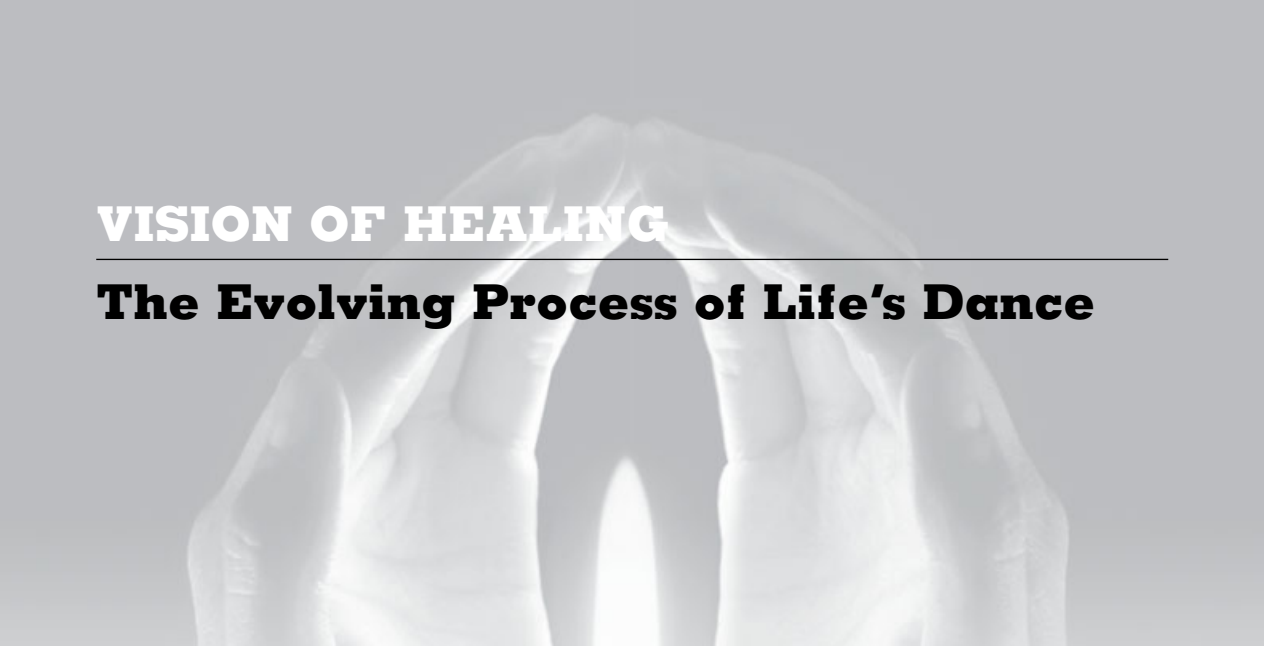
104. G.B. Holland, Nurturing Emotional Wisdom, *Noetic Sciences Review* 64 (2003):22.

105. G.B. Holland, Returning the Soul to Medicine, *Noetic Sciences Review* 61 (2002):16–21.

106. Ibid., 16.

107. Dossey et al., *Holistic Nursing: A Handbook for Practice*, 107.

108. L. Dossey, *Medicine and Meaning* (New York: Bantam Books, 1991), 108.



VISION OF HEALING

The Evolving Process of Life's Dance

The dance of human life is an evolving process that can be compared to the rhythms in nature of day and night, and the shades of light and darkness between. This analogy of light and darkness applies to our own lives, with the shades between seen only as contrasts. Without the light, we have no concept of the darkness. Contrast is essential in every aspect of our life. The familiar contrasts of daily experience include happiness and sadness, strengths and weaknesses, and wellness and illness. The only way that we have a concept of personal wellness is to have at some point in our life a firsthand experience with illness or major life stressors. Particularly in Western culture, the high peaks in life are emphasized, while the low points are ignored. In order to understand our wholeness, however, it is essential to recognize these differences. The human psyche does not cope well with these differences, for the ego loves clarity. Yet it is when we repress these differences that ambiguity is taken into our unconscious, which leads to disharmony and psychophysiologic disturbances.

When major stressors such as disaster or illness occur, the tendency is to repress the meaning of these events. When we repeatedly fail to recognize these life situations, we move away from our internal healing resources of hope, strengths, and new insights. At some point, we must address these life processes because they are always present. There is a part of us that always needs healing—the wounded healer—yet we are tempted to ignore this woundedness. We must learn to embrace our limitations as well as learn to recognize our strengths. All great healers acknowledge their inherent weaknesses and fallibilities.

When a client and nurse who are both denying their woundedness come together, the outcome of care is mechanical at best. Neither the client nor the nurse is able to use his or her inner wisdom to activate self-healing. Both have devalued this innate potential. Inner healing does not flow from the nurse to the client. The nurse cannot give inner healing to the client, for it already exists within the client. Rather, the nurse acts as a facilitator to evoke the client's process of inner healing. Healing occurs when the client and the nurse both acknowledge their life processes and use them to move toward balance and harmony.

As the best of traditional and holistic practices merge, much of the work that remains to be learned is the art of healing. When we recognize personal traits, attitudes, and stressors that are in need of healing, this time of reflection can also be a source of creativity and spontaneity. Hence, we need to acknowledge our own stressors in order to open cre-

atively to our clients. Being a healer requires work on the self—our imperfect, fallible self. We must affirm our weaknesses and strengths, and acknowledge our inadequacies. Only then can we know a powerful part of our being and allow new strengths to be born. The use of self, in a loving and compassionate way, provides us with our most powerful instrument for healing.

Chapter 7

Spirituality and Health

Margaret A. Burkhardt and Mary Gail Nagai-Jacobson

NURSE HEALER OBJECTIVES

Theoretical

- Describe spirituality.
- Compare and contrast spirituality and religion.
- Discuss common elements of spirituality and their varying manifestations in different people.
- Recognize mystery, suffering, love, forgiveness, hope, peacemaking, and grace as spiritual issues.
- Discuss the interplay of spirituality and psychology.

Clinical

- Explore the efficacy and place of prayer in healing.
- Discuss listening as intentional presence.
- Incorporate different approaches to spirituality assessment into holistic care.
- Discuss the use of story in spirituality assessment and care.
- Describe approaches for responding to spiritual concerns.

Personal

- Explore the need for nurses to nurture their own spirits and ways to do so.
- Discuss ways in which ritual, rest and leisure, play, and creativity relate to spirituality.
- Explore ways of naming and nurturing important connections.

DEFINITIONS

Spirituality: the essence of our being. It permeates our living in relationships and infuses our unfolding awareness of who and what we are, our purpose in being, and our inner resources. Spirituality is active and expressive. It shapes—and is shaped by—our life journey. Spirituality informs the ways we live and experience life, the ways we encounter mystery, and the ways we relate to all aspects of life. Inherent in the human condition, spirituality is expressed and experienced through living our connectedness with the Sacred Source, the self, others, and nature.

Religion: refers to an organized system of beliefs regarding the cause, purpose, and nature of the universe that is shared by a group of people, and the practices, behaviors, worship, and ritual associated with that system. Religion connects persons through shared beliefs, values,

and practices, making clear particular belief systems that are different from other belief systems, thus defining differences between groups of persons.

THEORY AND RESEARCH

We join spokes together in a wheel
but it is the center hole that makes the wagon move.
We shape clay into a pot,
but it is the emptiness inside that holds whatever we want.
We hammer wood for a house,
but it is the inner space that makes it livable.
We work with being,
but non-being is what we use.[1]

Spirituality is perhaps the most basic, yet least understood, aspect of holistic nursing. Spirituality often eludes the cognitive mind because it is intangible in many ways and defies quantification. A definition of spirituality is a starting point, appreciating that the mystery and human experience of spirituality cannot be fully captured by any definition. Language for expressing the experience of spirit or soul is limited, thus people speak of spirituality however they can, often with symbols, metaphor, and story.[2] The term *spirituality* derives from the Latin *spiritus*, meaning breath, and relates to the Greek *pneuma* or breath, which refers to the vital spirit or soul. Spirituality is the essence of who we are and how we are in the world and, like breathing, is integral to our human existence.

All people are spiritual. By virtue of being human, all persons, at all ages, are bio-psycho-social-spiritual beings. Attending to spirituality across the life span implies an understanding of the developmental aspects of spirituality, particularly an awareness that expressions of spirituality may vary with age. Some people describe themselves or others as not spiritual because they do not attend religious services or believe in God. This reflects the common practice of describing spirituality in terms of religious beliefs and practices. Nurses and other health care providers often link spiritual caregiving with determining a patient's religious affiliation and understanding the health-related beliefs, norms, and taboos of that religion. Although such knowledge is important for holistic nursing, spiritual caregiving requires an understanding that spirituality is broader than religion and a recognition that, although some people may not be religious, everyone is spiritual.

Relationship Between Spirituality and Religion

The nursing and health care literature makes it clear that spirituality and religion are not synonymous.[3–15] Spirituality, as noted, is integral to all persons. As the essence of who we are, spirituality is a manifestation of each person's wholeness and being that is not subject to choice, but simply *is*. Religion per se is not essential to existence. Religion is chosen. Spirituality is expressed and experienced in many ways, both within and beyond the context of religion.

Religion refers to an organized system of beliefs shared by a group of people and the practices related to that system. Ritual, worship, prayer, meditation, style of dress, and dietary observances are examples of such practices. Because culture influences a person's values and beliefs, religious and other spiritual expressions often relate to personal culture. Religions reflect particular understandings of spirituality, and are only one of many ways of understanding or experiencing spirituality. Religious precepts and practices often assist persons in attending to their spiritual selves; at times, however, these actions do little to nurture a person's true spirituality. Life issues that are spiritual in nature may or may not relate to religion. Knowledge of

the histories, symbols, beliefs, practices, and languages of various religious traditions increases the nurse's ability to hear, recognize, and address religious needs of patients; however, information alone about religious affiliation and practices offers only a glimpse into a person's spiritual self.

The literature suggests that nurses may be more comfortable discussing spiritual concerns when they arise within an identifiable religious context than when they occur within a broader perspective of spirituality. When it is assumed that satisfying the rites and rituals of a particular religion meets a patient's spiritual needs, interventions may become standardized rather than individualized to the patient's needs.[16] This is of particular concern when a patient's spirituality is not expressed through an affiliation or alignment with the practices of a particular religion.

Understanding Spirituality

One of the barriers to incorporating spirituality into holistic nursing care is the paucity of language within Western societies for discussing and expressing matters of the spirit or soul. This difficulty with the language of spirituality is evident in the nursing literature. Hall noted that, in Western cultures, the choice of a language for expressing spirit has generally been limited to that of science or that of religion derived from the Judeo-Christian tradition.[17] Indeed, much of the discussion of spirituality within nursing and other health care literature reflects Judeo-Christian values and perspectives regarding the Divine, relationships with others and the world, experience of suffering, prayer, and the like. Because spirituality is the essence of every person and is not limited to a particular religious perspective, nurses need to strive to be open to, or to create a language that allows room for, each person's unique expression of spirituality.

According to Engebretson,[18] the Western cultural bias can lead to misinterpretation of spiritual expression and concerns. She noted that not all assumptions of Western Judeo-Christian-Islamic traditions (e.g., monotheism, transcendence, dualism) are shared with Eastern and nature religious traditions. Monotheism is a belief in one God that is above and beyond nature, contrasted with a belief in the existence of many gods (polytheism) or the existence of the sacred in all living things (pantheism) found in Eastern and nature religions. Transcendence, which means to exist above material existence, is implied in the Western view of God as separate from humanity. People from such Western traditions often seek connection with the Divine by focusing outward through ritual and prayer. Eastern and nature traditions focus on immanence, the experience of the Divine within each person. Looking inward through meditation and spiritual exercises are ways of connecting with the Divine in these traditions. Dualism (the separation of spirit and matter) is a basic concept in Western traditions, while reality is conceived as a unified whole in Eastern metaphysical traditions of monism. Engebretson noted that the polarization of science and religion found in the West reflects the institutionalization of dualism. She stressed the importance of recognizing the impact of these assumptions on perceptions, definitions, and expectations of the spiritual experience within health care. She was especially concerned about labeling spiritual issues as pathology, or not recognizing them at all because they do not fit a familiar paradigm.

Many people experience a blurring of boundaries and a blending of various religious traditions in relation to their own spirituality. Some people express and experience their spirituality best in the distinctiveness of a particular religious tradition, while others address their spirituality through blending different religious and

philosophical traditions; still others experience their spirituality outside organized religious systems. Holistic nursing practice recognizes that religion and spirituality are different and honors the unique ways in which people express, experience, and nurture their spiritual selves.

Elements of Spirituality

The resurgence of interest in spirituality and health that has occurred in the past decade has generated many definitions and descriptions of spirituality within the health care literature. In many ways, however, trying to define spirituality is like trying to lasso the wind. The wind can be felt and its affect on things seen, but it cannot be contained within imposed boundaries, conceptual or otherwise. The similar nature of spirituality poses a particular challenge for minds that feel more at home with phenomena that can be categorized, quantified, and measured. Rather than being hostile to scientific debate, spiritual discourse actually complements such discourse.[19] Understanding spirituality requires opening to many ways of knowing, including cognitive, intuitive, aesthetic, experiential, and deep inner sensing or knowing.[20]

Although the health care literature provides no single agreed-upon understanding of spirituality, many authors note that spirituality reflects the essence of being; a unifying and animating force; the life principle of each person.[21–27] Spirituality permeates life, shapes our life journey, and is vital to the process of discovering purpose, meaning, and inner strength. Although matters of spirit transcend culture, a person's cultural perspective influences personal expressions of spirituality. Personal values are rooted in and flow from spirituality, and are reflected in a cultural perspective. Spirituality helps to ground one's sense of place and fit in the world. Because it is practical and relevant to daily life, people experience spirituality in the mundane as well as in the profound, the secular as well as the sacred.

A sense of peace, often described as inner peace, is a spiritual attribute. Peace in this context implies a deep confidence and an ability to remain calm in the midst of the storm, to know somehow that all is well. Spiritual peace is experienced in the space of the heart and may not make sense to the cognitive mind. In the Judeo-Christian tradition, references to "a peace which passeth understanding" flow from an awareness of life beyond immediate circumstances and unbounded by the past. This peace may feel like a background presence that becomes stronger in the face of life struggles and challenges. Peace of the spirit may also appear suddenly, in unexpected ways and times. Peace is a product of living in relationship with the Sacred Source, others, and all creation in a way that acknowledges and nurtures the soul in the midst of all that life brings.

A sense of trust that people have or are given the resources needed for dealing with whatever comes their way—expected or not—is a manifestation of spirituality. These resources include both strength and guidance from within and support from sources beyond themselves. Through encountering obstacles along their life path, learning through experiences, and developing new awarenesses, people gain appreciation for the ways that spirituality shapes and gives meaning to their unfolding life journey. To reach this point, people may find it necessary to reconcile new experiences with previously held values, resulting in new values and understandings. Often, the pattern of the journey and the meaning of life events become clear only in retrospect.

Research on spirituality reflects a strong element of interconnectedness between individuals and all that is within and around them. Nolan and Crawford summarized this in saying "the

spirit is that which enlivens, empowers, and motivates, and spirituality has to do with what takes place within, between, and beyond people."[28] Research continues to demonstrate that people express and experience spirituality in their relationships with the Sacred Source, nature, others, and the self.[29–37]

Connectedness with the Sacred Source

The Sacred Source may be experienced as a person, a presence, or as a mystery that is beyond words. The inadequacy of language is especially apparent when we try to discuss or describe that which is within and among us, yet beyond and a power greater than us. Humanity has searched and sought to understand the mysterious Sacred even before the beginning of recorded history. Various cultures, faith traditions, individuals, and groups use names such as Life Force, Source, God, Allah, Lord, Goddess, Absolute, Higher Power, Spirit, Vishnu, Inner Light, Tao, Great Mystery, Tunkasila, The Way, Universal Love, and the One with No Name to refer to that in which we live, and move, and have our being. For this discussion, this Being or Sacred Mystery is referred to as God or the Sacred Source.

Our rational minds cannot *think* or grasp God, and any descriptions or words used to speak of the Sacred Source are lacking. God is far more than anything the human mind can conceptualize. Words and descriptions are, however, tools of the rational mind that can point us toward God or the Sacred Source. Concepts of God developed by the rational mind may be personal or shared within a group. Persons find and name the Sacred Source in ways that are authentic to them, using terms and language that reflect their experiences and perspectives. Connecting with the Sacred Source may involve such things as prayer, ritual, reconciliation, and stillness. Teachings of various religious traditions offer their own perspectives and guidance on how to be in relationship with the Sacred Source. Understanding how persons seek and experience connection with the Sacred Source and the obstacles they may encounter are important in spiritual caregiving.

The concept of reverence is associated with many understandings of the Sacred Source. Reverence arises from a deep appreciation of human limitations and a sense of awe in relation to what is understood to be outside our control—God, truth, the natural world, even death. Awareness that the sacred is intrinsic and omnipresent engenders reverence toward the Sacred Source and all of life.[38] Reverence acknowledges that we are in and of God, yet, as Woodruff notes, keeps human beings from trying to act like gods.[39] Persons who do not claim a religion or give a name to that which they hold most sacred express and experience this sense of reverence in their recognition of that which is beyond and greater than their own understanding, but with which they experience an often mysterious relationship. This connection with the Sacred Source is at the heart of one's being.

Connectedness with Nature

Spirituality is frequently expressed and experienced in and through a sense of connectedness with nature, the environment, and the universe. Animals, birds, fish, and other creatures of the earth provide meaning and joy for people of all ages. Awareness of all the life forms of the earth, and their place within the natural order, is a source of connection with and appreciation of the spiritual.[40–44] Beavers at work on a dam, birds in flight, or bees among the flowers all illustrate the wonder of various life forms that may provide deeply spiritual experiences.

Awareness of a connectedness with the earth and, indeed, the entire cosmos is particularly evident within indigenous

spiritual traditions. A speech attributed to Chief Seattle emphasizes that all things are connected.[45] Individuals are not the weavers of the web of life; rather, each is a strand in the web. What they do to the web they do to themselves. Thus, what happens to the earth and the environment affects them, and conversely, their choices and actions in all levels of their being affect the earth.[46,47] Understanding the interconnectedness of spirit and matter is basic to some traditions and known at some level in all spiritual traditions, particularly among the mystics.

Many people, particularly those who live close to the land, experience a sense of connection with the Sacred Source through nature, regardless of their religious background. As Lamb noted, there is something extraordinarily alive among members of long established Southwestern cultures that comes "from paying close attention to matters of the spirit and living so intimately with the land that its seasons are felt in the heart."[48] People often express a particular feeling of closeness to their spiritual selves while walking on a beach, sitting by their favorite tree, viewing a sunset, listening to flowing water, watching a fire, caring for plants, and otherwise experiencing the natural order. Nature can be a source of strength, inspiration, and comfort, all of which are attributes of spirituality. A sense of awe at the wonder of life and a feeling of connectedness with all things, with or without a belief in a Divine being, is an experience of spirituality. For some, connection with nature flows from a sense of finding God in all things; many experience a relationship with the earth and all its creatures at an energetic level. Appreciating, respecting, and caring for the earth and all its inhabitants are elements of spirituality.

Connectedness with Others

Spirituality is known and experienced in and through relationships, with the comfort, support, conflict, and strife that mark those connections. People express and experience spirituality through an appreciation of a common bond with all humanity, and in their particular relationships with others. Spirituality is shaped and nurtured within one's experience of community, beginning with one's family. The many communities, both formal and informal, in which people live their lives provide a context for spiritual expression and development. Communities provide an opportunity for sharing spiritual journeys.

People often speak of their spirituality in terms of their relationships, both harmonious and discordant. The formation, work, nurture, and healing of relationships are an important part of one's spirituality. Being with others in loving and supportive ways is an expression of spirituality, as is struggling with painful and difficult relationships with family, friends, and acquaintances. Relationships that need healing are as important to spirituality as those that provide support and comfort. Spirituality embraces both the joys and sorrows of relationships, and it prompts reconciliation where the connection has been frayed. Lack of connections often produces a dispiriting sense of aloneness and isolation, and may lead to spiritual crisis.

Spiritual connectedness with others involves both giving and receiving. Receptive openness to Love, Light, Life, and the Sacred Source is a spiritual stance. Although it is common to think of spirituality in terms of doing for another, being able to receive from others, both the gift of themselves and the things that they do or say, is also an expression of spirituality. Indeed, the genuine presence that someone shares with another, with its implicit loving honesty and intimacy, is a manifestation of spirituality.[49–53] Spirituality is evident in both common experiences of daily living and special times shared with others: times of joy, sorrow, ritual, loving sexuality, prayer, play, encouragement, anger, reconciliation, and concern. The

recognition that relationships are a source of growth and change reflects spirituality.

Advances in technology have brought distant and isolated countries and cultures together into a world community. As a result, understanding factors that create and support community has become essential. The ability to see what people great distances away are experiencing enables better understanding of how personal and collective decisions impact the larger human family. Social structures that provide a context for relationships with others often are instrumental in nurturing the spiritual dimensions of community life. Structures such as health care, educational institutions, faith-based services, social organizations, and informal affiliations with others are often places that mediate and support the spiritual dimensions of life.

Connectedness with Self

Spirituality infuses the ever-unfolding awareness of who one is—of self-becoming. The ability to be in the place of awareness that flows from spirit or soul is a pivotal element of connectedness with self. Awareness opens people to the experience of living in the moment, present to their own body-mind-spirit, and allows them to receive all aspects of themselves without judgment. They experience awareness through *Being*, the art of stillness and presence with self, others, the Sacred Source, and nature. Being simply *is*. Being includes experiencing the present moment more deeply, aware from the physical experience of all levels of one's body-mind-spirit's energetic self in interaction with all in the environment.[54–56] Being is bringing one's whole self—alert, quiet, aware—to an experience, allowing one to pay attention to the quiet place inside and find inner peace, synchrony, harmony, and openness. Attentiveness to being allows a person to attune to sources of inner strength and deepest knowing.

Spirituality manifests and is experienced in *Knowing*, which includes cognitive, intuitive, and energetic dimensions. Knowing provides ways of understanding our multidimensional nature and our relationships to the Sacred Source, self, others, and the cosmos. Knowing flows from a stance of openness and attuning to an inner source. It involves actively seeking knowledge and insights, and maintaining an openness and receptivity to the lessons life offers. Spirituality reflected in one's knowing includes appreciation of life as a gift and a sense of connectedness to all creation.

From being and knowing flows *Doing*, the outward, and more visible aspect of spirituality. Because doing is more tangible and measurable, it is the manifestation of spirituality that is most often addressed in health care literature. Generally, the concept of doing brings to mind activities such as attendance at religious services or ceremony, scripture study, prayer or meditation, participation as student or teacher in religious education, and spiritual reading. Spirituality can be demonstrated as well through actions such as assisting others, gardening, becoming involved in environmental concerns, attending to the sick, caring for family, spending time with friends, taking a walk, taking time to nurture one's own spirit, and creating sacred space for self and others.

The concept of *sacred space* applies both to one's inner being and to places in one's environment. Although to "create" sacred space suggests doing something, inner sacred space is often the result of being in awareness and stillness. Buildings such as religious edifices or monuments represent sacred space for many. Special places in nature are often experienced as sacred. Any place can become sacred space if one intentionally brings awareness of the spirit into the setting. Words, actions, sounds, scents, colors, and objects may shape such spaces. A sacred space is a home for the spirit, providing rest, stillness, nurture, and opportunities for opening to various connections. A special plant in a sunlit space, a garden or

workshop, a room for prayer or meditation, a corner of a porch with a rocking chair, family surrounding a loved one in a hospital bed—each space touched by the intention of those who arrange it—are examples of sacred spaces.

SPIRITUALITY AND THE HEALING PROCESS

In a holistic paradigm, body-mind-spirit is an intertwined and interpenetrating unity; thus, every human experience has body-mind-spirit components. In considering spirituality and healing, it is useful to remember that the words *healing*, *whole*, and *holy* derive from the same root: Old Saxon *hal*, meaning *whole*. This suggests that, by its nature, healing is a spiritual process that attends to the wholeness of a person. The work of healing requires recognition of the spiritual dimension of each person, including the healer, and an awareness that spirituality permeates every encounter. The shared relationship acknowledging the common humanity and connectedness between the caregiver and the receiver, which is basic to healing, is a manifestation of spirituality.

Spiritual View of Life Issues

Spiritual issues are core "life issues" that often draw people to look into the deepest places in their beings. These issues are not quantifiable and are more authentically expressed as questions, tentative definitions, or as mysteries that cannot be fully explained. They challenge the individual to experience life at its highest heights and deepest depths. Considerations of mystery, love, suffering, hope, forgiveness, grace, peacemaking, and prayer are all inherent in the spiritual domain.[57–61]

Mystery

Mystery is inherent to human experience, and thus is inherent to spirituality. Mystery may be described as a truth that is beyond understanding and explanation. Many life experiences prompt questions of *why* and wonderings about *what if*. Appreciation of the mystery inherent in life events often sustains people in the unknowing. As people encounter that which is troubling and unexplainable, spirit recognizes mystery and helps them survive the unknowing. Spirituality supports and encourages them in the questioning and seeking that often emerges when they are faced with such mystery. The spiritual self helps them embrace both the darkness and the light, enabling them to appreciate the challenges and gifts of both. Discovering the personal and unique ways that people encounter mystery on their spiritual journeys is an important part of spiritual care.

Love

Love, which is the source of all life, fuels spirituality, prompting each person to live from the heart, the center where the ego is detached from outcomes. Love, like the spirit, is nonlocal, transcending place and time, and enabling its energy to be shared for healing at many levels.[62] The relationship of love to healing is a continuing source of exploration and wonder.[63–67] In its truest sense, love is a mystery that involves both choice and emotion, and it often underlies acts of courage and compassion that defy explanation. It is in both giving and receiving care that love is experienced and expressed. Love is both personal and universal. Flowing from and prompting interconnectedness, love includes dimensions of self-love, divine love, love for others, and love for all of life.

Loving presence is a key component of spiritual care.

Suffering

In both its presence and its meaning, suffering is one of the core issues and mysteries of life. It occurs on physical, mental, emotional, and spiritual levels. People throughout the ages have struggled to understand the nature and meaning of suffering. Their attempts to make sense of suffering have helped to shape cultural and religious traditions. Suffering may be a transformative experience, the nature of the transformation varying with each individual. For some, suffering enhances spiritual awareness; for others, suffering appears meaningless and engenders feelings of anger and frustration. One interpretation of burnout among health care professionals is that it represents the inability to find ways to tend the spirit as one suffers the suffering of another.

Viewed from various perspectives, certain forms of suffering may be seen as a blessing, or perhaps something to be endured, or even evidence of a curse. Not all people seek to alleviate suffering immediately. Sociocultural, religious, familial, and environmental factors influence an individual's response to suffering. Thus, having knowledge of personality, culture, religious traditions, and family background will help the nurse understand the nature and meaning of suffering for a particular person. In the same vein, nurses need to be aware of their own responses to and understanding of suffering, so as not to confuse their perceptions with those of the patient. This awareness enables nurses to be more fully present in an intentional, healing way with those who are suffering. Such presence allows nurses to discern whether honoring another's suffering requires action, presence, absence, or a combination of these. The ability to be with another who is suffering is crucial, particularly when nurses confront suffering that cannot be alleviated and must simply be borne. Such presence supports a person's spiritual journey toward discovering transcendent meaning within the experience.[68–70] Listening with one's whole being as another wonders aloud and expresses deep feelings regarding some of life's unanswered questions is a critical part of being with those who suffer.

Hope

Hope, a desire accompanied by an expectation of fulfillment, goes beyond believing or wishing. Hope is future-oriented. The saying "hope springs eternal" reflects this energy of the spirit and prompts the anticipation that tomorrow things will be better, or at least different! There are two levels of hope: The first, specific hope, implies a goal or desire for a particular event or outcome. The second is a more general sense of hope; i.e., hope that the future is somehow in safekeeping. Hope is a significant factor in overcoming illness and in living through difficult situations.[71,72] It helps people deal with fear and uncertainty and enables them to envision positive outcomes. There is a positive correlation among hope, spiritual well-being, intrinsic religiosity, and other positive mood states.[73]

Forgiveness

Ultimately a matter of self-healing, forgiveness is a deep need and hunger of the human experience. Religious beliefs, cultural traditions, family upbringing, and personal experience all help to shape an individual's attitudes about forgiveness, both given and received. Beliefs about the nature of God or the Sacred Source influence one's ability to offer and receive forgiveness. Difficulties with forgiving others, forgiving oneself, and accepting

forgiveness from others often relate to a misunderstanding of the nature of forgiveness. Forgiveness is something one does for oneself, not for others. Forgiveness does not necessarily mean forgetting, condoning, absolving, or sacrificing; rather, it is a process of extending love and compassion to self and others.[74–77] An act of the heart, forgiveness is an internal process of releasing intense emotions attached to incidents from the past, releasing any need to carry grudges, resentments, hatred, self-pity, or desire to punish people who have done hurtful acts, and accepting that no punishment of others will promote internal healing. Forgiveness, a sign of positive self-esteem, allows a person to put the past in proper perspective; to free energy once consumed by grudges, resentments, and nursing unhealed wounds; and to use this energy for opening to healing and moving on with life.

Self-forgiveness—releasing the desire or need to berate or punish oneself for past actions—is an important part of forgiveness, and is essential for spiritual growth and healing.[78,79] Self-forgiveness is not about regret or guilt, but rather concerns acknowledgment of responsibility for one's choices and actions. Kollmar describes self-forgiveness as a gift to oneself that provides an opportunity to remove the energetic consequences from past actions and thoughts, so that the cumulative energy of one's past actions will not adversely affect the self.[80] The notion of free will—that the actual or energetic result of one's actions and thoughts cannot be bypassed by God or the universe—is basic to self-forgiveness. The process of self-forgiveness removes the barriers to receiving help from God or the universe through acknowledgment of personal responsibility for past thoughts and actions, and the willingness to let go of any energetic attachment to these thoughts and actions. Kollmar used the following analogy to illustrate the self-forgiveness process: If someone goes for a walk and along the way steps on a thorn, every step from that point on is painful. The more the person walks, the more it hurts. The body cannot heal as long as the thorn is in the foot; however, once the thorn is removed, the body can begin the healing process. Self-forgiveness, like pulling out the thorn, enables the natural self-healing energy that is a part of the universe to begin and gives all of God's grace room to provide comfort.

Peace and Peacemaking

Peace, for many people, is inseparable from justice. Inner peace reflects a way of being, a space from which one is able to live and Be in ways that nurture and heal. This peace does not depend on external circumstances; it flows from the connections that sustain us. It is a great spiritual accomplishment "to come through brutal trials and then look back and see that mean times did not render us mean spirits."[81] Today as in the past there are people throughout the world who are experiencing brutal trials. Living as peacemakers in times and places of uncertainty, fear, injustice, and war is a spiritual challenge facing all citizens of the world, and it demands courageous and creative solutions. The work of peacemaking is grounded in the awareness that

> there is an inherent power in rightness, in goodness in love, and in love of peace and that if even a single individual chooses to act rightly and truthfully and peacefully in the midst of tempting and contrary choices, the power of that act and aspiration can change the world. By extension, if untold numbers of single individuals love peace enough, seek peace enough, stand for

peace enough, are themselves persons of peace, the ideal of peace will become the world's transforming reality.[82]

As persons appreciate and live in the reality of their connection with others and all creation across distance, time, and space, the possibility of peace with justice grows.

Grace

Experiences of grace contain elements of surprise, awe, mystery and gratitude. Grace, a support that is unplanned and unexpected, "meets us where we are but does not leave us where it found us."[83] Grace opens one's awareness to the experience of wholeness, healing, and connectedness. Grace is reflected in statements such as:

- He just showed up at the door right when I needed him.
- I didn't know how I was going to pay for everything; then this check arrived.
- I don't know why my spirits lifted that morning; perhaps it was the rain after such a long drought.
- I didn't think I could stand another bout of chemotherapy, but my friend said she will go with me and we'll take one day at a time.
- My CT scan was clear for the third time, something that the doctors didn't expect and that I didn't dare hope for.

While some see such happenings as coincidence or chance, others sense something deeper that connects persons within the web of life and enables us to find acceptance, courage, peace, and endurance beyond our own making or understanding. Grace is often spoken of as a gift from the Sacred Source, or from Life itself, that enables, assists, and empowers a person in the midst of difficult and sometimes seemingly overwhelming circumstances. The experience of grace as a blessing that comes into one's life unearned calls forth a response of gratitude.

Prayer

An expression of the spirit, prayer is a deep human instinct that flows from the core of one's being where the longing for and awareness of one's connectedness with the source of life are blended. Prayer represents a longing for communion or communication with God or the Sacred Source. The most fundamental, primordial, and important language that humans speak, prayer is an endeavor that starts and ends without words. In this understanding, prayer flows from yearnings of the soul that rise from a place too deep for words and move to a space beyond words.

Forms and expressions of prayer are as varied as the people who pray. Prayer, which is intrinsic to many religious traditions and rituals, may be public or private, individual or communal. It is not always a fully conscious activity. Speaking (sometimes silently), singing, chanting, listening, waiting, moaning, being attuned to what is going on in the present moment, and being silent can all be elements of prayer. Prayer includes petition, intercession, confession, lamentation, adoration, invocation, thanksgiving, being, and showing care and concern for others. Some people incorporate processes and techniques such as relaxation, quieting, breath awareness, focusing, imagery, and visualization into their prayer. Movement such as walking, dancing, or drumming may be expressions of prayer. A reminder of our nonlocal, unbounded nature, prayer is infinite in space and time. It is divine, the universe's affirmation that we are not alone.[84,85]

That prayer is an appropriate consideration for nursing is grounded in the writings of Florence Nightingale.[86,87] Research affirms the truth that people have known for ages: prayer can affect healing.[88–95]

Both directed prayer, which focuses on a specific outcome, and nondirected prayer, which focuses on the greatest good of the organism, can affect healing and other outcomes, although nondirected prayer may be more effective. Even at a distance, prayer alters processes in a variety of organisms, including plants and people. Furthermore, the observed effects of prayer do not depend on what the one prayed for thinks. In his book *Be Careful What You Pray For*, Dossey reminds us that prayer is a potent force that is best used thoughtfully, with care and discernment.[96]

Spiritual and Psychologic Dimensions

The term *psyche* means soul or spirit, reflecting the relationship between the spiritual and the psychologic that is evident even in the spoken language. Before the time of Freud, phenomena of the sentient realm that could not be explained physically often were considered matters of the spirit and viewed in religious terms. With the advent and ongoing development of psychology, matters of the soul often have been subsumed into psychologic theory and frequently interpreted as pathology. Within a holistic paradigm, spiritual and psychologic elements are interconnected because the body-mind-spirit is an integrated whole. Failing to differentiate the spiritual and psychologic dimensions, however, can lead nurses to miss cues regarding spiritual concerns and thus inappropriately label spiritual issues as psychopathology.[97–99] Although spiritual awakenings and deepenings may be accompanied by elements of psychologic distress, the "dark night of the soul" may be a very important part of the process of moving to greater awareness and enlightenment. Fortunately, more contemporary psychologic models such as psychosynthesis, logotherapy, and transpersonal, humanistic, and Jungian psychology address the spiritual dimension.

Unlike Eastern and indigenous traditions around the world, Western traditions have only a limited familiarity and comfort with the spiritual nature of different levels of awareness. The misinterpretation of behaviors, emotions, and reactions associated with individual experiences and expressions of the spiritual is keenly evident in the life of Florence Nightingale and the many interpretations of her life.[100–102] Some have interpreted the behaviors and health concerns evident throughout her life after her return from the Crimea as psychologic pathology, such as anxiety, neurosis, malingering, depression, and stress burnout. Approaching Nightingale's life from a spiritual as well as psychologic perspective, however, allowed Dossey to recognize Nightingale for the mystic that she was.[103,104] In a similar vein, appreciating the difference between spiritual and psychologic domains enables nurses to assess spiritual cues and spiritual crises more effectively, as well as to recognize opportunities to foster spiritual growth.

SPIRITUALITY IN HOLISTIC NURSING

Nurturing the Spirit

The way that nurses care for and nurture themselves influences their ability to function effectively in a healing role with another. The *spiritual* path is a *life* path. Attentiveness to one's own spirit is a key component of living in a healing way, and is foundational to integrating spirituality into clinical practice. Care of their spirit or soul requires nurses to pause for reflecting and taking in what is happening within and around them; to take time for themselves, for relationships, and for other things that animate them; and to be mindful about nourishing their spirits.[105–108] The many ways

nurses nurture their spirits and respond to their spiritual concerns are the same as those that they suggest to their patients.

Care of the spirit is a professional nursing responsibility and an intrinsic part of holistic nursing. Within a holistic perspective, providing spiritual care is an ethical obligation, which, if ignored, deprives patients of their dignity as human beings.[109,110] Nurses must become competent and confident with spiritual caregiving, expanding their skills in assessing the spiritual domain, and developing and implementing appropriate interventions. A persistent barrier to incorporating spirituality into clinical practice is the fear of imposing particular religious values and beliefs on others. Nurses who integrate spirituality into their care of others need to recognize that, although each person acts out of and is informed by her or his own spiritual perspective, acting from this foundation is not the same as imposing these beliefs and values on another. In fact, many practitioners believe that the more grounded they are in their own spiritual understandings, the less likely they are to impose their values and beliefs on others.

Assessing and Investigating Spirituality in Practice and Research

The renewed appreciation of the role of spirituality in health and healing is evident in the literature, in the number of professional conferences that include spirituality as a major theme, and in the efforts to incorporate courses on spirituality into health professions' education programs. The literature reflects attempts to make sense of spirituality within a scientific frame of reference, and clinicians and researchers continue to struggle with the inherent difficulties of assessing and measuring a phenomenon that defies definition. Many researchers approach the study of spirituality primarily through examining religious beliefs and practices. This approach can be problematic, however, in that many people do not express their spirituality within a religious tradition; conversely, religious practices do not necessarily indicate a person's true spirituality. Some assessment scales used in research on spirituality reflect a strong bias toward Judeo-Christian beliefs, suggesting that those who do not ascribe to these traditions may not be spiritual.

Attempts to quantify spirituality, even with more broadly applicable scales, must be viewed with caution regarding the results and the effect of such instruments on care. Hatch and colleagues suggested that credible, objective, quantitative instruments for spiritual inquiry will facilitate the integration of spirituality into health care by providing a mode of assessment similar to that of the mental status examination.[111] Hall, on the other hand, asserted that "allusive spiritual phenomena have been operationalized into constructs that have been developed as scales that measure such concepts as spiritual dimension, spiritual well-being, and spiritual needs that are supposed to stand for spirituality and are taken by researchers to be spirituality."[112] She noted that, when this occurs, both the concepts and their measurements may obscure rather than reveal the individual meanings associated with the spiritual journey and are poor substitutes for a holistic understanding of the person.

The difference in these two perspectives represents an ongoing question about how best to approach spirituality assessment in clinical practice and research. A goal of holistic nursing is to know a person in the fullness and complexity of her or his wholeness. Knowledge obtained about a person through any process of assessment is not an end in itself; rather, it is useful inasmuch as it contributes to understanding and knowing more of the *essence* of the person. Knowledge about a person

enables nurses to understand more of who the person is when it is enhanced by the person's perspective of the meaning of such knowledge. Although quantification may more readily capture the attention of the scientific and medical communities, reliance on quantitative measurements may indeed promote the use of diagnostic reasoning and structured interview formats as a substitute for listening.[113]

Listening and Intentional Presence

Attentive listening and focused presence are at the heart of caring for the spirit, and they are essential in any approach to spirituality assessment. This concept is simple in many ways, but is not always easy. Good therapeutic communication skills facilitate the exploration of spiritual issues. Broad, open-ended questions are often useful. Questions and statements such as "Tell me more about . . . ," "Help me to understand what you need," "I don't understand what you are trying to say," and "What was that like for you?" are useful as nurses seek a deeper understanding of their patients. Creating a sacred space in which spirituality can be expressed, and having clarity about their own spiritual perspective enhance nurses' facility with spirituality assessments. Practicing spiritual disciplines such as prayer, centering, awareness, and meditation make it easier for nurses to be fully present, available to be with and listen to another. In the face of distractions from within and without, the nurse's ability to focus on the relationship with a particular person in a particular moment is an important aspect of being a healing presence, one that greatly enhances spiritual care.

One of the gifts of intentional, active listening is that the client, in sharing with an open-hearted and fully present listener, often hears herself or himself with greater clarity and understanding. Such a listener provides a safe space for expression of negative as well as positive feelings and experiences. The contradictions, pains, questions, and struggles can be heard without judgment or advice. The person is able to express and often to hear and better understand the situation's richness and complexity and move toward the future with more awareness.

Holistic nurses assess their own abilities as listeners, considering barriers to intentional listening that are part of their personal journeys. There may be topics that make one uncomfortable. Although discomfort alone need not make one an unsuitable listener, being aware of one's discomfort, and its source and manifestations, is an important part of a self-evaluation. Nurses should consider how external distractions such as the environment or time pressures affect their ability to listen. In addition, they should be attentive to how body posture conveys presence and attention. A hospice patient illustrated an experience of intentional listening and presence in describing his relationship with one of the hospice workers on his team:

> It just makes me feel good to see him come in. One day he and I both fell asleep, kind of took a nap for a bit. He probably knows as much about me as anyone—because he's the kind of guy who's interested in everything I talk about, my family, my worries, my sickness. Sometimes he asks a question, but mostly he just listens—but I mean really listens, like he wants to know about whatever is on my mind.

Intentional listening and presence foster authenticity in the nursing process. Such listening and presence demand a recognition of both verbal and nonverbal cues in communication, and the valida-

tion by the patient of any of the nurse's interpretations. Nurses should ask themselves the following questions: When have I been intentionally present for another, listening with my whole being and with an open heart? What factors, internal and external, make that difficult for me? When have I been in the presence of one who was fully present for me? How did I recognize that full presence? How did that affect me? The core of active listening and healing presence lies in the intention and spirit of the nurse who recognizes all persons as spiritual beings. Exhibit 7–1 lists important considerations for nurses as they strive to listen in healing ways to their clients. According to Bruchac, "It all begins with listening. There are stories all around us, but many people don't notice those stories because they don't take the time to listen."[114]

Exhibit 7–1 Listening in Healing Ways

- Be intentionally present.
- Maintain focus on the patient/client as a whole person.
- Set aside the need to "fix," "answer," or "correct."
- Learn to be with another in silence.
- Interrupt as little as possible, recognizing that even what is not said at a particular time has meaning and that the way and sequence in which a story is told are part of the story.
- View the other as embodied spirit; an ongoing and unfinished story.
- Hear the journey, the relationships, and the meanings in the story.
- Listen with all your senses.
- Do not prematurely diagnose.
- Let the conversation flow, being with silence as well as words.
- Breathe!

Source: M.G. Nagai-Jacobson and M. Burkhardt, © 1997.

Using Story and Metaphor in Spiritual Care

Recognizing all persons, including themselves, as ongoing and unfolding stories offers nurses a valuable perspective from which to approach spiritual caregiving.[115–118] Spirituality is multidimensional; it reflects the depth and complexity of a person's being, and embraces that person's connections with the Sacred Source, the earth, other persons, and the self. Story and metaphor often provide a language and form for conveying the richness of one's spirituality when factual statements of experience fail to do so. Stories bring people enjoyment, teach them to solve problems, help them form identities, and are wonderful teachers. Few things help a person to understand the world better than a good story.[119] Through the vehicle of story, people learn to know each other from many perspectives. Stories reveal experiences of relationships, emotions, conflicts, struggles, and responses that are at once personal and universal. Nurses become part of the life stories of those for whom they care. Nurses' own life stories inform and form them, and understanding those stories deepens the awareness with which they hear another's story.

Listening and encouraging people to share their stories can be both assessment and intervention in spiritual care. Stories make it possible to move beyond physical symptoms, diagnoses, and theoretical constructs, which may be similar for any number of patients. Attentiveness to story allows nurses another glimpse into the wholeness and uniqueness of each person and the particular way in which he or she fits into the family and community. As an assessment approach,

story and metaphor provide insight into spiritual concerns such as supportive and disruptive relationships, questions of meaning, values and purpose, issues of forgiveness, hope and hopelessness, and experiences of grace. Listening is a reminder that life stories are ongoing and unfinished.

The sharing of story and metaphor can also be a nursing intervention. In sharing with a fully present listener, patients hear their own stories with new insights and appreciation for their own lives—affirmations and validations, conflicts and struggles, questions of meaning and dark times—life in its variety and fullness. In a safe space, patients can express fears and perceived failures, hopes and wonderings, disappointments and achievements, as they consider pages of their life stories. Through this process, patients come to see themselves more clearly and, in an atmosphere of acceptance, accept themselves in their full humanity. From such a stance, patients are able to participate more consciously in the present situation.

The case of Mr. M. is an example of the power of the story:

> Mr. M. has been diagnosed with probable cancer of the lungs and is scheduled for exploratory surgery in a few days. Several times he has asked the nurse, "How serious do you think this is?" After he asks once again, the nurse says, "Mr. M., you seem to be asking me more than how serious this is. Can you tell me more about what is concerning you?" He responds, "Well, to be honest, I've been thinking about telling the kids . . . especially my son in Chicago. You see, we haven't been on very good terms." And so begins an important story for Mr. M. to tell, and for the nurse to hear. The medical information about Mr. M.'s illness is but one piece of the greater fabric of his life as a family man and father. The nurse now hears Mr. M. talk about his concerns for his family and the relationships within the family as his upcoming surgery and uncertain future affect them. In telling his story, Mr. M. participates in both the assessment and intervention related to his spiritual care. The nurse learns about his relationships and his concerns surrounding them, and Mr. M. begins to understand what the most important aspects of his situation are from his unique perspective. With that understanding, he can begin to plan what he will do and what help he will seek. The nurse becomes a partner in his plan, which will be revised and updated as his story continues to unfold.

Sharing a story brings the listener face to face with quandaries, insights, struggles, joy, suffering, pain, and healing moments. Stories may make the listener feel helpless in the face of perceived hopeless situations or help the listener recognize the hope that lies in such a situation. Stories challenge nurses to understand the wholeness of a person and to listen for the meaning of a life. One nurse commented, "I used to think that people who told me stories about their lives were just wasting my time and theirs, but now I realize that they are telling me about what is really important. I've learned to listen and to use what they say to help them see who they really are, what they can really do. Even when they tell me things that are really hard to hear, or even to understand, it seems like they just want me to know that it is part of their life, too." Stories might help the nursing process fit the patient rather than requiring the patient to fit the process.

Some shared wonderings and questions that may help others share their stories include the following:

- If you were writing your life story, what would be the title?
- What is the title of the current chapter?
- Who are some of the heroines and heroes of your story?

- How would you like this chapter to turn out?
- Tell me more about how you handled your child's accident.
- I wonder where you get your spunk.
- I wonder what it's like to live with your physical limitations.
- You've mentioned several times that your sister is ill, and you seem worried.

Nurses can affirm the sharing of stories through statements such as "your sharing has helped me see this in a different light." As nurses encourage clients to share their stories, it is helpful to encourage the significant people in the clients' lives to participate in the process. The exercises presented in Exhibit 7–2 may increase attentiveness to story, both among nurses themselves and with clients.

Exhibit 7–2 Exercises To Facilitate Awareness of Story

1. Take a few moments to become quiet, perhaps using some breath awareness. In this quiet space, allow yourself to remember, in as much detail as possible, something about yourself, some event or incident that comes to mind. How has this experience or event become a part of who you are? What meaning does it have for your life at this moment?
2. Keep a journal in which you record events, feelings, experiences, insights, questions in your life. Periodically review your writings, noting themes flowing through your story. Reflect on your story as it keeps evolving.
3. Think about books, stories, songs, fairy tales, movies, plays, or works of art that have special meaning for you. Take time to consider why and how they hold that meaning for you. Think about the images, characters, colors, and sounds that are found in each of these and how they are reflective of your own story. What meanings do you find that provide insight into your own unfolding journey?
4. Write an autobiography for your eyes only. Take your time. Re-read and reflect on it. Are there parts you want to share? With whom would you share? What new awarenesses and learnings have come to you?
5. Look at some old family photos or photos of friends. What story do they tell? What memories and feelings come with these pictures? Do you want to tell someone else about them? What do you want to say? Would you like to hear someone else's story about these same photos?

Source: M. Burkhardt and M.G. Nagai-Jacobson, © 1997.

Using Guides and Instruments To Facilitate Spirituality Assessment

Different approaches to assessing spirituality are available to facilitate the integration of spirituality into holistic care.[120] When incorporated into a clinical setting, spirituality assessment guides are a means of gaining a deeper understanding of a person from a holistic perspective. Rather than considering the completion of an instrument to be an end point, nurses can use the questions of an assessment guide as openings or referent points for discussing spirituality with patients and thus come to know and understand them better as unique persons. Furthermore, nurses can adapt the various guides to the specific situation and person. Assessing a person's understanding of and ways of expressing spirituality includes exploring the role and influence of important connections in the present circumstances, issues related to meaning and purpose, important beliefs, values, and practices, prayer or meditation styles, and desire for connection with religious groups or rituals. The following are a few examples of different approaches to assessing spirituality.

The Spiritual Assessment Tool (Exhibit 7–3) is based on a conceptual analysis of spirituality derived from Burkhardt's critical review of the literature.[121] This instrument poses open-ended, reflective questions that assist nurses in developing awareness of

Exhibit 7–3 Spiritual Assessment Tool

To facilitate the healing process in clients/patients, families, significant others, and yourself, the following reflective questions assist in assessing, evaluating, and increasing awareness of the spiritual process in yourself and others.

Meaning and Purpose These questions assess a person's ability to seek meaning and fulfillment in life, manifest hope, and accept ambiguity and uncertainty.

- What gives your life meaning?
- Do you have a sense of purpose in life?
- Does your illness interfere with your life goals?
- Why do you want to get well?
- How hopeful are you about obtaining a better degree of health?
- Do you feel that you have a responsibility in maintaining your health?
- Will you be able to make changes in your life to maintain your health?
- Are you motivated to get well?
- What is the most important or powerful thing in your life?

Inner Strengths These questions assess a person's ability to manifest joy and recognize strengths, choices, goals, and faith.

- What brings you joy and peace in your life?
- What can you do to feel alive and full of spirit?
- What traits do you like about yourself?
- What are your personal strengths?
- What choices are available to you to enhance your healing?
- What life goals have you set for yourself?
- Do you think that stress in any way caused your illness?
- How aware were you of your body before you became sick?
- What do you believe in?
- Is faith important in your life?
- How has your illness influenced your faith?
- Does faith play a role in regaining your health?

Interconnections These questions assess a person's positive self-concept, self-esteem, and sense of self; sense of belonging in the world with others; capacity to pursue personal interests; and ability to demonstrate love of self and self-forgiveness.

- How do you feel about yourself right now?
- How do you feel when you have a true sense of yourself?
- Do you pursue things of personal interest?
- What do you do to show love for yourself?
- Can you forgive yourself?
- What do you do to heal your spirit?

These questions assess a person's ability to connect in life-giving ways with family, friends, and social groups and to engage in the forgiveness of others.

- Who are the significant people in your life?
- Do you have friends or family in town who are available to help you?
- Who are the people to whom you are closest?
- Do you belong to any groups?
- Can you ask people for help when you need it?
- Can you share your feelings with others?
- What are some of the most loving things that others have done for you?
- What are the loving things that you do for other people?
- Are you able to forgive others?

These questions assess a person's capacity for finding meaning in worship or religious activities and a connectedness with a divinity or universe.

- Is worship important to you?
- What do you consider the most significant act of worship in your life?
- Do you participate in any religious activities?
- Do you believe in God or a higher power?
- Do you think that prayer is powerful?
- Have you ever tried to empty your mind of all thoughts to see what the experience might be like?
- Do you use relaxation or imagery skills?
- Do you meditate?
- Do you pray?
- What is your prayer?
- How are your prayers answered?
- Do you have a sense of belonging in this world?

(continued)

Exhibit 7–3 continued

These questions assess a person's ability to experience a sense of connection with all of life and nature, an awareness of the effects of the environment on life and well-being, and a capacity or concern for the health of the environment.

- Do you ever feel at some level a connection with the world or universe?
- How does your environment have an impact on your state of well-being?
- What are your environmental stressors at work and at home?
- Do you incorporate strategies to reduce your environment stressors?
- Do you have any concerns for the state of your immediate environment?
- Are you involved with environmental issues such as recycling environmental resources at home, work, or in your community?
- Are you concerned about the survival of the planet?

Source: Based on M. Burkhardt, Spirituality: An Analysis of the Concept, *Holistic Nursing Practice*, Vol. 3, No. 3, p. 69, 1989. Reprinted from B.M. Dossey, *AHNA Core Curriculum for Holistic Nursing*, pp. 46–47, © 1997, Aspen Publishers, Inc.

spirituality for themselves and others. These questions are meant to be prompts to focus on pertinent spiritual concerns. Similar types of questions are equally appropriate. Some areas may be addressed more fully than others, depending on a particular client's needs. This instrument is meant to be a guide for nurses, to support and enhance their comfort and skills with spirituality assessment, and is not designed as a self-administered survey.

Howden's Spirituality Assessment Scale (SAS; Exhibit 7–4) is a 28-item instrument based on a conceptualization of spirituality as a phenomenon represented by four critical attributes.[122] These attributes and the corresponding items on the scale are:

1. ***Purpose and meaning in life***—the process of searching for or discovering events or relationships that provide a sense of worth, hope, or reason for existence (Items 18, 20, 22, 28)
2. ***Innerness or inner resources***—the process of striving for or discovering wholeness, identity, and a sense of empowerment, manifested in feelings of strength in times of crisis and calmness or serenity in dealing with uncertainty in life, a sense of being guided in living and being at peace with oneself and the world, and feelings of ability (Items 8, 10, 12, 14, 16, 17, 23, 24, 27)
3. ***Unifying interconnectedness***—the feeling of relatedness or attachment to others, a sense of relationship to all of life, a feeling of harmony with self and others, and a feeling of oneness with the universe or Universal Being (Items 1, 2, 4, 6, 7, 9, 19, 25, 26)
4. ***Transcendence***—the ability to reach or go beyond the limits of usual experience; the capacity, willingness, or experience of rising above or overcoming body or psychic conditions; or the capacity for achieving wellness or self-healing (Items 3, 5, 11, 13, 15, 21)

The SAS is a 6-point response-rating scale that uses the following numerical rating: strongly disagree (*SD*) = 1; disagree (*D*) = 2; disagree more than agree (*DM*) = 3; agree more than disagree (*AM*) = 4; agree (*A*) = 5; strongly agree (*SA*) = 6. There is no neutral option. It is scored by summing the responses to all 28 items; subscale scores may be obtained by summing the responses to subscale items. Psychometric evaluation resulted in a high internal consistency (alpha = 0.9164) for the SAS, indicating that the instrument appears to be a reliable measure of spirituality.

Exhibit 7–4 Spirituality Assessment Scale

DIRECTIONS: Please indicate your response by circling the appropriate letters indicating how you respond to the statements.

MARK:
SA if you STRONGLY AGREE
A if you AGREE
AM if you AGREE MORE than DISAGREE
DM if you DISAGREE MORE than AGREE
D if you DISAGREE
SD if you STRONGLY DISAGREE

There is no "right" or "wrong" answer. Please respond to what you think or how you feel at this point in time.

1.	I have a general sense of belonging.	SA	A	AM	DM	S	SD
2.	I am able to forgive people who have done me wrong.	SA	A	AM	DM	S	SD
3.	I have the ability to rise above or go beyond a physical or psychological condition.	SA	A	AM	DM	S	SD
4.	I am concerned about destruction of the environment.	SA	A	AM	DM	S	SD
5.	I have experienced moments of peace in a devastating event.	SA	A	AM	DM	S	SD
6.	I feel a kinship to other people.	SA	A	AM	DM	S	SD
7.	I feel a connection to all of life.	SA	A	AM	DM	S	SD
8.	I rely on an inner strength in hard times.	SA	A	AM	DM	S	SD
9.	I enjoy being of service to others.	SA	A	AM	DM	S	SD
10.	I can go to a spiritual dimension within myself for guidance.	SA	A	AM	DM	S	SD
11.	I have the ability to rise above or go beyond a body change or body loss.	SA	A	AM	DM	S	SD
12.	I have a sense of harmony or inner peace.	SA	A	AM	DM	S	SD
13.	I have the ability for self healing.	SA	A	AM	DM	S	SD
14.	I have an inner strength.	SA	A	AM	DM	S	SD
15.	The boundaries of my universe extend beyond usual ideas of what space and time are thought to be.	SA	A	AM	DM	S	SD
16.	I feel good about myself.	SA	A	AM	DM	S	SD
17.	I have a sense of balance in my life.	SA	A	AM	DM	S	SD
18.	There is fulfillment in my life.	SA	A	AM	DM	S	SD
19.	I feel a responsibility to preserve the planet.	SA	A	AM	DM	S	SD
20.	The meaning I have found for my life provides a sense of peace.	SA	A	AM	DM	S	SD
21.	Even when I feel discouraged, I trust that life is good.	SA	A	AM	DM	S	SD
22.	My life has meaning and purpose.	SA	A	AM	DM	S	SD
23.	My innerness or an inner resource helps me deal with uncertainty in life.	SA	A	AM	DM	S	SD
24.	I have discovered my own strength in times of struggle.	SA	A	AM	DM	S	SD
25.	Reconciling relationships is important to me.	SA	A	AM	DM	S	SD
26.	I feel a part of the community in which I live.	SA	A	AM	DM	S	SD
27.	My inner strength is related to belief in a Higher Power or Supreme Being.	SA	A	AM	DM	S	SD
28.	I have goals and aims for my life.	SA	A	AM	DM	S	SD

Source: Copyright © 1992, Judy W. Howden.

The usefulness of numerical scores derived from quantitative spirituality assessment instruments may be more apparent within the context of a research study. In a clinical setting, however, a scale such as the SAS can enable a nurse to gain an overall sense of a person's spirituality, either when administering the instrument or when discussing it with a client who has already completed it. The pattern of responses to individual items, more than a numerical score, provides nurses with insights into areas of spiritual strengths and concerns, enabling them to support the strengths and address the concerns. For example, discovering that a person may be experiencing a lack of kinship with others and a lack of connection to life enables the nurse to explore these concerns further and plan appropriate interventions. In the clinical arena, nurses need to remember that a quantitative measure should be an adjunct to, but not a replacement for, listening presence.

Barker offered yet another approach to spirituality assessment in her Personal Spiritual Well-Being Assessment (PSWBA) and Spiritual Well-Being Assessment (SWBA), presented in Exhibit 7–5.[123,124] These instruments, which originate in her clinical experiences and research,[125] were developed initially as a short process for assessing spiritual well-being among cancer patients. The SWBA is intended for use by clinicians as they elicit information about the patient's place in the spiritual walk. The PSWBA was originally intended for use by clinicians in determining and clarifying their own spiritual well-being prior to addressing the spiritual well-being of others, but may be useful with patients as well. The respondent is asked to verbalize thoughts regarding the key guide questions. Each instrument uses four broad facets of spiritual well-being: relationship to self, relationship to God/Creative Source, relationship to others, and relationship to nature. Although this type of assessment format can be self-administered, a greater depth of information and insight can be gained from an interactive process that allows for an exploration of responses.

Barker cautioned nurses to be aware of certain barriers related to spiritual well-being assessment. These barriers include believing that there is not enough time to do the assessment, being embarrassed about asking the questions, thinking that doing the assessment means that the nurse has to solve all of the patient's problems (rescue fantasy), doubting that the nurse can make a difference in the patient's life, feeling responsible for the patient's place in the cosmos, and accepting responsibility for the patient's choices. When experiencing such reactions, nurses can utilize the PSWBA or other processes to explore their own understanding of spirituality, to develop the necessary skills, and to become comfortable with this area of holistic nursing care.

Burkhardt's[126] *Care and Nurture of the Spiritual Self—Personal Reflective Assessment* (PRA) is derived from qualitative research and broad study of spirituality. This assessment process is designed for personal and clinical use, offering both health care professionals and patients an opportunity to reflect on the spiritual nature of their life journeys. The PRA encourages persons to take a deeper look at what gives meaning to their lives and important connections with Self, the Sacred Source, Others, Nature, and the balance between rest and activity that shapes their spiritual journey. The questions are designed to assist persons in becoming more aware of and attentive to spiritual needs, concerns, supports, and direction at the present time, acknowledging that responses, needs, and insights to

Exhibit 7–5 Spiritual Well-Being Assessment Instruments

Personal Spiritual Well-Being Assessment

Relationship to Self

Overall, in the last month, I feel _____ about myself.

Overall, this feeling is _____.

Overall, my "well" feels _____.

Relationship to God/Creative Source

Overall, in the last month, my sense of connection to God/my Creative Source is _____

_____.

Overall, I feel a purpose to being where I am today _____.

Overall, I feel _____ about my place in the world.

Relationship to Others

I feel most connected to _____.

This connection feels _____.

Overall, my relationships are _____.

I have one intimate relationship _____.

This relationship brings me _____.

Relationship to Nature

My favorite part of creation is _____.

The last time I was able to experience this part of creation was _____.

When I experienced this part of creation, I felt _____.

Spiritual Well-Being Assessment

What is *(the illness or other concern)* _____ like for you?

What do you do to cope with *(the illness or other concern)* _____?

What makes you smile? _____

If you could be anywhere, where would you be? _____

What relationships are most important to you? _____

How can I help? _____

Source: Copyright © 1996, Elizabeth R. Barker.

a particular question may vary with each visit. Because it is a reflective process, persons are encouraged to focus on those questions that speak to them at the present time. The following are examples of questions included in the PRA:

- ***Purpose and meaning:*** "What principles, values, or beliefs guide your life?" "How are your life choices congruent with what you consider to be your spiritual path?"
- ***Connection with self:*** "What helps you become more aware of who you are, your purpose in being, your place in the cosmos? How do you express your spirit through your physical body? How has your intuitive knowing supported your spiritual journey?"
- ***Connection with the Sacred Source:*** "What is most sacred for you? How do you seek and experience relationship with the Divine? What is prayer for you?"
- ***Connection with others:*** "Where is forgiveness needed in your life and relationships? How do you nurture your spirit through service to others? Which relationships allow you to be who you are, and to receive as well as to give?"
- ***Balance of rest and re-creation:*** "How do you incorporate Sabbath time—balance between activity and rest—into your life?"
- ***Connection with nature:*** "How is your spirit nurtured through nature? What kinds of connection with nature enliven you?"
- ***Reflecting on the journey:*** "As you reflect on your Soul Journey, what is the next thing you wish or need to do to support or attune to your wholeness, your self-becoming? How can you make this step real in your life?"

The reflective nature of the PRA encourages persons to identify spiritual strengths and supports, as well as needs and concerns, in caring for the spiritual self, and to commit to processes or actions that will assist and support them on the spiritual journey. Nurses can use this process personally and with patients to explore where they are on the spiritual journey, where they feel their path is leading them, where they might like to be going, and what their next step might be in the process.

Each of the assessment guides that have been discussed provides a process for exploring the elements of spirituality. For example, spirituality involves relationships, and each instrument offers a different way in which a nurse may enhance the patient's awareness of significant relationships. The Spiritual Assessment Tool addresses the area of harmonious interconnectedness; Howden's work asks the patient to consider questions related to unifying interconnectedness; Barker asks what relationships are most important to the patient; and Burkhardt explores relationships that need mending as well as those that provide support. As nurses become more at home with the concept of spirituality and its language, they will form their own questions and make their own observations in understanding another person as a whole being whose essence is spirit.

HOLISTIC CARING PROCESS CONSIDERATIONS

Spiritual caregiving requires an understanding of the holistic caring process that is integrative, in which assessment and intervention may well be the same process, and where description may be more useful than labeling. Identification of needs in the area of spirituality does not necessarily indicate pathology or impairment. Research on spirituality and health continues

to highlight the importance of describing the human spirit in the language of each person's unique experience and expression, and exploring individual meaning according to the particular person's values. Holistic nurses recognize that spirituality is an important consideration with any health concern, and they use the evolving nursing diagnoses regarding spirituality appropriately. Nurses need to collaborate with clients and their families in determining appropriate outcomes, developing a plan, and organizing overall care to ensure the incorporation of each person's selfhood, values, and world view. Nurses facilitate this process when they promote an atmosphere that is accepting and encouraging of spiritual expression in its many and varied forms. Understanding and awareness of their personal spiritual perspective improve nurses' ability to be alert to its influence on their relationships and work. Nurses are thereby able to recognize their own discomfort with a client's spiritual perspective and involve others in order to provide the needed care for the client.

Tending to the Spirit

Care of the spirit, a fundamental aspect of holistic nursing care, takes place in the context of the significant connections in a person's life. The nurse, for a time, enters the client's world and, through intentional presence in this relationship, may facilitate healing. Assessment, diagnosis, planning, and intervening are all experienced within a unique and particular relationship. Recognizing that all persons are spiritual beings provides the basis for being alert to the many and varied ways in which persons express their spirituality. Often, simply hearing and validating questions and concerns of the spirit are not only part of the assessment, but a part of the intervention as well. Simply giving clients the opportunity to discuss and reflect on spiritual concerns enables them to become more aware of their spirituality and personal spiritual journeys.

Awareness of and care for self as a spiritual being is an important aspect of holistic nursing care. Spiritual "co-counseling" among colleagues who also deal with spiritual issues and consciously pursue a spiritual path can nurture a nurse's spirit. Forming spiritual companionship, mentoring, or support groups within the work environment, even with one or two colleagues, can help nurses maintain their spirits in the midst of the daily demands on their energies.

Regular practices of prayer, centering, mindfulness, meditation, and/or starting the day with intention assist nurses in both maintaining and drawing from their own wholeness, and grounds their practice of intentional presence with each client encounter. With intentionality and consciousness, busy nurses can use common activities as processes or rituals for leaving past situations behind to be more fully present in a current client encounter. For example, when washing hands between patients, nurses can release the concerns of the previous patient and, thus, be more open to those of the next patient. Similarly, by consciously taking a breath before entering an examination room, nurses can clear their beings of other distractions so as to focus on the person to be seen. Pausing to center and focus; "stepping back" from a confusing, distressing situation in order to reenter from a point of calmness; and being silent as one listens deeply are skills that develop as nurses attend to spirit. With awareness and creativity, nurses can use almost any activity as a way to foster spiritual presence.

Touching

Physical contact through touch in its myriad forms may foster connection. Sensitivity to the meaning of touch for each person is essential in using touch therapeutically.

When appropriate, a hand on the shoulder can provide support, a handclasp can convey understanding and presence, an arm around the waist can literally and figuratively give a lift! One patient described a nurse's support in saying, "When the doctor came in to give me the news, she was standing beside me and I could feel her hand on my arm the whole time he was talking. I was so glad that she was just there with me."

Families and friends may need encouragement to share physical expressions of care and concern in the sometimes intimidating hospital environment. Nurses may encourage them with statements such as, "It's OK to hold her hand; you won't interfere with the tubes." "He mentioned that you give a wonderful back rub; would you like to give him one today?" "She seems to know when you are here and holding her hand." "I can show you how to massage her feet," and "Would you like to brush her hair?" Persons vary in their degree of comfort with touch and the conditions in which they may want to share touch. The nurse's own personal feelings about and comfort with touch help in assessing the place and potential use of touch in the patient's situation. At times when words cannot be found, or in circumstances where persons are more comfortable with physical expression than with words, touch is a powerful expression of spirit and instrument of healing.

Fostering Connectedness

Relationships are a major aspect of spirituality. An awareness and an appreciation of important relationships in the client's life enable the nurse to help strengthen meaningful and supportive bonds. Some family members may need encouragement and guidance in visiting and calling. Clients may need assistance in sharing some aspects of their situation with others—even when they very much want to explain what is happening to them and express their feelings about it. Nurses can remind clients of their network of care and support by recognizing and affirming the support of significant others. Statements such as, "You seem especially close to Marta" may provide an opportunity for sharing about a special relationship. Photographs, artwork, and memorabilia of loved ones provide reminders of connections beyond the confines of illness or injury. Pictures or discussions of special places or pets are evidence of other special connections. Visits from pets may be as spiritually uplifting for some people as those from human companions! Using imagery, pictures, and stories can help persons connect with important places, people, and experiences.

Contact with persons from religious, social, business, neighborhood, school, hobby, or interest groups may provide reminders of connections with and participation in the larger community and world. In some health care settings, such as intensive care or long-term care facilities, bonds of mutual caring develop among various patients, families, and caregivers. These networks of support can become very significant in the lives of all those involved. Holistic care implies a recognition of the healing potential in such relationships, and impels nurses to foster the development of such relationships.

The client's sense of connection with the environment may be an important source of comfort and strength. For persons to be able to feel the wind, see the stars, smell the flowers, touch the trees, and simply to experience the world may be a significant aspect of healing. Is there a window with a view of nature? Can the patient spend some time outside? Is there a photograph of a scene from nature on the wall, or one of a special place that can be placed at the bedside? Would the patient enjoy a plant, a bouquet of flowers, or a single rose? Some people enjoy audiotapes of music or of

nature sounds. Spiritual uplifting can occur when visitors share the progress of the vegetable garden, the news of a recent fishing trip, or reflect on the weather conditions.

Spirituality often calls to mind one's relationship with the sacred. People have unique and personal understandings and experiences of the sacred, and language may pose a problem when talking about this aspect of spirituality. Those who are comfortable with the Judeo-Christian tradition of God or Lord, or the Islamic Allah, may find themselves less comfortable with understandings expressed as Higher Power, Tao, Universal Light, or Absolute. The reverse may also be true. For some people, "new age" is a relevant term that connotes spiritual growth and expansion; for others, however, anything "new age" is suspect and can be spiritually distressing. Listening beyond specific words to hear what is most sacred for this person and how his or her relationship with the sacred may be nurtured is important in addressing spiritual concerns. Are particular words of importance to this person? What is the place of formal religion, and a person's own rabbi, priest, shaman, minister, imam, or spiritual leader in their spiritual journey? How do music, prayer, sacred texts, books, particular objects, foods, or rituals nurture the spirit of this person?

Sensitivity to and appreciation of persons who profess atheism (i.e., disbelief in the existence of a supreme being) or agnosticism (i.e., doubt surrounding the existence of God or ultimate knowledge) involve moving beyond what is not believed. Instead, the nurse must listen for that which gives meaning and purpose to the patient's life, including that which brings joy and satisfaction, the nature of hopes and fears, and the recognition of important relationships. How does this particular health crisis fit into the patient's understanding of her or his life, and how is she or he dealing with it? For example, an astronomer who noted that she was not religious and did not believe in God described her understanding and awe in regard to the evolution of the universe as a cause of deep wonder to her that all that had gone before led to this particular time. This sense gave her a feeling "that I belong." The words voiced were not traditionally religious language, but her expressions of appreciation, awe, wonder, and meaning spoke of spirituality.

Nurses who attend to spiritual concerns need to be willing to be present with mystery, uncertainty, pain, or suffering, seeking not to "fix" or to "answer," but to be in the mystery with another. Letting the client know that they are willing, with their whole being and intention, to stay the course through times of difficulty, pain, and mystery provides encouragement when nurses can only say, "I don't understand this either." This willingness on the part of the nurses may help family and friends to understand that, when they feel that there is nothing they can do, their presence and expressions of love and care are important and valuable components of their healing support.

As nurses learn to understand the relationships and connections that frame a client's life, they begin to be more aware of recurring themes and concerns. When such themes are noted, the nurse can reflect on and validate them with the client. Statements such as, "It seems I have often heard you speak of . . . with great concern" gives the client the opportunity to know the nurse's perceptions and to validate or correct them. In general, it is reassuring to the client to know that the nurse is indeed listening and responding to deep concerns.

Using Rituals to Nurture the Spirit

Rituals serve as reminders to allow sacred time and space in our lives. Both the ritual behavior and the mindfulness that accompanies it are important aspects of ritual. Achterberg and colleagues described three phases of ritual.[127] The first phase is the *symbolic breaking away* from everyday busyness. The second phase is the *transition phase*, which calls for the identification and focus on areas of life that need attention. The third and final phase, referred to as the *return phase*, is the reentry into everyday life. In essence, ritual gives a person time apart so that he or she may return to the world in a clearer, more centered way. Ritual then can enable nurses to be more intentionally present in healing ways with another. Exhibit 7–6 provides an example of a ritual that can enhance the healing process.

Exhibit 7–6 The First Ritual Guide to Getting Well

This ritual helps you decide what to do if you are diagnosed with the unknowable, the unthinkable, the awful, or the so-called incurable. By doing this, you can better determine how to survive treatment, yourself, your friends and family, and life in general.

1. Find a quiet place, a healing place, and go there. This might be a corner of your favorite room where you have placed gifts, pictures, a candle, or other symbols that signal peace and inner reflection to you. Or it might be in a park, under an old tree, or in a special place known for its spirit, such as high on a sacred mountain or on the cliffs overlooking a coastline or in the quiet magnificence of a forest.
2. Ask questions of your inner self about what your diagnosis or treatment means in your life. How will life change? What are your resources, your strengths, your reasons for staying alive? These deeply philosophical or spiritual issues often come to mind when problems are diagnosed. Listen with as quiet a mind as possible for any answers or messages that come from within, or from your higher source of guidance.
3. Take this time, knowing that very few problems advance so quickly that you must rush into making decisions about them immediately, without first gaining some perspective.
4. Find at least one friend or advocate who can be level-headed when you think you are going crazy; who can be positive for you when you are absolutely certain you are doomed; who can listen when your head is buzzing with uncertainty.
5. Love yourself. Ask yourself moment by moment whether what surrounds you is nurturing and life-giving. If the answer is no, back off from it. Kindly tell all negative-thinking people that you will not be seeing them while you are going through this. You may need never to see them again, and this is your right and obligation to yourself.
6. Assess your belief system. What do you believe? How did you get to believe it in the first place? What is really happening inside you and outside you? How serious is it? What will it take to get you well?
7. Gather information, keeping an open mind. Everyone who offers to treat you or give you advice has their life invested in what they tell you. Stand back and listen thoughtfully.
8. Now go and hire your healing team. Remember, you hired them—you can fire them. They are in the business of performing a service for you, and you are paying their salaries. Sometimes this relationship gets confused. Make sure they all talk to each other. You are in command. You are the captain of the healing team.
9. Don't let anyone talk you into treatment you don't believe in or don't understand. Keep asking questions. Replace anyone who acts too busy to answer your questions. Chances are, they're also too busy to do their best work for you.
10. Don't agree on any diagnostic or lab tests unless someone you trust can give you good reasons why they are being ordered. If the tests are not going to change your treatment, they are an expensive and dangerous waste of your time.

(continued)

Exhibit 7–6 continued

11. Sing your own song, write your own story, take your own spiritual journey through a journal or diary. A threat to health and well-being can be a trigger to becoming and doing all those things you've been putting off for the "right" time.
12. Consider these maxims in your journey:
    - Everything cures somebody, and nothing cures everybody.
    - There are no simple answers to complex issues, like why people get sick in the first place.
    - Sometimes disease is inexplicable to mortal minds.
13. You will not be intimidated by the overbearing world of medicine or alternative health know-it-alls but can thoughtfully take the best from several worlds.
14. You can teach gentleness and compassion to the most arrogant doctor and the crankiest nurse. Tell them that you need your mind and soul nurtured, as well as the best medical treatment possible in order to get well. If they are not up to it, you'll find someone someplace who is.

Source: From *RITUALS OF HEALING: Using Imagery for Health and Wellness*, by J. Achterberg, B. Dossey, and L. Kolkmeier. Copyright © 1994 by Jeanne Achterberg, Barbara Dossey, and Leslie Kolkmeier. Used by permission of Bantam Books, a division of Bantam Doubleday Dell Publishing Group, Inc.

Either shared with others or highly personalized, rituals are significant aspects of various religious traditions and cultures. Rituals come in many shapes and forms. Routine morning walks, daily prayer time, sharing of the day's experiences with family over dinner, or a soothing bath can all be rituals. Anything done with awareness may serve as a ritual. Rituals provide a rich resource in caring for the spirit, and attending to rituals in one's life can be an important aspect of self-care.

Developing an awareness of the place of ritual in their own lives establishes a basis from which nurses can facilitate and provide opportunities for patients to consider and experience the place of ritual in their lives. What rituals are significant for a particular patient? Are there rituals that might support the patient's healing process? Nurses need to consider what constitutes sacred space for each patient and to explore with them the resources that might help them better understand and include supportive rituals in their lives.

Developing Centering, Mindfulness, and Awareness

Spiritual disciplines are those practices that cause people to pause in the midst of their activities and busyness to attend to matters of the spirit or soul. The practice of spiritual disciplines requires intention and attention. Eastern and many indigenous traditions around the world emphasize the importance of mindfulness and awareness as disciplines that permeate all of life. Similar to the practice of centering prayer in Judeo-Christian traditions, the mystical path of many traditions calls one to quietness. Making the intentional decision to pause and be mindful of the present moment and all that it holds nurtures the ability to be centered and aware. Taking the time to observe what is going on within oneself, without judgment or elaboration, and to note thoughts, feelings, physical sensations, and distractions, provides valuable experiences in the practice of awareness. Observing what is going on in the

environment, attending to all senses, and experiencing all sensations enhance a person's full presence in the moment.

Processes of relaxation and imagery facilitate awareness and centering. The practice of spiritual disciplines provides access to a centered space from which the nurse and client can work together, confronting significant life experiences in an environment that is often busy and complex. Some clients may be versed in such disciplines; others may be unaware that they already incorporate spiritual disciplines into their lives that can assist them in times of health crises. Many clients are able to learn about such practices when they are presented in clear language that is appropriate to their cultural and spiritual perspectives. Questions such as, "Have you ever tried any particular methods of relaxing?" or "What kinds of activities help you find calm in the middle of a busy day?" may facilitate a person's practice of spiritual disciplines in a more intentional way.

Praying and Meditating

Prayer and meditation are spiritual disciplines practiced in many traditions, both cultural and religious. Appreciating the personal nature of these disciplines, the nurse, with respect and sensitivity, can help patients remember or explore ways in which they reach out to and listen for God or the Sacred Source. Recalling the place and meaning of prayer, and the ways in which they experience the presence of and communion with God or the Sacred Source, provides patients with a rich resource. In the clinical setting, both the nurse's and the patient's understanding of prayer will determine the role of prayer. Clarifying the patient's understanding of and need for prayer is a part of holistic care. Some patients want others to pray with or for them, while others do not believe in prayer. Nurses should support each patient's requests and needs for prayer, which may mean inviting others to take part in various forms of prayer with and for the patient, or simply praying with the patient themselves. The nurse can encourage expression of the patient's desire for shared prayer, for participation in religious worship, or for quiet, uninterrupted periods of time for personal spiritual practices. Facilitating the appreciation and practice of prayer in a patient's life is an important aspect of caring for the spirit.

When patients are physically confined to a hospital room, the practice of imagery may enable them to experience another space. Imagery can take a person to a temple, an ocean, a place of religious worship, a breakfast nook, or any "sacred space" that is a life-giving and healing place for her or him. In this other space, the patient may feel more comfortable in spirit and more able to engage in prayer. Family and friends, as well as other patients and staff, may be resources in the practice of imagery.

Exploring as many aspects of the prayer experience as possible enriches both the nurse's and the patient's understanding of the nature and place of prayer for a particular individual. Sacred or inspirational readings, music, drumming, movement, light or darkness, aromas, and time of day are among the many factors that may be important considerations in one's prayer life. The patient's prayer life, in all of its fullness and meaning, nurtures the spirit, and the nurse may be able to support the patient's prayer needs by facilitating changes in the environment or schedule. It is wise to remember that merely the process of listening to and appreciating the prayer life of another nurtures the

spirit, and acknowledges the spiritual dimension of that person.

Ensuring Opportunities for Rest and Leisure

Integral aspects of holistic living and care of the spirit, rest, leisure, and Sabbath time enhance growth, creativity, and renewal.[128–130] Leisure is an attitude of the heart that facilitates connection with the inner self and the Sacred Source, and opens one to reflect on and re-vision a life of doing to allow for more *Being*. Authentic leisure implies an approach to living that allows one to relax into a level of being that deepens self-awareness, nourishes one's wholeness, and enriches connections with the Sacred Source and other people. Assisting persons to consider the place of rest and leisure in their lives is part of holistic nursing. Taking stock of how they integrate rest and leisure into their own lives is a necessary part of self-care for nurses as well. In an increasingly busy society—where filling each moment is viewed in terms of productivity, where even leisure time is scheduled—the notion of rest and leisure deserves thoughtful consideration.

Holistic nurses try to enhance the patient's conscious awareness of how rest and leisure are, or are not, part of their lives. Such awareness makes those areas available for intentional evaluation, and, if desired, change. Observations and questions that may be helpful in the exploration of this aspect of spirituality include the following:

- I notice that you read a lot. What does reading do for you?
- You say you just can't rest. When have you been able to rest? Are there things that usually help you to rest?
- What is a real vacation like for you?
- What time of the day (year, season, week) is most restful or peaceful for you?
- How do you relax?
- Some people just help us to relax; who does that for you?
- Is there something I can do to help you to relax?

Regular exercise, music, imagery, a specific time for rest and quiet, and the commitment to incorporating these experiences into daily life encourage rest and leisure. Validating the importance of rest and leisure and encouraging a commitment to making time for renewal an essential part of one's life are important aspects of holistic care.

ARTS AND SPIRITUALITY

The arts have a role in the life of the spirit. Many persons find that various forms of artistic endeavor are doors to and expressions of the spirit. The term *artist* can include anyone who creates—the homemaker who cooks and sews and the carpenter who designs and builds, as well as the more easily recognized persons whose works are heard in symphonies or seen in galleries. As an expression of her or his wholeness, an artist's work is also a reflection of spirituality. L'Engle expressed this well:

> As I listen in the silence, I learn that my feelings about art and my feelings about the Creator of the Universe are inseparable. To try to talk about art and about Christianity is for me one and the same thing, and it means attempting to share the meaning of my life, what gives it, for me, its tragedy and its glory. It is what makes me respond to the death of an apple tree, the birth of a puppy, northern lights shaking the sky, by writing stories.[131]

Literature contains life stories, both real and fictional, to which people relate and from which they learn, gain comfort, and garner encouragement. Poetry contains deep truths, often in a few well chosen words, a rhythm, and spaces for silence. Music expresses feelings that are beyond words. Songs bring back memories or capture what people would like to say. Pottery awakens the senses of touch and sight as one forms a vessel or holds a favorite mug. Dance moves people, literally and figuratively, in space and time. Photography connects individuals, and sometimes moves their hearts for those known only through the images seen all over the world. Drumming awakens deep, basic yearnings, and calls some to worship. Gardens nourish not only the body, but also the senses of sight, touch, taste, and smell. Cave drawings are reminders of civilizations past and awaken a sense of wonder.

Creativity nourishes both observers and participants. People are in awe of ancient castles, and of children building sand castles, reveling in the sea, wind, and treasures of the ocean. They marvel at monuments and buildings that have stood the test of time, while joining with friends and neighbors to build a playground for today's children can enliven them. The passing down of skills joins the generations over time and space. How many gifts of the spirit came as one learned to bake cookies with a special grandparent or to play the fiddle under the guidance of a beloved mentor? An awareness of the breadth of the possibilities of using the arts to enrich the life of the spirit increases the nurse's ability to help the patient use the world of the arts for his or her own journey. The nurse and patient may recognize in books or movies struggles and questions that the patient now confronts, or they may share an appreciation for a special painting, musical piece, or homemade dessert. Providing an atmosphere that, as much as possible, is pleasing to the sensibilities of the patient may promote rest and relaxation. It may also facilitate the use of other interventions, such as imagery. Encouraging and facilitating opportunities for people to engage in or share stories of their creative endeavors is one of the ways that nurses include spirituality in care.

CONCLUSION

Because all persons, nurses as well as patients, are spiritual beings, care of the spirit is an integral component of holistic nursing care. Care of the spirit requires the evolution of language to express this dimension of ourselves better, and an approach to the nursing process that is integrative rather than linear. Spirituality assessment and intervention, which are often the same process, require intentional listening, presence, and a willingness to hear another's story. Spiritual care is based on a recognition that people express and experience their spirituality in and through relationships with the Sacred Source, others, nature, and self.

Spiritual care may incorporate "experts," such as representatives of particular religious traditions or other spiritual support people, but nurses need to do more than merely refer matters of the spirit to these persons. Although spiritual matters are both deep and personal, they often come to the forefront of life when health crises cause a person to stop, to take stock, to experience anxieties and fear, and to seek that which is at the heart of his or her life. Nurses offer spiritual support as they are able to be present with mystery and the life questions of others. Tending to matters of the spirit may include incorporating ritual, prayer, meditation, rest, art, and any activity that enhances awareness of oneself and one's place in the world.

DIRECTIONS FOR FUTURE RESEARCH

1. Further explore understandings of spirituality in health and illness across cultures and in different age groups, using qualitative methodologies.
2. Explore the influence of spirituality on staying healthy and on healing related to specific health concerns.
3. Investigate how attentiveness to spirituality in clinical practice may influence health outcomes, including economic considerations.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- In recognizing my wholeness, how would I describe my physical being, my psychologic–emotional being, and my spiritual being?
- What signals spiritual distress in my own life?
- How do I nurture my spirit?
- How would I describe the most significant connections in my life—the giving, receiving, and interplay in relationship with family, colleagues or peers, God or the Sacred Source, friends, and nature/environment/cosmos?
- What areas of the spirit need intentional care in my own life, perhaps because of pain or distress, or because there are areas in which I want to focus and grow?
- As I reflect on my own story, how is the growth and development of my spirit reflected in the events of my life?
- How have I experienced intentional presence?

NOTES

1. L. Tzu, *Tao Te Ching* (London: Penguin Books, 1988).
2. M.A. Burkhardt and M.G. Nagai-Jacobson, *Spirituality: Living Our Connectedness* (Albany, NY: Delmar Thompson Learning, 2002).
3. M.A. Burkhardt, Spirituality: An Analysis of the Concept, *Holistic Nursing Practice* 3 (1989):69–77.
4. M.G. Nagai-Jacobson and M.A. Burkhardt, Spirituality: Cornerstone of Holistic Nursing Practice, *Holistic Nursing Practice* 3 (1989):18–26.
5. J.D. Emblen, Religion and Spirituality Defined According to Current Use in Nursing Literature, *Journal of Professional Nursing* 8 (1992):41–47.
6. T.J. Mansen, The Spiritual Dimension of Individuals: Concept Development, *Nursing Diagnosis* 4 (1993):140–147.
7. N.C. Goddard, Spirituality as Integrative Energy: A Philosophical Analysis as Requisite Precursor to Holistic Nursing Practice, *Journal of Advanced Nursing* 22 (1995):808–815.
8. P. Nolan and P. Crawford, Towards a Rhetoric of Spirituality in Mental Health, *Journal of Advanced Nursing* 26 (1997): 289–294.
9. S. Sussman et al., On Operationalizing Spiritual Experience for Health Promotion Research and Practice, *Alternative Therapies in Clinical Practice* 4 (1997):120–124.
10. J. Walton, Spirituality of Patients Recovering from Acute Myocardial Infarction, *Journal of Holistic Nursing* 17 (1999):34–53.
11. T.A. Touhy, Touching the Spirit of Elders in Nursing Homes: Ordinary Yet Extraordinary Care, *International Journal for Human Caring* 6 (2001):12–17.
12. M.B. Råholm, Weaving the Fabric of Spirituality as Experienced by Patients Who Have Undergone Coronary Bypass Surgery, *Journal of Holistic Nursing* 20 (2002):31–47.
13. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness*.

14. G.J. Acton and E.W. Miller, Spirituality in Caregivers of Family Members with Dementia, *Journal of Holistic Nursing* 21 (2003):117–130.
15. C. Kociszewski, A Phenomenological Pilot Study of the Nurses' Experience Providing Spiritual Care, *Journal of Holistic Nursing* 21 (2003):131–148.
16. Mansen, The Spiritual Dimension of Individuals.
17. B.A. Hall, Spirituality in Terminal Illness, *Journal of Holistic Nursing* 15 (1997):82–96.
18. J. Engebretson, Considerations in Diagnosing the Spiritual Domain, *Nursing Diagnosis* 7 (1996):100–107.
19. Nolan and Crawford, Towards a Rhetoric of Spirituality.
20. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness*.
21. Burkhardt, Spirituality: An Analysis of the Concept.
22. M.A. Burkhardt, Becoming and Connecting: Elements of Spirituality for Women, *Holistic Nursing Practice* 8 (1994):12–21.
23. Emblen, Religion and Spirituality Defined.
24. Mansen, The Spiritual Dimension of Individuals.
25. P.G. Reed, An Emerging Paradigm for the Investigation of Spirituality in Nursing, *Research in Nursing and Health* 15 (1992):349–357.
26. J. Walton, Spiritual Relationships: A Concept Analysis, *Journal of Holistic Nursing* 14 (1996):237–250.
27. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness*.
28. Nolan and Crawford, Towards a Rhetoric of Spirituality, 291.
29. Burkhardt, Becoming and Connecting: Elements of Spirituality for Women.
30. M.G. Nagai-Jacobson and M.A. Burkhardt, Awareness and Relatedness: Elements of Spirituality for Men (Paper presented at Alpha Theta Chapter of Sigma Theta Tau and Gainesville, FL, Veteran's Administration Hospital National Conference: Dimensions of Caring and Spirituality in Health Care: Practice, Research, and Theory, Gainesville, FL, February, 6–7, 1997).
31. E.R.D. Barker, Being Whole: Spiritual Well-Being in Appalachian Women: A Phenomenological Study (Unpublished doctoral dissertation, University of Texas, Austin, 1989).
32. J. Walton, Spirituality of the Patient Recovering from an Acute Myocardial Infarction: A Grounded Theory Study (Unpublished doctoral dissertation, University of Missouri, Kansas City, 1997).
33. Reed, An Emerging Paradigm.
34. Råholm, Weaving the Fabric of Spirituality as Experienced by Patients Who Have Undergone Coronary Bypass Surgery.
35. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness*.
36. Acton and Miller, Spirituality in Caregivers of Family Members with Dementia.
37. C. Kociszewski, A Phenomenological Pilot Study of the Nurses' Experience Providing Spiritual Care.
38. V. Lincoln, Ecospirituality: A Pattern That Connects, *Journal of Holistic Nursing* 18 (2000):227–244.
39. P. Woodruff, *Reverence—Renewing a Forgotten Virtue* (Oxford: Oxford University Press, 2001).
40. B. Webb, *Fugitive Faith: Conversations on Spiritual, Environmental, and Community Renewal* (Maryknoll, New York: Orbis Books, 1998).
41. B.B. Taylor, *The Luminous Web* (Boston: Cowley Publications, 2000).
42. Lincoln, Ecospirituality: A Pattern That Connects.
43. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness*.
44. B. Kingsolver, *Small Wonder* (New York: Harper Collins, 2002).
45. S. Jeffers, *Brother Eagle, Sister Sky* (New York: Dial Books, 1991).
46. M.A. Burkhardt, Healing Relationships with Nature, *Complementary Therapies in Nursing and Midwifery* 6 (2000):35–40.
47. Webb, *Fugitive Faith: Conversations on Spiritual, Environmental, and Community Renewal*.
48. S. Lamb, *Pueblo and Mission* (Flagstaff, AZ: Northland Publishing, 1997), 2.
49. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness*.
50. B.L. Cull-Wilby and J.I. Pepin, Healing: A Theory and Practice, *International Journal for Human Caring* 6 (2001):12–17.
51. G. Robinson-Smith, Prayer After Stroke: Its Relationship to Quality of Life, *Journal of Holistic Nursing* 20 (2002):352–366.

52. M.J. McKivergin and M.J. Daubenmire, The Healing Process of Presence, *Journal of Holistic Nursing* 12 (1994):65–81.

53. Walton, Spirituality of the Patient Recovering from an Acute Myocardial Infarction.

54. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness.*

55. E. Tolle, *The Power of Now* (Novato, CA: New World Publishing, 1999).

56. E. Tolle, *Practicing the Power of Now* (Novato, CA: New World Publishing, 2001).

57. M.A. Burkhardt and M.G. Nagai-Jacobson, Reawakening Spirit in Clinical Practice, *Journal of Holistic Nursing* 12 (1994):9–21.

58. J. Emblen and B. Pesut, Strengthening Transcendent Meaning: A Model for the Spiritual Care of Patients Experiencing Suffering, *Journal of Holistic Nursing* 19 (2001):42–56.

59. Råholm, Weaving the Fabric of Spirituality as Experienced by Patients Who Have Undergone Coronary Bypass Surgery.

60. M.B. Råholm and K. Eriksson, Call to Life: Exploring the Spiritual Dimension as a Dialectic Between Suffering and Desire Experienced by Coronary Bypass Patients, *International Journal for Human Caring* 5 (2002):37–47.

61. J.E. Kennedy, R.A. Abbott, and B.S. Rosenberg, Changes in Spirituality and Well-Being in a Retreat Program for Cardiac Patients, *Alternative Therapies in Health and Medicine* 8 (2002):64–73.

62. L. Dossey, What's Love Got To Do with It? *Alternative Therapies in Health and Medicine* 2 (1996):8–15.

63. B. Siegel, *Love, Medicine, and Miracles* (New York: Harper & Row, 1986).

64. L. Dossey, What's Love Got To Do with It?

65. J. Green and R. Shellenberger, The Healing Energy of Love, *Alternative Therapies in Health and Medicine* 2 (1996):46–56.

66. Råholm, Weaving the Fabric of Spirituality as Experienced by Patients Who Have Undergone Coronary Bypass Surgery.

67. Råholm and Eriksson, Call to Life: Exploring the Spiritual Dimension as a Dialectic Between Suffering and Desire Experienced by Coronary Bypass Patients.

68. Råholm, Weaving the Fabric of Spirituality as Experienced by Patients Who Have Undergone Coronary Bypass Surgery.

69. Råholm and Eriksson, Call to Life: Exploring the Spiritual Dimension as a Dialectic Between Suffering and Desire Experienced by Coronary Bypass Patients.

70. Emblen and Pesut, Strengthening Transcendent Meaning: A Model for the Spiritual Care of Patients Experiencing Suffering.

71. V. Frankl, *Man's Search for Meaning* (New York: Washington Square Press, 1984).

72. E.R. Mackenzie, D.E. Rajagopal, M. Meibohm, and R. Lavizzo-Mourey, Spiritual Support and Psychological Well-Being: Older Adults' Perceptions of the Religion and Health Connections, *Alternative Therapies in Health and Medicine* 6 (2000):37–45.

73. R.J. Fehring et al., Spiritual Well-Being, Religiosity, Hope, Depression, and Other Mood States in Elderly People Coping with Cancer, *Oncology Nursing Forum* 4 (1997):663–671.

74. S.B. Simon and S. Simon, *Forgiveness: How To Make Peace with Your Past and Get on with Your Life* (New York: Warner Books, 1990).

75. W. Grossman, *To Be Healed by the Earth* (New York: Seven Stories Press, 1998).

76. L.M. Festa and I. Tuck, A Review of Forgiveness Literature with Implications for Nursing Practice, *Holistic Nursing Practice* 14 (2000):77–86.

77. B.L. Brush, E.M. McGee, B. Cavanaugh, and M. Woodward, Forgiveness: A Concept Analysis, *Journal of Holistic Nursing* 19 (2001):27–41.

78. W. Grossman, *To Be Healed by the Earth* (New York: Seven Stories Press, 1998).

79. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness.*

80. D. Kollmar, *Manifestation* (Workshop sponsored by The Complete Self-Attunement Associates, Charleston, WV, August 30, 1998).

81. Kingsolver, *Small Wonder*, p. 193.

82. M. Arnold, B. Ballif-Spanvill, and K. Tracy, eds., *A Chorus for Peace—A Global Anthology of Poetry by Women* (Iowa City, Iowa: University of Iowa Press, 2002), xv.

83. A. Lamott, *Traveling Mercies* (NY: Bantam Books, 1999), 143.

84. L. Dossey, *Healing Words: The Power of Prayer and the Practice of Medicine* (San Francisco: Harper, 1993).

85. L. Dossey, *Prayer Is Good Medicine* (San Francisco: Harper, 1996).

86. M.D. Calabria and J.A. Macrae, eds., *Suggestions for Thought by Florence Nightingale:*

Selections and Commentaries (Philadelphia: University of Pennsylvania Press, 1994).

87. B.M. Dossey, *Florence Nightingale: Mystic, Visionary, Healer* (Springhouse, PA: Springhouse Corporation, 2000).
88. L. Dossey, *Healing Words*.
89. L. Dossey, *Prayer Is Good Medicine*.
90. K.S. Dunn and A.L. Horgas, The Prevalence of Prayer as a Spiritual Self-Care Modality in Elders, *Journal of Holistic Nursing* 18 (2000):337–351.
91. J.B. Meisenhelder and E.N. Chandler, Prayer and Health Outcomes in Church Members, *Alternative Therapies in Health and Medicine* 6 (2000):56–60.
92. W.B. Jonas, Science and Spiritual Healing: A Critical Review of Spiritual Healing "Energy" Medicine, and Intentionality, *Alternative Therapies in Health and Medicine* 9 (2003):56–61.
93. Mackenzie et. al., Spiritual Support and Psychological Well-Being: Older Adults' Perceptions of the Religion and Health Connections.
94. Robinson-Smith, Prayer After Stroke: Its Relationship to Quality of Life.
95. D.A. Matthews, *The Faith Factor* (NY: Viking Press, 1998).
96. L. Dossey, *Be Careful What You Pray For* (San Francisco: HarperCollins, 1997).
97. Engebretson, Considerations in Diagnosing the Spiritual Domain.
98. Mansen, The Spiritual Dimension of Individuals.
99. Nolan and Crawford, Towards a Rhetoric of Spirituality.
100. B.M. Dossey, Florence Nightingale: A 19th-Century Mystic, *Journal of Holistic Nursing* 16 (1998):111–164.
101. B.M. Dossey, *Florence Nightingale: Mystic, Visionary, Healer*.
102. B.M. Dossey, Florence Nightingale: Her Crimean Fever Chronic Illness, *Journal of Holistic Nursing* 16 (1998):168–196.
103. B.M. Dossey, *Florence Nightingale: Mystic, Visionary, and Healer*.
104. B.M. Dossey, Florence Nightingale: A 19th-Century Mystic.
105. T. Moore, *Care of the Soul* (New York: HarperCollins, 1992).
106. J. Watson, *Postmodern Nursing and Beyond* (Edinbergh, Scotland: Churchill Livingston, 1999).
107. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness*.
108. Kociszewski, A Phenomenological Pilot Study of the Nurses' Experience Providing Spiritual Care.
109. K.B. Wright, Professional, Ethical, and Legal Implications for Spiritual Care in Nursing, *Image* 30 (1998):81–83.
110. Råholm, Weaving the Fabric of Spirituality as Experienced by Patients Who Have Undergone Coronary Bypass Surgery.
111. R.L. Hatch et al., The Spiritual Involvement and Beliefs Scale: Development and Testing of a New Instrument, *Journal of Family Practice* 46 (1998):476–486.
112. Hall, Spirituality in Terminal Illness, 86.
113. Hall, Spirituality in Terminal Illness.
114. J. Bruchac, *Tell Me a Tale* (New York: Harcourt, Brace, 1997), 1.
115. M.G. Nagai-Jacobson and M.A. Burkhardt, Viewing Persons as Stories: A Perspective for Holistic Care, *Alternative Therapies in Health and Medicine* 2 (1996):54–58.
116. M.A. Burkhardt and M.G. Nagai-Jacobson, Psychospiritual Care: A Shared Journey Embracing Wholeness, *Bioethics Forum* 13 (1997): 34–41.
117. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness*.
118. M.Z. Cohen, J. Headley, and G. Sherwood, Spirituality and Bone Marrow Transplantation: When Faith Is Stronger Than Fear, *International Journal for Human Caring* 4 (2000):40–46.
119. Bruchac, *Tell Me a Tale*.
120. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness*.
121. Burkhardt, Spirituality: An Analysis of the Concept.
122. J.W. Howden, Development and Psychometric Characteristics of the Spirituality Assessment Scale (Unpublished doctoral dissertation, Texas Woman's University, Denton, 1992).
123. E.R. Barker, Patient Spirituality Assessment: A Tool That Works (Paper presented at the Uniformed Nurse Practitioners Association Meeting, Seattle, WA, November, 1996).

124. E.R. Barker, How To Do Research, Get Finished, and Not Lose Your Balance (Presentation at the Nursing Research Symposium, San Diego, 1998).

125. Barker, Being Whole: Spiritual Well-Being in Appalachian Women.

126. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness.*

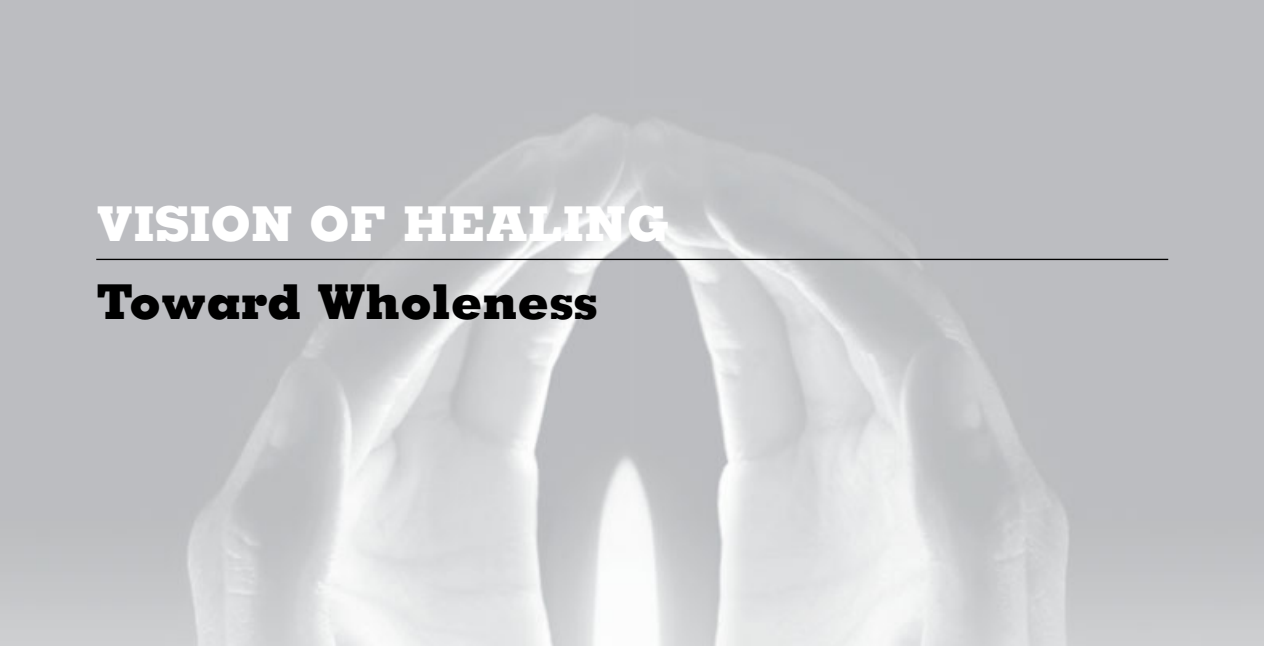
127. J. Achterberg et al., *Rituals of Healing: Using Imagery for Health and Wellness* (New York: Bantam Books, 1994).

128. L. Doohan, *Leisure: A Spiritual Need* (Notre Dame, IN: Ave Maria Press, 1990).

129. W. Mueller, *Sabbath: Restoring the Sacred Rhythms of Rest* (New York: Bantam Books, 1999).

130. Burkhardt and Nagai-Jacobson, *Spirituality: Living Our Connectedness.*

131. M. L'Engle, *Walking on Water: Reflecting on Faith and Art* (Wheaton, IL: Harold Shaw Publishers, 1980), 16.



VISION OF HEALING

Toward Wholeness

*The philosophy underpinning energetic healing is that the soul/mind precedes energy and that energy precedes biology. Radical, yes. It changes everything. If the soul/mind somehow determines the form energy will take, it is ultimately the builder of biology, chemistry, emotions, relationships—everything a person experiences. The body, mind, emotions, and spirit are integrated; in other words, they are different reflections of the same energy and of the same consciousness, not separate phenomena. This philosophy enables us to chart our own healing, rather than rely just on outside forces to help us heal. Understanding that energy precedes biology offers very personal avenues of healing and health through our energy fields. To do so, we must encounter our conscious, subconscious, unconscious, and long forgotten choices. Those choices and their aftermaths are held in the energy field as information, as energy in-*form*-ation. Our job is to engage those forms, recognize them and let them go so we can create new, more appropriate forms of energy, new ways of being.*

One way to begin such a journey is to become acquainted with our own energy, which will lead us to explore our body, mind, emotions, and spirit in different ways than we have. We will discover parts of us that are darker than we want to believe—and brighter. The journey to the wholeness of self is the journey of a lifetime, everyone's lifetime. It progresses through chaos and confusion until we begin to understand the meaning of our personal journey. We will discover within us a surprising wholeness and a breathtaking wisdom. We will discover more of who we are. It is a hero's or heroine's journey, one that begins with the wound of believing that we are made of separate parts and are separated from ourselves and from each other.

The journey to wholeness is an adventure that must be undertaken deliberately; it must be entered through choice. Everyone's healing journey will involve different paths, but all journeys toward personal wholeness involve learning one's own hidden history, a history that can be found in our energy fields. Through the information in our energy fields, we can discover our consciousness—our soul, perhaps—that helps mold us, guide us, and will lead us to wholeness. Energetic healing is one entry to the spiritual adventure of discovering ourselves.

Chapter 8

Energetic Healing

Victoria E. Slater

NURSE HEALER OBJECTIVES

Theoretical

- Name and describe three major energetic structures.
- Apply electromagnetic characteristics to the human.
- Discuss one view of chakras.
- Compare meridians to a direct electric current.
- Describe electrical induction.
- Discuss the quantum theories of holography and consciousness-created reality.
- Apply Assagioli's model of the dimensions of the psyche to holistic healing.
- Describe six principles that should direct energy healing research.

Clinical

- Identify one energetic healing modality for your clientele.
- Recognize the dimensions of psyche used by your clients/patients.

Personal

- Explore a variety of forms of energy to access information from the dimensions of the psyche.
- Discover how to engage your chakras, meridians, and aura to further your own health.
- Explore the use of induction in your personal relationships.
- Explore energetic healing modalities you have not previously used.

DEFINITIONS

Aura: an atmosphere; a vague, luminous glow surrounding something. It is an information-containing electromagnetic field and can be likened to the data contained within a computer.

Biophotons: very weak, pulsating ultraviolet (non-visible) light emitted by cells.

Centering: the act of focusing your attention on your heart, resulting in an increase in measurable extra-low frequency magnetic pulses of 0.3–3.0 cycles per second (Hertz), that are emitted by your hands. It can also be called a coherent energetic state.

Chakra: an energy center in the subtle, or energetic, body that is described as a whirling vortex of light.

Consciousness-Created Reality: The quantum theory that proposes that reality exists when a consciousness observes all possible quantum potentialities (wave functions) and selects one.

Energetic: having a capacity for work; active, showing great physical or mental energy.

Energetic Healing: The process of using a coherent energy field to induce a change in one's own or another's field.

Hologram: A three-dimensional image produced by an interference pattern of light (as laser light). Each individual part of the interference pattern contains the entire image, which is revealed when the interference pattern is exposed to coherent light of the proper frequency.

Intention: Purpose, aim, or objective. The choice to act in a certain way. One begins energetic healing by setting an intention that the work is for the highest good of the other, with harm to none. Such an intention results in "intensity of feelings, heart-felt motivation, lowered heart rate variability, and brain wave synchronization."[1]

Meridian: parallel pathways that are low voltage electrical conduits. In Eastern philosophies, the meridians are said to conduct chi, or universal energy. The meridians are organized in an electrical mesh that permeates the body and precedes development of vessels and organs.

Psychosynthesis: Assagioli's psychologic theory that proposes a multidimensional human psyche.

Self-referencing Biofeedback: Biofeedback is a technique of learning how to control bodily processes. Self-referencing biofeedback uses internal clues, rather than a machine's response, as a guide. Centering with intention is a self-referencing biofeedback state.

Subtle Energies: Barely noticeable energies from living organisms. Subtle energies are called chi (qi, ki), prana, etheric energy, and mana, among other names, and may be related to electrical and magnetic fields associated with organisms.

Tensegrity: A word coined by R. Buckminster Fuller to describe structures whose shape is created and maintained by a network that is in continuous tension. Geodesic domes, pop-up tents, and the human body are examples of tensegrity structures.

Energetic healing is a term used to describe healing that alters the subtle flow of energy within and around a person or organism. This subtle field is essential to the health of the organism, and many cultures have developed healing methods using those energies. This energy flow may be electromagnetic and is called by many names, including chi, ki, qi, mana, prana, and etheric. Energetic healing techniques can be classified as laying-on-of-hands, biofield therapy, and subtle energy healing. Other approaches use light, sound, aromas, and flower essences to influence the subtle energy field. The laying-on-of-hands types of energetic healing have three sources of understanding: (1) traditional conceptions of energetic structures and functions, (2) the personal experiences of energetic healers, and (3) physics.

Every culture has a concept that explains the energy that can be sensed around people, animals, and plants. Just as many cultures, such as Japan, China, and India, adopted Western healing methods to supplement or replace their traditional healing practices, many people in the West are adopting traditional healing practices to supplement surgery and medicines. Krieger, an American nurse, developed Therapeutic Touch, which is distantly related to Pranic Healing, an Indian practice. Chi Kung, Qigong, and Reiki, healing traditions from China and Japan, are popular in the United States. As the practice of subtle energy therapies grows, new versions evolve, such as Polarity and Healing Touch, which blend traditional and scientific concepts.

When people are first exposed to subtle energies, they often say that they feel nothing. Over time, they realize that they have always sensed the energies around themselves and others, but it has become a type of background noise that they either ignore, or notice but dismiss merely as bad or good "vibes." As people practice their energetic therapy of choice, they develop a sensitivity to the nuances of energy fields, and begin to experience it through more than just touch. Some people hear, see, smell, and taste it. Many discover that this energy field carries emotions and thoughts, as if people nonverbally broadcast what they think and feel. When people continue to work with energy fields, others and their own, they develop a surprising sensitivity to the nature and information within energy fields; what used to be ignored becomes so obvious that they wonder how they could have they missed it. As they bring their insights into their energetic practices, these expert healers can help clients heal a host of physical, emotional, and spiritual problems. These highly sensitive healers develop understandings of the human energy field and its contribution to the health of body, mind, emotions, and spirit that are difficult for scientists to measure and confirm. The human instrument is a much finer detector of subtle energies than any machine developed to date. Engineers and biophysicists, in time, may build machines that measure what expert healers sense; however, machines are unlikely to duplicate the human healer who can see, hear, taste, touch, smell, and know the subtle changes in a person's field and adapt to them with just a thought.

Energetic therapies work with phenomena that are more familiar to physicists than to biologists. Understanding energetic healing requires knowledge of electricity, electromagnetism, and quantum physics. While energetic healers look to physics to explain what they sense, the explanations are only tentative. Physicists rely on experimental results and mathematical formulas to describe phenomena; until a theory is confirmed experimentally, it is a metaphor. At this point, the physics explanations given energetic healing are metaphors because there is limited experimental data and no mathematical support of the energetic structures and processes described by energetic healers. As the research base grows, physicists, engineers, and other scientists will become interested in measuring the phenomena experienced and described by healers and, in time, they will develop mathematical models to explain it. But for now, we must rely on the insights from traditional healing and expert energetic healers to help us understand, even a little, the phenomenon of healing through subtle energies.

AN OVERVIEW OF ENERGETIC HEALING

The goal of holistic nursing is to assist each other's growth as integrated body-mind-emotional-spiritual people. All holistic nurses bring two things to patient/client interactions: (1) a philosophy of wholeness, and (2) his or her own presence. We know that being truly present to another is healing in itself. When the presence of the holistic nurse is combined with energetic healing, an opportunity for life-changing healing exists.

The basic tools of energetic healing are (1) the person receiving the healing, (2) the healer, and (3) energetic structures. Holistic nurses use energetic healing to help a person heal physical, emotional, mental, and spiritual pain and wounds. Pain relief, decreased depression and anxiety, wound healing, and spiritual growth are only a few of the many benefits of energetic healing treatments. The most profound changes are not immediately noticeable because

healing takes time—sometimes years of participating in a personal healing quest. Many adults live their lives with beliefs and fears that developed in childhood. Moving beyond those limitations requires healing energetic structures, understanding the larger picture and deeper meaning within experiences, and developing higher aspects of ourselves.

Energetic healing is not complete in itself. Dossey[2] and White[3] propose that it is not energy that is healing, but one's consciousness. White emphasizes this point when he writes:

> Some spiritual seekers, failing to understand [the] distinction, become "energy junkies." They learn with fine detail how to manipulate energy inside themselves or attract energy to themselves from outside .... Yet when the experience is over, their consciousness has not changed a whit .... After the internal pyrotechnics have subsided, it is consciousness alone that can bring understanding to the person.[4]

Energetic healing can help us grow open to a conscious aspect of our self that is not limited to the physical body or to our emotions and thoughts. Assagioli called this our Higher Self or Transpersonal Self.[5]

While all energetic healing treatments offer the opportunity for deep healing, research has shown that life-changing healing is more common after treatments from healers who have a greater breadth and depth of training, practice, and personal healing than from novice healers. Slater found that after receiving a single treatment from a novice energetic practitioner, clients reported transient changes, such as relaxation and pain relief. After receiving the identical technique from an expert practitioner, some clients experienced a permanent change, such as relief of pain of many years.[6] The difference was not the technique; it was the practitioner. Benner's model of the novice-to-expert illuminates this distinction. She found that experts transcend technique.[7] Merely doing techniques hundreds of times does not automatically make one an expert healer. Expert healers *understand* energetic processes and structures, including the meridians, chakras, and aura, and they know when to use an energetic healing approach. They also actively pursue personal healing, which opens one to a greater understanding of the possibilities within oneself as an instrument of healing.

Although energetic healing appears to be about the technique being used, the person being healed is the most important part of the healing equation. Expert healers have learned to use themselves as instruments to change the energy flow in the client's meridians, chakras, and aura, which are to the human what electrical wiring, software, and data are to a computer. These structures serve several functions. On the physical level, each acts like a common electrical device or phenomenon; at the more abstract level, they conduct, process, or store information. *Meridians* are described as the conductors of a very low frequency direct electric current.[8] *Chakras* act like modulators and processors of energy,[9] and as data processing programs. The *aura*, which resembles an electromagnetic field, serves as a site of information storage. The meridians, chakras, and aura collect, transmit, process, and store physical energy and the information the energy contains. The details and nuances of every experience one has had can be found in this remarkable electromagnetic field. The expert healer can help people encounter their information and heal it.

MERIDIANS

Traditional Explanations of Meridians

Traditionally, meridians are portrayed as twelve pairs of superficial and deep path-

ways that carry human subtle energy throughout the body. The Chinese call this energy *chi*, and the Japanese call it *qi*. Weil points out that although the meridians have names like the organs, they do not absolutely equate with the organ of their name.[10] For example, the liver meridian refers to the sphere of influence of that meridian, not the organ. When chi energy flows are compromised, illness will result in the parts of the body fed by that meridian.

Scientific Explanations of Meridians

Gerber has reviewed meridian literature and found histologic, radiographic, and kirlian photographic studies of their locations and possible functions.[11] In the 1960s, for example, a Korean research team headed by Kim Bong Han discovered that there are four layers of meridians that run along the internal organs, nerves, the outer walls of the blood and lymphatic vessels, and in the layers of the skin. The meridians within the skin are used for acupuncture and acupressure. Meridians weave in, out, and through the vascular and lymphatic vessels, and their fluids travel independently of the blood and lymph.

To test the integrity of meridians, Kim's team injected radioactive phosphorus into acupoints and veins of rabbits. The phosphorus injected into acupoints was taken up by a duct-like tubule approximately 0.5–1.5 microns in diameter. When injected in the nearby vein, little or none of the P^{32} could be detected in the meridian. Gerber reports that a French researcher, De Vernejoul, found that radioactive technetium 99m injected into acupoints of human patients moved 30 centimeters along the meridian associated with that acupoint in 4 to 6 minutes. Random injection of the same isotope in the skin, veins, and lymphatic system did not produce similar results. Further evidence of the independence of the meridian system is that meridian fluid contains DNA, RNA, amino acids, hyaluronic acid, free nucleotides, adrenaline, corticosteroids, estrogen, and other hormonal substances in different concentrations and levels than usually found in the bloodstream. In addition, Kim found small corpuscles beneath the acupoints that contained 10 times the amount of adrenaline as in blood. Gerber proposes that the "presence of hormones and adrenaline within ductal fluids would certainly suggest some link between the meridian system and the endocrine glands of the body."[12] A healthy endocrine system may be based, to some extent, upon a healthy meridian system.

The importance of meridians was further revealed when Kim found that the meridian ducts were formed within 15 hours of an embryonic chick's conception, which is prior to the formation of even the most rudimentary organs. His data suggest that meridians may act as the spatial guide for the vascular and lymphatic systems and for the internal organs. Kim also discovered that the meridian system is a continuous mesh around and through which organs, vessels, and nerves develop. The most minute meridian structures branch to connect with cell nuclei; thus, meridians link every cell in the body with every other cell.

Kim studied the effects of damaged meridians by severing them. A short time after he cut the meridian going to a frog's liver, microscopic changes showed enlarged hepatocytes with turbid cytoplasm. Within 3 days, vascular degeneration took place throughout the entire liver. When perineural meridian ducts were cut, neural reflexes were prolonged by more than 500% within 30 minutes and the effects lasted longer than 48 hours with only minor changes.

Becker, an orthopedic surgeon, looked at meridians in his study of animals who are able to regrow limbs. In 1985, Becker and Selden reported that meridians conduct an electric current that flows into the central nervous system. Perineural cells, which

compose 90% of the brain and surround every nerve cell (such as in the Schwann cell sheath) appear to conduct the current. The cytoplasm of all Schwann cells is linked, like pearls on a string, through holes in their adjacent membranes, forming an uninterrupted pathway for the electric current. Broken bones will heal only after the perineural sleeve mends, indicating that the electric current conducted through the perineural cells is required for healing to begin.[13] Multiple sclerosis is characterized by destruction of the Schwann cells and subsequent diminishing of neural reflexes, a picture similar to the effect on Kim's frog. Multiple sclerosis may be a meridian disease.

Becker's research revealed that the electric current carried by meridians was a low-voltage, low-amplitude direct current somewhere between a trillionth (a picoamp) and a billionth (a nanoamp) of an ampere.[14] All direct currents lose strength with distance and must be boosted at regular intervals; for example, a microvolt, nanoamp current needs boosters every few inches. Up to 90% of the traditional acupoints[15] have electrical characteristics consistent with a booster appropriate for a microvolt direct electric current. Becker also found that the current strength at the acupoints had a 15-minute rhythm, which may relate to De Vernejoul's discovery that meridian fluid travels 30 centimeters in 4–6 minutes, or 90 centimeters in 15 minutes. The wrist and elbow are about 30 centimeters apart, which suggests that meridian fluid and information could flow throughout most of the human body in 45 minutes.

Kirlian photography of acupoints demonstrates that the brightness of the acupoints changes prior to the onset of physical illness, sometimes even weeks before the advent of symptoms.[16] This evidence supports the traditional teaching that illnesses are reflected in the energy field prior to being experienced physically. It also suggests that if we can intervene in the energy field, physical illnesses can be mitigated, and that the speed of healing can be increased.

Intuitive Explanations of Meridians

> Pause for a moment and sense your own meridians. The Chinese teach that the meridian flow is from foot and hand to head, so it might be easiest to sense your flow if you begin by focusing your attention on your feet or your hands. Notice a subtle, barely distinguishable flow that may feel like an underground river, or may suggest a sense of movement. Relax into this experience, letting yourself become aware of a new and more subtle aspect of yourself. Keep trying.

A glance at the evolution of life may help explain meridians. The first life form was probably only one cell, such as a paramecium. To survive in its aquatic environment, it had to gather and transmit information throughout its one cell effectively and efficiently.

> Imagine yourself as a one-celled organism gathering information from your environment. How does the information come to you? Imagine the pressure and nature of the waves that rock you as another organism moves or floats by. How would you respond to a big wave, one made by a larger organism? To a smaller wave? How does your response change with the different strength waves?

A one-celled organism may not have awareness, but it gathers enough information to survive. The paramecium has primitive motility, digestion, respiration, circulation, and elimination. Perhaps its response to passing waves is a primitive information-gathering, processing, and defense system; the meridian system may be an adaptation of this ability. The meridian system may be a series of single

cells that transmit information from cell to cell as rapidly as they can handle the flow, which might be at a nanoamp or picoamp level of power.

The meridian system appears to act like part of the body's defense system, a system that may be sourced in the primitive defenses of single-celled organisms. The ability to gather information in a gestalt and send it from cell to cell may be primitive, but it is effective, even for humans. Meridians appear to receive information from the environment and send it into every cell nucleus. Meridians can be healthy, hyperalert, or sluggish. A hyperalert meridian system may create a hyperalert state and a sluggish one may lead to relative inertia. Threats may be physical, emotional, mental, spiritual, or, more accurately, a combination of all four. Malignant hypertension may be a meridian problem. As meridians gather data from an environment perceived as threatening, the body remains in a hyperalert state, which involves increases in blood pressure. Allergies may be a response to a hyperalert meridian system as well. Depression or psychological and physical sluggishness, on the other hand, may be due partially to a sluggish meridian system.

> Imagine your *skin* receiving information from the room, different information than you can gather by your five senses. Imagine this data moving through your body and into each cell nucleus. What subtle nuances are you aware of that you did not notice before? How do you respond? Are your meridians and their flow alert, hyperalert, or sluggish?

Some meridian techniques are acupuncture, acupressure, Jin Shin Jyutsu, and the Scudder, which is taught in the Healing Touch program. These techniques act quickly; recipients experience rapid relaxation of tissues and mood. Research indicates that acupuncture, the most researched meridian technique, is useful in a wide range of conditions, including stroke rehabilitation, infectious disease, angina pectoris, and immunomodulation in cancer patients.[17] Acupuncture is reputed to bring a body into balance. The same acupuncture technique given to both a hyperthyroid patient and a hypothyroid patient brings each closer to normal thyroid functioning.

Because acupuncture uses needles instead of the subtler interaction of the hands-on-healing techniques, its research results can be used only to suggest uses for other meridian techniques. Perhaps one effect of any meridian technique is to calm down a hyperalert meridian system and stimulate a sluggish one. The balancing effect of meridian techniques is temporary if the internal and external environments remain the same. If the meridian system is a defense mechanism, it will return to its hyperalert state if the environment continues to be perceived as threatening.

CHAKRAS

Traditional Explanations of Chakras

Chakra means vortex, or wheel of light, in Sanskrit. Chakra lore is varied, but there are two commonalities: chakras exist within and around the body, and they are ports for energy exchange with the environment. They bring in energy, give meaning to information, and release energy and information. It is through chakras that people broadcast their emotions and thoughts before they speak them. Chakra locations, colors, tones, and functions have been identified intuitively and differently. Four representative views of chakra functioning are listed in Table 8–1. In each, the first chakra is believed to function on the most concrete level and the seventh at the most abstract. Most views believe that the first chakra (at the tailbone) relates to survival; the fourth (heart), to love; the fifth

Table 8–1 Five Perspectives of Chakras

	Bruyere	*Brennan*	*Judith*	*Maslow*
7th Chakra	Release, surrender	Integration of total personality, spiritual aspects	Understanding, enlightenment, transcendence	Aesthetics needs, wonder, beauty, harmony
6th Chakra	Inspiration, insight	Visualization, carry out ideas	Clairvoyance, imagination	Need to know and understand
5th Chakra	Expression	Sense of self, taking in and assimilating	Communication, creativity	Self-actualization, realize one's potential growth, autonomy
4th Chakra	Secondary feeling (usually contrary to first feeling)	Love, openness to life, ego will	Love	Self-esteem, self-worth, dignity, self-reliance, self-respect, independence
3rd Chakra	Opinion	Healing who you are in the Universe	Power, will, humor	Love and belonging, intimacy
2nd Chakra	Feeling	Pleasure, sexual energy	Sexuality, emotions	Safety
1st Chakra	Concept, original idea	Physical energy, will to live	Survival	Survival

Source: Data from: R.L. Bruyere, *Wheels of Light: A Study of the Chakras,* Vol. 1 (Sierra Madra, CA: Bon Productions, 1989), p. 43; B.A. Brennan, *Hands of Light: A Guide to Healing Through the Human Energy Field* (New York: Bantam Books, 1987), pp. 47–54; A. Judith, *Wheels of Life: A User's Guide to the Chakra System* (St. Paul, MN: Llewellyn Publications, 1990); A.H. Maslow, *Motivation and Personality,* © 1954, Harper & Bros., pp. 35–51, and A. H. Maslow, *Psychological Review,* no. 50, pp. 370–396, © 1943.

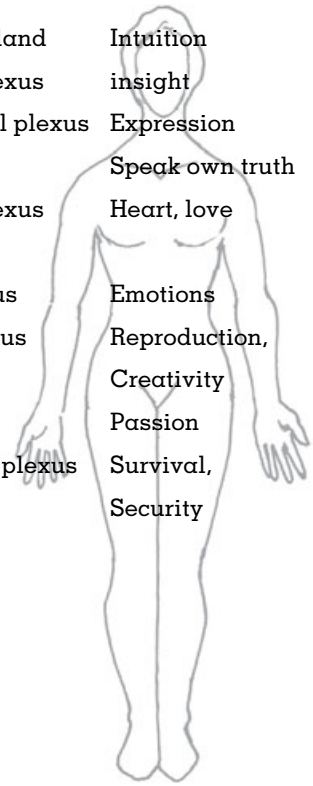
(throat), to expression; the sixth (brow), to insight, and the seventh (crown), to spirituality. Interpretations of the second and third chakras vary widely. Nurses are familiar with a chakra sequence in Maslow's hierarchy of needs.[18] Maslow described seven levels of needs, but only the first five needs—physiologic survival to self-actualization—are familiar to most people. He identified a sixth level, the need to know and understand, and a seventh level of aesthetic needs, including the need to wonder.

Most traditions identify 7 major chakras, all located near large collections of nerves or neuroendocrine glands, and attribute to them various colors and sounds. One well-known model assigns them the colors of the rainbow and tones of an octave (see Table 8–2), for example, the root chakra is seen as red, and is heard as the note middle C. People stimulate their chakras by the colors they wear and the music they hear. Physics teaches that cellular biology is built upon minute bundles of energy. Perhaps chakras bring in those bundles of energy, which are transported rapidly throughout the body by the nervous system and more slowly, but completely, by the meridians.

Some authors list other major chakras, such as a splenic and a gonadal chakra.[19] Joy identifies a chakra at the manubriosternal joint (the Angle of Louis),

Table 8–2 Chakra Locations, Associated Organs and Nervous Structures, and Attributes

Chakra Location	*Nervous System Structure*	*Function*	*Gland*	*Color*	*Tone*
7 Crown of head	Pineal gland	Spiritual	Pineal or pituitary	Violet/white	B
6 Brow	Pituitary gland Carotid plexus	Intuition insight	Pituitary or pineal	Indigo (red–blue)	A
5 Throat and shoulders	Pharyngeal plexus	Expression Speak own truth	Thyroid	Blue	G
4 Heart and knees	Carotid plexus	Heart, love	Thymus	Green	F
3 Stomach	Solar plexus	Emotions	Adrenals	Yellow	E
2 Lower abdomen Wrists and ankles	Pelvic plexus	Reproduction, Creativity Passion	Lymphatic tissue	Orange	D
1 Groin Palms and soles	Coccygeal plexus	Survival, Security	Gonads	Red	C



Source: Data from B.A. Brennan, *Hands of Light: A Guide to Healing Through the Human Energy Field,* p. 48, © 1987, Bantam Books; R.L. Bruyere, *Wheels of Light: A Study of the Chakras,* Vol. 1, p. 42, © 1989, Bon Productions; R. Gerber, *Vibrational Medicine: New Choices for Healing Ourselves,* p. 130, © 1988, Bear & Company; A. Judith, *Wheels of Life: A User's Guide to the Chakra System,* p. 23, © 1990, Llewellyn Publications; Z.F. Lansdowne, *The Chakras & Esoteric Healing,* p. 56, © 1978, Samuel Weiser, Inc.; A.E. Powell, *The Etheric Double,* p. 56, © 1978, Theosophical Publishing House; C.W. Leadbeater, *The Chakras,* pp. 40–41, © 1927, Theosophical Publishing House.

below the collar bone.[20] Concept: Synergy, which teaches meditative techniques, discusses twelve chakras: seven on the physical body and five off-body chakras, which are considered additional spiritual chakras.[21] Minor chakras include the palm, the sole of the foot, the base of the skull, and all joints in the body, including the spinal joints, which have been described as five octaves of chakras.[22] In the major-minor chakra scheme, there are more than 360 chakras in the human body,[23] which enables a person to gather and process the minute details of every experience.

The following oral tradition format adapted from Concept: Synergy is generally acceptable for the seven major chakras:

Root chakra: Survival and security.
Second chakra: Sexuality, sensuality, pleasure, primal creativity, your passions.
Third chakra: Emotions, "I feel it in my gut."
Fourth chakra (heart): Love of self and others, heart-felt love.
Fifth chakra (throat): Speaking your own truth about security, creativity, emotions, and what you love.
Sixth chakra (brow): The third eye: intuition, gestalts of awareness, perception. It provides insight into the first four chakras' activity and helps you speak a different truth.
Seventh chakra (crown): Gateway to your spiritual realm, to your higher chakras, and to your Transpersonal Self.

Many views of chakras list a mental chakra, a function that is not included in the chakra format used here. The ultimate decision about what to do with the data chakras process is external to the chakras, as if the individual were the overseer of the responses, rather than responses being instinctual or merely habitual. Assagioli's Dimensions of the Psyche model (Figure 8–1) offers two suggestions for the nature of that oversight: the Conscious self or the Transpersonal (or

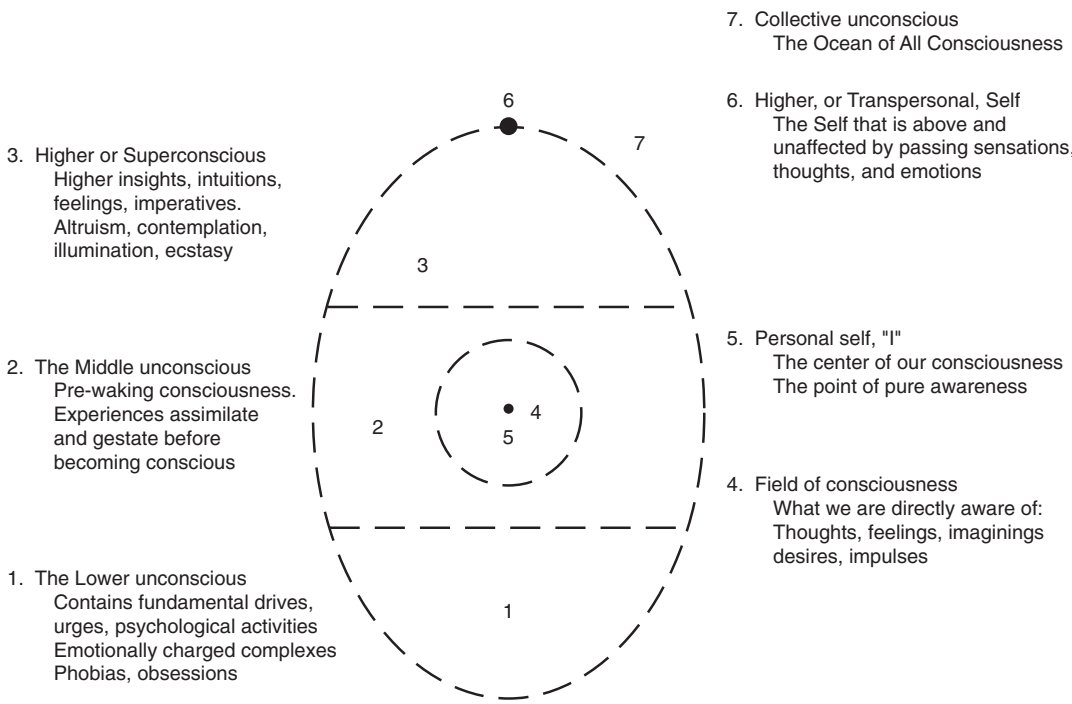


Figure 8–1. Assagioli's Dimensions of the Psyche. Source: From WHAT WE MAY BE by Piero Ferrucci. Copyright © 1983 by Piero Ferrucci. Used by permission of Jeremy P. Tarcher, an imprint of Penguin Group (USA) Inc.

Higher) Self. The Conscious self is the center of our consciousness, and is aware of thoughts, feelings, imaginings, desires, and impulses.[24] Its responses are less complex than those of the Higher Self. *That* Self is a Truer Self, one that is unaffected by passing thoughts, emotions, and sensations, but is aware of the larger and more complex picture of every situation. One can be working from either level of consciousness at any time, but to sustain a relationship with the Higher Self requires healed and energized chakras.

Scientific Explanations of Chakras

Valerie Hunt, a professor of physical therapy at the University of California, Los Angeles (UCLA), and Hiroshi Motoyama, of Japan, obtained objective evidence of chakra activity. Hunt placed electromyographic (EMG) electrodes on the skin of chakra areas. She found regular, high frequency, wave-like electrical signals from 100 to 1600 cycles per second (Hz), which is higher than any previously recorded human body frequency. (The frequency band of brain waves is between 1 and 100 Hz, muscle frequency reaches 225 Hz, and the heart frequency is as high as 250 Hz.)[25]

Gerber reports that Motoyama recorded the electrical state and changes over chakra areas of control subjects, advanced meditators, and people with histories of psychic experiences. Chakras that the meditators believed were "awakened" showed electrical readings of increased frequency and amplitude when compared to control subjects' chakras. Motoyama also found that subjects who could consciously project energy through their chakras displayed significant electrical field disturbances over the activated chakras.[26] Motoyama's finding that advanced meditators could consciously project energy through their chakras indicates that people can deliberately enhance this ability and thus can control their own energy. Gerber suggested that the "ability to activate and transmit energy through one's chakras is a reflection of a rather advanced level of consciousness development and concentration by the individual."[27]

Intuitive Explanations of Chakras

Chakras, like meridians, receive and carry data on electromagnetic frequencies. While meridians transmit data as a whole pattern—as a gestalt—chakras receive and process only a small range of frequencies, a part of the whole. Individual chakras act like inductance–capacitance (L–C) circuits. An L–C circuit is constructed to amplify only one frequency from the many it receives. Radios are collections of L–C circuits; the radio receives numerous frequencies, but each individual station picks up only the one it is designed for. The entire radio, or the entire chakra chain, receives the complete signal. Individual chakras, like radio stations, process only selected data. Chakras are highly efficient and rapid data processing system.

Chakras also act like transformers, devices that change voltage in currents. Any change in a primary coil's current will induce a voltage in an adjacent coil.[28] Similarly, the energy of a lower chakra radiates to the next higher one, inducing a voltage surge, which increases the power of the higher chakra. Higher power enables chakras to process more complex data. Insight, for example, is more complex than survival. Chakras act like both step-up and step-down transformers: step-up transformers increase the power in an adjacent, more complex coil, while step-down transformers modify the energy so a less complex coil can handle it. Hindu tradition teaches that the soul/spirit enters

the body through the crown chakra. Each chakra in turn down-steps the energy until it reaches the root chakra. The root chakra then up-steps the current so that each chakra can use it constructively for moment-to-moment responses. Each chakra acts like a step-down transformer, to bring in and modify universal energy so the body can use it, and as a step-up transformer, to empower the next higher chakra. The back and forth flow enables a person to process their information differently over time, to adjust to new situations, and to heal old emotional wounds.

Traditions have given the chakras various tasks, as shown in Table 8–1 and in Maslow's hierarchy of needs. However, chakras are more complex than these models suggest. Chakras receive and process information according to preestablished data processing programs, which are a culmination of prior experiences. When a person has the same or a similar experience frequently, a depth or weight of data develops. Chakras process any event containing similar elements according to an established response. Chakras will seek a familiar response to deal with a new experience. A person is likely to react with fear, anger, or love, for example, to a stimulus that has elicited those emotions in the past, even if many of the details within the new situation are different. The continuity provided by repeatedly using familiar responses is efficient, and contributes to a person's self-image and identity.

Established responses are one reason people do not grow emotionally with ease. As people mature, they do not always grow out of childhood responses, and their chakras will continue to process information as they always have. Damaged chakras are another reason for immature behavior in adults. Chakras can be stunted in their development by emotional or physical trauma that interferes with their ability to receive, transform, and transmit energy. In a chakra system with damaged chakras, the information and energy flow may be unable to reach the higher chakras. When it can't reach the 4th through 6th chakras, which process self-love, real communication, and insight, changes to unhealthy established patterns are unlikely.

The following exercise will help you become aware of your own chakra energy:

> Place one hand lightly over your perineum or coccyx (first or root chakra) and place the thumb of your other hand at your umbilicus. Your upper hand will be resting over your second chakra (sacral plexus). Ask the chakra under one hand to close. What do you notice? Ask that chakra to open. Is there a change? Open and close your chakra several times. Move your hands so that one hand is above the umbilicus and one below, with the thumb of one hand and the little finger of the other meeting at your umbilicus. The lower hand will be over the second chakra and the upper hand will be near the third (solar plexus). Notice any subtle changes under your hands. Now, ask the chakra beneath your lower hand to close. And open. Do that several times to allow yourself to tune into the subtle responses under your hands. Invite the chakra to close and open, and the energy to flow from the lower chakra into the one under your upper hand. What do you feel? When you ask a chakra to close, what happens under your hands? What happens to the rest of your body? To your emotions? To your thoughts?
>
> Move your hands over your sternum, about where you would do closed chest cardiac massage. That is the fourth, or heart chakra. Ask it to open and close several times. What happens to your breathing? Are there changes in the tension in your back? Your fifth chakra is at your throat in the area of the Adam's apple and suprasternal notch. It is the smallest of the seven major chakras, and about the size of

a 50-cent piece. Put your hands over it and ask it to close and open. What happens? By this time, you may have noticed that each time you ask a chakra to open and close, you feel a slight sensation or change of pressure or temperature under your hands. You may feel a movement like a flower opening. You may feel tense or have pain when chakras are closed, and a sense of relaxation when they are open.

Your sixth chakra, also called the third eye, is in the center of your forehead. Place one or both hands lightly over your third eye. Ask it to close and open. What happens? Your seventh chakra is at the top, or crown, of your head where your soft spot was. Sense your body and your emotions as you ask it to close and open. What do you experience?

Give yourself a chakra treatment. Place one hand over your first chakra, at your groin, and the other hand over the second chakra. For one minute, visualize universal energy flowing through your hands into your chakras. Then allow a flow of energy into your second and third chakras, above and below the umbilicus. Do the same for the third and fourth, fourth and fifth, fifth and sixth, and sixth and seventh chakras. How do you feel?*

*Adapted from W.B. Joy, *Joy's Way: A Map for the Transformational Journey. An Introduction to the Potentials for Healing with Body Energies* (Los Angeles: J.P. Tarcher, Inc., 1987).

Waves brought all information to one-celled organisms, which interpreted it as a whole, as a gestalt. When animals walked out of the primordial swamp, however, they needed more detailed and rapidly delivered information to cope with the more diverse light-filled (electromagnetic) environment. The bundled information carried by an electromagnetic light wave needed to be separated into its various components so that the animal could quickly perceive and interpret details, rather than gestalts of information. What was needed were devices that were able to take in the entire environment, separate the frequencies (a Fourier analyzer function), and analyze the information within each frequency (L–C circuit function). What was needed were chakras.

The feet and palms, or paws of four-legged animals, act like root chakras. The survival and security function of the root chakra is the first requirement for life. Land-based animals are rooted to the earth through their chakras in their paws and at the base of their spines. The whole of an animal's body is organized to gather information from the subtle and not so subtle pulses around it. The trunk and legs contain each of the first five chakras in the paw; the ankle, knee, and hip joints; and the long bones. A glance at the dog and cat drawings in Figure 8–2 suggests that the four legs collect data that flow into the trunk and to and through the major chakra chain. The standing animal has paws and metatarsal joints firmly planted to absorb data; the sitting animal is resting on its root. The chakras of both are sampling the pulses within the ground, and the upright spinal chakras and major and minor chakras are gathering data that is carried on the air. All of this information flows into the central chakra chain to be rapidly analyzed. Very little crucial data is likely to escape detection by such a finely crafted system.

Take a moment to sense your hand, foot, and spine chakras. Place your hands and feet on the earth. Allow each palm, sole, toe, and finger to become alive. Invite your spinal chakras to open. What do you feel? How do you feel? Is there a barely perceptible flow in your hands, feet, and/or spine that you did not notice before? How much more do you sense about your environment than you were aware of?

When *Homo erectus* stood up and took two chakras off the ground, it needed an adjustment to its L–C circuit chain. With only two-fifths of its input sites in constant

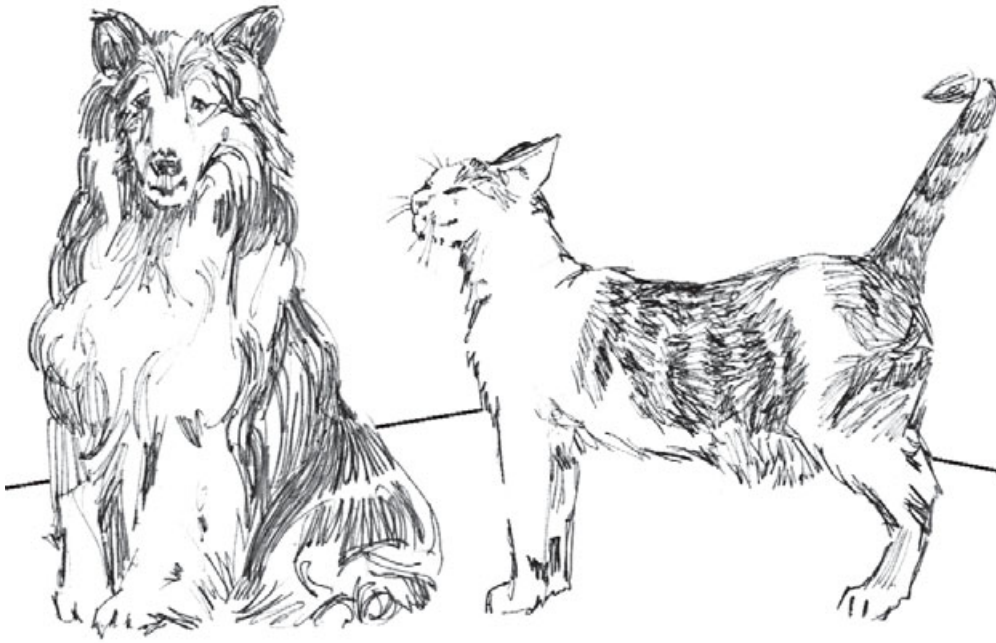


Figure 8–2 Dog Sitting and Cat Standing on Chakras. *Source:* Copyright © 1999, Carol Eckert.

contact with the ground, *Homo erectus* needed a more efficient and effective information processing system. As with the one-celled organism that evolved to walk on land, it needed to evolve to refine the data still further. Chakras were needed that could do more than receive, process, and transmit information; *Homo erectus* needed insight, intuition, and gestalts of awareness, all of which are provided by the sixth chakra in the brow. The sixth chakra needed to mature and evolve. As *Homo erectus* evolved into *Homo sapiens*, the seventh chakra matured and the Wise Human realized that it had a spiritual nature.

> Imagine yourself as an upright *Homo erectus*. Feel the energy flow stop at the fifth chakra in your throat. What do you sense about your environment? Now imagine that you have evolved into *Homo sapiens*. Allow the energy to move into the sixth chakra. What happens? What additional awareness does the sixth chakra give you? Sense the energy flow into the seventh chakra at the top of your head. Tradition calls the seventh chakra the spiritual chakra. What do you experience?

Chakra development can be seen in the evolution of the human species and in each individual. The imagined evolution of chakras suggests that they have evolved with changes in organisms. Chakras also develop with age. Bruyere stated that each chakra develops at a particular time of life (Table 8–3).[29] Another developmental pattern is suggested by the Fibonacci number sequence, a pattern of growth of plants and other organisms. When a plant begins to put out leaves in the spring, it will put out one leaf. Then one more leaf. Then two leaves and three leaves. Then five leaves. The pattern of 0-1-1-2-3-5-8-13-21-34-55-89-144-233-377-610-

Table 8–3 Theoretical Ages of Chakra Development

Chakra	*Chakra Function*	*Age Based on Fibonacci Number*	*Age Based on Bruyere Oral Teaching*
1st, Root, Sacrum	Survival	1 (conception/birth)	Birth to 3 or 4
2nd, Pelvic Plexus	Reproduction, creativity	1 to 2 (first cell division) and Age 2 to 3 ("Terrible Twos")	4 to 7
3rd, Solar Plexus	Emotion	3 to 5 to 8 years	8 to 12
4th, Heart	Love	13 to 21 years	13 to 19
5th, Throat	Expression	21 to 35 years	19 to 25
6th, Brow	Insight	35 to 55 years	25 to 35
7th, Crown	Spiritual	55 to 89 years	35+
8th, ?	?	89 to 144 years	
9th, ?	?	144 to 233 years	
10th, ?	?	233 to 377 years	
11th, ?	?	377 to 610 years	
12th, ?	?	610 to 987 years	

Fibonacci numbers are calculated by adding the previous two numbers together. The Fibonacci number sequence begins with 1, 1, 2, 3, 5, 8, 13, 21, 34, 55, 89, 144, 233, 377, 610, 987 . . . . . .

987 . . . . . is consistent throughout nature. Each number after the first is the sum of the two preceding numbers. In addition to plant growth, this sequence is seen in DNA, RNA, and the branching of the dendrites throughout the nervous system.[30] If the Fibonacci number sequence is a pattern that nature finds useful, then perhaps chakras develop along the same pattern.

The pattern suggested by the evolution of the species and the Fibonacci number sequence indicates that *Homo sapiens* is only the latest stage in human development. If the pattern of increasing life spans continues, perhaps the eighth chakra will mature between ages 89–144, the ninth between ages 144–233, the tenth between ages 233–377, and so forth. If the evolution of the species is tied to the evolution of the chakras, we cannot know what additional information we will be able to process or what life will be like with additional, mature chakras. The maturing of the spiritual chakras may create an evolution as dramatic as the difference between animals and humans. *Homo sapiens* may evolve into *Homo spiritualis*.

Individual evolution requires that a person heal their chakras and their emotional data. People may repeat the same painful or self-destructive behaviors because they are operating with programs that have not been transformed since they were created, perhaps even at birth. It is important to heal both the physical trauma chakras may experience and the programs created to process experiences. While there are many ways to gain insight into habitual responses, energetic healing at the hands of an expert can heal chakras and help one gain insight. Energetic healing also stimulates chakras, increasing the likelihood that the energy flow will be powerful enough to reach and open all of the major chakras. As Yomata noted, "you can only solve a problem from

a higher chakra,"[31] for only a higher chakra can give old data new perspectives and insights. Energetic healing can help open the higher chakras and, as energy moves up and down the chakras, we gradually will release what is habitual but no longer serves us. As we heal our chakras, our old ways of perceiving and interpreting life's events can change, and what was painful can become unimportant.

THE AURA

Traditional Explanations of the Aura

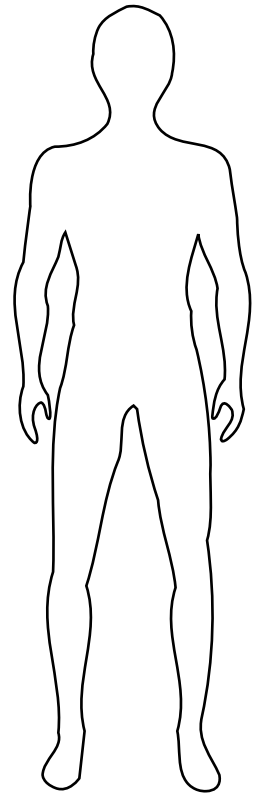
Complementing the meridians and chakras is the aura, traditionally described as a multilayer field of energy surrounding the physical body. There are several diverse understandings of the aura, including Brennan's and Kunz's. (See Table 8–4.) Brennan's seven-layer system includes three planes: physical, astral, and spiritual. The physical plane comprises three layers, including the well-known etheric body. Etheric is "the state between energy and matter."[32] The function of the physical plane involves day-to-day life. The spiritual plane also includes three layers and its functions, more abstract than those of the physical plane, involve interactions with the divine. Between the two multilayer planes lays the single-layer astral plane that moderates the love of others and humanity. Brennan described every other layer (1, 3, 5, 7) as highly structured, as if they serve as boundaries for the three, more fluid layers. She sees the structured layers as standing waves of scintillating light patterns with tiny electrical charges moving along them; the alternating layers appear as constantly moving colored fluids. According to Brennan, the aura is not like an onion, with separable layers. Rather, each layer interpenetrates the others, as well as the physical body, which is considered the densest layer. Brennan's seven-layer model also reflects chakra functions, with each auric level associated with a chakra.[33]

Kunz defined the aura as dense light and as "the personal emotional field."[34] She described it as a 12 to 18 inch thick multicolored elastic oval light that interpenetrates and surrounds the physical body. A green band that encircles the middle of the physical body links two colorful hemispheres. (See Table 8–4.) The upper hemisphere embodies "the innate qualities or character of a person: one's potential, which may or may not be fully realized in life. In one way these colors represent what a person essentially is, or can be."[35] While it changes over a lifetime, it is more stable than the lower hemisphere, which reflects one's past experiences and actions and is influenced by one's emotions. The lower hemisphere is divided further: the auric colors from the waist to the knees reflect the person's usual emotions; the colors below the knees to beneath the feet carry memories of his or her past experiences. The green band encircling the middle of the physical body begins to appear in children and widens as one matures. "It indicates our ability to put our ideas, feelings and interests into action, or, to state it differently, to actualize our potentialities."[36] The wider the green band, the more capable the person is of expressing himself or herself intellectually, artistically, and physically. Kunz believed that the color of the band related to one's work. For example, she saw yellow-green bands in people engaged in intellectual activities, blue-green in artists, and darker green bands in physical laborers. She added that chakras are an integral part of the anatomy of the aura.

While the two descriptions differ, they have several similarities. Brennan's seven-layer model contains two planes, the physical and spiritual, bridged by the astral plane. Kunz's model identifies a lower hemisphere of the present moment linked to an upper hemisphere of potential

Table 8–4 Chakra Functions and Aura Interpretations

Chakra Levels and Function	*Brennan's Aural Levels*	*Kunz's Aura Levels*
7, Spiritual 6, Intuition, insight 5, Speak own Truth	Spiritual	What a person can be
4, Heart, love	Astral body Love of others and humanity	Green band
3, Emotions 2, Re-production creativity 1, Survival, security	Physical Day-to-day life	Emotions and past experiences



Source: Data taken from B.A. Brennan, *Hands of Light: A Guide to Healing through the Human Energy Field* (New York: Bantam Books, 1987), pp. 47–54; D.v.G. Kunz, *The Personal Aura* (Wheaton, IL: Quest Books, 1991), pp. 39–41; Kunz's aura levels have been assigned to chakras by V. Slater.

by a green band of actualized potential. Both believe that chakras are integral to the aura. Bruyere perceives the heart chakra as green, suggesting that Kunz's green band and Brennan's astral body may be the same phenomenon seen through different eyes. Brennan's and Kunz's descriptions of the astral plane and green band resemble transformers.

The differences between Brennan's and Kunz's interpretations of the aura can be explained by Benor's research on multiple healers making simultaneous intuitive diagnoses of the same person. According to Benor, each healer "had the impression that he or she was perceiving THE true picture of each patient's condition, rather than *one out of many possible* pictures of this reality."[37] Benor and the healers were surprised that the differences in impressions far exceeded the similarities. Even though the healers' information was substantially different, patients found most of it relevant and helpful. Benor proposed

that intuitive diagnosticians obtain their impressions through a "window of observation" and that individual healers may have "blind spots." He recommended that intuitive diagnoses and healing treatments given by multiple healers might be more useful than those given by only one healer.[38] Just as Benor's healers saw different truths in the same aura, perhaps Brennan and Kunz have each seen different aspects of the aura.

Physics Explanations of the Aura

Brennan's description of the aura as layers of magnetic density that diminish as one moves further away from the body resembles physics' description of an electromagnetic field. (See Figure 8–3.) An electromagnetic field results whenever electrical charges change locations and speed. Electromagnetic fields decrease in density from core out, varying in strength with the square of the distance from the source. The electromagnetic field layer closest to the core is the densest, the next one is one-fourth as dense, and the third one is one-ninth. Field strength decreases rapidly at first but never reaches zero. Hence physicists will not say that an electromagnetic field disappears, only that it becomes undetectable.

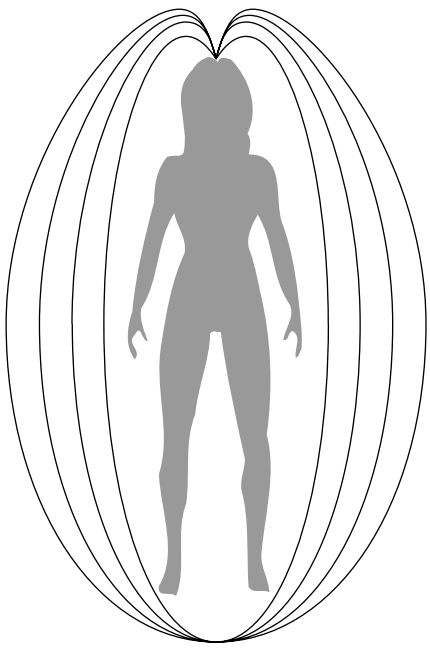


Figure 8–3 The Electromagnetic Human. *Source:* Copyright © 1999, Carol Eckert.

Engineers harness moving electrons to create electromagnets by surrounding an iron core with an electrical field. The human body has all the requirements of an electromagnet: the iron in hemoglobin surrounded by moving electrical charges to produce magnetic fields. Medical science uses the magnetic nature of the human body for diagnoses. The heart's magnetic field is measured with a magnetocardiagram (MCG), and the head's weak magnetic field is assessed with a magnetoencephalogram (MEG). The well-known MRI (nuclear magnetic imaging resonance) produces pictures of the body at the cellular level.[39] As science learns more about the magnetic nature of the body, electromagnetic healing devices will be developed. The primary healing of the future may be electromagnetic, through man-made machines and expert healers.

Intuitive Explanations of the Aura

The best way to understand the electromagnetic nature of the aura is to experience it yourself:

> Take a moment to sense your own electromagnetic field. Begin by stirring up the electrons in your hands. Rub your hands vigorously until you feel heat. Separate your hands slightly and notice the amount of pressure, heat, or other sensations between them. Slowly, move your hands further apart. Do you feel changes in the density, heat, or sensations as your hands separate? Move your hands closer to each

other. Do you sense any changes in pressure, density, temperature, tingling, movement, or anything else? Move your hands in and out several times, varying the speed and distance. Sometimes it is easier to feel other people's electromagnetic field levels rather than your own. Sense the electromagnetic layers surrounding several people by moving your hands around their bodies. Compare an area that hurts to one that doesn't. Notice the differences in the fields of an athletic person versus a sedentary one, of a man and a woman, and of a child and an adult. Sense your pet's field. Sense your own field again. What did you discover about the electromagnetic nature of your family, friends, pets, and yourself?

The aura can be damaged through surgery, radiation therapy, accidents, hateful stares, not speaking your own truth, and innumerable other traumas. Such wounds cause a person's energy to "leak out," leading to a host of physical, emotional, and social problems. Energetically, it feels as if the person "does not hold a charge;" i.e., a sense of power builds but then seeps away. Energetic healing can heal auric wounds, which will reduce fatigue, pain, lethargy, and other problems.

OTHER FORMS OF ENERGY: SMELLS, AROMAS, SOUNDS, COLORS, AND TOUCH

Nature designed senses, chakras, and meridians to receive all of the information in the environment. Eyes receive electromagnetic light, which moves in a shearing, back-and-forth motion. Ears process data carried on sound waves that move forward in a pulsing motion. We interpret taste and smell when molecules touch the tongue and structures in the nose. Touch, from a quantum perspective, is an electromagnetic interaction, one electromagnetic field encountering another. All data is converted into an electrical signal for the brain to interpret with the help of the chakras. Any form of energy has impact and will elicit and change a person's field and the information that is stored within it. Such a change can be negative or positive, depending on the integrity of the aura and conditions of the chakras.

In addition to the laying-on-of-hands approach to energetic healing, the senses offer other physics-based approaches to healing: *Aromatherapy* uses scents with and without massage to calm, excite, heal wounds, clear lungs, and loosen tight chests, among many other benefits. The body responds to the frequencies of odors in fairly predictable ways; the mind's and emotion's responses are more personal. One may remember a long-forgotten person or event when smelling an aroma associated with an earlier time in life. *Sound and music therapies* use both the pressure of sound waves and musical tones to calm, excite, stimulate people in comas, and assist the dying. Music to assist the dying is written to help open the chakras so that the person's spirit can more easily leave when it is time. Good symphonies move the sound through the entire chakra chain, leaving the listener calm and peaceful. However, music at some rock concerts stimulates fans' root chakras, but does not move the energy up through to the seventh chakra. Perhaps one reason for violence after such concerts is that the energy stimulated in the root chakra is not dissipated by the music. The effects of *colors* on mood is widely recognized and is used in emergency rooms and prisons to calm waiting patients or prisoners. When *touched*, especially when getting a massage, one may spontaneously discover pieces of their own histories that they may have forgotten or see in a new light. All of our senses are stimulated every day, and, just as energetic healers

do, one can choose colors, sounds, aromas, and touch that will encourage healing.

THE HEALER

Energetic healers' responsibility is to develop and maintain themselves as instruments of healing. Any instrument must be calibrated for the job at hand. Motoyama's discovery that practiced meditators control the output of their chakras offers insight into how expert energetic healers maintain a healing state. Self-control such as the meditators displayed is a type of self-referencing biofeedback, as described by Green and Green.[40] Biofeedback uses machines to provide feedback for biological control, but self-referencing biofeedback uses one's awareness of internal states for feedback. Energetic healers learn to use heart rate, sense of peace, inner calm, and other personal states as cues to create a lowered, more stable heart rate and a more coherent electromagnetic field.

Energetic approaches such as Healing Touch and Therapeutic Touch are called heart-centered modalities. Practitioners are taught to "stay in their hearts," called *centering*. Studies by the Institute of HeartMath have shown that one can learn to control one's own heart rate variability. HeartMath subjects were instructed to intentionally shift their attention to their heart and feel different emotions. When they felt frustration, their hearts developed a great deal of variability; when they felt appreciation, their heart rate variability decreased, and it decreased even more when they felt love. When they reduced their heart rate variability to near zero; i.e., when the heart fired at very regular intervals, they experienced a decrease of random thoughts and feelings. This state is identified as *internal coherence*. Subjects with healthy hearts were able to increase their internal coherence after they practiced a centering technique involving mental and emotional self-management, and decreased their heart rate variability for 6 to 36 months.[41] The HeartMath studies demonstrate that one's state of mind and emotions influence the rate, rhythm, and strength of heartbeat. The reverse is also true: the heart's rhythm influences the mind, emotions, and spirit.

One of the reasons that energetic healers influence a client's field may be due to the decreased heart rate variability. The heart produces one of the strongest magnetic fields in the body, and its magnetic influence is reflected throughout and beyond the body. The pulse spreads out in front and behind the body and can be detected up to 15 feet away.[42] When expert energetic healers maintain a coherent electromagnetic field, they experience a state of deep peace, inner harmony, and a steady heart rate. Just as in transformers, a change in one electrical current will induce a change in another. The healer's stronger, steadier, and more coherent field will induce a change in the client's field. The client's heart may adopt a similar heart rate, contributing to the client's deep peace and inner harmony—states that are common during energetic healing treatments. An expert healer will be able to maintain a more deeply centered state longer and more consistently than will a novice.

Healers also identify a healing intention. A common intention is that the treatment will be for the highest good of the client/patient, with harm to none, and aligned with Divine will. Gough and Shacklett define intention as focused choice and list four physiological consequences: "intensity of feelings, heart-felt motivation, lowered heart rate variability, and brain hemisphere synchronization."[43] Intention may add to the effect of an energetic healing treatment by increasing the intensity of heart-felt caring, the sense of peace due to decreased heart rate variability, increased brain wave synchronicity between client and healer, and increased

healer coherency. Synchrony between the weak magnetic fields of the healer's and client's heads may contribute to the common experience of each person seeing the same scene during a treatment, or having the same gestalt at the same time.

While a great deal of effort has gone into studying the brain wave patterns of meditators, energetic healers, and others, no one knows precisely what the electrical activity means; only that alpha and theta rhythms are present during meditative, healing, and other contemplative states.[44] Theta EEG activity is electrical energy between 4 and 8 cycles per second; alpha activity occurs between 8 and 13 cycles per second. Electroencephalogram (EEG) studies indicate that the healing state differs from the relaxed and the meditative states. Practicing meditators routinely increase their alpha rhythm during meditation, but energetic healers experience high amplitude alpha, beta, and gamma rhythms during relaxation and meditation. Healers produce high frequency, high amplitude beta and gamma rhythms and low amplitude theta rhythms during sessions with the client present, and during long-distance healing sessions when the client is not present.[45] Of greater interest than the actual rhythm was the synchrony that existed between the EEG patterns of client and healer even when they were not together.[46] Other studies have shown similar EEG synchrony between people, such as that between a psychoanalyst and patient, that is proportional to the amount of empathy between them.

EEG patterns, however, do not really *explain* what is occurring in a healing state. Atwater points out that EEGs measure brain function, but that mind-consciousness is not the brain. Mind- consciousness appears to be a phenomenon that uses the structures of the brain, rather than being limited to the brain. Thus EEG readings merely provide an indirect means of assessing how the mind-consciousness interacts with the brain.[47]

In the 1980s Zimmerman studied the magnetic fields of therapeutic touch practitioners' hands with the superconducting quantum interferometric (interference) device (SQUID).[48] Superconductors are materials that conduct electric current perfectly; that is, they offer no resistance to the electrical flow. Researchers have used the SQUID to detect some of the weakest human biomagnetic fields, such as the one emitted by the brain. During Zimmerman's study of therapeutic touch practitioners, the client and practitioner were in a magnetically shielded chamber. The practitioner touched the client before entering a centered-intention state to get a baseline reading. Immediately upon centering, the SQUID detected a huge biomagnetic field emerging from her hand. The field was so strong that the equipment had to be readjusted in order to record the response. The signal pulsed from 0.3 to 30 Hertz (cycles per second), mostly in the 7 to 8 Hz range, meaning that the biomagnetic field coming from the healer's hands swept or scanned through a range of electromagnetic frequencies concentrating in the alpha–theta range. Zimmerman was unable to detect similar pulses from nonhealers.

Sisken and Walker[49] report multiple studies of the effects of pulsed electromagnetic fields (PEMF), which are similar to the biomagnetic fields that healers emit. Studies have tested the effects of 0.5 to 500 Hz on would healing fields. The evidence indicates that various tissues respond to specific frequencies but not others, and that most tissues respond to very, very low electromagnetic frequencies. For example, a 22% increase in nerve regeneration occurred in cultures exposed to PEMF for .05 and 2 Hz. Crushed nerves in rats regenerated faster at 2 Hz, but transected nerves healed faster when exposed to 15 Hz PEMF. There is also enhanced growth of endothelial cells at 15 Hz. Ligaments healed faster in a 10 Hz PEMF environment. Studies of PEMFs on skin

healing are especially interesting to healers. At 15 Hz, there is increased growth of endothelial cells and small capillaries. With the faster development of small capillaries, there is a reduced risk of skin necrosis. One study demonstrated that rats with surgically created skin flaps who had PEMFs applied to their wounds immediately after surgery and for the next 5 days had significantly less necrosis when compared to the untreated controls. The greatest decrease in necrosis occurred on the third day. Sisken and Walker's review of the effects of PEMF gives tentative support to healers' claims that wounds heal faster with energetic healing, and that results improve even more rapidly with multiple treatments.

Jacobson et al.'s research supports Sisken and Walker's findings. The Jacobson team treated severed mice leg nerves with a picotesla range magnetic field (a very, very, *very* low magnetic field). Control nerves that were not treated degenerated and decayed; treated nerves maintained cellular and subcellular integrity over several weeks.[50] The picotesla magnetic fields are within the range that healers emit and may account for research results showing that energetic healing accelerates the rate of wound healing in mice and humans.[51,52]

THE ONE BEING HEALED

The aura, meridians, chakras, and five senses are the means by which information is gathered, transmitted, and stored. They do not interpret or give meaning to the data, just process it. Each person stores their data, the meaning given it, and details of every experience since birth in the subconscious and unconscious minds. Two quantum theories, holography and consciousness-created reality, may help explain how energetic healing helps people heal. Holographic theory is about information storage; the theory of consciousness-created reality purports that consciousness is the force that selects the information that will become apparent; i.e., that which will appear real.

Holographic Theory

Herbert describes the universe as depicted by holographic quantum theory as a universe of undivided wholeness, "a seamless and inseparable whole."[53] Holograms are means of storing information in a network of energy waves of various frequencies. The network is also called *interference patterns*. An easy way to imagine such interference patterns is to think of music. Many notes played randomly create a type of sound interference; if they were all played at the same time, it would merely be noise. But if each individual note contained information, then an immense amount of information could be stored in one sound. Getting to it would be the problem. To extract data, you would need to isolate one specific note from the many. Holography is like that. An immense amount of data is stored on overlapping and interfering frequencies of light that can all be stored in virtually the same space. For example, ten billion bits of information have been stored holographically in a cubic centimeter; a similar amount of data stored by conventional means would fill a shoebox. Scientists use coherent light of the right wavelength to extract data from an interference pattern. A holographic, seamless, and inseparable universe of overlapping frequencies is an information-filled universe. We are frequencies within that whole; to extract our data, we need coherent light of just the right frequency.

All data received from the environment and from our choices, intuitions, and insights is transferred into an electrical signal that is sent to the chakras and brain for interpretation. If such data were stored holographically, then the experiences of a

lifetime could be stored within the human body and field. Data may be stored holographically in the lymph, blood, and intercellular fluids in the same manner that information is stored in homeopathic solutions. Perhaps, as in homeopathy, the more dilute the information, the more influential it is. Energetic healers and clients may experience such holographic images when pictures of a client's past suddenly appear in the client's and/or healer's minds.

The event, the place, the emotions, and the thoughts of a client's past experiences can emerge as a gestalt or in snippets. Clients who have been traumatically abused appear to store data holographically in their body, and they tend to remember it in little bits at a time. Other types of energetic abuse, such as hatred, anger, witnessing abuse, and other less directly physical situations may be stored primarily in the hologram of the energy field. Some data may be stored and revealed in a gestalt, while other experiences may be stored as a gestalt but remembered in bits and bytes. More traumatic experiences seem to be remembered in smaller chunks than less traumatic ones, which may be revealed as an entire scene.

At the time of any incident, only part of the situation is meaningful; as more is revealed, a client will see the larger picture and will understand more. This allows additional insight and the opportunity to give different meaning to the episode. The client now can choose a response, rather than reacting automatically.

The collective unconscious, tribal memories, and past life memories may also be partially due to holographic data storage. Past life memories may be frequencies stored as part of the interference pattern of the collective unconscious of the inseparable, whole universe. Tribal and personal experiences may be stored in DNA. Because meridians reach through the cytoplasm to the cell's nucleus, all of one's physical, emotional, mental, and spiritual experiences may be stored within the cell's cytoplasm and nucleus. The egg and sperm (i.e., DNA) may store the parents' biological information, as well as their emotional responses, preferences, prejudices—even how they interpreted their own experiences. It is conceivable that DNA carries the same information of every biological ancestor. Thus, conception brings not just the physical legacy, but also the emotional memory of many generations.

Holographic theory can help explain how energetic healers may help clients recover and heal their own stories. Zimmerman's study found that the light that was emitted from therapeutic practitioners' hands covered a range of extra low frequencies (ELF), concentrating in the frequency of brain waves. Perhaps the ELF pulses a centered healer emits are the coherent frequencies needed to reveal details of a person's experiences.

Consciousness-Created Reality

The second quantum theory useful to energetic healing is consciousness-created reality. Quantum theory is concerned with the particles and their activities that are at and below the level of the atom.

> To make the theory of consciousness-created reality personal, first imagine the distance between the earth and the moon. How much space separates them? That space is filled with moving particles of energy. Now think about the atoms in your body. Relative to their size, there is more space between the nucleus of an atom and its electrons than between the earth and the moon. What fills the space that you believe is you? Moving particles of energy. How do they become you?

Quantum physics deals with minuscule particles moving within quantum space. As they move, they create nonphysical waves of light called electromagnetic

waves, or radiation. The tangible world we sense emerges, somehow, from these waves of visible and invisible light. How? One theory is that all possibilities reside within those quantum waves (which have no substance; they are inferred, mathematical, and called a quantum wave function). Perhaps all possibilities are stored holographically in quantum waves. When something measures (a physics word) or observes the quantum activity, some actuality "collapses" out of all possibilities. One quantum theory is that the act of measuring—the observing of the quantum potentialities—is what forces an actuality to appear. The major question is, "What does the observing?" The theory of consciousness-created reality suggests that the observer is consciousness,[54] perhaps each individual's Conscious self, Higher Self, the Divine's, or all.

> Take a moment to look at your life, your day. What would you like to have happen? Be clear. No ambiguities, no doubts. If you can't be clear on what you want, select something you are clear about. Imagine it happening. For 33 seconds, imagine exactly what you want. Let the image switch immediately to black. Do the 33-second meditation as often as you choose until what you want occurs; i.e., collapses into actuality.[55]

Understanding chakras gives us another view of how we may consciously create our own reality. Note on Table 8–2 that the information processed by the chakra chain is colored by the programming in the root chakra. Whatever a person defines as safe or unsafe, and their emotional response, will influence every experience.

> Play with consciousness-created reality. Try to change a situation by changing what you feel, what you emit from your chakras and aura. Can you change the mood in a room without saying anything? Try feeling love while listening/talking to someone. Try feeling sad, angry. Let yourself experiment with how the emotion you feel changes another person's response to you.

Assagioli's Seven Dimensions of the Psyche

Energetic healing can help open people to their higher levels of consciousness. The person focused primarily on the lowest chakra needs will create his/her reality from the perspective provided by the focus on security, reproducing security, and the emotions surrounding it. The individual who has matured to the higher chakras will create a very different reality. What type of consciousness has the potential to grow into a consciousness that is capable of insights and spiritual reflection? Assagioli's[56] seven dimensions of the psyche offer a useful model. As can be seen in Figure 8–1, Assagioli portrays the psyche as containing three levels of the unconscious and two selves. The three levels of the unconscious—the lower, middle, and higher—contain our past, present, and future, which is similar to Kunz's aura model. The Lower Unconscious contains our fundamental drives, emotionally-charged complexes, phobias, delusions, and the elementary psychological activities that enable humans to survive. We assimilate and gestate our experiences in the Middle Unconscious before we become aware of them. This is similar to the functions of chakras. The Higher Unconscious, or Superconscious, is the realm of our higher intuitions, inspirations, and feelings. It is much like Kunz's upper hemisphere of potentials and Maslow's seventh level of aesthetic needs.

The two selves are the Personal self, the I that is the center of consciousness, and the Higher, or Transpersonal, Self. The Personal self is directly aware of momentary sensations, images, thoughts, and feelings within the Field of Conscious-

ness, which may contain data the meridians and chakras process. The Transpersonal Self, that sees more globally, has no corresponding structure in Kunz's or Brennan's models, nor does the Collective Unconscious that is the sea of unconscious in which our psyches are bathed. We are separated from and united with the Collective Unconscious by a semi-permeable consciousness boundary. This porous boundary appears to separate us from, but gives us access to the frequencies of, the inseparable whole universe. When we focus primarily through our Personal self, we feel more separated; when we access our Transpersonal Self, we realize our oneness with the whole.

The quantum theory of consciousness-created reality holds that consciousness is the observer that selects one actuality from among all possibilities. Assagioli's dimensions of the psyche suggest that our Personal self, I, may prioritize the various sensations and perceptions gestating within our pre-waking Middle Unconscious. It may be the consciousness that creates a reality that is based on our relatively automatic perceptions and responses. The Personal self is not able to separate emotions, perceptions, and habitual responses to experiences. Only when the data package of sensations, perceptions, experiences, emotions, and thoughts reaches the higher chakras and, in time, the Transpersonal Self with its wider viewpoints, will a person be able to understand the larger picture. The person's Transpersonal Self creates a different experience by knowingly choosing responses, rather than allowing the lower aspects of consciousness to do so. The Transpersonal Self is present when we are asleep, unconscious, or in meditation, and is the aspect of consciousness that is instrumental in healing hidden wounds and beliefs that no longer serve us. Energetic healing can help move a person's energy up to the higher chakras; after numerous treatments, one becomes comfortable with the insights available in those higher chakras and can learn to access them without assistance. Energetic healing is not necessary to access the higher chakras, but it makes the process more efficient.

TWO POTENTIALLY INTERESTING CONCEPTS FOR ENERGETIC HEALING

Several tantalizing areas of research and conjecture hold promise for understanding the effects and phenomenon of energetic healing. One is biophoton emissions, which may explain some of the more dramatic energetic healings, and the other is the body's geodesic dome-type structure.

Biophotons

Biophoton emissions, or bio-electromagnetics, are very weak pulsing ultraviolet (nonvisible) light emitted by cells. Biophotons appear to be part of the biological system as a whole, not just part of single cells. A biological system maintains a relatively consistent size; when one cell dies, another replaces it. The dying cell (and thus, the resultant loss of biophoton emission), may cue the cell population to reproduce. The biophoton theory holds that the cell loss–cell division balance is mediated through the UV light that is emitted from cells. Active DNA in a living cell may be one of the primary sources of biophoton emissions.[57] They are believed to trigger cell division and have been detected in cultures of *candida utilis* about one hour before each of the two phases of cell division. Cancer cells emit too many biophotons when compared to normal cells, and sclerotic cells too few, suggesting that the overgrowth of cancer cells and diminished growth of sclerotic cells may be due to the quantity of biophotons emitted. Biophoton emissions are temperature dependent,

with more emissions at a higher body temperature than at a lower one. Stress is often accompanied by increased biophoton emissions.

Van Wijk alludes to what may be a major scientific endeavor of the future: integrative biophysics. He writes that "physicists see their task, in contrast to most biologists, in treating things simply, in order to understand complicated phenomena in a unified way, in terms of a few simple principles. One of these principles may be found in coherence."[58] He proposes that biophoton emissions are a feature of a coherent communication among all members of a cell population.[59] He believes that the speed of light communication among cells provides "the basic communication of cells in an organism . . . [and] might help to understand cancer growth in terms of rather fundamental properties of a coherent field."[60]

Cell-to-cell communication, also called bio-information, may be an effect of biophoton emissions. Two groups of similar cells, such as mammary or endocrine cells, were placed near each other, but separated by a quartz shield. Biological contact was impossible, but ultraviolet light (i.e., electromagnetic radiation) could pass through the shield. One cell group was stimulated to secrete hormones, and shortly thereafter, the second cell cluster began to secrete. The only known means of communication was through the pulses of UV light between the cells, suggesting that this light meditated cell-to-cell communication.[61]

Information on biophoton emissions generates a number of questions for energetic healing, but no answers. Healers in a coherent, centered state emit low frequency light. Does this light interact or influence the client's cellular biophoton emissions? Is this one means by which energetic healing helps bring systems into balance? When energetic healers sense distortions in the client's energetic field, are they detecting areas that are less coherent than the rest of the body? No research has been done to determine if there is biophoton communication between the collective cells of the healer and those of the client, and if there is, what is the resulting effect. However, Benford discovered that "individuals skilled in the art of bioenergy techniques, induce the fluctuation of high-energy light waves (photons) more dramatically than those not trained in bioenergy techniques, regardless of purposeful intention to heal."[62] This finding may explain why research in which trained practitioners gave mock treatments consistently had statistically nonsignificant results.[63] The trained practitioner was providing an effect by virtue of training that confounded the research results. The mock treatment was not mock. Biophoton emissions may influence healing responses, but the science is not yet sophisticated enough to determine whether a healer has impact on those emissions and the results.

Tensegrity and the Geodesic Dome Human

Tensegrity, a concept developed by R. Buckminster Fuller, is the basis of geodesic domes and pop-up tents, among other structures. The tension created by the stick-and-wire arrangement maintains the structure. Oschman reviewed Ingber's work showing that every level of the body—nucleus, cell, tissue, skeletal structure—behaves like a tensegrity structure. Tendons and muscles attached to bones create a three-dimensional tensegrity network that supports the body and permits flexibility and movement. "Tensegrity accounts for the ability of the body to absorb impacts without being damaged. Mechanical energy flows away from a site of impact through the tensegrous living matrix. The more flexible and balanced the network (the better the tensional

integrity), the more readily it absorbs shocks and converts them to *information* rather than *damage*."[64] When the tensegrity matrix is torqued, twisted, shortened, or tense in one area, the entire structure loses flexibility and balance. The result, for example, can be a tilted pelvis that results in one leg being "shorter" than the other, a twisted spine, pain, and numerous mild to severe chronic discomforts. All of this from a tensegrity structure that is out of balance.

The connective tissue (the myofascia) is part of this tensegrity system. The myofascia is a thin, spider web-like mesh that acts like thin wires supporting all of the internal "soft" structures, such as organs, nerves, veins and arteries.[65] Any impact to the body is felt throughout the entire myofascia network and can result in an energetic bottleneck. A flexible, balanced tensegrity structure allows the energy flow; it does not trap the energy, and thus avoids the formation of an energetic bottleneck. Over time, energetic bottlenecks will become larger, denser, and stronger, and can result in chronic problems. Some causes of such energetic obstructions are surgery, accidents, physical abuse, physical responses to emotions, and even birth.

The Bowen technique, a hands-on energetic therapy, is described as a myofascial release treatment.[66] As the practitioner gently move tendons and connective tissue in a prescribed formula, the tensegrity structure begins to vibrate and clears energetic obstructions. As tension is released, the structure of the body relaxes into a more balanced shape. Chronic structural pain can be relieved in a few treatments. As the twists and torques of the system relax, old emotions that have been trapped in the bottlenecks or torques of the system are released. As the tensegrity system returns to more of a balanced state, an energetic healer can more easily impact the meridians, chakras, and aura, thus healing rips, tears, and other wounds that diminish a person's power, cause physical and emotional problems, and retard emotional and spiritual growth.

RESEARCH AND RESEARCH IMPLICATIONS

Research on energetic healing has multiplied and improved rapidly. Benor has analyzed results of laying-on-of-hands energetic healing research with yeast, bacteria, plants, small animals, and humans. The preponderance of evidence from more than 120 studies is that energetic healing with a healer's hands held on or near the body is effective. Three of the most intriguing studies are Smith's studies of the effects of energetic healing on enzymes, and her suggestion that energetic healing moves an organism toward greater health. In each study, healers held enzyme solutions. In the first study, Smith tested the response of trypsin, which increased in metabolic rate. Trypsin participates in the breakdown of proteins, providing needed amino acids to the bloodstream. Smith reasoned that an increase in trypsin activity could contribute positively to the health of the organism. In her second study, she tested the effects of healing on an enzyme whose decreased activity supports greater health. Treatment of nicotinamide-adenine dinucleotide (NAD) by three healers showed a decrease in metabolic activity. The third study was of amylase-amylose, which indirectly triggers an increase in insulin secretion: An increase in insulin can lead to diabetes, so increasing amylase-amylose activity could be detrimental to health. None of the healers' treatments changed the enzyme's activity. Smith suggested two reasons for the result: The sample might have been impure, confounding the results, or the amylase-amylose system was balanced and optimal for the donor. In this study, the healers provided their own

blood for the test and were attempting to influence only one factor within the blood. While an impure sample might be a reasonable concern in a laboratory experiment, working with the entire blood picture is of more interest to healers, who deal with living people. Smith's three studies excite the imagination but, as Benor states, her conclusion that energetic healing moves an organism toward greater health is premature.[67] Additional studies of this intriguing hypothesis are needed.

Other interesting studies were on the effect of energetic healing on water used to water plants. Of interest to energetic healers is that water held by a healer had less surface tension than water held by a nonhealer or not held at all.[68] No research has been done on the changes in surface tension of human fluids following energetic healing. For example, a change in the surface tension of blood, urine, and other bodily fluids may influence the absorption of medications.

The immune effect of energetic therapies needs to be further studied. Bengston and Krinsley tested energetic healing of mice with mammary adenocarcinoma. The 33 mice that were treated had an 87.9% overall cure rate compared to 100% death rate of the untreated control group. Of particular interest is that none of the experimental mice had a recurrence of cancer and, even when they were reinjected with cancer cells, did not contract the disease again.[69] Quinn and Strelkauskas tested the immune effects of energetic healing on humans and found that bereaved subjects had positive changes in one immune factor. Their suppressor t-cells that keep the immune system suppressed were reduced, which indirectly enhanced the person's immune status. They also discovered that the two healers involved either increased their immune state or maintained an already high one.[70]

The few studies reported here are but a small sample of the 120-plus energetic healing studies from a number of healing traditions, including laying-on-of-hands, Healing Touch, Therapeutic Touch, and Reiki, to mention a few. Research findings suggest a number of implications for future research of energetic healing therapies, but first, the methodology that will best reveal the effects of energetic healing needs to be identified. Tiller lists a number of factors that can influence study results, even studies being repeated by the same researcher. "[Such] factors include the levels of background radiation, the local magnetic field, geocosmic factors such as sunspot activity—and most importantly, the subject himself or herself, that is the physiological state, focus, intention, and degree of inner self management and internal coherence, especially over time."[71]

Vandeveer listed six principles that should be taken into account in any research, energetic or conventional: (1) subject variable, (2) provider variable, (3) direction of greater health for the subject, (4) the interaction of factors 1–3, (5) the nature of a holistic person, and (6) clinical versus statistical significance.[72] Subject variable includes the person's thoughts before, during, and after a treatment, their physical and emotional states, and, as Tiller stated, their degree of inner self-management. Provider variable includes the experience and training of the provider, and how often they give energetic treatments. The direction of health of the subject, as implied by Smith's studies, suggests that researchers must not measure only the effects of a treatment, but must measure them against the greater health of the subject. One implication of the principle of greater health for the individual is in the use of healthy volunteers as subjects in energetic healing research. Because they are healthy, the treatment can be expected to have little or no effect, which is likely to give the impression that the treatment was ineffective. In fact, the

treatment may have been inappropriate for that volunteer. Healthy volunteers cannot be used in research of energy therapies because they are healthy, and healers believe that treatments will not take them out of a healthy state. This belief needs to be tested.

The fourth principle (the interaction of the provider, the subject, and the subject's healthiest state) cannot be known. How a subject responds to a provider will impact the outcome of a study. Studies with small populations and only one provider should be replicated using several expert energetic healers to provide treatments. Meta-analyses of research studies are needed. The fifth principle (the holistic nature of humans) dictates the subject's response, which requires that researchers look at the psychosocial variables that impact treatment responses, such as family, support, and emotional states. Finally, the sixth factor (significance of results) needs to be reported in terms of statistical significance and clinical significance. Statistically nonsignificant studies may be very significant clinically. If three people out of ten have permanent relief of chronic pain, there is clinical significance, even though such results are not statistically significant. The clinically, but not statistically significant, studies may provide greater insight into other factors that play a part in healing, including the nature of the subject, the provider, and their interactions.

Research in energetic healing adds to the growing body of evidence showing that experimenter's expectations influence a study's results.[73,74] But the theory of consciousness-created reality suggests that the subject's expectations also influence results. As Harman notes, there is "an issue of the degree to which research must be participative."[75] At a minimum, investigators need to know what subjects expect from treatments. Clinicians may want to ask clients the same question.

Some additional directions for future research are:

1. Examine the life changes that occur after individuals receive a series of energetic healing treatments.
2. Determine whether meridians participate in the immune function and what psychoneuroimmunological responses follow meridian techniques.
3. Determine if conditions such as hypertension, multiple sclerosis, and stress respond to meridian techniques.
4. Explore whether routine meridian and chakra treatments retard symptoms of diseases of the perineural cells, such as multiple sclerosis.
5. Determine how chakra techniques influence recovery from addictions and alcoholism.
6. Study the effect of energetic interventions on the process and results of counseling.
7. Examine the emotional responses that occur and what information emerges when someone is exposed to the pressure waves of sound.

CONCLUSION

This chapter reviewed what is known and what is intuited about meridians, chakras, and the aura. When viewed as a whole system rather than as separate structures, they can be seen to contribute to the individual's physical survival and to their emotional and spiritual growth. Energetic healing is the art of healing those structures so that the individual can heal physical, emotional, and spiritual pain. Healing is not instantaneous; it occurs gradually. Energetic healing promotes the *process* of healing. It makes the process more efficient, and increases the likelihood of success. The energetic healer assists the process, but does not direct it. Results

depend upon a person's choice and the effort they put into their own healing.

Assagioli's dimensions of the psyche offers a model of two levels of self. The Personal self provides a more limited, egocentric perspective of events, and the Transpersonal Self a wider view. Energetic healing will help a person access the Transpersonal Self more easily, enabling one's reality to be viewed more globally and making spiritual healing more likely.

In addition to subtle energy healing, such as in Healing Touch, Therapeutic Touch, and Reiki, healing modalities include the senses. Sound, light, smell, and touch impact the body, mind, and emotions. The impact can be incidental, traumatic, or healing. Energetic healers learn to use sensory stimulation for their healing effects.

The chapter concluded with a look at the future: the tantalizing discovery of biophoton emissions, which may be a key factor in disease and in healing, and the role of the body's tensegrity structure in our health. Science has just begun to look at these two phenomenon that have the potential to help explain the often profound effects of energetic healing that, to date, have been unexplainable. Research protocols will have to change to adequately study energetic healing, and new protocols and suggested guidelines may prove useful in traditional research. A few research topics are suggested to help stimulate thought and imagination.

Energetic healing does not stand alone; it is but one of many tools available to holistic nurses. It can help one heal chakras, meridians, auras; physical, emotional, and spiritual pain; and access the higher levels of the psyche. The goal of holistic nursing and energetic healing is the same: an integration of body, mind, emotion, and spirit, which leads to healing, peace, love, and joy within the self. As people change, so must the energy they emit, and this will change their world. Ultimately the person each of us needs to heal the most is ourselves. Most people who begin using energetic therapies soon realize that the energy they are working with is urging them to do their own healing work. Most will move deliberately into additional self-care, such as counseling, meditating, journaling, and/or receiving regular energetic healing treatments.

Take a moment to assess your journey. Is it deliberate? What means do you use to help resolve your hurts and pains, and the things that separate you from yourself and others?

Remember one thing that makes you angry, fearful, hurt, or feel a painful emotion. When was the last time you experienced this emotion? What was the situation? How old did you feel? Are you responding with the same response that you used as a child? Use the chakra healing exercise you practiced earlier in this chapter to move this painful emotion up to your Transpersonal Self for insight.

What data do your meridians and chakras give you about your environments? Close your eyes and invite your meridians and chakras to help you sense the space around you. Do the same in another room or when you are with friends, family, and at work. How do your responses change as the environment around you changes? Practice changing these situations with just your thoughts and emotions.

Look through the *AHNA Holistic Nursing: A Handbook for Practice* or another source, and select one modality you have not used before. Establish your healing intention and use it regularly for one month. Review your progress at the end of the month.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- How do my meridians contribute to my awareness?
- How do my chakras participate in processing information in my life?
- How easy is it for me to access my Transpersonal Self? How can I improve this? How can I help clients access their Transpersonal Selves?
- How can energetic healing blend with my practice as a holistic nurse? Do I wish to be a practitioner of energetic therapies, a client, refer clients to energetic healers, or all of the above?

NOTES

1. W.C. Gough and R.L. Shacklett, The Science of Connectiveness, Part III: The Human Experience, *Subtle Energies* 4, no. 3 (1993):187–214.
2. L. Dossey, Healing, Energy, and Consciousness: Into the Future or a Retreat to the Past? *Subtle Energies* 5, no.1 (1994):1–33.
3. J. White, Consciousness and Substance: The Primal Forms of God, *Journal of Near Death Studies* 5, no. 2 (1987):73–78.
4. Ibid., 75.
5. R. Assagioli, *Psychosynthesis: A Collection of Basic Writings* (New York, NY: Penguin, 1965).
6. V.E. Slater, Safety, Elements, and Effects of Healing Touch on Chronic Non-Malignant Abdominal Pain (Unpublished doctoral dissertation, University of Tennessee, Knoxville, 1996).
7. P. Benner, *From Novice to Expert* (Meno Park, CA: Addison-Wesley, 1984).
8. R. Becker and G. Selden, *The Body Electric: Electromagnetism and the Foundation of Life (*New York: William Morrow/Quill, 1985).
9. V.E. Slater, Toward an Understanding of Energetic Healing, Part I: Energetic Structures, *Journal of Holistic Nursing* 20, no. 10 (1995):209–224.
10. A. Weil, *Health and Healing* (Boston, MA: Houghton Mifflin Company, 1983).
11. R. Gerber, *Vibrational Medicine: The #1 Handbook of Subtle-Energy Therapies* (Rochester, VT: Bear & Company, 2001), 122–127.
12. Ibid., 124.
13. Becker and Selden, *The Body Electric*, 236–239.
14. Ibid., 142, 234.
15. S.S. Knox, Physics, Biology, and Acupuncture: Exploring the Interface, *Frontier Perspectives* 9, no. 1 (2000): 12–17.
16. Gerber, *Vibrational Medicine*, 127.
17. Knox, Physics, Biology, and Acupuncture, 13.
18. A.H. Maslow, *Motivation and Personality* (New York, NY: Harper, 1954).
19. C.W. Leadbeater, *The Chakras (*Wheaton, IL: Quest Books, 1927).
20. W.B. Joy, *Joy's Way: A Map for the Transformational Journey. An Introduction to the Potentials for Healing with Body Energies* (Los Angeles: J.P. Tarcher, Inc., 1987).
21. *The Power of Our Chakras: Removing Blockages to our Success*. Concept: Synergy. (NPN Publishing, Inc. ISBN 1-55638-296-0).
22. T. Gimbel, *Form, Sound, Colour and Healing* (Essex, UK: Daniel Company Limited, 1987), 65.
23. Gerber, *Vibrational Medicine*, 128–130.
24. Assagioli, *Psychosynthesis*.
25. Electronic Evidence of Auras, Chakras in UCLA Study, *Brain/Mind Bulletin*, 3, no. 9 (March 20, 1978).
26. Gerber, *Vibrational Medicine*, 132–133.
27. Ibid., 132.
28. I.M. Freeman, *Physics Made Simple* (New York, NY: Doubleday, 1990), 164.
29. R. Bruyere, oral teachings.
30. E.S. Wilson, The Transits of Consciousness, *Subtle Energies* 4, no. 2 (1993):177.
31. H. Yomata, oral teachings.
32. B.A. Brennan, *Hands of Light: A Guide to Healing Through the Human Energy Field* (New York: Bantam Books, 1987), 49.
33. Ibid.
34. D.v.G. Kunz, *The Personal Aura* (Wheaton, IL: Quest Books, 1991), 43.
35. Ibid., 39.
36. Ibid.

37. D.J. Benor, Intuitive Diagnosis, *Subtle Energies* 3, no. 2 (1992):41–64.

38. Ibid.

39. F.A. Wolf, *The Body Quantum: The New Physics of Body, Mind, and Health* (New York, NY: MacMillan, 1986).

40. E. Green and A. Green, *Beyond Biofeedback* (Ft. Wayne, IN: Knoll, 1977).

41. R. McCraty et al., New Electrophysiological Correlates Associated with Intentional Heart Focus, *Subtle Energies* 4, no. 3 (1993):251–268.

42. J.L. Oschman, What is 'Healing Energy'? Part 2: Measuring the Fields of Life, *Journal of Bodywork and Movement Therapies,* 1, no. 2 (1997):117–122.

43. Gough and R.L. Shacklett, The Science of Connectiveness, 198.

44. M.A. Tansey, Boundary Conditions: The Surrounds of a State of Mind, *Subtle Energies* 5, no. 2 (1994):180–194.

45. S.L. Fahrion, M. Wirkus, and P. Pooley, EEG Amplitude, Brain Mapping, and Synchrony In and Between A Bioenergy Practitioner and Client During Healing, *Subtle Energies* 3, no. 1 (1992): 19–52.

46. Tansey, Boundary Conditions.

47. F.H. Atwater. Accessing Anomalous States of Consciousness with a Binaural Beat Technology, *Journal of Scientific Exploration* 11, no. 3. (1997): 263–274.

48. J. Zimmerman, Laying-on-of-Hands Healing and Therapeutic Touch: A Testable Theory, BEMI Currents: Journal of the Bio-Electro-Magnetics Institute 2 (1990):8–17.

49. B.F. Sisken and J. Walker, Therapeutic Aspects of Electromagnetic Fields for Soft-Tissue Healing. In *Electromagnetic Fields: Biological Interactions and Mechanisms*, ed. M. Blank. Advances in Chemistry Series 250 (American Cancer Society, Washington, DC, 1995), 277–285.

50. J.I. Jacobson, W.S. Yamanashi, B. Brown, P. Parekh, D. Shin, and B.B. Saxena, Effect of Magnetic Fields on Damaged Mice Sciatic Nerves, *Frontier Perspectives* 3, no. 1 (2000):6–11.

51. D.J. Benor, Survey of Spiritual Healing Research, *Contemporary Medical Research* 4, no. 3 (1990):9–32.

52. D. Radin, Beyond Belief: Exploring Interactions Among Mind, Body and Environment, *Subtle Energies* 2, no. 3 (1991):1–42.

53. N. Herbert, *Quantum Reality: Beyond the New Physics. An Excursion into Metaphysics and the Meaning of Reality* (New York: Doubleday, 1985), 18.

54. Ibid.

55. *The Morning Tape*. Concept: Synergy (NPN Publishing, Inc. ISBN 1-55638-187-5).

56. Assagioli, *Psychosynthesis*.

57. F.A. Popp, Biophotons—Background, Experimental Results, Theoretical Approach and Applications, *Frontier Perspectives* 11, no. 1 (2002):16–28.

58. R. Van Wijk, Bio-photons and Bio-communication, *Journal of Scientific Exploration* 15, no. 2 (2001):183–194.

59. Ibid., 197.

60. Ibid., 190.

61. Ibid.

62. J.F. Quinn, Building a Body of Knowledge: Research on Therapeutic Touch 1974–1986, *Journal of Holistic Nursing* 7, no. 1: 19–25.

63. M.S. Benford, Comment on "The Effect of the 'Laying-On Of Hands' on Transplanted Breast Cancer in Mice" by W.F. Bengston and D. Krinsley, *Journal of Scientific Exploration,* 15, no. 1 (2001):126.

64. J.L. Oschman, *Energy Medicine: The Scientific Basis* (New York: Churchill Livingstone, 2000), 64.

65. R.L. Schultz and R. Feitis, *The Endless Web: Fascial Anatomy and Physical Reality* (Berkley, CA: North Atlantic Books, 1996).

66. D.J. Naddy, *The Bowen Technique: An Interpretation by Deanna J. Naddy RN, DSN* (Columbia: TN Self published manuscript, 2002), 2.

67. D.J. Benor, *Spiritual Healing: Scientific Validation of a Healing Revolution, Healing Research I* (Southfield, MI: Vision, 2001).

68. Ibid., 152–156.

69. W.F. Bengston and D. Krinsley, The Effect of the 'Laying on of Hands' on Transplanted Breast Cancer in Mice, *Journal of Scientific Exploration* 14, no. 3 (2000):353–364.

70. J.F. Quinn and A.J. Strelkauskas, Psychoimmunologic Effects of Therapeutic Touch on Practitioners and Recently Bereaved Recipients: A Pilot Study, *Advances in Nursing Science,* 15:4 (1993):13–29.

71. D. Stein, Book Review, Conscious Acts of Creation: The Emergence of a New Physics. By W.A. Tiller, W.E. Dibble, Jr. and M.J. Kohane,

Pavoir Publishing, Walnut Creek, California, USA, ISBN 1-929331-05-3, *Frontier Perspectives* 11, no. 1, (2002):42.

72. M. Vandeveer, personal communication.
73. A.H. Roberts, D.G. Kewman, L. Mercier, and H. Hovell, The Power of Nonspecific Effects in Healing: Implications for Psychosocial and Biological Treatments, *Clinical Psychology Review* 13 (1993):375.
74. R. Sheldrake, Experimenter Effects in Scientific Research: How Widely Are They Neglected? *Journal of Scientific Exploration* 12, no. 1(1998):73–78.
75. W.W. Harman, Towards an Adequate Epistemology for the Scientific Exploration of Consciousness, *Journal of Scientific Exploration* 7, no. 2 (1993):138.

Questioning the Rules of Science

Nothing is more important about the quantum physics principle than this, that it destroys the concepts of the world as "sitting out there," with the observer safely separated from it . . . . . To describe what has happened, one has to cross out that old word "observer," and put in its place the new word "participator." In some strange sense the Universe is a participatory universe.[1]

* * *

Nurses traditionally have relied on accumulated practice experience as though it were synonymous with knowledge. Nothing is more effective in shaking this belief system loose than a confrontation with the fact that not everyone's experience leads to the same conclusion.[2]

* * *

We are a peculiar people, we European/North Americans. We often demand to know why and how something works before we ask if it does. It isn't enough for us to experience something and to accept it. We can't accept something of value until we are convinced that it is logical, that the system fits within some preconceived mechanism or that it has been "proven" (by someone else) to work. We have even developed a unique system, the scientific method, to prove things. Science has become one of the special religions of our culture: it both regulates and comforts us.[3]

* * *

Great discoveries have been made by means of experiments devised with complete disregard for well-accepted beliefs.[4]

NOTES

1. J.A. Wheeler, Not Consciousness but Distinction between the Probe and the Probed as Central to the Elemental Quantum Level of Observations, in *Role of Consciousness in the Physical World*, ed. R. Jahn (Boulder, CO: Westview Press, 1981), 87–111.
2. F.S. Downs, Relationship of Findings of Clinical Research and Development of Criteria: A Researcher's Perspective, *Nursing Research* 29 (1980):94–97.
3. S. Eabry, *Massage* 47 (1994):36.
4. W.I.B. Beveridge, *The Art of Scientific Investigation* (New York: Vintage Books, 1957).

Chapter 9

Holistic Nursing Research

Cathie E. Guzzetta

NURSE HEALER OBJECTIVES

Theoretical

- Discuss ways in which the wellness model has redirected priorities in nursing research.
- Explore the concept of evidence-based practice.
- Compare and contrast quantitative and qualitative research methods.
- Read a quantitative research study (e.g., references 33–41) and identify the holistic implications.
- Read a qualitative research study (e.g., references 54–59) and identify the holistic implications.

Clinical

- Explore resources that can be used to establish an evidence-based practice in your clinical setting.
- Collect data from various clients who are participating in some form of complementary and alternative therapies to determine their subjective evaluations of their outcomes.
- Discuss ways to enhance holistic research with a nurse researcher.
- Design a holistic research study based on one of the questions found in the section "Directions for Future Research" at the end of this chapter.

Personal

- Set aside some time to learn more about research methods.
- Attend a research conference.

DEFINITIONS

Heisenberg's Uncertainty Principle: the idea that one cannot look at a physical object without changing it.

Meta-analysis: a statistical technique that combines the results of many studies related to a topic to establish an overall estimate of the therapeutic effectiveness of an intervention.

Placebo: a medically inert medication, preparation, treatment, technique, or ritual that has no specific effects on the body and is intended to have no therapeutic value.

Qualitative Research: a systematic, subjective form of research that is used to describe life experiences and give them meaning. Qualitative research focuses on understanding the whole, which is consistent with the philosophy of holistic nursing.

Quantitative Research: a systematic, formal, objective form of research in which numerical data are used to obtain information about the world. Quantitative research embodies the principles of the scientific method and is used to

describe variables, examine relationships among variables, and determine cause-and-effect interactions between variables.

Reductionism: the approach of breaking down phenomena to their smallest possible parts.

Research: a diligent, systematic inquiry or investigation to validate and refine existing knowledge and generate new knowledge.

Triangulation: the use of multiple research techniques to collect and evaluate data on a specific topic in order to converge on a complete representation of reality and confirm the credibility of the research findings.

WELLNESS MODEL

The framework of client/patient nursing research is shifting from an illness to a wellness model of health care. The wellness model views individuals holistically as bio-psycho-social-spiritual units who assume responsibility for their own health. This model emphasizes the enormous potential that each individual has in healing his or her own body-mind-spirit. A significant body of research provides evidence of the enormous effects of consciousness on both health and illness. Investigations have shown that complementary and alternative medical (CAM) therapies have the exciting potential to prevent illness and maintain high-level wellness. In addition, such research has been instrumental in guiding the development of humanistic and holistic approaches to health care. The challenge for us is to apply these findings in nursing practice.

EVIDENCE-BASED PRACTICE

The current mandate to use the best evidence that directs our clinical decisions and the actions we take is driven by the goal of achieving effective patient outcomes and making a positive difference in the lives of our patients. Two strategies used to accomplish this goal are the processes of research utilization and, more recently, evidence-based practice. Research utilization focuses on using research in practice in a way that resembles how it was done in the original research study.[1] It is used to translate research knowledge into what we do. In contrast, evidence-based practice involves more than just research utilization. It is the careful, deliberate use of the best available evidence for making decisions about patient care.[2] This process uses theory, clinical decision making, clinical judgment, and knowledge of research findings combined with clinical expertise, as well as patient values and preferences within the context of available resources.[3] The current emphasis on evidence-based practice is guided by the belief that practitioners need to incorporate the best evidence for practice improvements and solutions to clinical problems.

At the Gillette Nursing Summit on Integrated Health and Healing, held in 2002, 23 nurse leaders discussed the role of nursing in integrated health care and identified core recommendations that would enable nurses to provide leadership in this emerging field.[4] The group unanimously agreed that it is important to establish an evidence base to support integrative healing practices.[5] They also recommended that an interdisciplinary perspective and interdisciplinary research agenda be established when studying integrated health and healing.

Evidence-based practice needs to be reflected in clinical policies, procedures, and standards of practice. Many resources are currently available to help practitioners obtain information about evidence-based practice. Such information includes current research findings; practice guidelines developed by expert consensus and federal and professional groups; journal

and review articles; and current procedure manuals and books.[6]

The National Center for Complementary and Alternative Medicine (NCCAM) has partnered with the National Library of Medicine to create CAM, a web-based research system, on PubMed. This system can be used to locate more than 270,000 references of CAM-related articles (http://www.nlm.nih.gov/nccam/camonpubmed.html). In addition, NCCAM now has a database of all published studies from researchers who have received NCCAM funding. This site can be used to locate all published NCCAM-funded studies or to sort and find specific topics in CAM (http://nccam.nih.gov/cgi-bin/bibliography.cgi).

Current state-of-the-art knowledge of many CAM therapies has been reviewed. For example, a National Institutes of Health (NTH) Technology Assessment Panel has evaluated the research supporting the use of behavioral and relaxation interventions in the treatment of chronic pain and insomnia.[7] The panel found strong evidence to indicate that the use of relaxation, meditation, and hypnosis is beneficial in the treatment of chronic pain. Likewise, there was strong evidence to support the use of behavioral techniques such as autogenic training, meditation, progressive muscle relaxation, and biofeedback for the treatment of insomnia. In addition, the NIH sponsored a Consensus Development Conference on Acupuncture, which found acupuncture effective in treating adult postoperative and chemotherapy nausea and vomiting, as well as postoperative dental pain.[8]

Systematic reviews also synthesize the evidence on a given topic—even if the results are inconclusive or conflicting—because such reviews generally point out where knowledge gaps exist.[9] In 1996, for example, NCCAM funded a complementary medicine field within the Cochrane Collaboration, an international network of individuals and institutions committed to prepare, maintain, and disseminate systematic reviews on all topics of health care.[10] To date, systematic reviews (when possible, meta-analyses) have been completed on acupuncture, massage, homeopathy, and herbal medicine, with additional reviews planned for herbs, manual therapies, music therapy, therapeutic touch, and yoga (http://www.cochrane.org).[11]

Meta-analysis is a statistical technique that establishes an overall estimate of the therapeutic effectiveness of an intervention by combining the results of many experiments related to that intervention. The results of small but meaningful studies are synthesized and become cumulative. The final conclusions generally are stronger than those provided in systematic reviews because meta-analysis takes into account factors such as sample size, strength of the experimental methods, and threats to internal and external validity, using both qualitative and quantitative approaches.[12] Meta-analyses allow inferences to be made about the currently known effectiveness of a treatment, and provide valuable information to clinicians planning care and researchers planning future clinical studies. For example, nine studies were included in a meta-analysis on the effects of effleurage backrub on the physiologic components of relaxation. From this analysis it was concluded that effleurage backrubs of at least three minutes are an effective nonpharmacologic nursing intervention that promotes biologic and subjective relaxation. The findings were convincing enough for the authors to recommend that this traditional nursing activity be revitalized and implemented once again in clinical practice.[13]

The National Guideline Clearinghouse™ (NGC) is a comprehensive database of evidence-based clinical practice guidelines and related documents produced by the Agency for Healthcare Research and Quality (AHRQ) (formerly the Agency for Health Care Policy and Research [AHCPR]),

together with the American Medical Association and the American Association of Health Plans (http://www.guidelines.gov/index.asp). Information on evidence-based practice related to health care outcomes and a list of evidence-based practice centers also is provided by the AHRQ (http://www.ahcpr. gov/clinic/epcix.htm), including a small section on CAM therapies (http://www. ahcpr.gov/clinic/epcindex.htm#complementary). In addition, an online evidence-based nursing journal (http://ebn. bmjjournals.com), an evidence-based health care web site, (http://hiru. hirunet. mcmaster.ca), and the Briggs Institute for Evidence-Based Nursing (http://www. joannabriggs.edu.au) are other resources to assist the practitioner in obtaining information about evidence-based practice.

NEED TO CONDUCT HOLISTIC RESEARCH

The holistic care of clients must be based on the results of research for several reasons. Research provides the direction for selecting interventions with proved effectiveness. When we implement interventions that have been proved effective, patient outcomes are improved. Unfortunately, much of what we do is based on tradition, rituals, and the way we were taught, with little research evidence to support our actions.

One of the central arguments against using CAM therapies is that the efficacy of most of these therapies has not been proved.[14,15] Yet many practitioners are surprised to learn that most conventional medical practices also have not been proved by research.[16,17] Smith estimated that only 15 percent of all biomedical interventions are validated by reliable scientific evidence and, in fact, most orthodox interventions have never been researched at all.[18] For example, interventions such as episiotomy, laparoscopic vaginal hysterectomy, and radial keratotomy are widely practiced but have no research support.[19] Thus, it is important to realize that research is needed in both the conventional and complementary domains of health care.[20]

In nursing, there is much work to do. Research can be conducted to find out if there is a problem (e.g., not meeting patient/family needs to be together) and how big the problem is as a means of changing practice.[21] For example, when we attempted to implement in our emergency department a policy on family presence during cardiopulmonary resuscitation (CPR), we were told by our physicians that most families would not want to be present during resuscitative efforts. In response to this assertion, we conducted a retrospective telephone survey of 25 family members of patients who had died because of traumatic injuries in our emergency department.[22] Eighty percent said they would have wanted to be at the bedside during CPR had they been given the option. This data provided strong documentation in our journey to change practice.

Research also needs to be conducted to determine the effectiveness of our interventions on patient outcomes. Many holistic and CAM therapies have been used to treat a variety of problems in diverse settings, but their appropriateness and adequacy in various populations and settings have not been fully investigated. There is a need to determine under what conditions holistic and CAM therapies are effective, for which particular client/patient, and with what type of clinical problem. Comparative outcome studies also are needed to determine the usefulness, indications, contraindications, and dangers of such therapies. Moreover, the effectiveness of these interventions, as they are integrated with conventional treatments, requires evaluation not only in treating various ill-

nesses, but also in promoting high-level wellness and preventing illness.

In addition, research needs to be conducted to investigate the outcomes of healing on individuals. This area provides exciting opportunities for holistic researchers because few studies have evaluated the *mechanisms* of healing. To address this issue, the first American Samueli Symposium on Healing Research was held in 2003, and as a result of this conference a publication was created on the definitions and recommended guidelines for research protocols and methodologies in healing research.[23] Healing was defined as "those physical, mental, social, and spiritual processes of recovery, repair, renewal, and transformation that increase wholeness, and often (though not invariably) order and coherence."[24] The publication focuses on issues in consciousness and bioenergy research and an assessment of the clinical impact of healing relationships that occur during care by nurses and physicians. Six areas of research standards and guidelines were identified to include: laboratory research; randomized clinical trials; systematic reviews and meta-analyses; qualitative research; outcome, observational, and epidemiological investigations; and health services research and technology assessment.[25] There was consensus that all of these methodologies are necessary to enhance our understanding of healing and how it happens. Readers interested in conducting healing research related to the categories of bioenergy, distant healing intention, hands-on healing, prayer, and healing relationships should consult this comprehensive supplement.

With the creation of NCCAM at the NIH, many CAM therapies are now undergoing scientific evaluation to determine whether they affect the clinical course and outcomes of an illness or whether they enhance wellness. Approximately 40 percent of U.S. citizens use some form of CAM therapy and they are spending enormous amounts of out-of-pocket money.[26–28] It appears that the public is looking for something more in health care: humanistic, holistic approaches that address their body-mind-spirit needs.[29] For these reasons, the time has come to determine which of these therapies are beneficial and effective in health care.

To date, NCCAM has funded many studies to evaluate such therapies as acupressure, massage therapy, electrochemical treatment, hypnosis, music therapy, guided imagery, biofeedback, prayer, and administration of antioxidants. In addition, NCCAM has established 16 research centers in CAM to study the effects of such therapies on major health conditions and in various populations (e.g., addictions, aging and women's health, arthritis, cancer, cardiovascular diseases, craniofacial disorders, chiropractic, neurologic disorders, neurodegenerative diseases, pediatrics, and dietary supplements [see Chapter 1]). With both the recognition that nursing alone does not control patient outcomes and that the talents and knowledge from various disciplines can enhance the research process, increasingly more of theses studies involve multidisciplinary health care teams. The results of these studies will provide the scientific basis for determining which CAM therapies work, which ones do not, which ones are harmful, and, most important, which ones improve patient outcomes.

HOLISTIC RESEARCH METHODS

Quantitative Research

Research can be defined as a diligent, systematic inquiry or investigation to validate and refine existing knowledge as well as to generate new knowledge.[30] Descartes' teachings in the seventeenth century did much to advance the use of

the scientific method in medical research as we know it today.[31] His notion of reductionism in research—the idea of breaking down every question to its smallest possible parts—has been immensely beneficial in isolating those factors responsible for disease. For example, the physiologic part of a human being can be divided into organs, cells, and biochemical substances, then into molecular, atomic, and subatomic levels. Such an approach is useful for identifying the cause of disease (e.g., the finding that a virus causes acquired immune deficiency syndrome [AIDS]), and offers direction for studying the cure of disease (e.g., the use of antibodies to kill the bacteria associated with endocarditis).

Quantitative research is a systematic, formal, objective process in which numerical data are used to obtain information about the world. Embodying the principles of the scientific method, quantitative research involves (1) descriptive research, used to describe phenomena; (2) correlational research, used to examine relationships between and among variables; (3) quasi-experimental research, used to explain relationships, examine causal relationships, and clarify the reasons for events; and (4) experimental research, used to examine cause-and-effect relationships between variables.[32] (See references 33–41 for examples of such quantitative research.)

The gold standard in biomedical research is the randomized clinical trial (RCT). An RCT includes elements of randomization, an experimental intervention, a control or placebo group, and blinding (often in the case of drug trials), in which neither the patient nor the investigator knows whether the patient is receiving the experimental treatment or placebo.[42] Randomized clinical trials are used in biomedical research because their design is believed to control threats to the internal and external validity of the study, and thus allows inferences about cause-and-effect relationships.[43] The internal validity of a study refers to the extent that it is possible to infer that the experimental treatment, rather than uncontrolled factors, is responsible for the outcome in a study. External validity refers to the generalizability of the findings to other samples and settings.[44] Thus, if a study has been properly designed and controlled, the quantitative method makes it possible to generalize the results obtained in one study to other, similar client populations, and to replicate the results in similar studies. The key issue of the quantitative method is its ability to predict and control outcomes.

It has been argued that the RCT may not be the preferred strategy for evaluating some holistic and CAM therapies, because many of the therapies are not testable under blinded conditions, the choice of an appropriate control condition is not always clear, and eliminating threats to internal and external validity may not be ethically possible.[45] Thus, in holistic nursing, various quasi-experimental approaches—which may actually have greater internal or external validity than some RCTs—also can be used to produce important scientific findings characterizing cause-and-effect relationships.[46]

Biomedical research using quantitative methods abounds as scientists seek to identify unknown causes and cures for physiologic (and sometimes psychologic) illnesses. Efforts to find answers at the molecular level to such problems as the common cold, heart disease, cancer, AIDS, and essential hypertension, to name only a few, have consumed enormous numbers of personnel hours and dollars. Statistical analyses of isolated parts and group comparisons have indeed validated cause and effect in many cases. The quantitative method, however, does not take into account (1) the responses of the whole human being to variables, (2) the characteristics of one individual's pathway to a

particular problem, and (3) the unique patterns and interacting variables of one individual.[47] Thus, the distinctive features of unique individuals are lost in aggregate means, standard deviations, and various statistical analyses.[48] Historically, such distinctions have been deemed irrelevant in the biomedical paradigm.

Qualitative Research

Current holistic and bodymind researchers have challenged the very roots of the biomedical paradigm. In his general systems theory (see Chapter 1), von Bertalanffy proposed that the study of systems requires an understanding of the whole rather than investigation of its separate parts. The field of psychoneuroimmunology has generated astounding research findings to support the interactive nature of psychophysiologic variables. There is conclusive evidence that thoughts and emotions affect the neurologic, endocrine, and immune systems at the cellular and subcellular levels. As a result, nurses have come to realize that the fit between quantitative methods and holistic nursing research is not always an ideal one.

Because quantitative methods seek to find answers only to parts of the whole, nurses have looked to alternative philosophies of science and research methods that are compatible with investigating humanistic and holistic phenomena.[49,50] Termed qualitative research, this approach is a systematic, subjective form of research that is used to describe and promote an understanding of human experiences such as health, caring, loneliness, pain, and comfort.[51] It is used to investigate the context and meaning of observed patterns, producing a richly articulate, in-depth, and coherent understanding of the phenomenon. Qualitative methods are used when little information is known about a phenomenon, or in areas that are difficult to measure.[52,53] Qualitative research focuses on understanding the whole, which is consistent with the philosophy of holistic nursing (see references 54–59 for examples of such qualitative research).

Five major types of qualitative research are (1) phenomenology, which is used to describe an experience as the whole person lives it; (2) hermeneutics, which focuses on meaning and is used to access the sociocultural experiences of individuals; (3) ethnography, which is used to study a culture and the people within the culture; (4) grounded theory research, which is used to uncover the problems in a social situation and the way in which the persons involved handle them; and (5) historical research, which is used to describe or analyze events that occurred in the past to better understand the present.[60,61]

For example, Parse and associates used the phenomenologic research approach to describe the experience of health. They conducted a study to discover a definition of health as people live and experience it in everyday life. They asked the question, What are the common elements in a feeling of health among several different age groups?[62] One hundred subjects between 20 and 45 years old wrote a description of their feelings, thoughts, and perceptions of the experience during an episode in which they felt healthy. The researchers used the subjects' actual words when reporting the findings. From the data collected, they identified 30 descriptive expressions of health (Table 9–1). Three central themes emerged from these 30 descriptors: spirited intensity, fulfilling inventiveness, and symphonic integrity. Based on these central themes, the researchers then formulated the following definition: "Health is symphonic integrity manifested in the spirited intensity of fulfilling inventiveness."[63] The descriptors in the table are so rich that they provide a clear understanding of the lived experience of health and make it possible to develop a definition of health that is fuller and much more holistic than the

Table 9–1 The Experience of Health—Descriptive Expressions from Participants in a Phenomenological Study

Spirited Intensity	*Fulfilling Inventiveness*	*Symphonic Integrity*
1. Being enthusiastic	1. Finishing a project that takes up time	1. Being at ease
2. Catching a second wind	2. Accomplishment	2. Feeling of worth
3. Exercising and walking	3. Winning the game of life	3. Enjoying own space at that moment
4. Feeling in peak condition	4. Trying some new endeavor	4. Peaceful feeling inside while bicycling
5. Positive outlook on life	5. Feeling something enriching my life	5. A "just right" feeling about everything
6. Feeling of refreshment	6. Doing what I struggled for	6. Drinking in the beauty of the day
7. Feeling full of energy	7. Pushing a little extra	7. Peaceful attitude
8. A glowing light of energy burning brightly in my eyes	8. Feel successful as a person	8. Rhythmical, easy, warm
9. A whip the world feeling	9. Ability to extend to limits of endurance	9. Glowing and good inside
10. A surge of energy	10. Accomplishing something	10. Feeling loved

Source: Reprinted with permission from R.R. Parse, A.B. Coyne, and M.J. Smith, *Nursing Research: Qualitative Methods*, p. 32, © 1985, Appleton & Lange.

traditional biomedical view of health, defined as the "absence of disease."

It has taken centuries to generate convincing data that refute the idea of a separation between the body and the mind. Many health care professionals remain tied to the biomedical model, however, and perceive holistic principles and their corresponding research approaches as unscientific. They have doubted the psychophysiologic link between mind and body because the primary evidence supporting the link has been provided in the form of anecdotes or personal testimonials. "Hard core" researchers who embrace the quantitative method have not placed much value on the "softer" data obtained from qualitative studies. Even when quantitative studies support the link, questions arise about their retrospective designs, methodologic problems, or lack of measurement tools with psychometric properties.[64]

Qualitative and quantitative methods, however, should not be viewed from an either/or perspective. Both methodologies are needed in holistic research[65] because they provide complementary approaches for more fully understanding a particular problem (Exhibits 9–1 and 9–2). By virtue of their day-to-day care of clients, nurses are in a unique position to observe, document, quantify, and analyze the interactive relationship of variables in health and illness.[66]

ENHANCING HOLISTIC RESEARCH

Triangulation

Researchers can use several strategies in planning studies to enhance the completeness and holistic nature of their investigations. For example, triangulation methodologies involve both holistic and

Exhibit 9–1 Quantitative and Qualitative Research Characteristics

Quantitative Research	*Qualitative Research*
Hard science	Soft science
Focus: concise and narrow	Focus: complex and broad
Reductionistic	Holistic
Objective	Subjective
Reasoning: logistic, deductive	Reasoning: dialectic, inductive
Basis of knowing: cause-and-effect relationships	Basis of knowing: meaning, discovery
Tests theory	Develops theory
Control	Shared interpretation
Instruments	Communication and observation
Basic element of analysis: numbers	Basic element of analysis: words
Statistical analysis	Individual interpretation
Generalization	Uniqueness

Source: Reprinted with permission from N. Burns and S.K. Grove, *The Practice of Nursing Research: Conduct, Critique and Utilization*, p. 27, © 1993, W.B. Saunders.

Exhibit 9–2 Investigating an Apple: A Quantitative vs. a Qualitative Approach

Quantitative Approach

A **quantitative** researcher might examine an apple by
- Inspecting the apple closely
- Carefully weighing it
- Cutting into it
- Separating the skin from the meat and
  - Weighing each
  - Analyzing each for sugar, salt, water, fiber, calories, vitamins, and then statistically analyzing the differences between the skin and the meat
- Counting the seeds and examining the inside of the seeds

Qualitative Approach

A **qualitative** researcher might examine an apple by
- Looking at the apple from all sides, top, and bottom
- Feeling it
- Smelling it
- Shining it
- Rolling it
- Appreciating its wholeness
- Biting into it, eating it, and enjoying it, describing its
  - Sound
  - Taste
  - Texture
  - Temperature
- Planting its seeds to determine what they might produce

Note: The author wishes to thank Elizabeth H. Winslow, PhD, RN, FAAN for sharing this example.

multidimensional approaches to collect and evaluate data on a specific topic in a way that ensures a complete representation of reality and strengthens the credibility of the research results. These methodologies, which are compatible with good science and holistic research, include data source, methodologic, investigator, interdisciplinary, theory, and analyses triangulation.[67,68]

Data source triangulation strengthens the rigor of the research by using several sources of data to assess a single clinical phenomenon. For example, in a study evaluating the effects of family presence at the bedside during emergency department CPR,[69] researchers conducted interviews with family members, nurses, and physicians present during the event to determine the benefits and problems of the experience from the perspectives of all those involved. In addition to the interviews conducted in this study, questionnaires, attitude scales, and observations of family behavior while at the bedside during emergency procedures were also used. In this example of *methodologic* triangulation, the qualitative findings (identification of themes emerging from the interviews) confirmed and validated the quantitative findings (scores on the attitude scale, yes/no responses tallied from the questionnaire, and observations of family behavior). The understanding of the family presence experience, therefore, was more complete than if only one of the strategies had been used alone. Likewise in this study, *investigator* triangulation played a role, because there were several clinical nurse co-investigators, a nurse research consultant, and a qualitative nurse researcher, who all independently evaluated the data and then collaboratively interpreted the findings on the families' and health care providers' perception of the experience. *Interdisciplinary* triangulation (collaboration between two or more investigators from different disciplines to examine a phenomenon) was also a factor, as a nurse–physician team developed the family presence study. The nurse and the physician later evaluated the results of the data collection independently and then collaborated in interpreting the findings based on their professional orientation to yield a more comprehensive perspective of the benefits and problems of family presence.

Theory triangulation uses two or more conceptual frameworks to examine the phenomenon under study. For example, in a study examining the reasons that individuals use CAM therapies, researchers used health belief, motivational, and holistic theories to interpret predictors of CAM therapy use.[70] *Data analysis* triangulation involves the use of two or more methods of data analysis to evaluate a phenomenon. For example, regression analyses could be used to predict the effects of three kinds of distraction on pain, and analysis of variance could be used to determine any differences among the three types of distraction.[71]

Psychophysiologic Outcomes

The holistic researcher will quickly discover the shortage of holistic instruments available to measure outcomes. If holistic and CAM therapies have the ability to affect an individual's body-mind-spirit, however, it is reasonable to believe that it should be possible to measure these effects. Yet, too often, researchers have studied body effects or mind effects, but rarely have they studied the interaction and relationship between the two.

The various physiologic instruments available to study the effects of holistic and CAM therapies are often used in combination to develop a physiologic profile of observed outcomes. Researchers tend to use psychologic instruments with less confidence, on the other hand, viewing them as less reliable and less valid than their

physiologic counterparts. Many of the psychologic instruments currently available are not sensitive enough to demonstrate the subtle, yet significant, psychologic changes that occur with CAM therapies. The finding that a psychologic indicator is not significant does not necessarily disprove the existence of a significant psychologic effect. It may indicate that the wrong variable was studied, or that the psychologic tool used was not sufficiently sensitive to measure the effect.

Holistic and CAM therapies influence many psychophysiologic parameters, but they do not necessarily influence the same variables in different individuals. Thus, a number of parameters must be used to satisfactorily evaluate the outcomes of these interventions. Psychologic and physiologic outcomes should be used in combination and the effects of these outcomes should be correlated as a means of increasing the validity of the findings and discovering bodymind links. Psychologic and physiologic measurements should be combined in developing new psychophysiologic tools. More quantitative tools to study holistic phenomena such as health beliefs, functional status, comfort, dyspnea, dependency, and appraisal of stressors are appearing in the literature. In addition, a variety of visual analog and numerical rating scales, diaries, logs, and graphs can be used to capture the holistic, longitudinal, and individualized perceptions of patient experiences.

Multimodal Interventions

Quantitative intervention studies can be approached more holistically by taking into consideration the interactive nature of the patient's body-mind-spirit. Many of the holistic and CAM interventions, when used in combination as a multimodal intervention, may have a more powerful effect on outcomes than any one intervention used alone. For example, the combination of relaxation techniques and music therapy has been shown to be effective in producing the relaxation response, particularly in anxious patients; a head-to-toe relaxation script is used first to reduce muscle tension, and then soothing music is added to enhance relaxation.[72] In a recent study evaluating the effects of distraction combined with positioning (i.e., child–parent chest-to-chest sitting position) on the pain and distress of small children undergoing venipuncture, it was believed that distraction combined with positioning and parental support would be more effective than either one of these interventions alone.[73] Likewise, much of the work in biofeedback has increasingly added abdominal breathing, the quieting response, progressive muscle relaxation, autogenic training, imagery, and music to the biofeedback protocol to enhance client outcomes.[74]

Ornish, a cardiologist, and associates conducted two landmark, controlled, randomized clinical studies to determine the effects of a holistic, comprehensive, lifestyle change intervention program for patients with coronary artery disease.[75,76] For the experimental group, current state-of-the-art knowledge on preventing heart disease related to diet, exercise, support groups, and stress reduction was the basis for the intervention. Subjects in the control group were treated with traditional medical approaches. Both groups were similar at the start of the study regarding demographic characteristics and disease severity. The outcomes of the study were determined by angiographic measurement of the size of coronary artery lesions after the first year of intervention and measurement of the size and severity of perfusion abnormalities using positron emission tomography after the fifth year of intervention. The results were astonishing. Patients in the experimental group demonstrated significant regression of their coronary artery disease during the first year

following intervention, whereas those in the control group demonstrated a significant progression of their disease.[77] Likewise, after five years, the size and severity of the myocardial perfusion abnormalities documented by tomography improved in patients in the experimental group and worsened in control group patients.[78]

Until these studies were conducted, researchers had been unable to demonstrate regression of coronary artery lesions. Both studies were successful because the interventions used addressed the whole patient and the interactive nature of each patient's biologic, psychologic, sociologic, and spiritual dimensions. The researchers did not try to isolate the effects of diet, exercise, support groups, and stress reduction as is done in most investigations. Rather, Ornish put these elements together in a holistic, multimodal intervention package. Which part of the intervention was most effective? No one knows for sure. It is likely that the interactive nature of the interventions was more powerful than any one of the interventions alone in helping patients to repattern their pathways toward wellness. It appears that such holistic, multimodal, interactive interventions were responsible for reversing an outcome that had never before been changed.

Objectivity in Scientific Investigation

Most researchers accept the universal principle that objectivity must govern scientific inquiry. However, Heisenberg, who studied information obtained from an electron, has shaken this belief. His uncertainty principle states that it is impossible to look at a physical object without changing it,[79] which suggests that objects and clients change when researchers observe them. The holistic researcher realizes the enormous implications of this principle: Researchers do not stand apart from the research or research subject; they are *part* of the research. They are not objective observers of the world, but rather participants in that world. This participation, in turn, affects the results that they obtain through research. Their participation may be a word, an action, a touch, an observation, or simply their presence. For example, even in observational or descriptive studies in which the researcher does not intervene, the very act of observing or measuring something—such as the healing relationship between the healer and the healee—changes the relationship and what is being measured.[80] Thus, the term *nonparticipant observer* in research is meaningless. The researcher becomes an integral part of the experiment and its outcomes.

One of the topics addressed at the American Samueli Symposium in 2003 examined the research guidelines for assessing the impact of the healing relationship in clinical nursing.[81] Healing relationships were defined as the "quality and characteristics of interaction between the healer and healee that facilitate healing. Characteristics of this interaction involve empathy, caring, love, warmth, trust, confidence, credibility, honesty, expectation, courtesy, respect, and communication."[82] If the healing relationship between a client and a practitioner is a factor in affecting client outcomes as a result of either conventional or CAM therapies (or both), then it justifies scientific evaluation. This area of research offers an unique opportunity for researchers because the impact of the healing relationship is essentially unstudied.[83] For example, what are the indicators of healing? How can these indicators be measured? What standard health-related outcomes are most influenced by a healing relationship? Based on the experiences and reports of both nurses and patients, what is a healing relationship?[84] Because the healing relationship involves at least two persons, it is critical that both

persons (healer and healee) involved in the relationship be studied.

Heisenberg also postulated that it is not possible to obtain a complete description of a physical object because describing it changes it. Thus, it is impossible to obtain all the data that describe an object; some information will always be unknown.[85] Observations verify research effects, but, if it is impossible to obtain a complete description of a physical object, some outcomes will be unknown. It is misleading to suggest that research always can be validated in terms of testable or observable effects. Yet, the effects of a certain experiment, whether they are observable or not, will ultimately affect the subject.[86]

Certain phenomena related to holistic research may not be accessible to scientific investigation because they cannot be objectively measured. The individual who experiences certain effects while using CAM therapies, for example, may be unable to conceptualize or express them or unable to translate or communicate these effects to another. Likewise, the researcher may be unable to interpret the effects because he or she lacks experience with these effects, or because our language is inadequate for describing and communicating these phenomena. Heisenberg, in explicating the difficulties of describing atoms in common language, once said "the problems of language here are really serious."[87]

The Placebo Response

Scientists have often viewed the placebo response as a nuisance and an unreliable factor that distorts research results. Many have assumed that a placebo is effective only when the illness is somehow unreal. Recently, however, we have begun to understand the power of the placebo effect and the mechanisms involved.[88]

Placebo means "I will please." The term refers to a medically inert preparation or treatment that has no specific effects on the body and is intended to have no therapeutic benefit. Yet, this medically inert substance or treatment can evoke a placebo response, relieving pain or dramatically affecting the patient's symptoms or disease.

The placebo response (also called the general healing response) has been studied for several decades in a variety of patients. In an analysis of 15 double-blind studies, placebo medications were found to be effective in pain relief for 35 percent of patients with postoperative pain.[89] An analysis of 11 subsequent double-blind studies in which 36 percent of the patients received at least 50 percent pain relief from placebos confirmed these findings.[90] In addition, the worse the pain or the more stressful the situation, the more effective the placebo.[91] The placebo effect may be even higher than these findings indicate. One study indicated that approximately 70 percent of patients in preliminary trials of five new promising medical treatments (for asthma, ulcers, and herpes) showed symptomatic improvements,[92] although later the treatments proved useless. It appears that, for more than one-third of clients, and probably for even more, the pharmacologically inert placebo is able to activate bodymind healing mechanisms.[93,94]

The placebo response also has been found to be present in the following conditions and therapeutic procedures, demonstrating the mind's ability to produce neurohormonal messenger molecules that alter the autonomic, endocrine, and immune systems:[95]

- hypertension, stress, cardiac pain, blood cell counts, headaches, pupillary dilation (suggesting the mind's ability to alter the autonomic nervous system)

- adrenal gland secretion, diabetes, ulcers, gastric secretion and motility, colitis, oral contraceptive use, menstrual pain, thyrotoxicosis (suggesting the mind's ability to alter the endocrine system)
- the common cold, fever, vaccinations, asthma, multiple sclerosis, rheumatoid arthritis, warts, cancer (suggesting the mind's ability to alter the immune system)
- surgical treatments (e.g., for reducing angina pectoris)
- biofeedback instrumentation and various medical devices
- psychologic treatments, such as conditioning (systematic desensitization) and perhaps all forms of psychotherapy
- making an appointment to see a physician

Thus, the placebo response is a common mechanism that occurs because of a communication link between the body and the mind, that is probably present in all clinical situations.[96] Furthermore, the placebo response probably exists, more or less, in each one of us.

It is known that how a drug is given or how a procedure is performed and by whom can affect the intensity of the placebo response. Therefore, the faith that the client has in the caregiver and the client's expectation that the drug or therapy will work greatly influence the placebo response. Likewise, the faith that the caregiver conveys to the client regarding the drug or therapy, as well as the trust and rapport established between the two, affects the placebo response.[97–99]

It is time to recognize the powerful effects of the placebo. We must learn to incorporate the placebo response in our research and our clinical practice in order to maximize its potential. For instance, to enhance the placebo response when administering medications we can discuss with our clients the medication's known potency and effectiveness. As another example, when patients receive morphine intravenously for chest pain we can ask them to visualize the molecules of this powerful, pain-killing medicine traveling through their veins to the source of the chest pain. We can suggest that clients work to enhance the medication's effectiveness by allowing the relaxed, warm, and comfortable feeling associated with morphine to flow throughout their bodies.[100]

The essence of the placebo response involves positive attitudes and emotions.[101] Many CAM therapies, such as imagery, music therapy, relaxation, and exercise, increase endorphin production.[102] When clients believe that they are doing something to enhance healing, their endorphin levels can rise. Therefore, clients can influence the course of their own illnesses and their responses to therapy by using their own consciousness.[103] Because basic nursing interventions such as touching, giving backrubs, teaching, positioning, and distracting all have the potential to raise endorphin levels, it is critical that we discuss with our clients the possible therapeutic benefits of each therapy as a part of our research protocols and practice. When we realize that what we say to our clients can augment the placebo response, we will develop new communication skills to enhance our clients' healing responses and maximize the benefits of our nursing interventions.

CONCLUSION

The shift to the wellness model has caused the profession to take a new look at research priorities, methodologies, and findings. The current mandate to use the best evidence that directs our clinical decisions and the actions we take is driven by the goal of achieving effective patient outcomes. Because most holistic and CAM therapies are in need of investi-

gation, more research needs to be conducted so that we can establish an evidence base to support integrative healing practices.

DIRECTIONS FOR FUTURE RESEARCH

1. Evaluate CAM therapies that may potentially promote wellness behaviors in specific client populations.
2. Determine whether CAM therapies can be combined to augment their effectiveness in achieving desired client outcomes (e.g., combine relaxation with biofeedback, or music therapy with imagery and progressive relaxation).
3. Determine the most effective way to integrate CAM therapies with traditional modes of therapy to achieve optimal client outcomes.
4. Explore the experiences of patients, clients, nurses, and physicians to identify how each defines a healing relationship.
5. Identify which standard health-related outcomes (e.g., in cardiology, rehabilitation, or during pregnancy) are most influenced by a healing relationship.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or will begin a process of answering the following questions:

- What is my role in establishing an evidence-based practice?
- How do I feel about the importance of research in advancing holistic nursing practice?
- What is my role in nursing research?
- How can I become more involved in holistic clinical research?

NOTES

1. D.F. Polit, C.T. Beck, and B.P. Hungler, *Essentials of Nursing Research: Methods, Appraisal, and Utilization*, 5th ed. (Philadelphia: Lippincott, 2001), 431.
2. D. Sackett, S. Richardson, W. Rosenberg, and R. Haynes, *Evidence-Based Medicine: How to Practice and Teach EBM* (New York: Churchill Livingstone, 1997).
3. J. Barnsteiner and S. Prevost, How to Implement Evidence-Based Practice, *Reflections on Nursing Leadership* 28, no. 2 (2002):18.
4. M.J. Kreitzer and J. Disch, Leading the Way: The Gillette Nursing Summit on Integrated Health and Healing, Supplement to *Alternative Therapies in Health and Medicine* 9, no.1 (2003).
5. Ibid., A4–A5.
6. M. Chulay, C.E. Guzzetta, and B.M. Dossey, *AACN Handbook of Critical Care Nursing* (Stamford, CT: Appleton & Lange, 1997).
7. NIH Technology Assessment Panel on Integration of Behavioral and Relaxation Approaches into the Treatment of Chronic Pain and Insomnia, *Journal of the American Medical Association* 276, no. 4 (1996):313–318.
8. NIH, Consensus Development Statement on Acupuncture, *NIH Consensus Statement Online* 15, no. 5 (1997):1–9.
9. J. Ezzo et al., Complementary Medicine and Cochrane Collaboration, *Journal of the American Medical Association* 280, no. 18 (1998):1628–1630.
10. L. Bero and D. Rennie, The Cochrane Collaboration: Preparing, Maintaining, and Disseminating Systematic Reviews on the Effects of Health Care, *Journal of the American Medical Association* 274, no. 24 (1995):1935–1938.
11. J. Ezzo et al., Complementary Medicine and Cochrane Collaboration, 1630.
12. R.J. Gatchell and A.M. Maddrey, Clinical Outcomes Research in Complementary and Alternative Medicine: An Overview of Experimental Design and Analysis, *Alternative Therapies in Health and Medicine* 4, no. 5 (1998):41.

13. S.E. Labyak and B.L. Metzger, The Effects of Effleurage Backrub on the Physiological Components of Relaxation: A Meta-Analysis, *Nursing Research* 46, no. 1 (1997):59–62.

14. M. Angell and J.P. Kassirer, Alternative Medicine: The Risks of Untested and Unregulated Remedies, *New England Journal of Medicine* 339, no. 12 (1998):839–841.

15. P.B. Fontanarosa and G.D. Lundberg, Alternative Medicine Meets Science, *Journal of the American Medical Association* 280, no. 18 (1998):1618–1619.

16. L. Dossey, On Double-Blinds and Double Standards: A Response to the Recent *New England Journal* (Editorial), *Alternative Therapies in Health and Medicine* 4, no. 6 (1998):18–20.

17. D.A. Grimes, Technology Follies, *Journal of the American Medical Association* 269, no. 23 (1993):3030–3033.

18. R. Smith, Where Is the Wisdom? *British Medical Journal* 303 (1991):798–799.

19. Grimes, Technology Follies, 18.

20. W.B. Jonas, Alternative Medicine—Learning from the Past, Examining the Present, Advancing the Future, *Journal of the American Medical Association* 280, no. 18 (1998):1616–1617.

21. D. Diers, Research as a Political and Policy Tool, in *Policy & Politics in Nursing and Health Care*, eds. D.J. Mason, J.K. Leavitt, and M.W. Chaffee (St. Louis: Saunders, 2002), 151.

22. T. A. Meyers, D.J. Eichhorn, and C.E. Guzzetta, Do Families Want to be Present during CPR? A Retrospective Survey, *Journal of Emergency Nursing* 24, no. 5 (1998):400–405.

23. W.B. Jonas and R.A. Chez, Definitions and Standards in Healing Research, supplement to *Alternative Therapies in Health and Medicine* 9, no. 3 (2003):A1–A104.

24. L. Dossey, Samueli Conference on Definitions and Standards in Healing Research: Working Definitions and Terms, in Definitions and Standards in Healing Research, eds. W.B. Jonas and R.A. Chez, supplement to *Alternative Therapies in Health and Medicine* 9, no. 3 (2003):A11.

25. W.B. Jonas and R.A. Chez, The Role and Importance of Definitions and Standards in Healing Research, in Definitions and Standards in Healing Research, eds. W.B. Jonas and R.A. Chez, supplement to *Alternative Therapies in Health and Medicine* 9, no. 3 (2003):A6.

26. D. Eisenberg, Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use, *New England Journal of Medicine* 328 (1993):246–252.

27. D.M. Eisenberg et al., Trends in Alternative Medicine Use in the United States, 1990–1997, *Journal of the American Medical Association* 280, no. 18 (1998):1569–1575.

28. J. Astin, Why Patients Use Alternative Medicine: Results of a National Study, *Journal of the American Medical Association* 279, no. 19 (1998):1548–1553.

29. Ibid.

30. Polit and Hungler, *Essentials of Nursing Research*, 4–28.

31. L. Dossey, *Space, Time, and Medicine* (Boston: Shambhala, 1982), 12–14.

32. Polit and Hungler, *Essentials of Nursing Research*, 167–203.

33. T.A. Meyers, D.J. Eichhorn, C.E. Guzzetta, A.P. Clark, J.D. Klein, E. Taliaferro, and A. Calvin, Family Presence During Invasive Procedures and Resuscitation: The Experiences of Family Members, Nurses, and Physicians, *American Journal of Nursing* 100, no. 2 (2000):32–42.

34. J.D. Edinger, W.K. Wohlgemuth, R.A. Radtke, G.R. Marsh, and R.E. Quillian, Cognitive Behavioral Therapy for Treatment of Chronic Primary Insomnia, *Journal of the American Medical Association* 286 (2001):1856–1864.

35. B. Krakow, M. Hollifield, L. Johnson, M. Koss, R. Schrader et al., Imagery Rehearsal Therapy for Chronic Nightmares in Sexual Assault Survivors with Posttraumatic Stress Disorder, *Journal of the American Medical Association* 286 (2001):537–545.

36. S. Wint-Sander, D. Eshelman, J. Steele, and C.E. Guzzetta, Effects of Distraction Using Virtual Reality Glasses During Lumbar Puncture of Adolescents with Cancer, *Oncology Nursing Forum* 29, no.1 (2002):E8–E15.

37. M.A. Bennett, J.M. Zeller, L. Rosenberg, and J. McCann, The Effect of Mirthful Laughter on Stress and Natural Killer Cell Activity, *Alternative Therapies in Health and Medicine* 9, no.2 (2003):38–45.

38. M.E. McNamara, D.C. Burnham, C. Smith, and D.L. Carroll, The Effects of Back Massage Before Diagnostic Cardiac Catheterization, *Alternative Therapies in Health and Medicine* 9, no.1 (2003):50–56.

39. P.K. Nicholas, I.B. Corless, A. Webster, C.A. McGibbon, S.M. Davis, S.E. Dolan, and A. Paul-Simon, A Behavioral-Medicine Program in HIV: Implications for Quality of Life, *Journal of Holistic Nursing* 21, no. 2 (2003):163–178.

40. K. Bally, D. Campbell, K. Chesnick, and J.E. Tranmer, Effects of Patient-Controlled Music Therapy During Coronary Angiography on Procedural Pain and Anxiety Distress Syndrome, *Critical Care Nurse* 23, no. 2 (2003):50–58.

41. M.C. Smith, F. Reeder, L. Daniel, J. Baramee, and J. Hagman, Outcomes of Touch Therapies During Bone Marrow Transplant, *Alternative Therapies in Health and Medicine* 9, no.1 (2003):40–48.

42. A. Vickers, Old Myths Given New Voice: The Nuffeild Report: Researching and Evaluating Complementary Therapies: The State of the Debate, *Complementary Therapies in Medicine* 4 (1996):198–201.

43. Gatchell and Maddrey, Clinical Outcomes Research, 36–42.

44. Polit and Hungler, *Essentials of Nursing Research*, 192–201.

45. A. Margolin et al., Investigating Alternative Medicine Therapies in Randomized Controlled Trials, *Journal of the American Medical Association* 280, no. 18 (1998):1626–1628.

46. Gatchell and Maddrey, Clinical Outcomes Research, 39.

47. D.F. Bockmon and D.J. Riemen, Qualitative versus Quantitative Nursing Research, *Holistic Nursing Practice* 2, no. 1 (1987):71–75.

48. D. Lukoff et al., The Case Study as a Scientific Method for Researching Alternative Therapies, *Alternative Therapies in Health and Medicine* 4, no. 2 (1998):44–52.

49. M.A. Newman, *Health as Expanding Consciousness* (St. Louis: C.V. Mosby, 1986), 91–96.

50. M.C. Silva and D. Rothbart, An Analysis of Changing Trends in Philosophies of Science on Nursing Theory Development and Testing, *Advances in Nursing Science* 6, no. 2 (1984):1–13.

51. Polit and Hungler, *Essentials of Nursing Research*, 206–226.

52. M. Sandelowski, "To Be of Use:" Enhancing the Utility of Qualitative Research, *Nursing Outlook* 45 (1997):125–132.

53. M. Sandelowski, Rigor or Rigor Mortis: The Problem of Rigor in Qualitative Research Revisited, *Advances in Nursing Science* 16, no. 2 (1993):1–8.

54. D.J. Eichhorn, T.A. Meyers, C.E. Guzzetta, A.P. Clark, J.D. Klein, E. Taliaferro, and A. Calvin, Family Presence During Invasive Procedures and Resuscitation: Hearing the Voice of the Patient, *American Journal of Nursing* 101, no. 5 (2001):48–55.

55. E.J. Taylor and F.H. Outlaw, Use of Prayer Among Persons with Cancer, *Holistic Nursing Practice* 16, no. 3 (2002):46–60.

56. P.A. Singer, D.K. Martin, and M. Kelner, Quality End-of-Life Care: Patients' Perspectives, *Journal of the American Medical Association* 281, no. 2 (1999):163–168.

57. K.A. Keaton and L.L. Pierce, Cardiac Therapy for Men with Coronary Artery Disease, *Journal of Holistic Nursing* 18, no. 1 (2000):63–85.

58. C. Kociszewski, A Phenomenological Pilot Study of the Nurses' Experience Providing Spiritual Care, *Journal of Holistic Nursing* 21, no. 2 (2003):131–148.

59. Y. Tatsumura, G. Maskarinec, D.M. Shumay, and H. Kakai, Religious and Spiritual Resources, CAM, and Conventional Treatment in the Lives of Cancer Patients, *Alternative Therapies in Health and Medicine*, 9, no. 3 (2003):64–71.

60. Polit and Hungler, *Essentials of Nursing Research*, 206–226.

61. N. Denzin and Y. Lincoln, eds., *Handbook of Qualitative Research* (Thousand Oaks, CA: Sage, 1994).

62. R.R. Parse et al., The Lived Experience of Health: A Phenomenological Study, in *Nursing Research: Qualitative Methods*, eds. R.R. Parse et al. (East Norwalk, CT: Appleton & Lange, 1985), 27.

63. Ibid., 31.

64. C.E. Guzzetta, The Human Factor and the Ailing Heart: Folklore or Fact? (Editorial), *Journal of Intensive Care Medicine* 2, no. 1 (1987):3–5.

65. L.C. Dzurec and I.L. Abraham, The Nature of Inquiry: Linking Quantitative and Qualitative Research, *Advances in Nursing Science* 16, no. 1 (1993):73–79.

66. B.B. Granger and M. Chulay, *Research Strategies for Clinicians* (Stamford, CT: Appleton & Lange, 1999), 2–3.

67. D. Hamilton and G.A. Bechtel, Research Implications for Alternative Health Therapies, *Nursing Forum* 31, no. 1 (1996):6–10.

68. B.J. Breitmayer et al., Triangulation of Qualitative Research: Evaluation of Completeness and Confirmation Purposes, *Image* 25, no. 3 (1993):237–243.

69. Eichhorn, Meyers, Guzzetta, Clark, Klein, Taliaferro, and Calvin, Family Presence During Invasive Procedures and Resuscitation: The Experiences of Family Members, Nurses, and Physicians, 32–42.

70. Astin, Why Patients Use Alternative Medicine.

71. Hamilton and Bechtel, Research Implications for Alternative Health Therapies.
72. C.E. Guzzetta, Effects of Relaxation and Music Therapy on Patients in a Coronary Care Unit with Presumptive Acute Myocardial Infarction, *Heart and Lung* 18 (1989):609–616.
73. K. Cavender, M. Goff, E. Hollon, C.E. Guzzetta, Parental Participation in a Positioning-Distraction Intervention with Children Undergoing Venipuncture Effects on Pain, Fear, and Distress Levels, *Journal of Holistic Nursing* (Submitted for publication, May 2003).
74. M. Cowan et al., Self-Management Biofeedback Therapy for Sudden Cardiac Arrest Subjects: The Use of Process Variables, in *Nursing Research and Its Utilization*, eds. J.J. Fitzpatrick et al. (New York: Springer, 1994), 83–90.
75. D. Ornish, Can Lifestyle Changes Reverse Coronary Heart Disease? *Lancet* 336 (1990):129.
76. K.L. Gould et al., Changes in Myocardial Perfusion Abnormalities by Positron Emission Tomography after Long-Term, Intense Risk Factor Modification, *Journal of the American Medical Association* 274, no. 11 (1995):894–901.
77. D. Ornish, Can Lifestyle Changes Reverse Coronary Heart Disease?
78. Gould et al., Changes in Myocardial Perfusion Abnormalities.
79. W. Heisenberg, *Physics and Philosophy* (New York: Harper & Row, 1978), 42.
80. J.F Quinn, M. Smith, C. Ritenbaugh, K. Swanson, M.J. Watson, Research Guidelines for Assessing the Impact of the Healing Relationship in Clinical Nursing, in Definitions and Standards in Healing Research, eds. W.B. Jonas and R.A. Chez, supplement to *Alternative Therapies in Health and Medicine* 9, no. 3 (2003):A75.
81. Ibid., A65–A79.
82. Dossey, Samueli Conference on Definitions and Standards in Healing Research: Working Definitions and Terms, A11.
83. Quinn, Smith, Ritenbaugh, Swanson, Watson, Research Guidelines for Assessing the Impact of the Healing Relationship in Clinical Nursing, A66.
84. Ibid.
85. G. Zukav, *The Dancing Wu Li Masters: An Overview of the New Physics* (New York: William Morrow, 1979), 111–114.
86. C. Tart, *States of Consciousness* (New York: E.P. Dutton, 1975), 207–228.
87. W. Heisenberg, quoted in N. Herbert, *Quantum Reality* (Garden City, NY: Anchor/Doubleday, 1987).
88. C.E. Guzzetta and B.M. Dossey, *Cardiovascular Nursing: Holistic Practice* (St. Louis: Mosby–Year Book, 1992), 392–393.
89. H. Beecher, The Powerful Placebo, *Journal of the American Medical Association* 159 (1955):1602.
90. F. Evans, Expectancy, Therapeutic Instructions, and the Placebo Response, in *Placebo: Theory, Research, and Mechanism*, eds. L. White et al. (New York: Guilford Press, 1985).
91. Dossey, *Space, Time, and Medicine*.
92. A. Roberts, Placebo Therapies Spark "Improvement" for 7 of 10, *Brain Mind Bulletin* 18, no. 12 (1993):1.
93. J. Frank, Mind-Body Relationships in Illness and Healing, *Journal of Internal Academic Preventative Medicine* 2 (1975):46.
94. E. Rossi, *The Psychobiology of Mind-Body Healing* (New York: W.W. Norton, 1993), 15.
95. Ibid.
96. Ibid., 16.
97. A.H. Roberts, The Powerful Placebo Revisited: Magnitude of Nonspecific Effects, *Body/Mind Medicine* 1 (1995):35–43.
98. Frank, Mind-Body Relationships in Illness and Healing, 46.
99. L. Dossey, *Healing Words: The Power of Prayer and the Practice of Medicine* (San Francisco: HarperCollins, 1993), 134–135.
100. Guzzetta and Dossey, *Cardiovascular Nursing: Holistic Practice*, 392–393.
101. Rossi, *The Psychobiology of Mind-Body Healing*, 11–22.
102. C.B. Pert, *Molecules of Emotion: Why You Feel the Way You Feel* (New York: Charles Scribner's Sons, 1997).
103. Dossey, *Space, Time, and Medicine*, 36.

CORE VALUE 3

Holistic Nurse Self-Care

VISION OF HEALING

Toward the Inward Journey

The root word of healing and healer is "hael," which means to facilitate movement toward wholeness or to make whole on all levels—physical, mental, emotional, social, and spiritual. As sophisticated as our modern medical system is, there are no criteria for what constitutes healing. In fact, it often seems that there are two different sets of criteria for the evaluation of healing. One set of criteria looks at "the numbers" of biologic data; the other set is more subjective and assesses the experience of the client "feeling stronger" or "feeling better." If we use the root word in the true sense, healing incorporates both sets of criteria. The either/or—that is, either a body problem or an emotional or spiritual problem—is a false dichotomy. There is no such thing, for the body-mind-spirit is a single, integrated entity.

A healer is aware of the importance of understanding the belief systems of self and others. A healer recognizes that consciousness and the human spirit operate not only within a person, but also operate between and among individuals—between nurse and client, as well as among nurse, client, family, and colleagues. Nurses have the unique opportunity of being present to guide people in understanding meaning in their life, whether it be through wellness instruction, acute situational crisis intervention, chronic illness management, or the transition to peaceful death. Being present to guide and help the client in making connections of body-mind-spirit is healing. The clearest way to understand this interaction is through the concept of the nurse as a healer. The fundamental principle that a nurse follows to become a healer is skillfully bringing together inner resources of knowledge and intuition. The nurse healer must identify his or her own woundedness, the life polarities, and the purposes and meaning in life.

When nurses live and practice from a holistic perspective, they recognize that there is no separation between their personal and professional selves. As they expand their consciousness and repattern their lives with healing intention, they take into all aspects of their life and work a sense of sacredness. When nurses develop a sense of sacredness about their work and explore the state of "nurse as healing environment," then nurse healing is manifest at the highest level. As we challenge ourselves to understand more deeply the sacredness of our work and to understand ourselves as healing environments, we too are healed. We must reawaken our spirit and cultivate it if all the powers of our soul are to act together in perfect balance and harmony. There can never be any real opposition between spirituality and science, for one is the complement of the other. Self-knowledge brings us face to face with the mystery of our own being.

Chapter 10

The Nurse As an Instrument of Healing

Maggie McKivergin
with contributions by Amy Quarberg

NURSE HEALER OBJECTIVES

Theoretical

- Discuss the importance of the practice of presence as the essence of care upon which to build nursing interventions.
- Explore the relationship between the qualities of presence and the attributes of grace and "grace-filled-ness."
- Describe the qualities and characteristics of the nurse as an instrument of healing.

Clinical

- Identify opportunities in which to practice presence with self, clients, and colleagues.
- List the qualities that allow nurses to be most present with themselves and others.
- Discuss ways to create sacred space.
- Identify appropriate methods of intervention that will access an individual's inner healer/teacher.
- Assess one's personal skills as an instrument of healing and identify areas in which to expand their quality and practice of healing.

Personal

- Learn techniques to become more present and integrate these experiences into your daily life.
- Acknowledge your inner response when you are fully present with yourself and others.
- Recognize opportunities in which to acknowledge the quality of grace operating in your life.
- Align with qualities of becoming an instrument of healing for self and others, thus creating a healing environment that contributes to the overall good of the earth.

DEFINITIONS

Centeredness: a fine-tuned sensitivity to life's inner and outer patterns and processes;[1] a state of balance of self that allows optimum levels of attention and presence to the moment.

Chaos: a naturally occurring systemic pattern of uncontrolled activity, whose direction cannot be predicted.[2]

Grace: seemingly effortless beauty or charm of movement, form, or proportion; a disposition to be generous or helpful; Divine love and protection bestowed freely on people.[3]

Graceful Presence: a presence which flows from the embodiment of Divine love; moving mindfully with a kinesthetic awareness of the sacredness of being grace-filled and graceful; a lightness of being; an intentional love-infused presence.

Guide: one who helps others discover and recognize insights and healing awareness about their life journeys and priorities.[4]

Healing: the return of the integrity and wholeness of the natural state of an individual;[5] the emergence of right relationship at, between, and among all levels of the human being;[6] the process of bringing together parts of oneself (physical, mental, emotional, spiritual, relational) at deeper levels of inner knowing, leading to an integration and balance, with each part having equal importance and value.[7]

Healing Environment: an environment that facilitates the emergence of the Haelen effect—the synergistic, organismic, multidimensional response of the whole person in the direction of healing and wholeness;[8] the physical, emotional, social, kinesthetic, and energetic properties of the surroundings/field that can provide a climate of support for the healing process.

Intention: the conscious alignment with creative essence and divine purpose that allows the highest good to flow through a healing intervention or through life itself.

Intuition: a perceived inner knowing and insight into things and events without the conscious use of rational processes;[9] the ability to be present to another dimension of knowing.

Mindfulness: paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally; the art of conscious living.[10]

Nurse As an Instrument of Healing: a nurse who offers unconditional presence and helps remove the barriers to the healing process; one who creates the space, enhances the environment, and is present to the phenomenon of the unfolding of healing in another; a practitioner who opens the opportunity for another to feel safe and bring into alignment that which has been painful and out of relationship with the self, others, Creator, and creation.[11]

Presence: a multidimensional state of being available in a situation with the wholeness of one's individual being; the relational style and quality of "being with" rather than "doing to."[12]

Relationship: the nature, depth, and degree of connection and interaction between the self, others, Creator, and creation.

Transcendence: the ability to rise above circumstance and develop a broader perspective for experience that brings deeper meaning into and through the context of life.

Whole Person Assessment: a physical, intellectual, emotional, relational, spiritual, vocational, environmental, kinetic, and intuitive interpretation of another individual in relationship to himself or herself, others, Creator, and creation.[13]

THEORY AND RESEARCH

Healing does not occur in a vacuum. Life has its challenges and opportunities in which to learn, heal, and grow. An individual's response to each of those moments determines the effect of any given event upon his or her body, mind, spirit, relationships, work, and life. Understanding responses to life's challenges is critical, as people often are faced with decisions that tip the scales between life-giving or self-destructive behaviors.

People think, feel, and behave in ways that are influenced by their perception of what is happening in their lives. Based on that perception, they either make sense of what is going on, or they respond with fear and confusion, which can send their system into a stressed state. The choice depends on how they place a particular event within their lives and the meaning that they attribute to the ongoing story.[14] It is at this point that the healing presence offered by a nurse committed to nurturing the essence, wholeness, and integrity of the individual can be a support for clients and their families. This quality of presence can initiate a response from an individual that can bring perspective, discernment, alignment, balance, meaning, and healing.[15] The nurse has the opportunity to give the gift of relationship freely, helping to create the foundation on which all healing and interventions can be based.

The Concept of Healing

It is a challenge to find truth and support for a one's own healing journey in this world, as life is not always healing. The person, being sensitive in nature, is not always surrounded by an environment conducive to peace/harmony/loving; therefore, people are often subject to actual or perceived threats to the natural integrity and wholeness of their essence. Throughout life, individuals encounter many challenges to the integrity of their systems. Family dysfunction, cultural influences, and unhealthy systems in which they find themselves (e.g., schools, churches, communities, corporations) all affect the quality of their life and health. Such threats to one's system, either actual or perceived, make it necessary to protect oneself. Fortunately, the body has a wonderful system to build immunity and defense.

Understanding how to protect oneself helps in choosing responses to life's challenges. The system protects itself by closing down to varying degrees, some of which are healthy and some of which can impede the degree of energy flow. Because a closed system does not have a healthy flow of life-giving energy and does not release that which is toxic to the system, it can result in patterns of disease, pain, negative energy, and just as a disconnection from the flow of life-giving energy. The picture of a patient in pain, lying in a hospital bed, contracted not only physically but also emotionally and spiritually, comes to mind when thinking of a closed system. Many times, nurses have attempted to reach out to these people who are so fragile, who need the gift of connection to help alleviate some of their suffering. As these individuals open up to share the stories of their lives, the dynamics of their unfolding story reflect much pain, and put the physical pain within the context of life's pain. Part of the healing occurs through listening to these stories and identifying cues that indicate more of the essence of disease.

Disease is often rooted in responses to life's challenges. Not only energetic blocks to flow, which are manifestations of responses to the patterns of life, but also an imbalance in many of the dimensions that encompass the human experience can produce disease. Changes in perceived levels of energy in relationship to areas of life, as well as the scanning of the energetic field, can be sensed earlier than the actual manifestation of physical symptoms.[16]

Healing is defined as the return of the integrity and wholeness of the natural state of an individual.[17] It can occur across the continuum of illness through reaching one's highest potential at any moment in time. It can be defined as the emergence of

the right relationship at, between, and among all dimensions of the human being. B.M. Dossey defines healing as the process of bringing together all parts of one's self (physical, mental, emotional, spiritual, relational) at deeper levels of inner knowing, leading to an integration and balance, with each part having equal importance and value.[18]

The process of healing is one in which the nurse exchanges energy, truth, and communication with clients to help those clients attune to their own healing capacities and implement the healthiest response possible for any given situation. The nurse serves as a mirror to the client in helping reflect in a healing way the essence of the challenge and opportunity at hand. Connections are made in which a sensitive, selfless regard for another opens the door for a meaningful relationship. The immense power evoked in the relationship between the nurse and client is instrumental in the therapeutic process of healing.[19] The essence of the healing relationship is the nature of the nurse's presence.

The Concept of Presence

Paterson and Zderad first described the concept of presence as "a mode of being with the wholeness of one's unique individual being: a gift of self which can only be given freely, invoked or evoked."[20] They defined presence as a relational style within nursing interactions that involve "being with" as well as "doing with." Presence is generally defined as a multidimensional state of being available in a situation with the wholeness of one's individual being.[21] It is a holistic self-giving exchange, the acknowledgment of a sacred quality operating within one person that can intentionally connect with that sacred quality in others. This process results in an exchange and linking of authentic essence and a meaningful awareness that offers integration and balance in the relationship of healing.[22]

Doona and associates describe presence as "an intersubjective encounter between a nurse and a patient in which the nurse encounters the patient as a unique human being in a unique situation and chooses to spend herself on the patient's behalf while, at the same time, the patient invites the nurse into his experience."[23] The essence of presence, or "being with," implies a conscious intention to appreciate the connection of the moment. A moment in time—the reality of the shared experience in the "now"—creates an open container through which life, energy, and healing can flow. Letting go of past concerns and/or future fears, even for a moment, can create the space and opportunity for the system to open up and reveal what is needed to make it more whole.

Caregivers can encourage this presence and help to focus and bring forth the deepest desires for wholeness from another, creating the safe and nurturing environment that allows another to explore avenues of healing.[24] Doona and associates describe the coexistence of nursing judgment and presence as so inextricably linked that one does not occur without the other.[25]

There are many levels, dimensions, and ways in which to provide a whole-person approach that combines the skills of nursing judgment and presence. Three levels of presence are described in Table 10–1:

1. Physical presence: the nurse's "being there" for the patient in physical service. Many nursing interventions are carried out at this level, including the routine tasks that are prescribed for the patient. The way in which one person touches another communicates many meanings: love, anger, distress, or sadness can all be communicated nonverbally. The challenge for the caregiver is to let go of

Table 10–1 Levels of Therapeutic Presence

Levels of Interaction	*Type of Contact*	*Skills*
Physical presence	Body to body	Seeing, examining, touching, doing, hearing, hugging
Psychological presence	Mind to mind	Assessment, communicating, active listening, writing, reflecting, counseling, attending to, caring, empathy, being nonjudgmental, accepting
Therapeutic presence	Spirit to spirit Whole being to whole being Centered self to centered self	Centering, meditating, intentionality, at-one-ment, imagery, openness, intuitive knowing, communion, loving, connecting

Source: M. McKivergin and J. Daubenmire, The Essence of Therapeutic Presence, *Journal of Holistic Nursing*, Vol. 12, No. 1, pp. 65–81, © 1994. Reprinted by permission of Sage Publications, Inc.

personal life issues in the caregiving experience to focus intentionally on caring for the client.

2. Psychological presence: the nurse's using self as an intervention tool; "being with" the client in a therapeutic milieu that meets the client's needs for help, comfort, and support. Recognizing belief systems and their effect on a person's response to life is critical in understanding the degree of presence needed from a cognitive standpoint. This relates to levels of knowing, which include intellectual thinking, rationalization, memory, and the mental component of health. Psychological presence provides understanding, interpretation, and meaning to life's events.
3. Therapeutic presence: the nurse's relating to the client as whole being to whole being, using all the resources of body, mind, emotions, and spirit. The spiritual dimension of presence is experienced as unconditional love, the letting go of judgments, and believing a person is doing his or her best in the situation. When a person is surrounded by unconditional love, which requires the caregiver's intention of presence, the person can access innate healing abilities and, thus, gain insights into self-healing.[26]

Osterman and Schwartz-Barcott described four ways of "being there": (1) physically present with energy focused on the self; (2) physically present with energy focused on the task; (3) physically present and psychosocially focused (energy focused interpersonally); and (4) physically, psychosocially, and spiritually in relationship that is transforming (energy-centered) and illuminates the oneness of nurse and patient.[27] The latter is defined as "transcendent presence" and is felt as peaceful, comforting, and harmonious. An outcome of this is positive change in the affective state, such as diminished anxiety, and a feeling of being connected to another and thus not being alone.

Qualities of Presence

The skill of being present to others evolves as a nurse gains professional experience. The initial focus for a new nurse is developing the adequate skill level to provide safe care through the acquisition and practice of basic skills and techniques. Maturity in the nursing profession increases the sensitivity of recognizing the connection

between a person's life and health, as well as the perception of the person's body as metaphor. With each level of understanding, the nurse's attitude shifts from "What can I do?" to "How can I be with the person in this moment in a way that will provide the best possible outcome?"

As nurses have taken courses and explored the concept of presence, they have identified the qualities of presence to include unconditional acceptance, patience, lovingness, nonjudgmental attitude, understanding, good listening skills, honesty, empathy, and many other such descriptors.[28]

Five distinguishing features of nursing presence include:

1. Self-giving to another at the moment at hand; being available and at the disposal of another
2. Listening to the other
3. Knowing the privilege in participating in the healing experience
4. Giving of one's self
5. Being with another in a way the other person perceives as full of meaning[29]

The nurse can encounter a patient in a variety of states that warrant the adoption of the qualities of presence. The patient experience can be chaotic, like a hurricane, swirling uncontrollably on a course beyond determination. Nurses can offer the gift of presence in the storm by being present in at least four ways: (1) being in the midst of the swirl with the patient; (2) offering a groundedness that can help anchor the patient; (3) providing a centering influence that is likened to being in the eye of the hurricane, but needs to be sensitive to its flow or you get caught up in the worst winds; or (4) offering a transcendent quality that helps the patient to rise above the whole situation and put it into perspective (like the weatherman looking at the clouds from above), thus expanding consciousness.[30] To remain with a person in the midst of the storm, exposing one's humanness and offering comfort and healing support, is one of the greatest gifts that nurses can offer. The journey with another helps promote a sense of well-being, offering silent presence or helping to understand and interpret the challenge at hand.

The Concept of Grace and Presence

The concept of grace is multifaceted, for there are physical, psychosocial, and spiritual components within its description. The word grace is derived from the Hebrew root meaning "favor," and is defined in the dictionary as "seemingly effortless beauty or charm of movement, form, or proportion; a disposition to be generous or helpful; Divine love and protection bestowed freely on people."[31] Theologians describe grace as "the living will of God"[32] and "the quality of Divine order."[33] Sanctifying grace is defined as "the supernatural quality Divinely infused in the soul of man, to be used to heal the soul, give power to will the good and grant perseverance."[34]

Exploring the connection between the qualities of presence and the attributes of grace, as noted in the various definitions, suggests an expanded description and definition of a healing or therapeutic presence, namely "graceful presence." Graceful presence is defined as a presence that flows from the embodiment of Divine love; moving mindfully with a kinesthetic awareness of the Sacredness of being grace-filled and graceful; a lightness of being; an intentional love-infused presence.[35] Having the awareness of being infused with the Creator's love and offering it unconditionally is the underlying premise in being a "graceful presence."

This embodiment of a Divine connection that is infused in our soul is scientifically supported by the pioneering research per-

formed by Candace Pert, Ph.D. She discovered that there is something beyond the bodymind that is directing cellular functions simultaneously throughout the body. Considering where this information comes from she states " . . . it cannot belong to the material world which we comprehend through our senses, but must belong to its own realm, one that we can experience as emotion, the mind, the Spirit—an *infore-alm!* Others mean the same thing when they say field of intelligence, innate intelligence, the wisdom of the body. Still others call it God."[36]

The Taoist tradition believes that "Being *present*, is to acknowledge that everything is spiritual."[37] It is this ability to move with the awareness that everything is spiritual, this mindfulness of being grace-filled with the embodiment of unconditional love and effortless beauty of actions, that makes graceful presence so healing.

Having the intellectual and scientific understanding of a Divine connection within our bodymind is only one part of the equation for projecting a graceful presence. The other, more powerful, part is the physical or kinesthetic awareness of the Divine connection and the intention to activate it. When a nurse feels the lightness of being and radiant energy of God's love infused in her/his body, a graceful presence is projected.[38] Examples of one's "graceful presence" include the calm and competent aura that is radiated when a nurse walks into the room; the gentle tone of voice; the loving touch and genuine connection through the eyes. It is the nurse's ability to see the patient as a whole person, allowing the patient to remember who they really are, and loving them with a compassionate heart.

In the context of the privilege of relationship, a nurse can intentionally align with the Divine in order to be an instrument of grace and healing. Practicing the essence of therapeutic presence can be further understood by examining the nature of four key relationships in which healing can be manifested: the relationships between self, others, Creator, and creation.

THE NATURE OF HEALING RELATIONSHIPS

An essential part of being human is the fact that people are not isolated entities, but rather are automatically in relationship with themselves, others, Creator, and creation. An important example follows:

> Once a friend who had suffered many losses contacted me (the nurse) with a concern that they were "going crazy." The person inquired what my definition of crazy was, and in thinking of a response I answered that there are four critical elements for sanity: relationship with self, others, Creator, and creation. When we lose touch with all of these relationships, we have trouble feeling connected to this life. The person was comforted in that they had a strong sense of creation, and shifted through their moment of chaos to ground their anxiety and grow in their understanding of the nature of relationships in the other areas.

In 1992, the Pew-Fetzer Task Force postulated that the foundation of care given by practitioners is the relationship between the practitioner and the patient, a relationship vitally important to both.[39] This relationship is a medium for the exchange of all forms of information, feelings, and concerns; a factor in the success of therapeutic regimens; and an essential ingredient in the satisfaction of both the patient and practitioner. For patients, the relationship with their provider is the most therapeutic aspect of the health care encounter.[40] The phrase "relationship-centered care" captures the importance of the

interaction among people as the foundation of any therapeutic or healing activity.[41] The implications of this report are far-reaching and need to be included in the practice of all care given in any health care environment. Principles of presence are the essence of relationship-centered care and are integral in nurturing the relationships with one's self, others, Creator, and creation.

Relationship with the Self

A healing relationship with the self implies conscious and mindful approaches to being in the moment; i.e., being present to the present, and recognizing the implications of life events on one's self. Focusing attention and care on what is bringing energy to or draining energy from one's life helps to guide the relationship with the self. Assessing the physical, emotional, intellectual, spiritual, vocational, environmental, and relational dimensions of one's life, and asking what in each of the areas is contributing to or diminishing the energy experienced in life, helps one to achieve deeper meaning and recognition of the unique gift of life and to nurture growth and life to the fullest capacity. Alignment with a personal process of healing and unfolding takes conscious intent, sensitivity, and awareness.

Dossey and associates have described the characteristics of nurse healers that affect the relationship they have with themselves as instruments of healing:

- Awareness that self-healing is a continual process
- Familiarity with the terrain of self-development
- Recognition of strengths and weaknesses
- Openness to self-discovery
- Continued effort to develop clarity about life's purposes to avoid mechanical behavior and boredom
- Awareness of present and future steps in personal growth
- Modeling of self-care in order to help self and clients with the inward process
- Awareness that a nurse's presence is as important as technical skills
- Respect and love for clients regardless of who or how they are
- Willingness to offer the client methods for working on life issues
- Ability to guide the client in discovering creative options
- Presumption that the client knows the best life choices
- Active listening
- Empowerment of clients to recognize that they can cope with life processes
- Sharing of insights without imposing personal values and beliefs
- Acceptance of what clients say without judging
- Perception of time with clients as being there to serve and share with them[42]

It is important to realize that we are all wounded healers—that there is a part of us that is in need of healing. Yet we are tempted to ignore this woundedness.[43] Often, nurses find themselves caring for others at home, at work, in the community, or within their marriages, and they do not take care of themselves. This leaves them drained, burned out, and fragmented. As caregivers, we must balance out the giving with the receiving in order to ensure our ability to introduce ourselves as part of the equation of care.

Embracing one's perceived limitations provides guidance to increased wholeness. Making one's wounds a source of healing calls for a constant willingness to see the pain and suffering as rising from the depth of the human condition that is common to all, and brings meaning to experience. Healing from one's woundedness creates strength and a growth from the alignment with healing that enhances a nurse's therapeutic capacity—the ability

to hold another in deeper, broader, and more powerful ways.

Because it exposes one's vulnerability in the sometimes uncontrollable journey of being human, presence may be uncomfortable. Nurses may use defense mechanisms to avoid true connection with another. Manifestations of avoidance include turning and walking away, maintaining the integrity of an impenetrable defense system. Nurses often shield themselves under the guise of professionalism by using their role, counseling techniques, or communication skills as a protective wall to maintain distance.[44] Blocks to presence can be unintentional or intentional and are manifested as some of the following:

- Busyness/task focus
- Fear
- Concern over what other people will think
- Feelings of inadequacy ("I'm not ____ enough")
- Lack of desire/intent to be present
- Distractions
- Need to be in control
- Goal direction, responsibilities
- Lack of patience
- Lack of openness
- Personal or physical limitations[45]

At times a nurse may be too tired, too busy, or unable to offer depth of presence and service to another. It is important for nurses to be aware of this and communicate limitations to their patients. Should these blocks become a recurring pattern in which a nurse is running away from the cumulative effect of situations that are painful or uncomfortable or that make the nurse feel inadequate, it is essential for that nurse to process his or her own reactions and gain an insight into his or her own responses. It is thus that nurses become present to the most important of relationships—the one with themselves, and the need to care for themselves as a Sacred instrument of healing.

Nurses should create their own support team for their process of healing. They can then begin to understand how best to be present in relationship to others, enhancing their capacity to be therapeutic and to serve as instruments of healing for others. As they foster the characteristics Dossey and associates listed, they form themselves through their intentions to know, love, and serve. They then have an abundance from which to share in their ministry to others.

Relationship with Others

Being in relationship with another is offering the multidimensional gift of interpersonal connection with another. The connection with another can be physical, emotional, psychological, intuitive, spiritual, kinetic, or therapeutic in nature, with varying levels of depth and transcendence. The following experience as a story by the author illustrates connections on many levels:

> Several years ago I was visiting a Native American village in the Southwest, where upon arrival I immediately lost the party with whom I was traveling. Being aware that it felt out of the ordinary to be in this situation, I asked Spirit to guide me, and I was led through the village, across a bridge, and to an artist's studio. In the studio was a charming young Native woman who asked if I did healing work. In acknowledging my gift, she asked if I could help her with some back pain she had been experiencing. I was delighted to be of service.
>
> I asked her how long she had been experiencing the low back pain, and she replied that it had been one year. I then asked her about what had been going on in her life at that time. She shared that her mother had died and her aunt, who was an elder of the tribe, had stolen her inheritance and lied about the incident. Afraid to challenge an elder, she let the incident go,

but the pain in her back developed shortly thereafter.

Her intention for our time together was not only to be healed from her pain but also to forgive her aunt, as her feelings were hampering her spiritual essence of being a good Christian. I reflected that what her aunt had done was wrong and that forgiveness for something that is wrong may not be the first step in healing. I suggested that we might want to try to understand why the aunt did what she did so that we might develop compassion for her, which eventually may lead to forgiveness.

With that, it was as if we both could see a movie screen, one that revealed to us a picture of the old days on the plains. The buffalo were roaming, and the Natives were quietly watching the peaceful scene of grazing under the big sky. White man entered the scene and proceeded to shoot the buffalo, stealing the Native's land and lying to the Native people with promises of payment and respect. With this vision, the Native woman and I looked at each other, and I stated, "Look, your aunt has become what she hates! It was wrong for the white man to do that, and it is wrong for your aunt to do this to you. We need to design a way to bring forth justice. I would suggest you find a woman on the council who can mentor you in regaining your property in a just and truthful way. Then I want you to climb to the top of that peak (I pointed to a peak which just so happened to be the tribe's holy mountain), look down on the village, and realize how small all of this is. Adopt the Spirit of the Eagle, and rise above the situation. Then you will free yourself."

By this time, most of the pain in her back had already subsided. I then smoothed out the energy in her lower back, and the woman was released from her pain, staying pain-free. She shared with me a present of a silver carving of her village so that we would always be connected.

This story reflects presence to the many dimensions of physical, emotional, psychological, intuitive, spiritual, and cultural healing, integrating and healing the many parts of the Native American woman's experience. She demonstrated the courage to heal and to address that which was painful to her.

Presence implies relating to another person in the moment at hand in a way that the other person defines as meaningful. This presence is more powerful when connected with self, Creator, and creation. A healthy balance of relationship with each of these areas promotes well-being. When there is a deficit in any of these relationships, imbalances and voids can occur in that area. When individuals are unable to love themselves, for example, or are unable to be in relationship with themselves in ways that promote joy and happiness, they often depend on their relationship with others to fill that void. Increased expectations from others, whether from friends, spouse, or children, can create an unhealthy balance that can lead to codependence, or relationships with others that are dependent on needs rather than shared experience.

With intention and practice, a nurse can learn to help bring people toward a more inclusive, unobstructed relatedness to life. Moss identified three qualities of relatedness:

1. Creative involvement: an original and spontaneous participation in life without judgment
2. Intensity: the quality of attention; the depth from which our involvement with life emanates
3. Unconditional love: the principle of inclusivity; an implicit sense of prior wholeness[46]

Qualities of a healthy relationship with others include reciprocity, the ability to give and receive respect; care for the

unique path of the other; the ability to offer freedom for others to be themselves; openness to the wholeness of others without categorizing them; happiness in being together; trust; truth telling; freedom from physical or emotional abuse; willingness to tend to the connection with the other and self, to accept change in another without trying to stifle that growth, to share feelings, to share relationships within the context of community; and the ability to honor the Sacred within the other, as well as between both. Key to quality relationships is that they are heart-centered, offering unconditional love in each moment of presence to each other.

Relationship with Creator

As instruments of healing, nurses acknowledge that healing does not come *from* them, but *through* them. In their openness to the potential for healing that comes from the relationship not only between the caregiver and the individual, but also in relationship with Creator and the energetic environment, they begin to experience the power and depth of the mystery of healing unfolding. Bringing the presence of Creator into the many dimensions (e.g., physical, emotional) can bring a deeper understanding of wholeness, integrity, meaning, and truth of the moment/situation/self. It reveals what is naturally to be addressed in the healing of each individual at each given time.

The recognition of self as Sacred integrates the essence of Creator in this life through inspiration, transcendence, truth, grace, hope, forgiveness, and love. Openness to the unfolding of our lives in any moment, and co-creating the unique expression of the gift of our lives with our Creator/Spirit, is the essence of our loving nature.

As an instrument of healing, a nurse develops an ear to listen for the themes of spiritual distress, namely, those areas in which a person feels unconnected; is yielding to emptiness or a lack of faith; has a diminished sense of trust in the process; or feels fear, hatred, and a lack of forgiveness for self and others. Identifying areas of imbalance and helping the individual to recognize the spiritual essence that will help bring trust, forgiveness, courage, compassion, and love into his or her experience creates an openness that is healing and allows the wonders of Creator to become manifest.

It is important to respect the definition that each individual brings to the concept of Creator/Spirit. Honoring the individual's belief system permits access to the individual's innate healing abilities and avoids imposing one agenda (our own) on another, thus diminishing the therapeutic potential of the dynamic of healing.

Mindfulness techniques are an effective and easy way for caregivers to feel in their body the awareness of being connected kinesthetically to something Sacred. Mindfulness is defined as "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally . . . it is the act of conscious living."[47] The simple act of paying attention to the body as one walks down the hall, or to the movement of air flowing in and out as one breathes, are just two examples of mindfulness techniques that a nurse can use to deepen Divine connection and be present in the moment.

For example, imagine the energetic shift that happens when one starts to pay attention to the mechanisms of walking—the feel of the floor beneath the soles of the feet, the hinged movement of the joints, the lubricating fluid within the joint sockets, and the support of the spine holding the body erect. This focused attention on the movement of the body and the soles of the feet on the ground literally helps one to be more centered and grounded, and less likely to be 'running around with their head cut off.' "In bringing mindfulness to your

body as a whole, you can reclaim your entire body as the locus of your being and your vitality, and remind yourself that 'you' whoever you are, are not just a resident of your head."[48] As a nurse healer, integrating the awareness of your body and claiming it as part of yourself is a necessary component for projecting a healing, "graceful presence" because it opens you to the wisdom and Sacredness of your body.

Another approach to gain awareness of the inner and outer flow of grace is through mindful breathing. The breath is a natural cue for nurses as they practice presence to themselves. The breath is also our body's natural means for activating the relaxation response and is an essential component for centering.[49] The Latin word for breath is *spiritus* and, thus, many cultures associate a connection between the breath and Spirit.[50] "If breath is the movement of Spirit in the body—a central mystery that connects us to all of creation—then working with the breath is a form of spiritual practice."[51] The ability to control one's response to an event, stress, or pain by becoming literally through the breath helps one to be more present to each moment and open to the Spirit within. It is thus that we can feel the presence of grace in life.

Relationship with Creation

Sensitivity to the essence of life and its seasons and rhythms, and recognizing the message, meaning, and life-giving energy inherent in all of creation, heals us in many ways. In a healing interaction between two people, for example, the frequency of their different energies synchronizes with the same frequency of the earth.[52] The vibration between two people who are aligned in intention and open to the rhythm of healing produces a resonant vibration that is called *entrainment*. The mutuality of vibration that can be healing in nature helps to remove the blocks that inhibit the flow of energy.[53]

Nature teaches important themes related to the organic healing process. Seasonal themes hold rich metaphors in relating to the spectrum of life—from the beginning of creation to new life, blossoming, fullness of life, letting go, changing, and finally to recreation and rebirth. Metaphors of growth (e.g., the seed, planting, nurturing, harvesting, renewal) are instrumental in understanding the cycles of experience. In addition, rich messages lie within the phenomena of nature, such as flow, flexibility, and rootedness, all of which ground us to the earthly experience.

The native peoples from around the world have a deep respect for the Sacredness of natural healing and the importance of the healing essence of nature. They see themselves not as separate from the land, but as one with nature. In the Western culture, however, society is so fast-paced that people are losing touch with this inherent rhythm and are becoming divided from this natural, healing connection. As instruments of healing, it is important for nurses to be grounded within themselves, as well as to assist others in their healing process and to understand the wealth of beauty and energy that the earth has to offer. It is important to help people develop a sense of connection with the earth, its rhythms, and its seasons, as well as the healing energy that it has to impart through its essence and messages.

THE NURSE AS A HEALING ENVIRONMENT

There is immense power in the relationship between the nurse and the client that is instrumental in the therapeutic process of healing. Through the intention of unconditional presence, the nurse provides an environment of support and healing by patterning the environment to evoke the healing response. With both attention and intention, the environment can become one in which the client can feel safe and

explore the dimensions of self in the healing moment. The nurse who understands the nature of a healing environment can shape both the physical environment (external) and the personal environment (relationship-focused) to evoke the healing process. This environment is sacred in its essence, and with focused intention can create an energetic climate to promote and enhance healing.

By connecting with the Sacred within each person and accessing the person's inner healer, the alignment with the Divine enhances and guides the healing process in a powerful way. In the process of expanding their consciousness and creating a Sacred space in which healing can occur, nurses are also healed. Rogers postulated that the fundamental unity of the living system is an energy field that is coextensive with the environmental energy field; therefore, each one is affected by the other.[54]

The nurse not only is in the healing environment, but also offers himself or herself as an environment in which the individual can dwell.[55] Nelms related the gift of presence to the "creation of home being twofold, for in making a home for their patients, the nurse created homes for themselves; places where, as the nurse enables patient-being to be unconcealed, her own nurse-being is more fully revealed."[56]

The following enhance a nurse's capacity to develop greater depth, breadth, and height in becoming an instrument of healing:

- Self-care; not only physically, but also in all dimensions that remove the blocks to personal flow of energy and healing
- Personal interpretation of life's lessons and meaning
- Rootedness and expansiveness; an understanding of the art of balance between a grounded approach and the intuitive inspiration that creates a vision of health and wholeness and moves one in that direction
- Understanding of core dynamics; recognition of the holographic nature and metaphor of systems and the essential nature of life, health, and healing
- Expansion of consciousness; the ability to broaden one's thinking, shift perspectives, and encompass a new approach to life
- Growth in love; the ability to increasingly grow in loving presence to self, others, and the world in a way that creates the highest level of healing
- Courage; the ability to overcome the fear that is encountered in the healing process as one walks through the fight or flight response with the clarity of intention to get through the block/pain
- Alignment with the Divine
- Openness to being an instrument of Creator's healing grace
- Ability to detach oneself from the outcomes
- Groundedness and reliability
- Patience
- Authenticity
- Mindfulness
- Integrity[57]

The process of healing is one in which the nurse engages with individuals in an authentic exchange of energy, truth, and communication in order to help them attune to their own healing capacities. By creating an environment of support and reflection, the nurse encourages them to reflect on past, present, and future perceptions and helps them to access their inner teacher, guide, and healer to reframe past experience, create a new reality which is healing, and release strong ties of belief, even at a cellular level, in the process of becoming more whole. This process can have the effect of relaxation or actually demonstrate profound changes as one

faces that which has been numbed, buried, or blocked because of its painful nature.

The emotional, social, and energetic properties of the surroundings/field have a profound effect on the individual. The physical properties of natural light, running water, plants, earth elements, fresh air, color, pleasant sounds, music, healing smells, comfortable temperature, the flow of energy or feng shui, and order in the surrounding space contribute their therapeutic influence to a healing environment.

Nurses involved with healing modalities often cleanse and make Sacred the energetic environment through a variety of blessings and rituals, possibly including the use of holy water, Epsom salts, and alcohol; smudging with sage; and prayer. The intention of creating an environment of healing is critical in providing a place where the client feels safe, light, and open.

HEALING INTERVENTIONS

Healing can occur in many ways, on many levels, and in many dimensions. Nurses can complement care by their presence, by the environment that they create, and by the spectrum of interventions that they choose, guided by the individual's need and response in the moment. It is important to address physical pain as a first priority in providing comfort, as pain relief can then help the individual to relax and be open and receptive to additional interventions and healing.

Preparation for a healing intervention is important to enhance the potential of the interaction. In addition to preparing the external environment, nurses prepare themselves through intention, centering, and alignment with the Divine. Part of the preparation is the degree of consciousness offered to a situation. There is a conscious awareness that is required in setting the intention of becoming an instrument of healing of self and others. Honoring the Sacredness of the potential of the healing relationship, offering the gift of an unconditional loving presence, and connecting with the Divine are the essence of allowing oneself "to be" with another in a way that creates the environment for healing to occur.

"Unknowing" is a necessary foundation for openness within the dynamic of healing.[58] Approaching another or a new situation with the "beginner's mind" provides openness, freshness, and the opportunity to respect mutual knowing. This state evokes a mutual response rather than placing the patient in a dependent position, and it provides access to the inner healer, teacher, and guide. The healing power of vulnerability comes as a result of the nurse's willingness to be present in the moment with the willingness to co-create the outcome rather than to impose a preconceived agenda for the moment.

Part of a nurse's intention is to protect himself or herself from some of the dynamics of the energetic interaction. As instruments of healing, nurses sometimes absorb the negative energy or patterns of others. Healthy ways in which they can protect themselves include:

- having the intention to give and receive only love
- praying for protection from Creator
- taking a focusing, centered breath
- visualizing white light surrounding self and other
- being intentional about healthy boundaries
- being in a healthy, centered, energetic place themselves; determining if their own personal level of energy is adequate in considering being an instrument of healing to another

Preparing one's self as an instrument of healing and creating the container, whether physically or energetically, in which a person can experience healing is the most important component of a healing intervention, like preparing the ground for a seed to be planted.

Steps of the Holistic Caring Process

The nurse who serves as an instrument of healing goes through the steps of the holistic caring process, a circular process that involves six steps that may occur simultaneously. These steps are assessment, patterns/challenges/needs, outcomes, therapeutic care plan, implementation, and evaluation. (See Chapter 14.)

Assessment includes:

- interviews, involving the outline of the individual's story and listening to themes and responses to life's events
- whole person well-being
- functional capacity
- health risk indicators
- quality-of-life indicators
- process analysis/personal goals
- the openness or closure of the person as a system, with identification of possible places that would indicate the direction of an intervention
- scanning of the energy field of the person
- interpretating with the person the meaning of the mutual exchange[59]

Assessment is a mindful process that assumes an approach that is deliberate and attentive to the many levels of being. In modulating the human energy field and its flow and thus facilitating an energy balance, the source of the pattern disturbance often comes into awareness, and the nurse helps to access the inner healer within the client so as to co-create a conscious repatterning of thought, memories, emotions, pain, anxiety, tension, and energy flow.

Healers worldwide focus on the aspects of inner healing and provide deep inner work that has profound physical effects. Krieger and Kunz were first to describe and research the procedure of energy field intervention in nursing, referring to it as *therapeutic touch*.[60] Simultaneously, other schools of healing and individuals that help to provide understanding to the nurse and the individual have emerged:

1. Therapeutic touch
2. Healing touch
3. Hakoni
4. Reiki
5. Barbara Brennan's school
6. Inner Focus School of Energy Field Healing

Each of the different schools supplies a variety of actual approaches to healing work that nurses can use in the moment of shared experience:

- Center, align, and focus attention.
- Intend for the highest good of the client with detachment from ego needs of the healer and healee and outcomes.
- Be and create an environment within which the client feels safe and healing can emerge. Be conscious of giving and receiving only love.
- Assess the energy field intuitively as well as by running the hands over the different levels of the aura, meridians, and chakras (See Chapter 8).
- Note areas of energy congestion or stagnation, and provide feedback to the client in order to enhance synchrony and to ensure that the process is one of conscious awareness.
- Be present to the many levels of the client's being as energy is modulated, blocks to flow removed, and congestion dissipated.
- Encourage open communication in the healing process as it unfolds, so as to enhance the depth of the healing experience.
- Apply different techniques as appropriate to help drain pain, chelate the energy, and relax and smooth the area while helping the individual to breathe into the area and release unhealthy patterns. Adjunct modalities (e.g., massage, prayer, reflexology) can be used to enhance the experience.

- Provide grounding as the client explores new dimensions to his or her being by continuing to reflect truth while providing openness for reflection and exploration.
- Help the client in reframing experiences and memories in the release of what no longer serves the client's well-being, so as to remove emotional and sensory blocks that surface within the healing dynamic.
- Be aware of levels of energy patterning within the aura and field of the client, and facilitate the flow of energy as the healing emerges.
- Smooth out the whole field at the completion of the session, and help the person become grounded, conscious to the present, and oriented with the change.
- Ritualize the closure of the session by honoring the process as sacred (e.g., a prayer of thanksgiving, blow out the candle, give a gift of a flower).[61]

Techniques of healing are as varied as each individual's need. Skills of energy field healing coupled with the modalities of prayer, massage, reflexology, aromatherapy, music, and many others enhance the options for a full spectrum of care and whole-person healing.

Outcomes of a Healing Intervention

Outcomes that reflect a change in a person's awareness, perception, behavior, and relationship to self, others, Creator, and creation are assessed as they were before the healing intervention, and may include the following:

- Whole-person outcomes
    1. Physical: decreased pain, enhanced wound healing, increased energy
    2. Emotional: enhanced ability to feel, name feelings, and express oneself; decreased anxiety; decreased sense of vulnerability; ability to give and receive more love
    3. Intellectual: perceptual reframing of an experience that influences the belief structure, attitudes, and ways of thinking about life and its influence; healing of a painful memory; increased enthusiasm and expression of self; expansion of consciousness
    4. Relational: improved relationship with self, self-esteem, and self-concept; deeper connection with others; sense of being supported by others; understanding of the reciprocal nature of relationships
    5. Spiritual: deeper sense of connectedness with all of life, self, Creator, creation; more hope, courage, trust, and wisdom; enhanced meaning regarding a life event; forgiveness of self or others
    6. Vocational: identification of and alignment with life's purpose and path of expression of gift in the world; improved excitement and creativity in work
    7. Environmental: in tune with harmony of nature and inherent healing rhythms; recognition of meaning and metaphor in the symbols of the earth
- Increased coping strength, even in the midst of unchanged circumstances; access to relaxation response; ability to maintain a flow state; decreased exhibition of self-destructive behavior; decreased perception of the impact of stress on daily life
- Increased sense of well-being/quality of life; demonstration of increased happiness, life satisfaction, and sense of security
- Functional capacity: increased ability to care for self, move, have less pain; enhanced range of motion

- Systemness: freer and more open feeling; establishment of healthy boundaries; feeling of connectedness to a healthier direction (like a cog in the wheel); lessened sense of isolation; sense of freedom to change and become less defined by external parameters.[62]

Evaluation of a Healing Intervention

Scandrett-Hibdon and Freel describe five recurring elements of self-involvement that appear to be aspects of the natural healing process of a client:[63]

1. Awareness
2. Appraisal
3. Choosing/setting intention
4. Alignment
5. Acceptance

In terminating a session with a client, nurses should ask him or her to share the insights of the experience to see if these five elements are present. The release of chaotic patterns or the bringing of awareness and energy into areas that are stagnant yields a variety of outcomes as reported by the client. The nurse should:

- note significant areas of change and energy balance
- have the client report the significance of this experience with implications for next steps
- support the shift of consciousness within the client by sharing the nature of the changes and insights gained with possible ways to approach life and health differently
- affirm positive self-care initiatives[64]

It is important to assist the client with the next steps and follow-up as appropriate. For example, the nurse may advise the client to schedule a personal daily time of reflection as an opportunity to be present to the process of self unfolding, perhaps through journaling, art therapy, music therapy, and meditation. In addition, the nurse may help the individual access a team of support to help bridge and support the change as indicated. Such a team may include a therapeutic/pastoral counselor, physical support with fitness coach, body worker, chiropractor, physician, and significant family members or friends who can help nurture.

Follow-up with the client is important to ensure continuation of the healing process and to identify additional needs. It is also important to evaluate the personal interpretations that the nurse experiences as a result of the healing dynamic.

OTHER CONSIDERATIONS FOR INTEGRATION OF CONCEPTS

Educational Considerations

The concept of relating the essence of disease to the story of a person's response to life, and not just caring for symptoms, is one of the most basic educational considerations. Using techniques for whole-person/whole-life assessment, studying the body as metaphor, and using energy field principles for assessment need to be the foundations for nursing education. Education programs should incorporate techniques for relaxation, energy field assessment, and balancing, as well as courses in complementary pathways to enhance the current body of knowledge. Practicing techniques of being present to patients, as well as self-care strategies, creates a nurturing environment that embodies the essence of nursing.[65]

Practice Considerations

Presence inspires patient care and helps guide nurses in the mystery of each moment, yielding qualities of care described and felt by nurses and their

patients. Natural cues can help nurses be more mindfully present with another.

Nurses who work in the hospital can use the cue of the door to the room as a reminder to be centered and focused. A deep breath while standing outside the patient's door can help in the centering process as a reminder to be inspired in the moment. As the nurse prepares to leave the room, washing the hands can also be a conscious gesture on processing the dynamics of the connection and then moving on to the next moment of awareness with the next person.

Hospital-based practice, outpatient clinics, schools, corporations, parish nurse programs, and private practice are all ways in which to integrate the concepts of whole-person assessment and healing. Holistic dimensions of physical, emotional, intellectual, relational, spiritual, vocational, and environmental can be assessed, as well as integrated into care strategies that are school-, church-, work- or home-based. Nurses who offer their healing presence in each of these settings expand the role of the nurse as an instrument of healing as they become more integrated into the key systems of daily life. They can help advise and design programs that will help others understand the importance of personal interpretation and responses to life.

Themes of healing can be adapted to systems that are organic in nature, such as those found in families, schools, corporations, and communities. These systems represent the same dynamics as the human system, including the openness or closure of the system, areas of pain, and attributes on which to build. The nurse incorporates the skills of assessment of imbalances—scanning the energetic dynamics looking for blocks—as well as open doors for growth and healing. The nurse as an instrument of healing systems offers presence through relationship and knowledge of whole-person/whole-system dynamics and thus brings insight and outcomes that are healing to each of the arenas.

Research Considerations

There is limited research on the effectiveness of healing interventions, as well as on the integration of complementary therapies into care. Research has been essentially inconclusive regarding the effectiveness of interventions such as therapeutic touch, in that few measurement tools can capture the profound changes that happen during a healing intervention.[66–70]

A design that uses both qualitative and quantitative approaches is best for healing research. Qualitatively, the essence of healing is still being defined, still descriptive, and phenomenologic in nature. The research design should include a minimum investigation of the individual's experience with questions about how the individual defines the experience, what the experience means to him or her, and how he or she feels before and after the intervention. The key question is whether a person feels better as a result of the intervention. Reported outcomes of each intervention should be listed and clustered to identify the themes of healing. This approach creates a holographic model of systemic healing that permeates all systems. Descriptors would include the measurements of the openness or closure of the system, defined areas of pain relative to the system, attributes upon which to build, and directions for growth and healing.

Quantitative measures include such categories as demographic input, vital signs, diagnostic study findings, and cost implications. Types of patients can be grouped in a hospital by diagnosis or symptoms. For instance, ventilator-dependent comatose patients on intracranial monitors can be monitored pre- and post-therapeutic touch for changes in vital signs that could demonstrate a relaxing

effect in a controlled study. State-trait anxiety tools can be used to identify level of stress experience pre- and post-intervention. Whole-person qualities can be measured by the use of instruments that measure well-being.[71]

Future research should address the design of the tools and questionnaires that demonstrate the effectiveness of healing intervention. Effectiveness can be measured in patient satisfaction, decreased pain, decreased anxiety, enhanced well-being, and increased functional capacity, as well as the demonstration of physical, intellectual, and emotional effects.

As instruments that scan the human energy field become refined, this diagnostic approach will become as commonplace as magnetic resonance imaging (MRI) and will demonstrate the effectiveness of energy field interventions such as healing touch, therapeutic touch, aromatherapy, reflexology, acupuncture, and biofeedback. In addition, scanning the energy field for the effect of negative thought patterns and their physiologic effects will demonstrate more strongly the bodymind connection and modifications that alter the field before they are actually manifested as symptoms. The challenge is to continue to refine the art of nursing, not only with what nurses do, but also by understanding the power of who they are. Researching qualitative and quantitative approaches and techniques to expand the spectrum of care is critical in demonstrating the healing effect of the qualities of caring, as well as the ways in which nurses use different techniques to heal others.

CONCLUSION

Nurses interested in becoming an instrument of healing must understand the nature of healing, the sources of healing, and the ways in which to offer their presence in relationship to self, others, Creator, and creation that can promote the dynamic of healing. The nurse has the opportunity to give the gift of self freely to another to nurture this growth. The exchange of presence in any particular moment celebrates the privilege of conscious and intentional involvement with another. It is this relationship that forms the cornerstone of health care and provides the foundation for the practice of caring for others.

The skill of becoming an instrument of healing is one that can be cultivated. The ability to assess the multidimensional nature of another person in reference to that person's life experience is complex and requires an intuitive, spiritual, and skilled approach, as well as an understanding of the deeper meaning of human response to life.

As instruments of healing, nurses combine wisdom (what they know as well as do not know) with their skills (what they do), integrating these with the essence of who they are (their being) to form a holistic approach to caring for self, others, and creation. They partner in the journey of healing, offering new insights, new ways of coping, and a release from the bondage of fear and pain. Nurses offer the gift of walking with a person so that the person is not left alone to face the crossroads of healing and can emerge into new life—the manifestation of the powerful inner longing at every level to be whole. It is thus that life and health become a celebration of the unfolding of the essence and beauty of the human spirit, and the nurse truly becomes an instrument of healing.

DIRECTIONS FOR FUTURE RESEARCH

1. Study the effect of a particular type of healing intervention on a group of patients with a common symptom.

Determine if the intervention has made a difference as measured by vital signs, well-being instrument, and levels of anxiety.

2. Design a qualitative questionnaire to accompany a healing intervention that would include the following questions:
   - What was your experience of this intervention?
   - How would you describe this experience?
   - What do health and healing mean to you?
   - Do you feel better as a result of this intervention?
3. Identify thought patterns and belief systems that affect a person's health negatively, and research the effectiveness of introducing new belief systems into a person's thinking.
4. Implement a standard of practice regarding presence on a patient care unit and measure patient and nurse satisfaction.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or will begin the process of answering the following questions:

- How do I understand healing?
- What do I consider healing to be?
- How do I experience grace in my life?
- What are ways in which I can enhance the relationship I have with myself? Others? Creator? Creation?
- What do I experience when I consciously practice presence to myself? To others?
- How can I create opportunities in which to heal myself and thus enhance my therapeutic capacity?
- What are the characteristics of my inner teacher/healer?
- What are ways in which I can be more of a healing presence for others?
- How can I contribute positively to the environment around me?
- How do I feel when I consider myself as an instrument of healing?

NOTES

1. B.M. Dossey, Nurse As Healer, in *Holistic Nursing: A Handbook for Practice*, 2nd ed., eds. B.M. Dossey et al. (Gaithersburg, MD: Aspen Publishers, 1995), 62.
2. M.J. Wheatley, *Leadership and the New Science* (San Francisco: Berrett-Koehler, 1994).
3. *The American Heritage Dictionary of the English Language*, 4th ed. Boston, MA: Houghton Mifflin Company, 2002.
4. Dossey, Nurse As Healer, 62.
5. M.J. McKivergin, *The Essence of Presence* (In press, 2004).
6. J.F. Quinn, Holding Sacred Space: The Nurse As Healing Environment, *Holistic Nursing Practice* 6, no. 4 (1992):26–36.
7. B.M. Dossey et al., eds., *Holistic Nursing: A Handbook for Practice*, 2nd ed. (Gaithersburg, MD: Aspen Publishers, 1995).
8. F. Nightingale, *Notes on Nursing* (Philadelphia: Lippincott, 1992).
9. Dossey, Nurse As Healer, 62.
10. J. Kabat-Zinn, *Wherever You Go, There You Are* (NY: Hyperion, 1994).
11. M.J. McKivergin, The Nurse As an Instrument of Healing, in *Core Curriculum for Holistic Nursing*, ed. B.M. Dossey (Gaithersburg, MD: Aspen Publishers, 1997), 17–25.
12. J.G. Paterson and L.T. Zderad, *Humanistic Nursing* (NY: John Wiley & Sons, 1976).
13. McKivergin, *The Essence of Presence*.
14. M.J. McKivergin and A. Day, Presence: Creating Order Out of Chaos, *Seminars in Perioperative Nursing* 7, no. 2 (1998):96.
15. McKivergin and Day, Presence: Creating Order Out of Chaos, 96.

16. J. Zimmerman, *Laying-on-of-the-Hands and Therapeutic Touch: A Testable Theory*, Unpublished research (Boulder, CO: Bio-Electro-Magnetics Institute, 1988).
17. McKivergin, The Nurse As an Instrument of Healing, 17.
18. Dossey, Nurse As Healer, 62.
19. McKivergin, The Nurse As an Instrument of Healing, 21.
20. Paterson and Zderad, *Humanistic Nursing*, 122.
21. McKivergin, The Nurse As an Instrument of Healing, 17.
22. McKivergin and Day, Presence: Creating Order Out of Chaos, 98.
23. M.E. Doona et al., Nursing Presence: An Existential Exploration of the Concept, *Scholarly Inquiry for Nursing Practice: An International Journal* 11, no. 1 (1997):12.
24. McKivergin, The Nurse As an Instrument of Healing, 19.
25. Doona et al., Nursing Presence: An Existential Exploration of the Concept, 6.
26. M.J. McKivergin and J. Daubenmire, *Essence of Therapeutic Presence: The Course*, Presented at Riverside Methodist Hospital, Columbus, Ohio, 1991–1995.
27. P. Osterman and D. Schwartz-Barcott, Presence: Four Ways of Being There, *Nursing Forum* 31, no. 2 (1996):28.
28. McKivergin and Daubenmire, *Essence of Therapeutic Presence*.
29. J. Pettigrew, Intensive Nursing Care: The Ministry of Presence, *Critical Care Nursing Clinics of North America* 2, no. 3 (1990):503–508.
30. McKivergin and Day, Presence: Creating Order Out of Chaos.
31. *The American Heritage Dictionary of the English Language*, 4th ed. (Boston, MA: Houghton Mifflin Company, 2002).
32. J. Hastings, *The Encyclopedia of Religion and Ethics*, vol. V (NY: Charles Scribner's Sons, 1961).
33. Ibid.
34. Ibid.
35. A.L. Quarberg, *Graceful Presence: Using Mindfulness Movement for Deepening Divine Connection*, unpublished position paper for Master's of Arts Degree from St. Mary's University (Minneapolis, MN, 2002).
36. C. Pert, *Molecules of Emotion* (NY: Touchtone, 1999).
37. M. Deng, *Everyday Tao* (NY: Harper Collins, 1996).
38. Quarberg, *Graceful Presence*.
39. Pew-Fetzer Task Force, *Health Professions Education and Relationship Centered Care* (San Francisco: Pew Health Professions Commission, 1994).
40. Ibid., 9.
41. Ibid., 11.
42. Dossey, Nurse As Healer, 63–64.
43. H. Nouwen, *The Wounded Healer* (Garden City, NJ: Image Books, 1979).
44. McKivergin, The Nurse As an Instrument of Healing.
45. Ibid., 20.
46. R. Moss, The Mystery of Wholeness, in *Healers on Healing*, eds. R. Carlson and B. Sheild (Los Angeles: Tarcher, 1989).
47. J. Kabat-Zinn, *Wherever You Go There You Are* (NY: Hyperion, 1994).
48. J. Kabat-Zinn, *Wherever You Go There You Are* (NY: Hyperion, 1994).
49. H. Benson, *The Relaxation Response* (NY: William Morrow, 1975).
50. A Weil, *Spontaneous Healing* (NY: Kawcett Columbine).
51. J. Kabat-Zinn, *Wherever You Go There You Are* (NY: Hyperion, 1994).
52. Zimmerman, *Laying-on-of Hands and Therapeutic Touch: A Testable Theory*.
53. E.L. Rossi, *The Symptom Path to Enlightenment: The New Dynamics of Self Organization in Hypnotherapy: An Advanced Manual for Beginners* (Pacific Palisades, CA: Palisades Gateway, 1997).
54. M. Rogers, *The Theoretical Basis of Nursing* (Philadelphia: F.A. Davis, 1970).
55. Quinn, Holding Sacred Space, 19.
56. T.P. Nelms, Living a Caring Presence in Nursing: A Heideggerian Hermeneutical Analysis, *Journal of Advanced Nursing* 24, no. 2 (1996):368–374.
57. McKivergin, The Nurse As an Instrument of Healing.
58. P. Munhall, Unknowing: Toward Another Pattern of Knowing in Nursing, *Nursing Outlook* 41, no.3 (1993):125–128.
59. McKivergin, The Nurse As an Instrument of Healing.
60. D. Krieger, Therapeutic Touch: Searching for Evidence of Physiological Change, *American Journal of Nursing* 79, no. 4 (1979):660–662.
61. McKivergin, The Nurse As an Instrument of Healing.

62. Ibid.

63. S. Scandrett-Hibdon and M.I. Freel, The Endogenous Healing Process: A Conceptual Analysis, *Journal of Holistic Nursing* 7, no. 1 (1989):66–71.

64. McKivergin, The Nurse As an Instrument of Healing.

65. D. Hines, *The Development of the Measurement of Presence Scale* (University Microfilms International, 1991).

66. J.R. Snyder, Therapeutic Touch and the Terminally Ill: Healing Power through the Hands, *American Journal of Hospice and Palliative Care* 14, no. 2 (1997):83–87.

67. B. Daley, Therapeutic Touch, Nursing Practice and Contemporary Cutaneous Wound Healing Research, *Journal of Advances in Nursing*, no. 6 (1997):1123–1132.

68. D.P. Wirth et al., Wound Healing and Complementary Therapies: A Review, *Journal of Alternative and Complementary Therapies* 4, no. 2 (1996):1123–1132.

69. E. Shuzman, *The Effect of Trait Anxiety and Patient Expectation of Therapeutic Touch on the Reduction of State Anxiety in Preoperative Patients Who Receive Therapeutic Touch* (University Microfilms International, No. PUZ9423009, 1997).

70. P.P. Hughes et al., Therapeutic Touch with Adolescent Psychiatric Patients, *Journal of Holistic Nursing*, no. 14 (1996):6–23.

71. M.J. McKivergin, *The Effects of a Non-Traditional Healing Intervention on Physiological and Qualitative Measures of Well-Being in Women* (University Microfilms International No. 1339540, 1990).

CORE VALUE 4

Holistic Communication, Therapeutic Environment, and Cultural Diversity

VISION OF HEALING

Human Care

The human care process between a nurse and another individual is a special, delicate gift to be cherished. The human care transactions make it possible for two individuals to come together and establish contact; one person's body-mind-spirit joins another's body-mind-spirit in a lived moment. The shared moment of the present has the potential to transcend time, space, and the physical world as we generally view it in the traditional nurse-client relationship.[1]

* * *

We nurses now find ourselves within a profession that ascribes to the holistic model. Because this model differs philosophically from the traditional biomedical model, it has been called a paradigm shift. Such a philosophic shift has monumental implications that are certain to change the profession forever. Not only does this paradigm make us realize that treating pathophysiologic problems with medical therapy is only half the answer, but it also weaves a tapestry of the interconnectedness of all human beings and suggests the presence of an undefined and powerful healing energy that remains to be harnessed. It challenges us to entertain new ideas that may conflict with our logic and science. It forces us to move away from a purely mechanistic view of the way in which human beings function.

Fashioning a new portrait of ourselves and our profession, this new paradigm alters the image of who we are and who we can become. It also is destined to alter the way in which we practice nursing. The challenge is to determine the course of this destiny. The boundaries within which we can assist patients to achieve wellness and help them to realize their own healing potential remain to be defined. Nonetheless, as we help patients facilitate their inner healing, we discover our own—and begin our journey as nurse healers. Each of us, however, must discover the path.[2]

NOTES

1. J. Watson, *Nursing: Human Science and Human Care* (New York: National League for Nursing Press, 1985), 47.
2. C.E. Guzzetta and B.M. Dossey, *Cardiovascular Nursing: Holistic Practice* (St. Louis: Mosby–Year Book, 1992), xvii.

Chapter 11

Therapeutic Communication: The Art of Helping

Sharon Scandrett-Hibdon

NURSE HEALER OBJECTIVES

Theoretical

- Describe the art of helping through therapeutic communication.
- Determine the differences between therapeutic communication and natural conversation.
- Compare differences between counseling and psychotherapy.
- Recognize when to refer clients for deeper work.

Clinical

- Integrate therapeutic communication skills into clinical practice.
- Evaluate the effects of helping skills on patient satisfaction and clinical outcomes.

Personal

- Refine personal communication skills to enhance personal clarity and effectiveness.
- Integrate therapeutic communication into daily life.
- Evaluate the quality of personal interactions when therapeutic communication skills are used.

DEFINITIONS

Therapeutic Communication: a systematic way of relating to another person that enhances self-discovery and ownership of personal issues; use of specific communication skills that support self-exploration and offer feedback to the client.

Therapeutic Communication Helping Model: a three-staged model of relationship that facilitates clear communication and self-discovery, and promotes change through constructive problem solving.

THEORY AND RESEARCH

Communication is constantly occurring, whether with words, silence, or behavior; one may or may not be conscious of the communication. Holistic in nature, communication includes many dimensions that influence one's ability to send and receive a message. One's perception and ability to take a message into account can be complex. "Taking into account" is considered to be the most important factor in the process of communication,[1] as a person experiences simultaneous information from radio, television, children talking, and a spouse requesting something. Communication occurs only when the receiver

takes into account a message from one of the sources or senders, when a message "gets through" to the receiver's consciousness. The receiver maintains control over which message will receive attention.

The process of communication is constant. What changes is the understanding of the process. In nursing, models of communication tend to be linear, reflecting a mechanistic approach in which the nurse develops a message to affect the client in a certain way so that the client will adopt a desired behavior, often around a healthier lifestyle. A feedback loop is used. For example, when the nurse asks the client how he or she is feeling, the client's response is carefully attended to and reflected back in order to ensure clear understanding. This reflection is helpful to both the nurse and the client, and offers a way for both parties to agree on a similar meaning. Using this technique, the client usually feels heard and "cared about," which builds rapport between the client and the nurse.

Nurses know, at some level, that much more is going on during exchanges with others than is being addressed. Often that sixth sense or "intuitive hit" nurses talk about is a form of covert communication with a client. To understand such covert communication, the communicator must expand personal awareness.

In the counseling field, there is general debate as to the "helpfulness" of helping. Some take the position that "helping is never helpful," while others believe that "helping is always helpful." Evidence exists on both sides, but the general conclusion of most practitioners is that helping can be helpful. Evidence suggests that competent helpers do make a difference. "Helping is not neutral; it is for better or for worse."[2] Becoming a skilled, competent helper through the use of effective communication is imperative if holistic nurses are to make a significant contribution to healing.

THERAPEUTIC COMMUNICATION

A counseling approach that makes the client's self-discovery the key focus is a therapeutic communication process that builds a positive, supportive relationship that enables the client to explore his or her personal experience and behavior. This model of communication builds a style of practice that moves from professional control to patient empowerment. The client can check the accuracy of perceptions immediately with the helper by using interpersonal skills. This provides the client with timely and constructive feedback on personal issues. As a result of the obtained insights, the client can make the clearest decisions for desired changes.

The helper must use many personal skills to achieve therapeutic communication. The aspects of self involved in this process include accurate listening skills, personal awareness, solicitation of personal understanding about one's life and life themes, wisdom, knowledge of the change process which is not linear or in stages, and intuitive knowing.[3] Systematic training in and practice of interpersonal skills has been found to enhance the helper's performance in helping, as well as increase self-efficacy and cognitive complexity.[4–6] A more complex cognitive processing affords the helper more ability to take a point of view discrepant from their own and manage information better.[7] Personal development of the helper occurs as one's understanding of their own communication style and others are highlighted.

Another important element of helping is keeping the majority of focus on the client's wholeness rather than on the dysfunctions that he or she presents. This attention to the whole person provides the

energetic emphasis for the client to attain the greatest possible growth. In medicine, however, focus on pathology often dominates the energetic exchange.

In ordinary conversation, participants frequently use skills such as active listening, validation, and questioning. Each participant is usually invested in being heard, as well as in sharing his or her own story. The relationship is expected to be equal in that both parties benefit from the interaction. Often, painful feelings are "cut off" or diminished because many people have difficulty handling emotional issues. Advice is often solicited and given. Pleasing and judging each other are usually parts of the process.

In therapeutic communication, the helper's entire focus is on the client. Initially, the helper puts his or her own reactions, feelings, and thoughts aside to affirm and assist in clarifying the client's personal expression and meaning. As the relationship develops, the helper begins to guide the client deeper into areas of behavior or patterns of which the client may not be fully aware, thus affording greater clarity, ownership, and the opportunity for change. In illuminating patterns, the helper uses personal awareness, such as reactions during the interaction or exploration of deeper feelings, to provide information for the client. The purpose of these exchanges is to assist the client in making desired changes in his or her life.

Helping skills used in psychotherapy are part of a deep process in which clients learn about their own personality and heal those aspects that are damaged. Corrective emotional experiences are important in psychotherapy so that clients can experience a healthier way of being than they ever have before. Shifting the personality is a key goal. Psychotherapy can take years and often addresses many issues.

The helper refers a client to a psychotherapist whenever the client seems to have a serious life problem that is causing depression, suicidal thoughts, or feelings of helplessness. Also, referrals are appropriate if the client seems to need inner child work, corrective emotional experiences, or deep inner work (e.g., hypnosis) to heal family wounds. Other problems that require psychotherapy or psychiatric care include personality disorders, physical or psychologic abuse, addictions, and psychoses. The helper can be a great support to these conditions, but further intervention is usually needed.

THERAPEUTIC COMMUNICATION HELPING MODEL

Having evolved from the study of master communicators in counseling and the beneficial outcomes that they have produced for clients, the therapeutic communication helping model has three stages: (1) building of the relationship, (2) deeper exploration, and (3) implementation (Exhibit 11–1). Research on qualities of counselors who produced casualties in therapy were examined as well. Early researchers involved in this work were Curt Truax and Robert Carkhuff.[8,9] Gerard Egan offers a problem management approach to helping based on the most effective of these skills.[10]

Stage 1 begins with a focus on *building a relationship* in which the client can choose a problem that will lead to some significant improvement in the quality of his or her life. The helper's task at this stage is to develop rapport with the client, support the client's self-discovery and self-exploration, and establish trust between the helper and the client. The client explores relevant experiences, behaviors, and feelings as concretely as possible.

Self-defeating behaviors are identified. Personal participation in the helping process is facilitated and ownership of

Exhibit 11–1 Therapeutic Communication Helping Model

Stage 1: Building of the Relationship

The helper's goal is to build rapport, positive regard, and trust by reflecting to the client at the level presented through use of the following skills:

- Empathy
- Respect
- Genuineness
- Concreteness

The client uses this relationship to explore the self.

Stage 2: Deeper Exploration

The helper's goal is to help the client to integrate understanding about personal patterns. The skills used include the following:

- Additive empathy
- Self-disclosure
- Feedback
- Confrontation
- Immediacy

The client must listen nondefensively and attempt to understand the self through the dynamics of personal patterns.

Stage 3: Implementation

The helper's goal is to assist the client in taking action. The following skills are useful at this stage:

- Problem solving
- Support
- Action plans

The client must collaborate with the helper, taking personal risks to make the desired changes and to take action in his or her life.

Source: Data from G. Egan, *The Skilled Helper,* © 1994, Brooks/Cole Publishing Co. and A. Turok, *Interpersonal Skills Laboratory Experience,* 1979, University of Iowa Mental Health Authority, Iowa City, Iowa.

personal healing is clarified. The four interpersonal skills used primarily in this stage—empathy, respect, genuineness, and concreteness—provide safety for the client to "cover the waterfront" of concerns. As the material shared becomes repetitive, the helper knows it is time to begin deeper exploration in an area of immediate concern for the client.

Stage 2 provides the client with the opportunity to clarify his or her life patterns through *deeper exploration* of them. Some of these patterns are functional; others are dysfunctional. As the helper listens to the client talk about life, the pattern pieces begin to emerge. The skill of additive empathy puts those patterns neatly together so the client can see what is occurring and what the reward is for continuing that pattern. Various resources and environmental conditions affecting the situation are explored. Patterns that the client may be reluctant to reveal may be explored by using the skills of feedback, confrontation, and immediacy. The helper uses personal life experiences and knowledge to help identify some of the patterns and underlying feelings. Self-disclosure in particular is one skill that leads the client deeper through the helper's sharing. Workable goals that will empower the client to manage the problem begin to emerge.

Stage 3 focuses on clarification of the goal and *implementation* of a plan to meet that goal. As the goal is clearly defined

and owned by the client, the helper and the client together determine the plan. Mutual planning includes identification of steps in the change process that are manageable. Change is threatening, so active planning must be realistic in order to ensure the client's success. Potential obstacles and resources, as well as a discussion of the ways that the client may sabotage the goal, are revealed. Progress toward the goal is evaluated on an ongoing basis. As the client is empowered and progressing, the relationship is evaluated and plans are made for termination of the helping relationship. Often, the client learns how to cope with future difficult situations by experiencing this mutual problem-solving process.[11]

Therapeutic Communication Skills

Stage 1: Building of the Relationship

Helpers must master specific skills to enhance therapeutic communication. Within Stage 1, ***empathy*** is the core skill to build rapport and trust between the helper and the client. This skill allows the helper to communicate to the client understanding and acceptance of the client's expressed feelings and the reasons for those feelings. Each time a thought is born, a feeling or emotion follows. In Western society, feelings often have been split from content so that only the reasons for reactions are shared. The skill of empathy reconnects these parts, so the client can experience the full meaning of what is being shared.

The helper must complete several tasks to hear the client accurately. First, inner distractions must be avoided so that the helper can listen to what is being said and how it is said. It often is helpful to repeat what the client says before responding. The client's dominant feeling is then identified and the reasons for that feeling considered. The helper responds with fresh words that reflect the same meaning as those offered by the client in a concise and incisive manner. The structured format to practice this skill is

You feel _____ because _____.

In the first blank space, the helper inserts an incisive word that matches the general meaning and intensity of the client's described feeling. In the second space, the helper paraphrases the reasons for the feeling with fresh words.[12] For example, the client might state, "I am afraid to leave my husband because I don't know if I can make it on my own." One empathic response the helper could offer to convey understanding would be, "You fear leaving him because you are not sure that you can live on your own." Other feeling words that the helper may use are scared, uneasy, threatened, intimidated, or apprehensive. The judge of the accuracy of the feeling description is the client. The client will correct the helper immediately by saying "no" if the feeling word is inaccurate, and will then proceed to clarify the meaning. If the empathic response is accurate, the client will often delve deeper into the problem or situation because the initial feelings were acknowledged by the helper.

With practice, the helper can adapt the format of this skill as long as both components (feeling and reasons) are included in the empathic response. The helper matches the level of intensity with the meaning of the client. The helper's affirmation at each step of the way allows the client to lead and deepen the self-discovery process. The client knows exactly where important events or understandings need to go.

One mistake helpers often make is to jump ahead of the client or prematurely interpret what is being said. Premature interpretation adds another's (the helper's) meaning to the exchange, which leaves the client "in the dust" and may reduce the trust level because the helper is no longer

affirming the client's feelings at the rate the client feels safe to self-disclose. Another problem arises when the helper asks questions to gather more information, which leads the client and may distract him or her from what is important in that moment.

Practice:

1. **I am feeling depressed because I cannot get ahead of the demands placed upon me.**

   Empathy statement: You feel _____ because _____.

   Example response: You feel down because you cannot catch up with the demands on you.

2. **I am excited about having time off to play during these holidays.**

   Empathy statement: You feel _____ because _____.

   Example response: You feel elated that you will have time to play during the holiday.

   Formulate empathy statements for many situations and share those that feel appropriate.

The second core skill used in the first stage of the model is ***respect***. Each client is a unique human being who is a precious whole being. Even when perceiving a client's many problems, the helper must see the innate wholeness within the person to actualize the client's maximum potential. In fact, one of the greatest things a helper can give another person is self-respect.[13] Clients usually know what they need for their healing and are capable of making decisions that are best for themselves. Helpers should encourage self-determination.

Acknowledging one's resources is a way to build self-respect. Often, a person who is wrapped up in problems loses sight of the resources required to deal with the situation. Gentle reminders of skills used to cope with current or past problems can strengthen a client's coping. Helping the client to cultivate resources is another powerful tool that fosters self-respect. Accurate listening through the use of empathy is a skill that the helper can use to further enhance self-respect.[14]

Genuineness enhances therapeutic interactions by allowing the helper to present himself or herself as a human being rather than as a role.[15] The helper may share some feelings directly with the client. For example, if the helper feels bored with some topic that has been shared previously, the helper may say, "We have discussed this topic before; what is going on right now?" If the repetitive behavior persists, then the helper may even say, "I feel tired of hearing about this topic because no movement is being made." The purpose of this transaction is to provide the client with a genuine response to the way he or she interacts, which in this case is to play a 'script' that is safe. If such behavior occurs in the helping session, it most likely occurs elsewhere. Being genuine also means being spontaneous and free in communicating what is occurring in the helper.

Concreteness is the final core skill of this stage of the model; it includes purposeful questioning and summarization.[16] Purposeful questioning is used when the client's statements are vague. Often, a client encodes or disguises an important issue (also called nominalization) by using one word to signify a larger issue. Asking for further concrete information on that issue is helpful. Often, the lead "tell me more about this," can elicit more information. Other questions that can help are "What does _____ (*vague word*) mean?" or, "Describe what being in that situation is like."

Using *how*, *what*, *when*, and *describe* encourages clients to detail further what they are experiencing. Avoid using *why*

because this question requires the client to have a full understanding of what has happened. If the client just presents the content or facts with no feelings, then a good question to ask is, "What does that feel like?" or, "What is that experience like?" This technique adds to the holistic nature of the communication. The important thing is to continue connecting feelings with content.

Summarization is helpful when the client has presented a large amount of material. Stopping the client and offering a summary statement or two will let the client know that the helper is listening. Use of empathy conveys understanding. Frequent use of empathy will produce a similar response, which allows the client to move deeper into issues instead of trying to provide large amounts of information to make sure that the helper has "all the facts."

Practice:

Client: I feel so tired these days. I am working 70 hours a week, 7 days a week. There isn't enough time to complete the daily tasks that need to be done at home. I always feel I am behind.

Helper: You feel _____ because _____.

Client: I know that I must slow down. My teenage daughter gets upset when I am gone so much and that bothers me. I hate leaving her alone so much.

Helper: _____.

Client: She has been a very responsible teen. I appreciate that she has been helping with cleaning the house.

Helper: _____.

Client: I really want to have a different lifestyle in which I can be there for her more of the time. I know that talking is a problem here.

Helper: _____.

As the helper uses the core helping skills in therapeutic communication, the client can easily learn some of them. Turok believed that teaching clients the use of the helping skills was therapeutic in that communications became clearer.[17] Learning to use the skill of empathy, for instance, forces the client to listen very carefully to others. Accurate listening can help to build positive connections between people.

The time to move to the second stage of the therapeutic communication model occurs when topics and emotions presented by the client begin to feel repetitive. The client is usually ready to begin deeper exploration of the issues. In nursing, the tendency at this point is to move directly to the third stage, that of problem solving. Yet the helper and the client may not have revealed the underlying patterns on which real changes must be based.

Stage 2: Deeper Exploration

There are five skills used in the second stage of the therapeutic communication model: additive empathy, self-disclosure, feedback, confrontation, and immediacy. The goal of this stage is to reveal the client's deeper patterns and let the client acknowledge how these patterns are maintained. The helper provides a wider view than the client can see within their own perspective of their life.

In ***additive empathy***, the helper listens for and describes underlying feelings and behavioral themes. Usually, the client is not fully aware of these underlying feelings. Bringing these to the surface gives the client an opportunity to see clearly how such feelings operate and to decide whether to continue them. This skill has three parts: (1) focusing on surface and deeper feelings, as well as underlying fears; (2) identifying the themes and patterns of response that the client typically uses; and (3) identifying the client's personalization of the pattern.

The first part of this skill connects the surface feelings to the underlying deeper

feelings. For example, "You feel angry at your son, yet I also sense you feel terrified that he will get hurt by pursuing this friend." Leading the client into the deeper feeling allows for exploration of more threatening feelings, such as fear, rage, vulnerability, a sense of being out of control, and failure. The transitional statement to underlying feelings is

> You say you feel _____ (*expressed feeling*), but it sounds like you also feel _____ (*underlying feeling*) because _____ (*cause of feeling*).[18]

The second part of the additive empathy skill is to identify the client's patterns and themes. Themes occur in many dimensions. Emotional themes include feeling like a failure, being pessimistic or optimistic, feeling used, martyred, manipulative, or depressed. Behavioral themes may include sabotaging oneself, rising to opportunities, procrastinating, taking advantage of others, and being passive or aggressive. Cognitive themes include believing one is trapped, helpless, powerless, powerful, or successful. Experiential themes are less overt, as they involve perceiving things in certain ways (e.g., seeing life through rose-colored glasses or always looking at the negative side of events). The thematic part of the communication skill includes a triggering event or stimulus, the pattern of response, and the consequence of that pattern. For example, "When no one calls to remind you, you feel disrespected and withdraw from activities, and it leaves you feeling more alone." The thematic statement is

> When _____ (*triggering event*), you choose to _____ (*pattern of response*), and it leaves you _____ (*consequence of behavior*).[19]

The third part of additive empathy is called personalizing. The client may see the pattern, but it is essential that the client understand how this is maintained. Often a pattern is maintained to keep the client feeling "bad" about the self. An example of personalizing is, "You feel disgusted with yourself when you continue allowing your child to take advantage of you, and you want to assert yourself by putting limits on his behavior." The personalizing stem is

> You feel _____ (*self-judgment*) with yourself because you do not _____ (*deficit behavior*) and you want to _____ (*goal behavior*).[20]

Practice:

Bill complains that he feels unhappy with himself. He is constantly putting things off until the last moment, then he has to scramble to get caught up. He is working toward a promotion, but feels unsure that it will come through this time because he has so many incomplete projects. He does feel that his work is very good, but wonders how long management will put up with his delayed deadlines.

Create an additive response to Bill. Make sure you include all three aspects of the skill.

_____.
_____.
_____.

An example of the whole additive empathy statement would be: "I sense you feel frustrated that you never feel caught up, yet I also hear that you fear failure to accomplish all that is being asked. When new requests are made of you, you readily accept them with no question, which leaves you feeling further behind. You

despise yourself for continuing to accept more work when you would like to be assertive and plan a more reasonable work load."

The purpose of the ***self-disclosure*** skill is to lead the client into an exploration of deeper feelings. The helper uses his or her own life experience to assist in this process. It is most important to match the feeling area and to deepen the sharing about the underlying fears, although the life situation need not match exactly what the client shares. This skill quickly takes clients back to their own self-discovery. The format is

> When I _____ (*life experience*), I felt _____ (*deeper feeling than client had shared*). I wonder if that fits for you.[21]

For example, if a client expresses despair about being alone and unable to meet anyone who holds similar interests, the helper may say, "When I worked in a factory as a clinic nurse, I felt isolated and misunderstood. I wonder if that fits for you." This skill is often misused in that helpers talk about when they were in a similar situation and successfully survived. The message of this kind of sharing is embedded advice: Do what I did. Telling bigger and better stories of survival or trouble than the client is another error, as it diminishes the client's experience.

Feedback is a fairly familiar skill that provides a great deal of information to the client. This technique is commonly used in educational and training situations to assist learners in gaining information about their performance. Guidelines for this skill include making sure that the motivation for sharing information is to assist the other person, defining specific behaviors that can be changed, making no assumptions or interpretations about client behavior, conveying the impact of the behavior on others, giving feedback directly to the client as soon as the behavior occurs, and making sure that the client is in a receptive mode to hear the feedback. The format for this skill is

> May I share something with you? (*get permission*)
>
> When I _____ (*observed behavior*),
>
> I feel _____ (*reactive feeling*).
>
> I want to _____ (*desired behavior*).
>
> Right now I am _____ (*what actually will be done*).[22]

An example of this is

> "I would like to share something with you, Jane. (OK.)
>
> When I call and you always have me hold while you take care of something else, I feel unimportant.
>
> I want to hang up on you and say, "Get the information yourself."
>
> Right now, I am letting you know how difficult this is for me."

Some believe that the desired behavior should be deleted, but this part demonstrates the intensity of the helper's response and provides the client with a great deal of information about the behavior's effect on others. Remaining nonjudgmental is important, because the goal of this skill is to provide maximal information to the client about some aspect of behavior that the client may wish to change. Repeating the feedback received in the above format allows time to clarify any misunderstanding.

The skill of **confrontation** invites the client to examine ***discrepancies*** in behavior, in what is said, thought, felt, experienced, and done. Some of these behaviors may be in the consciousness of the client, and some may not. The format used for confrontation is

> On the one hand, you feel/say/do _____ (*give behavior*), and on the other hand, you feel/say/do _____ (*behavior*).[23]

For example, "You say you are excited about the upcoming visit, yet it looks to me like you are sad and depressed."

Misuse of this skill often involves blame, punishment, "put downs," assumptions about motives, ambiguity, or dogmatic attitudes. Thus, the helper's motives must be examined prior to using this fairly invasive skill. The client initially may deny the truth of the information. The helper then gently repeats the information in fresh words after the client has been acknowledged for the reaction through the use of primary empathy.

Immediacy means exploring the relationship at this moment. The occasions when immediacy is important are those in which the client's psychological needs and intentions try to influence the helper to take on a certain role that will satisfy those needs. The client may not be conscious of this influencing behavior, so bringing it into awareness can be very important for self-discovery and healing. Some of the roles that helpers may be influenced to assume are lover, protector, punisher, excuser, advocate, caretaker, victim, judge, comforter, and adversary.[24]

The helper must use immediacy carefully, as there is a risk of losing the relationship because immediacy is very confrontive and will threaten the relationship. Guidelines for the use of immediacy begin with the helper experiencing the influencing effort, noting the recycling patterns in communication that create the maneuver, and hypothesizing about what the client is trying to say that cannot be said directly, what the helper is feeling prompted to say, do, or feel, and what the client will gain from this maneuver. The format for delivering the immediacy statement is

> Right now I sense you expect or want me to _____ (*desired action or role*).[25]

For example, "Right now I sense you expect me to wait on you." After making this statement, the helper can use primary empathy to help the client examine the immediacy issues. The client may find these issues very threatening, and denial may surface initially. It is then helpful to share examples of when this influencing effort has occurred in the past.

> **Practice:**
>
> Recall a time when you were interacting with a client and found yourself frightened. What did you fear might happen? What was the client saying that triggered your fear? What did you want to say/do, but chose not to? What did you say/do? Now do the same with a time when you were angry. Repeat the exercise with a situation in which you recognize a family's recurring pattern of communicating, "Here we go again."[26]

Stage 3: Implementation

The client who has identified a goal and appears ready to take action has reached the **problem-solving** stage of the model, one of the most important stages to ensure successful change for a client. The first step is to clarify the exact goal, and the helper must help the client set an appro-

priate one. Some helpful questions are: What does the client want now? What does the client want next year? What is the client invested in keeping? What are the client's resources and capabilities? Where can the client willingly begin? Can the client support this goal 100 percent? How might the client sabotage this goal?

All goals need to be specific enough for the client to recognize the accomplishment of each specified goal. One guideline for setting goals is to ask if the goal would be visible, concrete, and specific enough to be observed by others.[27] Examples of such goals are, "I will relax daily," "I will reduce my stress by avoiding extra activities for the next month," and "I will enhance my courage by saying yes when opportunities come that feel exciting to me."

Once a clear goal is set, the various options for the client should be examined. Often, the client sees only one or two options, which the client has probably already tried. By brainstorming possible ways to achieve the goal, the client and the helper may find many options. Brainstorming options should be done rapidly, with no option rejected, and a list of all possible options presented should be recorded. The helper can be quite active in this process, and even outrageous—adding humor to the process.

Once the list is compiled, the client should ***select three alternatives*** that are the most appealing or workable. The remainder of the list is kept for future reference. The client then takes each of the three alternatives and ***evaluates*** them using a ***cost–gain analysis*** to decide which one to use first. In other words, the client balances what would be lost with option A against what would be gained.

Once an alternative is selected, a ***specific action plan*** is developed by both the client and the helper. Again, the helper must be active in this process, planning with such care that the client cannot fail. Very ***small, achievable steps*** ensure success in reaching each goal. Change is frightening for most people, so it is important to make the steps small enough to guarantee success. (If a client accomplishes more each week than planned, watch for the enhancement of his or her self-esteem.) Another approach is to ask clients if they can think of any possible barriers to fulfilling the desired goal. Action plans for ***trouble shooting*** help overcome the rough spots and can avert failure. It is helpful to explore with the client what "rewards" would occur for failure, as planning for possible sabotage also must be done. If a plan does not work as expected, how would the client respond?

Case Study

Helper: Mary, what is going on for you today?

Mary: I am distressed because I can't seem to get my son to help me.

Helper: You feel upset because you can't influence your son to help.

Mary: Yes, I really at this time need some support and help around the house. My job drains me badly. All he wants to do is stay out late, drink with his buddies, and play videogames.

Helper: You need assistance because your energy is low.

Mary: Yes, I am beginning to resent allowing him to live there. Yet I need to have some companionship.

Helper: You feel angry with him, yet you need him.

Mary: Yes, it's better than coming home to an empty house all of the time.

Helper: What would coming home to an empty house mean, Mary?

Mary: Well, I feel very vulnerable right now since the divorce, and my job really

takes it out of me. Having someone there seems to give me a sense of security.

Helper: You feel more secure when someone is there.

Mary: Yes, although in reality, he is rarely there and is hostile whenever I ask him to do anything.

Helper: What is that like, Mary? To have someone rarely there and hostile?

Mary: Well, I feel guilty for taking his father away, and I want to help my son, but he sure does little to help me.

Helper: Mary, it seems like you feel responsible for your son, yet feel betrayed by him in that he uses you and continues to live there.

Mary: (*tears*) Yes.

Helper: When you ask for the help you need and nothing gets done, you allow the behavior to continue and abandon yourself, even though you really need support and nurturing.

Mary: (*crying harder*) Yes, I do need nurturing, and I do allow this to continue.

Helper: You blame yourself for your divorce and feel you owe your son something, when you need to be taking better care of yourself.

Mary: That's exactly right. I do need to take better care of myself. I don't blame myself for the divorce; I did the best I could in the relationship. I do feel like I owe my son something, partly for contributing to the divorce at this time in his life. He's not on his feet yet either. But I do need help.

Helper: Mary, what would you like to do about this?

Mary: Well, it is imperative that I take care of myself, or I will become sick. So I need to begin working on that.

Helper: What would that be like, Mary?

Mary: Well, I want to feel that my home is a supportive place for me. That I don't have to wait on anyone else, even though I am willing to share space with him.

Helper: So what would be the specific goal?

Mary: I want to come to a peaceful, orderly home and not feel like I have to wonder where my son is and when he will be coming in or who he will drag in.

Helper: So the goal would be coming in to a peaceful, orderly home and being informed of your son's plans?

Mary: Yes, that would be wonderful.

Helper: Let's play a bit and see if together we can come up with some ideas on how these goals could be met.

Mary: OK.

Helper: You could have him pay rent and hire a housekeeper to clean once a week.

Mary: That would be great. Although getting him to pay rent would be a problem.

Both: You could tell him to move out unless he can afford to have a housekeeper come once a week.

I could make sure he has a beeper so I could contact him when he doesn't come in on time.

You could have him leave you a note each day.

I could make him call me at work before he leaves the house.

You could charge him for the meals he eats here.

You could have him move out and have a friend move in, charging them rent.

I could have weekly massages in my home.

You could make him pay for the massages!

Helper: Mary, of all of the things suggested, what are three things that you could begin, knowing that you always have the option to come back to any of these?

Mary: Well, I like the idea of charging him rent and hiring a housekeeper. Also, I want him to leave me a note daily. I like the idea of weekly massages as well.

Helper: This week I would like to have you work on assessing each of these options with a cost–gain analysis. You have two goals you are working on, and we have over 100 alternatives to choose from. Please take three of these and work with

them, bringing them back to our next session so we can create a plan for the one you wish to begin.

(*Next week*)

Mary: I want to charge him rent and hire a housekeeper. I feel like that is a fair request, even if I only charge him what a housekeeper would cost.

Helper: How would you like to do this, Mary?

Mary: I can call and find out housekeeper fees and then talk to him about my need for more help. If he cannot provide the help, then I can set the fee needed to hire the help and require him to pay that. If he won't do that, I can then tell him that he must find another place to live.

Helper: You have thought through this, haven't you?

Mary: Yes, I feel so good to be making plans to support *me*. I really needed this boost. Already I have a more positive outlook just by the possibility of having a change.

Helper: How would you undermine this happening, Mary?

Mary: If he throws a fit and I do my usual thing, which is to give in and make peace.

Helper: What can you do to prevent this behavior from happening?

Mary: I can think of how bad I am feeling when I have no support. I can insist that I am as important in this house as he is and remember that I have been abandoning myself.

Helper: Is that enough to hold you steady if he confronts you?

Mary: Yes, I really didn't look at how I always put myself last. I did that in the marriage as well.

Helper: So the plan is that you will get competitive prices on a housekeeper, tell your son that he either will help with the cleaning or pay the cost of a housekeeper. If he refuses, you will tell him he must find another place to live?

Mary: Yes, I feel good about this.

Helper: How will you handle your feelings of responsibility and guilt?

Mary: I have realized as I listened to myself that I have nothing to feel guilty about. I provided well for him and gave him a good home for many years. Now it is my turn to at least be equally considered.

Practice: Go back through the preceding interaction and highlight the stages of the therapeutic communication helping model and label the skills used.

CONCLUSION

Helping skills consistently have been proved to assist individuals to become more aware of their own issues. This model provides the client with maximal support for self-discovery and change. Holistic nurses are committed to empowering the client. Use of this approach provides a powerful way to enhance the client's self-healing. Teaching the client the skills also gives him or her the tools to build better relationships with others.

DIRECTIONS FOR FUTURE RESEARCH

1. Evaluate the outcomes of using the therapeutic communication helping model in various clinical settings.
2. Determine the effectiveness of using therapeutic communication with clients and nurses in achieving their desired change in lifestyle.
3. Document and quantify the coping changes clients make when they use the helping skills themselves.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin the process of answering the following questions:

- How can these therapeutic communication skills become a long-term investment in my life?
- In what way would my personal and professional communications change if I incorporated these skills into my life?
- Do I hold a clear mirror for each client to see the majesty of his or her life?
- Do I recognize the privilege of being of service to others in helping them empower their lives and to feel self-respect?
- While working with others, do I continuously focus on their wholeness or do I see mostly their disturbed patterns?

NOTES

1. L. Thayer, *Communication and Communication Systems* (Homewood, IL: Richard D. Irwin, 1968).
2. G. Egan, *The Skilled Helper* (Pacific Grove, CA: Brooks/Cole, 2002).
3. E. Torres-Rivera, L.T. Phan, C. Maddux, M.P. Wilbur, and M.T. Garrett, Process Versus Content: Integrating Personal Awareness and Counseling Skills to Meet the Multicultural Challenge of the Twenty-first Century, *Counseling Education & Supervision*, Sept. 2001, vol. 41:1.
4. S.A. Urbani, The Effect of the Skilled Counselor Training Model on Counseling Skill Acquisition and Counselor Self-efficacy by Counselors-in-Training. Dissertation Abstract International Section A: *Humanities & Social Sciences,* vol. 62 (8–A, 2002).
5. H.M. Schroder, M.J. Driver, and S. Streufert, *Human Information Processing* (New York: Holt, Rinehart, & Winson, 1967).
6. D.K. Duys and S. M. Hadstrom, Basic Counselor Skills Training and Counselor Cognitive Complexity, *Counselor Education & Supervision*, Sept. 2000, vol. 40:1.
7. Schroder, Driver, and Streufert, *Human Information Processing*.
8. K.B. Truax and R.R. Carkhuff, *Toward Effective Counseling and Psychotherapy: Training and Practice* (Chicago: Aldine, 1967).
9. R.R. Carkhuff, *The Art of Helping IV*, 4th ed. (Amherst, MA: Amherst Resource Development Press, 1980).
10. Egan, *The Skilled Helper*.
11. A. Turok, *Interpersonal Skills Laboratory Experience* (Iowa City: University of Iowa Mental Health Authority, 1979).
12. Egan, *The Skilled Helper*.
13. W. Stephenson, Professor, Lectureship in Communications, University of Iowa, 1970.
14. Turok, *Interpersonal Skills Laboratory Experience*.
15. Ibid.
16. Ibid.
17. Ibid.
18. Ibid., p. 12.
19. Ibid.
20. Ibid.
21. R.R. Carkhuff and R.M. Pierce, *Trainer's Guide to the Art of Helping: An Introduction to Life Skills* (Amherst, MA: Human Resource Development Press, 1975), 113.
22. Turok, *Interpersonal Skills Laboratory Experience*.
23. A. Turok, Immediacy in Counseling: Recognizing Clients' Unspoken Messages, *Personnel and Guidance Journal* 59 (1980):168–172.
24. Turok, *Interpersonal Skills Laboratory Experience*.
25. A. Turok, Verbal Instruction in Training of Trainers Workshop, Iowa City, Iowa, 1974.
26. Turok, *Interpersonal Skills Laboratory Experience*.
27. Ibid.

Building a Healthy Environment

The use of the environment has become one of today's foremost issues. Nurses have risen to the occasion by proactively forming national organizations and sponsoring conferences to address environmental concerns. The American Holistic Nurses' Association (AHNA) has developed and propagates a statement on environmental issues:

American Holistic Nurses' Association Position Statement in Support of a Healthful Environment

The philosophy of the American Holistic Nurses' Association includes the belief that "health involves the harmonious balance of body, mind, and spirit in an ever-changing environment."

The environment involves both our immediate as well as global surroundings. Many of us are aware of a need to expand our consciousness regarding environmental issues and believe that this can have an effect on our own personal and community well-being.

Our concerns come from a reverence for the beauty and integrity of the earth which sustains us and is our home, our Mother Earth. Relevant environmental issues include preserving the integrity of the air, soil, and water as well as issues such as global warming, acid rain and other equally challenging situations. We believe as holistic nurses, we have a responsibility for increasing awareness regarding these issues in others, through role modeling and educating within our communities.

The AHNA encourages self-responsible behavior as well as participation in socially responsible environmental groups, to protect and support improvement of the health of our environment.[1]

The reason that politicians, nurses, and most other segments of society are becoming involved in environmental issues is the growing awareness of the relationship between our physical reality and the earth. The twentieth century witnessed two dramatic events: a sudden, startling surge in human population and an abrupt acceleration of the scientific and technologic revolution.

From the beginning of humanity's appearance on the earth to 1945, it took more than 10,000 generations to reach a world population of 2 billion people. Now, in the course of one human lifetime, the world population increased from 2 to more than 9 billion people.[2] Those of us working with computers and hospital equipment can attest to the exponential explosion of technology during our careers. These factors and others have magnified our power to affect the world around us by burning, cutting, digging, moving, and transforming the physical matter that makes up the earth. As a society, we are straining under the burden of a burgeoning population that is demanding not only the fulfillment of

basic needs, but also access to health care and space-age technology. In trying to meet the ever-increasing demands, we have contaminated our air, soil, and waters with by-products, and we have attenuated our foods with herbicides, pesticides, and overprocessing. Urban and suburban areas reverberate with noise and violence, and frustrations mount as increasing numbers crowd into congested living areas.

Nurses are seeking to discover the best ways to utilize the environment to maximize the overall healing effort. All of us must aspire to develop global ecologic skills if we are to endure. Environmental scientists and nurses can cooperate in unique ways to promote a global healing ethic.[3]

On an individual level, the way in which people use their personal space affects not only the way that they feel, but also, in today's shrinking world, the space around others. For example, when we play our stereos or radios, the broadcast should fill only the short space between us and the speaker, not blare so loud that it reaches into the personal space of others who may not want to hear the program. In increasingly congested areas, we must take care to honor each person's right for quiet space. All of us need to work together to find individual and community solutions to the serious environmental issues that face us in the twenty-first century.

NOTES

1. Reprinted from *Environmental Philosophy* with the permission of the American Holistic Nurses' Association, 2733 East Lakin Drive, Suite #2, Flagstaff, AZ 86004, phone: 800-278-AHNA or 520-526-2196, FAX: 520-526-2752.
2. A. Gore, *Earth in the Balance: Ecology and the Human Spirit* (New York: Plume, 1993), 31.
3. J. Case, The Biosphere and the Healing Arts, *Holistic Nursing Practice* 6, no. 4 (1992):10–19.

Nishmat Kol Chai (The Soul of All Living Things)—a Jewish morning prayer

Every day we find a new sky and a new earth
with which we are entrusted like a perfect toy.
We are given the salty river of our blood
winding through us, to remember the sea and our
kindred under the waves, the hot pulsing that knocks
in our throats to consider our cousins in the grass
and the trees, all bring scattered rivulets of life.

We are given the wind within us, the breath
to shape into words that steal time, that touch
like hands and pierce like bullets, that waken
truth and deceit, sorrow and pity and joy,
that waste precious air in complaints, in lies,
in floating traps for power in the dirty air.
Yet holy breath still stretches our lungs to sing.

We are given the body, the momentary kibbutz
of elements that have belonged to frog and polar
bear, corn and oak tree, volcano and glacier.
We are lent for a time these minerals in water
and a morning every day, a morning to wake up,
rejoice and praise life in our spines, our throats,
our knees, our genitals, our brains, our tongues.

We are given fire to see against the dark,
to think, to read, to study how we are to live,
to bank in ourselves against defeat and despair
that cool and muddy our resolves, that make us forget
what we saw we must do. We are given passion
to rise like the sun in our minds with the new day
and burn the debris of habit and greed and fear.

We stand in the midst of the burning world
primed to burn with compassionate love and justice,
to turn inward and find holy fire at the core,
to turn outward and see the world that is all
one flesh with us, see under the trash, through
the smog, the furry bee in the apple blossom,
the trout leaping, the candles our ancestors lit for us.

Fill us as the tide rustles into the reeds in the marsh.
Fill us as the rushing water overflows the pitcher.
Fill us as the light fills a room with its dancing.
Let the little quarrels of the bones and the snarling
of the lesser appetites and the whining of the ego cease.
Let silence still us so you may show us your shining
and we can out of that stillness rise and praise.

Marge Piercy

Source: From *Available Light* by Marge Piercy, Copyright © 1988 by Middlemarsh, Inc. and *The Art of Blessing the Day* by Marge Piercy, Copyright © 1999 by Middlemarsh, Inc. Reprinted by permission of Alfred A. Knopf, Inc. and the Wallace Literary Agency, Inc.

Chapter 12

Environment

Lynn Keegan

NURSE HEALER OBJECTIVES

Theoretical

- Name four ways in which substantive systems changes can diminish toxic exposures in life.
- Identify three principles that can direct human endeavors toward a sustainable future.
- Describe three characteristics of a learning community.
- Differentiate between the terms *schooling* and *education*.
- Increase awareness of environmental hazards, and make a commitment to reducing these hazards.

Clinical

- Subscribe, or arrange to have consistent access, to periodical literature specific to clinical application of environmental principles (e.g., *WorldWatch*, a bimonthly magazine of the World Watch Institute).
- Identify and act on three ways to influence environmental accountability in the workplace.
- Consider joining an organization created to influence the direction of future sustainability.
- Become sensitive to the environmental space in the home, institution, health agency, or clinic.

Personal

- Seek out at least one other person for mutual support in examining ways to make a difference toward future sustainability.
- Make a consistent effort to eliminate, not just diminish, the concept of waste in your life.
- Assume a "beginner's mind," being open to knowing what is essential about environmental relationships in your life.
- Whenever possible, eliminate negative aspects of your personal environment (e.g., stale air, inadequate lighting, subliminal noises).
- Experiment with healing colors, scents, textures, sound, and lighting in your personal environment.

DEFINITIONS

Ambience: an environment or its distinct atmosphere; the totality of feeling that one experiences from a particular environment.

Anthropocentrism: the world view that places human beings as the central fact or final aim of the universe.

Chaos Theory: sometimes called the "new science," offers a way of seeing order and pattern where formerly only the

random, the erratic, and the unpredictable had been observed.

Ecology: the scientific study of interrelationships between and among organisms, and between them and all aspects, living and nonliving, of their environment.

Ecominnea: the concept of an ecologically sound society.

Environment: everything that surrounds an individual or group of people: physical, social, psychologic, cultural, or spiritual characteristics; external and internal features; animate and inanimate objects; seen and unseen vibrations; frequencies and climate; and energy patterns not yet understood.

Environmental Ethics: a division of philosophy concerned with valuing the environment, primarily as it relates to humankind, secondarily as it relates to other creatures and to the land.

Environmental Justice: a sub-branch of ethics examining the innate and relational value among organisms and all aspects of their environment.

Epistemology: the branch of philosophy that addresses the origin, nature, methods, and limits of knowledge.

Ergonomics: the study of and realization of the importance of human factors in engineering.

Personal Space: the area around an individual that should be under the control of that individual, including air, light, temperature, sound, scent, and color.

Restorative Justice: an ethical perception that directs that environmental damages not only be curtailed, but also repaired and recompensed in some meaningful way.

Superfund Sites: hazardous waste landfills or abandoned manufacturing sites, names of which appear on the Environmental Protection Agency's National Priorities List.

Sustainable Future: meet the needs of the present without compromising the needs of future generations.

Toxic Substance: a substance that can cause harm to a person through either short- or long-term exposure, as by (1) inhalation; (2) ingestion into the body in the form of vapors, gases, fumes, dusts, solids, liquids, or mists; or (3) skin absorption.

THEORY AND RESEARCH

To engage successfully with life in modern times, people are challenged to commit themselves to maturity as Earth dwellers—Earth *citizens*—who are willing to

- live in a world of vast complexity and unpredictability
- engage in their own grief work
- work with contradiction and paradox
- risk everything through the clarity of their values and convictions
- reside in joy of spirit and lightness of heart, the constants for everyone as children of the universe who are here because they are integral to the teeming fullness of life

Environmental Education for Holistic Nurses

In its broadest sense the term *environment* can mean everything, both within and external to each person. As a result, it is a challenge to determine what "should be" provided to holistic nurses as a basic educational resource. Although many configurations are feasible and worthy, five themes can be used to form a constellation—a "mental map"—to conceptualize the environmental world and the human place in it: (1) telling personal and collective life stories, (2) living in a toxic world, (3) choosing a sustainable future, (4) build-

ing learning communities, and (5) working from the inside out.

Theme 1: Telling One's Story

Each nurse has a unique and personal story to tell of the reasons that he or she is in nursing and the travails, rewards, and joys of the pathway. Sometimes, individuals tell themselves their story, in a reflective moment; sometimes, they share choice vignettes with others. Who has not reminisced with fondness about some shared early experiences when with colleagues? Nursing is for most practitioners, if not all, a joyous "soul-home," and they like to speak of this in the sacred circle of companions when circumstances are conducive to such disclosure.

When considering the environment, it is imperative to listen and respond to a larger story, not only as individual practitioners, but also as members of humankind. This reaffirms what we know through all the senses to be basic and important: What does it mean to be human? What does it mean to be an Earth citizen? How can we face the great crises of our time, ecologic, political, social, economic, intellectual, psychologic, and spiritual? People cannot ignore the matrix of their own being if they are to understand and respond to contemporary needs. They must consider their existential context. Richard Tarnas, a philosopher and historian of Western thought, helped bring the human drama into consciousness.[1]

Two Stories of the Evolution. There are two versions of the evolution of human consciousness. Both are basic truths and deep patterns in the psyche that inform an individual's day-to-day experience in various ways. One is *progress and heroic advance*, characterized by gradual, progressive, and familiar milestones of discovery and accomplishment: the printing press; the harnessing of electricity; the invention of the telephone, radio, computers; and so forth. These are learned in basic education. Generally, this version equates ever-increasing and refined knowledge with fulfillment and well-being. The scientific mind is the apex of this world view, having its roots in ancient Greece and the flourishing in the European enlightenment of the eighteenth century. The modern mind is known for individualistic democracy, power, and emancipation. Inventiveness, endurance, will to succeed, and adventuresome spirit are sources for pride. The "miracles of modern medicine" are found here.

The second version of the evolution of human consciousness is the *fall and tragic separation*, which is a deep wounding or schism that separates humankind from nature. Manifestations of this version include exploitation of the natural environment, devastation of indigenous cultures, and an increasingly unhappy state of the human soul. Through the lens of tragic separation, humanity and nature are seen as having suffered grievously under an increasingly dualistic domination of thought and society. The worst consequences of this development are directly derived from the hegemony of modern industrial society, empowered by science and technology.

All individuals are challenged, although they may not recognize it, to reconcile these perspectives in their day-to-day lives. Are we embroiled in progress? Are we victims of tragedy? The two perspectives are both correct in a certain way; the gestalt differs, while the data remain the same. For example, it is possible to maintain life support systems, equal to progress; however, the person may be maintained beyond all parameters of the natural dignity of dying, equal to tragedy. Both are readings, but only partial apprehensions of a deeper, larger, and more complex story. Gain and loss have been working together simultaneously until the dialectic has reached an almost climactic moment at present.

Nurses are aware of pervasive and intense suffering, not only in their own inner work, but beyond, to the transpersonal and collective unconscious. The whole planet is in a transformative crisis.

The Core Elements Driving the Multidimensional Crisis. The modern mind—the mind of progress—originates in the world view that there is a radical and irreconcilable distinction between the human self as subject and the world as object. In contrast, the primal world view is that spirit or soul permeates the entire universe, within which the soul is embedded. The human essence participates in a world soul, or *anima mundi*. The modern mind condemns this as a naive epistemologic error; childish, immature, and to be outgrown. The wisdom of the modern mind asserts that the human self is the exclusive repository of conscious intelligence; all meaning in the universe comes from the human subject. This is the classic existentialist assumption that, without humankind, the universe is meaningless.

Typically, a modern person's allegiance is to science, in the belief that science rules the cosmos and objective world, while poetry, music, and spiritual strivings inhabit the internal world. Our cherished Western autonomy, offspring of the progress perspective, has been purchased at a staggering price: gradual dilution and diminution of soul, meaning, and spirit. Thus, the purpose of the entire world is exclusive to the human self. Everything else is "out there," resulting in the demise of the metaphysical world and the disenchantment of the cosmos. Whether in conscious awareness or not, the greatest demand of modern time is to reconcile the imperatives of the two versions of what it means to be human. Must everyone choose and align themselves with one or the other? Must everyone consign themselves to an existence where "progress" is purchased with the coin of soul loss?

Tarnas contends that modern culture itself is immersed in a rite of the most epochal and profound kind: the entire path of human civilization has taken humankind, the planet, and all its members into a trajectory of complete alienation, that is part of the mythic death/rebirth story.[2] Something new is being formed, however, which is a new participative and holistic vision of the universe amply reflected by contemporary scientific and philosophic insights. In this emerging view, the human self is both highly differentiated, yet re-embedded in a participatory, meaning-laden universe.

Transformative Unfolding to a More Integral World. Expanding the epistemology from empiricism and rationalism, the paradigms of progress, to draw from the wider epistemologies of the heart is the first step toward a more integral world. There are ways of knowing that integrate imagination, intuition, aesthetic sensitivity, revelatory or epiphanic capacity, and the abilities to love and be loved. Another powerful remedy against the pervasive ills of the modern world is a fundamental movement of remorse: a sustained weeping and grief for collective and individual offenses against humankind, other species, the innocent, the defenseless, the trusting. A self-overcoming, or metanoia, is our radical sacrifice integral to the shift of world view. Within the context of this evolving paradigm, there is an acknowledgment of a power greater than our own. It is the recognition that, when the self has been totally emptied in the moment of death, in the ego death, in the dark night of the soul, something else happens. That is when the Divine can come through and when, finally, it is not 'other.' It is *within* us. It is who we are.

There can be no responsible discussion and deliberation about the environment and the role of holistic nursing without knowing and honoring human history with all its triumph and terror, its puniness and

majesty. Despite their various personal views of the world, including what is real and what is important, holistic nurses strive for clarity of meanings, values, and relationships about which they are impassioned! It is instructive, in this context, to hear what Macy related about a Tibetan Buddhist prediction of the twelfth century:

> In these days of misery, war, crises and economic collapse, and when the world itself is on the threshold of annihilation, there arises a multitude of Shambhala Warriors. These warriors are of every color, age, gender, from every culture and are found in all corners of the earth, in humble circumstances and in corridors of power. These men and women, elders and children wear no uniforms nor do they carry martial banners. Each wields two weapons: compassion and clear intent.[3]

Holistic nurses live the identical existential anguish of those they care for and care about. They are "wounded healers," a role that augments rather than diminishes their effectiveness. The role is reciprocal: they are healed as they heal. Additionally, they know the healing role is not confined to humankind, but is a common and shared attribute of all creation. Florence Nightingale, through her 13 canons, gave the most basic instruction of all: "the art of nursing requires us to alter the environment safely."[4] This simple injunction is the bedrock on which rests all environmental aspirations, values, thought, and activity, for today and for any foreseeable future.

At this juncture, it is helpful to reflect on the wisdom of the I Ching, "The superior man (our essential self) eats, drinks, is joyous and of good cheer."[5] We are not ordinarily accustomed to prolonged apocalyptic reflection so may become ill at ease in its presence. We are children of the universe, however. We belong here as part of the wondrous greening of things. We exist! That alone is cause for joyous celebration!

Theme 2: Living in a Toxic World

A guaranteed formula for depression is to make a list of "problems," thus dwelling energetically and metaphorically in a room without sunlight or exit. A more life-affirming exercise is to clarify individual and collective goals and then work toward those goals. Although grief and remorse are appropriate responses to ubiquitous planetary degradation, which has its genesis with humankind, they are counterproductive within themselves. Grief and remorse alone, without action, lead inexorably into downward emotional spirals or into diversionary escapes. Human beings are characterized by the ability to choose and change; the past need not be perpetuated. Human beings have the ability to elect life-affirming ways, relinquishing that which kills them, in both body and spirit.

Environmentalism evolved in several stages, all of which coexist today.[6] The U.S. conservation movement began in the late nineteenth century in reaction to the devastation of what had seemed an inexhaustible wilderness. The national park system arose from this new awareness. Wilderness advocates such as anglers, hunters, and hikers still represent a large percentage of environmentalists. Carson exposed the dangers of DDT, introducing a second stage of the environmental movement.[7] Activists of the 1960s and 1970s targeted other hazardous materials—polychlorinated biphenyls (PCBs), mercury, lead, and other heavy metals. Environmental legislation that created state and federal protection agencies widened the focus from preservation to protection.

The discovery in the 1980s of the hole in the ozone layer over Antarctica, along with escalating concern over global warming, introduced a third phase of environmentalism. Rather than focusing on dangers

from toxic substances, this stage emphasizes sustainability, which is protecting future generations from the dangers of exceeding nature's ability to restore itself. A fourth stage addressed the notion of environmental equity—a determination of a safe global quota for emission of gases that cause the greenhouse effect and the allotment of an equal share of that quota to each human inhabitant of the planet. Other evolving perspectives speak of environmental justice and environmental ethics. The main thrust of the first two categories is preventing toxic wastes from endangering others, such as factory emissions close to neighborhoods or the export of radiologically active by-products to other countries.

The configuration of stages, or perspectives, has two commonalities. First, it is anthropocentric in that virtually all efforts are directed to the well-being of humankind. Only tangentially are other creatures considered; they have no inherent "rights." Second, popular literature rarely addresses the imperative to alter lifestyles, even though the difficulties that abound are immediately attributable to living in collective excess in collusion with a market-driven economy. Macy noted, "While the agricultural revolution took centuries, and the industrial revolution took generations, this ecological revolution has to happen within a matter of a few years. It also has to be more comprehensive—involving not only the political economy but the habits and values that foster it."[8]

We inhabit a toxic world.[9] The products and by-products of industrial society are poisoning the earth and its inhabitants. Caring, inventive people know that a very different community could be created by using alternative strategies to provide the same essential services that chemicals provide, however. The world's most gifted engineers have gathered in places like Silicon Valley, formerly Santa Clara Valley, of the San Francisco Bay area; Silicon Desert in Arizona; Silicon Glen in Scotland; and Silicon Plateau in India over the past 20 years. An immense infrastructure has developed to support this high-technology world.[10] Silicon Valley is a particularly poignant example of the "progress" versus the "tragedy" metanarrative. Before "clean" industrialization, few places in the world equaled the fertility of this agricultural mecca. In some places, the topsoil of fine loam was 40 feet deep, alluvial fans laid down by two mountain stream systems. Below that were huge freshwater aquifers of gravel and clay, permitting irrigation through a vast system of artesian wells. When industries entered the valley, however, at the peak of computer chip manufacturing—a highly water-intensive process—Santa Clara county was forced to import water.

Industries have struggled to maintain a positive image despite the endemic proliferation of poisoned wells, leaking chemical tanks, and illegal sludge dumps. The once pristine Santa Clara Valley now has 29 Superfund sites, the most dense concentration of highly hazardous waste dumps in the United States. Even the most sophisticated clean-up methods cannot remove the toxic solvents (such as the trichloroethylene [TCE] used in chip production) from aquifers. Studies by IBM and the Semiconductor Industry Association have linked the use of solvents to problems in workers' reproductive health and to birth defects.[11] High concentrations of heavy metals in sewage emissions have had a disastrous impact on San Francisco Bay. Shoreline communities harvested 15 million pounds of oysters annually at the turn of the century; since 1970, the entire oyster population has been too contaminated to eat.[12]

Through hindsight, it is evident that even the economic bottom line must address quality-of-life issues. Furthermore, only from a broad bioregional base can planners consider the complex inter-

actions among jobs, profits, housing, farmland and water quality, parks and playgrounds, ethnic diversity, class tensions, and freeway build-ups. Now in Silicon Valley, actions are under way to preserve strips of open land and stop further expansion; private sector coalitions are forming to protect farms, open land, and wildlife. Natural soaps and citrus solutions are replacing toxic manufacturing processes, and light-rail lines are improving the rapid transit system.

In less than one lifetime, production of synthetic organic chemicals (e.g., dyes, plastic, solvents) has increased more than 1,000-fold in the United States alone.[13] There are roughly 70,000 different synthetic chemicals on the global market, with more in continuous production. In addition, many chemicals are emitted as by-products of production or incineration (particularly relevant to the hospital industry). Some chemicals, such as antihistamines, have direct health benefits. Others, such as pesticides and herbicides, are designed to be usefully lethal (many were developed as military offense measures during the Vietnam War). The most pernicious and pervasive were not meant to come into human contact. When PCBs were created in 1929, for example, they were intended for use only in electrical wiring, lubricants, and liquid seals. Today PCBs, along with 250 other synthetic chemicals, can be found in the bodies of almost everyone in the industrial world.[14]

According to a recent tally, 40 carcinogens appear in drinking water, 60 are released by industry into the ambient air, and 66 are sprayed on crop food as pesticides.[15] Whatever a person's past exposure, often bioaccumulative, this is the current situation. An issue yet to be examined in any depth is the interactional effect of all these substances. It is known that one pharmacologic substance may potentiate the action of another; the same dynamic is logical for industrial chemicals and by-products. As a result of evidence that began to appear in the early 1990s, a specific cause of alarm is the role of 50 or more chemicals as endocrine disruptors and, more particularly, as hormone mimics with likely linkages to breast cancer.[16] A narrow focus on genetic roots, as well as an emphasis on lifestyle, obscures cancer's environmental roots, as well as the underlying genesis of other illnesses.

Clearly, the hazards that Carson noted 50 years ago have flourished.[17] They are a robust presence among us despite vast concern, legislation, grassroots actions, and deep-down engagement with the problem by many people and organizations. For the most part, even the best-intentioned activities are temporary stopgap measures that can only delay the demise of the natural world as presently known. Much like the fleeting relief offered by some of the contemporary biomedical regimens, they provide alleviation and management of symptoms, not systemic change. A way of life—a conscious choice—is possible if we are willing to work, really work, to change from the industrial growth society to a life-sustaining society. It is possible to meet our needs without destroying our life support system.

Three Key Principles. As with any major enterprise, basic guidelines provide parameters and rationale to illumine the path. The removal of all carcinogens and other noxious substances is unlikely, but even the elimination of some would reduce the physiologic and bioregional burden, thus preventing considerable suffering and loss of life. Steingraber offered three principles based on the ideal that it is every person's right to live in a nonpolluted environment:[18]

1. *Precautionary Principle.* Public and private interests should act to prevent harm before it occurs; an indication of harm rather than proof of harm

should trigger action. Current methods rely on the "dead body" approach: wait until damage is proved before action is taken (e.g., definitive remedial steps taken 11 years after the first discovered evidence of ozone layer depletion).

2. *Principle of Reverse Onus.* Safety rather than harm should necessitate demonstration. Those who seek to introduce chemicals should demonstrate that what they propose to do will not hurt anyone. This is the current standard for pharmaceuticals, but most industrial chemicals have no firm requirement for advanced demonstration of safety.
3. *Principle of the Least Toxic Alternative.* Toxic substances should not be used as long as there is another, safer way of accomplishing the task. Society in general proceeds on the assumption that toxic substances will be used; the only question is how much.

Life-Affirming Trends. As consumers' awareness and knowledge of the effects of chemical and other exposures in the workplace and homes increase, so does their influence on industry as well as retail outlets. Public awareness, especially if it is organized, can revolutionize both industry and the marketplace. As evidence, the organic food industry has increased 20 percent each year since 1990.[19]

Environmental efforts are part of a general societal thrust to have a habitable planet, now and in years to come. Many of these efforts, in the aggregate, are pragmatic and based on economic interests; others are derived from a philosophic outlook such as environmental justice. Many, if not most, of the movements remain human-centered, addressing impacts as they relate to humankind. Any benefit for the rest of the biotic community is a by-product from that frame of reference. The holistic outlook, as has been stated, recognizes all systems as interacting. If one part is affected, change of a greater or lesser magnitude occurs everywhere.

The ultimate purpose of this way of thinking is to weave the human economy back into the earth economy. Cowan, a building and landscape architect, noted that toxicity, waste, and extravagant resource use are all symptoms of poor design and production processes.[20] Around the world, innovative companies and product designers are taking ecology as the basis for design, thus phasing out toxicity, cutting waste, and increasing resource efficiency. Other companies, such as Andropogon, are restoring the ecologic integrity of the landscape by restoring native vegetation, reestablishing water flow, and reconnecting wild areas.[21]

Karl-Henrik Robert, a Swedish oncologist and founder of *The Natural Step*, became dissatisfied with scientific and regulatory approaches to the symptoms of systemic failure. In his medical practice, bizarre tumors among his patients could be traced to underlying environmental toxicity. He elected to set aside his medical practice to address the issue with zeal and vigor.[22] With the help of the Swedish scientific community, he established a guide toward sustainability based on four rigorous systems conditions that must be satisfied for any company, municipality, or nation to move toward a more healthy environment:

1. Substances from the earth's crust must not systematically increase in nature (e.g., strive for a cessation of dispersion of heavy metal contaminants by industries through the waterways, soil, and/or by incineration).
2. Synthetic compounds must not systematically increase in nature (e.g., promote the use of natural substances to accomplish the tasks formerly accomplished by herbicides and pesticides).

3. The physical basis for the productivity and diversity of nature must not be systematically allowed to deteriorate (e.g., establish stringent guidelines for land use and human population mobility to safeguard the ability of the bioregion to sustain itself).
4. There must be fair and efficient use of resources with respect to meeting human needs (e.g., consider social justice issues, such as not stripping the rain forest acreage to make way for cattle grazing).

Cowan proposed strategic questions for use in evaluating which products, companies, and initiatives will lead to a less toxic world.[23] Four major categories of questions can be asked when potential products are considered for use: substitution, stewardship, ecology, and simplicity (Exhibit 12–1).

Theme 3: Choosing a Sustainable Future

The World Commission on Environment and Development (the Brundtland Commission) stated, "Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs."[24] In the United States, the President's Council on Sustainable Development was convened in 1993 to find ways to meet people's needs without jeopardizing the future. In its

Exhibit 12–1 Strategic Questions to Evaluate Products, Companies, and Initiatives for a Less Toxic World

1. **Substitutions of Materials**
   - Is it synthetic? Does it biodegrade? Does it accumulate in living tissues?
   - Is it a known carcinogen, mutagen, teratogen, endocrine disrupter, or acute toxin?
   - When it degrades, off-gases, combusts or reacts, does it pose any of the above threats?
2. **Substitution of Less Toxic or Nontoxic Products**
   - How toxic is this product during its extraction, manufacturing, use, recycling, or disposal?
   - Is this product durable, easy to maintain, repair, reuse, remanufacture, or upgrade?
   - Does it have replaceable or reusable components, parts and materials?
   - Will the manufacturer take responsibility for this product and packaging?
   - Will the manufacturer completely recycle the product and packaging?
   - Can the benefits of this product best be provided by turning it into a service product?
3. **Industrial Ecology**
   - If "waste equals food," what processes does this chemical or product feed during its entire life cycle?
   - Can this entire class of chemicals or products be phased out by reconfiguring industrial ecosystems?
   - At the most basic level, what services does this product provide?
   - Can these services be provided by healthy ecosystems instead?
4. **Voluntary Simplicity**
   - Despite all efforts, does this product remain unacceptably toxic? If so, is it truly essential?
   - Does the product have other purposes? Does it meet basic needs?
   - What level of this product or service genuinely contributes to the quality of my life?
   - Can this level of service be best supplied through my own initiative and that of my local community?

Source: Adapted with permission from Stuart Cowan, *A Design Revolution* in *Yes! A Journal of Positive Futures,* No. 6, p. 30, © 1998.

vision statement, the 30-member Council stated, "Our vision is of a life-sustaining earth. We are committed to the achievement of a dignified, peaceful and equitable existence. A sustainable United States will have a growing economy that provides equitable opportunities for satisfying livelihoods, and a safe, healthy, high quality of life for current and future generations. Our nation will protect its environment, its natural resource base, and the function and viability of natural systems on which all life depends."[25]

Grant advised caution regarding the term *sustainable development*, which is regularly used in the sense of *sustainable growth*, a self-contradictory concept supporting growth as a solution to all problems.[26] The simple fact is that growth, demographic or economic, is ultimately *un*sustainable; perpetual growth is mathematically impossible in a finite space such as the earth. Sustainability demands a redefinition of consumption goals, such as use of renewable resources at a rate that does not exceed their rates of regeneration and use of nonrenewable resources at a rate that does not exceed the rate at which sustainable, renewable substitutes are developed. The task is to confine human activity so that it can be pursued without damage to the natural systems. No goal including sustainability is absolute, however. For every contemplated policy or action, it is essential to consider what the threat to sustainability is and whether the anticipated gains are so overwhelming that they justify the action.

Support for "sustainability" is worthless unless it is translated into policy. The President and Congress do not address sustainability directly.[27] They advance it or set it back through policies or legislation that are ostensibly directed to other ends, such as welfare, health, employment, trade, land use, or agricultural price supports. Because of systems interactions, decisions in these areas affect the rate of resource use, the environment, immigration, and U.S. population growth, among other considerations. In U.S. population growth, two principal variables drive the demographic future: fertility and migration.[28] Population restraint is central to long-term environmental sustainability. Yet, suggestions to bring human fertility in line with replacement level, rather than above it as it is presently, are judged racist or elitist, and limiting immigration is perceived as xenophobia. As sensitive and incendiary as these issues are and will remain, they are intimately bound to present and future sustainability and quality of life.

Orr, an environmental studies professor, presented sustainability from another perspective.[29] He claimed that much of academic communities' ennui in the face of the environmental crises is a combination of denial coupled with the conviction that money and technology hold all the answers. Colleges and universities continue to equip students for short-term success in an extractive economy, not for long-term success in a sustainable and resilient community. If administrators and trustees are aware of the reality of global change, that awareness rarely influences institutional policy. For Orr, denial coupled with lack of imagination prevent us from educating ourselves and others in "love of life." "Denial is not just a way of avoiding the future; it is also a way to avoid discussing our own complicity in the larger problems of our time."[30]

Part of being a sustainable and resilient community is the conscious intent to bring all stakeholders into future planning. On one university campus, a full design team was engaged from the inception of an idea for a new ecologic center building.[31] Students, faculty, and administrators, as well as architects, were integral to this rich, real-life experience of planning and implementation. The basic building program emerging from a one-year planning

phase demonstrates decisions based on principles of sustainability. Most, if not all, the project goals can be applied to other building or renovation projects as well. The building

- discharges no waste water (i.e., "drinking water in; drinking water out")
- generates from sunlight more electricity in the course of a year than it uses
- uses no material known to be carcinogenic, mutagenic, or an endocrine disruptor
- uses energy and materials efficiently
- uses products or materials grown or manufactured sustainably
- is landscaped to promote biologic diversity
- promotes analytic skills in assessing full costs over the lifetime of the building
- promotes ecologic competence and mindfulness of place
- is genuinely pedagogical in its design and operations
- meets rigorous requirements for full cost accounting

This is a building that permits no ugliness, either human or ecologic, at this or any other time or place.

Historically, there are five major categories of organization and influence in the world: (1) business, (2) education, (3) religion, (4) the military, and (5) government. The fact that health care arose from the religious and military spheres is responsible for some of the earlier traditions in nursing, such as uniforms and reliance on a rigorous chain of command. Where is the weighting of influence now? Observation indicates three: business, education, and government. Despite this considerable shift in emphasis from earlier times, each of the five categories has a pervasive history and role that influence contemporary outlooks. Business, a major polluter and exploiter on many fronts, is beginning to make contributions to future sustainability in terms of clean design and production. Education has pockets of excellence, but has shown no obvious leadership; too often, it serves the needs of business. Religion is beginning in many quarters to move from a "dominator" model toward stewardship and, more recently, into partnership, co-creating with Creator or Life Force. The military remains the greatest source of large-scale pollution and destruction of life support systems; it is virtually exempt from any regulation or sanction beyond itself. Government provides guidelines and safeguards for the environment, but they are frequently diluted or diverted by partisan and/or specific interest groups. There remain, of course, grassroots activists—citizens who have clear vision with zest, caring, and drive to see something better.

Because the emerging world paradigm is a participative one, a community's environmental sustainability depends in large measure on how well it is able to recruit and retain citizen involvement at all levels. America Speaks, a not-for-profit organization committed to linking citizen voices to governance in new ways, has distilled nine criteria characteristic of communities that have successfully mobilized citizen engagement at all levels:[32]

1. Political, corporate, and civic leadership listen to all voices in the community.
2. Community activists focus on the common good.
3. Media (print, television, radio, and Internet) value and commit resources to building community.
4. Technology, hardware, and software are of sufficient quantity and quality to enable community and regional deliberation processes.
5. Projects reflect natural ecologic and economic regions; they are not bound by traditional political jurisdictions.

6. Citizen involvement in a project can continue for the long term.
7. Resources are committed to enhancing community members' skills for the short and long term.
8. There is an established sense of trust and mutual valuing among community members.
9. Leaders recognize that needed changes are systemic, not isolated, and that both individuals and institutions are responsible for making them.

The concept of sustainability is complex and intertwined because it has to do with interrelated systems. The bottom line is wonderfully simple and straightforward, however: to live as if we belong here and are planning to stay a while.

Theme 4: Building Learning Communities

A learning community is a group of people who choose to enter into a discovery mode, meaning that each person is willing to teach or learn, depending on what he or she has to contribute. Characterized by safety, support, and openness, the learning community focuses on personal and societal learning. Within the context of seeking a sustainable future, the search for humankind's rightful and responsible place in the natural world fuels learning.

A glance at the history of public education in the United States reveals that, at the height of the Industrial Revolution from 1886 to 1920, financiers, industrialists, and their private charitable foundations spent more money on required schooling than did the government itself, with the aim of binding schooling to the service of business and the political state.[33] Thus, a system of modern schooling was constructed without public comprehension or participation. The trend was magnified following World War II, when virtually everyone went to school courtesy of the G.I. Bill. Higher education changed; the economy and industry boomed with a vast supply of educated workers. Geographic mobility increased, largely from rural to urban settings. The individual's worth was frequently weighted on the scales of economic value and productivity, making him or her a cog in a well-oiled machine.

Gatto made a clear distinction between schooling and education.[34] Schooling takes place in an environment that is controlled by others and often is for the purposes of others. Schooling is never adequate, even when offered by those who care about and strive to understand the student. Education describes largely self-initiated efforts to take charge of life with wisdom and understanding. Education is a process more than a state; a tapestry woven from information, mistakes, experiences, commitments, and risk taking. Growth and mastery come to those who are vigorously self-directed: initiating, being alone, working within group or community, reflecting, creating, doing. Schooling can help or hinder education, and it requires individuals to respond collectively. While there are excellent educational opportunities regarding a sustainable future in established public and private institutions, the topic is not consistently valued or available.

The community bond for many groups is the opportunity to honor deeply held values that integrate personal, social, and spiritual lives. Members enrich their inner lives while selectively engaging in some form of service work. These small grassroots efforts are conducting much of future sustainability work.

In some select instances, business communities are assuming leadership in striving toward sustainability. The trend engenders a different type of learning community, one that is integral to the preferred corporate image. Perhaps the most remarkable contemporary example is Interface, a global manufacturing enterprise that produces 40 percent of the world's carpeting.[35] Because of a personal, radical commitment to sustainability, its

founder and chief executive officer, Ray Anderson, committed his company to becoming a zero-waste enterprise. It is well on its way to realizing this goal. To accomplish this immense task, involving 26 manufacturing sites delivering to 110 outlets worldwide, a very specific educational process has been initiated to engage the conscious commitment of employees at all levels over time, as well as that of stockholders. Increasingly, businesses are seeing that "green is good"—economically, socially, and sustainably.

Many facilitative and reliable resources are available to seekers and learners, from neighborhood 'wise persons' to the Internet. Highly authoritative avenues for learning and practicing sustainability include, but are not limited to, the three named here because of their excellence and widespread recognition over time: (1) *Co-op America*,[36] an organization dedicated to creating a just and sustainable society through economic means; (2) World Watch Institute,[37] which provides in-depth analysis of environmental issues and trends; and (3) *Yes! A Journal of Positive Futures*,[38] which fosters the evolution of a just, sustainable, and compassionate future.

A concerned informal learning group, Friends Committee on Unity with Nature/Sustainability Committee provided a sense of the whole:

> Sustainability includes a resolve to live in harmony with biological and physical systems, and to work to create social systems that can enable us to do that. It includes a sense of connectedness and an understanding of the utter dependence of human society within the intricate web of life; a passion for environmental justice and ecological ethics; an understanding of dynamic natural balances and processes; and a recognition of the limits to growth due to finite resources. Our concern for sustainability recognizes our responsibility to future generations, to care for the earth as our own home and the home of all who dwell herein. We seek a relationship between human beings and the earth that is mutually enhancing.[39]

Theme 5: Working from the Inside Out

As holistic nurses who are sensitive to environmental issues, we know, at least intuitively, that the sole thing we have to offer is the way we live our lives. The way we live our lives is crafted from our day-to-day choices.

We live in a world of vast complexity and diversity. Our choice is to do whatever it takes to commit to and maintain our basic values, whatever we determine them to be. Only we can arrive at the personal meanings and understanding of relationships that provide coherence to our existence. While we may have models, support, and assistance, each of us is called to make this determination. In our holistic practice, we assist others in examining their options and encourage them to make life-affirming choices. Our primary task is to be with our clients within their life circumstances. Often, our greatest contribution is to walk freely with our clients as they face their ordeals, joys, and transitions.

We engage in our own grief work. We acknowledge and choose to make amends for our complicity, whether conscious or unintended, in the seemingly insurmountable environmental degradation observed today. We are not immobilized or demoralized by grief, however. We use it to fuel our resolve to "make it right." Because humankind has brought us to today's apparent impasse, we as members freely claim accountability. We have a heightened sense of belonging as we walk this path, for we know in some way that the ills we see through our nursing practice derive in large measure from the pervasive sense of alienation and loneliness of our clients and, indeed, of communities and larger

societies. We have a heightened awareness that the emotions attendant to "not belonging" give rise to disease states with innumerable manifestations.[40]

We work with contradiction and paradox. As humans, we often seek a state of entropy or comfort; we tend to cling to familiar patterns and routines. Yet, contradiction and paradox are so commonplace that we cannot always be sure what should command our attention. For example, what does it take to be a health care system rather than an illness care system? Why do we call artery-clogging foods, "treats"? Why do we solicit research funding for health projects from industries that manufacture illness-causing chemicals? We see holistic practitioners working consciously to restore sanity and balance in all settings.

We risk everything through the clarity of our values and convictions. Being human is not for the fainthearted. Being human calls for every shred of body, mind, and spirit that we can muster. Before we can take a stand or set a direction on an issue, we must reflect long and carefully about what counts the most in our lives. One approach is to seek clarity, within ourselves, about our purpose for existence. Some people believe that we have a fourfold purpose: to learn, to serve, to love, and to be loved. If this or something else is a personal credo, certain choices follow: we have direction and anchor, a lifestyle. Williams, a naturalist, suggested that we invoke the archetype of bear: fierce, not neat, not bloodless, and not cozy.[41] The bear is free to roam, stripped of society's musts, oughts, and shoulds. The bear relentlessly shreds and devours illusions, and is never so domesticated that it turns away from the life-giving work at hand.

We reside in joy of spirit and lightness of heart. Although the universe could unfold without us, we are here. Again, we have choices: to founder in the mire of impotent rage, fear, and confusion in the face of our planetary peril; to claim our birthright; or, as the new paradigm proposes, to be integral to the development of a new way. All the universe conspires to give us our heart's deepest desire. Holistic nurses are uniquely positioned to access the fountainhead of wisdom and strength within ourselves and to assist others to reclaim their own inner strength. The work, as in all authentic endeavors, is born in silence and stillness. Striving with joy and equanimity for an environmentally impeccable life means aspiring to be part of a larger whole, our inner life a seamless garment with its outer manifestation.

Environmental Conditions and Health

One of the reasons that it is difficult to study the link between environmental conditions and illness or disease is that there are so many intervening variables. Hundreds of substances and lifestyle factors are involved. Furthermore, not all toxic substances and environmental conditions induce immediate untoward reactions; many toxins seem to cause disease later, perhaps years after the period of exposure. Breathing asbestos fibers, for example, seldom causes immediate symptoms, but often has resulted in serious chronic disease many years later. Other environmental elements now known to be hazardous include lead, cigarette smoke, silica, benzene, mercury, chlorine, poor lighting, stress, and noise. Converging themes from the fields of environmental health, ecology and health, and human ecology highlight opportunities for innovation and advancement in environmental health theory and practice.[42]

Since the 1970s, national attention has focused on efforts to clean up the nation's environment and to ensure workers' safety. Two federal agencies, the Environmental Protection Agency (EPA) and the Occupational Safety and Health Administration (OSHA), were formed to monitor environ-

mental concerns. In the 1980s, several states enacted right-to-know laws that require employers to notify employees of health hazards; to provide formal education regarding the safe use of toxic substances; and to keep medical records of those workers routinely exposed to specific toxic substances. Federal agencies were fully involved in public safety amid concerns about the fires and suspected presence of toxic materials in the rubble pile following the collapse of the World Trade Center (WTC) buildings on September 11, 2001.[43]

In 1991, the Ecological Society of America published the *Sustainable Biosphere Initiative (SBI),* calling for a coordination of ecologic research, environmental education, and policy making. The project focuses on global change, loss of biodiversity, and sustainability. Its purpose is to gain a full understanding of the interactions of the biotic and the abiotic worlds in space and time.[44]

Internationally, the England Health and Safety Executive launched a huge campaign in 1991 to pique British awareness of health concerns at work. Called Lighten the Load, one program is designed to raise awareness of work-related musculoskeletal disorders and encourage employers to adopt programs that will reduce the frequency with which these disorders occur. Occupational health nurses play a major part in implementing this program, which includes assessment, intervention, evaluation, and prevention of stresses emanating from environmental working conditions.[45]

Environmental concerns range from eating contaminated poultry, hormone-fed beef, and irradiated fruits and vegetables to living near high-voltage power lines, understanding the Antarctic atmospheric ozone hole, and coping with other new high-technology hazards that we only now are recognizing (Figure 12–1). Noise, lighting, air quality, space allocation, and

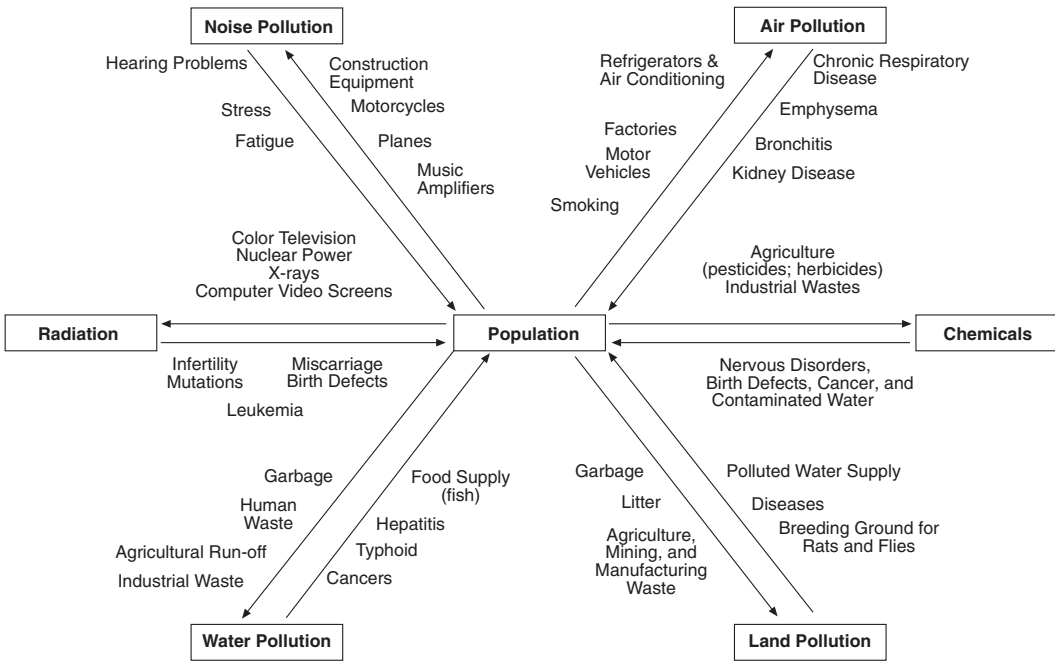


Figure 12–1 Current Environmental Concerns. *Source:* Reprinted with permission from the *Journal of Health Education,* August/September 1986, pp. 26–27. The *Journal of Health Education* is a publication of the American Alliance for Health, Physical Education, Recreation and Dance, 1900 Association Drive, Reston, VA 20191.

workplace toxins have gained increasing attention as chronic stressors.

Noise

Although its danger still is, for the most part, unrecognized, noise pollution may be the most common modern health hazard. The danger posed by noise pollution is a function of the volume of sound heard over a period of time. Sound and its intensity are measured in decibels, abbreviated dB (Table 12–1).

A growing body of data suggests a link between noise pollution and adverse mental and physical health. In the United States, the federal government has limited its responsibilities with respect to noise control after an initial interest in the 1970s, when legislation was passed promising to protect the American people against the harmful effects of noise. These past years anti-noise activists in the United States have been working arduously to urge the federal government to take an active role once again in abating and controlling noise. They have also been enlisting more citizens to their cause as they educate them to the hazards of noise.[46]

Even low frequency noise is a problem. One study found that low frequency noise interfered with a proofreading task by lowering the number of marks made per line read. The subjects reported a higher degree of annoyance and impaired working capacity when working under conditions of low frequency noise. The effects were more pronounced for subjects rated as high-sensitive to low frequency noise, while somewhat different results were obtained for subjects rated as high-sensitive to noise in general. The results suggest that the quality of work performance and perceived annoyance may be influenced by a continuous exposure to low frequency noise at commonly occurring noise levels. Subjects categorized as high-sensitive to low frequency noise may be at highest risk.[47]

The auditory system is permanently open—even during sleep. Its quick and overshooting excitations caused by noise signals are subcortically connected via the amygdala to the hypothalamic-pituitary-adrenal-axis (HPA-axis). Thus noise causes the release of different stress hormones (e.g., corticotropin releasing hormone: CRH; adrenocorticotropic hormone: ACTH), especially in sleeping persons during the vagotropic night/early morning phase. These effects occur below the waking threshold of noise and are mainly without mental control. The widespread extrahypothalamical effects of CRH and/or ACTH have the potential to influence nearly all regulatory systems causing, for example, stress-dysmenorrhea, as a sign of disturbed hormonal balance.[48]

An Australian group monitored noise levels in six intensive care units.[49] The measuring instruments included a Brugel and Kjaer microphone and measuring

Table 12–1 Decibel Levels of Various Sounds

Decibel (dB) Level	*Generating Sound*
120–140	Jet engine at take-off Amplified rock band at close range
100–110	Power lawn mower Oncoming subway train Chain saw Jackhammer
80–100	Alarm clock Screaming child Truck traffic at close range Cocktail party
60–80	Electric kitchen aids Washing machine
40–60	Normal conversation Refrigerator hum
20–40	A cat's purr
0–10	Threshold of hearing

amplifier. After noting the high baseline or ambient noise level, the researchers found that there were three primary sources of noise: people (i.e., patients, staff, and visitors), equipment, and furniture. People-generated noise was in the range of 70 to 76 dB. The variety of noises generated from equipment included the random beeping alarms. Noise levels were as high as 80 dB when plastic chairs were being moved and 85 dB when garbage was being removed. Noise from other routine tasks, such as disposing of used needles, tearing paper from monitors, and wheeling in stretchers, were commonly 10 to 20 dB above the baseline noise levels of the continuously operating machinery.

Considerable empirical evidence supports the claim that advances in hospital technology have led to increased sound levels in the critical care unit. In one study, 70 patients were randomly assigned to a noise- or quiet-controlled environment while attempting to sleep overnight in a simulated critical care unit. Researchers sought to determine if the sound levels suppress rapid eye movement (REM) sleep. Subjects in the noise group heard an audiotape recording of critical care unit nighttime sounds. These subjects showed poorer REM sleep on 7 of 10 measures. Thus, there appears to be a causal relationship between critical care units and suppression of REM sleep.[50] In a related study of 105 females, a comparison with subjects in quiet environments showed that subjects in noise-simulated conditions had poorer sleep efficiency, more difficulty falling and staying asleep, more intrasleep awakenings, and less time in REM.[51]

Hospital noise has been associated with sleep deprivation, sensory overload, increased perception of postoperative pain, and intensive care unit psychosis.[52] A controlled study of 28 surgical intensive care unit patients indicated that noise not only was disturbing, but also caused the heart rate to accelerate.[53] A degree of hearing loss has occurred in newborns placed in incubators with ultrasonic nebulizers.[54] In addition, there is concern about the impact of the nursery environment on the development of low-birthweight infants. In contrast to the uterine environment, the neonatal intensive care unit is characterized by bright, often continuous lighting; loud, sharp, unpredictable sound; limited, unpredictable, and often noxious tactile stimulation; and severe limitations on mobility. It has been suggested that such an environment, which differs markedly from the expected, may irrevocably alter neonatal development in ways not yet clearly understood.[55]

It is clear that we need more research in this area. Compared to other environmental issues, only a limited number of epidemiological studies are available on the relationship between such things as noise and cardiovascular diseases.[56]

Food Irradiation

What is irradiation of food? The following is a technical explanation:

> Food irradiation is a process by which food is exposed to a controlled source of ionizing radiation to prolong shelf life and reduce food losses, improve microbiologic safety, and/or reduce the use of chemical fumigants and additives. It can be used to reduce insect infestation of grain, dried spices, and dried or fresh fruits and vegetables; inhibit sprouting in tubers and bulbs; retard postharvest ripening of fruits; inactivate parasites in meats and fish; eliminate spoilage microbes from fresh fruits and vegetables; extend shelf life in poultry, meats, fish, and shellfish; decontaminate poultry and beef; and sterilize foods and feeds.[57]

Irradiation kills microbes primarily by fragmenting their DNA. The sensitivity of organisms increases with the complexity of the organism. Thus, viruses are most

resistant to destruction by irradiation, and insects and parasites are most sensitive. Spores and cysts are quite resistant to the effects of irradiation, because they contain little DNA and are in highly stable resting states. Toxins and prions, which have few chemical bonds to disrupt, are resistant to irradiation, as well. The conditions under which irradiation takes place (i.e., temperature, humidity, and atmospheric content) can affect the dose required to achieve the food processing goal, but these are well-described and easily controlled.[58]

Regulatory Explanation

Food irradiation is considered a "process" by many nations. The U.S. Congress explicitly included sources of irradiation as "food additives" under the 1958 Food Additives Amendment to the Federal Food, Drug and Cosmetic Act of 1938. This designation places food irradiation under the same regulatory umbrella of the U.S. Food and Drug Administration (FDA) as other food additives. Thus, irradiated food is defined as adulterated and illegal to market unless irradiation conforms to specified federal rules. The FDA has authorized the following four sources of ionizing radiation for food treatment: cobalt 60, cesium 137, machine-generated accelerated electrons not to exceed 10 million electron volts, and machine-generated x-rays not to exceed 5 million electron volts.[59]

The use of irradiation to improve the safety, protect the nutritional benefits, and preserve the quality of fresh and processed foods is a well-established and proven technology. Over the past 35 years, the U.S. government has invested in the science to confirm safety and in the technology to show application. The United States Department of Agriculture (USDA) and the Food and Drug Administration have approved sources of ionizing radiation for the treatment of foods, and their application to most meats, fruits, vegetables, and spices.[60]

Food irradiation is a technology that has been approved for use in selected foods in the United States since 1963.[61] Despite the value of this technology to the food industry and to the health and welfare of the public, only minimal application of this technology occurs. This underscores the importance of increasing the public's understanding of radiation risks relative to other hazards. Accordingly, in 1995, the Committee on Interagency Radiation Research and Policy Coordination of the Executive Office of the President made recommendations for the creation of a centralized National Radiation Information Center that would work closely with federal departments and agencies in responding to public queries about radiation issues and federal programs. In the past six years, some progress has been made, including the establishment of a government-operated Food Irradiation Information Center, and the completion of final rule-making by the USDA, thus permitting the safe treatment of meats and poultry.[62]

Current Status of Food Irradiation in the United States

In 1991, Food Technology Services Incorporated opened the first dedicated food irradiation facility in North America near Tampa, Florida. Strawberries, tomatoes, and citrus fruits from this facility have been marketed directly to consumers in Florida and Illinois since 1992. Fruits from Hawaii, including papaya and lychees, were irradiated and sold in several states during 1995. Although irradiated spices and herbs have been approved for use since 1963, they have only been marketed in the United States since 1995. Vidalia onions irradiated in Florida have been marketed at the retail level in Chicago since 1992. Since 1993, small quantities of irradiated chicken have been available in retail outlets in Florida, Illinois, Iowa, and Kansas. Very little irradi-

ated food is currently sold to consumers in the United States.[63]

New regulations are developed as a result of ongoing research studies. For example, Staphylococcus aureus is a common pathogen that causes food-borne illness. Traditional methods for controlling S. aureus do not address post-process contamination. Low-dose gamma irradiation is effective in reducing pathogens in a variety of foods and may be effective in reducing S. aureus in ready-to-eat foods. The effects of gamma irradiation on product packaging should also be considered. One investigation studied the effects of gamma irradiation on product packaging and on S. aureus in ready-to-eat ham and cheese sandwiches. Results demonstrated that low-dose gamma irradiation is an effective method for reducing S. aureus in ready-to-eat ham and cheese sandwiches and proved to be more efficacious than refrigeration alone. Investigators also learned that package integrity was not adversely affected by gamma irradiation.[64]

Food irradiation's history of scientific research, evaluation, and testing spans more than 40 countries around the world and it has been endorsed or support by numerous national and international food organizations and professional groups. Food irradiation does not replace proper food production, processing, handling, or preparation, nor can it enhance the quality of or prevent contact with foodborne bacteria after irradiation. In the United States, manufacturers are required to identify irradiated food sold to consumers with an international symbol (Radura) and terminology describing the process on product labels. In addiction, food irradiation facilities are thoroughly regulated and monitored for worker and environmental safety. The American Dietetic Association (ADA) position is that food irradiation enhances the safety and quality of the food supply and helps protect consumers from food-borne illness.[65]

Meat Irradiation

Food manufacturers in the United States are currently allowed to irradiate raw meat and poultry to control microbial pathogens and began marketing irradiated beef products in 2000. Consumers can reduce their risk of food-borne illness by substituting irradiated meat and poultry for nonirradiated products, particularly if they are more susceptible to food-borne illness. However, a study of 10,780 adults found that only 50% were willing to buy irradiated meat or poultry.[66]

Why is Food Irradiation Controversial?

Recent well-publicized outbreaks of food-borne illness have heightened general interest in food safety. Widespread use of irradiation remains controversial, however, because of public concern regarding the safety of the technology and the wholesomeness of irradiated foods.[67]

New food technologies traditionally have been met with resistance. When pasteurization was first developed in the late 19th century, it was considered highly suspect. Many of the objections raised to its dissemination were similar to arguments made today about food irradiation. Opponents worry that irradiation might be used to mask spoilage and enable the sale of unsafe food. However, the chemical and physical changes that are characteristic of spoiled food cannot be reversed by irradiation. Odor, color, and texture changes remain despite destruction of spoilage microorganisms. In addition to health and food safety concerns, irradiation of food also has raised concerns related specifically to expansion of the nuclear technology itself.[68]

For example, members of The Canadian Association of Physicians for the Environment (CAPE) debate Health Canada's

proposal to allow the irradiation of ground beef and poultry. They claim it replaces good food handling practices and is not based on sound science. In Canada, opponents charge that irradiation does not address the root cause of food-borne illnesses: industrial agriculture. Factory farms and feed lots confine large numbers of animals in small pens, creating an environment where both the animals and their food and water supply are exposed to large amounts of feces. Animals are then transported to industrial-sized slaughtering facilities where as many as 300 cattle are killed per hour. Critics say that the large number of animals slaughtered in a short time makes it impossible to keep fecal material out of meat products.[69]

The Canadian Cattlemen's Association petitioned Health Canada to change the regulations because Canadians deserve the same safety technology as Americans, who approved the irradiation of red meat in 2000. Health Canada is considering feedback from groups such as CAPE before approving or altering its proposed regulations, which will also allow shrimp, prawns, and mangoes to be irradiated. Wheat, flour, potatoes, onions, dehydrated seasoning preparations, and whole and ground spices are currently the only foods Health Canada allows to be irradiated and sold.

Opponents say there has not been any research on long-term effects on humans who consume irradiated foods and on the plant workers who oversee the treatment process. Some opponents compare it with the way industry was allowed to use humans as guinea pigs to assess the long-term impact of products such as tobacco and leaded gasoline.

A review of the research on short-term effects by U.S.-based Public Citizen, a consumer organization founded by Ralph Nader, says the evidence is contradictory and inconclusive (www.citizen.org). It also claims that the quality and safety of food is affected. For instance, irradiation destroys a third of the vitamin C in potatoes. All irradiated foods must be labeled to allow consumers to buy nonirradiated items if they wish.[70]

Smoking

Everyone, including the at-risk population of nonsmokers, is aware of the health hazards related to smoking tobacco products. Worldwide, though, it seems that women comprise the group most at risk. Smoking prevalence is lower among women than men in most countries, yet there are about 200 million women in the world who smoke, and in addition, there are millions more who chew tobacco. Approximately 22% of women in developed countries and 9% of women in developing countries smoke, but because most women live in developing countries, there are numerically more women smokers in developing countries. Unless effective, comprehensive, and sustained initiatives are implemented to reduce smoking uptake among young women and increase cessation rates among women, the prevalence of female smoking in developed and developing countries is likely to rise to 20% by 2025. This would mean that by 2025 there could be 532 million women smokers. Even if prevalence levels do not rise, the number of women who smoke will increase because the population of women in the world is predicted to rise from the current 3.1 billion to 4.2 billion by 2025. Thus, while the epidemic of tobacco use among men is in slow decline, the epidemic among women will not reach its peak until well into the 21st century. This will have enormous consequences not only for women's health and economic well-being but also for that of their families. The health effects of smoking for women are more serious than for men. In addition to the general health problems common to both genders, women face additional hazards in pregnancy, female-specific cancers such as cancer of the cervix, and exposure to passive smoking. In Asia,

although there are currently lower levels of tobacco use among women, smoking among girls is already on the rise in some areas. The spending power of girls and women is increasing, so that cigarettes are becoming more affordable. The social and cultural constraints that previously prevented many women from smoking are weakening, and women-specific health education and quitting programs are rare. Furthermore, evidence suggests that women find it harder to quit smoking. The tobacco companies are targeting women by marketing light, mild, and menthol cigarettes, and introducing advertising directed at women. The greatest challenge and opportunity in primary preventive health in Asia and in other developing areas is to avert the predicted rise in smoking among women.[71]

Nurses' Working Environment

Over the past three decades, a growing body of literature has indicated that nursing is a stressful profession. Improved technology and a greater turnover of acutely ill patients are two factors that have increased nurses' work pressure.[72] The constant caring for acutely ill patients with a myriad of physical and emotional needs occurs within an often complex organizational system.[73] Hospital work environment stressors include limited control of tasks, ongoing job changes, and continual technologic change.[74] Based on this and additional data, many nurses are proactively addressing this issue. For example, nurses at Kaiser Permanente Hospital in California designed a program to create a better work environment for their staff. Before strategic changes were implemented, only 32% of the staff felt the hospital did a good job of making nurses feel important. After management had been restructured and a more participative decision-making style adopted, 62% felt that they had an opportunity to influence decisions about their professional practice environment.[75]

Rationales for the workplace as a primary site for environmental health promotion activities include the large amount of time spent there by the majority of the population, the economic and other incentives for employers to invest in employee health promotion, the opportunity to mobilize peer pressure to help employees make desirable changes in health habits, and the many reports of workplace success in making health promotion changes. Converging themes from the fields of environmental health, ecology and health, and human ecology highlight opportunities for innovation and advancement in environmental health theory and practice.[76]

HOLISTIC CARING PROCESS

Assessment

In preparing to exercise environmental control, assess the following parameters as they apply to the client:

- Personal space for comfort, lighting, noise, ventilation, and privacy
- Environment for people or objects that induce anxiety
- Awareness that environmental concerns affect individual and family coping skills
- Awareness of objects or other environmental factors in the physical space that induce comfort or discomfort
- Environmental concerns, as well as the family's environmental concerns
- Possible environmental fears (e.g., a feeling of claustrophobia from being confined to a hospital intensive care bed or intravenous lines, or a fear of death because the patient in the next bed just died)
- Grief and its relationship to environmental factors (e.g., Is the client in the same home atmosphere in which the spouse just died? Are others

around the client sad and depressed? Are the colors in the environment dark and heavy?)
- Personal health maintenance in relation to environmental factors (e.g., Can the client easily reach self-care hygiene items? Are throw rugs anchored? Are sunglasses worn outside to prevent glare?)
- Ability to maintain and manage his or her own home
- Risk of injury associated with factors in the environment
- Activity deficits as a result of environmental factors
- Home environment for its potential impact on effective parenting
- Potential noncompliance because of environmental factors
- Risk of impairment in physical activity because of environmental factors
- Risk of impairment in respiratory function because of environmental factors, such as feather pillows, polluted or stale air, cigarette smoking, known or suspected allergens, or overexertion with chronic respiratory conditions
- Possible sleep deficit because of agents in the environment, such as lighting, noise, overstimulation, overcrowding, or allergenic pillows
- Alterations in thought processes that may be influenced by environmental factors, such as sensory bombardment with noise, lack of sleep, and transient living patterns

Patterns/Challenges/Needs

The patterns/challenges/needs compatible with environmental interventions and related to the 13 domains of Taxonomy II (see Chapter 14) are as follows:

- Potential for ineffective choices
- Altered self-care
- Altered growth and development
- Potential for sensory perceptual alteration
- Impaired environmental interpretational syndrome
- Potential for knowledge deficit
- Altered comfort
- Altered role performance

Outcomes

Table 12–2 guides the nurse in client outcomes, nursing prescriptions, and evaluation for the use of the environment as a nursing intervention.

Therapeutic Care Plan and Implementation

Before the Session

- Become aware of personal thoughts, behaviors, and actions that may contribute to the teaching, counseling, or caring environment.
- Prepare the physical environment for optimal lighting, seating, air quality, and noise control.
- Consider your internal environment. Is it calm, centered, and ready to interact with others?
- Clear your mind of other matters or personal encounters in order to be fully present when meeting with the client.

Beginning the Session

- Allow the client to express specific environmental concerns.
- Guide the client to consider changes that would improve his or her personal and employment environment.
- Encourage the client to write down areas of concern or improvement.

During the Session

- Encourage the client to initiate specific intervention ideas in his or her personal or professional work environment.
- Suggest to clients that they can serve on the environmental control committee at their place of employment or if

Table 12–2 Nursing Interventions: Environment

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client will demonstrate awareness of environment.	Assist the client in shaping his or her own personal space environment.	The client personalized his or her own environment.
	Assist the client with choices that contribute to a positive, safe environment for those who share his or her personal and community space.	The client monitored and controlled the noise that he or she contributed to the surrounding area.
		The client respected the rights of others by not polluting air, water, and public places with wastes.
		The client did not violate the personal space of others with tobacco smoke.
	Provide the client with information that helps in expanding concern for the concept of a healthy global environment.	The client participated in discussions, committees, or programs to work for a safe global environment.
The client will avoid contact and exposure to toxic substances and/or hazardous materials.	Give the client ideas for how to participate in safety education programs at his or her place of employment.	The client participated in his or her workplace offerings of environmental safety programs.
	Teach the client the importance of not handling unnecessary toxic substances.	The client did not handle unnecessary toxic substances and educated himself or herself about the dangers of hazardous materials.

their agency does not have one, that they volunteer to form one.
- Urge clients to consider the areas of sound (e.g., noise, music, machinery), air (e.g., quality, smell, circulation), and aesthetics (e.g., art, color, design, texture), as well as other topics specific to the overall environment.
- Educate hospitalized clients about the deleterious effects of too much noise.
- Encourage hospitalized clients to limit the time spent watching television and instead listen to their own personal cassette players with headphones.
- Create mechanisms whereby music, imagery, relaxation, color, aromas, and the like can be introduced into the workplace settings.

At the End of the Session

- Be aware that you function as a role model. As such, modulate your voice. Speak audibly, but softly, during the session.
- Help clients learn practical ways to cope with hazards in the environment (Table 12–3).
- Work together to write down goals and target dates.
- Give handout material to support established goals.
- Schedule follow-up sessions.

Specific Interventions

Personal Environment. Strategies to heal the environment abound on both a personal and a professional level. Personally,

Table 12–3 Coping with Environmental Hazards

Problem	*Solution*
Too much noise	1. Turn off radios and televisions. 2. Lower your voice. 3. Ask your colleagues to quiet down. 4. Ask to serve on the agency's environmental control committee.
Inadequate lighting	1. Add more lights. 2. Use incandescent bulbs instead of fluorescent tubes whenever possible. 3. Open curtains and blinds whenever possible. 4. Go outdoors for full-spectrum light breaks, rather than taking cafeteria coffee breaks.
Stale air	1. Make sure agency ventilation systems work. 2. When doing home health visits, open the doors and windows and get fresh air in the home when appropriate. 3. Request that broad-leaf green plants be stationed in the workplace. They are aesthetically pleasing and give off oxygen. 4. Wear masks or protective gear if there is any risk of toxic inhalants.
Long periods at computer video display terminal	1. Use a shield that cuts down glare and radiation and grounds the field of electrostatic charge. 2. Learn some relaxation exercises to do at your desk. 3. Ask your institution or agency to have minimassage available on the premises. 4. Take frequent eye and movement breaks away from the screen. 5. Use properly designed chairs.
Space allocation	1. Try to find some personal space in the workplace. 2. Respect others' personal space. Ask before entering the client's room, closet, or dresser. 3. Make the space you are allocated as pleasant as possible. Decorate with colorful objects, soothing scents, and aesthetic objects.

we begin to modify our own internal environment. The ability to regulate our state of consciousness, thought patterns, and reactive behaviors gives us the power to move smoothly through external crises both at work and at leisure. Approaching a hectic external environment with internal composure and tranquility makes it possible to transform crises into manageable situations. Clean, clear internal environments can influence all the external environments in which we work and live.

As we develop the optimal workplaces and living areas to foster self-actualizing conditions and maximize bodymind responses, we must be aware of the impact of all aspects of the environment on human health. Many nurses find that the following exercise increases their sensitivity to the environment and its impact on their lives:

> At different times during the day, close your eyes, and take a few moments to listen carefully to all the sounds in your environment.
> - Jot down the many different sounds you hear, noting which are pleasant and which are distracting or disturbing noises.
> - Become aware of all the sounds that you ordinarily hear, such as the air conditioner, radios and televisions, the hum of fluorescent lights, the beeping and

buzzing of hospital machinery, or the incessant Muzak that some institutions play over the speaker system.
- Notice new smells, feelings of temperature, and so forth. There will be many sounds, smells, and sensations of which you may not previously have been aware.

Workplace Noise. Noise seems to be a major area of environmental concern that nurses can control for the most part. It is the accumulation of noises that adds up in decibels and adds up to stress. By becoming increasingly sensitive to all potential environmental stressors, the nurse becomes more attuned to the opportunities for specific interventions.

Some specific recommendations to reduce workplace noise include:

- developing staff education programs about noises, their source, and ways to quiet them
- setting telephones and alarms to low volumes, or replacing sound devices with flashing lights
- installing buffers in open space areas to minimize impact noise
- closing the patients' doors whenever feasible
- using bedside chairs with wheels in patient rooms with hard floors
- choosing quieter equipment
- placing computer printers away from patient rooms and/or installing soundproof covers
- giving patients headphones to listen to television or radio so that they do not disturb others
- lowering our voices when we speak

Planetary Consciousness. Schuster suggested that there is an impetus and underlying reason for our developing environmental consciousness. She noted that we are all hoping to foster and sustain our fullest conscious participation in the ongoing web of interrelationships.[77] Three points emerge as most salient within the context of nursing in general, and holistic practice in particular.

1. It is important to address the nature of being human and, in our Western mode, the pervasive influence of the self–other dichotomy.
2. We must be aware that we have viable choices of how we want to be and how we represent ourselves in the world.
3. An integration of items 1 and 2 develops a personal orientation to all environmental concerns. With such an orientation, we can act from internal conviction and relatedness, rather than from institutional directives.[78]

The most enduring and far-reaching environmental work originates with individuals as consumers and practitioners, not with organizations, however enlightened they may be.[79] Thus, it is up to each of us to develop an environmental sensitivity in our daily lives and become increasingly cognizant of our opportunities to institute positive change.

Case Study

Setting:	Outpatient clinic, or private visit
Client:	A.B., a 55-year-old married man
Patterns/ Challenges/ Needs:	1. Altered comfort related to recurrent headaches 2. Ineffective individual coping related to environmental stress

A.B. visited the occupational health nurse because of recurrent headaches and chronic fatigue. A physical examination and laboratory tests revealed no pathology or disease, but his subjective declaration of feeling stress in the workplace warranted a closer examination of his workplace environment. A detailed history of his work hours, commuting travel, and

work setting yielded evidence of environmental imbalance. A.B. began his day with a 45-minute automobile commute through a suburban area to the inner city; he finished the day the same way. He had made this commute for years, but the traffic had lately increased and road repairs frequently slowed his pace. When he arrived at work, he went to his office, an interior room with no windows and fluorescent ceiling lights. The office walls were the standard institutional beige color; A.B. had done nothing to decorate or personalize his office. Instead of a secretary outside his office, he now had his own computer inside his office. During the company's modernization process, middle managers had been taught computer skills, and many secretarial positions had been eliminated. Each manager was now responsible for developing reports and interacting with others via personal computer terminals. A.B.'s work routine had little variation. It consisted of meetings, telephone work, and online computer time.

This information suggested that A.B. was experiencing environment-related stress, and the nurse worked with him to develop a five-step plan of action:

1. Vary the commuting time. Begin the commute 15 minutes earlier to decrease the rushed feeling of getting to work on time. Join a health club in the city, and stay after work to exercise. The traffic would be considerably less one hour later, and the commute would then take only 30 minutes. Total morning and evening commute time would remain the same as before, but more would have been accomplished with less environmental stress.
2. Implement and practice computer protection skills (see Table 12–3).
3. Mount a shoulder rest on the telephone to prevent neck strain after long periods on the telephone.
4. Personalize the office with soft, soothing colors. Add a wall picture of a mountain valley and stream that have personal significance.
5. Put an incandescent lamp on the desk, and use that rather than the overhead fluorescent lights for desk work.

A copy of this plan was posted in a prominent place in A.B.'s home. Along with a plan for exercise and weight management (see Chapters 19 and 27) and a plan for the development of relaxation and imagery skills (see Chapters 21 and 22), this program incorporated A.B.'s need for motivation, lifestyle change, and values clarification.

When A.B. returned for his follow-up visit two months later, his headaches had abated, and he had made some progress toward his weight loss. He and his wife had redecorated his office, and on his own he had added a small cassette player to play his favorite classical music.

Six months later, A.B. was free of headaches. He had spearheaded a no-smoking policy for his workplace and asked the company director to install full-spectrum lights on all ceiling overhead panels. He felt he had regained some sense of control over his environment and was working on improvement in the other areas for which he and the nurse had developed plans.

Evaluation

Each environmental intervention should be measured. The nurse can evaluate with the client the outcomes established before the implementation of any interventions (see Table 12–2). To evaluate the results further, the nurse can explore the subjective effects of the experience with the client, based on the evaluation questions in Exhibit 12–2. Nurses have always been sensitive to environmental issues. Historically, nurses have been the health care providers primarily concerned with health promotion, sanitation, and improvement in the quality of life for all people. Our tech-

Exhibit 12–2 Evaluating the Client's Subjective Experience with Environmental Concerns

1. Were you aware that noise, lighting, air quality, space allocation, and workplace toxins could be chronic stressors?
2. Are there any of these potential stressors in your environment? If so, can you do anything to reduce or remove them?
3. Do you realize that you can contribute to a healthier planet by virtue of changing elements in your own personal space?
4. Do you have an environmental sensitivity group at your workplace? If one existed, would you like to be a part of it?
5. Do you feel empowered to be the person who initiates change in your work setting?
6. What are some specific things that you would like to do to create a healthier environment in your personal space or work setting?
7. What is your next step (or your plan) to integrate these changes in your life?

nologic society has raised new issues and concerns, ranging from the use of increasingly toxic substances to high-technology machinery. Last year's methods of handling laboratory specimens and chemotherapy preparations, for example, may be outdated next year. Nurses keep abreast of the changing face of the environment in order to equip themselves with the newest strategies to counteract hazards. Future nurses would be well advised to remember and recall some of the basic nursing tenets of yesteryear that are still most relevant today. These interventions include fresh air, control for a comfortable climate, cheerful colors and sights, and noise reduction.

Much of how we relate to and what we do about environmental issues is based on the development of our personal philosophy. We continue to become increasingly aware that each of the small things that we do for or against the environment has short- and long-term ramifications. Nurses want to be alert for ways to contribute to positive environmental changes for their own lives, their clients' lives, and the overall health of the planet. Environmental concerns are important to all of us, and one person's actions can have a ripple effect on many other lives. Nurses can be key agents to ensure that the environment is held sacred, supported, and tended as it supports and gives life to all of the earth's people.

DIRECTIONS FOR FUTURE RESEARCH

1. Evaluate the perception of quality of rest by subjects with different types of auditory stimulation.
2. Study the relationship between environmental hazards (e.g., artificial lighting, working on video display terminals, unventilated air, shift work, high noise levels) and the rise in infertility rates, conditions affecting unborn fetuses, and neonate abnormalities.
3. Investigate the use of tactile, auditory, and/or olfactory stimuli on wound healing, rate of complications, length of recovery, and other health-related factors.
4. Study the effect of the environment on the reduction of stress and/or anxiety in ambulatory clients.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- How does the environment affect my job satisfaction?
- What are the environmental stressors at work and at home?
- What strategies can I incorporate in my environment to be healthier?
- What things can I do to improve my own personal and workplace environment?
- How can I be involved with environmental issues at work and in my community?

NOTES

1. R. Tarnas, The Great Initiation, *Noetic Sciences Review*, no. 47 (1998):24–31, 57–59.
2. Ibid., 28.
3. J. Macy, *Coming Back to Life: Practices to Reconnect Our Lives, Our World* (Gabriola Island, BC, Canada: New Society Publishers, 1998), 60–61.
4. L. Selanders, *Florence Nightingale: An Environmental Adaptation Theory* (Newbury Park, CA: Sage Publications, 1993), 19.
5. C. Anthony, *A Guide to the I Ching*, 3rd ed. (Stow, MA: Anthony, 1988), 21.
6. E. Schuster, Environment Needs Nurses Who Care, *The American Nurse* 24, no. 4 (1992):25.
7. R. Carson, *Silent Spring* (Boston: Houghton Mifflin, 1962).
8. J. Macy, *Coming Back to Life*, 17.
9. J.D. Mitchell, Nowhere to Hide: The Global Spread of High Risk Synthetic Chemicals, *World-Watch* 9, no. 2 (1997):27–36.
10. A. Sachs, Virtual Ecology: A Brief Environmental History of Silicon Valley, *World-Watch* 12, no. 1 (1999):12–21.
11. Ibid.
12. T. Colburn, *Our Stolen Future* (New York: Penguin Books, 1996), 19.
13. Mitchell, Nowhere to Hide, 28.
14. L.C. Oliver and B.W. Shackleton, The Indoor Air We Breathe: A Public Health Problem of the '90s, *Public Health Reports* 113, no. 5 (1998):398–409.
15. S. Steingraber, *Living Downstream: An Ecologist Looks at Cancer and the Environment* (New York: Addison-Wesley, 1997), 270.
16. T. Colburn, *Our Stolen Future*, 73–75.
17. Carson, *Silent Spring*.
18. Steingraber, *Living Downstream*, 254–272.
19. Mitchell, Nowhere to Hide, 28–29.
20. S. Cowan, A Design Revolution, *Yes! A Journal of Positive Future*, Summer no. 6 (1998):27–30.
21. Ibid.
22. Ibid.
23. Ibid.
24. The World Commission on Environment and Development, *Our Common Future* (London: Oxford University Press, 1987), 43.
25. The President's Council on Sustainable Development, *Sustainable America: A New Consensus for Prosperity, Opportunity and a Healthy Environment* (Washington, DC: U.S. Government Printing Office, 1996), iv.
26. L. Grant, Sustainability: Part I. On the Edge of an Oxymoron, *Negative Population Growth Forum*, March (1997):1–6.
27. L. Grant, Sustainability, Part II. A Proposal to Foundations, *Negative Population Growth Forum*, March (1997):6.
28. Ibid., 1.
29. K. deBoer, David Orr and the Greening of Education, *Earthlight* 7, no.1 (1996):1, 23.
30. D. Orr, Transformation or Irrelevance: The Challenge of Academic Planning for Environmental Education in the 21st Century, 3. Address to the North American Association for Environmental Education, Florida Gulf Coast University, March 4–8, 1998.
31. Ibid., 5–6.
32. America Speaks, How Sustainable Is Your Community's Citizen Involvement? *Wingspread* 19, no. 2 (1997):18.
33. J.T. Gatto, Universal Education, *Yes! A Journal of Positive Futures* 3, no. 1 (1998/99):14–18.
34. Ibid.
35. Interface, *Sustainability Report* (Atlanta: Interface Research Corporation, 1996).
36. Co-op America, 1612 K Street, #600, Washington, DC 20006.
37. Worldwatch Institute, 1776 Massachusetts Avenue, N.W., Washington, DC 20036. See www.worldwatch.org.
38. *Yes! A Journal of Positive Futures*, P.O. Box 10818, Bainbridge Island, WA 98110.
39. Friends Committee on Unity with Nature/Sustainability Committee, Ecological Sustainability as a Witness, *Friends Journal* 45, no. 2 (1999):26–27.
40. C.B. Pert, *Molecules of Emotion: Why You Feel the Way You Feel* (New York: Charles Scribner's Sons, 1997).
41. S. Abercrombie, Faith, the Feminine and Bear, *Earthlight* 30, no. 3 (1998):8–9.
42. M.E. Northridge, G.N. Stover, J.E. Rosenthal, D. Sherard, Environmental Equity and Health: Understanding Complexity and Moving Forward, *American Journal of Public Health* 93, no. 2 (2003 Feb):209–214.
43. Occupational Exposures to Air Contaminants at the World Trade Center Disaster Site—New York, September–October, 2001. *MMWR Mor-*

bidity and Mortality Weekly Report 51, no. 21 (2002 May 31):453–456.

44. J. Lubchenco et al., The Sustainable Biosphere Initiative: An Ecological Research Agenda, *Ecology* 72, no. 2 (1991):371–412.
45. C. Meusz, The Nurse's Role in Workplace Assessment, *Nursing Standard* 6, no. 49 (1992):29–32.
46. A.L. Bronzaft, Noise: Combating a Ubiquitous and Hazardous Pollutant. *Noise Health* 2, no. 6 (2000):1–8.
47. K. Persson Waye, J. Bengtsson, A. Kjellberg, and S. Benton, Low Frequency Noise "Pollution" Interferes with Performance, *Noise Health* 4, no. 13 (2001):33–49.
48. M. Spreng, Possible Health Effects of Noise Induced Cortisol Increase, *Noise Health* 2, no. 7 (2000):59–64.
49. A. White and M. Burgess, Strategies for Reduction of Noise Levels in ICUs, *The Australian Journal of Advanced Nursing* 10, no. 2 (1992–1993):22–26.
50. M. Topf and J. Davis, Critical Care Unit Noise and Rapid Eye Movement (REM), *Heart and Lung* 22 (1993):252–258.
51. M. Topf, Effects of Personal Control over Hospital Noise on Sleep, *Research in Nursing and Health* 15, no. 1 (1992):19–28.
52. J.P. Griffin, The Impact of Noise on Critically Ill People, *Holistic Nursing Practice* 6, no. 4 (1992):53–56.
53. C. Baker, Discomfort to Environmental Noise, *Critical Care Nursing Quarterly* 15, no. 2 (1992):75–90.
54. R.W. Beckham and S.C. Mishoe, Sound Levels inside Incubators and Oxygen Hoods Used with Nebulizers and Humidifiers, *Respiratory Care* 35, no. 12 (1990):1272–1279.
55. M.J. Lotas, Effects of Light and Sound in the Neonatal Intensive Care Unit Environment on the Low-Birth-Weight Infant, *NAACOG's Clinical Issues in Perinatal & Women's Health Nursing* 3, no. 1 (1992):34–44.
56. W. Babisch, Traffic Noise and Cardiovascular Disease: Epidemiological Review and Synthesis, *Noise Health* 2, no. 8 (2000):9–32.
57. K.M. Shea and the Committee on Environmental Health Technical Report, Irradiation of Food, Committee on Environmental Health, *Pediatrics* 106, no. 6 (2000 Dec):1505–1510.
58. Ibid.
59. Ibid.
60. A.L. Young, Food Irradiation: After 35 Years, Have We Made Progress? A Government Perspective, *Environmental Science and Pollution Research International* 10, no. 2 (2003):82–88.
61. Shea, Irradiation of Food.
62. Young, Food Irradiation.
63. Shea, Irradiation of Food.
64. J.L. Lamb, J.M. Gogley, M.J. Thompson, D.R. Solis, and S. Sen, Effect of low-dose gamma irradiation on Staphylococcus aureus and product packaging in ready-to-eat ham and cheese sandwiches, *Journal of Food Protection* 65, no. 11 (2002 Nov):1800–1805.
65. O.B. Wood and C.M. Bruhn, Position of the American Dietetic Association: Food Irradiation, *Journal American Dietetic Association* 100, no. 2 (2000 Feb):246–253.
66. P.D. Frenzen, E.E. DeBess, K.E. Hechemy, H. Kassenborg, M. Kennedy, K. McCombs, and A. McNees, FoodNet Working Group, Consumer Acceptance of Irradiated Meat and Poultry in the United States, *Journal of Food Protection* 64, no. 12 (2001 Dec):2020–2026.
67. Shea, Irradiation of Food.
68. Ibid.
69. B. Sibbald, Health Canada's Food-Irradiation Proposal Sets Off Debate, *Canadian Medical Association Journal* 168, no. 5 (2003, March 4):168.
70. Ibid.
71. J. Mackay and A. Amos, Women and Tobacco, *Respirology* 8, no. 2 (2003 June):123–130.
72. G.A. Baker et al., The Work Environment Scale: A Comparison of British and North American Nurses, *Journal of Advanced Nursing* 17, (1992):692–698.
73. N.R. Tommasini, The Impact of a Staff Support Group on the Work Environment of a Specialty Unit, *Archives of Psychiatric Nursing* 6, no. 1 (1992):40–47.
74. G. Thomas, Working Can Be Harmful to Your Health, *Canadian Nurse* 89, no. 6 (1993):35–38.
75. M.B. Townsend, Creating a Better Work Environment, *Journal of Nursing Administration* 21, no. 1 (1991):11–14.
76. M. Parkes, R. Panelli, and P. Weinstein, Converging Paradigms for Environmental Health Theory and Practice, *Environmental Health Perspective* 111, no. 5 (2003 May):669–675.
77. E. Schuster, Earth Dwelling, *Holistic Nursing Practice* 6, no. 4 (1992):1–9.
78. Ibid.
79. Ibid.

Sharing Our Healing Stories

In each moment, we nurses have many levels of story; some heal, and some do not. Transforming our own healing, the healing of health care, and developing innovative practice models begin with dialogue. We must initiate the dialogue that envisions, builds trust, and establishes community in the deepest sense. A healthy dialogue means that an individual does not hold a fixed position, but rather listens to others explore diverse realities. Being open and engaging in dialog with members of a different culture is a crucial step in becoming culturally sensitive.

It is important to realize that we cannot export practices from a different culture without considering the history and context of that culture. Therefore the meaning of the practice will be much different if operationalized by a different culture. Exporting or co-opting practices can be exploitative or sacrilegious if a practice is taken out of the sacred context of a cultural belief. Nonetheless, with globalization and increasing intercultural communication now occurring, practices and behaviors from different cultures are absorbed and integrated. In some cases even superficial use of a cultural practice can be beneficial. One such practice is that of the talking stick that has been used to enhance group work and communication. The talking stick is a practice among some Native American tribal councils. The stick is passed to a member who speaks and while that person is holding the stick, everyone listens and focuses on the person talking. The stick is then offered to others in the group, so all have an opportunity to speak and be heard. Often there is a silence between speakers when members can think about what was spoken. This practice has a powerful effect on group dynamics. Most of us are not aware, until participating in this practice, of how often our meetings have interruptions and some people are never heard. It is a revealing experience to focus solely on another's words, and to have others be silently attentive as we speak. A brief period of silence between speakers to ponder what was said is often uncomfortable in our fast paced culture yet it can be extremely powerful in communication. This process allows for deliberation in what we say and a respect for each person's words.

Chapter 13

Cultural Diversity and Care

Joan C. Engebretson and Judith A. Headley

NURSE HEALER OBJECTIVES

Theoretical

- Compare common value orientations associated with cultures.
- Describe the influence of technology on cultural development and communication systems.
- Analyze components of cultural diversity.
- Describe the components and principles of cultural competence.
- Discuss cultural influences on beliefs and explanatory systems related to health and illness.

Clinical

- Discuss the role of culture in interactions with clients.
- Use components of transcultural assessment in caring for clients.
- Identify appropriate patterns, challenges, and needs of clients in the cultural domain.
- Explore interventions that reflect cultural competence.
- Discuss ways in which nursing interventions may be evaluated in relation to cultural competence.

Personal

- Clarify your own values, beliefs, and ideas related to your cultural heritage.
- Identify barriers in your own life to acceptance of cultural diversity.
- Explore activities that will increase your awareness and acceptance of cultural differences.

DEFINITIONS

Acculturation: the process of the adaptation, assimilation, or accommodation of an individual immigrant or immigrant group to a new culture.

Assimilation: the process of integration, or taking as one's own, of a new culture by an individual immigrant or immigrant group.

Culture: "the complex whole, which includes knowledge, belief, art, morals, laws, custom and any other capabilities and habits acquired by man as a member of society."[1]

Culturally Competent Health Care: the ability to deliver health care with knowledge of and sensitivity to cultural factors that influence the health and illness behaviors of an individual client or family.

Ethnicity: designation of a population subgroup sharing a common social and cultural heritage.

Ethnocentrism: a world view that is based to a great extent on the socialization of individuals within their own culture, to the extent that such individuals believe that all others see the world as they do.

Race: a social classification that denotes a biologic or genetically transmitted set of distinguishable physical characteristics.

Stereotyping: consigning cultural attributes to a group of people based on assumptions, opinions, or attitudes.

Xenophobia: an inherent fear or hatred of cultural differences.

THEORY AND RESEARCH

Culture is the whole of ideas, customs, skills, arts, and other capabilities of a people or group, although as a whole, it is more complex than any one of these elements. Culture is learned from birth through language acquisition and socialization, the process by which an individual adapts to the group's organized way of life. This process also provides for the transmission of culture from one generation to another. Members of the cultural group share cultural beliefs and patterns of behavior that create a group identity, which has a powerful influence on behavior, usually on a subconscious level. Culture is largely *tacit*; that is, generally unexpressed or discussed at a conscious level. Most culturally derived actions are based on implicit cues rather than written or spoken sets of rules.

While many of the underlying beliefs and value systems of a culture are stable, all cultures are inherently dynamic and changing; therefore, it is difficult to generalize from one situation or time to another. Cultural practices are continually adapting to the environment, historical context, technology, and availability of resources. As a result, the context in which people live influences, and is influenced by, cultural practice. Anthropology, the study of cultures, and nursing are both based on a holistic perspective. Culture has a significant impact on health and illness behaviors and patterns of response. It directly influences health behaviors such as diet and exercise. Cultural beliefs and practices also affect the types of health problems that are attended to, and the actions taken to deal with them. Activities taken to promote, maintain, or restore health are all performed in a cultural context; therefore, understanding of the client's perceptions and the context in which he or she lives is necessary for optimal client care.

Culture also determines much of the relationship and communication between a client and a health care provider. Given that the United States is a culturally diverse nation, nurses and other health care providers encounter individuals and groups whose habits of health maintenance, reactions to illness or disease, and use of health care services may differ from their own. An awareness of and accommodation to the cultural aspects of health and illness behaviors enable one to promote health by skillfully blending professional knowledge with knowledge of the individual's or group's beliefs. Culturally competent care is the delivery of health care with skill, knowledge, and sensitivity to cultural factors. With the increase in cultural pluralism in North America, it is essential that nurses develop cultural competency to deliver holistic care.

Cultural Competency

With increasing diversity in the population, and the recognition that health disparities exist across ethnic groups, health care regulatory agencies recommend that cultural competency become a goal in the provision of health care. This recommendation applies to the institutional level as well as to the individual provider. Institutions are mandated to provide adequate translation, and individual providers are

encouraged to develop more culturally appropriate care.[2]

A popular model of cultural competency describes a continuum from cultural destructiveness to cultural competency.[3] We seek to counter cultural destructiveness, the lowest level of the continuum, through laws such as the Civil Rights Act of 1964 (Title 6), which mandates that health care providers do not discriminate according to race, ethnicity, or creed. The ethic of nonmaleficence, or "do no harm," also addresses this basic level. The second level of the continuum, cultural incapacity, refers to nonintentional practices that may be harmful to patients through ignorance or insensitive attitudes, or improper allocation of resources. Cultural blindness, the third level, is exemplified by treating all patients alike without accommodating cultural differences. Creating programs that address diverse groups' access to care, providing translators, and health education aimed at specific cultural groups are good examples of cultural precompetence (level 4). Cultural competence (level 5) is best described as an ongoing learning process for the provider who can integrate cultural knowledge into individualized patient-centered care; this eventually leads to the highest level of the continuum, cultural proficiency. Practicing in a culturally competent manner also entails the three aspects of evidence-based practice: best research evidence, provider's clinical expertise, and the patient's values and unique preferences.[4]

Culturally competent health care must be provided within the context of a client's cultural background, beliefs, and values related to health and illness in order to attain optimal client outcomes. In addition to the Transcultural Nursing Society, there is a corpus of literature in nursing about cultural competence.[5–11]

Bernal has identified five components of culturally competent care: (1) open-mindedness, (2) awareness of one's own cultural values, (3) understanding of differences, (4) knowledge, and (5) adaptation skills.[12]

1. ***Awareness and acceptance of cultural differences require an open-minded attitude about other worldviews.*** Competency starts with the attitude that providing care based on one's own worldview may not be in the best interest of the client. Nurses who use a nonjudgmental approach in learning about a client's cultural belief system will not only gain a wealth of information, but also will readily establish mutual trust in their nurse–client relationships.
2. ***An awareness of one's own biases and attitudes that create barriers to direct interaction with a group or groups makes it possible to overcome them.*** Recognition of personal cultural attitudes requires conscious effort; most people are unaware of their cultural beliefs because their beliefs are so integrated into their perception of the world. Personal reflection and values clarification are useful strategies to facilitate awareness.[13] Values clarification facilitates self-understanding, focuses on what is meaningful to the individual, and includes values that are both fixed and changing. Clarification of values is a critical thinking process that involves making choices from a variety of alternatives that are consistent with one's own beliefs. As nurses become more aware of their own values, they can enable clients to clarify and express what is important for them. Nurses must not assume that their own values are right, nor should they judge a client's values according to their own values, for such action might lead to ethnocentrism. Knowledge and understanding of the values, beliefs, and behaviors of a culture

enable a nurse to individualize nursing interventions.

3. ***It is essential to understand dynamic differences and to recognize basic differences among cultures without promoting the superiority of one culture over another.*** Many people, in an effort to connect with people of other cultures, assume that there are few differences among cultures and focus only on fundamental similarities. Although this is useful for connecting with other cultures, it can obscure some basic differences that must be clear for cultural understanding. For example, a European-American cannot fully understand an African-American without recognizing the legacy of slavery in the African-American culture.
4. ***With a basic knowledge about a client's culture, nurses can develop and share knowledge and skills in a straightforward manner.*** The best way to learn about diverse cultures is to interact with people from those cultures, as participation and communication provide opportunities to discuss and experience cultural variances. Opportunities to become immersed in another culture are not always available, however. Culturally focused literature, films, and music can enhance cultural understanding. Stories by and about a specific cultural group can provide a microscopic view of factors that have shaped lives, have influenced values, and reflect beliefs related to health and illness. The false notion of a single monolithic culture can be dispelled through reflections of literature, such as the depiction of the concept of health and related underlying beliefs, values, and behavior patterns of life in an African-American community in the book and film *The Color Purple*.[14]
5. ***Adaptation skills include being receptive to different cultures, actively seeking advice and consultation from individuals of that culture, and incorporating those ideas into one's practice.*** Skills include the ability to articulate an issue from another's perspective, as well as to recognize and reduce resistance and defensiveness. The ability to admit errors is important, as resolving errors in interacting with someone from another culture allows for the exploration of cultural issues that enhance understanding and communication. It is often better to risk a confrontation than to avoid the issue, resulting in continued misperception or lost opportunity for better cultural understanding.

Cultural Diversity and Health Disparities

Despite the fact that humans are 99.9% identical at the DNA level, there are differences in prevalence of illness between groups. This may be explained by genetic differences, dietary, cultural, environmental, and socioeconomic factors, or a combination thereof.[15] Health disparities in the United States exist for multiple health outcomes. For example, African-Americans have the highest overall risk of developing cancer and the greatest overall risk of dying from it.[16] In the U.S., infant mortality is inversely related to the mother's educational level. It is also highest for infants of non-Hispanic black mothers and is lowest for those of Chinese mothers.[17] Some common issues that have been identified are socioeconomic status, social discrimination based on gender or race/ethnicity, distribution of health care resources, and social policies.[18] Determinants of health include social conditions, environmental hazards, lifestyle and cultural practices, access to health care, and human biology and genetics. Socioeconomic status under-

lies three major determinants of health: health care, environmental exposure, and health behaviors.[19]

Race and Ethnicity

Ethnicity refers to values, perceptions, feelings, assumptions, and physical characteristics associated with ethnic group affiliation. Often, ethnicity refers to nationality, a group sharing a common social and cultural heritage. In contrast, race typically refers to a biologic, genetically transmitted set of distinguishable physical characteristics. In some literature, however, race has often been misused to describe differences in people that have no basis in biology or science. Demographic data are commonly gathered with no differentiation of ethnicity or definitions of race. Both skin color and country of origin have been used to classify race. For example, many natives of India (considered racially Caucasian) have darker skin than do many natives of Africa.

Race and culture have significant relationships to illness states, as biologic differences can make certain groups of people vulnerable to specific diseases. For example, genetic predisposition for sickle cell disease affects people of African and Mediterranean descent; predisposition for Tay–Sachs disease affects Ashkenazi Jews. Also, certain diseases that may be attributable to a combination of genetic predisposition and lifestyle, including nutritional patterns, are more prevalent in some groups. One example is the disproportionately high prevalence of diabetes in Native Americans and Hispanics. Some diseases are connected to lifestyle risks, such as substance abuse and human immunodeficiency virus (HIV) infection, which are related to particular social behaviors. An emerging body of information on the differences in response to pharmaceuticals by ethnic and racial groups has led to a new field of pharmacogenonics.[20] Cultural sub-groups can be attributed to multiple factors that determine values, beliefs, and behaviors. Ethnicity is the most common cultural demarcation, but intra-ethnic variations may be more pronounced than inter-ethnic variations, especially in a culturally pluralistic society. Other variables that have been proposed as influencing cultural groupings are religion, socioeconomic status, geographic region, age, common beliefs, and professional orientation, such as nursing and medicine.

Factors Related to Culture

Religion is an important factor in determining the values and beliefs of a culture. An organized system of beliefs, religion is differentiated from spirituality, which is born out of each person's unique life experience and his or her efforts to find meaning and purpose in life.[21] Religious faith and the institutions derived from that faith have a powerful influence over human behavior. All religions have experiential, ritualistic, ideologic, intellectual, and consequential dimensions. Religious views have historically served as a unifying force for groups of people according to a set of core values and beliefs.

Socioeconomic status refers to one's social status, occupation, education, economic status, or a combination of these. Socioeconomic explanations are often discounted when determining the relationships between ethnicity or race and health status or health. It is necessary to distinguish between cultural identification and the common experience of being poor in our society. By illustration, the experience of being poor in our society is different from that of being Hispanic and must be further distinguished from being both poor and Hispanic. The impact of socioeconomic status on both morbidity and mortality measures of specific groups is highly significant and is related to health disparities; lower socioeconomic status

groups have higher morbidity and mortality rates for various diseases.[22]

The local or regional manifestations of the larger culture address such distinctions as rural, urban, Southern, or Midwestern. For example, African-Americans living in the Southern region of the United States may have different beliefs and behaviors than those in the Northern region, based somewhat on their heritage of slavery and exposure to the civil rights movement.

Age of the individuals within a cultural group has a profound influence over their beliefs and behaviors. Value systems are tied to historically shared events that occur in childhood; therefore, each generation develops a unique value system. For example, persons born in the United States prior to the 1940s generally maintain traditional values, while those born during the 1940s and 1950s often consciously strive to reject those values.[23]

Common beliefs or ideologies may unite a cultural group as well as differentiate that group from the larger culture. These value systems may be related to religion (e.g., the Amish), lifestyle (e.g., communal groups), sexual orientation (e.g., gay and lesbian groups), or political ideologies (e.g., feminist separatist groups). Social or professional orientations often constitute a type of cultural grouping. For example, the biomedical culture of many hospitals constitutes an unfamiliar culture for many lay people. Health care professionals use a unique and esoteric language, as well as rituals, roles, expectations and patterns of behavior, and symbolic communication that are often alien to the lay person.

Common Myths and Errors

Errors of stereotyping are common among those who define the world by strict categories of ethnicity or race. Also problematic are presumptions that all members of another culture conform to a common pattern without regard to individual characteristics or the variety found within one cultural grouping. For example, some people assume that all African-Americans eat soul food or that all Hispanics are Catholic. Failure to recognize that values from a particular cultural group can vary across time and location can lead to stereotyping cultures with values that no longer guide the group's thinking or behaviors. Stereotyping is less obvious in some cases, such as a nurse manager's assigning all Hispanic clients to the Mexican-American nurse. Such action does not take into account the differences within the Hispanic group, presumes that all Hispanics are alike, and disregards the individual.

The heterogeneity of ethnic groups is often underestimated, but as mentioned earlier, the variations within ethnic groups may be as great or greater than those between ethnic groups. For example, the Hispanic culture includes persons of Puerto Rican, Cuban, Spanish, and South and Central American origins. These people are from many different socioeconomic backgrounds and represent the Caucasian, Mongoloid, and Negroid racial groups. Sometimes Asians from different countries and backgrounds are grouped together and treated as generic Asians, an attitude that totally ignores the historical differences among Asians. Kipnis related a clinical incident that occurred in Hawaii, in which a Korean patient with a serious medical condition refused a treatment that promised a better than 50 percent recovery with minimum risks.[24] Clinical staff were puzzled by his refusal of treatment coupled with his request for life support if he experienced cardiopulmonary arrest. On further investigation, he mentioned that all his physicians were Japanese. In the early 1900s, Japan had ruthlessly tyrannized Korea, much as the Nazis in Germany tyrannized Poland prior to and during World War II. Thus, the Korean gentleman very

much wanted to live, but his cultural history caused him to refuse treatment directed by the Japanese physicians.

Ethnocentrism is the tendency, usually unconscious, for individuals to take for granted their own values as the only objective reality and to look at everyone else through the lens of their own cultural norms and customs. Ethnocentric views often result from a lack of knowledge of other cultures and the presumption that one's own behavior is not influenced by culture. Many people of the dominant culture falsely assume that they have no cultural practices and beliefs. This restrictive view of the world perceives people and cultures with different beliefs and behaviors as culturally inferior. An extreme and more conscious form of ethnocentrism is xenophobia, an inherent fear of cultural differences, which often leads people to bolster their security in their own values by demeaning the beliefs and traditions of others. This attitude often takes the form of prejudice or racism.

Cultural imposition is the perception that successful cultural adaptation involves a change to the cultural views of the dominant group, regardless of an individual's cultural heritage. This posits an inherent view that the dominant culture is superior, and its values are imposed upon others.

Often disguised as equal treatment for everyone, cultural blindness ignores cultural differences as if they did not exist. This view overlooks real diversity and the importance of other perspectives. The concept of the "melting pot" assumes that, in the process of acculturation and assimilation, everyone takes on significant aspects of the dominant culture such that the original culture is largely lost. This assimilation or "melting pot" view is challenged by concepts of heritage consistency, which is the degree to which one maintains practices and beliefs that reflect one's own heritage.[25]

Development of Cultural Patterns and Behaviors

Anthropologists have studied the similarities between cultures related to the universal experience of being human. Their major focus has been on the variations in the ways that humans organize and structure their social world. Some of the factors that contribute to the development of cultural patterns and behavior are geography and migration, gender-specific roles, value orientations and cultural beliefs, and technological development.

Geography and Migration

Social groups evolve through interaction with the climate, and in conjunction with the availability of food and resources. The persistence of dietary patterns reflects the types of food available in a particular region. For example, fish constitutes a large portion of the traditional diet of people from Norway and the Philippines, whereas dairy products and meats are dominant in food patterns in Finland and Germany.

Social organization has followed these geographic patterns. For example, the social structure of a fishing village differs from that of a nomadic group that hunts for food, and from that of a settled agrarian culture. Urbanization and industrialization are also important in the way society organizes and social roles develop. Social roles become patterned and often institutionalized into hierarchical structures that reflect social, economic, and political power. These social structures and roles greatly alter people's daily lives and the economics of providing for families.

Climate, environmental conditions, and political and economic factors are very important in migration patterns. Climate change, famine, political upheaval, or overpopulation beyond the immediate environmental resources have been responsible for migration. For example, a

large wave of Irish immigrants came to the United States in the late 1840s following a potato famine that was causing starvation, disease, and death in Ireland. Many immigrants came to the United States to flee political unrest in El Salvador in the 1980s. Many Vietnamese and Southeast Asians sought political refuge and opportunities in the United States following the Vietnam War. A large number of nurses seeking professional and economic opportunities moved to the mainland United States from the Philippines in the 1980s. Even in the 1990s and the early twenty-first century, a large number of immigrants have steadily come to the United States seeking economic opportunities.

Cultural patterns change through the sharing of ideas, beliefs, and practices that follow trade or migration. Immigrants bring cultural patterns, values, and beliefs with them. Along with their adaptation to the new host culture, they expose the host culture to a different set of cultural beliefs and practices. Both cultures assimilate aspects of the other.

The historical context of the immigration is important and varies among groups. Many African-Americans arrived involuntarily and endured a lengthy history of slavery; Hispanics may be immigrants seeking economic opportunity, refugees from political upheavals, or descendants of people living in the Southwest before it became a part of the United States. The fact that many Asian immigrants find it necessary to take a job with lower status than they had in their country of origin creates cultural and economic hardship for the family. In many Hispanic families, the father immigrates alone to establish a better economic future for the family. Estranged from the family, he may be at risk for such behavioral health risks as AIDS and alcohol abuse. Health issues may also arise because of low income and low self-esteem.

Acculturation is an important process in the adaptation, assimilation, or accommodation of immigrant groups to a new culture. Often, acculturation is a process of assimilation, in which immigrants integrate the new culture into their beliefs and lifestyle and yet retain heritage consistency, maintaining pride in and adhering to their parent culture. According to the theory of orthogonal cultural identification, this process does not take place along a single continuum, but rather has numerous dimensions that operate independently from each other.[26] Intergenerational gaps frequently develop within the traditional culture during the process of acculturation. As youth become more quickly acculturated to the dominant society, they challenge the more traditional values, beliefs, and customs of their parents; this, in turn, may threaten the integrity and lines of respect in the family and roles within the family and society, particularly the role of women. Conflicts that arise from intergenerational gaps can lead to the alienation of young people and families from both the ethnic culture and the general dominant culture.

Gender Roles

Over the past century, the social role for women in the United States has undergone many changes. The role of women has expanded from its traditional focus on childbearing and child rearing to include participation in the workplace and marketplace. The feminist movement has championed this expanded role and has heightened consciousness about opportunities consistent with the American values of individualism, equality, and political freedom. Furthermore, the feminist movement has challenged the values and structures developed by masculine power elite, such as competition, strong focus on objectives and goals, harnessing and control of nature, principle-based ethics, and pro-

ductive activities. Feminists have promoted cultural practices and organizations that espoused more feminine values such as teamwork, focus on social process, working in harmony with nature, relationship-based ethics, and social connections. As people from other cultures move into the United States, these differing values and expanded roles for women may challenge the traditional family roles.

Women have played significant roles in the healing arts as well. Historically and cross-culturally, women have discovered and preserved information about healing herbs and plants. In the Middle Ages, women were often persecuted for their knowledge of plants and other healing arts, which were deemed mysterious and suspicious. As medicine became more scientific and moved into a professional and scientific status, women were disengaged from the official healing roles.[27] Women were associated with nature, and men with developing technology to tame and control nature. Women's roles in the healing arts reflected this dichotomy. With the establishment of medical professions, women's roles even in midwifery—a traditional role for women—were reduced, and physicians took over the practice and moved it into hospitals. Women who worked in medical professions were often in nonphysician roles or positions of lower power and social status, such as nurses, social workers, and physical therapists. Women have a strong presence, however, among complementary healers and users of complementary therapies.[28]

Value Orientations and Beliefs

All cultures hold certain values which are central to their cultural patterns of behavior. These values can be both implicit and explicit. They influence an individual's perception of others, direct that individual's responses to others, and reflect his or her identity. These values are the basis for self-reflection; serve as the foundation for positions on personal, professional, social, political, and philosophic issues; motivate behavior and direct goals; and give meaning to life.[29] In the United States, for example, the public generally perceives values as having a strong moral orientation with an emphasis on active instrumental mastery over the world according to external standards. Individual and peer relationships rather than hierarchical relationships are stressed. The focus is on progress and change with a rationalistic rather than traditional approach. Orderliness and attention to structure and form are important.

Value Orientations. Variants of value orientations have been outlined following Kluckhohn's five categories, reflecting the way in which a culture solves the universal problems of human nature:[30]

1. **Innate human nature.** Cultures' dominant views of human nature range from seeing human beings as basically evil, or perfectible only with discipline and effort, to seeing human beings as good and being unalterable or incorruptible. Some see human nature as mixed, a combination of good and evil, but with the capacity for self-control. Individuals' views of human nature have implications for their trust in the medical establishment. These views are often reflected in parenting styles.
2. **Relationship to nature.** Various cultures are more fatalistic, seeing humans as subjugated to nature in their destiny. Others believe that humans coexist with nature in harmony. Mastery over nature is the perspective that natural forces are to be overcome and put to human use. A culture's view of the cause of disease often is based on the perceived relationship of humans to nature. These

views may explain patients' patterns of seeking or not seeking medical care.

3. **Relationship to time.** Past-oriented people value tradition and have a great respect for the wisdom of ancestors and elders. They may first seek guidance for health problems from older family or group members or from folk healers. Present-oriented people live in the moment and may be late for appointments, have trouble making ends meet financially, and delay educational goals to meet immediate needs of self or family. In future-oriented cultures predominant in the United States, most middle-class individuals tend to delay gratification to pursue education or career and set high future goals. They value punctuality and efficiency and plan actions to save time and money. They may alter their lifestyle to promote health, and the emphasis is on youth and new ideas. The latter pervade contemporary health care and may not be congruent with patients' orientations.
4. **Purpose of being.** Cultures oriented toward "being" express impulses and desires spontaneously and are not focused on development. "Being-in-becoming" cultures are oriented toward self-development and self-realization wherein the self is contained and controlled within. This detachment from the outer world brings enlightenment. In "doing" cultures, people actively strive to meet goals, and they evaluate their accomplishments competitively against externally applied standards of achievement. Individuals' culturally determined interpretations of their purpose for being affect their responses to illness and disability.
5. **Relationship to other persons.** Lineal relationships have continuity through time and are expressed in heredity, kinship ties, and orderly succession. Emphasis on the welfare of society, group goals, and family orientation is the hallmark of the collateral value. In individual oriental cultures, where personal autonomy and independence are primary, group goals are secondary to individual goals. The type of relationships among members of a particular culture often influence how health care decisions are made and by whom, and how individuals respond to dependency on others.

Cultural Beliefs. A group's beliefs are tenets with a shared meaning. These tenets provide a set of metaphores used to explain the phenomenon of nature and form a worldview or a paradigm. Spiritual teachings and the social codes of behavior stem from these worldviews. Often formalized into religious systems that are the institutionalization of a belief set, these worldviews are the source of many of the assumptions that people have about creation, reality, behavior, and rituals.

Three dominant cosmology assumptions essential to worldviews held by Western Judeo-Christian-Islam beliefs differ from those in some of the other world religions.[31] Monotheism, the belief in one God Creator who is separate from humans, contrasts with the beliefs common in many agrarian societies whose members believe in polytheism (multiple gods with different attributes), or pantheism (i.e., the locus of the sacred in all living things). The Western view of transcendence, or relating to God as separate from humans and knowing God through prayer, supplication, and rituals to connect to the Divine, can be contrasted with the Eastern view of immanence, or finding God by looking inward and doing other spiritual exercises to discover the sacred. Finally, Western dualism, separation of material from nonmaterial aspects of being, is in contrast to *monism*, or the essential unity found in both the pantheistic and Eastern belief

systems. Many "New Age" perspectives are exploring these issues as they are exposed to different cultural beliefs.

Technology and Culture

In contemporary Western culture, as well as in much of the world, technology is widely expanding. The development of technology impacts values, religion, politics, and the arts and sciences. Medical technology in particular has progressed in its development of intricate instruments that allow for more complex procedures, such as microsurgery, cryopreservation, and gene mapping. The development of these technologies poses new ethical and cultural questions related to the impact this technology may have. Often the use of these technologies challenges existing cultural values. New fields of diagnosing and treating diseases, such as pharmacogenomics, targeted therapies, and computer-based imaging have emerged. Once the technology is available for use, it often becomes the fuel for ethical debates related to such issues as allocation of resources, fetal tissue transplantation and right to life, and genetic testing and right to privacy.

Technology also has held a powerful influence on culture through its use in communication, which affects not only how information is conveyed, but also what type of knowledge is valued.[32] Traditionally, knowledge was passed on by oral means in stories, parables, and poetry. Essential knowledge (e.g., cultural wisdom associated with oral tradition) was preserved through memory, often aided by rhythm and rhyme. Many cultures today have their roots in oral traditions.

With the advent of written communication, the Western world became a different culture based on the type of knowledge that was conveyed and developed. Printed materials recorded information with detail, precision, and accuracy in a way that oral speech could not. The ability to read this information also facilitated discussions and formation of complex thoughts. Thus, scientific and factual information gained value, giving rise to the development of modern scholarship.

Today's electronic culture, dependent on telephones, radio, television, and computers to communicate information, has an enormous impact on the beliefs, values, and behaviors of contemporary society. Electronic media, allowing for fast and more universal dispersal of information, has promoted intercultural communication throughout the world as never before. Global economic, health care, and political issues can be rapidly communicated. Such communication has led to unprecedented exposure to different cultures, with results ranging from attempts to integrate diverse ideas to facilitation of overt conflict and violence. Related to health care, patients have access to a plethora of health-related information from multiple sources. This has presented new challenges for health care providers to help patients interpret information and make appropriate choices.

Changing Beliefs and Values

In the late twentieth century, people in the developed and industrialized world have been exposed to a number of different cultures, as a result of both immigration and electronic technology. Scientific and technologic advances, as well as global, political, social, and economic changes, have challenged existing cultural systems and increased the velocity of cultural change. Some cultural critics have predicted a major cultural change in the United States. They believe that concern for the quality of life, personalization, and a reverence for nature will replace modernism, which focuses on materialism, scientific progress and objectivism, and the role of humans in controlling and exploiting nature.[33,34] Anderson described a shift in contemporary culture as evidenced by the emphasis

on the environment, religion and spirituality, and postmodern multiculturalism.[35]

A large marketing survey indicated that the U.S. population could be divided into three groups according to values. Ray identified Cultural Creatives as those who are on the leading edge of change, comprising nearly one-quarter of the population.[36] This group holds a holistic philosophy of health; values ecologic preservation, spirituality, relationships, and self-actualization; and expresses interest in other cultures and new ideas. The largest group (47%), the Moderns, places a high value on success, consumerism, materialism, and technologic rationality. The third group (29%), the Traditionalists, or Heartlanders, believe in the nostalgic images of small towns and strong churches that define the "Good Old American Way."

In a survey of more than 1,000 adults, Astin found that those who use alternative/complementary therapies have a higher education level and a more holistic orientation to health, were more likely to have had a chronic health problem or other recent illness, and often had been through a transformational experience that changed their worldview.[37] This group expressed a set of values, beliefs, and philosophic orientations that included commitment to environmentalism, feminism, and interest in spirituality and personal growth. Other studies have described these consumers as generally well educated and affluent members of the middle class.[38–40] The use of complementary therapies and the search for holistic approaches to health care is consistent with the cultural beliefs of the Cultural Creatives. This percentage of the population is substantial and, according to Ray,[41] is growing, while individuals in the Traditionalist groups are generally older and the group is not growing as quickly.

Ethnic Groups in North America

Culturally diverse groups in the United States have grown to substantial proportions of the population. In their practice, nurses are likely to encounter representatives of several different cultures. Reading about and engaging in discussions and activities with members of these cultural groups will help to avoid stereotypic interpretations of these groups and aid in developing cultural competency.

Native Americans

The indigenous peoples of the Americas number 2.5 million and live across the United States, Alaska, and the Aleutian Islands.[42] Only 5.6% of Native Americans are age 65 or older, compared to 14% of the European-Americans, indicating a shorter life expectancy. They cluster in tribal groups, with the largest concentrations located in the Pacific and Western Mountain regions of the United States. There is considerable variation among the tribes regarding language, beliefs, customs, health practices, and rituals. Tribes or clans constitute a social unit in which members may or may not be blood relatives, and both family and clan are powerful sources of the Native American's identity and support. Largely because of the respect for the wisdom accrued with aging, elders are the leaders. Value orientations center on harmony with nature, a present-time orientation, and an integration of rituals and religion into everyday life. Many Native Americans still adhere to folk healing practices, seeking out local healers before going to a health care clinic. Folk healing practices may fall into the shamanic category or often be understood in a supranormal paradigm. Common health problems include diabetes, obesity, infectious disease, alcohol abuse, and diseases associated with poverty.[43]

Years of racism, dehumanization, and oppression have left a legacy in which many Native Americans may mistrust Caucasian health care providers.

European-Americans

The largest ethnic group in North America is made up of the European-Americans. They constitute the dominant culture and comprise approximately 75% of the population of the United States.[44] The largest emigrations from various regions in Europe occurred in the late 1700s, all through the 1800s, and into the first half of the twentieth century. Many immigrants to the United States carried the European ideas of the Age of Reason, dominance over nature, and the belief in progress and technologic advancement. Their quest for freedom enhanced an abiding value of individualism. They were generally action-oriented, future-directed, and focused on progress and productivity. Families are an important social unit among European-Americans, but the value of individualism is pervasive. Although this group is diverse, the values are usually consistent with dominant values of the culture. Therefore, members of this group may not be as aware of the role that culture plays in their lives as are members of other cultural groups.

African-Americans

The 2000 Census estimated the number of African-Americans in the United States to be 35 million, or 12% of the population, and this is anticipated to increase to 61 million by 2050.[45] One-third of this population was under the age of 18 in 2000. This group is very heterogeneous and varies in economic status, religion, education, and regional background. Many African-Americans are descendants of slaves who were brought to the United States; others are recent immigrants from Africa and the Caribbean Islands. Within the social structure of slavery, families were dispersed and individuals were not allowed to read. Thus, a tradition of strong matriarchal family units with a rich oral tradition developed. Social organization centers on the family, kinship bonds, and the church. Some of the health disparities may be related to the disproportional rate of poverty. Many African-Americans have absorbed much of the dominant culture, but some adhere to ancestral beliefs of illness as disharmony with nature and supranormal healing rituals or folk healing. The history of slavery and the Tuskeegee atrocities have made some African-Americans mistrustful of receiving professional health care or participating in clinical research studies.

Asian-Americans

Constituting 4% of the total U.S. population, or approximately 10.5 million people in 2000, Asian-Americans are expected to represent 8% of the population by 2050.[46] Approximately two-thirds reside in the Western part of the United States. This group is composed of immigrants and refugees from the Pacific Rim countries: China, Japan, Korea, Thailand, Laos, Vietnam, Cambodia, the Philippines, and other Asian countries. People from India are often included in this group as well. There is wide diversity in language, customs, and beliefs. Traditional Asian families tend to be patriarchal, to revere their elders, and to value achievement and honor. Certain infectious diseases, such as tuberculosis and hepatitis, are common among Asian-Americans, depending on the country from which they emigrated. Stress-related diseases and suicides are high, as many do not seek mental health care because of an associated stigma and a threat to honor. Asians' traditional health practices often are oriented around

the balance paradigm in which health is equated with balance and unimpeded flow of energy, or "chi." Traditional healing includes the use of herbal preparations, and many families practice traditional dermabrasion procedures such as coining, pinching, or rubbing.

Pacific Islanders and Native Hawaiians

The Native Hawaiian and Other Pacific Islander (NHPI) population constituted 874,000 individuals, or 0.3% of the U.S. population in the 2000 census.[47] Native Hawaiians are the largest subgroup (58%), although the majority of this group reported one or more other races as well. Nearly three-fourths of this population lives in the west, with over half living in California and Hawaii combined. For the 2000 Census, there were several differences in the way that questions about race were asked, and this was the first census in which NHPIs were separated statistically from the Asian group. Thus, comparisons are difficult, but this group increased approximately 9% since 1990 for individuals selecting a single race category. There is great diversity in beliefs and customs. As an aggregate group, NHPIs are socioeconomically disadvantaged and underserved in terms of access to social and health services. Pacific Islanders have high rates of health-related risk behaviors, such as smoking, heavy alcohol consumption, and high fat and caloric intake, which leads to obesity. Native Hawaiians have the second highest overall cancer incidence rate and the highest age-adjusted cancer mortality rate compared to other ethnic groups, with high rates of breast, colorectal, prostate, lung, and stomach cancers.[48] Native Hawaiians are 2.5 times more likely to have diabetes than white residents of Hawaii of similar age. Other common illnesses among NHPIs are asthma, hypertension, and hypercholesterolemia.[49]

Hispanic or Latino Americans

The Hispanic population in the United States includes more than 35 million people, or 12.5% of the U.S. population, and is predicted to reach 24% by 2050.[50] The majority of these immigrants come from Mexico, with others from Puerto Rico, Cuba, and Central and South America. This is the fastest growing group in the United States. Although the Spanish language is a common factor, there is much diversity in dialects and cultural practices. This group comprises indigenous peoples of the Americas, Spanish and other European settlers, and some African-Caribbean groups. Predominant religions are Catholicism and Pentecostalism. The family and extended family are important, and the family unit is traditionally patriarchal. Many believe that illness may be punishment for sins or the result of witchcraft *brujería*, or the "evil eye." Traditional health beliefs regarding hot and cold remedies for various maladies reflect humoral balance beliefs. Healing also incorporates many spiritual elements, such as worship of saints and use of talismans.

Impact of Culture on Health Care

Cultural understandings of health and illness reflect larger philosophic worldviews, or paradigms, that provide a way of understanding the body and the forces that influence health and illness. According to Andrews and Boyle,[51] three major types of cross-cultural paradigms operate: magicoreligious, holistic, and scientific. Although aspects of all three are found in most cultures, one usually predominates.

In the magicoreligious health paradigm, the fate of the world depends on God, gods, or supernatural forces. Events such as sorcery, breach of taboo, intrusion of a disease-causing spirit, or loss of soul are considered responsible for illness. This

paradigm relates to a psychic or metaphysical need of humanity for integration and harmony.[52] For example, people from some African-Caribbean cultures believe that parts of a person such as hair, fingernails, or blood represent the person and can be used in healing. Also, they may believe that lack of protection for these body parts can make the person vulnerable to illness.

In the holistic health paradigm, the forces of nature must be kept in harmony according to natural laws and the larger universe. These systems often have a strong emphasis on health rather than on the treatment of disease.[53] In Ayurvedic medicine from India, for example, health results from being in harmony with oneself, others, and the environment. Diet and activity are adapted according to the individual's doshas (i.e., forces of the human body whose composition varies among individuals) and the seasonal variations in the environment. In Western culture, this idea appears in humoral theories, such as the concepts of balancing hot and cold held by Hispanic, Arab, African, Caribbean, and other societies. Holistic health care is regaining some popularity in developed countries, bastions of the scientific paradigm, as the focus begins to shift to promoting health.

The scientific or biomedical paradigm is characterized by four main concepts:

1. **Determinism.** A cause-and-effect relationship exists for all natural phenomena.
2. **Mechanism.** The relationship of life to the structure and function of machines suggests the possibility of control through mechanical or engineered interventions.
3. **Reductionism.** The division of all life into isolated smaller parts, such as the dualism of mind and body, facilitates the study of the whole.
4. **Objective materialism.** That which is real can be observed and measured.[54]

This paradigm is the basis for health care systems in Western society, where the disease is viewed as the "enemy," the body is the "battlefield," and the physician is the "general." Great effort, expense, and technology are invested in determining the underlying cause of disease. The "system at fault" is isolated, and the most medical attention is directed toward measuring the functions of and repairing this faulty part. Persons are often placed in foreign environments (e.g., hospitals) in which limited attention is given to individual needs and cultural beliefs.

Cultural Sectors

Health care systems in most cultures have certain sectors in common. Kleinman identified three sectors that are generally present: professional, popular, and folk.[55] Cultures vary widely in the way that they combine these three systems. Usually, one is dominant, although simultaneous use is common.

In the United States, the professional, or orthodox biomedical, sector of health care has held a legal/political and ideologic monopoly for most of the twentieth century. This sector corresponds to the scientific paradigm described earlier. Nurses and other health care professionals are part of this sector.

The popular sector, in the broadest sense, includes all the personal and social networks that lay people use to understand their health and plan their health care. Individuals, family, and social networks determine whom to consult, when to seek a consultation, whether to adhere to suggested treatments, when to switch treatments, and how to evaluate the usefulness of treatments. Nearly all persons are active in their own health care decisions and practice some form of private or self-prescribed health care.

All secular and sacred healers that are generally outside the professional sector make up the folk sector. This sector also

includes healing practices used to promote health and treat illness. According to Giger and Davidhizar,[56] folk medicine frequently classifies diseases or illnesses as natural or unnatural. Natural events arise from the way that a higher power made the world and intended it to be. The basic principle is that everything in nature is connected and events can be explained in terms of this relationship. In some folk sectors, disease represents a disturbance in that relationship with nature. A natural disease or illness results from a disturbance in the person's relationship or balance with nature, and recovery requires the restoration of this relationship. This view is common among Native Americans, whose concept of medicine embraces the forces of nature. Because death is seen as part of the life cycle, a component of natural harmony, a cure for illness is not necessarily sought. Unnatural illnesses are usually attributed to punishment from a higher power for one's sins or improper behavior. The origin of unnatural illnesses in folk medicine is based on the continuous battle between good and evil forces. Witchcraft and breaking of a taboo are sometimes considered the origin for unnatural illnesses.

Explanatory Models of Health and Illness

Concepts of health and healing are rooted in culture. The concept of disease generally refers to the diagnostic label used to describe a particular disorder, while the concept of illness incorporates the personal, social, and cultural aspects of the experience. Some cultural principles influence an individual's behavior to promote, maintain, and restore health; others help the individual cope with illness or dying.

The beliefs of an individual or group about the causes, symptoms, and treatments of illness is an explanatory model. Culturally specific explanatory models are interpretations of the culture's worldview as it pertains to health and healing, and generally provide an understanding of disease and direct treatment. Explanatory models of health and healing are used to recognize, interpret, respond to, cope with, and make sense of an illness experience.[57] For example, a client who believes that the cause of his or her illness is related to committing a sin or breaking a taboo may not accept medication as a cure. Some form of catharsis, forgiveness, or ritual may be necessary. The questions in Exhibit 13–1 may be used to elicit a client's explanatory model.[58]

Exhibit 13–1 Questions To Elicit Explanatory Models

- What do you call your problem? What name does it have?
- What do you think has caused your problem?
- Why do you think it started when it did?
- What does your sickness do to you? How does it work?
- How severe is it? Will it have a short or long course?
- What do you fear most about your sickness?
- What are the chief problems your sickness has caused you?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from the treatment?

Source: Adapted with permission from Kleinman et al., Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research, *Annals of Internal Medicine*, Vol. 88, pp. 251–258, © 1978, American College of Physicians—American Society of Internal Medicine.

Multiparadigm Model of Healing

As Western culture is becoming increasingly culturally pluralistic, a number of alternative and complementary healing practices and beliefs are surfacing. The meaning of the word "holistic" is related to the word "health," which stems from the root word "hale," the same root as "to

make whole." This definition would necessarily incorporate multiple approaches to support health. One effort to place diverse modalities into a unified model is illustrated in Exhibit 13–2.[59] Paradigms of health and healing are based in underlying philosophy, cultural beliefs, and explanatory models of health and illness. Hence, there is resonance between the biomedical model and the technologic development of modern society. In this unified model, modalities or healing activities are suggested based on the explanation that healers have given for their use.

The unified model illustrated in Exhibit 13–2 uses four paradigms across the horizontal axis: mechanical, purification, balance, and supranormal. The mechanical paradigm best describes the biomedical model or the professional sector, in which the prevailing views are that the body is a system of structure and function, disease is a disruption of its mechanism of action, and the purpose of treatment is to restore or replace that function. The mechanical paradigm is self-correcting and produces increasingly sophisticated understandings of the mechanics of the function of the human body.

The purification paradigm underlies many illness/disease healing and religious healing practices. The general intention is to cleanse and rid the body of polluting influences. This approach to healing is evident as far back as the early Egyptians, who understood and used some of the concepts of purification in the process of mummification. This paradigm

Exhibit 13–2 Multiparadigm Model of Healing

Positivist ← → **Metaphysical**

Material ↕ **Nonmaterial**

Modalities	Mechanical	Purification	Balance	Supranormal
Physical manipulation	Biomedical Surgery	Colonics Cupping	Magnetic healing Polarity	Drumming Dancing (Dervishes)
Applied and ingested substances	Pharmacology	Chelation	Humeral medicine	Flower remedies Hallucinogenic plants
Energy	Laser/radiation	Bio-energetics	T'ai chi Qigong Acupuncture Acupressure	Healing touch Laying-on of hands
Psychological	Mind-body	Self-help (confessional type)	Mindfulness	Imagery
Spiritual	Attendance at organized religious functions	Forgiveness Penance	Meditation Chakra balancing	Primal religious experience Prayer

Source: This figure originally appeared in *Advances in Nursing Science,* volume 20, number 1, pages 21–33. Reprinted with permission. © 1997 Aspen Publishers, Inc.

was quite dominant in European medicine as late as the nineteenth century and was the rationale behind purges, bloodletting, and other cathartic treatments.

Evident in many cultures, the balance paradigm is epitomized in many of the Oriental healing practices that balance yin and yang and the harmonious flow of "chi." "Chi" is defined as "matter on the verge of becoming energy, or energy at the point of materializing."[60] This concept also was part of Hippocratic medicine in the balancing of the humors, and still is evident in Mexican dietary patterns used to balance disorders with cold or hot foods.

The final paradigm, supranormal, corresponds to some of the magicoreligious healing practices and has been used cross-culturally to explain phenomena that physical laws cannot explain. Many paradoxical healings that defy a scientific understanding of physiology may be more clearly understood from this paradigm. Many of the more mystical spiritual practices of ritual, pilgrimages, prayer, and other activities of religious discipline related to healing mind, body, and spirit stem from this paradigm. Spontaneous healing that has no medical explanation may be attributed to divine intervention, miraculous synergy, vital energies, or capabilities of living organisms beyond the current understanding of medicine. Many of the explanations refer to abilities acquired in an altered state of consciousness by the healer, healee, or both. Several complementary modalities of healing, such as visual imagery, healing touch, or prayer, are best understood through this paradigm. This paradigm is the most distant from the mechanical paradigm, an opposition that may contribute to resistance to these types of healing activities.

In the multiparadigm model, the healing activities on the vertical axis are classified as physical manipulation, applied or ingested substances, uses of energy, psychologic modalities, and spiritual modalities. Each of the paradigms contains all types of healing activities. As one moves to the right in the model (see Exhibit 13–2), however, all healing is conceptualized as more holistic; all activities affect the entire human. For example, a physical manipulation in the supranormal paradigm is assumed to have spiritual effects, and vice versa.

Healing activities are inserted in the model as examples; other modalities can be added. Among the examples that are useful to illustrate healing activities is the practice of cupping, which involves placing heated cups on parts of the body. The cooling of the air creates suction, causing superficial capillaries to break, and blood to collect in the cup. Cupping exemplifies physical manipulation in the purification paradigm, a healing modality that removes toxins or impurities from the body. Bach flower remedies are viewed as an ingested or applied substance in the supranormal paradigm, as their action is understood through a more spiritual or essential manner than a biochemical mechanism. Acupuncture is an energy activity in the balance paradigm because it is the energy that is being acted on, not the physical manipulation of the needles on the physical body. Mindfulness is a mental discipline based on Eastern thought. This practice is a process of becoming detached and observing thoughts, feelings, and perceptions while remaining fully attentive and in the present. This is a psychological activity in the balance paradigm. Spiritual practices extend through all paradigms. Attendance at organized religious functions is an example of spiritual activities in the mechanical paradigm. Epidemiologic research has indicated that attendance at religious events or membership in religious organizations has a salutary effect on health.[61] Some

proposed explanatory mechanisms are that these individuals have healthier lifestyles, benefit from social support, or have better stress-coping abilities. This example illustrates the link of mental and spiritual activities to physical outcomes. This breakthrough understanding has promoted the legitimacy of many of the psychological and spiritual activities that holistic nurses use in promoting physical health within the mechanical paradigm.

In many cultures, systems of healing combine many levels of activities. For example, shamanism includes physical manipulation, applied and ingested substances, use of vital energy, psychological aspects of belief, and spiritual practices that cluster in the supranormal paradigm. Contemporary complementary healers may use modalities from several paradigms. An understanding of the paradigm from which the modality was developed is important for appropriate use in conducting research.

NURSING APPLICATIONS FOR DEVELOPING CULTURAL COMPETENCY

Members of minority groups may distrust and fear the Western biomedical health care system, of which nurses are a part. As the element of trust is essential to the formation of a therapeutic nurse–client relationship, clients need to know that nurses are receptive and nonjudgmental regarding their differences. Nurses must approach cultural competency through knowledge of self and knowledge of other cultures. To develop the ability to interact with clients appropriately, nurses should clarify their personal values, recognize the health care system as a culture, learn about the specific culture of each client, interact and intervene in a culturally consistent manner, and elicit feedback regularly from the client and family. Skills such as listening, explaining, acknowledging, recommending, and negotiating facilitate a nonjudgmental perspective toward the client's cultural beliefs. Nurses and clients should validate their perceptions and discuss similarities and differences in their perceptions to formulate health-related goals and interventions.

Cultural competency is a dynamic, challenging process faced by all health care providers, regardless of their cultural background or association. Members of minority cultural groups also encounter situations in which cultural competency is desirable. Various principles are important in developing cultural competency.[62] The process of sharing information in a straightforward manner demystifies other cultures and, for example, makes it possible for the nurse and client to find common ground and understand the context of differences. To find common ground, it is necessary to consider terminology. Many individuals may consider some terms such as *Negro*, *Black*, or *foreigner* inappropriate and possibly offensive. The terms *Hispanic*, *Latino*, and *Chicano* all are used to describe people from Spanish-speaking cultures. The terms may be used by the individuals themselves in some cases or, in other cases, may be considered insulting. Individuals working together in provider–client interactions need to ensure that the terminology used is mutually understood and acceptable. Researchers and scholars need to strive for consensual cultural terminology so that research findings can be appropriately applied and compared.

Recently, the Office of Minority Health issued the Culturally and Linguistic Appropriate Services (CLAS) standards in an attempt to synthesize cultural competency definitions and requirements into a single set of standards.[63] The CLAS standards contain a number of regulations and

recommendations for organizations regarding the use of translations and providing culturally appropriate health care.

Communication

Interactions between the health care provider and client are based on the communication between the two, and reflect their respective cultures. Both the provider and the client bring their personal beliefs, values, and cultural backgrounds to the interaction. These factors then affect the transfer of information, decision making, adherence to treatment, and healing outcomes. The professional nature of the encounter brings the culture of the health care system into the exchange, even if the meeting occurs in the client's home or community setting. An understanding of the cultural world of the client and the cultural world of the health care system enables the provider to deliver culturally appropriate care. Nurses often act as cultural brokers between the client and the biomedical culture.

All health care providers of the professional sector in the United States have acculturated to the biomedical model and accompanying technology by virtue of their education and the sociology of the health care institution where they practice. Each institution has its own culture that defines the norms, protocols, and hierarchy, both formal and informal. Most health care institutions are based on the biomedical model and accept clients into the system because of a perceived physical or mental disease or illness. In contrast, healers in the folk sector are more likely to approach health from a holistic perspective, with focus on the emotional and spiritual domains, as well as on the physical domain. Such healers have become acculturated to the holistic model through education, which is often based on an apprenticeship with a more experienced practitioner.

The purposes of communication in the health care environment are to create an interpersonal relationship, exchange information, and allow for decision making. Specific barriers may impede the achievement of these goals. First, communication between the provider and client generally involves individuals of unequal positions, with the provider assuming a higher rank to some extent simply by virtue of greater medical knowledge. Second, communication related to health care is often not planned, involves vitally important issues, and is emotionally laden. Finally, differences in language, both verbal and nonverbal, may isolate the client and the family. Nonverbal aspects of oral communication, such as voice tone, eye contact, and body positioning are often as significant as verbal communication. If the cultural backgrounds of the provider and the client are significantly different, these communication factors may make it difficult to obtain and provide health care without misunderstandings.

Roles in the relationship between the provider and client are frequently derived from cultural norms and can enhance or impede communication. Such roles can be seen as a spectrum of control ranging from paternalistic to mutualistic.[64] In a paternalistic (provider-centered) relationship, the provider has the control, directs care, makes decisions about treatment, and is authoritative. A mutual client-centered relationship involves shared decision making and is more egalitarian. Problems can arise in communication and the therapeutic relationship if the expectations of the client do not match those of the provider with respect to control and decision making.

Problems can also arise if communication styles, both nonverbal and verbal, differ. Such expectations are often culturally

related, and nurses can avoid some problems by developing sensitivity to various communication styles.[65]

Use of Translators

The increasing number of languages and dialects in the United States means that nurses, even those who are bilingual, often rely on translators or interpreters to communicate with clients. Translators play powerful roles in the exchange of valuable information between nurses and their clients.[66] The national CLAS standards require that language services be made available for all individuals with limited English proficiency who seek services at all institutions receiving federal funds. Language assistance service specifications, including qualifications of individuals providing such services, have been set forth by the Office of Minority Health.[67] Bilingual staff or trained on-site interpreters are preferred over family members. If interpretation is needed emergently or the language is infrequently encountered, then telephone interpreter systems should be used.

Untrained translators may provide misinformation to the client, but also may use words, tones, or gestures that emphasize the translator's own personal preferences, omit portions of a message deemed irrelevant, or diminish the importance of the intended message. Indeed, translators may dominate the conversation. It is best to avoid using family members as translators whenever possible, as they are likely to filter information based on what they want the client to hear. Also, it might be culturally inappropriate for the client to discuss some health matters with certain family members. Regardless of the source or skill of the translator, nurses should attempt to:

1. Orient the client to the process and the purpose of using a translator.
2. Orient the translator to the topics to be covered, the client's situation, and the degree of accuracy required.
3. Avoid standing; sit so that the client can observe the nurse and make eye contact; avoid placing the translator between them and the client.
4. Observe the client for nonverbal communication that does not match the message intended and request clarification.
5. Slow down the communication process.
6. Encourage the translator to let the nurse know when something is difficult to translate so that it may be reworded.
7. Limit the use of medical jargon, slang, and metaphors in order to reduce the chances for errors.
8. Consider the impact of differences in gender, educational level, and socioeconomic status between the client and translator. This is particularly important when topics of a sensitive or personal nature are to be discussed.
9. Ask translators to translate in the client's own words and ask clients to repeat the information communicated to increase accuracy.[68,69]

HOLISTIC CARING PROCESS

When engaged in the holistic caring process, nurses need to understand concepts that are affected by cultural background. Six phenomena evidenced in all cultural groups have variations that are relevant to the provision of culturally competent nursing assessment and care:[70]

1. **Communication.** There are cultural variations in expression of feelings, use of touch, body contact, gestures,

and verbal and nonverbal communication. Language shapes experiences and influences perceptions and actions. Warmth and humor are two communication factors that are interpreted differently through various cultures. Many Asians may not overtly express their emotions as they may fear "losing face."

2. **Personal space.** Spatial behavior refers to the comfort level related to personal space, the area that surrounds a person's body. Spatial territoriality is the need to have and to control personal space. Cultures vary in the level of proximity to others that is acceptable. For example, Western culture has three zones: intimate zone (less than 18 inches), personal zone (18 inches to 3 feet), and social zone (3 feet to 6 feet). Cultural background also influences aspects of objects within space, such as orderliness, cleanliness, and structural boundaries of furniture and architecture.
3. **Time.** Cultures vary in their orientation toward time, both social time and clock time. Social time refers to patterns and orientations related to the ordering of social life, whereas clock time represents an objective, ordered approach of viewing time in a linear fashion that infers causality. Some cultures orient around cyclic approaches that attach time to natural events that repeat, such as seasons or migration patterns. For example, in mystical thought, magic or ritual may negate the temporal order of causality and reverse a bad event. All cultures contain the three orientations of future, present, and past, with one being dominant.
4. **Social organization.** Families, religious groups, kinship groups, workplace groups, and special interest groups are social organizations. Families vary by structure, dynamics, roles, and organizational patterns. Kinship structures and the relative geographic location of family members have cultural implications. Religious organizations provide not only social connections, but also a context in which to understand one's relationship to the world, the cosmos, and the meaning in life.
5. **Environmental control.** Different cultures have different perceptions of the ability of an individual to control nature, the environment, and personal relationships. The locus of control may be external (i.e., an event contingent on luck or fate), internal (i.e., an event contingent on one's own behavior or characteristic), or outside (i.e., an event in harmony with nature, as in some Asian cultures). In folk medicine, for example, events are perceived as natural and unnatural. Natural events have to do with the world as God intended and the laws of nature. Unnatural events upset the harmony of nature and are outside the world of nature.
6. **Biologic variations.** In a pluralistic culture, it is important to determine those factors that are strictly biologic (i.e., genetic) and those that are ethnic adaptations related to living in a particular environment (e.g., availability of certain types of food) or in certain social conditions (e.g., socioeconomic status or lifestyle). Biologic factors to be considered are body size and structure, including variations in teeth, facial features, and skin color; variations in metabolism and enzyme production that result in drug reactions, interactions, and sensitivities and susceptibility to disease (e.g., hypertension, diabetes, sickle cell anemia). Nutritional issues, including food preferences, habits and patterns, and deficiencies such as lactose intolerance all have medical implications.

These six components of human environmental responses are incorporated into Table 13–1, depicting cultural variation among Asian-Americans, Native Americans, African-Americans, and Hispanics.[71] This information, however, should never replace careful individual assessment, as there is more intracultural variation than intercultural variation.

Assessment

Leininger defines a cultural nursing assessment as "a systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine specific needs and interventions within the cultural context of the people being evaluated."[72] A cultural assessment should be performed during the initial contact with a client; it may be brief, with questions about ethnic background, religion, family patterns, food preferences, and health practices.[73] Data from a brief assessment can be used to determine the need for a more in-depth assessment that focuses on more specific parameters, such as nutritional patterns, social support networks, and coping (Exhibit 13–3).[74] The Resource List at the end of the chapter suggests further resources that may be helpful in conducting a cultural assessment.

Tripp-Reimer and colleagues recommended that an in-depth assessment be conducted in two phases: a data collection phase and an organization phase.[75] During the data collection phase, it is essential to obtain details that are specific enough to develop culturally appropriate interventions related to healing, and identify cultural factors that may influence the effectiveness of the interventions. Depending on the individual situation, it may be important to ask for information related to developmental milestones, such as puberty, or rituals and customs related to birth and death. As the community passes cultural tradition through the family, frequently through women, it is helpful to ask about the practices or beliefs of the client's mother or grandmother. During the organization phase, data are systematically examined to identify areas of incongruence between the client's needs and the goals of Western medicine. Patterns, challenges, and needs related to culture can then be formulated, based on the areas of incongruence. For example, a difference in time perception between an individual who is present-oriented and thus has little concern for health consequences and the future orientation of American culture may lead to a disregard for dietary restrictions. The problem of lack of adherence related to incongruent value systems could be formulated, and one nursing intervention would be to focus on the immediate benefits of health promotion strategies.

Patterns/Challenges/Needs

In the cultural domain, client's needs typically involve biophysical and psychologic disturbances, alterations, impairments, and distresses. These patterns, challenges, and needs are largely derived from the conceptual areas of normalcy based on North American culture and heavily influenced by biomedicine. Examples of patterns, challenges, and needs associated with cultural differences related to the 13 domains of Taxonomy II are as follows (see Chapter 14):

- **Altered or impaired communication related to language differences or communication style.** Even with the aid of translators, language and dialect differences may exist based on the region in which the client was born (e.g., China).
- **Altered or impaired social interaction related to sociocultural dissonance.** Difficulties in relating with members of the health care team may occur

Table 13–1 Cultural Variation in Human-Environmental Responses (Four Examples)

Response Variants	*Asian-American (Hmong)*	*Native American*	*African-American*	*Hispanic*
Communication	Oral tradition. Gender- and age-specific patterns. Group learning. Spiritual link. Taboos guiding topics. Conversation focus to promote harmony. Language barrier—interpreter.	Oral tradition. Storytelling. Group learning. Spiritual foundation of life. Only able to speak for self, nonaggressive. Role of elder.	Black English. Specific dialect. Significance of names/terms. Nonverbal: talk-look at, listening-look away, prolonged eye contact, frequent touch, emotional sharing. Group learning.	Language barrier—interpreter. Verbal: privacy, avoid conflict, emotional, expressive. Nonverbal: touch, handshake, avoid prolonged eye contact. Group learning.
Space	Avoid eye contact. Sacred parts of body. Avoid public display of affection and extreme emotions.	Avoid eye contact, limit touch. Negative significance rt handshake.	Often space much closer than "Anglos."	Familial closeness—demonstrative.
Time	Cyclical, present-oriented, holistic, fatalistic. Social time vs. clock time.	Circular, holistic, present-oriented, fatalistic.	Wide variation. Social time vs. clock time.	Present-oriented, "Latin Time," polychronic.
Social Organization	Clan structure. Decision-maker: elder male, clan leader. Family-patrilineal. Male dominant in affairs extending beyond the home. Female more active role within the home. Clearly defined roles/responsibilities—age and gender. Children indulged until the age of five then more strict discipline—"communal focus."	Clan/family/tribes. Role of elder. Role definition. Social relations—wheel of life. Core values: thanks, harmony, sharing, and hospitality.	Disruptive influence of slavery and discrimination on the family structure. Today variance, a link with social economic status (SES). Lower SES: matrifocused—present focused. Mid/Upper SES: egalitarian. Children—socialized to be in control, independent at earlier age. Importance of extended kinship.	"La familia": patrilineal, extended, gender significance. Machismo: decision-maker, protector. Marianismo: nurturer, mediator. Respect elders. Children a priority, dependency. Family value: respect, pride, responsibility, spirituality (Catholic).
Environmental Control	Explanatory Model of Health/Illness (H/I): H: Mandate for life, predetermination, maintain harmony. I: Supernatural, soul loss, spiritual, disharmony, imbalance, sins of ancestors, self in relation to others. Curers: Herbalist,	Explanatory Model of Health/Illness (H/I): Beliefs—balance with mother nature, predetermination—Creator. I: lack of harmony, failure to live according to code of life, evil spirits, fear and jealousy of other	Explanatory Model of Health/Illness (H/I): I: an inability to function due to a hex, sins, disharmony, natural or supernatural. Curers: family first, "Old lady" or "Granny," voodoo priest, spiritualist, root doctor. Tx:	Explanatory Model of Health/Illness (H/I): I: Severity rt pain or blood, unable to perform roles/ADLs. Illness: mild or severe, lg of time. Causes: sins, will of God, "evil eye," "nerves," "bad blood"—loss of

continues

Table 13–1 Continued

Response Variants	*Asian-American (Hmong)*	*Native American*	*African-American*	*Hispanic*
	Shaman. Tx: foods, maintain harmony with the forces, spiritual divination, massage, herbs, foods, coining, pinching, cupping. Special Tx for certain conditions, e.g., childbirth.	nations. Curers: Shaman/faithkeeper, Midwife, False Face Society, Herb specialist. Tx: herbs, ceremonies, e.g., sweat and medicine lodge, vision quest, talking circle, etc. Significant elements.	includes use of teas, cod liver oils, dietary choices, laxatives for purging, wearing of garlic, amulets, copper or silver bracelets. Folk practices include: silver dollar to navel, oil—baby's bath, cradle cap, prayer cloth to diaper, PICA.	respect, imbalance of humors or hot and cold. Direct re between certain illnesses—supernatural intervention. Many folk illnesses. Curers: family, curandero herbalist, spiritualist. Tx: prayer, massage, ceremonies rt specific illnesses.
Biological	Small stature, small bone structure, Mongolian spots, eyes. Disease susceptibility: Hepatitis, TB, lactase deficiency, hemoglobinopathies, altered drug metabolism.	Taller, bigger, heavier bone structure. Cheek bones, dark eyes. Disease susceptibility: Diabetes mellitus, ETOH abuse, TB, SIDS, AIDS. Health Risks: Pneumonia, malnutrition, adolescent suicide, MVA, homicide.	Skin variance: Mongolian spots, keloids, vitiligo, nigra. Heavier/denser bones, shorter trunk, longer legs. Body fat link to economics. Disease susceptibility: TB, hypertension/CV, sickle cell anemia, enzyme disorders, diabetes. Health Risks: Obesity, ETOH abuse, infant mortality, homicide, AIDS.	Skin color. Susceptibility to disease: Diabetes, TB, AIDS. Health risks: Obesity, alcoholism, adolescent pregnancy.

Source: Copyright © 1994, American Nephrology Nurses Association.

when there are socioeconomic or educational gaps.

- **Lack of adherence related to incongruent value systems between provider and client.** Clients may be considered noncompliant with follow-up appointments when differences in the perception of time are at the root of missed or late appointments.
- **Anxiety related to culturally unusual expectations for behavior and treatment; fear related to unknown environment or customs.** The biomedical health care system may be particularly anxiety-provoking for clients whose custom is to be cared for in the home during an illness.

Outcomes

Culturally appropriate outcomes would be developed with the client for each culturally related pattern, challenge, or need.

Exhibit 13–3 Cultural Areas Critical to a Nursing Assessment

- Nutritional patterns
- Exercise and physical activities
- Decision making: how made, who is involved, and why
- Health and healing practices
- Family organization, structure, and role differentiation and child care practices
- Social support networks and relationships
- Spiritual beliefs, rituals, and practices
- Cognitive attributive style and personal/family coping approaches
- Demographics and socioeconomic status, employment patterns
- Immigration and cultural history
- Communication style and relationship toward authority

Source: From J. Engebretson, "Cultural Diversity and Care" in *Core Curriculum for Holistic Nursing,* ed. B.M. Dossey (Gaithersburg, MD: Aspen Publishers, 1997), 114.

Therapeutic Care Plan and Implementation

Knowledge and acceptance of the client's right to alternative solutions and modalities should be incorporated into the plan of care so that the plan is mutually designed. Explanatory models must be integrated into the care plan. Questions such as those suggested in Exhibit 13–1 are helpful in identifying explanatory models. The focus should be on the concept of engagement rather than compliance, as the concept of compliance implies an authoritative relationship in which the provider is active and in control while the client is in a passive, accepting role.[76] Engebretson and Littleton have developed an interactive model of cultural negotiation that parallels the nursing process.[77]

Cultural healing practices should be part of the client's care unless they are contraindicated. Nurses should convey respect for the practice and should make every effort to acquire appropriate foods, people, artifacts, and so on, as well as to secure space and time for such practices. Three modes of intervention involving clinical decision making incorporate the client's cultural practices:[78]

1. Cultural preservation and/or maintenance refers to professional actions that retain relevant care values in health promotion, restoration, management of disabilities or chronic illness, and death. Nurses using cultural preservation can support those aspects of the client's culture that positively influence his or her health care.
2. Cultural accommodation and/or negotiation refer to professional actions to bridge the gap between the client's culture and biomedicine for beneficial health outcomes. Nurses using cultural accommodation recognize the cultural relevance of a practice and assist the client to integrate it into the planned treatment, even though the cultural practice has no scientific basis for health promotion or disease prevention.
3. Cultural repatterning and/or restructuring refers to professional actions that help a client improve his or her life pattern while respecting cultural values and beliefs. Nurses using cultural repatterning should assist clients to make changes in, but not discard, cultural behaviors that are harmful, negative, or maladaptive to their well-being.

A variety of healing modalities may be used, depending on the illness and cultural preferences. Touch as communication has culturally specific meaning. In some Arab and Hispanic cultures, male providers may be prohibited from examining or touching parts of the female body. Some Asians believe that the center of strength lies in the head, and touching the head is a sign of disrespect or threat. Thus, the process of shaving the head preoperatively may be viewed very nega-

tively. Gentle touch may be seen as a caring gesture. Many cultures have traditions of laying on of hands. Specific healing modalities using human touch can be viewed from an energetic or spiritual framework. Clients in Western cultures are often unfamiliar with such techniques of healing.

Foods or herbs may be used for many different purposes with respect to illness. The use of hot or cold foods may remedy an imbalance in the body. Many preparations are used to purify and remove toxins from the body, such as emetics and colonic irrigations. For the treatment of specific illnesses, herbs used in traditional healing have antiseptic and healing properties. Herbs such as *Echinacea* or foods such as garlic may also be used to prevent illness. Other herbs facilitate body processes. Chamomile and mint teas are used to aid digestion, and barley water is used to promote lactation.

Many cultures approach healing from a spiritual perspective. Rituals and practices to protect one from evil, disease, or danger include the use of amulets, talismans, ritualistic behavior, the avoidance of taboos, exorcism, and purification or cleansing rituals. Rituals may be positive in nature, including those related to spiritual growth, redemption, and life transitions, such as birth or initiations into adulthood.[79] Often viewed as having divine gifts, healers are believed to be able to negotiate with the spiritual world through prayer, meditation, blessings, chants, and other primal religious experiences, many incorporating altered states of consciousness. Individuals also may seek healing forces by sacrifice, penance, and pilgrimages.

Evaluation

Together, the nurse, the client, and any member of the extended family or social group whom the client feels is significant should evaluate desired client outcomes. Evaluation must be woven throughout the entire holistic caring process, as it is essential to obtain validation through mutual understanding when there are differences between the cultural backgrounds of nurse and client. It is important to note the purpose of the activity in evaluating its effectiveness. A massage that is given for the purpose of comfort needs to be evaluated on the basis of comfort, for example, not its medical effect on the disease process. A healing activity that is understood by the client as having multiple effects (e.g., spiritual benefits, psychological benefits, and better health) should be evaluated on many levels and should not be discounted if the physical benefits are not comparable to those of a pharmaceutical product. Each component of the health care plan and each nursing intervention should be carefully examined to ensure that it is understandable and acceptable to the client, effective for achievement of short- and long-term goals, and appropriately revised as necessary during the evaluation process. Cultural modifications can be made upon careful evaluation.

DIRECTIONS FOR FUTURE RESEARCH

1. Survey patterns of usage of healing modalities from various paradigms and cultural backgrounds.
2. Develop efficient and effective ways of assessing the degree of acculturation in clients with various cultural backgrounds.
3. Analyze effective models for interaction between biomedical and traditional health care systems.
4. Evaluate the degree to which health care goals are achieved when nurses deliver culturally competent care.
5. Analyze various methods for teaching nursing students or staff how to provide culturally competent care.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- What are my values and beliefs regarding health and illness in relationship to models of healing?
- How do I feel when caring for clients whose cultural backgrounds differ from my own?
- What are my biases and attitudes toward clients with various cultural backgrounds?
- How can I determine if I am offering culturally competent care in a holistic manner?

RESOURCE LIST

Books

Andrews, M.M. and J.S. Boyle, eds. (1999), *Transcultural Concepts in Nursing Care*, 3rd ed., New York: Lippincott.

Galanti, G.A. (1997), *Caring for Patients from Different Cultures,* 2nd ed., Baltimore, MD: University of Pennsylvania Press.

Giger, J.N. and R.E. Davidhizar, eds. (1999), *Transcultural Nursing: Assessment and Intervention*, St. Louis: Mosby.

Lipson, J., Dibble, S., and P. Minarik, eds. (1996), *Culture and Nursing Care*, San Francisco: UCSF Nursing Press.

Spector, R. (2000), *Cultural Diversity in Health and Illness*, 5th ed., Upper Saddle River, NJ: Prentice-Hall.

Books on Specific Ethnic Groups

Fadiman, A. (1997), *The Spirit Catches You and You Fall Down*, New York: Farrar, Straus and Giroux. (Hmong)

Hammerschlag, C.A. (1988), *The Dancing Healers: A Doctor's Journey of Healing with Native Americans*, San Francisco: Harper & Row.

Ohnuki-Tierney, E. (1984), *Illness and Culture in Contemporary Japan*, Cambridge: Cambridge University Press.

Payer, L. (1996), *Medicine and Culture: Varieties of Treatment in the United States, England, West Germany, and France*, New York: Henry Holt & Co.

Snow, L.F. (1993), *Walkin' Over Medicine*, Boulder, CO: Westview Press. (African-Americans)

Websites on Cultural Competency

Resource for Cross Cultural Care: www.divesityrx.org

National Multicultural Institute: www.nmci.org

National Center for Cultural Competence: www.georgetown.edu/research/gucdc/ nccc/products.html

University of California Center for Health Professions: http://futurehealth.ucsf.edu

---

NOTES

1. M.M. Andrews and J.S. Boyle, eds., *Transcultural Concepts in Nursing Care*, 4th ed. (Philadelphia: J.B. Lippincott, 2003).
2. Office of Minority Health, Public Health Service, USDHHS, A Practical Guide for Implementing the Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care, 2002, http://www.omhrc.gov (accessed August 27, 2002).
3. T. Cross, B. Barzon, K. Dennis, and M. Issacs, *Toward a Culturally Competent System of Care*, Vol 1. (Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center, 1989).
4. D.L. Sackett, S.E. Strauss, W.S. Richardson, W. Rosenberg, and R.B. Haves, *Evidence-Based Medicine: How to Practice and Teach EBM*, 2nd ed. (Edinburgh: Churchill Livingstone, 2000).

5. J. Campinha-Bacote, A Model and Instrument for Addressing Cultural Competence in Health Care, *Journal of Nursing Education* 38 (2001):204–207.
6. M. Douglas, Developing Frameworks for Providing Culturally Competent Health Care, *Journal of Transcultural Nursing* 13 (2002):177.
7. L. Purnell and B. Paulanka, *Transcultural Health Care: A Culturally Competent Approach*. (Philadelphia: F. A. Davis, 1998).
8. R.E. Spector, *Cultural Diversity in Health and Illness*, 5th ed. (Upper Saddle River, NJ: Prentice Hall, 2000).
9. Andrews and Boyle, *Transcultural Concepts in Nursing Care*.
10. M. Leininger, *Culture Care Diversity and Universality: A Theory of Nursing* (Boston: Jones & Bartlett, 2001).
11. J. Giger and R. Davidhizar, *Transcultural Nursing: Assessment and Intervention*, 3rd ed. (St. Louis: Mosby, 1999).
12. H. Bernal, Delivering Culturally Competent Care, in *Psychosocial Nursing: Care of Physically Ill Patients and Their Families*, ed. P.D. Barry (Philadelphia: J.B. Lippincott, 1996), 78–99.
13. S.M. Steele and V.M. Harmon, *Values Clarification in Nursing*, 2nd ed. (Norwalk, CT: Appleton-Century-Crofts, 1983).
14. G.M. Bartol and L. Richardson, Using Literature to Create Cultural Competence, *Image: Journal of Nursing Scholarship*, 30 (1998):75–79.
15. F. Collins, Genomics and Health Disparities, *Disparities in Health in America: Working Toward Social Justice* (Houston, TX: Summer Workshop, June 22, 2003).
16. S.M. Underwood, Minorities, Women, and Clinical Cancer Research: The Charge, Promise and Challenge, *Annals of Epidemiolgy* 10(S8) (2000):S3–S12.
17. Health Status and Determinants of Health in the United States 2002. www.cdc.gov/nchs (accessed July 1, 2003).
18. J.A. Macinko and B. Starfield, Annotated Bibliography on Equity in Health, *International Journal for Equity in Health* 1 (2002). www.equityhealthj.com/content/1/1/1 (accessed July 1, 2003).
19. N.E. Adler and K. Newman, Socioeconomic Disparities in Health: Pathways and Policies. Inequality in Education, Income, and Occupation Exacerbates the Gaps Between the Health "Haves" and "Have-nots," *Health Affairs* (Millwood) 21 (2002):60–76.
20. V.J. Burroughs, R.W. Maxey, and R.A. Levy, Racial and Ethnic Differences in Response to Medicines: Towards Individualized Pharmaceutical Treatment, *Journal of the National Medical Association 94(10/Supp)* (2002):1–25.
21. Andrews and Boyle, *Transcultural Concepts in Nursing Care*.
22. R.G. Evans et al., eds., *Why Are Some People Healthy and Others Not? The Determinants of Healthy Populations* (New York: Aldine de Gruyter, 1994).
23. M. Massey, *What You Are Isn't Necessarily What You Will Be* (Videotape No. 3123.03) (Farmington, MI: Magnetic Video Corp., 1977).
24. K. Kipnis, Quality Care and the Wounds of Diversity (Paper presented at the meeting of the American Society for Bioethics and Humanities, Houston, TX, November 18, 1998).
25. Spector, *Cultural Diversity in Health and Illness*.
26. E.R. Oetting and F. Beauvais, Orthogonal Cultural Identification Theory: The Cultural Identification of Minority Adolescents, *International Journal of Addiction* 25 *(5A–6A)*, (1990–1991):655–685.
27. J. Achterberg, *Woman As Healer* (Boston: Shambhala, 1990).
28. J. Engebretson, Comparison of Nurses and Alternative Healers, *Image: Journal of Nursing Scholarship* 28 (1996):95–99.
29. Andrews and Boyle, *Transcultural Concepts in Nursing Care*.
30. F.R. Kluckhohn, Dominant and Variant Value Orientations, in *Transcultural Nursing: A Book of Readings*, ed. P.J. Brink (Englewood Cliffs, NJ: Prentice Hall, 1976), 63–81.
31. J. Engebretson, Considerations in Diagnosing in the Spiritual Domain, *Nursing Diagnosis* 7 (1996):100–107.
32. N. Postman, *Technopoly* (New York: Vintage Books, 1993).
33. F. Capra, *The Turning Point: Science, Society and the Rising Culture* (New York: Bantam Books, 1982).
34. H. Smith, *Beyond the Post-Modern Mind* (New York: Crossroad Publishing Co., 1982).
35. W.T. Anderson, *The Truth About the Truth* (New York: G.P. Putnam's Sons, 1995).
36. P.H. Ray, The Emerging Culture, February, 1997, American Demographics: www.demographics.com (accessed June 1998).
37. J.A. Astin, Why Patients Use Alternative Medicine, *Journal of the American Medical Association* 279 (1998):1548–1553.
38. Engebretson, Comparison of Nurses and Alternative Healers.

39. D.M. Eisenberg, R.B. Davis, S.L. Ettner, et al., Trends in Alternative Medicine Use in the United States, 1990–1997, *Journal of the American Medicine Association* 280 (1998):1569–1575.
40. M.B. McGuire and D. Kantor, *Ritual Healing in Suburban America* (New Brunswick, NJ: Rutgers University Press, 1988).
41. Ray, The Emerging Culture.
42. United States Census Bureau, 2000 Census Brief. http://www.census.gov/population/www/cen2000/briefs.html (accessed July 1, 2003).
43. Ibid.
44. Ibid.
45. Ibid.
46. Ibid.
47. Ibid.
48. Intercultural Cancer Council, Native Hawaiian and Pacific Islanders & Cancer. http://iccnetwork.org/cancerfacts/ICC-CFS5.pdf (accessed July 7, 2003).
49. Hawaii Department of Health. http://www.state.hi.us/health/stats/survey/hhs/hhs01t46.pdf (accessed July 7, 2003).
50. United States Census Bureau, 2000 Census Brief.
51. Andrews and Boyle, *Transcultural Concepts in Nursing Care*.
52. Ibid.
53. Ibid.
54. Ibid.
55. A. Kleinman, *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine and Psychiatry* (Berkeley, CA: University of California Press, 1980).
56. Giger and Davidhizar, *Transcultural Nursing: Assessment and Intervention*.
57. J. Engebretson, A Multiparadigm Approach to Nursing, *Advances in Nursing Science* 20 (1997):22–34.
58. Kleinman, *Patients and Healers in the Context of Culture*.
59. Engebretson, A Multiparadigm Approach to Nursing.
60. T.J. Kaptchuk, *The Web That Has No Weaver: Understanding Chinese Medicine* (New York: Congdon & Weed, 1983).
61. J.S. Levin, Religion and Health: Is There an Association, Is It Valid and Is It Causal, *Social Science in Medicine* 29 (1994):589–600.
62. M.A. Orlandi, ed., *Cultural Competence for Evaluators: A Guideline for Alcohol and Other Drug Abuse Practitioners Working With Ethnic-Racial Communities* (Washington, DC: U.S. Department of Health and Human Services, 1992).
63. Office of Minority Health, Public Health Service, USDHHS, A Practical Guide for Implementing the Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care.
64. D.W. Sue and D. Sue, *Counseling the Culturally Different: Theory and Practice*, 4th ed. (New York: John Wiley & Sons, 2003).
65. Sue and Sue, *Counseling the Culturally Different: Theory and Practice*.
66. C. Degazon, Cultural Diversity and Community Health Nursing Practice, in *Community Health Nursing: Promoting Health of Aggregates, Families and Individuals*, 4th ed., eds. M. Stanhope and J. Lancaster (St. Louis: Mosby, 1996), 117–134.
67. Office of Minority Health, Public Health Service, USDHHS, A Practical Guide for Implementing the Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care.
68. Degazon, Cultural Diversity and Community Nursing Health Practice.
69. Bernal, Delivering Culturally Competent Care.
70. Gigar and Davidhizar, *Transcultural Nursing: Assessment and Intervention*.
71. J. Engebretson and J. Headley, Cultural Diversity and Care, in *Core Curriculum for Holistic Nursing*, eds. B.M. Dossey, L. Keegan, and C. Guzzetta (Gaithersburg, MD: Aspen Publishers, 2000):283–310.
72. M.M. Leininger and M.R. McFarland, *Transcultural Nursing: Concepts, Theories, Research and Practices*, 3rd ed. (New York: McGraw-Hill, Medical Publishing Division, 2002).
73. T. Tripp-Reimer et al., Cultural Assessment: Content and Process, *Nursing Outlook* 32 (1984):78–82.
74. B.M. Dossey et al., eds., *Holistic Nursing: A Handbook for Practice*, 2nd ed. (Gaithersburg, MD: Aspen Publishers, 1995).
75. Tripp-Reimer et al. Cultural Assessment: Content and Process.
76. Dossey et al., *Holistic Nursing: A Handbook for Practice*.
77. J. Engebretson and L. Littleton, Cultural Negotiation: A Constructivist-Based Model for Nursing Practice, *Nursing Outlook* 49 (2001):223–230.
78. Leininger and McFarland, *Transcultural Nursing: Concepts, Theories, Research and Practices*.
79. D. Kinsley, *Health, Healing, and Religion: A Cross-Cultural Perspective* (Upper Saddle River, NJ: Prentice-Hall, 1996).

CORE VALUE 5

Holistic Caring Process

VISION OF HEALING

Working with Others

As we engage in holistic nursing and embark on our inward journey for self-change, what we communicate by word, act, attitude, and setting will affect our potential for change. We must consciously learn the skills to stay in the present moment because change takes place in the present, not in the past or future. Everything affects our clients, our choice of words, our presence, and our greeting. Our beliefs are important and affect our self-image, which, in turn, affects our actions. It also influences our capacity for self-healing.

Our beliefs are conveyed to our clients. We must perceive ourselves and the client as whole. When we perceive the cancer patient as a person with cancer, we release the label and learn to focus primarily on the person's healing potential. In the healing system, every part is connected *to every other part, and every part* affects *every other part. We form a network in which everyone participates. There is no such thing as an independent observer. Nurse and client are always creating change in one another.*

We must consider all of the client's life potentials—physical, mental, emotional, spiritual, relationships, and choices. Only when we consider the whole client and his or her significant others do we have a chance to direct the client toward wholeness. We must continue to gain new skills and become self-experienced in all modalities that we offer to the client. We cannot guide clients down new paths to new experiences if we do not know the path from experience. The more we know from experience, the more we know that change is possible. We must remind the client to acknowledge all changes, however slight, because each change leads to another and each slight change is progress.

When we teach from experience, we are in a better position to help the client learn without judgment. We also teach in such a manner that the client cannot fail because goals are realistic and measurable. For example, nurses should encourage a person with migraine headaches to "be with the process"—not to blame himself or herself for the headache symptoms, but to focus on stress management skills to decrease the headache pattern. The client must learn that the body is not the problem, but part of the solution. As we teach clients to reframe experiences positively, their internal thoughts create new beliefs that most often lead to new, healthier response patterns. If failure is not reframed, it leads to more failure. Instead of "the glass is half-empty," the client reframes it by saying, "the glass is half-full." We must also encourage the client to involve friends and family in the learning. Learning is an ongoing process and new skills must be practiced, shared, and integrated into all aspects of life.

Chapter 14

The Holistic Caring Process

Pamela J. Potter and Cathie E. Guzzetta

NURSE HEALER OBJECTIVES

Theoretical

- Define the terms 'nursing process' and 'holistic caring process.'
- Outline the steps of the holistic caring process.
- Explore the ways in which conceptual models of nursing inform and guide the holistic caring process.
- Discuss the ways in which standards of holistic nursing practice are incorporated into the holistic caring process.

Clinical

- Analyze the assessment tool that you are using in clinical practice to determine whether the tool is consistent with a holistic nursing perspective.
- Explore the possible ways to incorporate nursing diagnoses, the Nursing Interventions Classification, and the Nursing Outcomes Classification within a holistic nursing practice.
- Identify the nursing diagnoses and interventions most relevant to your clients.
- Integrate prevention, health promotion, and wellness diagnoses into practice.
- Use the trifocal model of nursing diagnosis as an organizing structure for a visual composite of the three levels of a person's health patterns in prioritizing and planning nursing interventions and patient outcomes within the nurse–person interaction.
- Implement the Standards of Holistic Nursing Practice of the American Holistic Nurses' Association (AHNA) in your work and life.

Personal

- Observe the pattern appraisal-identification process in your everyday life as you walk into a new situation.
- Identify the four patterns of knowing (empirical, ethical, aesthetic, and personal knowledge) as they guide you within the nurse–person interaction.
- Develop and trust your intuitive thinking processes when assessing clients' conditions.
- Evaluate the impact of intuitive thinking in both your professional and personal lives.
- Explore your own beliefs and values regarding the concepts of holistic nursing.
- Write down specific examples of holistic nursing at each step of the holistic caring process.

DEFINITIONS

Holistic Caring Process: a circular process that involves six steps which may occur simultaneously. These steps are assessment, patterns/challenges/needs, outcomes, therapeutic care plan, implementation, and evaluation.

Holistic Nursing: see Chapter 1.

Intuition: the perceived knowing of things and events without the conscious use of rational processes; using all of the senses to receive information.

NANDA: North American Nursing Diagnosis Association.

Nursing Diagnosis: a clinical judgment about the individual, family, or community responses to actual and potential health problems/life processes. A nursing diagnosis is the basis for the selection of nursing interventions to achieve outcomes for which the nurse is accountable.[1]

Nursing Interventions Classification (NIC): a standardized comprehensive classification or taxonomy of treatments that nurses perform, including both independent and collaborative, as well as direct and indirect.[2]

Nursing Outcomes Classification (NOC): "a comprehensive taxonomy of patient outcomes influenced by nursing care."[3]

Nursing Process: the original model describing the "work" of nursing, defined as steps used to fulfill the purposes of nursing, such as assessment, diagnosis, client outcomes, plans, intervention, and evaluation.

Paradigm: a model for conceptualizing information.

Patterns/Challenges/Needs: a person's actual and potential life processes related to health, wellness, disease, or illness, which may or may not facilitate well-being.

Person: an individual, client, patient, family member, support person, or community member who has the opportunity to engage in interaction with a holistic nurse.

Standards of Practice: a group of statements describing the expected level of care by a holistic nurse.

Taxonomy I: a classification schema for the organization of the accepted list of NANDA nursing diagnoses based on nine human response patterns; it has been replaced by Taxonomy II.

Taxonomy II: a multiaxial classification schema for the organization of the accepted list of NANDA nursing diagnoses based upon functional domains and classes.[4]

Taxonomy of Nursing Practice—NANDA/NIC/NOC (NNN): an atheoretical taxonomic framework that describes nursing practice by linking nursing diagnoses with nursing interventions and nursing outcomes. The NNN Taxonomy of Nursing Practice is a formalized common taxonomic structure for nursing practice that incorporates the NANDA/NIC/NOC classifications and possibly other languages as well.[5]

THEORY AND RESEARCH

The holistic caring process is an adaptation and expansion of the nursing process that incorporates holistic nursing philosophy. It is a systematic, dynamic, living framework for discovering, describing, and documenting health patterns unique to a person. These patterns, identified within the nurse–person relationship, provide the foundation for mutual goals and responses to actions initiated in the nurse–person caring process.

The contemporary definition of nursing from the American Nurses' Association incorporates the concept of caring for the whole person. This definition of

nursing acknowledges four essential features of practice:

- Attention to the full range of human experiences and responses to health and illness without restriction to a problem-focused orientation.
- Integration of objective data with knowledge gained from an understanding of the person's or group's subjective experience.
- Application of scientific knowledge to the processes of diagnosis and treatment.
- Provision of a caring relationship that facilitates health and healing.[6]

Focused on establishment of health and well-being within the person, the holistic caring process is circular and includes six steps: assessment, patterns/challenges/needs, outcomes, therapeutic care plan, implementation, and evaluation. The original concept of "nursing process" can be traced to the late 1950s and early 1960s, when nursing in the United States sought to identify itself as a distinct, autonomous profession within health care. Kreuter first formally identified the conceptualization of the nursing process as an orderly approach to the conduct of independent nursing activities in 1957.[7] Proponents of the nursing process saw it as a tool for unifying the language of nursing, systematizing nursing practice and education, and enhancing independent practice.

Frisch and Frisch noted that there are two definitions for the nursing process. The first defines it as a step-by-step linear process for solving problems. The second, more compatible with holistic nursing, defines the nursing process as "a means of reflecting on the entire process of the nurse–client interaction"; furthermore, "process means a series of actions leading to an end" [8] (Figure 14–1). Intervention begins with the first nurse–person interaction, while evaluation is continuous and does not merely come at the end of the process. Within the circular view of the nursing process, the steps become organizing principles for documenting and describing nursing care and the person's response to that care.

Gradually, the circular view of the nursing process faded when the first definition of nursing process as a problem-solving model based on the scientific method became the generally accepted definition. This model was accepted without question as the foundation for nursing practice and education until the early 1980s, when nursing scholars began to focus on philosophy and theory in nursing.[9] Emphasizing holistic care in their theory of Modeling and Role Modeling, Erickson and associates reclaimed the circular view and described the nursing process as "the ongoing, interactive exchange of information, feelings, and behavior between the nurse and client(s), wherein the nurse's goal is to nurture and support the client's self care." [10]

Critics of nursing process theory say it is reductionistic, too steeped in positivism and a scientific rationality that emphasizes science as the source of knowledge while disallowing other ways of knowing, such as intuition and experience. Those who criticize the application of the nursing process in practice assert that it serves the interests of the nursing profession over the interests of the person and results in burdensome, time-consuming, reductionist jargon that deemphasizes the patient's role and labels the patient. The problem may not lie in the nursing process per se, but rather in the differing philosophic perspectives used to describe it. Varcoe suggested that "the nursing process is compatible with a variety of philosophical positions, and that the critique of the nursing process is really criticism of a positivist–philosophical orientation which has been illogically identified with the process itself." [11]

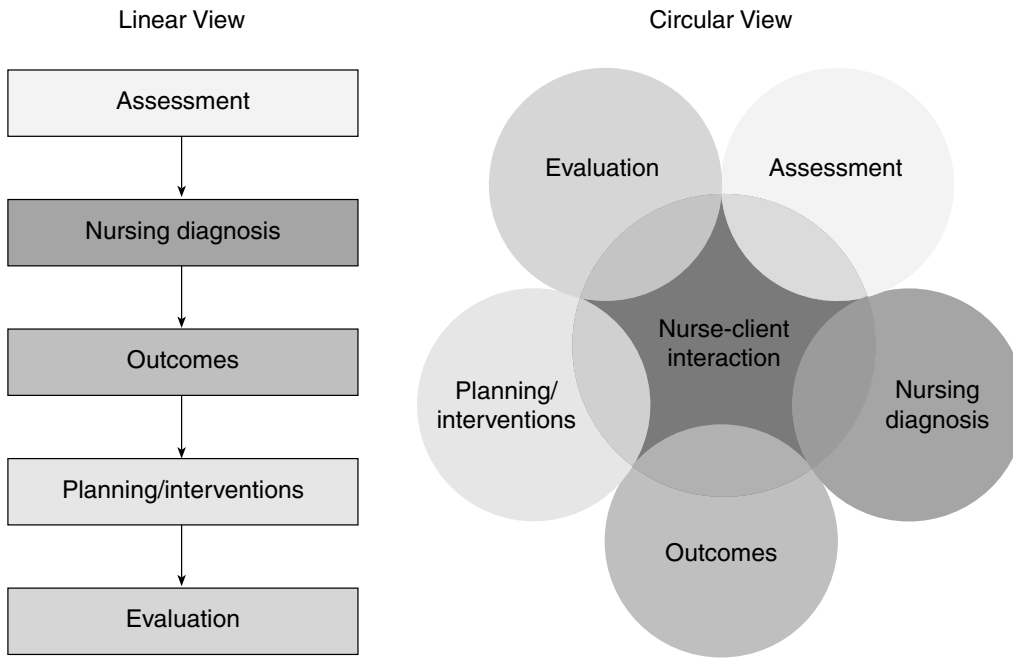


Figure 14–1 Two Views of the Nursing Process. *Source:* Reprinted by permission. *Psychiatric Mental Health Nursing: Understanding the Clients as Well as the Condition* by Frisch, Delmar Publishers, Albany, New York, Copyright © 1998.

The origins of the nursing process reside within the concept of pattern recognition, an innate tendency found among humans. Pattern recognition may be observed even in young infants who, early on, recognize and react to familiar as well as unfamiliar patterns (facial, vocal, and kinesthetic) in their caregivers. When nurses encounter a patient for the first time, they observe the state of the patient's health. They notice the patient's color (pale or cyanotic), affect and eye contact, respiration depth and rate, rate and volume of speech, body odor, scars, wounds, and more. Within 60 seconds, they notice if something is different from the expected and whether any nursing action is necessary. This is pattern appraisal and pattern recognition. Using all their nursing knowledge, nurses apply the patterns they observe to known patterns, make decisions about those patterns, and then act upon those decisions. After doing so, they reappraise and react based on the response of the person.

Further, this nursing process is culturally shaped, inseparable from the culture within which it is practiced. Engebretson and Littleton[12] describe the nursing process from an ecological perspective as one of cultural negotiation wherein the nurse and the person enter into a mutual partnership in which they exchange expert knowledge, collaborate on the analysis and interpretation of information, engage in joint decision-making, implement mutually derived plans for action, and undertake an analytical appraisal of both process and expected outcomes. Key to the nursing process is the recognition that the reality of health and the health care environment is "constructed from selective observations and interpretations" by the culture within which it is sit-

uated.[13] An ecological approach to nursing process "is based in an understanding and negotiation of cultural and formal knowledge, experience, and unique individual factors that both client and nurse bring to this interaction."[14]

Since conceptually nursing cannot be separated from the cultural context within which it is practiced, the holistic nurse must consider this context when implementing theory-based practice. For example, although one's theoretical underpinnings for nursing may define nursing as "the practice of presence" within the nurse-person relationship, the culture and the patient may define nursing by activities carried out by the nurse on behalf of the patient. Holistic nurses who work within contemporary health care culture must balance formal knowledge and expertise gained from nursing education and practice with philosophies of health that may not yet be fully embraced by mainstream culture.

Reflective Practice

The holistic caring process is established upon reflective practice. Insights derived from the four patterns of knowing identified by Carper guide the nurse's process within the nurse–person interaction.[15] Empirical or scientific knowledge is based on objective information measurable by the senses and by scientific instrumentation. Ethical knowledge flows from the "basic underlying concept of the unity and integral wholeness of all people and of all nature."[16] Aesthetic knowledge draws on a sense of form and structure, and of beauty and creativity, for discerning pattern and change. Personal knowledge incorporates the nurse's self-awareness and knowledge, as well as the intuitive perception of meanings based on personal experiences, and is demonstrated by the therapeutic use of self.

The Johns model of reflective practice within Carper's fundamental ways of knowing in nursing enables "the practitioner to access, understand and learn through, his or her lived experiences and, as a consequence, to take congruent action towards developing increasing effectiveness within the context of what is understood as desirable practice."[17] Within this structured reflection a set of cue questions challenges the nurse's unexamined norms and habitual practices, allows for interpreting the nurse's subjective experience, and facilitates projection of the effects of nursing actions upon the observed outcomes (Exhibit 14–1).

Applications of Holistic Nursing Theory

Like the nursing process itself, nursing diagnoses, interventions, and expected outcomes must be guided by theory in their application to nursing care. Certainly, the theoretical context of the nurse, as well as the nursing institution, can constrain the nursing process as a framework for nursing practice. Nurses who contend that they work "without a theory" very likely base their practice unquestioningly on a rational, biochemical, mechanical, medical model. Application of holistic nursing philosophy to the nursing process emphasizes a holistic perspective and yet remains incomplete without a nursing theoretical framework compatible with holism. There are many conceptual models of nursing, such as Nightingale's Theory of Environmental Adaptation,[18] Roy's Adaptation Model,[19] Erickson's Theory of Modeling and Role Modeling,[20] Rogers' Unitary Human Being Theory,[21] King's Systems Model,[22] Leininger's Theory of Cultural Care,[23] Orem's Self-care Model,[24] Watson's Human Care Model,[25] Parse's Human Becoming Theory,[26] and Newman's Health as Expanding Consciousness Model.[27] The theory that guides nursing

Exhibit 14–1 A Model of Structured Reflection (10th version)

Write a description of the experience

Cue questions

Aesthetics	What was I trying to achieve?
	Why did I respond as I did?
	What were the consequences of that for
	the patient?
	others?
	myself?
	How was this person feeling? (Or these persons?)
	How did I know this?
Personal	How did I feel in this situation?
	What internal factors were influencing me?
Ethics	How did my actions match with my beliefs?
	What factors made me act in incongruent ways?
Empirics	What knowledge did or should have informed me?
Reflexivity	How does this connect with previous experiences?
	Could I handle this better in similar situations?
	What would be the consequences of alternative actions for
	the patient?
	others?
	myself?
	How do I *now* feel about this experience?
	Can I support myself and others better as a consequence?
	Has this changed my way of knowing?

Source: Reprinted by permission. C. Johns, Framing Learning Through Reflection within Carper's Fundamental Ways of Knowing in Nursing, *Journal of Advanced Nursing* 22 (2001):226–234.

practice will be identifiable in the application of nursing process. (See Chapter 4 for a discussion of nursing theories.) Adaptation and expansion of the nursing process based on holistic nursing philosophy includes the person as a mutual participant in nursing care. The holistic caring process adds emphasis to the understanding that the person is primary in the nurse–person relationship. This has not always been the case. Historically, the disease or the problem was foremost. In today's managed care environment, sometimes the requirements of the insurance "payer" appear to take precedence over the person in the health care relationship.

The holistic caring process incorporates both the problem-solving components of natural science methodology and the caring dimension of the human science approach, which emphasizes the unmeasurable human side of the traditional art of nursing.[28] It accommodates the whole person—as a bio-psycho-social-spiritual being within the environmental context. Thus, the advantages of a holistic caring process parallel those delineated for the nursing process in general—with the addition of the whole-person perspective. The holistic framework is a person-centered process. This approach examines a person's reality, perceptions, and life meanings for insight into the lived experience of health and well-being. The holistic caring process is a relational process. Through mutual relationship, the nurse collaborates with the person to identify and pursue goals for health enhancement. As a synthesis of natural and human sciences, the holistic caring process reflects an equal valuing of qualitative and quantitative dimensions of the person's health patterns.

A systematic process for the practice of holistic nursing acts as a guiding structure for the novice and as internalized ballast for the experienced nurse; it "unifies, standardizes, and directs nursing practice."[29] Standardization of language about

nurses' activities and responsibilities affords a unified structure for the application of nursing theory and subsequent nursing research. The holistic caring process lends itself to theory application. Within the holistic caring process, information relevant to the person's care is gathered and processed according to a theoretical model. Nurses must choose a theoretical practice model that is realistic, useful, and consistent with their professional values and philosophy. Patterns, desired outcomes, and nursing actions are identified through a synthesis of the theory base and information gathered from the person in mutual process with the nurse. Care is evaluated and documented in the language of the theory.

Taxonomy of Nursing Practice

In an effort to establish nursing as a distinct, recognizable health care profession with distinct, billable services, educators and practitioners have worked toward standardizing language, practice, and outcomes. Nursing diagnoses, as delineated by the North American Nursing Diagnosis Association (NANDA), are patterns frequently appraised by nurses in giving care.[30] The Nursing Interventions Classification (NIC) is a list of activities performed by nurses for the purpose of achieving nurse–person care goals.[31] Frequently identified goals, observable throughout the course of care, are listed as the Nursing Outcomes Classification (NOC).[32]

Because the NANDA/NIC/NOC (NNN) taxonomies are atheoretical they yield quite well to the holistic perspective.[33] The linking of these languages allows for the possibility of uniform billing for nursing activities and a systematic evaluation of outcomes as nurse-sensitive indicators of patient/person care for quality management, as well as for guiding nursing research questions. Within the holistic caring process, the uniform standardized nursing languages of nursing diagnosis, nursing intervention, and nursing outcomes are presented as a means to organize, describe, and evaluate the data generated within the therapeutic nurse–person relationship. A formal process is under way by representatives of these classification systems to develop a common structure linking them through the NNN Taxonomy of Nursing Practice.[34]

HOLISTIC CARING PROCESS

Nurses who adhere to the holistic caring process focus on the care of the whole unique person, respecting and advocating for the person's rights and choices. Based on a holistic assessment and identification of the person's health patterns, decisions about care flow from collaboration with the person, other health care providers, and significant others. The person assumes an active role in health care planning and decision-making by seeking the professional expertise of the nurse via various nurse–person interactions. Facilitated by the nurse in the healing relationship, the person expresses health concerns and strengths—a unique health pattern—which the nurse identifies and documents in the health care record. The person is encouraged to participate as actively as possible, taking responsibility for personal health choices and decisions for self-care. The nurse must remember that the holistic caring process is merely a tool; a framework for ordering, documenting, and discussing the nurse–person interactions. Excessive reliance on structure and objectivity may reduce the person to a mere object.[35]

Assessment

> Holistic nurses assess each person holistically using appropriate conventional and holistic methods while the uniqueness of the person is honored.[36]

Assessment is the information-gathering phase in which the nurse and the person identify health patterns and prioritize the person's health concerns. A continuous process, assessment provides ongoing data for changes that occur over time. Each nurse–person encounter provides new information that helps to explain interrelationships and validates previously collected data and conclusions. A key to a holistic assessment is to appraise the overall pattern of the responses.[37] The nurse gleans information about the person's patterns via interaction, observation, and measurement. Each pattern identification taps into the hologram of the person, contributing to the revelation of the whole. Interpersonal interaction reveals perceptions, feelings, and thoughts about health patterns/challenges/needs as identified by the person. Nursing observation relies on information perceived by the five senses, and intuition, while measurement provides quantifiable information obtained from instruments. The client is the primary source and interpreter of the meaning of information obtained by the assessment process. Family, significant others, other health care professionals, and measurable data provide supplemental information. Within the cultural context of negotiation, the assessment phase may be seen as an "exchange of expert knowledge" wherein both the nurse and the person bring expertise to the exchange.[38]

During assessment of the person's bio-psycho-social-spiritual patterns, the holistic nurse looks for the overall pattern of interrelationships, uses appropriate scientific and intuitive approaches, assesses the state of the energy field, and identifies stages of change and readiness to learn. The nurse also collects pertinent data from previous client records and other members of the health care team, if appropriate. All pertinent data are documented in the person's record.

The holistic nurse views the person as a whole and listens for the meaning of the current health situation to the person within the environment. While acknowledging his or her own patterns and their potential influence on the healing relationship, the nurse reflects on the person's patterns recognized from the assessment. In response, the person validates the meanings of these identified health patterns. Assessment and documentation are continuous within the nurse–person interaction, as changes in one pattern always influence the other dimensions. A lack of awareness about one's own personal beliefs and patterns may subtly influence the nurse–client interaction (e.g., communication barriers relative to culture, class, age, gender, sexual orientation, education, or physical limitation) and impede holistic assessment.

Intuitive Thinking

Holistically assessing the status of a person involves evaluation of data not only from a rational, analytic, and verbal (or left brain) mode, but also from an intuitive, nonverbal (right brain) mode. Unfortunately, we in nursing have not placed much value on "soft" data that cannot be measured and validated through scientific methods. Intuitive perceptions have been seen as opposing the empirical knowledge base of practice.[39] The idea that only quantifiable data are important in science is changing, however (see Chapter 9). Intuitive thinking does not conflict with analytic reasoning.[40] It is simply another dimension of knowing. There are multiple ways of knowing and assessing the status of clients, and intuition is a desirable component of the nursing process.[41] In addition to analysis, scientific exploration is now known to involve a qualitative, yet undefinable, process that scientists use to organize fragmented findings into meaningful wholes.[42] This undefinable process

is called intuition—the tacit dimension—which is fundamental to all knowing.[43] It is a process whereby people know more than they can explain.

Effkin proffers an explanation of intuition from an ecological psychology perspective based on Gibson's theory of perception.[44–46] *Perception* is the direct detection of environmental information. *Intuition*, characterized as direct perception, occurs when the holistic nurse perceives in the environment higher-order variables that call for action. Opportunities for action may go unrealized by the novice nurse who through experience must learn to recognize and distinguish among opportunities for action. Framing intuition as direct perception offers an explanation for how experts who perceive complex higher-order variables cannot report with accuracy underlying lower-order properties, as well as how new information, outside of the nurse's previous experience, may be interpreted intuitively as an opportunity for action. Expert nurses, like "smart devices," sensitive to and capable of acting immediately upon higher-order information, directly apprehend environmental information as a whole—as a complex or composite variable. When characterized as direct perception, intuition becomes an "observable, lawful phenomenon that is measurable, potentially teachable and appropriately part of nursing science."[47]

Intuitive perception allows one to know something immediately without consciously using reason.[48] Clinical intuition has been described as a "process by which we know something about a client which cannot be verbalized or is verbalized poorly or for which the source of the knowledge cannot be determined."[49] It is a "gut feeling" that something is wrong or that we should do something, even if there is no real evidence to support that feeling. The most experienced and technically proficient nurses have been found to be intuitive thinkers. Within the caring relationship between nurse and person, intuitive events emerge as the nurse is open and receptive to the person's subtle cues, such as color, activity, movement, tone, and posture.

Nursing intuition may be conceptualized as the "integration of forms of knowing in a sudden realization" which then precipitates analytic process and facilitates a caring action.[50] Intuition functions both as a process and as a product.[51] The intuitive process involves a nurse–person encounter in which cues, feelings, and past experience become integrated with the current event. The intuitive product is a conclusion in the form of knowing something, doing something, or both.

Certain conditions or attributes facilitate intuitive thinking.[52] For example, direct person/client contact and nursing experience have been shown to be associated with intuitive perceptions.[53] In addition, the nurse must be emotionally able and willing to receive information. Personal and emotional problems reduce receptivity. For example, the nurse's energy level influences his or her readiness to receive, perceive, and interpret information. A nurse whose energy level is low, as in times of illness or stress, is less intuitive. Self-confidence also facilitates intuitive thinking by enabling the nurse to believe in the validity of his or her intuition.

Benner's work has been enormously useful in clarifying why the novice nurse can never view the world of nursing from the same perspective as the expert.[54,55] She described a hierarchy of thinking, judgment, behavior, and experience that clearly differentiates the novice from the expert: Novice nurses cling to rules and checklists to guide practice and often miss the big picture. Because of the richness of their experience, expert nurses have an intuitive grasp of the situation and are

able to focus on the real problem.[56] They are able to recognize patterns, understand the challenge, and know instinctively when the situation is urgent and warrants immediate action. Moreover, they are skillful in convincing others to change the treatment plan when necessary. Their practice is person-driven.[57]

Intuitive judgment appears to increase proportionately with nursing experience. Although clinical experience is a significant common denominator for the most proficient application of nursing intuition, intuition is not limited to the expert and can be observed and cultivated in the novice as well. The research suggests that intuition can be taught through mentoring and role modeling by expert nurses. Within an educational environment that stresses a linear approach to nursing care, however, cultivation of intuition in the novice nurse is an ongoing concern for those educators who value a holistic approach to nursing education and practice.

Another important discovery related to nursing intuition is that the expert nurse gives significant credence to the *patient's* perceptions/intuitions.[58] Intuitive nurses acknowledge and follow up on those vague descriptions a person may give about how he or she is feeling; they perceive that the patient is often the first to know when something is not right. Based upon nurses' descriptions, nursing intuition may be categorized as cognitive, gestalt, or precognitive.[59] Cognitive inference evolves from the rapid processing of cues. Gestalt intuition perceives the situational pattern as a whole and fills in the gaps. Intuition functions precognitively, suggestive of an energy field interaction, when the nurse perceives a change before it happens.

Intuition is refined in the crucible of experience. Benner's work makes it clear that intuitive events occur more often in the expert than in the novice.[60,61] Expert nurses should become mentors who help novice nurses cultivate and develop their intuitive skills.[62] Within the context of the educational setting, Beck developed a teaching strategy for explicating the intuitive moments within the nursing practice of graduate students and then framing them as a teaching tool for undergraduate nursing students.[63] The resulting narratives and concept analysis were then presented to the undergraduate nursing students to show the steps of concept analysis, to give actual examples of intuitive thinking in nursing practice, and to validate intuitive knowledge as a way of knowing within the nursing process. Both graduate and undergraduate students responded enthusiastically to this learning experience.

Novice nurses can learn the skills necessary to recognize subjective data and to verbalize feelings, cues, and decisions in order to enhance their intuitive perceptions.[64] Various exercises to enhance intuition and open a beginner's awareness to intuitive and spiritual experiences include listening to music, participating in physical exercise, progressive muscle relaxation, writing in a journal, and using a technique to cluster ideas (e.g., brainstorming). Exercises to deepen the intuitive process for more advanced intuitive thinkers include meditation, contemplation of harmonic symbols, directed drawing, guided imagery, and dialogue with the transpersonal self.[65] Educators and clinicians can also cultivate intuitive processes by

- emphasizing the value of intuitive thinking combined with analytic thinking in nursing and continuing education (e.g., by taking this position in nursing articles, textbooks, and conferences)
- encouraging nurses to use their intuition and senses in combination with analytic, objective thinking when assessing the clinical status of patients

- providing inexperienced nurses with subtle, repeated cue patterns that will assist them in recognizing intuitive information, thereby increasing their confidence about interpreting the cues and acting on their decisions
- encouraging nurses to trust their intuition
- using educational strategies that encourage pattern recognition (e.g., case studies, role playing, interactive videos)
- systematically evaluating the usefulness of the cues in making correct decisions
- sharing intuitive experiences with students and colleagues
- supporting nurses who have experienced intuitive events and encouraging them to review and analyze the process
- creating a climate of openness, curiosity, and the yen to discover[66,67]

A holistic, intuitive approach, as suggested by the holistic caring process, incorporates a balanced perspective: application of the common language of nursing diagnoses, interventions, and outcomes within the context of both the intuitive and analytic practice of nursing. Such an approach requires creating new language where necessary and deviating from the path as the situation dictates, thus fostering a living, growing body of nursing knowledge.

Patterns/Challenges/Needs

> Holistic nurses identify and prioritize each person's actual and potential patterns/challenges/needs and life processes related to health, wellness, disease, or illness, which may or may not facilitate well being.[68]

Within the second step of the holistic caring process, the nurse describes a person's patterns/challenges/needs based on a standardized language that is understandable to nurses, other health care professionals, the managed care provider, and the person receiving nursing care. Nursing diagnoses as delineated by NANDA provide the most universal descriptor language for common patterns identified by nurses giving care.[69] (See Exhibit 14–2 for the Domains of Nursing Diagnosis based on Taxonomy II.)

A nursing diagnosis can be defined as a "clinical judgment about the individual, family, or community responses to actual and potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable."[70] After nursing diagnoses are identified and prioritized, they become the basis for the remaining steps of the nursing process.

North American Nursing Diagnosis Association

Although patterns/challenges/needs identification has always been an important function of nursing practice, there was little effort to standardize the terminology used until 1973, when NANDA evolved out of the First National Conference for the Classification of Nursing Diagnoses.[71] By defining, explaining, classifying, and researching summary statements about health concerns related to nursing, NANDA has worked to standardize the labels for identified patterns/challenges/needs, facilitate communication, and encourage research so that specific potential outcomes and nursing interventions can be developed for each diagnosis.[72] As clinical practice and scientific research continue to validate it, the nursing diagnosis movement has the potential for enhancing the quality of nursing care and identifying those patterns/challenges/needs and activities that are unique to nursing.

What began out of a concern for systematically defining and describing nursing

Exhibit 14–2 Taxonomy II: Domains of Nursing Diagnosis

Domain 1: Health Promotion

The awareness of well-being or normality of function and the strategies used to maintain control of and enhance that well-being or normality of function

Domain 2: Nutrition

The activities of taking in, assimilating, and using nutrients for the purposes of tissue maintenance, tissue repair, and the production of energy

Domain 3: Elimination

Secretion and excretion of waste products from the body

Domain 4: Activity/Rest

The production, conservation, expenditure, or balance of energy resources

Domain 5: Perception/Cognition

The human information processing system including attention, orientation, sensation, perception, cognition, and communication

Domain 6: Self-Perception

Awareness about the self

Domain 7: Role Relationships

The positive and negative connections or associations between persons or groups of persons and the means by which those connections are demonstrated

Domain 8: Sexuality

Sexual identity, sexual function, and reproduction

Domain 9: Coping/Stress Tolerance

Contending with life events/life processes

Domain 10: Life Principles

Principles underlying conduct, thought, and behavior about acts, customs, or institutions viewed as being true or having intrinsic worth

Domain 11: Safety/Protection

Freedom from danger, physical injury, or immune system damage, preservation from loss, and protection of safety and security

Domain 12: Comfort

Sense of mental, physical, or social well-being or ease

Domain 13: Growth/Development

Age-appropriate increases in physical dimensions, organ systems, and/or attainment of developmental milestones

Source: Reprinted with permission from North American Nursing Diagnosis Association. *Nursing Diagnoses: Definitions and Classification 2003–2004* (Philadelphia: NANDA, 2003).

decision-making and process has evolved into a language suitably adaptable to the computer-based patient record and inclusion in standardized multidisciplinary vocabularies. NANDA has asserted that the standardized language of nursing diagnosis places nursing in timely flow with future trends: "As we move to a true multidisciplinary, patient-focused care environment, the standardized vocabularies and nomenclatures of all disciplines are being scrutinized for inclusion into an overall standardized vocabulary for the CPR [computer-based patient record]."[73] Furthermore, NANDA has established a liaison with the International Council of Nursing (ICN) and the World Health Organization for developing the International

Classification of Nursing Practice, a global effort to standardize nursing language.

The Diagnostic Statement

Nursing diagnoses describe human responses to health conditions/life processes in an individual, family, or community. The diagnostic label is a "concise phrase or term which represents a pattern of related cues" that defines the diagnosis in practice.[74] Related factors are those "factors that appear to show some type of patterned relationship with the nursing diagnosis."[75] They may be antecedent to, associated with, related to, or abetting the problem. They help identify what is maintaining the problem and what is preventing improvement. Related factors guide the plan of care, because they indicate the changes necessary for the client to achieve a state of health.[76] A nursing diagnosis and related factors are connected by the phrase 'related to,' forming a two-part diagnostic statement,[77] such as "deficient knowledge about acute myocardial infarction related to unfamiliarity with information resources characterized by verbalization of the problem." (The phrase 'related to' is preferable to the phrase 'caused by' because cause and effect have not yet been established for most nursing diagnoses.)[78] The diagnostic statement should be specific enough to guide the remaining steps of the nursing process.

Before making a specific nursing diagnosis, the nurse assesses the defining characteristics of the diagnosis, those behaviors or signs and symptoms (observable cues and inferences) that cluster together as manifestations of the diagnosis.[79] They are necessary to identify the diagnostic entity and to differentiate between various nursing diagnoses. The list of diagnoses with defining characteristics and associated factors or risk factors, depending on the type of diagnosis, has been published and updated regularly to assist nurses in verifying a particular nursing diagnosis.[80] After assessing a client's condition and formulating the possible nursing diagnoses, a nurse refers to the list of defining characteristics to determine if there are sufficient critical indicators to confirm the diagnosis. Although a particular diagnosis may have quite specific defining characteristics, nurses must use their knowledge, education, experience, and intuition to determine if the signs and symptoms observed during the nursing assessment are sufficient to confirm the existence of the particular health pattern/challenge/need.

For many diagnoses, research has not yet validated the defining characteristics. NANDA has established a formal process for research and validation of these diagnoses. Sometimes, when none of the available nursing diagnoses appear to fit the person's circumstances, the nurse must develop a diagnosis. If such a diagnosis appears to recur in the nurses' practice, she or he may consider a formal submission of the diagnosis to NANDA. The American Nurses' Association Psychiatric Mental Health Nursing Group submitted an extensive list of labels for development as specialty nursing diagnoses, all of which were subsequently incorporated in the taxonomy.[81] Although many diagnoses have not yet been identified, the current organizational structure, Taxonomy II, facilitates the identification of gaps to be filled.

Multiaxial Structure of Nursing Diagnoses

Since its inception, the NANDA taxonomy has evolved to a multiaxial structure with seven axes (Exhibit 14–3).[82] This is more in accordance with the organizational structure of other medical taxonomic systems, thus facilitating integration within health care billing systems. Each axis is incorporated explicitly or implicitly in every nursing diagnostic statement.

Exhibit 14–3 Structure of Taxonomy II: Seven Axes

Axis 1	The diagnostic concept
Axis 2	Time (acute, chronic, intermittent, continuous)
Axis 3	Unit of care (individual, family, group, community)
Axis 4	Age (fetus to old-old adult)
Axis 5	Health status (wellness, risk, actual)
Axis 6	Descriptor (limits or specifies the meaning of the diagnostic concept)
Axis 7	Topology (parts/regions of the body)

Source: Reprinted with permission from North American Nursing Diagnosis Association (2003). *Nursing Diagnoses: Definitions and Classification 2003–2004*, Philadelphia: NANDA.

AXIS 1: The ***diagnostic concept***, consisting of one or more nouns (e.g., anxiety; caregiver role strain), is the "principal element or fundamental and essential part, the root, of the diagnostic statement."[83] The diagnostic concepts are readily identifiable in each of the nursing diagnoses listed in Exhibit 14–4. ***AXIS 2: Time***, "the duration of a period or interval" may be described as acute (less than six months), chronic (greater than six months), intermittent, or continuous.[84] ***AXIS 3:*** The ***unit of care***, the population referred to by the diagnostic concept, may be an individual, family, group, or community. ***AXIS 4: Age***, "the length of time or interval during which an individual has existed," ranges from fetus through old-old adult.[85]

AXIS 5: Health Status reflects "the position or rank on the health continuum of wellness to illness (or death)," accommodating actual, risk, and wellness diagnoses.

Actual Nursing Diagnoses exist in fact or reality at the present time. A description of an individual's actual health challenges in terms of a pattern of related cues (e.g., disturbed energy field related to slowing or blocking of energy flows related to surgical procedure) is the actual nursing diagnosis. Actual nursing diagnoses may reflect those acute challenges to patients that require a more immediate or timely intervention by the nurse to prevent further deterioration (e.g., acute pain as observed by protective gestures and facial mask related to surgical procedure), or more enduring conditions requiring long-term intervention strategies (e.g., hopelessness demonstrated by passivity, decreased verbalization and shrugging in response to the speaker, related to prolonged activity restriction creating isolation).[86] Actual nursing diagnoses may reflect the biomedical paradigm or they may reflect a complementary/alternative medical paradigm.

Risk Nursing Diagnoses reflect "vulnerability, especially as a result of exposure to factors that increase the chance of injury or loss."[87] A risk nursing diagnosis is a diagnosis that "describes human responses to health conditions/life processes which may develop in a vulnerable individual, family, or community. It is supported by risk factors that contribute to increased vulnerability."[88]

Risk nursing diagnoses are associated with risk factors: "environmental factors and physiologic, psychologic, genetic, or chemical elements that increase the vulnerability of an individual, family, or community to an unhealthful event."[89] The risk factors guide nursing interventions to reduce or prevent the occurrence of the problem. The diagnosis and the risk factors are connected by the phrase 'related to' and written as a two-part statement; for example, "risk for infection related to recent surgical procedure; or risk for imbalanced nutrition: more than body requirements related to dysfunctional eating patterns."[90]

Specifically stating which clients are at risk for a particular problem is essential to providing quality nursing care. Moreover, nursing will be better able to demonstrate and document its contribution to desired

Exhibit 14–4 Taxonomy II: Domains, Classes, and Diagnoses

Domain 1 Health Promotion

Class 1 Health Awareness Recognition of normal function and well-being

Class 2 Health Management Identifying, controlling, performing, and integrating activities to maintain health and well-being

Approved Diagnoses

00082	*Effective therapeutic regimen management*
00078	*Ineffective therapeutic regimen management*
00080	*Ineffective family therapeutic regimen management*
00081	*Ineffective community therapeutic regimen management*
00084	*Health-seeking behaviors (specify)*
00099	*Ineffective health maintenance*
00098	*Impaired home maintenance*
00162	*Readiness for enhanced management of therapeutic regimen**
00163	*Readiness for enhanced nutrition**

Domain 2 Nutrition

Class 1 Ingestion Taking food or nutrients into the body

Approved Diagnoses

00107	*Ineffective infant feeding pattern*
00103	*Impaired swallowing*
00002	*Imbalanced nutrition: Less than body requirements*
00001	*Imbalanced nutrition: More than body requirements*
00003	*Risk for imbalanced nutrition: More than body requirements*

Class 2 Digestion The physical and chemical activities that convert food-stuffs into substances suitable for absorption and assimilation

Class 3 Absorption The act of taking up nutrients through body tissues

Class 4 Metabolism The chemical and physical processes occurring in living organisms and cells for the development and use of protoplasm, production of waste and energy, with the release of energy for all vital processes

Class 5 Hydration The taking in and absorption of fluids and electrolytes

Approved Diagnoses

00027	*Deficient fluid volume*
00028	*Risk for deficient fluid volume*
00026	*Excess fluid volume*
00025	*Risk for imbalanced fluid volume*
00160	*Readiness for enhanced fluid balance**

Domain 3 Elimination

Class 1 Urinary System The process of secretion and excretion of urine

Approved Diagnoses

00016	*Impaired urinary elimination*
00023	*Urinary retention*
00021	*Total urinary incontinence*
00020	*Functional urinary incontinence*
00017	*Stress urinary incontinence*
00019	*Urge urinary incontinence*
00018	*Reflex urinary incontinence*
00022	*Risk for urge urinary incontinence*
00166	*Readiness for enhanced urinary elimination**

Class 2 Gastrointestinal System Excretion and expulsion of waste products from the bowel

Approved Diagnoses

00014	*Bowel incontinence*
00013	*Diarrhea*
00011	*Constipation*
00015	*Risk for constipation*
00012	*Perceived constipation*

Class 3 Integumentary System Process of secretion and excretion through the skin

Class 4 Pulmonary System Removal of byproducts of metabolic processes, secretions, and foreign material from the lung or bronchi

Approved Diagnoses

00030	*Impaired gas exchange*

Domain 4 Activity/Rest

Class 1 Sleep/Rest Slumber, repose, ease, or inactivity

Approved Diagnoses

00095	*Disturbed sleep pattern*
00096	*Sleep deprivation*
00165	*Readiness for enhanced sleep**

(continued)

***Denotes wellness diagnoses**

Exhibit 14–4 Continued

Class 2 Activity/Exercise Moving parts of the body (mobility), doing work, or performing actions often (but not always) against resistance

Approved Diagnoses

00040	*Risk for disuse syndrome*
00085	*Impaired physical mobility*
00091	*Impaired bed mobility*
00089	*Impaired wheelchair mobility*
00090	*Impaired transfer ability*
00088	*Impaired walking*
00097	*Deficient diversional activity*
00109	*Dressing/grooming self-care deficit*
00108	*Bathing/hygiene self-care deficit*
00102	*Feeding self-care deficit*
00110	*Toileting self-care deficit*
00100	*Delayed surgical recovery*

Class 3 Energy Balance A dynamic state of harmony between intake and expenditure of resources

Approved Diagnoses

00050	*Disturbed energy field*
00093	*Fatigue*

Class 4 Cardiovascular/Pulmonary Responses Cardiopulmonary mechanisms that support activity/rest

Approved Diagnoses

00029	*Decreased cardiac output*
00033	*Impaired spontaneous ventilation*
00032	*Ineffective breathing pattern*
00092	*Activity intolerance*
00094	*Risk for activity intolerance*
00034	*Dysfunctional ventilatory weaning response*
00024	*Ineffective tissue perfusion (specify type: renal, cerebral, cardiopulmonary, gastrointestinal, peripheral)*

Domain 5 Perception/Cognition

Class 1 Attention Mental readiness to notice or observe

Approved Diagnoses

00123	*Unilateral neglect*

Class 2 Orientation Awareness of time, place, and person

Approved Diagnoses

00127	*Impaired environmental interpretation syndrome*
00154	*Wandering*

Class 3 Sensation/Perception Receiving information through the senses of touch, taste, smell, vision, hearing, and kinesthesia and the comprehension of sense data resulting in naming, associating, and/or pattern recognition

Approved Diagnoses

00122	*Disturbed sensory perception (specify: visual, auditory, kinesthetic, gustatory, tactile, olfactory)*

Class 4 Cognition Use of memory, learning, thinking, problem solving, abstraction, judgment, insight, intellectual capacity, calculation, and language

Approved Diagnoses

00126	*Deficient knowledge (specify)*
00161	*Readiness for enhanced knowledge (specify)**
00128	*Acute confusion*
00129	*Chronic confusion*
00131	*Impaired memory*
00130	*Disturbed thought processes*

Class 5 Communication Sending and receiving verbal and nonverbal information

Approved Diagnoses

00051	*Impaired verbal communication*
00157	*Readiness for enhanced communication**

Domain 6 Self-perception

Class 1 Self-Concept The perception(s) about the total self

Approved Diagnoses

00121	*Disturbed personal identify*
00125	*Powerlessness*
00152	*Risk for powerlessness*
00124	*Hopelessness*
00054	*Risk for loneliness*
00167	*Readiness for enhanced self-concept**

(continued)

***Denotes wellness diagnoses**

Exhibit 14–4 Continued

Class 2 Self-esteem Assessment of one's own worth, capability, significance, and success

Approved Diagnoses

00119	*Chronic low self-esteem*
00120	*Situational low self-esteem*
00153	*Risk for situational low self-esteem*

Class 3 Body Image A mental image of one's own body

Approved Diagnoses

00118	*Disturbed body image*

Domain 7 Role Relationships

Class 1 Caregiving Roles Socially expected behavior patterns by persons providing care who are not health care professionals

Approved Diagnoses

00061	*Caregiver role strain*
00062	*Risk for caregiver role strain*
00056	*Impaired parenting*
00057	*Risk for impaired parenting*
00164	*Readiness for enhanced parenting**

Class 2 Family Relationships Associations of people who are biologically related or related by choice

Approved Diagnoses

00060	*Interrupted family processes*
00159	*Readiness for enhanced family processes**
00063	*Dysfunctional family processes: Alcoholism*
00058	*Risk for impaired parent/infant/child attachment*

Class 3 Role Performance Quality of functioning in socially expected behavior patterns

Approved Diagnoses

00106	*Effective breastfeeding*
00104	*Ineffective breastfeeding*
00105	*Interrupted breastfeeding*
00055	*Ineffective role performance*
00064	*Parental role conflict*
00052	*Impaired social interaction*

***Denotes wellness diagnoses**

Domain 8 Sexuality

Class 1 Sexual Identify The state of being a specific person in regard to sexuality and/or gender

Class 2 Sexual Function The capacity or ability to participate in sexual activities

Approved Diagnoses

00059	*Sexual dysfunction*
00065	*Ineffective sexuality patterns*

Class 3 Reproduction Any process by which new individuals (people) are produced

Domain 9 Coping/Stress Tolerance

Class 1 Post-Trauma Responses Reactions occurring after physical or psychological trauma

Approved Diagnoses

00114	*Relocation stress syndrome*
00149	*Risk for relocation stress syndrome*
00142	*Rape-trauma syndrome*
00144	*Rape-trauma syndrome: Silent reaction*
00143	*Rape-trauma syndrome: Compound reaction*
00141	*Post-trauma syndrome*
00145	*Risk for post-trauma syndrome*

Class 2 Coping Responses The process of managing environmental stress

Approved Diagnoses

00148	*Fear*
00146	*Anxiety*
00147	*Death anxiety*
00137	*Chronic sorrow*
00072	*Ineffective denial*
00136	*Anticipatory grieving*
00135	*Dysfunctional grieving*
00070	*Impaired adjustment*
00069	*Ineffective coping*
00073	*Disabled family coping*
00074	*Compromised family coping*
00071	*Defensive coping*
00077	*Ineffective community coping*
00158	*Readiness for enhanced coping**
00075	*Readiness for enhanced family coping**
00076	*Readiness for enhanced community coping**

(continued)

Exhibit 14–4 Continued

Class 3 Neurobehavioral Stress Behavioral responses reflecting nerve and brain function

Approved Diagnoses

00009	*Autonomic dysreflexia*
00010	*Risk for autonomic dysreflexia*
00116	*Disorganized infant behavior*
00115	*Risk for disorganized infant behavior*
00117	*Readiness for enhanced organized infant behavior**
00049	*Decreased intracranial adaptive capacity*

Domain 10 Life Principles

Class 1 Values The identification and ranking of preferred modes of conduct or end states

Class 2 Beliefs Opinions, expectations, or judgments about acts, customs, or institutions viewed as being true or having intrinsic worth

Approved Diagnoses

00068	*Readiness for enhanced spiritual well-being**

Class 3 Value/Belief/Action Congruence The correspondence or balance achieved between values, beliefs, and actions

Approved Diagnoses

00066	*Spiritual distress*
00067	*Risk for spiritual distress*
00083	*Decisional conflict (specify)*
00079	*Noncompliance (specify)*

Domain 11 Safety/Protection

Class 1 Infection Host responses following pathogenic invasion

Approved Diagnoses

00004	*Risk for infection*

Class 2 Physical Injury Bodily harm or hurt

Approved Diagnoses

00045	*Impaired oral mucous membrane*
00035	*Risk for injury*
00087	*Risk for perioperative positioning injury*
00155	*Risk for falls*
00038	*Risk for trauma*
00046	*Impaired skin integrity*
00047	*Risk for impaired skin integrity*
00044	*Impaired tissue integrity*
00048	*Impaired dentition*
00036	*Risk for suffocation*
00039	*Risk for aspiration*
00031	*Ineffective airway clearance*
00086	*Risk for peripheral neurovascular dysfunction*
00043	*Ineffective protection*
00156	*Risk for sudden infant death syndrome*

Class 3 Violence The exertion of excessive force or power so as to cause injury or abuse

Approved Diagnoses

00139	*Risk for self-mutilation*
00151	*Self-mutilation*
00138	*Risk for other-directed violence*
00140	*Risk for self-directed violence*
00150	*Risk for suicide*

Class 4 Environmental Hazards Sources of danger in the surroundings

Approved Diagnoses

00037	*Risk for poisoning*

Class 5 Defensive Processes The processes by which the self protects itself from the nonself

Approved Diagnoses

00041	*Latex allergy response*
00042	*Risk for latex allergy response*

Class 6 Thermoregulation The physiologic process of regulating heat and energy within the body for purposes of protecting the organism

Approved Diagnoses

00005	*Risk for imbalanced body temperature*
00008	*Ineffective thermoregulation*
00006	*Hypothermia*
00007	*Hyperthermia*

Domain 12 Comfort

Class 1 Physical Comfort Sense of well-being or ease

Approved Diagnoses

00132	*Acute pain*
00133	*Chronic pain*
00134	*Nausea*

(continued)

***Denotes wellness diagnoses**

Exhibit 14–4 Continued

Class 2 Environmental Comfort Sense of well-being or ease in/with one's environment

Class 3 Social Comfort Sense of well-being or ease with one's social situations

Approved Diagnoses
00053 Social isolation

Domain 13 Growth/Development

Class 1 Growth Increases in physical dimensions or maturity of organ systems

Approved Diagnoses
00113 Risk for disproportionate growth
00101 Adult failure to thrive

Class 2 Development Attainment, lack of attainment, or loss of developmental milestones

Approved Diagnoses
00111 Delayed growth and development
00112 Risk for delayed development

***Denotes wellness diagnoses**

Source: Reprinted with permission from North American Nursing Diagnosis Association (2003). *Nursing Diagnoses: Definitions and Classification 2003–2004*, Philadelphia: NANDA.

client outcomes when the quality of nursing care prevents or reduces problems in clients at risk. Also, the risk category is beneficial in justifying allocation of resources and personnel, as well as in obtaining third-party reimbursement.

Wellness Nursing Diagnoses convey the "quality or state of being healthy, especially as a result of deliberate effort."[91] A wellness nursing diagnosis is one that "describes human responses to levels of wellness in an individual, family, or community that have a potential for enhancement to a higher state."[92] Wellness diagnoses are written as relational statements, such as "readiness for enhanced coping related to use of a broad range of problem-oriented and emotion-oriented strategies" or "readiness for enhanced spiritual well-being related to expressed desire for peace, serenity and self-forgiveness."[93] Wellness and health promotion have become national priorities; wellness nursing diagnoses broaden nursing's perspective from an illness-dominated framework to one that incorporates a positive, wellness orientation. Wellness nursing diagnoses listed in Exhibit 14–4 and identified by an asterisk (*) are used together with the phrase "readiness for enhanced." Further, twelve proposed health-promoting diagnoses are listed in Exhibit 14–5.

AXIS 6: The ***descriptor or modifier*** conveys a "judgment that limits or specifies the meaning of the nursing diagnosis." (Exhibit 14–6). Descriptors modify the diagnostic concept with a judgment about the person's health response. For example, grieving may be anticipatory or it may be dysfunctional. Anticipatory grieving is a response to "perception of potential loss" while dysfunctional grieving is an "extended, unsuccessful" response to the "perception of loss."[94]

AXIS 7: Topology refers to parts/ regions of the body—all tissues, organs, anatomical sites, or structures. Diagnoses related to elimination may address the urinary, gastrointestinal, integumentary, or pulmonary system. Diagnoses related to sensation/ perception may address the comprehension of sense data via touch, taste, smell, vision, hearing, or kinesthesia.

The Wellness Pyramid

There is a distinction between the concepts of illness prevention (or risk reduction), health maintenance, and health promotion. Illness prevention or risk reduction involves behaviors aimed at

Exhibit 14–5 New Health Promotion Diagnoses

Readiness for enhanced self-care: A pattern of performing activities for oneself that is sufficient for meeting health-related goals and can be strengthened.
Readiness of enhanced activities of daily living: A pattern of executing the tasks of daily living that is adequate for meeting health-related goals and can be strengthened.
Readiness for enhanced bowel elimination: A pattern of bowel function that is adequate for meeting elimination needs and can be strengthened.
Readiness for enhanced comfort: A pattern of contentment that is sufficient for well-being and can be strengthened.
Readiness for enhanced decision-making: A pattern of choosing courses of action that is sufficient for meeting short- and long-term goals and can be strengthened.
Readiness for enhanced exercise: A pattern of physical activity that is sufficient to meet health-related goals and can be strengthened.
Readiness for enhanced grieving: A pattern of feelings and behaviors pertaining to loss that is sufficient for recovery and can be strengthened.
Readiness for enhanced hope: A pattern of expectations and desires that is sufficient for mobilizing energy on one's own behalf and can be strengthened.
Readiness for enhanced immunization status: A pattern of conforming to local, national, and/or international standards of immunization to prevent infectious disease(s) that is sufficient to protect a person, family, or community and can be strengthened.
Readiness for enhanced power: A pattern of participating knowingly in change that is sufficient for well-being and can be strengthened.
Readiness for enhanced recreation and/or leisure: A pattern of planned activities and responses to spontaneous events that is sufficient for pleasure and growth and can be strengthened.
Readiness for enhanced values/beliefs: A pattern of disposition towards persons, objects, or ideas that is sufficient for giving direction and meaning to life and can be strengthened.

Source: Reprinted with permission from North American Nursing Diagnosis Association (2003). *Nursing Diagnoses: Definitions and Classification 2003–2004*, Philadelphia: NANDA.

Exhibit 14–6 Diagnostic Descriptors

Ability: Capacity to do or act
Anticipatory: To realize beforehand, foresee
Balance: State of equilibrium
Compromised: To make vulnerable to threat
Decreased: Lessened; lesser in size, amount, or degree
Deficient: Inadequate in amount, quality, or degree; not sufficient; incomplete
Defensive: To feel constantly under attack and the need to justify quickly one's actions
Delayed: To postpone, impede, and retard
Depleted: Emptied wholly or in part, exhausted of
Disproportionate: Not consistent with a standard
Disabling: To make unable or unfit, to incapacitate
Disorganized: To destroy the systematic arrangement
Disturbed: Agitated or interrupted; interfered with
Dysfunctional: Abnormal, incomplete functioning
Effective: Producing the intended or expected effect
Excessive: Characterized by an amount or quantity that is greater than necessary, desirable, or useful
Functional: Normal, complete functioning
Imbalanced: State of disequilibrium
Impaired: Made worse, weakened, damaged, reduced, deteriorated
Inability: Incapacity to do or act
Increased: Greater in size, amount, or degree
Ineffective: Not producing the desired effect
Interrupted: To break the continuity or uniformity
Low: Containing less than normal amount of some usual element
Organized: To form as into systematic arrangement
Perceived: To become aware of by means of the senses; assignment of meaning
Readiness for enhanced (for use with wellness diagnoses): To make greater, to increase in quality, to attain the more desired

Source: Reprinted with permission from North American Nursing Diagnosis Association (2003). *Nursing Diagnoses: Definitions and Classification 2003–2004*, Philadelphia: NANDA.

actively protecting against or reducing the chances of encountering disease, illness, or accidents.[95,96] The risk nursing diagnoses are directed toward prevention. Nursing interventions associated with these diagnoses are actively selected to reduce or prevent the particular problem.[97] Health maintenance focuses on sustaining a neutral state of health. For example, the nursing diagnosis for people who are unable to identify, manage, or seek help to maintain health would be ineffective health maintenance (Exhibit 14–7).[98] For these clients, nursing interventions would include activities not only to prevent illness, but also to protect health (e.g., eating a balanced diet, stopping smoking, having regular medical examinations, sleeping six to eight hours per night).

Health promotion goes beyond illness prevention or health maintenance. Because it involves a personal responsibility for their health, individuals strive actively to improve their lifestyle to achieve high-level wellness.[99] The diagnosis of health-seeking behaviors (i.e., health-promoting behaviors) is consistent with the concept of health promotion (Exhibit 14–8). Health-seeking behaviors may include such activities as requesting additional information and recipes to enhance a low-cholesterol, low-fat, low-salt, low-sugar, and high-fiber diet; practicing daily relaxation techniques; and participating in aerobic exercises three to five times per week.[100] The category of

Exhibit 14–7 Ineffective Health Maintenance

Definition

Inability to identify, manage, and/or seek out help to maintain health

Defining Characteristics

Demonstrated lack of knowledge regarding basic health practices; demonstrated lack of adaptive behaviors to internal/external environmental changes; reported or observed inability to take responsibility for meeting basic health practices in any or all functional pattern areas; history of lack of health-seeking behavior; expressed interest in improving health behaviors; reported or observed lack of equipment, financial, and/or other resources; reported or observed impairment of personal support systems.

Related Factors

Ineffective family coping; perceptual/cognitive impairment (complete/partial lack of gross and/or fine motor skills); lack of, or significant alteration in, communication skills (written, verbal, and/or gestural); unachieved developmental tasks; lack of material resources; dysfunctional grieving; disabling spiritual distress; lack of ability to make deliberate and thoughtful judgments; ineffective individual coping.

Source: Reprinted with permission from North American Nursing Diagnosis Association (2003). *Nursing Diagnoses: Definitions and Classification 2003–2004*, Philadelphia: NANDA.

Exhibit 14–8 Health-Seeking Behaviors (Specify)

Definition

Active seeking (by a person in stable health) of ways to alter personal health habits and/or the environment in order to move toward a higher level of health.

Defining Characteristics

Expressed or observed desire to seek a higher level of wellness; demonstrated or observed lack of knowledge in health-promotion behaviors; stated or observed unfamiliarity with wellness community resources; expression of concern about current environmental conditions on health status; expressed or observed desire for increased control of health practice

Related Factors

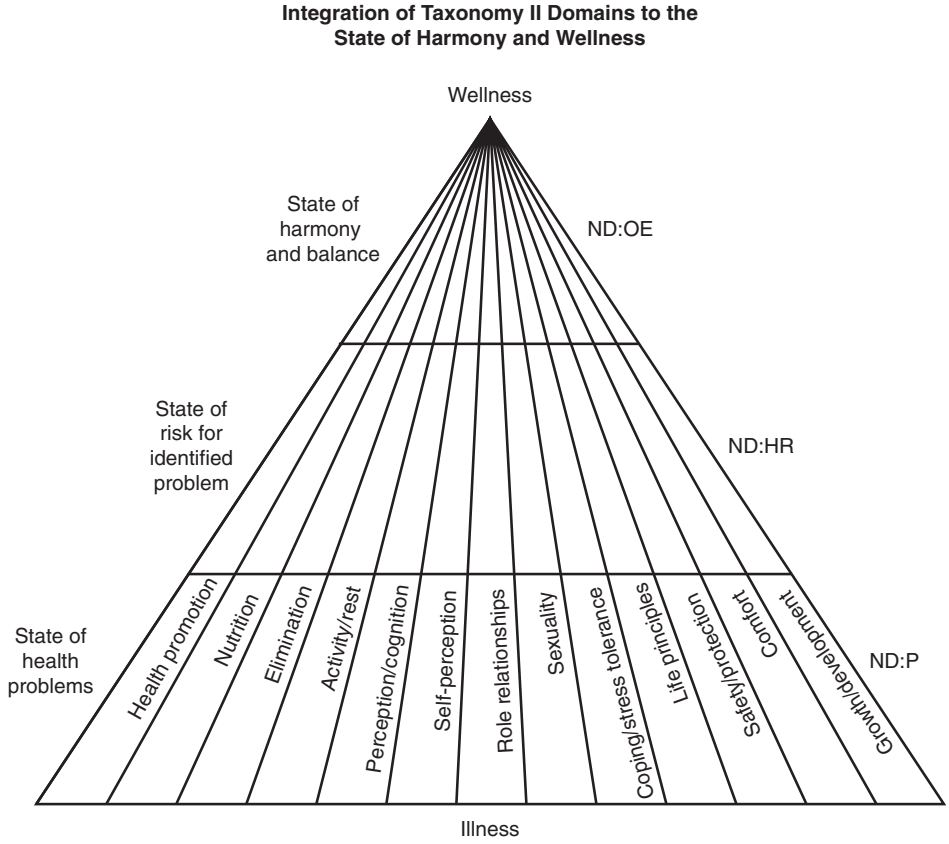
To be developed

Note: Stable health is defined as achievement of age-appropriate illness-prevention measures; client reports good or excellent health, and signs and symptoms of disease, if present, are controlled.

Source: Reprinted with permission from North American Nursing Diagnosis Association (2003). *Nursing Diagnoses: Definitions and Classification 2003–2004*, Philadelphia: NANDA.

wellness nursing diagnoses using Taxonomy II with the qualifier of readiness for enhanced also addresses health promotion activities and allows the nurse to focus on wellness, facilitate responsibility for self-care, and promote healthy behaviors.

A trifocal model for nursing diagnosis as developed by Kelley and associates organizes the person's patterns/challenges/needs in a wellness pyramid.[101] (Figure 14–2) The base of the pyramid, modified to accommodate Taxonomy II, represents actual health problems/challenges for each of the 13 NANDA domains. The next level, representing a higher level of wellness than manifest problems, identifies areas where the person is at risk for developing problems. The apex of the pyramid represents patterns/needs that may be potentially enhanced, thus facilitating a state of harmony and



Legend
ND: Nursing diagnosis
OE: Opportunity for enhancement
HR: High risk
P: Problem

Figure 14–2 Trifocal model of nursing diagnosis. *Source:* Adapted with permission from J. Kelley, N. Frisch, and K. Avant, A Trifocal Model of Nursing Diagnosis: Wellness Revisited, *Nursing Diagnosis,* Vol. 6, pp. 123–128, © 1995, North American Nursing Diagnosis Association.

balance.[102] Frisch and Frisch observed that this model "gives the nurse a framework to use the diagnostic language in all aspects of nursing care."[103] The flexibility of the trifocal model allows the nurse to identify and map a multidimensional picture of the person who always has strengths that may be substantially enhanced in the midst of moving through potential or manifest illness. The trifocal model also may serve as a motivational communication device to use with the person in creating a mutual plan of care.

A Descriptive Tool

Essential to the holistic caring process is the understanding that nursing diagnosis is a means for describing a person's health pattern manifestation; nursing diagnoses are not the pattern. They are merely a descriptive tool for articulating patterns identified in the nurse–person relationship, rather than a rigid, limiting diagnostic label that might constrict and stereotype care. The person's value system, not the nurse's, is the basis for holistic nursing decisions and diagnostic labeling. Setting aside preconceived notions about health enhancement for the person, the nurse chooses diagnoses that most accurately reflect the person's perceptions about his or her health patterns. Whenever possible, the nurse collaborates with the person to validate and prioritize nursing diagnoses. Impediments to a holistic nursing diagnosis result from neglecting to make the person the focus of the process and failing to have a continual, focused awareness of the person as a whole. Fitting the pattern of a dynamic, changing human being into an arbitrary diagnostic statement rather than reflecting the actual pattern of the person limits the effectiveness of the holistic caring process.

Utilization of a nursing theoretical framework in concert with a standardized language that describes nurses' phenomena of concern meets the cultural requirements of health care for a common language that demonstrates and documents the value of nursing care based on logic and predictive outcomes. This is essential for providing quality patient care as well as necessary for remuneration of nursing services. Frisch and Kelley suggest theory-oriented strategies that include: "the use of theory-specific language in the 'related-to' clause of the diagnosis, writing narrative notes along with the standard classifications, and documenting impact of nursing activities on client conditions."[104] Such an approach meets system requirements and adds the possibility of evaluating theory-based practice outcomes. Further, theoretically derived nursing diagnoses and outcomes can be introduced to the standardized systems. For example the newly proposed diagnosis, "Readiness for enhanced power," wherein power is defined as "a pattern of participating knowingly in change that is sufficient for well being and can be strengthened,"[105] appears to draw upon Barrett's theory of Power as Knowing Participation in Change.[106] Holistic nursing is both the practice of presence and the implementation of process. Distinguishing nursing roles from other caregiver roles is essential for the profession; "a matter of extinction or distinction."[107] Frisch and Kelley observe: "the capacity to administer expert technical care in conjunction with expert human care constitutes the unique contribution of nursing."[108]

Outcomes

> Holistic nurses specify appropriate outcomes for each person's actual or potential patterns/challenges/needs.[109]

An outcome is a direct statement of a nurse–person identified goal to be achieved within a specific time frame; the person's significant others and other health care practitioners may participate

in goal setting. An outcome indicates the maximum level of wellness that is reasonably attainable for the person in view of objective circumstances and the person's perceptions.[110,111]

After the person's patterns/challenges/needs have been identified, one or more specific and concisely stated outcomes are written for each. Outcome criteria must be measurable and may fall into the following categories:

- circumstances that should or should not occur in the client's status
- the level at which some change should occur
- the client's verbalizations about what he or she knows, understands, or feels about the situation
- specific client behaviors or signs/symptoms that are expected to occur as a result of intervention
- specific client behaviors that are expected to occur as a result of adequate management of the environment[112,113]

Outcome criteria outline the specific tools, tests, observations, or personal statements that determine whether the patient outcome has been achieved. They reflect the goals of the nurse–person intervention. The holistic nurse selects interventions on the basis of desired outcomes, discussing with the person possible ways for achieving these desired outcomes. The person helps to establish observable milestones for knowing whether desired changes have occurred and makes a commitment to move toward those desired changes. Client outcomes direct the plan of care.

Similar to the attempt to classify and codify nursing diagnoses, there has been major effort to standardize outcome measures. The Nursing Outcomes Classification (NOC) developed by the Iowa Outcomes Project at the University of Iowa provides a comprehensive taxonomy of 330 outcomes organized into seven domains and 29 classes. Outcomes describe the expected effect or influence of the intervention upon the person. Within this classification system a nursing-sensitive patient outcome is: "An individual, family, or community state, behavior or perception that is measurable along a continuum and responsive to nursing intervention(s)."[114] Using variable concepts allows for measurement of change as positive, negative, or no change in the person's situation, behaviors, or perceptions. Each coded outcome is associated with a label, definition, set of indicators, a measurement scale, and supporting literature. Outcome measures can be utilized as indicators of individual change as well as for quantitative comparison with a greater population.

The seven NOC domains are (1) Functional Health, (2) Physiologic Health, (3) Psychosocial Health, (4) Health Knowledge and Behavior, (5) Perceived Health, (6) Family Health, and (7) Community Health. (See Exhibit 14–9 for an example of the classes for the domain of Psychosocial Health and Exhibit 14–10 for measurable indicators for the nursing outcome Self-Esteem.) As with NANDA nursing diagnoses, the NOC provides common nursing language for communicating about the effectiveness of nursing actions, a language that can be recognized by providers, payers, and other health care professionals.

If outcomes are to be achieved, the nurse must establish them with the assistance of the patient and family. The person must be motivated to establish healthy patterns of behavior. Assumptions made by the nurse concerning desired outcomes without collaboration with the person impede outcome achievement. Rigid adherence to specific outcomes by the person or the

Exhibit 14–9 Classes for the Nursing Outcome Domain of Psychosocial Health

Level 1	**3) Domain III—Psychosocial Health Outcomes That Describe Psychological and Social Functioning**			
Level 2	**M-Psychological Well-Being**	**N-Psychosocial Adaptation**	**O-Self-Control**	**P-Social Interaction**
	Outcomes that describe an individual's emotional health	Outcomes that describe an individual's psychological and/or social adaptation to altered health or life circumstances	Outcomes that describe an individual's ability to restrain behavior that may be emotionally or physically harmful to self or others	Outcomes that describe an individual's relationships with others
Level 3	1200-Body Image 1208-Depression Level 1201-Hope 1202-Identity 1203-Loneliness 1204-Mood Equilibrium 1205-Self-Esteem 1207-Sexual Identity: Acceptance 1206-Will to Live	1300-Acceptance: Health Status 1301-Child Adaptation to Hospitalization 1302-Coping 1303-Dignified Dying 1304-Grief Resolution 1306-Pain: Psychological Response 1305-Psychosocial Adjustment: Life Change	1400-Abusive Behavior Self-Control 1401-Aggression Control 1402-Anxiety Control 1409-Depression Control 1403-Distorted Thought Control 1404-Fear Control 1405-Impulse Control 1406-Self-Mutilation Restraint 1407-Substance Addiction Consequences 1408-Suicide Self-Restraint	1500-Parent–Infant Attachment 1501-Role Performance 1502-Social Interaction Skills 1503-Social Involvement 1504-Social Support

Note: The numbers represent the numeric code assigned by the Nursing Outcomes Classification.
Source: M. Johnson, M. Maas, and S. Moorhead, *Nursing Outcomes Classification (NOC),* 2nd Edition, © St. Louis, Mosby, 2000. Reprinted by permission.

nurse may make it impossible to recognize the value of the journey with its myriad other paths and other possible outcomes.

Therapeutic Care Plan

Holistic nurses engage each person to mutually create an appropriate plan of care that focuses on health promotion, recovery, restoration, or peaceful dying so that the person is as independent as possible.[115]

During the planning stage, nurses who use the holistic caring process help the person identify ways to repattern his or her behaviors to achieve a healthier state. The planning process reveals interventions that will achieve outcomes. The plan outlines nursing prescriptions, which are the

Exhibit 14–10 Measurable Indicators for the Nursing Outcome of Self-Esteem (1205)

Self-Esteem (1205)

Domain=Psychosocial Health (III)
Class=Psychological Well-Being (M)
Scale=Never positive to Consistently positive (k)

Definition: Personal judgment of self-worth

Self-Esteem	**Never Positive 1**	**Rarely Positive 2**	**Sometimes Positive 3**	**Often Positive 4**	**Consistently Positive 5**
Indicators:					
120501 Verbalizations of self-acceptance	1	2	3	4	5
120502 Acceptance of self-limitations	1	2	3	4	5
120503 Maintenance of erect posture	1	2	3	4	5
120504 Maintenance of eye contact	1	2	3	4	5
120505 Description of self	1	2	3	4	5
120506 Regard for others	1	2	3	4	5
120507 Open communication	1	2	3	4	5
120508 Fulfillment of personally significant roles	1	2	3	4	5
120509 Maintenance of grooming/ hygiene	1	2	3	4	5
120510 Balance of participation and listening in groups	1	2	3	4	5
120511 Confidence level	1	2	3	4	5
120512 Acceptance of compliments from others	1	2	3	4	5
120513 Expected response from others	1	2	3	4	5
120514 Acceptance of constructive criticism	1	2	3	4	5
120515 Willingness to confront others	1	2	3	4	5
120516 Description of success in work or school	1	2	3	4	5
120517 Description of success in social groups	1	2	3	4	5
120518 Description of pride in self	1	2	3	4	5
120519 Feelings about self-worth	1	2	3	4	5
120520 Other _____ *(specify)*	1	2	3	4	5

Source: M. Johnson, M. Maas, and S. Moorhead, *Nursing Outcomes Classification (NOC),* 2nd Edition © St. Louis, Mosby, 2000. Reprinted by permission.

specific actions that the nurse performs to help the person solve problems and accomplish outcomes.[116] Nursing prescriptions direct the implementation of care.

A nursing intervention has been defined as "any direct care treatment that a nurse performs on behalf of a client. The treatments include nurse-initiated treatments resulting from nursing diagnoses, physician-initiated treatments resulting from medical diagnoses, and performance of the daily essential functions for the client who cannot do these."[117] During the planning phase, the nurse generally chooses interventions by

- determining whether the intervention will be useful in helping the client achieve the desired outcome
- identifying the characteristics of the patterns/challenges/needs (i.e., whether the intervention is aimed at the etiology, at signs/symptoms, or at potential problems)
- evaluating the research base that validates the effectiveness of the intervention, its clinical significance, and the nursing control associated with the intervention
- determining the feasibility of implementing the intervention in terms of any other diagnoses and their respective priorities, and the cost and time involved with the intervention
- evaluating the acceptability of the intervention to the client in terms of his or her own goals and priorities related to the treatment plan
- ensuring the nursing competency necessary to implement the intervention successfully[118,119]

Efforts are under way to develop a classification of nursing interventions that parallels the classification of nursing diagnoses. The Iowa Intervention Project developed the Nursing Interventions Classification (NIC), which contains an alphabetic list of 486 interventions.[120] Each intervention is listed with a label, a definition, a set of related activities that describe the behaviors of the nurse who implements the intervention, and a brief list of background readings. The NIC includes all direct care interventions, both independent and collaborative, that nurses perform for patients.

Holistic nurses frequently select complementary alternative modalities and generally noninvasive nursing interventions to complement standard nursing care (Exhibit 14–11). Holistic nurses incorporate complementary modalities into their practice as interventions for treating the body (biofeedback, therapeutic massage), relieving the mind (humor, imagery, meditation), comforting the soul (prayer), and supporting significant interpersonal interaction (healing presence).[121] Therapies like acupressure and meditation are actually listed as nursing interventions in the taxonomy. Others that are not listed, like Reiki or aromatherapy, may be considered within the scope of nursing practice in some jurisdictions, provided that the nurse is trained in those modalities and uses them appropriately. Nurses should refer to the rules/regulations within their state of licensure.

Alternative Link*, a company specializing in information products for health care practitioners, developed ABC codes, which are alphanumeric representations of alternative medicine, nursing, and other integrative health care services and products.[122] These codes complement conventional medical codes and can be used to file for third-party reimbursement. The particular codes developed for nursing incorporate

*For more information about ABC codes contact: Alternative Link, 6121 Indian School Road NE, Suite 131, Albuquerque, New Mexico 87110, 505-875-0002, www.alternativelink.com.

Exhibit 14–11 Noninvasive Nursing Interventions

4920 Active Listening
4310 Activity Therapy
1320 Acupressure
Addictions Counseling*
AMMA Therapy*
4320 Animal-Assisted Therapy
5210 Anticipatory Guidance
5820 Anxiety Reduction
Aroma Therapy*
4330 Art Therapy
4340 Assertiveness Training
6710 Attachment Promotion
5840 Autogenic Training
Back Remedies*
1610 Bathing
4360 Behavior Modification
4680 Bibliotherapy
5860 Biofeedback
Biomagnetic Healing*
5220 Body Image Enhancement
0140 Body Mechanics Promotion
5880 Calming Technique
7040 Caregiver Support
4700 Cognitive Restructuring
5230 Coping Enhancement
5240 Counseling
Craniosacral Therapy*
6160 Crisis Intervention
5250 Decision-Making Support
7370 Discharge Planning
7920 Documentation
5270 Emotional Support
0180 Energy Management
6480 Environmental Management
0200 Exercise Promotion
7110 Family Involvement Promotion
7130 Family Process Maintenance
7140 Family Support
7150 Family Therapy
1660 Foot Care
5280 Forgiveness Facilitation
5290 Grief Work Facilitation
5300 Guilt Work Facilitation
Hakomi Counseling*
Healing Touch*
7960 Health Care Information Exchange
5510 Health Education
Herbal Remedies*
Holistic Self-Assessments*
6520 Health Screening
7400 Health System Guidance
5310 Hope Instillation
5320 Humor
5920 Hypnosis
Journaling*
5244 Lactation Counseling
5520 Learning Facilitation
5540 Learning Readiness Enhancement
2380 Medication Management
5960 Meditation Facilitation
4400 Music Therapy
4410 Mutual Goal Setting
5246 Nutritional Counseling
1400 Pain Management
4420 Patient Contracting
7710 Physician Support
Polarity Therapy*
5340 Presence
1460 Progressive Muscle Relaxation
5360 Recreation Therapy
8100 Referral
Relationship Counseling*
Reiki*
5424 Religious Ritual Enhancement
4860 Reminiscence Therapy
8120 Research Data Collection
6610 Risk Identification
5370 Role Enhancement
5390 Self-Awareness Enhancement
5400 Self-Esteem Enhancement
4470 Self-Modification Assistance
Self-Reflection*
4480 Self-Responsibility Facilitation
Sexual Abuse Counseling*
5248 Sexual Counseling
Shen Therapy*
6000 Simple Guided Imagery
1480 Simple Massage
6040 Simple Relaxation Therapy
1850 Sleep Enhancement
4490 Smoking Cessation Assistance
5426 Spiritual Growth Facilitation
5420 Spiritual Support
6340 Suicide Prevention
5430 Support Group
5440 Support System Enhancement
7500 Sustenance Support
5604 Teaching: Group
5606 Teaching: Individual
8180 Telephone Consultation
4430 Therapeutic Play
5465 Therapeutic Touch
5450 Therapy Group
5460 Touch
5470 Truth Telling
5480 Values Clarification
Violence Counseling*
1260 Weight Management
Wellness Counseling*

*Not yet recognized by the Nursing Interventions Classification Code.
Note: The numbers represent the numeric code assigned by the Nursing Interventions Classification.
Source: Data from J.C. McCloskey and G.M. Bulechek, Nursing Interventions Classification (NIC), 3rd Edition, © 2000, Mosby.

NIC into the accounting structure. Such a coding system facilitates "instantaneous economic and health outcomes assessments on a per intervention, per practitioner and per state basis." Historically lacking such a system, nursing outcomes, especially in terms of cost, have been embedded in and indistinguishable from medical outcomes. Such codes allow nurses and complementary practitioners to measure, manage, and analyze the delivery of health care in a system that historically only has accounted for conventional physician practices.

The organization of the holistic care plan reflects the priority of identified opportunities to enhance the person's health. Priorities for intervention are based on an assessment of the urgency of the threat to the person's life and safety. The holistic nurse chooses interventions based on utility, relationship to the person's patterns/challenges/needs, effectiveness, feasibility, acceptability to the person, and nursing competency. Holistic nursing interventions reflect acceptance of the person's values, beliefs, culture, religion, and socioeconomic background. Any revision of the care plan reflects the person's current status or ongoing changes. This plan is documented in the person's record.

Implementation

> Holistic nurses prioritize each person's plan of holistic care and holistic nursing interventions are implemented accordingly.[123]

Nurses who are guided by a holistic framework approach the implementation phase of care with an awareness that (1) people are active participants in their care; (2) nursing care must be performed with purposeful, focused intention; and (3) a person's humanness is an important factor in implementation. During this phase the various persons deemed appropriate—the nurse, the person, the family, or another person or agency—implement the planned strategies.[124]

Within the holistic framework, anything that produces a physiologic change causes a corresponding psycho-social-spiritual alteration. Conversely, anything that produces a psychologic change causes a corresponding physio-social-spiritual alteration. Thus, a nurse's encounter with a person, be it for the purpose of talking to the person, touching the person, or taking a blood pressure, produces psychophysiologic outcomes. The encounter changes the consciousness and the physiology of both the nurse and the person. Because human emotions can be translated into physiologic responses, the greatest tool/intervention for helping and healing clients is the therapeutic use of self.[125]

Evaluation

> Holistic nurses evaluate each person's responses to holistic care regularly and systematically and the continuing holistic nature of the healing process is recognized and honored.[126]

Evaluation is a planned review of the nurse–person interaction to identify factors that facilitate or inhibit expected outcomes. Within the holistic caring process, evaluation is a mutual process between the nurse and the person receiving care. Data about the client's bio-psycho-social-spiritual status and responses are collected and recorded throughout the holistic caring process. The information is related to the person's patterns/challenges/needs, the outcome criteria, and the results of the nursing intervention. The nurse, in collaboration with the person during the course of care, may use measures from the NOC to document the effectiveness of the nursing interventions received.

The goal of evaluation is to determine if outcomes have been successful and, if so, to what extent. The nurse, person, family,

and other members of the health care team all participate in the evaluation process. Together, they synthesize the data from the evaluation to identify successful repatterning behaviors toward wellness. During the evaluation, the person becomes more aware of previous patterns, develops insight into the interconnections of all dimensions of his or her life, and sees the benefits of repatterning behaviors. For example, does the person understand that his or her current job and level of stress have a direct impact on the current illness?

The evaluation of outcomes must be continuous because of the dynamic nature of human beings and the frequent changes that occur during illness and health. It may be necessary to develop new outcomes and revise the plan of care. Factors facilitating effective outcomes or preventing solutions to problems must also be explored. The failure to recognize that all measurable outcomes may not be immediate, but are in a process of becoming, is an impediment to evaluation.

Evaluation of the holistic caring process comes full circle with a self-aware appraisal of the entire nursing process by the nurse.[127] The John's model of reflective practice provides a possible script[128] (Exhibit 14–1). From an ecological perspective the evaluation of the holistic caring process extends beyond the level of the person to include the short- and long-term impact on the health care delivery system, the physical environment, as well as the greater social context. The holistic nurse must also reflect upon the greater implications of the holistic caring process for professional practice standards and for health and environmental policy.

CONCLUSION

By definition, any nurse in any setting can practice holistic nursing. The Standards of Holistic Nursing Practice (Appendix 1–A) can be framed in the universal language of the holistic caring process and may easily be combined with other more physiologically based standards, such as those for cardiovascular and critical care nursing. Thus, the Standards of Holistic Nursing Practice can be incorporated into all subspecialty standards of care to ensure not only quality physiologic care, but also quality holistic nursing care to these specialty populations. Table 14–1, which lists nursing interventions central to differing specialty practices, provides an interesting opportunity for speculating about ways in which the holistic nursing perspective may contribute to nursing care in two different practice realms—critical care nursing and psychiatric nursing—thus enhancing nursing practice.

The Standards of Holistic Nursing Practice necessitate the application of a whole new lens to the nursing process. Although standardized language is beneficial for the acknowledgment and documentation of nursing expertise and practice, such labels do not always communicate adequately the person's health situation and need for care. Viewing standardized nursing diagnosis, interventions, and outcomes through a lens of the Standards of Holistic Nursing Practice gives nurses a means to refine and enhance their care as well as a means to describe and document the caring process of nursing.

DIRECTIONS FOR FUTURE RESEARCH

1. Evaluate each nursing diagnosis, nursing intervention, and nursing outcome for compatibility with holistic nursing practice standards.
2. Explore whether writing nursing diagnoses related to holistic nursing standards (e.g., readiness for enhanced nutrition) enhances outcomes.
3. Evaluate the effectiveness and nature of intuitive judgments used by holistic nurses.

Table 14–1 Nursing Interventions and Core Use by Specialty Organizations

American Association of Critical-Care Nurses	*American Holistic Nurses' Association*	*American Psychiatric Nurses' Association*
Acid-Base Monitoring	Active Listening*	Abuse Protection Support
Airway Management	Acupressure	Active Listening*
Airway Suctioning	Animal-Assisted Therapy	Anger Control Assistance
Analgesic Administration	Anticipatory Guidance	Anxiety Reduction*
Anxiety Reduction*	Anxiety Reduction*	Assertiveness Training
Artificial Airway Management	Art Therapy	Behavior Management: Overactivity/Inattention
Cardiac Care	Autogenic Training	Behavior Management: Self Harm
Cardiac Care: Acute	Bibliotherapy	Behavior Management: Sexual
Cardiac Precautions	Body Image Enhancement*	Behavior Modification
Caregiver Support*	Calming Technique*	Behavior Modification: Social Skills
Code Management	Caregiver Support*	Body Image Enhancement*
Conscious Sedation	Cognitive Restructuring*	Calming Technique*
Critical Path Development*	Coping Enhancement*	Cognitive Restructuring*
Decision-Making Support*	Counseling*	Complex Relationship Building
Delegation	Critical Path Development*	Coping Enhancement*
Discharge Planning*	Decision-Making Support*	Counseling*
Documentation*	Diet Staging	Crisis Intervention
Electrolyte Management	Discharge Planning*	Delusion Management
Electrolyte Management: Hyperkalemia	Documentation*	Eating Disorders Management
Electrolyte Management: Hypokalemia	Emotional Support*	Elopement Precautions
Electrolyte Monitoring	Energy Management	Environmental Management: Violence Prevention*
Emergency Care	Environmental Management*	Family Therapy
Emotional Support*	Exercise Promotion	Grief Work Facilitation
Family Involvement*	Family Involvement*	Guilt Work Facilitation
Fluid Management	Health Education	Hallucination Management
Fluid Monitoring	Health Screening	Impulse Control Training
Fluid/Electrolyte Management	Hope Instillation	Limit Setting
Hemodynamic Regulation	Humor	Milieu Therapy
Intravenous (IV) Therapy	Meditation	Mood Management
Invasive Hemodynamic Monitoring	Music Therapy	Physical Restraint
Mechanical Ventilation	Mutual Goal Setting	Play Therapy
Mechanical Ventilatory Weaning	Nutritional Counseling	Reality Orientation
Medication Administration	Physician Support*	Seclusion
Medication Administration: Oral	Presence	Self-Awareness Enhancement*
Medication Administration: Parenteral	Progressive Muscle Relaxation	Self-Esteem Enhancement*
Multidisciplinary Care Conference	Self-Awareness Enhancement*	Substance Use Treatment: Alcohol Withdrawal
Neurologic Monitoring	Self-Esteem Enhancement*	Substance Use Treatment: Drug Withdrawal
Oxygen Therapy	Self-Modification Assistance	Suicide Prevention
Pain Management	Self-Responsibility Facilitation	Therapy Group
Patient Rights Protection	Simple Guided Imagery	
Physician Support*	Simple Massage	
Positioning	Simple Relaxation Therapy	
Respiratory Monitoring	Spiritual Support	
Teaching: Procedure/Treatment	Teaching: Group	
Technology Management	Teaching: Individual	
Visitation Facilitation	Therapeutic Touch	
Vital Signs Monitoring	Touch	
	Truth Telling	
	Values Clarification	

*Interventions in common across two or three disciplines

Source: Data from J.C. McCloskey and G.M. Bulechek, *Nursing Interventions Classification* (*NIC*), 3rd Edition, © 2000, Mosby.

4. Investigate whether incorporating the holistic caring process into practice positively affects subjective and objective client outcomes.
5. Determine the effects of incorporating the holistic caring process into practice on nurse work satisfaction and turnover.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or will begin a process of answering the following questions:

- How am I guided in my everyday life and work by the holistic caring process?
- How do I reconcile what I know about health and healing with whatever beliefs and realities that might be held by the people to whom I give care and by my coworkers?
- How can I systematically begin to apply the holistic caring process in terms of standardized nursing taxonomies for diagnoses, interventions, and outcomes?
- How can I cultivate my intuitive processes?
- How do I react when clients indicate that they are not motivated to change health patterns and behavior?
- How do I feel when I incorporate the principles of holistic nursing into my nursing practice?

NOTES

1. North American Nursing Diagnosis Association, The NANDA definition of nursing diagnosis, in *Classifications of Nursing Diagnosis: Proceedings of the Ninth Conference,* ed., R.M. Carroll-Johnson (Philadelphia: Lippincott, 1991), 65–71.
2. J.C. McCloskey and G.M. Bulechek, *Nursing Interventions Classification (NIC),* 3rd ed. (St. Louis: Mosby, 2000).
3. M. Johnson and M. Maas, The Nursing Outcomes Classification, *Journal of Nursing Care Quality* 12, no. 5 (1998):9–20.
4. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 2003–2004* (Philadelphia: NANDA, 2003).
5. Ibid.
6. American Nurses' Association, *Nursing's Social Policy Statement* (Washington, DC: ANA, 1995), 6.
7. F.R. Kreuter, What Is Good Nursing Care? *Nursing Outlook* 5 (1957):302–304.
8. N.C. Frisch and L.E. Frisch, *Psychiatric Mental Health Nursing: Understanding the Client As Well As the Condition*, ed. L. Keegan (Albany, NY: Delmar Publishers, 1998), 97.
9. C. Varcoe, Disparagement of the Nursing Process: The New Dogma? *Journal of Advanced Nursing* 23 (1996):120–125.
10. H.C. Erickson et al., *Modeling and Role-Modeling: A Theory and Paradigm for Nursing* (Englewood Cliffs, NJ: Prentice Hall, 1983), 103.
11. Varcoe, Disparagement of the Nursing Process, 123.
12. J. Engebretson and L. Y. Littleton, Cultural Negotiation: A Constructivist-Based Model for Nursing Practice, *Nursing Outlook* 49 (2001):223–230.
13. Ibid., 224.
14. Ibid., 230.
15. B.A. Carper, Fundamental Patterns of Knowing in Nursing, *Advances in Nursing Science* 1, no. 1 (1978):13–23.
16. American Holistic Nurses' Association, Position Statement on Holistic Nursing, in *Code of Ethics for Holistic Nurses* (Raleigh, NC).
17. C. Johns, Framing Learning Through Reflection within Carper's Fundamental Ways of Knowing in Nursing, *Journal of Advanced Nursing* 22, (2001):226–234.
18. L.C. Selanders, The Power of Environmental Adaptation: Florence Nightingale's Original

Theory for Nursing Practice, *Journal of Holistic Nursing* 16, no. 2 (1998):247–263.

19. C. Roy, *Introduction to Nursing: An Adaptation Model* (Englewood Cliffs, NJ: Prentice Hall, 1976).
20. Erickson et al., *Modeling and Role-Modeling: A Theory and Paradigm for Nursing*.
21. M. Rogers, *Introduction to the Theoretical Basis of Nursing* (Philadelphia: F.A. Davis, 1969).
22. I. King, *Toward a Theory of Nursing* (Boston: Little, Brown and Company, 1981).
23. M. Leininger, *Cultural Care Diversity and Universality: A Theory of Nursing* (New York: National League for Nursing, 1991).
24. D. Orem, *Nursing Concepts of Practice* (New York: McGraw-Hill, 1980).
25. J. Watson, *Nursing: Human Science and Human Care* (Norwalk, CT: Appleton-Century-Crofts, 1985).
26. R.R. Parse, Human Becoming: Parse's Theory of Nursing, *Nursing Science Quarterly* 5 (1992):35–42.
27. M. Newman, *Health As Expanding Consciousness* (St. Louis: C.V. Mosby, 1986).
28. Watson, *Nursing: Human Science and Human Care*.
29. J.W. Kenney, Relevance of Theory-Based Nursing Practice, in *Nursing Process: Applications of Conceptual Models*, eds. P.J. Christensen and J.W. Kenney (St. Louis: Mosby, 1995), 9.
30. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 2003–2004*.
31. J.C. McCloskey and G. M. Bulechek, *Nursing Interventions Classification (NIC)*.
32. S. Moorhead, M. Johnson and M. Maas, eds., *Nursing Outcomes Classification (NOC)*, 3rd ed. (St. Louis: Mosby, 2004, in press).
33. N.C. Frisch and J.H. Kelley, Nursing Diagnosis and Nursing Theory: Exploration of Factors Inhibiting and Supporting Simultaneous Use, *Nursing Diagnosis* 13, no. 2 (2002):53–61.
34. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 2003–2004*.
35. M. Leininger, *Care: The Essence of Nursing and Health* (Thorofare, NJ: Charles B. Stack, 1984).
36. American Holistic Nurses' Association, AHNA *Standards of Holistic Nursing Practice* (Flagstaff, AZ: AHNA, 2003).
37. B. Dossey et al., Nursing Diagnoses Use and Issues: American Holistic Nurses' Association, in *Classification of Nursing Diagnoses: Proceedings of the Tenth Conference*, eds. R.M. Carroll-Johnson and M. Paquette (Philadelphia: J.B. Lippincott, 1994), 160–166.
38. Engebretson and Littleton, Cultural Negotiation.
39. C.E. Young, Intuition and Nursing Process, *Holistic Nursing Practice* 1, no. 3 (1987):54.
40. C. Jung, *Psychological Types* (New York: Harcourt Brace, 1959).
41. P. Benner, *Novice to Expert: Excellence and Power in Clinical Nursing Practice* (Reading, MA: Addison-Wesley, 1985).
42. M. Polanyi, *Personal Knowledge* (New York: Harper & Row, 1958).
43. Ibid.
44. E.J. Gibson, *Principles of Perceptual Learning and Development* (New York: Appleton-Century-Crofts, 1969).
45. J.J. Gibson, *The Ecological Approach to Visual Perception* (Hillsdale, NJ: Lawrence Erlbaum, Inc., 1986) (First published 1979).
46. J.A. Effken, Information Basis for Expert Intuition, *Journal of Advanced Nursing* 34, no. 2 (2001):246–254.
47. Ibid., 252.
48. B.D. Schraeder and D.K. Fisher, Using Intuitive Knowledge in the Neonatal Intensive Care Nursery, *Holistic Nursing Practice* 1, no. 3 (1987):47.
49. Young, Intuition and Nursing Process, 52.
50. L. King and J.V. Appleton, Intuition: A Critical Review of the Research and Rhetoric, *Journal of Advanced Nursing* 26 (1997):195.
51. Young, Intuition and Nursing Process.
52. Ibid.
53. Schraeder and Fisher, Using Intuitive Knowledge in the Neonatal Intensive Care Nursery.
54. Benner, *Novice to Expert*.
55. P. Benner et al., *Expertise in Nursing Practice: Caring, Clinical Judgment and Ethics* (New York: Springer, 1996).
56. King and Appleton, Intuition: A Critical Review of the Research and Rhetoric.
57. P. Benner et al., From Beginner to Expert: Gaining a Differentiated Clinical World in Critical Care Nursing, *Advances in Nursing Science* 14 (1992):13–28.
58. King and Appleton, Intuition: A Critical Review of the Research and Rhetoric.

59. L. Rew, Intuition in Decision-Making, *Image* 20, no. 3 (1988):150–154.
60. L.A. Ruth-Sahd, A Modification of Benner's Hierarchy of Clinical Practice: The Development of Clinical Intuition in the Novice Trauma Nurse, *Holistic Nursing Practice* 7, no. 3 (1993):10.
61. V.E. Slater, Modern Physics, Synchronicity, and Intuition, *Holistic Nursing Practice* 6, no. 4 (1992):20–25.
62. L. Rew, Intuition: Nursing Knowledge and the Spiritual Dimension of Persons, *Holistic Nursing Practice* 3, no. 3 (1989):60.
63. C.T. Beck, Intuition in Nursing Practice: Sharing Graduate Students' Exemplars with Undergraduate Students, *Journal of Nursing Education* 37, no. 4 (1998):169–172.
64. Young, Intuition and Nursing Process.
65. Rew, Intuition: Nursing Knowledge and the Spiritual Dimension of Persons.
66. Young, Intuition and Nursing Process, 61.
67. Ruth-Sahd, A Modification of Benner's Hierarchy of Clinical Practice, 13.
68. American Holistic Nurses' Association, *AHNA Standards of Holistic Nursing Practice*.
69. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definition and Classification, 2001–2002* (Philadelphia: NANDA, 1999), 1–7.
70. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 1999–2000* (Philadelphia: NANDA, 1999), 149.
71. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 1999–2000*.
72. A.M. McLane, Classification of Nursing Diagnoses: Proceedings of the Third and Fourth National Conference (New York: McGraw-Hill, 1992–1993).
73. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 1997–1998* (Philadelphia: NANDA, 1996), 7.
74. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 1999–2000*, 150.
75. Ibid.
76. North American Nursing Diagnosis Association, *Taxonomy I: Revised* (Philadelphia: NANDA, 1990).
77. C.E. Guzzetta and B.M. Dossey, Nursing Diagnoses, in *Cardiovascular Nursing: Holistic Practice*, eds. C.E. Guzzetta and B.M. Dossey (St. Louis: Mosby–Year Book, 1992).
78. M.D. Mundinger and G. Jauron, Developing a Nursing Diagnosis, *Nursing Outlook* 23 (1975):94.
79. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 1999–2000*, 150.
80. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 2003–2004*.
81. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 1997–1998*, 89.
82. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 2003–2004*.
83. Ibid., 222.
84. Ibid.
85. Ibid., 224.
86. Ibid.
87. Ibid., 225.
88. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 2001–2002*, 219.
89. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 1999–2000*, 150.
90. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 2003–2004*, 105, 125.
91. Ibid., 225.
92. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 1999–2000*, 149.
93. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 2003–2004*.
94. Ibid., 83–84.
95. C.J. Allen, Incorporating a Wellness Perspective for Nursing Diagnosis in Practice, in *Classification of Nursing Diagnoses: Proceedings of the Eighth Conference*, ed. R.M. Carroll-Johnson (Philadelphia: J.B. Lippincott, 1989), 37–42.
96. N.J. Pender, Languaging a Health Perspective for NANDA Taxonomy on Research and Theory, in *Classification of Nursing Diagnoses: Proceedings of the Eighth Conference*, ed. R.M. Carroll-Johnson (Philadelphia: J.B. Lippincott, 1989), 31–36.
97. G.M. Bulechek and J.C. McCloskey, Nursing Interventions: Treatments for Potential Nursing Diagnoses, in *Classification of Nursing Diagnoses: Proceedings of the Eighth Confer-*

ence, ed. R.M. Carroll-Johnson (Philadelphia: J.B. Lippincott, 1989), 23–30.

98. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 2003–2004*.
99. Ibid.
100. Guzzetta and Dossey, Nursing Diagnoses.
101. J. Kelley et al., A Trifocal Model of Nursing Diagnosis: Wellness Reinforced, Nursing *Diagnosis* 6, no. 3 (1995):123–128.
102. Ibid.
103. Frisch and Frisch, *Psychiatric Mental Health Nursing*, 81.
104. N.C. Frisch and J.H. Kelley, Nursing Diagnosis and Nursing Theory: Exploration of Factors Inhibiting and Supporting Simultaneous Use, *Nursing Diagnosis* 13, no. 2 (2002):53–61.
105. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification, 2003–2004*, 248.
106. E.A.M. Barrett, C. Caroselli, A.S. Smith, and D.W. Smith, Power as Knowing Participation in Change: Theoretical, Practice, and Methodological Issues, Insights and Ideas, in *Rogerian Patterns of Knowing,* ed. M. Madrid (New York: National League for Nursing, 1997), 31–46.
107. L. Nagle, A Matter of Extinction or Distinction, *Western Journal of Nursing Research* 21:71–82.
108. Frisch and Kelley, Nursing Diagnosis and Nursing Theory, 61.
109. American Holistic Nurses' Association, *AHNA Standards of Holistic Nursing Practice*.
110. J.C. McCloskey and G.M. Bulechek, Classification of Nursing Interventions: Implications for Nursing Diagnoses, in *Classification of Nursing Diagnoses: Proceedings of the Tenth Conference*, eds. R.M. Carroll-Johnson and M. Paquette (Philadelphia: J.B. Lippincott, 1994), 116.
111. C.F. Capers and R. Kelly, Neuman Nursing Process: A Model of Holistic Care, *Holistic Nursing Practice* 1, no. 3 (1987):23.
112. Guzzetta and Dossey, Nursing Diagnoses.
113. G.M. Bulechek and J.C. McCloskey, Nursing Interventions: What They Are and How To Choose Them, *Holistic Nursing Practice* 1, no. 3 (1987):43.
114. S. Moorhead, M. Johnson, and M. Maas, eds., *Nursing Outcomes Classification (NOC)*, 3rd ed. (St. Louis: Mosby, 2004, in press).
115. American Holistic Nurses' Association, *AHNA Standards of Holistic Nursing Practice*.
116. Guzzetta and Dossey, Nursing Diagnoses, 116.
117. McCloskey and Bulechek, Classification of Nursing Interventions: Implications for Nursing Diagnoses.
118. Bulechek and McCloskey, Nursing Interventions: What They Are and How To Choose Them, 40.
119. McCloskey and Bulechek, Classification of Nursing Interventions: Implications for Nursing Diagnoses, 114.
120. J.C. McCloskey and G. M. Bulechek, *Nursing Interventions Classification (NIC).*
121. N.C. Frisch, Standards for Holistic Nursing Practice: A Way to Think About Our Care That Includes Complementary and Alternative Modalities, *Online Journal for Issues in Nursing* 6, no. 2 (2001): Manuscript 4.
122. Alternative Link, *ABC Codes—Fact Sheet and Talking Points* (Albuquerque, NM: Alternative Link, 2003).
123. American Holistic Nurses' Association, *AHNA Standards of Holistic Nursing Practice*.
124. Engebretson and Littleton, Cultural Negotiation.
125. D. Krieger, *Foundation of Holistic Health Nursing Practice* (Philadelphia: J.B. Lippincott, 1981).
126. American Holistic Nurses' Association, *AHNA Standards of Holistic Nursing Practice*.
127. Engebretson and Littleton, Cultural Negotiation.
128. Johns, Framing Learning Through Reflection within Carper's Fundamental Ways of Knowing in Nursing.

Actualization of Human Potentials

Each of us has the ability to achieve a balanced integration of human potentials: physical, mental, emotions, relationships, choices, and spirit. Effective self-care and self-healing depend on taking all of these potentials into account. We are challenged to gain access to our inner wisdom and intuition and apply them in our daily lives. As we take responsibility for making effective choices and changes in our lives, we place ourselves in a better position to clarify our life patterns, purposes, and processes.

There are several ways to recognize and validate the healing work that we do each day with our colleagues. After the beginning of shift report each day, for example, it may be possible to take a few minutes to share with each other different personal concerns that are in need of healing. One person may say, "When you think of me today, send me energy, because my sister is ill and I'm worried about her" or, "I'm grieving over Sarah's death last week, and my heart still aches." Another idea is to establish a certain time every other week to discuss healing moments that each person has experienced. Someone may have taught a patient a relaxation exercise that significantly reduced her anxiety; someone else may have learned a new technique to manage stress in the workplace. This time together can validate skills and intuition, build trust, and develop a mutual appreciation that will facilitate the healing process in self and others.

An in-service education committee may develop a questionnaire to establish nurses' desires and needs to learn about specific skills necessary to promote healing. Some classes may be on self-nurturing; learning ways to increase skills of presence to serve and share with intention, therapeutic touch, or empowerment sessions.

Actualizing human potentials means first recognizing and then accepting all the potentials of our being, even those we wish to change. Developing our potentials requires a willingness to assess our position in life, to develop an action plan for change, and then to evaluate our new position in a lifelong process.

Chapter 15

Self-Assessments: Facilitating Healing in Self and Others

Barbara Montgomery Dossey and Lynn Keegan

NURSE HEALER OBJECTIVES

Theoretical

- List the six parts of the circle of human potential.
- Define biodance.

Clinical

- Identify specific areas in each potential that can maximize a nurse's effectiveness in clinical practice.
- Seek ways to increase conscious attention to feelings, environment, relationships, life patterns, and processes in clinical practice.
- Use the self-assessment and the circle of human potential as interventions with clients.

Personal

- Tabulate your self-assessment score to determine if you are maximizing your human potential.
- Establish areas that you wish to focus on in order to create changes and choices that lead to new health behaviors.
- Increase your awareness of ways to gain access to your inner healing.

DEFINITIONS

Biodance: The endless exchange of all living things with the earth in which all living organisms participate.

Healing: a process of bringing all parts of one's self together at deep levels of inner knowing, leading toward an integration and balance, with each part having equal importance and value; also referred to as self-healing or wholeness.

Healing Awareness: the conscious recognition and focusing of attention on sensations, feelings, conditions, and facts dealing with needs of self or clients.

Nurse Healer: one who facilitates another person's growth and life process toward wholeness (body-mind-spirit connections), or who assists with recovery from illness or transition to peaceful death.

Process: the continual changing and evolution of one's self through life; the reflection of meaning and purpose in living.

Transpersonal Self: the self that transcends personal individual identity and meaning to include purpose, meaning, values, and unification with universal principles.

Transpersonal View: the state that occurs with a person's life maturity whereby the sense of self expands.

CIRCLE OF HUMAN POTENTIAL

The circle is an ancient symbol of wholeness. As seen in Figure 15–1, the circle of human potential has six areas: physical,

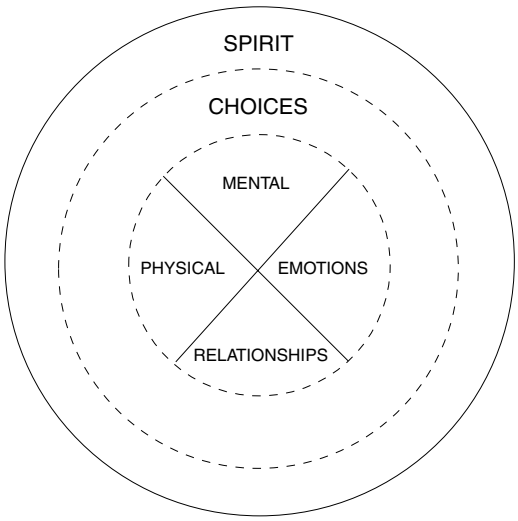


Figure 15–1 Circle of Human Potentials.

mental, emotions, relationships, choices, and spirit. All are important parts of the self that are constantly interacting. When any one part becomes incomplete, the entire circle loses its completeness because all parts are necessary to maintain the whole. When people become aware of their strengths and their weaknesses, they begin to move to their highest capabilities. The area of choices is surrounded by inner and outer dotted circles; these represent the idea that the continually evolving spiritual development of people guides what they consciously and unconsciously choose. Spirit is placed in the outer circle to show that it transcends all of the other dimensions and helps to maximize our human potentials.

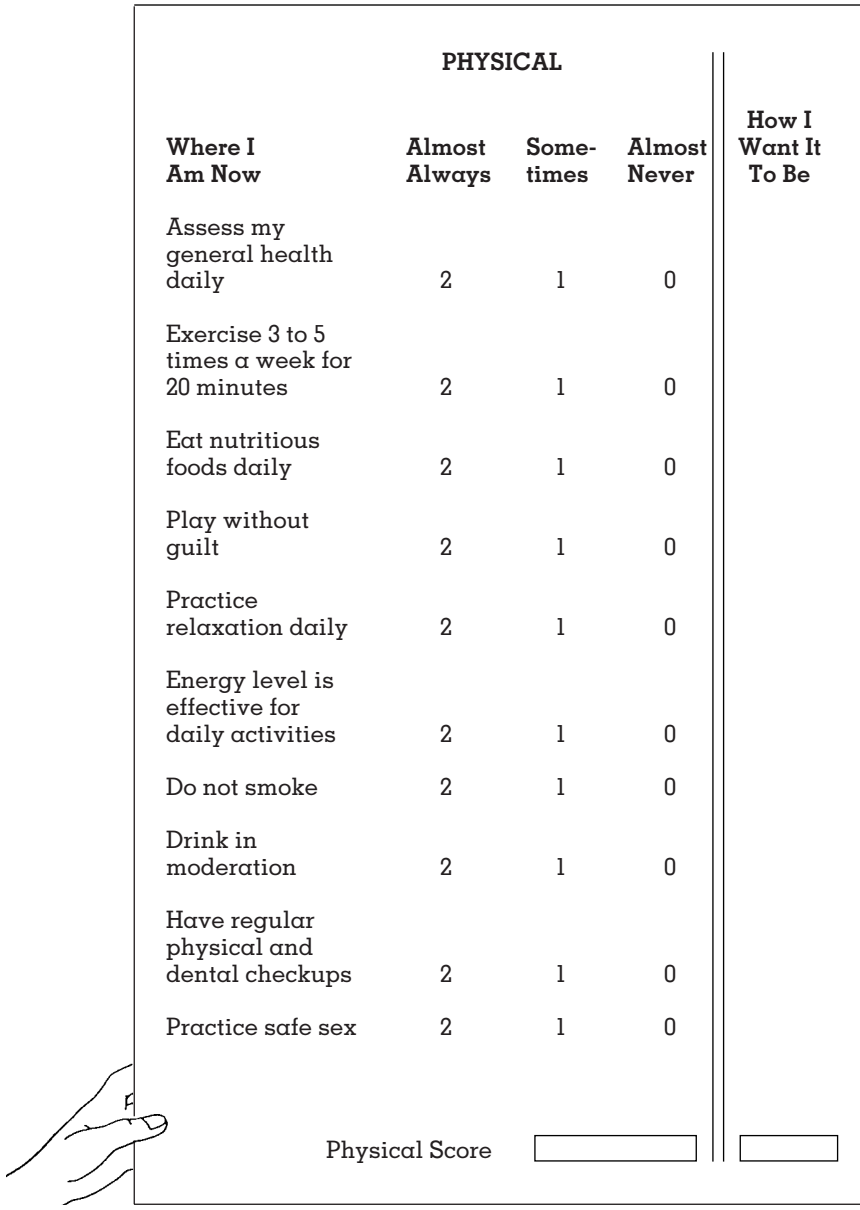
All people are complex feedback loops. As we learn about these feedback loops, we are able to understand our body-mind-spirit connections. Our bodies are in a constant state of change of which we are unaware. Life is a biodance, the endless exchange of all living things with planet Earth in which all living organisms participate. It exists not only as we live, but also as we die. We do not wait until death to make an exchange with planet Earth, for we are constantly returning to the universe while alive. In every living moment, a portion of the 1,028 atoms in our body returns to the world outside. This is another idea of wholeness, which explains why the notion of "boundary" begins to seem an arbitrary idea rather than a physical reality.[1]

Assessing our human potential attunes us to our healing awareness; it is the innate quality with which all people are born. It must be developed in order to be actualized to the fullest. Healing is recognizing our feelings, attitudes, and emotions, which are not isolated, but are literally translated into body changes. Images cause internal events through mind modulation that simultaneously affects the autonomic, endocrine, immune, and neuropeptide systems (see Chapter 6). Everyone has the potential—and choice—to tap into this innate healing potential. When we acknowledge our body-mind-spirit relationships, true healing can occur. Times of stress and crisis in our daily routine can block self-healing. Therefore, it is necessary for us to continually assess and reassess our wholeness.

SELF-ASSESSMENTS

In order to maximize our human potentials, it is important to assess each aspect of our being: physical status, mental status, emotions, relationships, choices, and spirit. The self-assessments in Figures 15–2 through 15–7 help us more clearly identify our current positions in each of these areas.[2] Exhibit 15–1 explains the scoring.

The practice of self-assessment has mushroomed in the past several years as the number of assessment tools has increased and their use has become more common. There are now individualized tools for special interest groups. For example, a recent study provided evidence for



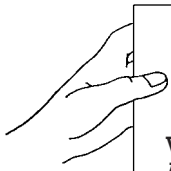
PHYSICAL

Where I Am Now	Almost Always	Some-times	Almost Never	How I Want It To Be
Assess my general health daily	2	1	0	
Exercise 3 to 5 times a week for 20 minutes	2	1	0	
Eat nutritious foods daily	2	1	0	
Play without guilt	2	1	0	
Practice relaxation daily	2	1	0	
Energy level is effective for daily activities	2	1	0	
Do not smoke	2	1	0	
Drink in moderation	2	1	0	
Have regular physical and dental checkups	2	1	0	
Practice safe sex	2	1	0	
Physical Score				

Figure 15–2 Physical Self-Assessment. *Source:* Reprinted with permission from L. Keegan and B. Dossey, *Self Care: A Program To Improve Your Life,* © 2004, Holistic Nursing Consultants.

the reliability and validity of a self-care instrument to measure the self-care component of the Abilities Assessment Instrument for elderly women.[3]

Self-assessments are also successfully used in acutely ill hospitalized patients such as adult COPD dyspnea patients.[4] One study found that a combination of

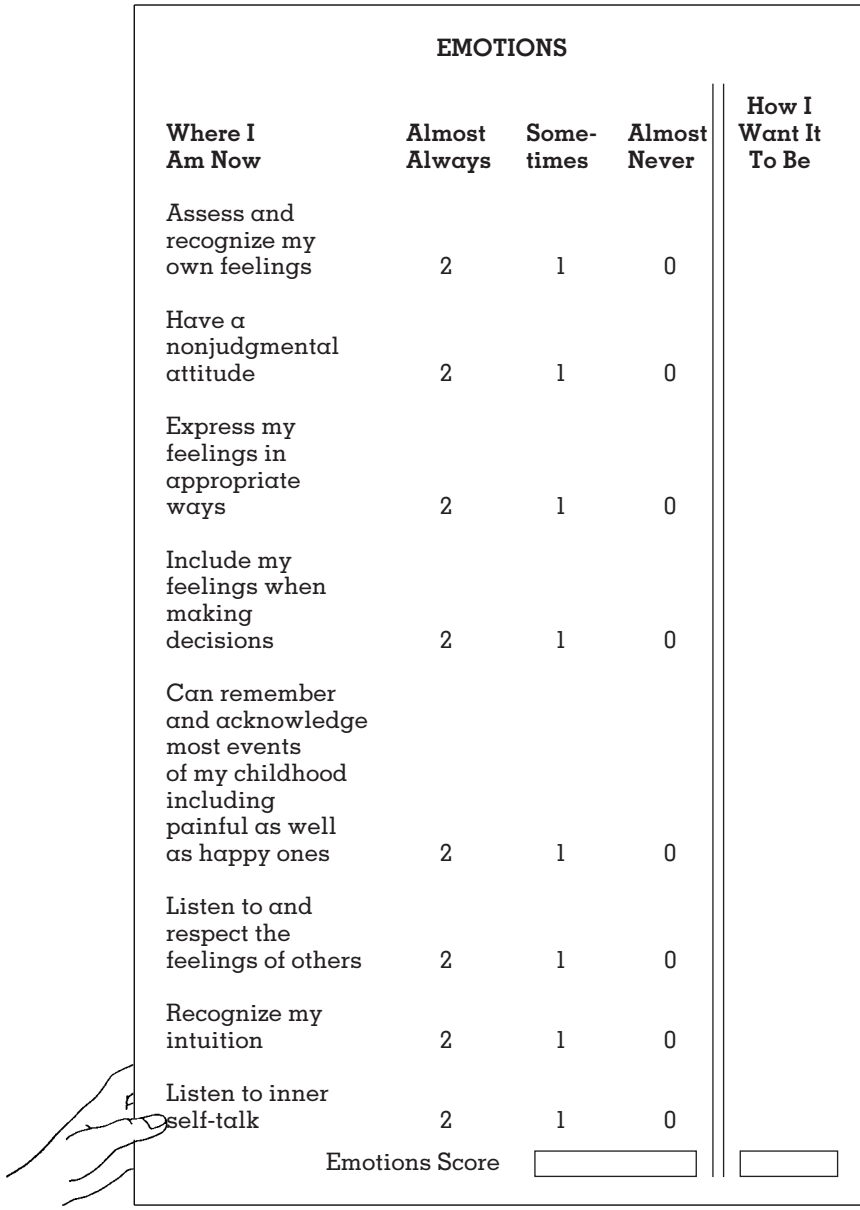


MENTAL

Where I Am Now	Almost Always	Some-times	Almost Never	How I Want It To Be
Am open and receptive to new ideas and life patterns	2	1	0	
Read a broad range of subjects	2	1	0	
Am interested in and knowledgeable about many topics	2	1	0	
Use my imagination in considering new choices or possibilities	2	1	0	
Prioritize my work and set realistic goals	2	1	0	
Enjoy developing new skills and talents	2	1	0	
Ask for suggestions and help when I need it	2	1	0	
		Mental Score		

Figure 15–3 Mental Self-Assessment. *Source:* Reprinted with permission from L. Keegan and B. Dossey, *Self-Care: A Program To Improve Your Life*, © 2004, Holistic Nursing Consultants.

physiologic, clinician, and patient self-assessments can provide a more thorough assessment of a patient's condition. Results indicate that the self-report measures performed as well as, or better than, the physiologic or clinician assessments as predictors of hospitalization. The self-report measures have the added advan-



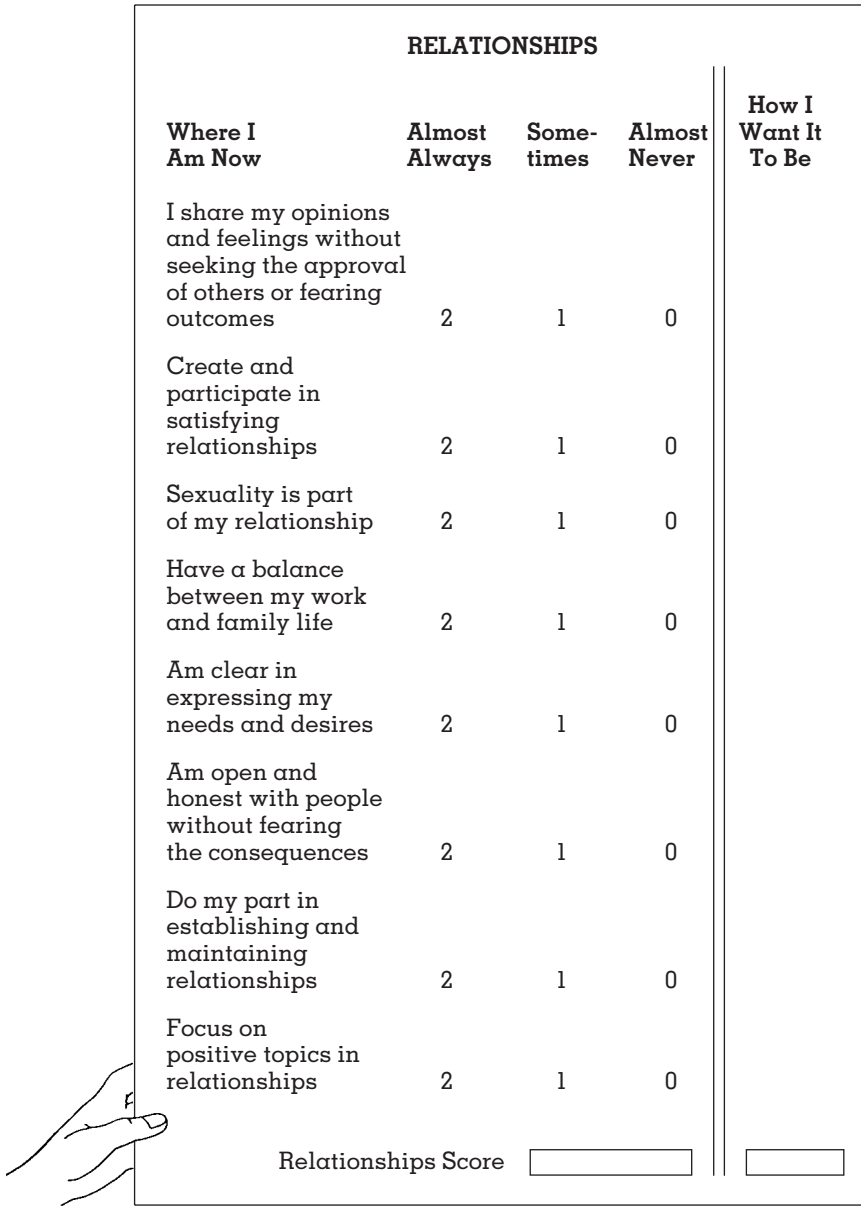
EMOTIONS

Where I Am Now	Almost Always	Some-times	Almost Never	How I Want It To Be
Assess and recognize my own feelings	2	1	0	
Have a nonjudgmental attitude	2	1	0	
Express my feelings in appropriate ways	2	1	0	
Include my feelings when making decisions	2	1	0	
Can remember and acknowledge most events of my childhood including painful as well as happy ones	2	1	0	
Listen to and respect the feelings of others	2	1	0	
Recognize my intuition	2	1	0	
Listen to inner self-talk	2	1	0	
		Emotions Score		

Figure 15–4 Self-Assessment of Emotions. *Source:* Reprinted with permission from L. Keegan and B. Dossey, *Self-Care: A Program To Improve Your Life*, © 2004, Holistic Nursing Consultants.

tage of being inexpensive, noninvasive, and easily obtained, allowing for assessments of change.[5]

Use of self-assessment tools is not limited to the United States. In the United Kingdom, a tool that uses self-assessment items was designed and evaluated for use with cancer patients. It was deemed reliable and represented a valid means of assessing the impact of the disease on

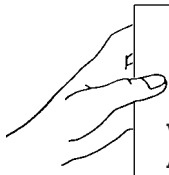


RELATIONSHIPS

Where I Am Now	Almost Always	Some-times	Almost Never	How I Want It To Be
I share my opinions and feelings without seeking the approval of others or fearing outcomes	2	1	0	
Create and participate in satisfying relationships	2	1	0	
Sexuality is part of my relationship	2	1	0	
Have a balance between my work and family life	2	1	0	
Am clear in expressing my needs and desires	2	1	0	
Am open and honest with people without fearing the consequences	2	1	0	
Do my part in establishing and maintaining relationships	2	1	0	
Focus on positive topics in relationships	2	1	0	
Relationships Score				

Figure 15–5 Self-Assessment of Relationships. *Source:* Reprinted with permission from L. Keegan and B. Dossey, *Self-Care: A Program To Improve Your Life*, © 2004, Holistic Nursing Consultants.

patient well-being. Self-assessment was found to be simple to use and straightforward to score and appeared accurately to reflect the patients' general condition.[6] In China, Quality of Life (QOL) recently has become one of the most important focuses in oncology nursing practice and research. The aims of one study were to evaluate the

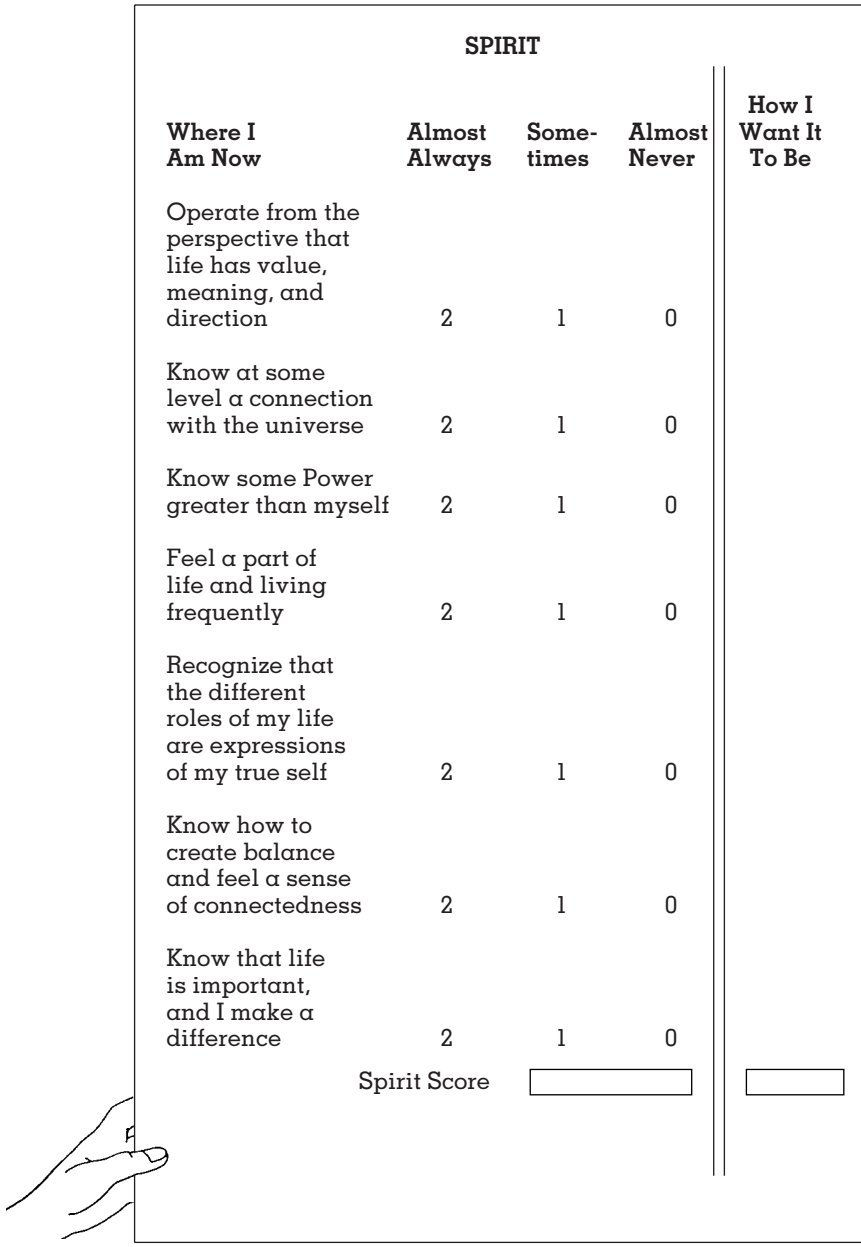


CHOICES

Where I Am Now	Almost Always	Some-times	Almost Never	How I Want It To Be
Manage my time to meet my personal goals	2	1	0	
Am committed and disciplined whenever I take on new projects	2	1	0	
Follow through and work on decisions with clarity and action steps	2	1	0	
Am usually clear on decisions	2	1	0	
Take risks	2	1	0	
Can accept circumstances that are beyond my control	2	1	0	
Take on no more new tasks than I can successfully handle	2	1	0	
Recognize shortcomings of people and events for what they are	2	1	0	
Choices Score				

Figure 15–6 Self-Assessment of Choices. *Source:* Reprinted with permission from L. Keegan and B. Dossey, *Self-Care: A Program To Improve Your Life*, © 2004, Holistic Nursing Consultants.

QOL in Chinese cancer patients under chemotherapy and to explore the discrepancy between patients' and nurses' assessments of the patients' conditions. Findings demonstrated that the nurses in this study tended to estimate the patients' QOL inaccurately, except for a few objective aspects. The results of this study can



SPIRIT

Where I Am Now	Almost Always	Some-times	Almost Never	How I Want It To Be
Operate from the perspective that life has value, meaning, and direction	2	1	0	
Know at some level a connection with the universe	2	1	0	
Know some Power greater than myself	2	1	0	
Feel a part of life and living frequently	2	1	0	
Recognize that the different roles of my life are expressions of my true self	2	1	0	
Know how to create balance and feel a sense of connectedness	2	1	0	
Know that life is important, and I make a difference	2	1	0	
	Spirit Score			

Figure 15–7 Spirit Self-Assessment. *Source:* Reprinted with permission from L. Keegan and B. Dossey, *Self-Care: A Program To Improve Your Life*, © 2004, Holistic Nursing Consultants.

help nurses in planning interventions to enhance the QOL of patients by getting nurses' and patients' assessments that are more closely related.[7] It is important always to cross-verify that the nurses and patient assessment match, and if not, to ascertain why not. In Israel, one study documented that people with intellectual

Exhibit 15–1 Meaning of the Tallied Scores

Scores of 14 to 20
Congratulations! Your score shows that you are aware of the important areas of your life. You are using your knowledge to work for you by practicing good life patterns that reflect health and balance. As long as you continue with high scores, you will be maximizing your human potential. You are a good model of health to family and friends. Since your score is high in this area, move to other areas where your scores are low and identify areas for improvement.

Scores of 10 to 13
Your life patterns in this area are good, but there is room for improvement. Reflect on the "Sometimes" or "Almost Never" answers. What could you do to change your score? Even the slightest change can make a difference to improve the quality of your life.

Scores of 6 to 9
Your life stressors are showing. You need more information about these important life areas and what changes you can make. Read on to obtain guidance.

Scores of 0 to 5
Your life is full of unnecessary stress. You are not taking good care of yourself. You need to take some time and learn the principles of self-care.

When you finish this exercise you have a composite picture not only of where you are now, but where you want to go. ENJOY THE JOURNEY!

Source: Copyright © L. Keegan and B. Dossey.

disabilities also benefit from using self-assessment tools.[8]

DEVELOPMENT OF HUMAN POTENTIALS

Physical Potential

All humans share the common biologic experiences of birth, gender, growth, aging, and death. Once each person's basic biologic needs for food, shelter, and clothing have been met, there are many ways to seek wholeness of physical potential. Many elements influence physical potential; the major ones are physical awareness of proper nutrition, exercise, relaxation, and balance between work and play. Many people have become obsessed with these elements of the physical potential, but have failed to recognize that they are not separate from—or more important than—the other potentials. Health is more than the absence of pain and symptoms; it is present when there is a balance. As we assess biologic needs, we also must take into consideration our perceptions of these areas. Many illnesses have been documented as stress-related because our consciousness plays a major role in health and physical potential.

Our body is a gift to nurture and respect. As we nurture ourselves, we increase our uniqueness in energy, sexuality, vitality, and capacity for language and connection with our other potentials. This nurturance strengthens our self-image, which in turn causes several things to happen: First, our body-mind-spirit responds in a positive and integrated fashion. Second, we become a role model with a positive influence on others. Finally, we actually enhance our general feeling of well-being. It is impossible to gain such strengths or empowerment without these changes being manifest and influencing the lives of other people.

Mental Potential

Early in our lives, we have various role models who influence our thoughts, behaviors, and values. As we mature and gain life experience, shifts occur in our thinking, our behavior, and our values. Conflicts develop when we do not take the time to examine our new perceptions and

discard old beliefs and values that no longer fit.

Our challenge is to create accurate perceptions of the world through our mental potential. Through both logical and nonlogical mental processes, we become interested in a broad range of subjects and expand our full appreciation of the many great pleasures in life. Not only should we increase our awareness of ways to use both logical and intuitive thought, but also we should increase our skills to create better simultaneous integration of both ways of knowing.

With interventions such as relaxation and imagery, we learn to be present in the moment. It is during these moments that we release our critical inner voice that is constantly judging in self-dialogue. These are the moments when we expand our mental knowing. As we increase our openness and receptivity to information and suggestions, mental growth can occur. Every aspect of our life is a learning experience and becomes part of a lesson in changing.

Emotions Potential

Involved in our emotions potential are our willingness to acknowledge the presence of feelings and value them as important, and the ability to express them. Emotional health implies that we have the choice, and freedom, to express love, joy, guilt, fear, and anger. The expression of these emotions can give us immediate feedback about our inner state, which may be crying out for a new way of being.[9]

Emotions are responses to the events in our lives. True healing occurs when we confront both positive and negative intense emotions. Various degrees of chronic anxiety, depression, worry, fear, guilt, anger, denial, or repression result from our failure to confront our emotions. One of the greatest challenges we face is to acknowledge, own, express, and understand our emotions. We are living systems who constantly make exchanges with our environment. All life events affect our emotions and general well-being.

As we become more balanced in living, we allow our humanness to develop. We reach out and ask for human dialogue that is meaningful. Increasing the emotions potential allows spontaneity and a positive, healthy zest for living to emerge. We must be aware of and take responsibility for expression that allows spirit and intuition to flower. It is important to have a consistent harmony between thought processes and emotions, as disharmony causes dissonance.

Emotions are gifts. Frequently, a first step toward releasing a burden in a relationship is to share deep feelings with another. There is no such thing as a good or bad emotion; each is part of the human condition. Emotions exist as the light and shadow of the self; thus, we must acknowledge all of them. They create the dance of life, the polarity of living. The only reason that we can identify the light is that we know its opposite, the shadow. When we see the value in both types of emotions, we are in a position of new insight and new understanding, and we can make more effective choices. As we increase our attention to body-mind-spirit interrelationships, we can focus on the emotions that move us toward wholeness and inner understanding.

Relationships Potential

Healthy people live in intricate networks of relationships and are always in search of new, unifying concepts of the universe and social order. Human beings need to explore and develop meaningful relationships. A healthy person simply cannot live in isolation. In a given day, we interact with many

people—immediate family, extended family, colleagues at work, neighbors in the community, and numerous people in organizations. Because we spend at least half of our waking hours at work with colleagues, we must support and nourish these relationships. We also must extend our networks to include our nation and planet Earth. Each of us must take an active role in developing local networks of relationships that can have a ripple effect on global concerns.

Relationships have different levels of meaning, from the superficial to the deeply connected. The challenge in relationships is to extend ourselves and to learn to exchange feelings of honesty, trust, intimacy, compassion, openness, and harmony. Sharing life processes requires a true interchange between self and others. Only when we increase our awareness and intention can we promote such interchanges with our family, friends, colleagues, clients, and the community at large. As we increase our network from one person to another, the fact that one contact leads to many more extends our boundaries even further.

It is essential that we identify both the cohesiveness and the disharmony in our relationships. We must be aware of the impact that we have on clients, family, and friends. Something always happens when people come together, for life is never a neutral event. Our attitudes, healing awareness, and concern for self and others have a direct effect on the outcome of all our encounters.

Choices Potential

People have an enormous capacity for both conscious and unconscious choices in their lives. Conscious choices involve awareness, and skills such as discipline, persistence, goal setting, priorities, action steps, knowledge of options, and recognition of perceptions. We can enhance our awareness, knowledge, and new skills for living and be active participants in daily living, not passive observers who hope that life will be good to us.

The unconscious also plays a major role in our choices.[10] Jung conceived of the unconscious as a series of layers. The layers closest to our awareness may become known; those farthest away are, in principle, inaccessible to our awareness and operate autonomously. Jung saw the unconscious as the home of timeless psychic forces that he called archetypes, which generally are invariant throughout all cultures and eras. He felt that every psychic force has its opposite in the unconsciousness—the force of light is always counterposed with that of darkness, good with evil, love with hate, life with death, and so on. Jung believed that any psychic energy could become unbalanced and that life's greatest challenge was to achieve a dynamic balance of the innate opposites and to make this balancing process as conscious as possible.

Each of us is responsible for assessing our own values and desires. No one else can make decisions for us. When we do not exercise our ability to make choices, the values of others are imposed on us and we never reach our highest potential. Choice involves taking risks. We may make some mistakes along the way, but we also gain experience.

Continuing to develop clarity in life enables us to meet goals. A simple process for changing behavior is to learn to change perception. Changing all the "shoulds" in our thoughts and actions to "I could, and I have a choice" is a good place to start. For example, "I should be more loving" can become "I could be more loving, and I have a choice." We create more effective choices when we take the time not to be judgmental and to release fears and guilt. We can all change, and it is a skill of awareness to acknowledge that we are worth the effort.

PHYSICAL

- I assess my general health daily.
- I exercise three to five times a week for 20 minutes.
- I eat nutritious food daily.
- I play without guilt.
- I practice relaxation daily.
- I have energy levels effective for daily activities.
- I do not smoke.
- I drink in moderation.
- I have regular physical and dental check-ups.
- I practice safe sex.

EMOTIONS

- I assess and recognize my own feelings.
- I have a nonjudgmental attitude.
- I express my feelings in appropriate ways.
- I consider my feelings when making decisions.
- I acknowledge both happy and painful memories.
- I listen to and respect the feelings of others.
- I recognize my intuition.
- I listen to inner self-talk.

MENTAL

- I am open and receptive to new ideas and life patterns.
- I read a broad range of subjects.
- I am interested in and knowledgeable about many topics.
- I use my imagination in considering new choices or possibilities.
- I prioritize my work and set realistic goals.
- I enjoy developing new skills and talents.
- I ask for suggestions and help when I need it.

RELATIONSHIPS

- I share my opinions and feelings without seeking the approval of others or fearing outcomes.
- I create and participate in satisfying relationships.
- I allow sexuality to be a part of my relationships.
- I have a balance between my work and my family life.
- I am clear in expressing my needs and desires.
- I am open and honest with people without fearing the consequences.
- I do my part in establishing and maintaining relationships.
- I focus on positive topics in relationships.

CHOICES

- I manage time to meet my personal goals.
- I am committed and disciplined whenever I take on new projects.
- I follow through and work on decisions with clarity and action steps.
- I am usually clear on decisions.
- I take risks.
- I can accept circumstances beyond my control.
- I take on no more new tasks than I can successfully handle.

SPIRIT

- I operate from the perspective that life has value, meaning, and direction.
- I know, at some level, a connection with the universe.
- I know some power greater than myself.
- I feel a part of life and living frequently.
- I recognize that the different roles of my life are expressions of my true self.
- I know how to create balance and a sense of connectedness.

Source: L. Keegan and B. Dossey, *Self-Care: A Program to Improve Your Life*, © 2004, Holistic Nursing Consultants.

Spirit Potential

Throughout history, there has been a quest to understand the purpose of human life experience. Humankind is incomplete unless the human condition for transcendence evolves (see Chapters 1, 2, 7, and 10). Spirit comes from our roots—the universal need to understand the human experience of life on planet Earth. It is the vital element and the driving force in how we live our lives. It impacts every aspect of our life choices and the degree to which we develop our human potentials. Spirit involves the development of our higher self, also referred to as the transpersonal self. A transpersonal experience (or transcendence) is described as a feeling of oneness, inner peace, harmony, and wholeness and connection with the universe.[11–16] The meaning and joy that flow from developing this aspect of our human potential allow us to have a transpersonal view. Some of the ways we may come to know this transcendence are through prayer, meditation, organized religion, philosophy, science, poetry, music, inspired friends, and group work.

Like the other potentials, spirit potential does not develop without some attention. Every day, with each of our experiences, we need to acknowledge that our spirit potential is essential to the development of a healthy value system. We shape our perception of the world through our value system, and our perceptions will influence whether we have positive or negative experiences. Even through the pain of a negative experience, we have the ability to learn. Pain can be a great teacher. On the other side of the experience is new wisdom, self-discovery, and the chance for making new choices based on wisdom.

AFFIRMATIONS

As strong, positive statements acknowledging that something is already so, affirmations can help us change our perceptions and beliefs. If we believe an affirmation to be true, our perceptions selectively reinforce it because we change our self-talk. Our mind is constantly engaged in dialogue with ourselves; in fact, the person we talk to the most in a day is the self. Self-talk even operates in our unconscious through dreams while we sleep. Thus, an important way to influence our unconscious is to focus on positive images and affirmations before we drift to sleep and immediately on awakening. Positive images and affirmations also reinforce those things that have meaning and value. They help us in our spiritual development because they move into the deep layers of the unconscious, become part of our myths, and influence our daily lives.

If our thoughts are hopeful and optimistic, our body responds with confidence, energy, and hope. If negative thoughts dominate, however, our body responds with tightness, uneasiness, and an increase in breathing, blood pressure, and heart rate. Affirmations are statements we select to affirm our intentions and choices; they can help us

- identify what is true for us so that the truth can manifest itself in behavior and more options
- clarify goals, take actions, and conduct self-evaluations
- assume more responsibility for our actions, thoughts, beliefs, and values
- envision a new way of being

CONCLUSION

No matter where we are, each of our human potentials affects our whole being. Our challenge in all aspects of our personal and professional lives is to strive to integrate all our human potentials. When we assess our human potentials and decide how we want our lives to be, we evoke meaning and purpose in life. If one area of our human potential is left undeveloped, things do not seem to be as good

as they could be. When one strives to develop all areas, however, a sense of wholeness emerges, one's self-worth increases, and life goals are actualized. Being alive becomes more exciting, rewarding, and fulfilling. Even when frustrations arise, the whole person is able to recognize choices and decrease the barriers to maximizing human potentials.

DIRECTIONS FOR FUTURE RESEARCH

1. Determine if the percentage of desired client outcomes increases when the nurse uses the circle of human potential as an assessment tool and a nursing intervention.
2. Determine if the nurse's self-esteem increases when the concepts of the circle of human potential and affirmations are integrated each day.
3. Determine if the client's self-esteem increases when the concepts of the circle of human potential and affirmations are taught.
4. Evaluate changes in behavior and perceived quality of life when clients learn awareness skills in regard to their human potentials.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- What is my process when I assess my circle of human potentials?
- Am I consciously aware of the daily opportunity to manifest my own human potentials?
- What can I do to increase my conscious awareness of fully participating in living?
- How do I feel when I use the word "healer" to describe myself?
- What is my inner awareness when I acknowledge my healing potential?

NOTES

1. L. Dossey, *Space, Time and Medicine* (Boston: Shambhala, 1982).
2. L. Keegan and B. Dossey, *Self Care: A Program To Improve Your Life* (Port Angeles, WA: Holistic Nursing Consultants, 2004).
3. C.M. Lyle and D.L. Wells, Description of a Self-Care Instrument for Elders, *Western Journal of Nursing Research* 19, no. 5 (1997):637–653.
4. M.M. Heinzer, C. Bish, R. Detwiler. Acute Dyspnea As Perceived by Patients with Chronic Obstructive Pulmonary Disease, *Clinical Nursing Research* 12, no. 1 (2003 Feb):85–101.
5. D.E. Stull, K. Rempher, N. Jairath, and J. Kapustin. The Utility of Multidimensional Assessments of Physical Health in Patient Care, *AACN Clinical Issues* 14, no. 2 (2003):251–60.
6. S. Holmes, and J. Dickerson. The Quality of Life: Design and Evaluation of a Self-Assessment Instrument for Use with Cancer Patients, *International Journal of Nursing Studies* 40, no. 5 (2003 Jul):515–20.
7. H. Zhao, K. Kanda, S.J. Liu, and X.Y. Mao. Evaluation of Quality of Life in Chinese Patients with Gynaecological Cancer: Assessments by Patients and Nurses, *International Journal of Nursing Practice* 9, no. 1 (2003 Feb):40–8.
8. C. Schwartz, and S. Rabinovitz. Life Satisfaction of People with Intellectual Disability Living in Community Residences: Perceptions of the Residents, Their Parents and Staff Members, *Journal of Intellectual Disabilities Research* 47 (Pt 2) (2003 Feb):75–84.
9. L. Keegan, *Nurse As Healer* (Albany, NY: Delmar Publishers, 1994).
10. L. Dossey, *Healing Words: The Power of Prayer and the Practice of Medicine* (San Francisco: Harper San Francisco, 1993).

11. J. Achterberg et al., *Rituals of Healing: Using Imagery for Health and Wellness* (New York: Bantam Books, 1994).
12. T. Moore, *Care of the Soul* (New York: HarperCollins, 1992).
13. P. Burkhardt and M. Nagai-Jacobson, Reawakening Spirit in Clinical Practice, *Journal of Holistic Nursing* 12, no. 1 (1994):9–21.
14. J. Kornfield, *A Path with Heart* (New York: Bantam Books, 1993).
15. L. Dossey, *Recovering the Soul: A Scientific and Spiritual Search* (New York: Bantam Books, 1989).
16. L. Dossey, *Meaning and Medicine: Lessons from a Doctor's Tales of Breakthrough and Healing* (New York: Bantam Books, 1991).

Changing Outcomes

Whatever we focus on expands.

Glenda Lippman[1]

Because our thinking influences the way that we interpret our world, changing our thoughts can change our physical and emotional interaction with society. As clients share their inner dialogue and interpretation of events with nurses, we are allowed glimpses into their distinctive worldview.

Our inner conversation forms a backdrop against which our lives unfold; if it is optimistic and affirmative, our actions and attitudes take on a positive tone. If, on the other hand, the inner conversation is negative and bleak, so follows our behavior, and in some cases, our mental and physical health. Gently helping clients identify discrepancies between their thoughts and reality allows them to bring the world into a clearer focus. By examining the silent dialogue that accompanies every interaction with the outer world—identifying false assumptions, distortions, and misinterpretations—clients can choose to make healthy changes. Sensitive questions, frequent restatement of clients' accounts of their perceptions, and requests for clarification will help guide the nurses and clients on the road to accurate interpretation of events, thoughts, and feelings.

Caregivers should proceed into the inner world of the clients' minds with reverence and respect. We are only guests in that world, and must facilitate healthy redirection with regard for the multitude of unknown stories that contribute to the wholeness of our clients.

NOTE

1. Personal communication.

Chapter 16

Cognitive Therapy

Eileen Stuart-Shor and Carol Wells-Federman

NURSE HEALER OBJECTIVES

Theoretical

- Define cognitive therapy.
- Identify the three main principles of cognitive therapy.
- Discuss the connection between cognition(s), health, and illness.
- Identify four major contributors to the development of cognitive therapy.
- Compare and contrast potential bio-psycho-social-spiritual-behavioral responses to stress and their effects on health and illness.
- Discuss the roles of contracting and goal setting in cognitive restructuring.

Clinical

- Discuss the major diagnoses and health problems that respond favorably to cognitive therapy.
- Describe ways to facilitate cognitive restructuring.
- Identify stress warning signals.
- Describe and identify automatic thoughts.
- Describe and identify cognitive distortions and irrational beliefs.
- Describe a simple model for cognitive restructuring.
- Outline the guidelines for organizing a cognitive therapy session.
- Explore different practice settings in which cognitive restructuring can be used.
- Evaluate client progress toward goals by assessing both short- and long-term goals of therapy.

Personal

- Identify stress warning signals.
- In response to stress: Stop, take a breath, reflect on the cause of the stress, and choose a more healthy response.
- Develop a list of meaningful personal rewards.
- Begin a healthy lifestyles/healthy pleasures journal.

DEFINITIONS

Cognition: the act or process of knowing.

Cognitive: of or relating to consciousness, or being conscious; pertaining to intellectual activities (such as thinking, reasoning, imagining).

Cognitive Distortions: inaccurate, irrational thoughts; mistakes in thinking.

Cognitive Restructuring: examining and reframing one's interpretation of the meaning of an event.

Cognitive Therapy: a therapeutic approach that addresses the relationships among thoughts, feelings, behaviors, and physiology.

THEORY AND RESEARCH

Historically, cognitive therapy is rooted in the treatment of anxiety and depression; however, in the last 10 years its application has broadened greatly. This chapter explores the application of cognitive therapy in the context of nursing practice along the wellness–illness continuum and the bio-psycho-social-spiritual domains. Cognitive therapy is integrated into expert nursing practice in myriad ways that are discussed throughout this chapter. In addition, the unique perspective that nurse-healers bring to the application of cognitive therapy is addressed.

Cognitive therapy is based on the premise that stress and suffering are influenced by *perception*, or the way people think, and postulates that the thoughts which create stress are often illogical, negative, and distorted. These distorted negative thoughts can affect emotions, behaviors, and physiology, and can influence the individual's beliefs. By changing negative illogical thoughts, specifically those that trigger and perpetuate distress, the individual can change physical and emotional states.

In this chapter, to understand the relationship between illogical thoughts that trigger and perpetuate stress and changes in physical and emotional states we draw from the bio-psycho-social model.[1] The dimension of spirituality has been added to Engel's existing model.[2] In this eclectic bio-psycho-social-spiritual model, there is a tacit understanding that stress, or the perception of threat, can lead to changes in physical, emotional, behavioral, and spiritual states. If we accept that stress causes changes in physical and emotional states and is influenced by *perception*, and if we accept that *perception* is influenced by distorted thinking patterns (negative thoughts), then we have created a link between cognitive therapy, which restructures distorted, negative thinking patterns, and mind-body interactions, which influence health and illness. This link has implications for health promotion, symptom reduction, and disease management. Because understanding the dynamic interaction of cognitive therapy and the psychophysiology of mind-body connections is fundamental to the application of cognitive therapy in nursing, it is explored in greater detail later in this chapter.

Cognitive therapy was first used for depression and anxiety, as a short-term treatment that focused on helping people to recognize and change automatic, distorted thoughts that trigger and perpetuate distress.[3] It is now being applied successfully to reduce health-risking behaviors, physical symptoms, and the emotional sequelae of a variety of illnesses to which stress is an important causative or contributing factor.[4] Cognitive therapy is also useful in value clarification, which is the first step in establishing meaningful health goals.[5]

Cognitive therapy has ancient origins. A millennium ago, the Greek philosopher Epictetus described how people most often are disturbed not by the things that happen to them but by the opinions they have about those things. Theorists including Beck,[6,7] Ellis,[8,9] Meichenbaum,[10] and Burns[11,12] have advanced the modern interpretation of cognitive therapy. In the late 1960s, Beck conceptualized cognitive theory as a model to treat depression and anxiety, and developed effective intervention strategies to restructure cognitive distortions and successfully mitigate the symptoms of depression and anxiety. Ellis developed the approach known as Ration-

al Emotive Therapy to recognize and challenge distorted thinking. Ellis was particularly interested in uncovering those beliefs and assumptions that people hold as absolutes, and that provide the lens (or filter of life experience) that causes distortions. Meichenbaum and Burns further enhanced the theory and practice of cognitive therapy through research and clinical experience.

Research on cognitive therapy continues to provide evidence of its broad application to both psychologic and physical health problems. In a 30-year retrospective, Beck provided a comprehensive overview of several important outcome studies. He cited a meta-analysis of 27 studies that demonstrated the efficacy of cognitive therapy in treating unipolar depression and its superiority to other treatment methods, including antidepressant drug therapy. He also referenced five published studies that indicated that the use of cognitive therapy to treat depression is more effective in maintaining gains and preventing relapses than is antidepressant drug therapy. The review cited literature that demonstrates a nearly complete reduction of panic attacks after 12–16 weeks of treatment. Successful application of cognitive therapy to treat generalized anxiety disorder, eating disorders, heroin addiction, and inpatient depression has been reported.[13]

Empirical evidence continues to grow in support of the application of cognitive therapy to treat a wide variety of physical symptoms. Emmelkamp and van Oppen published an overview of the contribution of cognitive approaches to a reduction in physical symptoms and emotional sequelae of hypertension, bulimia, chronic pain, tension headache, acquired immunodeficiency syndrome (AIDS), cancer, and asthma.[14] Other authors have reported its effective use to treat insomnia,[15] infertility,[16] diabetes,[17] coronary artery disease,[18,19] arthritis,[20] hypertension,[21] chronic pain,[22,23] chronic disease,[24] and medically unexplained physical symptoms.[25] In addition to improving health outcomes, cognitive therapy has been shown to be cost effective as an intervention strategy in behavioral medicine.[26]

Effects of Cognition on Health and Illness

Stress (the *perception* of a threat to one's well-being, and the *perception* that one cannot cope) can cause physical, psychologic, behavioral, and spiritual changes. Both cognition (the way one thinks) and perception (the way one views, interprets, or experiences someone or something) are important to an understanding of cognitive restructuring. If individuals change the way they think (cognition), they may change their perception of the situation. And if they change their perception of a situation so that they no longer view that situation as threatening, they may not experience stress. Thus, changing thoughts and perceptions can influence physiologic, psychologic, behavioral, and spiritual processes. The following paragraphs delineate the effects of stress on physical, psychologic, social/behavioral, and spiritual pathways.

Physiologic Effects of Stress

In response to a perceived threat (stress), the body gears up to meet the challenge. This perception of threat (stress) stimulates a cascade of biochemical events initiated by the central nervous system (Figure 16–1).[27] Termed the *fight or flight response*[28] and later the *stress response*,[29] this heightened state of sympathetic arousal prepares the body for vigorous physical activity. Repeated exposure to daily hassles or prolonged stress activates the musculoskeletal system, increasing

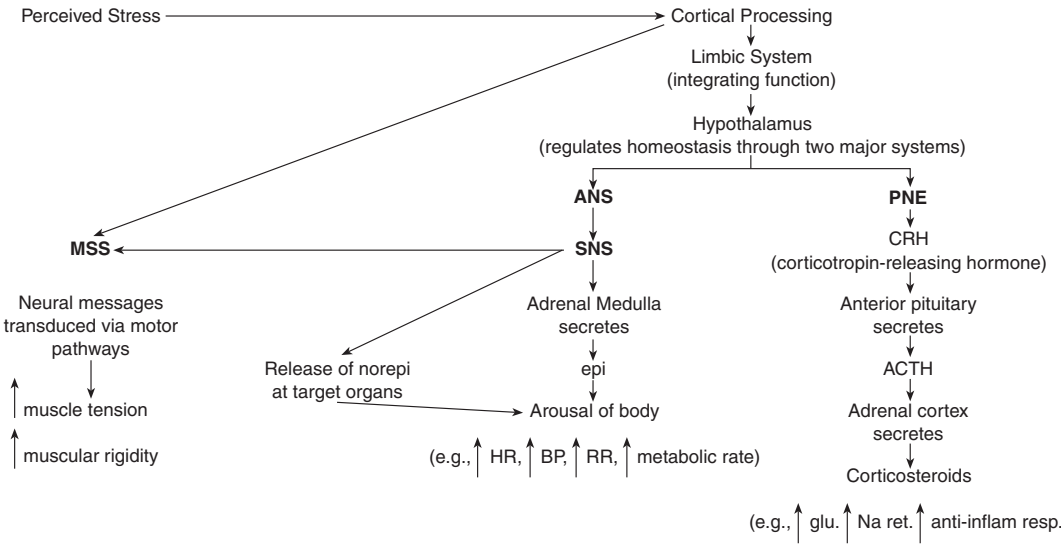


Figure 16–1 Stress Response. ACTH = adrenocorticotropic hormone; ANS = autonomic nervous system; BP = blood pressure; epi = epinephrine; glu. = blood glucose level; HR = heart rate; MSS = musculoskeletal system; Na ret. = sodium retention; norepi = norepinephrine; PNE = pituitary-neuroendocrine system; RR = respiratory rate; SNS = sympathetic nervous system. *Source:* Reprinted with permission from C.L. Wells-Federman et al., *Clinical Nurse Specialist,* Vol. 9, No. 1, p. 60, © 1995, Williams & Wilkins.

muscle tension. Concurrently, the autonomic nervous system, via the sympathetic branch, produces a generalized arousal that includes increased heart rate, blood pressure, and respiratory rate. In addition, there is a heightened awareness of the environment, shifting of blood from the visceral organs to the large muscle groups, altered lipid metabolism, and increased platelet aggregability.[30] The neuroendocrine system, in response to stimulation of the hypothalamic-pituitary-adrenal axis and the secretion of corticosteroids and minerolocorticoids, increases glucose levels, influences sodium retention, and increases the anti-inflammatory response in the acute phase. Over time, however, immune function decreases.[31,32] In addition, levels of other hormones regulated by the neuroendocrine system, such as reproductive and growth hormones, endorphins, and encephalins, can be affected.[33,34]

Prolonged or repeated exposure to stress has been shown to cause or exacerbate disease or symptoms of diseases such as angina, cardiac dysrhythmias, pain, tension headaches, insomnia, and gastrointestinal complaints. This influence is documented in extensive experimental and clinical literature.[35–37] Interestingly, but not surprisingly, Cohen and colleagues found that, under stressful conditions, individuals are more likely to catch the common cold.[38] Stress has been found to influence the development of coronary artery disease in women[39] and to influence slow wound healing in women caregivers of relatives of dementia.[40]

Psychologic Effects of Stress

The psychologic effects of stress are manifested by negative mood states such as anxiety, depression, hostility, and anger. These emotions (mood states) can in turn negatively influence a person's ability to

concentrate and effectively problem solve. In addition, a growing body of research demonstrates the correlation between prolonged negative mood states and increased morbidity and mortality in several diseases.[41,42] The Framingham Heart Study found that, among middle-aged men, anxiety levels measured two decades earlier predicted the occurrence of hypertension.[43] Similarly, Williams and colleagues[44] found that increased measures of hostility at age 18 predicted hypertension at age 45. Depression has been shown to be associated with increased risk for morbidity and mortality, particularly from cardiovascular disease.[45]

Concurrently, a growing body of research supports the importance of managing stress in the treatment of many diseases. Cancer and other diseases of the immune system have been shown to respond to interventions that reduce the stress response, as have arthritis, chronic pain, hypertension, cardiac dysrhythmias, insomnia, premenstrual syndrome, infertility, and the nausea and vomiting associated with chemotherapy.[46–50]

Kobasa[51] detailed the benefits of developing a positive attitude and approach to stress. Individuals with what they described as stress-hardy characteristics who also exercised and enjoyed social support were shown to be less vulnerable to stress-related symptoms and diseases. The characteristics of stress-hardiness are *control*, *challenge*, and *commitment*. For individuals with these characteristics, stress is seen as a *challenge* rather than a threat; they feel in *control* of situations in their lives and are *committed* to, rather than alienated from, work, home, and family. A more recent study[52] found that hardiness moderates the relationship between stress and depression.

Better health has also been associated with an optimistic explanatory style. The link between optimism and health was made by researchers tracking the lives of a group of Harvard alumni who graduated in 1945.[53] They found that individuals who were optimistic in college were healthier in later life, whereas those who were pessimistic were less healthy. By middle age, the pessimists experienced more health problems. A more recent study[54] found that a pessimistic explanatory style is associated with early mortality. It is theorized that a pessimistic explanatory style or attitude, in addition to adversely affecting behavior, may weaken the immune system through a prolonged increase in sympathetic arousal. For example, pessimists have more health-risking behaviors such as smoking, alcohol misuse, and sedentary lifestyle. Recognizing the influence of explanatory style on health and well-being furthers the understanding of how thoughts, feelings, behaviors, and physiology interact.

Social/Behavioral Effects of Stress

In response to stress, people often revert to less healthy behaviors.[55] The *social/behavioral pathway* is best illustrated by appreciating the effect of behavior patterns on the incidence and progression of disease. How and what people eat, drink, and smoke, as well as how they take prescribed or illegal drugs, influences health. For many, stressful events can increase behaviors such as overeating or excessive intake of alcohol. As stress increases, self-control decreases. Lapse to behaviors that provide immediate gratification is more likely when stress is high. This inability to control health-risking behaviors as a result of increased stress is called the *stress-disinhibition effect*.[56]

Behaviors such as social isolation that may be influenced by stress and negative thinking patterns have been shown to be associated with higher morbidity and mortality in the first year after myocardial infarction.[57] Conversely, social support has been found to have a positive effect on health outcome in medical settings. A report by Frasure-Smith and Prince[58] revealed that among patients hospitalized

for myocardial infarction, those receiving social support through nurses' visits after discharge had a significantly lower risk of a second event compared with those in a control group. The authors theorized that positive changes in the emotional state of patients in the experimental group modulated the stress response.

Positive health outcomes in labor and delivery appear to be affected by emotional support as well. The most common surgical procedure performed in the United States is Caesarean section (C-section). Delivery by C-section increases the risk of complications for mother and child, as well as extends the length of their hospital stay. The presence of a supportive woman during labor and delivery has been shown to reduce the need for C-section, shorten labor and delivery time, and reduce prenatal problems.[59,60] The benefits of social support to both the patient's health and the health care system can easily be seen from these studies.

Recent research on programs that influence behavior change have shown positive modification of some of the most widespread diseases. Lifestyle behavior change has been demonstrated to influence regression of coronary artery disease and reduce cardiac risk factors.[61,62] These are only a few of the hundreds of studies that provide continuing evidence of the multidirectional relationships among thoughts, feelings, beliefs, behaviors, and physiology.

Spiritual Effects of Stress

In response to stress, people can become disconnected from their life's meaning and purpose. In *Man's Search for Meaning*, Frankl draws a parallel between connection with life's meaning and survival.[63] He describes the survivors of the World War II concentration camps as being those individuals who were able to retain their sense of meaning and purpose, and to draw meaning and purpose from this experience. A feeling of disconnection, however, in addition to being an effect of stress, can also be a precursor to stress. Several studies have examined the effects of spirituality, defined as connection with life's meaning and purpose, on health.[64–66] Increased scores on measures of spirituality correlated with increased incidence of health-promoting behaviors.[67] Other studies have explored the association between religious affiliation and health and have found a positive correlation.[68–72] This area of study is of considerable interest in the scientific literature today.

COGNITIVE THERAPY

In the preceding pages, a foundation has been established for how cognitions, which are exquisitely sensitive to perception, can influence physiologic, psychologic, social/behavioral, and spiritual processes. Because of this influence, cognitive therapy is an important intervention in optimizing the positive links between mind, body, and spirit and in minimizing the negative consequences of adverse interactions. Cognitive therapy helps individuals reappraise, or reevaluate, their thinking. It is often referred to as *cognitive restructuring* because the intent of the intervention is to change or restructure the distortions in thinking patterns that cause stress. The basic principles of cognitive therapy are:[73–75]

- Our thoughts, not external events, create our moods.
- The thoughts that create stress are usually unrealistic, distorted, and negative.
- Distorted, illogical thoughts and self-defeating beliefs lead to physiologic changes and painful feelings, such as depression, anxiety, and anger.
- By changing maladaptive, unrealistic, distorted thoughts, individuals

can change how they feel (both physically and emotionally).

The goals of cognitive therapy include training clients to

- pinpoint the negative automatic thoughts and silent assumptions that trigger and perpetuate their emotional upsets
- identify the distortions, irrational beliefs, or *cognitive errors*
- substitute more realistic, self-enhancing thoughts, which will reduce the stress, symptoms, and/or painful feelings
- replace self-defeating *silent assumptions* with more reasonable belief systems
- develop improved social skills, as well as coping, communication, and empathic skills[76]

The Process of Cognitive Therapy

Cognitive therapy is a short-term intervention used to help modify habits of thinking that may be distorted, negative, or irrational. In the context of cognitive therapy, cognitive restructuring is an approach, or series of strategies, that helps people assess their thoughts, challenge them, and replace them with more rational responses. Importantly, cognitive restructuring does not deny affliction, suffering, misfortune, or negative feelings. There are many experiences in life where it is appropriate to feel angry, sad, depressed, or anxious. The technique of cognitive restructuring is used to help people experience a broad range of feelings when they become "stuck" in powerful negative mood states.

The nurse-provider serves as a guide in the process of cognitive therapy. Unlike in biomedical interventions, the provider cannot perform this intervention to or for the client, but instead guides the individual to do it for himself or herself. There is no way to predict what will surface during the therapy or what meaning it will have to the individual. The nurse must honor the premise that each individual can best interpret his or her own experience(s), belief(s), and/or distortion(s).

Step I: Awareness

Developing awareness is the first step in a systematic approach to guide clients to a restructuring of their cognitive distortions. Clients are asked to bring to their conscious awareness two things: First, an awareness of how habits of distorted, negative thinking and silent assumptions influence them physically, emotionally, behaviorally, and spiritually. Second, an awareness that a habit pattern (silent assumptions, irrational beliefs, and cognitive distortions) underlies these automatic negative thoughts. To facilitate development of this awareness, a four-step approach is used to explore a stressful situation systematically: Clients are asked to *stop* (break the cycle of "awfulizing," escalating thoughts—become aware that a stress has taken place); *take a breath* (release physical tension, promote relaxation—become aware of physical changes that have occurred in response to stress); *reflect* (realize what is going on—become aware of automatic thoughts, distortions, beliefs, assumptions); and *choose* (decide how to respond—become aware of choices in responding).[77]

Clients are first asked to identify their warning signals of stress. Exhibit 16–1 is a sample form for identifying and recording this information. These cues (or signals) can be physical, emotional, behavioral, or spiritual. When asked to monitor responses to a particular event, clients become more consciously aware of these cues. Exhibit 16–2 is an example of a format for recording this information. Although it may initially increase an individual's perception of physical pain or emotional discomfort, conscious awareness is a necessary first step in recognizing the relationship of thoughts,

Exhibit 16–1 Stress Warning Signals

Physical Symptoms
- ❑ Headaches
- ❑ Indigestion
- ❑ Stomachaches
- ❑ Sweaty palms
- ❑ Sleep difficulties
- ❑ Dizziness
- ❑ Back pain
- ❑ Tight neck, shoulders
- ❑ Racing heart
- ❑ Restlessness
- ❑ Tiredness
- ❑ Ringing in ears

Behavioral Symptoms
- ❑ Excess smoking
- ❑ Bossiness
- ❑ Compulsive gum chewing
- ❑ Attitude critical of others
- ❑ Grinding of teeth at night
- ❑ Overuse of alcohol
- ❑ Compulsive eating
- ❑ Inability to get things done

Emotional Symptoms
- ❑ Crying
- ❑ Nervousness, anxiety
- ❑ Boredom—no meaning to things
- ❑ Edginess—ready to explode
- ❑ Feeling powerless to change things
- ❑ Overwhelming sense of pressure
- ❑ Anger
- ❑ Loneliness
- ❑ Unhappiness for no reason
- ❑ Easily upset

Cognitive Symptoms
- ❑ Trouble thinking clearly
- ❑ Forgetfulness
- ❑ Lack of creativity
- ❑ Memory loss
- ❑ Inability to make decisions
- ❑ Thoughts of running away
- ❑ Constant worry
- ❑ Loss of sense of humor

Do any seem familiar to you?

Check the ones you experience when under stress. These are your stress warning signs.

Are there any additional stress warning signals that you experience that are not listed? If so, add them here.

_____

_____

_____

_____

_____

Source: Reprinted with permission from H. Benson and E.M. Stuart, *The Wellness Book,* p. 182, © 1992, Carol Publishing.

feelings, behavior, and physiology to distorted thinking patterns.

Often, clients have long ignored the cues their minds or bodies give them. Consider the client with disabling headaches who often ignores the shoulder and neck tension that precede his headaches. Had he attended to his early stress warning signs (neck and shoulder tension), he might have avoided the headache. Becoming aware of these stress warning signs is the first step. Attending to the cues is the next. Once they make this connection, clients can much more easily develop skills to reduce negative mood states, unhealthy behaviors, and physical symptoms. To continue with the example above, it is easier to prevent a tension headache—the client notices shoulder tension and stops, takes a few deep diaphragmatic breaths, and gently stretches the area—than it is to wait for the headache to become incapacitating before acting.

> **Exercise:** Ask the client to identify his or her stress warning signals. Then have the client identify a stressful experience and the physical or emotional reaction to this particular experience. For example, after being instructed to stop, take a breath, and

Exhibit 16–2 Challenging Stress and Winning—Stop, Take a Breath, Reflect, Choose

Situation Briefly describe a situation that caused you stress this week.	**Physical Response** Describe how you felt physically in this situation.	**Automatic Thoughts** Write your automatic thoughts in this situation.	**Moods and Emotions** Describe how you felt emotionally in this situation.
Exaggerated Beliefs Write down the exaggerated beliefs behind your automatic thoughts.	**Behavior** Describe how you behaved during or immediately after the situation.	**More Effective Response** Describe how you might think or act differently that would help you cope more effectively.	**Potential Outcome** Describe how this might make you feel and behave.

Source: Reprinted with permission from H. Benson and E.M. Stuart, *The Wellness Book,* p. 245, © 1992, Carol Publishing.

notice the physical and emotional response to a stressful situation, one client related the following:

On my way home from work yesterday I sat in traffic. I noticed that my hands were gripping the steering wheel, my neck and shoulders were tight, and my jaw was clenched. I felt angry and frustrated because I wanted to be home.

Becoming aware of stress warning signals is an important first step. Although this seems very straightforward, the average person often is quite unaware of the effects of stress on the bodymind. Once the client

is aware of the effects of stress, he or she may be able to release tension more easily. Clients build on this awareness as they proceed through cognitive restructuring.

Step II: Automatic Thoughts

Once the client has been able to identify a stress or a stressful situation, and identify the changes in bodymind that accompany this stress, the next step is to identify the automatic thoughts. These thoughts usually occur automatically in response to a situation. Because these thoughts occur automatically and often are not in the conscious awareness of the individual, they are described as knee-jerk responses. Clients are taught a systematic approach to identifying these self-defeating automatic thoughts.

Automatic thoughts have certain characteristics in common. They are

- reflex, or knee-jerk, responses to a perceived stressor
- usually negative
- quick, fleeting, a kind of shorthand (e.g., should, ought, never, always)
- usually not in our conscious awareness
- frequently unrealistic, illogical, and distorted

Because these thoughts form so quickly, it often is difficult to notice that they have occurred. Typically, people attribute the stress they experience or the feeling they have to the person or situation that is causing the stress. By stopping, taking a breath, and asking the question, "What is going on here?" clients gradually become aware that their stress does not always come from an outside event or situation but may come from the way they interpret these events. Automatic thoughts can be viewed as habits of thinking, inner dialogue, or perceptions, which in turn create the experience and influence the individual's physiology, emotions, and behaviors.

> **Example:** A very popular and successful teacher was reviewing the evaluations at the end of the semester. He read 20 very positive reviews. Then he read one that contained some criticism of his teaching style. Instantly he felt a tense sensation in his stomach and chest.
>
> After stopping and taking a breath, he was able to identify the following automatic thoughts: *"there's **always** one in a crowd . . . **ought** to have done (whatever) . . . **never** could teach that concept well . . . **should** have included the new material I saw in the library . . . I **always** come up short."*

Notice that the teacher had an *instant* reaction to this stress (perception of threat) and that his automatic thoughts were quick, fleeting, negative, and probably not in his conscious awareness. (Does he *really* believe he *always* comes up short?) Identifying automatic thoughts is an important step in allowing clients to look realistically at their automatic reaction to a stressor and put it into perspective.

One of the most important and difficult tasks in cognitive restructuring is developing an awareness that these automatic thoughts occur. One reason that these reflex, knee-jerk responses are so pervasive is that the body does not know the difference between things that are imagined and things that are actually experienced. Another reason is that people are always talking to themselves, and after they say something to themselves often enough they begin to believe it. A third reason is that people rarely stop to question their thoughts or emotions. For these reasons, clients need to be taught a structured way of exploring stress and uncovering these automatic thoughts.

> **Exercise to uncover automatic thoughts, feelings, and physical responses** (see Exhibit 16–2)

- **Stop** (break the cycle of escalating, awfulizing thoughts).
- **Take a breath** (release physical tension, promote relaxation).
- **Reflect:**
  — Physically, how do I feel?
  — Emotionally, how do I feel?
  — What are my automatic thoughts (e.g., should, always, ought, never, etc.)?

Step III: Cognitive Distortions

Once clients have learned to identify stressful situations, their physical, emotional, and behavioral responses to stress, and the automatic thoughts that precipitate the experience, the next step in the process is to teach clients to identify distortions in thinking. Cognitive distortions are illogical ways of thinking that can lead to adverse body-mind-spirit states. The problem is not that these thoughts are wrong or bad, but that people hold the beliefs so strongly. Cognitive distortions are based on beliefs or underlying assumptions that are generally out of proportion to the situation. These beliefs or assumptions are usually long-held, are based on life experience, and often are not in one's conscious awareness.

Through years of research and clinical experience, Burns[78] identified ten general categories of cognitive distortions that lead to negative emotional states:

- ***All-or-nothing thinking:*** Viewing things in black or white; considering oneself as a total failure when a performance falls short of perfection. (Think back to the example of the teacher. In the face of 20 excellent evaluations, and one constructive criticism, the teacher immediately focused all his attention on the imperfection and felt anxious and upset. *"I should have taught the course all differently." "I never get a good review."*)
- ***Overgeneralization:*** Viewing a single negative event as a never-ending pattern. *"Fixing my car cost twice what they said it would. All mechanics are dishonest and always will be."*
- ***Mental filtering:*** Picking out a negative detail and dwelling on it exclusively, "catastrophizing" or "awfulizing." *"I got a lousy grade on that test. I'll probably have to drop out of school. I won't be able to find a decent job and will have to move back in with my parents."*
- ***Disqualifying the positive:*** Rejecting positive experiences as if they don't count. *"It was nothing."* Being unable to accept praise. *"You're just saying that because you have to."*
- ***Jumping to conclusions:*** Reading the minds of others or predicting negative outcomes without sufficient evidence. *"He went off to bed without saying anything. He's angry with me for working late again."*
- ***Magnification:*** Exaggerating the importance of mistakes or inappropriately minimizing the significance of one's own assets. *"My performance tonight was horrible—I'll never get the lead part."*
- ***Emotional reasoning:*** Assuming that one's emotions reflect the way things are. *"I feel worthless—I must be worthless."*
- ***"Should" statements:*** Trying to motivate oneself with shoulds and shouldn'ts. *"Good employees should always get to the office early and be willing to stay late."*
- ***Labeling:*** Name calling; labeling oneself a "loser" if a mistake is made; making an illogical leap from one characteristic to a category. *"She's blonde. What do you expect? She's an airhead."*
- ***Personalization:*** Blaming oneself inappropriately as the cause of a negative event; seeing events only in

relation to oneself. "*It's my fault that my child didn't do well in school, because I work.*"

Exaggerated, unrealistic, illogical, and distorted automatic thoughts are a result of deeply held silent assumptions and beliefs that are usually not in one's conscious awareness. A client is more likely to experience stress in any given situation if he or she holds these beliefs as absolutes. Situations that are encountered are far more likely to precipitate stress if the world is viewed in terms of black or white (e.g., all good or all bad) than if there is room for shades of gray. An important understanding for the clinician is that it is not the belief that needs to be examined, it is the degree to which the belief is held. All clients are entitled to their individual sets of beliefs. Assigning value, right or wrong, to their beliefs is not in the nurse's purview. The nurse is simply inviting clients to examine their beliefs in the context of their stress and to assess whether the degree to which they hold these beliefs serves them well or contributes to stress. Clients very easily can be alienated if they feel the nurse is making value judgments about their beliefs. The core concept here is not to examine beliefs to decide whether they are right or wrong, but to decide whether they are practical or impractical. Some commonly held assumptions and beliefs are:[79]

- If I treat others fairly, then I can expect them to treat me fairly.
- I must always have the love and approval of family, friends, and peers to be worthwhile.
- I must be unfailingly competent and perfect in all that I do.
- My worth as a human being depends upon my achievements (or intelligence or status or attractiveness).

Everyone has a right to his or her beliefs and opinions. Problems develop only when these beliefs are held as absolutes and therefore provide no room for flexibility in an imperfect world.

Example: Reflect back on the previous example of the teacher who had a strong reaction to criticism when reading course evaluations.

After taking a breath, interrupting his automatic response, and identifying his automatic thoughts, he was able to identify his cognitive distortions and irrational beliefs. They included *all-or-nothing thinking* (must be perfect all the time), *overgeneralization* (never will get it right), *disqualifying the positive* (20 excellent reviews wiped out by one negative review), and the *belief* that "I must be unfailingly competent and perfect in all I do in order to be loved and/or respected by family, friends, and peers."

Exercise to uncover cognitive distortions (see Exhibit 16–2)

- **Stop** (break the cycle of escalating, awfulizing thoughts).
- **Take a breath** (release physical tension, promote relaxation).
- **Reflect:**
  - — Physically, how do I feel?
  - — Emotionally, how do I feel?
  - — What are my automatic thoughts (e.g., should, always, ought, never, etc.)?
  - — What is going on here?
  - — Is it really true?
  - — Am I jumping to conclusions?
  - — Am I catastrophizing, awfulizing, getting things out of perspective?
  - — Is it really a crisis?
  - — Is it as bad as it seems?

— Is there another way to look at the situation?
— What is the worst that can happen?

Because these strongly held assumptions and beliefs are mostly silent or not in people's conscious awareness, it is a challenge to discover their existence and, consequently, their influence on people's thoughts, emotions, and behaviors. In addition to the systematic approach to explore a stressful situation described above (stop, take a breath, reflect, and choose), another technique that is helpful in discovering underlying assumptions and beliefs is the Vertical Arrow Technique developed by Burns.[80]

Vertical Arrow exercise: Ask the client to identify a stressful situation and to challenge the underlying assumptions in this stress. The client can challenge the assumption by asking the question, "If that is true, why is it so upsetting?"

For example, a nursing school student had severe panic that kept her from speaking up in class. Class participation was 50 percent of the grade, so she wanted to change this behavior. When she was asked why it was stressful to ask a question, the following sequence of thoughts emerged.

"If I speak up, I may say something stupid."
↓
If this is true, why is it so upsetting?
↓
"They will think I'm stupid."
↓
If this is true, why is it so upsetting?
↓
"The smart students won't invite me to join their study group."
↓
If this is true, why is it so upsetting?
↓
"I won't pass unless I'm in a good study group."
↓
If this is true, why is it so upsetting?
↓
"I'll flunk out of school."
↓
If this is true, why is it so upsetting?
↓
"My family and friends will be embarrassed."
↓
If this is true, why is it so upsetting?
↓
"They won't love me."
↓
If this is true, why is it so upsetting?
↓
"I'm unlovable."

Using this vertical arrow technique allowed the student to see how out of perspective her automatic thoughts were. She clearly could see that her stress was influenced by the exaggerated belief that to make a mistake would make her less than perfect, and to be less than perfect was bad and would make people cease to love her. The awareness of this pattern of thinking allowed her to put the situation in perspective and helped her to get past her fear of asking a question.

Once a fear is recognized, it can be approached like any other stressor. If it is

irrational, it can be challenged through cognitive restructuring. If it is rational, then appropriate problem solving and coping strategies are required.

Identifying Emotions. The way people feel emotionally is an important part of health. Feelings of vigor, vitality, and general well-being are important correlates of health; conversely, feelings of anger, hostility, anxiety, or depression can contribute to ill health. Many people find their emotions troubling, either because they are out of touch with them or because they feel overwhelmed by them. Family and cultural influences have a great deal to do with the way emotions are experienced. Many families and cultures do not encourage the expression of emotions, and individuals learn to ignore this aspect of their lives. As individuals become aware of their body-mind-spirit responses to stress by identifying their emotional stress warning signals, they become aware of their feelings and emotions, and the connection between these feelings and emotions and stress.

Feelings of depression, anger, fear, and guilt are all part of the human experience; however, individuals may need to be encouraged to acknowledge and honor these emotions. Emotions are genuine, and people are entitled to the way they feel. On the other hand, emotions—particularly exaggerated emotions—can interfere with effective problem-solving. Individuals need to be guided through the process of recognizing their emotions and the thoughts that underlie these feelings. For example, anger often is perpetuated by thoughts of unfair treatment. Frustration often is the result of unmet expectations. Thoughts related to loss contribute to the feeling of depression, and perception of a loss of control often causes anxiety. It is important to distinguish healthy fear from neurotic anxiety. Thoughts underlying healthy fear are realistic, keep one alert, and warn one of dangers. Neurotic anxiety is related to thoughts that are distorted and unrealistic, and often contain "what ifs": "What if I don't get the job?" "What if I don't find a partner?" A great deal of time and energy are wasted on events that may never take place. The nurse must guide the client in discovering the thoughts that are behind the emotion. In this way, the nurse can facilitate a process of challenging the thoughts and dealing with the emotions.

When feelings are ignored, denied, or suppressed, they often become intertwined with stress. In this case, clients sometimes have difficulty identifying either the emotion or the automatic thoughts related to the emotion. Cognitive restructuring allows individuals to become aware of the emotions, the automatic thoughts related to a particular emotion, and the connection with stress. Reflecting on these underlying themes often helps individuals to explain why they feel as they do and, in turn, to choose a more effective coping mechanism.

Another danger in denying feelings is that individuals can become trapped in one of these emotional states, so that the mind becomes a filter, letting into conscious awareness only material that confirms or reinforces their mood. For example, when people are depressed, they notice and experience only things that depress them more; nothing that would bring joy and pleasure is allowed into their awareness. Through cognitive restructuring, they can learn to reduce the frequency, length, and intensity of these feelings.

Exercise to uncover the relationship of thoughts and feelings (see Exhibit 16–2)

- **Stop** (break the cycle of escalating, awfulizing thoughts).
- **Take a breath** (release physical tension, promote relaxation).

- Reflect (What am I feeling? What am I thinking? Is there a theme that underlies my stress triggers?).

Feeling	Thoughts related to[81]
Anger	Being treated unfairly
Frustration	Unmet expectations
Depression	Loss
Anxiety	Loss of control, fear of the unknown

As an example, consider the situation of a person who is laid off from his or her job. An angry person often views situations through the lens of his or her standard of fairness. In response to being laid off, such a person might be angry and think, "Why me? I've worked hard all these years, never complaining, doing more than I was asked, and this is how they reward me?" A depressed individual often responds with distortions such as all-or-nothing thinking, personalization, and over- generalization. In response to being laid off, such a person might become depressed and think, "This shows what a complete failure I am. I'll never amount to anything." In the same situation, an anxious person might experience an entirely different set of distortions. This person might predict dire consequences (jump to conclusions) and take them as facts. An anxious person who just got laid off might think, "What if I never get a job again? I'll be broke, on the street, and living on welfare in a matter of months."

The nurse helps the client become aware of the relationship of these emotional themes to stress triggers and cognitive distortions. When the nurse guides the client through a stress awareness exercise, if the client identifies his or her emotional response as anger, the nurse helps the client to make the connection with automatic thoughts related to being treated unfairly (e.g., "This shouldn't have happened to me"; "Why me?"; "This is so unfair.").

Because clients often have spent so many years ignoring their emotional cues, they sometimes have difficulty recognizing either the thoughts or the emotions that are related to stressful situations. Keeping a diary or journal reflecting thoughts and feelings about stressful events has been found to be a valuable tool that clients can use to identify automatic thoughts and underlying emotions. (This method will be explained further in the section on coping.[82]) In addition to understanding stressors and common themes that trigger stress, acknowledging and honoring emotions is important to a healthy sense of self. Healthy self-esteem, in turn, is an important ingredient in stress-hardiness, or the ability to greet stressful events as challenges to be met rather than viewing them as threats to be feared.

Step IV: Choosing Effective Coping

The final step in the process of cognitive therapy is to help the client restructure or reframe distortions and beliefs and choose a more effective way of responding or coping. To accomplish this, one must recognize that stressful situations have two components, which Ellis termed the *practical problem* and the *emotional hook*. The practical problem is the situation at hand, or the problem that needs to be addressed. The emotional hook is the client's opinion about the problem or the individual(s) who have caused the problem. Quite often people respond to situations as if they can solve the problem by addressing the emotional

hook. In the following example, note the difference in these two elements of the stress.

> **Example:** John related that he became very upset one day when he was late for an appointment and someone cut in front of him while he was in line at the grocery store.
>
> To cope effectively with this situation, John needed to separate the *practical problem* (getting through the line) from the *emotional hook* (his opinion about people who cut in line and his "right" to be treated fairly). When asked to stop, take a breath, and reflect, he was able to uncover his physical response (tense, tight jaw), his emotional response (anger), his automatic thoughts ("This *always* happens to me"; "People *ought* not to cut in line"; "Late"), and silent assumptions underlying the distorted thinking ("I treat others fairly, and I expect to be treated fairly.").

This example shows clearly that the process of solving the practical problem is quite different from the process of addressing the emotional hook. If John were to expend his energy convincing the person who cut in front of him of the error of his ways, John would be unlikely to solve the problem (he was late and needed to get through the line efficiently). Moreover, in practical terms, John had no control over this other person. How likely was it that John could influence this person's behavior in future situations? Automatic thoughts—shoulds, nevers, always, musts, and oughts—often interfere with finding practical solutions to the problem. The emotional hook robs individuals of their ability to see the options for responding. This failure can make it impossible for clients to recognize when they have no control over a situation and need to concentrate on the practical problem rather than the emotional hook.

In this example, once John recognized how his underlying beliefs and assumptions were influencing his choices, he could take steps to stop the escalation of emotional upset and choose the best solution for the problem. Doing so involved making a decision about how to respond from conscious awareness and without continued emotional arousal. He might see several options. For example, he might choose to change lines or to calmly ask the person who cut in front of him to go to the end of the line (direct action). Or, he might choose just to let it go because, although it is important to be treated fairly, in this instance he was in a hurry, he didn't have the time or desire to deal with this individual, and, because this didn't *always* happen to him, it wasn't worth getting upset about (acceptance, reframing). Whatever the decision, it could be made with awareness and choice, not in reaction to a deeply held belief about how people ought to behave, and without further escalating emotional distress.

Exercise for reframing and problem solving (see Exhibit 16–2)

- **Stop:** Train a client to stop each time a stress is encountered, before thoughts escalate into the worst possible scenario. The simple act of thinking "Stop" can help break a pattern of automatic response.
- **Breathe:** Teach the client to breathe deeply and release physical tension. Physically taking a deep, diaphragmatic breath can be important, because during times of stress, most people hold their breath. Taking a deep breath can elicit the physiologic changes of the relaxation response, the opposite of the stress response. This practice facilitates awareness of stress warning signals and the interaction between stress and body-mind-spirit changes.
- **Reflect:** Teach clients to ask themselves several questions

about the automatic thoughts and underlying beliefs. Is this thought true? Is this thought helpful? (This is the process of developing awareness of automatic thoughts and cognitive distortions and challenging these distorted thoughts, beliefs, and assumptions.)

- **Choose:** Train clients to select the most effective way to cope with and/or solve the problem. Instruct the client to ask a series of questions:
  - —What is the practical problem?
  - —What is the emotional hook?
  - —How can I substitute more realistic, self-enhancing thoughts to reduce the painful feelings?
  - —How can I replace self-defeating silent assumptions (e.g., by substituting "I'm doing the best I can" for "I can't cope with this")?
  - —What do I need?
  - —What can I do?
  - —What do I want?
  - —What is possible?
  - —Do I have the time, skills, and personal investment to achieve a practical solution?
  - —Is the practical problem within my control to solve?
  - —Do I need to temper my emotional response before I can act responsibly, practically, and appropriately?
  - —Am I avoiding the best solution because it will be difficult for me?

Many techniques can be used to help clients effectively problem solve and cope with stressors. Effective coping requires that one attend to both the practical problem and the emotional hook. This sometimes requires two different approaches. Careful thought must be given to each stressful situation in order to choose the most effective coping strategy. The following list suggests a few ways to cope.[83]

Distraction. Worry about resolving a stress can be put off until the time is right. (For example, the client receives a letter from the manager of the bank asking to speak with the client as soon as possible, but it is after closing hours. Distraction involves putting this worry aside until the bank opens the next day, at which time the client can deal directly with the situation. This is quite different from procrastination or denial because it is a necessary delay as opposed to avoidance.)

Direct action. The problem can be dealt with directly to resolve it.

Relaxation. Using relaxation techniques to reduce emotional arousal is a way of coping with a stress that cannot be changed or avoided. Techniques to elicit the relaxation response include meditation, yoga, mindfulness, Tai Chi, as well as many others. Relaxation techniques are covered in Chapter 21.

Reframing. Looking at a situation differently can help individuals cope. A glass filled halfway can be labeled either half full or half empty. This label changes the experience greatly. Illness, for example, can be viewed as catastrophic and life shattering or as an opportunity for reconnection with what is meaningful in one's life.

Affirmations. Positive thoughts can be used to recondition one's thinking. For example, individuals frequently tell themselves they cannot do something, and the statement becomes a self-fulfilling prophecy. Affirmations are a way of countering self-defeating silent assumptions. An

affirmation is simply a positive thought, a short phrase, or a saying that has meaning for the individual. Clients can be coached to create an affirmation as a way of reframing or choosing a more helpful, reasonable belief system.

> **Exercise for developing an affirmation:** Ask the client to choose an aspect of life that is causing stress, such as work, family, or health. Have the client decide what he or she would want to have happen or how he or she would want to feel in the situation. Formulate the goal as a first-person statement, in the present, and in the positive (e.g., "I am confident in my work"; "I can handle it"; "I am peaceful"; "I am becoming healthy and strong"). Have the client repeat the affirmation often during the day, perhaps before or after eliciting the relaxation response or as part of a breathing exercise.
>
> In a short time, affirmations can become second nature and help to enhance self-esteem and reduce stress.

Spirituality. A sense of connection to the universe, God, or a higher power, or connecting with what is important and meaningful in our life, can aid in coping with stress. Connection with life's meaning and purpose is addressed in greater detail in Chapter 5.

Catharsis. Emotional catharsis—either laughing or crying—can be very effective in relieving emotional distress.

Journal Writing. Using a journal to write about thoughts, feelings, and experiences often is helpful in processing emotions. Pennebaker and colleagues found that writing in order to get in touch with one's deepest thoughts and feelings can measurably improve physical and mental health.[84] Suggest to clients that they get a special notebook and colorful pens for their journal. Chapter 17 contains more detailed information on journal writing.

Social Support. Having supportive family, friends, and coworkers is important to effective coping and has been shown to contribute to stress-hardiness.[85] Talking out problems is often helpful to obtain good advice or uncritical support. Social support has been found to reduce the incidence of heart disease as well as other health problems. In the social support literature, it has been noted that both the number of supporters and the quality of the relationships are important.[86]

Assertive Communication. Communication is an important skill to help in solving problems and reducing conflicts and stress. Although communication is addressed in Chapter 11, it is considered in some detail here because it is an important coping and problem-solving skill that can be adversely affected by deeply held beliefs and silent assumptions. Cognitive restructuring can influence the ability to communicate effectively and, in turn, improve coping.

People who have difficulty with communication usually experience the following problems:[87]

- disparity between what they say (statement) and what they want (intent)
- confusion about or resistance to stating clearly how they feel, what they want, or what they need (assertiveness); there is either a tendency to deny their own feelings (passiveness) or to be indifferent toward the feelings of others (aggressiveness)
- inability to listen

The importance of matching the statement with the intention is illustrated in the following example.

> **Example:** After spending a long day at work and stopping to pick up some groceries at the store, Jill arrives home to find her husband Jack at his desk in his office going over some bills. Coming in the door, she remarks, "Wow, busy day. I just picked up some groceries." She begins bringing the bags of groceries into the kitchen, walking past him. Following each trip to the garage, she shuts the door a little more forcefully and sets each bag down a little more loudly as Jack continues to sit at his desk.
>
> When he finally says, "Anything wrong?" Jill answers, "Nothing!" and storms out of the room, feeling that, if he loved her, he would know what she needed and wanted.

The first principle of effective communication is to be clear about what one wants and needs (intent) in statements to others. Although it would be wonderful if spouses, friends, and others were mind-readers, assuming that they are does not help with communication. Matching statements with intentions is both an art and a skill. It requires that individuals recognize their automatic thoughts, emotions, and cognitive distortions and take responsibility for their part of the conversation.

Consider the above example. If Jill's *intention* was for her husband to help bring the groceries into the house, then her *statement* should have reflected this. She might have said, "Wow, what a busy day. I just picked up some groceries. Could you help me bring them into the house?" Clients must understand that the other person is not obligated to respond as they would wish. However, what they are asking for will be a lot clearer to others if the statement reflects the intent.

The next principle of effective communication is to be assertive.[88] In most cases, assertive communication is the most effective way to communicate. An assertive statement expresses one's feelings and opinions and reaffirms one's identity and rights. It is not judgmental. The general format of an assertive statement is, "I feel (label the emotion) when you (label the behavior) because (provide an explanation)." The formula requires that all three elements be included. Cognitive restructuring facilitates assertive communication because it requires clients to identify their thoughts and feelings. In the example above, Jill would

- **Stop** (break the cycle of escalating, awfulizing thoughts).
- **Take a breath** (release physical tension, promote relaxation)
- **Reflect:**
  - —Emotionally, how do I feel? (frustrated)
  - —What are my automatic thoughts? ("If he loved me, he would get up and help me! He never helps me with the house. He always expects me to do everything around here. He doesn't care about me. He's never going to change.")

Recognizing her thoughts and feelings would help Jill to formulate an assertive statement when her husband asks, "Anything wrong?" She could then say, "I feel *frustrated* (emotion) when you *don't help me bring in the groceries* (behavior) because *if you cared for me you would help me more with the chores around the house* (explanation)." In this way, she would both have made her feelings clear and have explained why she felt that way. This, in turn, would have provided a better opportu-

nity to work on problem solving. If clients cannot articulate both their feelings and their needs, they leave it up to others to figure them out. When others fail to do so correctly, the clients feel let down and blame others for not understanding. The nurse can help clients to recognize that they have a right to speak up and a responsibility to do so in an assertive rather than passive or aggressive way. The nurse can guide clients in matching their emotions with the explanation (e.g., frustration = unmet expectation) by reviewing the exercise on matching thoughts and emotions as in the preceding example. Clients should be reminded that this technique will feel awkward and uncomfortable at first. They may have to practice it many times before communications improve. Other people need time to adjust to the changes they are trying to make. Effective communication takes practice, as well as patience, with oneself and with others.

Empathy. Empathy is the ability to take into consideration the other person's perspective. It is an effective coping technique because it facilitates communication. It helps clients become better listeners.

> **Exercise to promote empathy:** Empathy can be facilitated through active listening. This technique requires conscious, non-judging awareness. It helps to clarify the issues involved and can de-escalate many emotional exchanges. Consider a situation in which the mother announces to her teenage child, "I can't stand this room anymore. It's a mess." The response to this statement may be critical to resolving the issues without contributing to further miscommunication and escalating the problem. Instead of becoming hooked by a defensive emotional reaction, clients can learn to operate from empathy using the four-step approach:
>
> - **Stop** (break the cycle of escalating, awfulizing thoughts).
> - **Take a breath** (release physical tension, promote relaxation).
> - **Reflect:**
>   - —Emotionally, how do I feel? (hurt, angry)
>   - —What are my automatic thoughts? ("How could she say that? I work hard, too. I'm always being blamed for how things are around here. No one understands kids.")
>   - —What are the thoughts and emotions being expressed by the other person? (The simple practice of asking this question provides a very different perspective as the client begins to formulate a response).
> - **Choose:**
>   - —My feelings are hurt, but I choose not to react defensively.
>   - —I choose to listen actively to the other person's response and will try to understand that person's perspective, using this phrase: "You sound (emotion) about (situation)."
>
> Rogers suggested using this last phrase as a way to facilitate communication and gain awareness of another person's perspective.[89] In the above scenario, the teenage child might say, "You sound *upset* about the *messy house*." Possible responses from the mother might include: "It's not just the room, everything seems to be in a mess, here and at the office. I can't seem to get anything done." Or she might say, "You're right about that. I hate coming home to a messy house after a busy day."

When a client uses the skill of active listening, the other person often feels heard, which may help to defuse further emotional arousal and defensive behavior. In addition, he or she now has an opportunity to clarify any misunderstanding. Also, active listening allows the client to buy time to obtain a better perspective on what the other person is thinking and feeling. Clients can then choose how they want to respond. This may be a time to use assertive communication or problem-solving, or a time to step away from the interaction until emotions and defenses have settled. Active listening allows reflective, empathic, objective, and nonjudgmental communication. Coaching clients to use cognitive restructuring skills that include active listening techniques facilitates effective communication, in turn reducing conflict and stress.

Acceptance. Acceptance is facing the fact that some situations or people cannot be changed or avoided, and letting go of resentment. Forgiveness is often a part of acceptance. Coping successfully means gaining the wisdom to achieve the delicate balance between acceptance and action, between letting go and taking control. It is the art of choosing the right strategy at the right time.[90]

When clients feel that they can cope effectively, the harmful effects of stress are buffered. The situation is perceived not as a threat but as a challenge. This subtle difference has profound physiologic, psychologic, behavioral, and spiritual effects. It is what allows people facing great adversity (such as illness) to see the opportunity the situation presents. Above all, as noted above, clients need to recognize that coping is the art of finding a balance between acceptance and action, between letting go and taking control. Cognitive restructuring helps clients distinguish these differences by providing a format for observing or objectifying their experiences. In so doing, they gain a sense of control that minimizes or buffers the harmful effects of stress.

Application of the General Principles of Cognitive Therapy

Cognitive therapy is most useful for individuals, not for relationship problems or interpersonal conflict.[91] The nurse must be imaginative and tenacious. Cognitive therapy requires constant shifting between technique and process. The therapy combines problem resolution using cognitive and behavioral techniques with empathic focus on the client's feelings. The process requires the skills of presence, intention, and communication. Several attempts and several different ways of looking at a situation may be required before a client recognizes the automatic thoughts and underlying beliefs involved.

Cognitive therapy can be used in both inpatient and outpatient settings, but the goals and process are different. The goal of cognitive therapy in the outpatient setting generally is to restructure cognitive distortions to enhance a variety of self-management skills and healthy lifestyle behaviors, which in turn help to promote health, reduce symptoms, or manage illness. Outpatient cognitive therapy can be provided either individually or in a group. The majority of this chapter has been written for this application.

The goal of cognitive therapy in the inpatient setting is typically confined to assisting the patient to cope more effectively with those stresses that arise during hospitalization for an acute illness. In this context, the nurse must remember that he or she is viewing the patient from a cross-sectional perspective (through one episode in the continuum of the patient's life). Patients bring to this hospital experience a reliance on long-standing coping

styles—some adaptive, some maladaptive, and many influenced by cognitive distortions. In view of the short hospital stay and critical needs during this time, long-standing maladaptive coping patterns are best left to be addressed after discharge from the hospital.

In the hospital, cognitive therapy can be integrated effectively into the many nurse–patient communications that occur each day. Each interaction can be an occasion to assist patients in identifying the relationship of thoughts, feelings, and behaviors to biology as it applies to their current symptoms and illness. The nurse can utilize the structure of cognitive therapy to assist the patient in identifying distorted thinking patterns and realistically appraising the situation as well as in seeing opportunity in adversity. Thus, the patient often can choose a more realistic and less stressful way to view the situation. This, in turn, can decrease physical and emotional symptoms.

Hospitalization can be a time of opportunity, despite its difficulties. Because hospitalization usually occurs when individuals are in need or crisis, they often feel vulnerable and may be more open to exploring different ways of thinking. In addition, they may be more open to discussing the role that negative thoughts, pessimism, and stress play in their illness, or the role that enhanced self-management skills would play in promoting wellness. For this reason, the inpatient stay offers multiple opportunities for the nurse to integrate cognitive therapy. Such integration can help establish a plan of care that is congruent with the patient's core values and beliefs. In one study, patients reported that the social support offered by nursing staff (organized around cognitive restructuring) was an important factor in their ability to successfully modify adverse lifestyle behaviors.[92]

HOLISTIC CARING PROCESS

Assessment

In preparing to use cognitive therapy interventions, the nurse assesses the following parameters:

- the client's ability to monitor and appraise inner dialogues and to communicate effectively
- the client's perception of the problem and the degree to which the client wishes to change a thought or behavior
- the client's ability to identify stress warning signals
- the client's readiness for and openness to changing thoughts or behaviors
- the client's level of experience with each of the interventions to be used

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with cognitive therapy that are related to the 13 domains of Taxonomy II (see Chapter 14).

- Altered verbal/nonverbal communications
- Altered, actual, or potential; Impaired social interaction; social isolation; altered parenting
- Altered coping; ineffective individual and family
- Altered self-concept: disturbance in self-esteem, body image, role performance, personal identity
- Altered thought processes
- Anxiety, fear

Outcomes

- Long-term goals (outcomes) are established prior to therapy, and short-term goals are set prior to each session.

- Goals are set with the client and must be mutually acceptable. A contract may be established to monitor progress and promote adherence.
- A general list of optimal cognitive therapy outcomes includes the following. The client will be able to:
  - —recognize connections among cognition, emotions, behaviors, and physiology
  - —identify physical, psychologic, and behavioral stress warning signals
  - —demonstrate the ability to recognize cognitive distortions and examine the evidence for and against key beliefs
  - —change the way that he or she thinks (views situations) and try alternative conceptualizations or more rational responses independently
  - —report a decrease in arousal, anxiety, fear, depression, or somatic complaints and an elevation in self-esteem after correcting cognitive distortions

Setting Goals

It is important to establish clearly defined desired outcomes that are mutually agreed upon by both client and nurse prior to beginning cognitive therapy. These mutually agreed-upon outcomes form the basis for establishing short- and long-term goals. Clients are more likely to accomplish goals if they play an integral role in establishing them. As clients assume more responsibility for their health and become more active partners with health care providers, the nurse must respect their input to maximize successful outcomes. Goals should be specific, concrete, and measurable; in addition, they should be achievable.

The process of establishing outcomes should take into account the client's

- beliefs about health and illness (i.e., health belief model)
- experience with healthy behaviors (i.e., health behaviors)
- self-awareness, self-monitoring (i.e., self-efficacy theory, self-regulation theory)
- stage of change and readiness to change (i.e., change theory, the transtheoretical model)
- motivation to change (i.e., the dynamics of motivation)
- understanding of the relationship between illness/wellness and behavior (i.e., dynamics of health-wellness–disease-illness)
- preferences (i.e., client rights)
- attitudes, beliefs, and values

Goal setting is a dynamic process that involves both the client and the nurse at each level. The nurse can facilitate this process by:

- Accumulating a complete bio-psychosocial-spiritual database that is appropriate to the setting and diagnosis.
- Identifying and prioritizing challenges to be addressed.
- Setting mutually agreed-upon short- and long-term goals.
- Helping clients clarify goals. This involves asking clients to determine what is important and meaningful to them. Suggest that they focus on those things that sustain meaning and purpose in their lives. Focus on goals that allow them to achieve rewards from health rather than from sickness. Encourage clients to challenge themselves when their behaviors are not congruent with what is important and meaningful to them. For example, when a client with a high cholesterol level eats high-fat foods, have them contrast that behavior with what is meaningful to them

(e.g., family). The cost-benefit is usually clear and places the responsibility for the behavior with the client, not the provider. Asking the following questions may help clients clarify long-term goals:
  - What is most important and meaningful in your life?
  - What would you most like to change about your life right now?
  - How can you begin the first step in that change?
  - On what date would you like to achieve that goal?
  - How can you reward yourself for success?
  - How will your life be different when you succeed?
  - How can I help?
- Using the 2 × 50 rule when setting goals. Ask the client to state the goal, then double the amount of time set for accomplishing the goal or reduce its difficulty by 50 percent. For example, losing 10 pounds in the next month is probably an unrealistic goal; losing 10 pounds in 2 months or losing 5 pounds in the next month is probably a more realistic, attainable goal. Smaller, more attainable goals create a sense of achievement, build self-esteem, and foster enthusiasm to set further goals.
- Establishing a health contract. A health contract is a formal way to enhance goal attainment. It is a way to increase the quality of communication between client and nurse and also can help a client become a more willing participant in self-care. The client's failure to achieve the goals of the contract opens the door to further discussion of the reasons for difficulties with compliance and ways of modifying behavior(s) to achieve a mutually agreed-upon goal.
- A successful contract includes more than simply a list of behavioral goals. Successful attainment of goals depends on skills the client learns during the process of developing the contract. This process provides the opportunity to analyze behaviors in relationship to the environment and to choose strategies that facilitate learning, changing, or maintaining a behavior.[93]
- Contracts may be verbal, but all parties are likely to take written contracts more seriously. If a contract is written, both the client and the nurse should sign it. Contracts should always contain the following key elements:
  - a desirable, concrete, attainable, measurable goal
  - a time for completion as well as identified times to evaluate progress toward goals
  - the responsibilities of involved parties (e.g., client and nurse, client and spouse)
  - an identified reward for achieving the stated goal
- Some clients find the word *contract* threatening or uncomfortable. In this case, the contract may be referred to as an agreement or a statement of mutual goals. In establishing a contract, the nurse assumes the role of facilitator. The nurse introduces the concept of contracting and identifies the reasons that such an approach may be valid in the client's circumstances. After this, the nurse may limit his or her involvement to guidance and support. The greater the client input, the greater the likelihood that the client will achieve the goal of the contract. The contract should identify small, achievable steps to facilitate reaching the desired goals. In this way, the client is more likely to succeed.
- Assisting the client in identifying rewards for achieving a goal. Re-

wards can enhance goal attainment, but often clients find it difficult to identify appropriate rewards. Many people feel uncomfortable rewarding themselves and fail to realize that rewards are important in both learning and maintaining new behaviors. Rewards should be congruent with the difficulty of the goal set. The reward need not cost money or even be tangible. Ideally, as clients gain confidence and independence in self-management, they learn to self-reward.

Therapeutic Care Plan and Interventions

Before the Session

- Establish a therapeutic relationship by creating a space in which both you and the client feel physically and emotionally safe and comfortable.
- Provide materials for recording cognitive distortions and alternative rational thoughts and statements (e.g., paper and pen, blackboard, preprinted forms).
- Center yourself; clear your mind of personal or professional issues in order to be fully present.
- Establish the long-term goals (outcome) of therapy with the client.

At the Beginning of the Session

- Assess the client's level of mood, discomfort, or relaxation.
- Review homework from the previous session, if appropriate. Ask the client to describe any changes that have occurred since the previous session.

During the Session

- Determine, with the client, which issues need to be addressed and set short-term goals for the session.
- Listen and guide with focused intention. Provide appropriate feedback, clarification, support, or interpretation.

At the End of the Session

- Have the client identify and verbalize changes that have occurred during the session. Assess progress toward goals.
- Assign homework to be done for the next session.
- Schedule a follow-up session.

Case Study

The same process that has been discussed throughout this chapter can also be used in an acute situation as seen in the following case study. The nurse can respond to this potentially urgent situation while gently guiding the patient through the following exercises.

Setting:	Coronary Care Unit
Client:	E.C., a 43-year-old man
Patterns/ Challenges/ Needs:	Altered comfort related to chest pain. Anxiety related to acute illness

- **Stop:** Break the cycle of escalating, awfulizing, negative automatic thoughts. "*I need you to stop and focus on letting go of the worry cycle. If we work together, we will get the best outcome. We have things under control, and I want you to let me worry about the technical things that need to be done. I want you to . . .*"
- **Breathe:** Release physical tensions. "*Focus on your breathing and leave the rest to me. Take nice, slow breaths, in and out. Concentrate on letting go of tension in your hands, jaw, and feet. Put all of your effort into feeling your fingers and toes, and let the jaw be relaxed and easy. Do*

you still feel tension somewhere in your body? If so, begin to relax that area. With each breath in, breathe in relaxation; with each breath out, breathe out tension. Now, begin to think about a favorite place and, as you breathe in, feel the peace of that place fill you; as you breathe out, let the worries and tension of the moment flow out."

The nurse guides the person through this relaxation/distraction exercise as he or she proceeds to treat the patient's chest pain. Obviously, it is not in the client's best interest for the nurse to stop what he or she is doing; rather, this skill needs to be such an integral part of the nurse's practice that it can be done while technologic tasks are performed. Empathic communication, presence, and touch enhance the process.

The next steps occur after the acute situation is over. "Tidying up" might be useful as a metaphor for dealing with the feelings that probably emerged in the patient. To continue with the chest pain example, the nurse guides the patient through the remainder of the cognitive restructuring steps:

- **Reflect:** Think back on what happened during the chest pain.
  - —Physically, how did you feel? Were there any areas you felt were particularly tense? Were you able to release physical tension? What works for you to release tension? (The nurse discusses the effect of relaxation on ischemia and mental stress, thus empowering the patient with a specific skill that can be called upon to help treat his or her myocardial ischemia.)
  - —Emotionally, how did you feel? (The nurse invites the patient to talk about his or her feelings during this episode (e.g., worry, fear, anger, sadness). Using the concepts of awareness, automatic thoughts, and cognitive distortions, the nurse guides the patient through the process of realistic appraisal. Giving the patient permission to discuss his or her emotions and stress may help avoid all-or-nothing thinking, overgeneralization, jumping to conclusions, mental filtering, disqualification of the positive, and magnification. The patient is allowed to talk. The patient is gently encouraged to reveal any fears. The nurse helps the patient make an association between the emotional reaction to pain and the cycle of escalating pain this can create. Drawing a picture or writing in a journal can be useful if the person is reluctant to talk. The person's ability to identify his or her emotions needs to be accepted in a no judging way. Using a real-life, real-time, stressful experience provides a rich opportunity for dialogue and for teaching concrete self-management skills.)
  - —Is there another way to look at the situation? Are there opportunities here? An opportunity to reconnect with what is important in life? An opportunity to learn self-management skills that can treat the underlying pathophysiology? An opportunity to break the cycle of stress/worry/chest pain/stress/worry/chest pain? (This is also an opportunity for the nurse to praise the patient for doing the best he or she could in a very stressful situation.)
- **Choose:** Replace maladaptive, unrealistic, distorted thinking patterns with a more effective and realistic

response. At this stage of illness, it is most helpful to focus on a plan that replaces the anxiety/tension response to chest pain with focused relaxation and affirmation. Additional coping mechanisms can be addressed later in the hospital stay or in the outpatient setting.

Evaluation

Client outcomes that were established prior to initiating cognitive therapy and the client's subjective experiences are used to evaluate progress toward *long-term goals*. To evaluate progress toward *short-term goals*, client outcomes that were established prior to starting the session and the client's subjective experiences are used. Revising and updating goals are a part of each session.

Recognizing self-defeating automatic thoughts and silent assumptions, in addition to changing long-standing health-risking behaviors, often is challenging and frustrating to clients. With careful choice of interventions, honest and thoughtful feedback, and continuing support, the nurse can help clients gain significant health-affirming benefits. In turn, the nurse can realize the value of enhancing the client's autonomy and self-confidence in healthy behavior change and self-regulation.

DIRECTIONS FOR FUTURE RESEARCH

1. Evaluate the effectiveness of using the four-step approach of cognitive restructuring in helping clients change health-risking behaviors such as smoking, alcohol misuse, or overeating.
2. Evaluate whether there are differences in the application of cognitive therapy among different age groups.
3. Investigate cognitive distortions in children. Do the distortions change or intensify as children grow? Do children with similar distortions develop similar health issues as they mature?

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin the process of answering the following questions:

- What are my stress warning signals?
- What are the current stressors in my life?
- Can I pinpoint my negative automatic thoughts and the silent assumptions that trigger and perpetuate my emotional upset?
- Can I use the four-step approach to help reduce my distress and effectively solve problems?
- Is there an affirmation I can create to help me counter self-defeating automatic thoughts and silent assumptions?
- When setting goals, have I made certain that:
  - —they are desirable, concrete, attainable, and measurable?
  - —I have set a time for completion, as well as identified times to evaluate progress?
  - —I have identified steps or short-term goals that will help me achieve my desired long-term goal?
  - —I have identified a reward for achieving the stated goal?

NOTES

1. G. Engel, The Clinical Application of the Biopsychosocial Model, *American Journal of Psychiatry* 137 (1980):535–544.
2. E.M. Stuart et al., Spirituality in Health and Healing: A Clinical Program, *Holistic Nursing Practice* 3 (1989):35–36.
3. A.T. Beck, A Systematic Investigation of Depression, *Comprehensive Psychiatry* 2 (1961):163–170.
4. H. Benson and E. Stuart, *The Wellness Book: A Comprehensive Guide to Maintaining Health and Treating Stress-Related Illness* (New York: Fireside, Simon & Schuster, 1993).
5. Ibid.
6. A.T. Beck, *Cognitive Therapy* (New York: New American Library, 1979).
7. A.T. Beck, *Prisoners of Hate: A Cognitive Basis of Anger, Hostility and Violence* (New York: Harper Collins Publisher, 2000).
8. A. Ellis, *Reason and Emotion in Psychotherapy* (New York: Lyle Stewart, 1962).
9. A. Ellis, A Critique of the Theoretical Contributions of Nondirective Therapy, *Journal of Clinical Physiology* 56 (2000):897–905.
10. D. Meichenbaum, *Cognitive Behavior Modification: An Integrative Approach* (New York: Plenum Press, 1977).
11. D.D. Burns, *Ten Days to Self-Esteem* (New York: William Morrow, 1993).
12. D.D. Burns, *The New Mood Therapy* (New York: William Morrow and Company Inc., 1999).
13. A.T. Beck, Cognitive Therapy: A 30-year Retrospective, *American Psychologist* (1991): 368–375.
14. P.M. Emmelkamp and P. van Oppen, Cognitive Interventions in Behavioral Medicine [Review], *Psychotherapy and Psychosomatics* 59 (1993):116–130.
15. G.D. Jacobs et al., Home-Based Central Nervous System Assessment of a Multifactor Behavioral Intervention for Chronic Sleep-Onset Insomnia, *Behavior Therapy* 24 (1993):159–174.
16. A.D. Domar et al., The Impact of Group Psychological Interventions on Distress in Fertile Women, *Health Psychology* 1 (2000):568–575.
17. F.J. Mendez and M. Belendez, Effects of a Behavioral Intervention on Treatment Adherence and Stress Management in Adolescents with IDDM, *Diabetes Care* 20 (1997):1370–1375.
18. D. Ornish et al., Intensive Lifestyle Changes for Reversal of Coronary Heart Disease, *Journal of the American Medical Association* 280 (1998):2001–2007.
19. Writing Group of the PREMIER Collaborative Research Group, Effects of Comprehensive Lifestyle Modification on Blood Pressure Control: Main Results of the Premier Clinical Trial, *Journal of the American Medical Association* 289 (2003):2083–2093.
20. J.F. Keefe et al., Spouse-Assisted Coping Training in the Management of Osteoarthritic Pain: Long-Term Follow Results, *Arthritis Care and Research* 12 (1999):101–111.
21. J. Spence et al., Lifestyle Modifications to Prevent and Control Hypertension: Recommendations on Stress Management, *Canadian Medical Association Journal* 160 (1999): S46–S50.
22. S. Morley et al., Systematic Review and Meta-Analysis of Randomized Controlled Trials of Cognitive Behavior Therapy and Behavior Therapy for Chronic Pain in Adults, Excluding Headache, *Pain* 80 (1999):1–13.
23. C. Wells-Federman et al., Nurse-Led Pain Management Program: Effect on Self-Efficacy, Pain Intensity, Pain-Related Disability, and Depressive Symptoms in Chronic Pain Patients, *Pain Management Nursing* 3 (2002):131–40.
24. K. Lorig et al., Evidence Suggesting that a Chronic Disease Self-Management Program Can Improve Health Status While Reducing Hospitalization: A randomized trial, *Medical Care* 37 (1999):5–14.
25. A.E. Speckens et al., Cognitive Behavioral Therapy for Medically Unexplained Physical Symptoms: A Randomized Controlled Trial, *British Medical Journal* 18 (1995):1328–1332.
26. R. Friedman et al., Behavioral Medicine, Clinical Health Psychology, and Cost Offset, *Health Psychology* 14 (1995):509–518.
27. G.M. Bartol and N.F. Courts, The Psychophysiology of Bodymind Healing, in *Holistic Nursing: A Handbook for Practice*, eds. B. Dossey, C. Guzzetta, and L. Keegan (Gaithersburg, MD: Aspen Publishers, Inc., 2000), 69–88.
28. W.B. Cannon, The Emergency Function of the Adrenal Medulla in Pain and the Major Emotions, *American Journal of Physiology* 33 (1914):356–372.

29. H. Selye, Handbook of Stress: Theoretical and Clinical Aspects, in *History and Present Status of Stress Concept*, eds. L. Goldberger and S. Breznitz (New York: The Free Press, 1982), 7–20.
30. J. Shelby and K.L. McCance, Stress and Disease, in *Pathophysiology: The Biologic Basis for Disease in Adults and Children*, eds. K.L. McCance and S.E. Heuther (St. Louis: Mosby, 1998.)
31. S.F. Maier and L.R. Watkins, Cytokines for Psychologists: Implications of Bidirectional Immune-to-Brain Communication for Understanding Behavior, Mood, And Cognition, *Psychological Review* 105 (1998):83–107.
32. J.K. Kiecolt-Glaser and R. Glaser, Psychological Influences on Immunity, *American Psychologist* 43 (1988):892–898.
33. Shelby and McCance, Stress and Disease.
34. C.R. Chapman and J. Gavrin, Suffering: The Contributions of Persistent Pain, *The Lancet* 353 (1999):2233–2236.
35. Bartol and Courts, The Psychophysiology of Bodymind Healing.
36. Chapman and Gavrin, Suffering: The Contributions of Persistent Pain.
37. Shelby and McCance, Stress and Disease.
38. S. Cohen et al., Psychological Stress and Susceptibility to the Common Cold, *New England Journal of Medicine* 325 (1991):606–612.
39. E. Arnold, The Stress Connection: Women and Coronary Heart Disease, *Critical Care Nursing Clinics of North America* 9 (1997):565–575.
40. J.K. Kiecolt-Glaser, Slowing of Wound Healing by Psychological Stress, *Lancet* 346 (1995): 1195–1196.
41. N. Frasure-Smith et al., Depression Following Myocardial Infarction: Impact on 6 Month Survival, *Journal of the American Medical Association* 270 (1993):1819–1825.
42. N. Frasure-Smith et al., Social Support, Depression, and Mortality During the First Year After Myocardial Infarction, *Circulation* 101 (2000):1919–1924.
43. J. Markovitz et al., Psychological Predictors of Hypertension in the Framingham Study. Is There Tension in Hypertension? *The Journal of the American Medical Association* 270 (1993): 2439–2443.
44. R.B. Williams, Coronary-prone Behaviors, Hostility, and Cardiovascular Health: Implications for Behavioral and Pharmacological Intervention, in *Behavioral Medicine Approaches to Cardiovascular Disease Prevention*, eds. K. Orth-Gomer and N. Schneiderman (Hillside, N.J.: Lawrence Erlbaum Associates, 1996.)
45. N. Frasure-Smith et al., Social Support, Depression, and Mortality During the First Year After Myocardial Infarction.
46. Benson and Stuart, *The Wellness Book*.
47. K. Lorig et al., Evidence Suggesting that a Chronic Disease Self-Management Program Can Improve Health Status While Reducing Hospitalization: A Randomized Trial, *Medical Care* 37 (1999):5–14.
48. F. Fawzy et al., Malignant Melanoma. Effects of an Early Structured Psychiatric Intervention, Coping, and Affective State on Recurrence and Survival 6 Years Later, *Archives of General Psychiatry* 50 (1993):681–689.
49. D. Spiegel et al., Effect of Psychosocial Treatment on Survival of Patients With Metastatic Breast Cancer, *Lancet* 2 (1989):888–891.
50. M. Caudill et al., Decreased Clinic Use by Chronic Pain Patients: Response to Behavioral Medicine Intervention, *Clinical Journal of Pain* 7 (1991):305–310.
51. S.C. Kobasa et al., Hardiness and Health: A Prospective Study, *Journal of Personality and Social Psychology* 42 (1982):391–404.
52. J.W. Pengilly and E.T. Dowd, Hardiness and Social Support as Moderators of Stress, *Journal of Clinical Psychology* 56 (2000):813–820.
53. R.C. Colligan et al., CAVEing the MMPI for an Optimum-Pessimism Scale: Seligman's Attributional Model and the Assessment of Explanatory Style, *Journal of Clinical Psychology* 50 (1994):71–95.
54. T. Manuta et al., Optimists vs. Pessimists: Survival Rate Among Medical Patients Over a 30-Year Period, *Mayo Clinic Proceedings* 75 (2000):140–143.
55. A. Steptoe et al., Social Support and Health-Related Behavior: A Study of Smoking, Alcohol Consumption and Physical Exercise, *Journal of Psychosomatic Research* 41 (1996): 171–180.
56. G. Marlatt, Relapse Prevention: Theoretical Rationale and Overview of the Mode, in *Relapse Prevention*, eds. G. Marlatt and J. Gordon (New York: Guilford, 1985).
57. Frasure-Smith et al., Social Support, Depression, and Mortality During the First Year After Myocardial Infarction.
58. N. Frasure-Smith and R. Prince, Long-Term Follow-up of the Ischemic Heart Disease Life Stress Monitoring Program, *Psychosomatic Medicine* 47 (1989):485–513.

59. J. Kennell et al., Continuous Emotional Support During Labor in a U.S. Hospital: A Randomized Controlled Trial, *Journal of the American Medical Association* 265 (1992).
60. M.K. Klaus et al., Assistance and Support in Labor: Father, Nurse, Midwife or Doula?, *Clinical Consultations in Obstetrics and Gynecology* 4 (1992):211–217.
61. Ornish et al., Intensive Lifestyle Changes for Reversal of Coronary Heart Disease.
62. Writing Group of the PREMIER Collaborative Research Group, Effects of Comprehensive Lifestyle Modification on Blood Pressure Control: Main results of the Premier Clinical Trial.
63. V. Frankl, *Man's Search for Meaning* (Boston: Beacon Press, 1963).
64. M. Schlitz, Intentionality and Intuition and Their Clinical Implications: A Challenge for Science and Medicine, Advances, *The Journal of Mind-Body Health* 12 (1996):58–66.
65. D. Larson and M. Milano, Are Religion and Spirituality Clinically Relevant in Health Care?, *Mind/Body Medicine* 1 (1995):147–157.
66. J.S. Levin et al., Religion and Spirituality in Medicine: Research and Education, *Journal of the American Medical Association* 278 (1997):792–793.
67. J. Kass et al., Health Outcomes and a New Index of Spiritual Experience, *Journal for the Scientific Study of Religion* 30 (1991):203–211.
68. Levin et al., Religion and Spirituality in Medicine: Research and Education.
69. H.G. Koenig et al., The Relationship Between Religious Activity and Blood Pressure in Older Adults, *International Journal of Psychiatry in Medicine* 28 (1998):189–213.
70. E.M. Adalf and R.G. Smart, Drug Use and Religious Affiliation, Feelings, and Behavior, *British Journal of Addiction* 80 (1985):163–171.
71. L.B. Bearon and H.G. Goenig, Religious Cognitions and Use of Prayer in Health and Illness, *The Gerontologist* 30 (1990):249–253.
72. L. Dossey, *Prayer Is Good Medicine* (San Francisco: Harper, 1996).
73. Burns, *The New Mood Therapy*.
74. A.R. Childress and D.D. Burns, The Basics of Cognitive Therapy, *Psychosomatics* 22 (1981):1017–1027.
75. A. Webster et al., How Thoughts Affect Health, in *Wellness Book*, eds. H. Benson and E. Stuart (New York: Fireside, Simon & Schuster, 1993).
76. Childress and Burns, The Basics of Cognitive Therapy.
77. E. Stuart et al., Coping and Problem Solving, in *Wellness Book*, eds. H. Benson and E. Stuart (New York: Fireside, Simon & Schuster, 1993).
78. D. Burns, *The Feeling Good Handbook: Using the New Mood Therapy in Everyday Life* (New York: William Morrow, 1989).
79. A. Ellis, *How to Make Yourself Happy and Remarkably Less Disturbable* (Lafayette, CO: Impact Publishers, 1999).
80. Burns, *The New Mood Therapy*.
81. Burns, *The Feeling Good Handbook*.
82. J. Pennebaker, *Opening Up: The Healing Power of Confiding in Others* (New York: William Morrow, 1990).
83. Stuart et al., Coping and Problem Solving.
84. J. Pennebaker, Telling Stories: the Health Benefits of Narrative, *Literary Medicine* 19 (2000):3–18.
85. Ellis, *How to Make Yourself Happy and Remarkably Less Disturbable*.
86. Frasure-Smith et al., Social Support, Depression, and Mortality During the First Year After Myocardial Infarction.
87. M.A. Caudill, *Managing Pain Before It Manages You*, 2nd ed. (New York: Guilford Press, 2002).
88. Burns, *The New Mood Therapy*.
89. C. Rogers, *Client-Centered Therapy* (Boston: Houghton Mifflin, 1951).
90. Stuart et al., Coping and Problem Solving.
91. Burns, *The New Mood Therapy*.
92. C.J. Medich et al., Healing Through Integration: Promoting Wellness in Cardiac Rehabilitation, *Journal Cardiovascular Nurse* 3 (1997):66–79.
93. S. Boem, Patient Contracting in Nursing Interventions, in *Nursing Interventions: Essential Nursing Treatments*, 2nd ed., eds. G. Gulechek and J. McCloskey (Philadelphia: W.B. Saunders Co., 1992), 425–433.

Healthy Disclosure

Diaries, journals, logs, reviews, stories, and letters enable us to keep track of and enhance the patterns of our lives. Research shows that, in addition to helping us find meaning and depth in our life experiences, writing about occurrences such as trauma or illness improves our health.[1] Writing about an experience also may help to make it our own: As we write about the experience we explore its meaning, the way we came to possess it, and, ultimately, the way we can release it.[2]

As adolescents, we may have written in a diary, entering into it both the mundane and the deeply moving events of our days. With the transition into adulthood, we may well have reduced these diary entries to lists of things to do, appointments, chores, and dates. We find time only to jot short notes on a calendar or in a blank book, making longer entries in a loose-leaf notebook, or perhaps putting into a box scraps of paper that contain ideas, thoughts, bits of poetry, and plans for a golden tomorrow. Even these abbreviated records provide a skeletal reflection of our lives; they can be filled out and given form by memories.

As nurses, we can refresh our own self-reflection techniques and perfect new ones to help us record and grow from our experiences, intuitions, and connections. We can learn to help ourselves and our clients tap into the spiritual and self-healing aspects of the complex and beautiful web of our existence. Self-reflection helps us evoke more trust and truth in daily living.

> As the gods created the universe, they discussed where they should hide Truth so that human beings would not find it right away. They wanted to prolong the adventure of the search.
>
> "Let's put Truth on top of the highest mountain," said one of the gods. "Certainly it will be hard to find there."
>
> "Let's put it on the farthest star," said another. "Let's hide it in the darkest and deepest of abysses."
>
> "Let's conceal it on the secret side of the moon."
>
> At the end, the wisest and most ancient god said, "No, we will hide Truth inside the very heart of human beings. In this way they will look for it all over the Universe, without being aware of having it inside themselves all the time."[3]

NOTES

1. J. Pennebaker, *Opening Up: The Healing Power of Confiding in Others* (New York: Avon Books, 1990).
2. M. Crichton, *Travels* (New York: Ballantine Books, 1988), xi.
3. P. Ferrucci, *What We May Be* (Los Angeles: Jeremy P. Tarcher, 1982), 143.

Chapter 17

Self-Reflection: Consulting the Truth Within

Lynn Rew

NURSE HEALER OBJECTIVES

Theoretical

- Define the concept of self-reflection.
- Define cognitive, intuitive, and transcendent awareness.
- Describe scientific evidence of the connections between mind, body, and spirit.
- Discuss theories of self-identity, awareness, and health as they relate to the concept of self-reflection.
- Describe self-reflection interventions.

Clinical

- Match each self-reflection intervention with a potential client.
- Keep a diary for one month of self-reflection interventions used with clients.
- Identify at least two positive outcomes for each client with whom you initiated a self-reflection intervention.

Personal

- Identify two ways in which your intuitive awareness has had a healing influence on your life.
- Keep a journal of self-reflection interventions that you use to enhance your health or that of your family.
- Discuss with another nurse ways in which self-reflection has helped each of you improve your nursing practice.

DEFINITIONS

Awareness: alertness, watchfulness, and knowledge about oneself and the environment, including events that take place.

Health: harmony or unity of one's body-mind-spirit within an ever-changing environment.

Identity Status: one of four categories of adolescent identity formation processes.

Self: a principle underlying and organizing subjective experience.

Self-Identity: the process of awareness of who one is and what one's place in the world is.

Self-Reflection: the process of turning awareness inward, communicating with one's inner wisdom for the purpose of healing and well-being.

THEORY AND RESEARCH

Self-reflection is the process of turning one's attention or awareness inward to examine thoughts, feelings, beliefs, and behaviors. It is a deliberate process with the goals of discovery and learning.[1] Self-reflection means to look within oneself

and to listen to the self-talk and associated feelings that guide behavior. Self-reflection activities are an essential component of expert nursing practice and also may be used as interventions for clients who would benefit from increased self-understanding.

Self-reflection nursing interventions have been developed in response to theories and research findings from a variety of disciplines. The concept of the self and theories of self-identity form the base for exploring the phenomenon of self-reflection. Similarly, theories of awareness that include cognitive, intuitive, and transcendent dimensions expand this basic framework and acknowledge the holistic nature of human beings. Recent research findings that validate the connections between body, mind, and spirit substantiate the theoretical understanding and support for these interventions.

Self

Questions about the reality of the self have been posed and answered historically through the disciplines of philosophy and psychology. The first American psychologist, William James, who was also a profound philosopher, provided one of the earliest explanations of the self and influenced the development of subsequent psychologic theories of the self. According to James, the self consists of the material Self (James used the upper case), the social Self, and the spiritual Self.[2] James identified the physical body and the clothes that a person wears as the innermost part of the material Self. In addition, the material Self includes a person's family, home, and material possessions. The social Self includes a person's fame, honor, and any image that another person carries of the person. The spiritual Self, according to James, is the inner or subjective being, which is the most intimate and enduring component of a person's self.

James noted that, to consider the spiritual Self, one had to be reflective and to abandon one's outward point of view. This aspect of self is *felt* rather than *seen*. The spiritual self includes inner psychic qualities such as volition, or will, and emotions such as desire. Much debate has occurred in both philosophy and psychology since James' writings in the late 1800s. Primarily, the question of when the self is first recognizable in humans has not been easily answered. Some theorists believe that there is an innate "kernel of self" that gradually develops over time and through experience.[3] This innate self is the consciousness, or awareness, of self that emerges out of interactions with others and the ability to think about oneself.[4] Kagan, a developmental psychologist, argues convincingly that, until some time in the second year of life, there is little evidence that children are aware of themselves.[5] Kagan points out that two- year-olds smile when they master a task, even when playing alone, and they begin to attempt to direct the behaviors of others (e.g., by placing a toy telephone at their mother's mouth and gesturing for her to talk). Kagan concludes that the ability to reflect on one's experience, including one's feelings, thoughts, and behaviors, indicates that there is a unifying principle of the self.

Self-Identity

Human beings take their unique places in the world through a complex process of self-identification and differentiation. As infants grow and develop, they soon come to recognize what is oneself and what is the other. Their process of learning who they are, who they are not, and what their place is in the world involves a dynamic interaction between the child, the family, and the larger society. Erikson identified eight stages, or crises, through which each individual passes in the process of coming

to know the self.[6] His theory is based on the assumption that within each person is a drive to overcome each developmental crisis and to form a solid sense of identity that then allows the individual to engage in intimate relationships with others, to be productive in life, and to feel that life has integrity. Self-identity is both a *process* and an *outcome*.[7]

According to Erikson's theory, infants face a crisis of trust versus mistrust as they learn to differentiate themselves from their mothers. An immature sense of the self and one's place in the world is nurtured through the relationship between the infant and the mother (or other primary caregiver) and other persons within the infant's larger family and community. This embryonic sense of identity is further developed in the second phase or crisis of development in which the toddler masters autonomy versus shame and doubt. With increasing awareness of themselves as different and independent from others, toddlers and young children gain confidence in their awareness and knowledge of who they are and what they are capable of doing. As young children develop further and expand their interaction with a larger society, such as in the context of school and other social institutions, they face the third developmental crisis of developing initiative and industry versus guilt and inferiority. The development of initiative and industry occurs primarily in the performance of tasks that are shared with and/or evaluated by others. In the context of culture, older children spend increasingly longer periods of time away from the persons (most often the parents) who nurtured them during their initial formation of a sense of identity and perceptions of the world at large. Children are exposed to further experiences that help them develop their sense of who they are and where they belong in the world through school and extracurricular activities. In each of these early stages of development, the individual becomes increasingly capable of knowing about the self, and about his or her intellectual, emotional, and spiritual capabilities. With each developmental success, the child becomes more sure of the self and is then capable of moving forward to resolve future developmental crises. With this development and maturity also comes the ability to think more deeply and seriously about the self.

The adolescent faces a new crisis of identity formation that calls into question how well the previous developmental crises have been mastered. Erikson called this the crisis of identity versus identity diffusion. Adolescence creates its own threats to identity related to the physiologic changes of puberty. This adolescent stage is often characterized by intense internal conflict and confusion about oneself. Rapid physical development and sexual maturity are accompanied by new—and often more intense—emotional experiences, that can shake the foundation of one's sense of who one is and what one is to do in the world. Society also places increasingly greater demands on adolescents than on children, giving them both more freedom and more responsibilities. The purpose of the adolescent crisis of identity formation is to prepare the person for more intimate and responsible relationships with others, and for feelings of being sound and whole. Much introspection occurs during adolescence, and this natural phenomenon informs much of what we know about self-reflection as a healing process.

Expanding on Erikson's work, Marcia studied the identity formation of adolescents and described four different outcomes of this process.[8] He referred to these resolutions of identity as *statuses* and conceptualized them as a type of path or continuum. In the ideal outcome, consistent with Erikson's conceptualization of identity formation, the person makes a commitment to a way of being in the world after

first considering several possibilities. Persons with this ideal status are termed the *identity achievement group*; this group includes those who make a commitment to an identity after a period of exploring various possibilities. Another group of adolescents belong to the *foreclosure group*, those who make identity commitments without exploring possible alternatives. These individuals foreclose on an identity that may be more like their identity as a child and is often ascribed to them by those around them, such as teachers or other influential adults. A third set of youths belong to the *moratorium group*, which includes those who are actively in a state of crisis or exploration as they attempt to formulate an identity. The final category of adolescents are those in the *identity diffusion group*, who have made no identity commitments, have not explored possibilities, and have not foreclosed on an identity from childhood.

The concept that one reflects on oneself and examines the possible alternatives of who one might become suggests that adolescence may be a time of profound self-reflection. It is this process of looking inward for a guiding wisdom that leads to a sense of purpose and generativity, as well as feelings of wholeness and integrity, that Erikson claims characterize the later stages of ideal adult development.

While there is little empirical research to support a relationship between an adolescent's position in one of the aforementioned groups and health, some evidence suggests that individuals who are in the moratorium group experience anxiety and guilt that can block further healthy exploration and development of a comfortable sense of self-identity. Similarly, many of those who are in the foreclosure group lack the practice of self-reflection and tend to engage in self-denial and excessive moralism that prevents them from being open to others and to new experiences.[9]

Self-Awareness

To optimize one's personal development as well as one's health and well-being, one must be fully aware of his or her self. To be aware is to be watchful, alert, and knowledgeable.[10] To be aware of oneself is to know one's own identity and one's relationship to others; to be aware of oneself is to know what one can do and where one fits within the social order of the world. The process of healing, which is never fully completed, requires an ongoing awareness of one's body-mind-spirit. Awareness of one's place within society and within the universe occurs in three dimensions: the cognitive, the intuitive, and the transcendent. This multidimensional awareness includes rational knowledge of facts and laws that govern the physical world. This is *cognitive awareness* and it includes "consciously knowing facts and processing the constant flow of information coming in through the senses."[11] This is the awareness that accompanies the first two stages of identity formation in Erikson's stages of development. Cognitive awareness is used throughout one's life to provide information about the physical world and one's behaviors in it.

Intuitive awareness is another way of knowing about oneself and the world. It is an affective sense of knowing by feeling some truth directly. Rather than following the rational and linear steps of empirical knowledge gained through the senses, intuitive awareness comes as an intense feeling of certainty that may be accompanied by a sense of mystery or confusion.[12] It is a direct way of knowing that is very personal and often poorly communicated to others. As individuals grow and

develop, this sense of intuition may flourish or be stunted by those who do not trust its wisdom.[13]

A third kind of awareness is that of the spiritual dimension, and is known as *transcendent awareness*. Transcendent awareness is not bound by time or matter. It is a way of knowing that represents an exchange of energy occurring without rational thought.[14] It may be evident to the individual through prayer or meditation. As depicted in Figure 17–1, these types of awareness vary in their degree of concreteness. On the most practical or concrete level is cognitive awareness—knowledge of the physical world and one's own physical attributes. On the second, more abstract level is intuitive awareness—knowledge obtained by feeling or sensing something directly without having to think about it, or without having direct evidence. Finally, on the most abstract level is transcendent awareness—knowledge that flows directly from one's soul or spirit. Within a person, each of these three types of awareness is synthesized into a resource of inner wisdom that may be tapped in self-reflection activities.

The idea of transcendent awareness is derived from the works of William James,[15] who identified the spiritual Self, and Viktor Frankl,[16] who described self-transcendence as the tendency of human beings to reach beyond themselves and either to discover or to create purpose and meaning in their lives. Frankl's primary thesis was that the search for meaning is the primary motivation in human life. He identified three major ways in which people find meaning or purpose in life; (1) creating a work or doing a deed; (2) experiencing something or encountering another person; and (3) choosing an attitude in the face of circumstances that cannot be

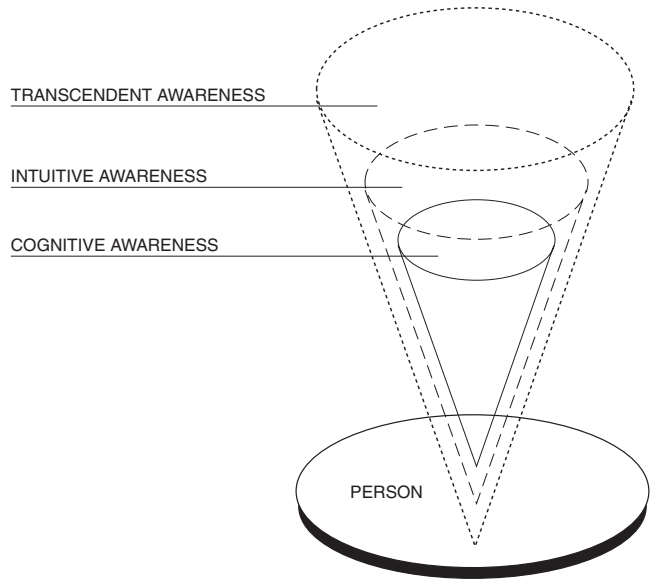


Figure 17–1 Dimensions of Cognitive, Intuitive, and Transcendent Awareness. *Source:* From *Awareness in Healing, 1st edition,* by L. Rew, © 1995. Reprinted with permission of Delmar Publishers, a division of International Thomson Publishing.

changed, or that involve suffering. Others have studied self-transcendence as an aspect of the spiritual dimension of people. For example, Reed developed a mid-range nursing theory of self-transcendence based on life span development theories.[17] She asserted that nurses can help clients expand their self-boundaries through meditation, visualization, peer counseling, journal keeping, self-reflection, and life review, thus enabling them to look both inward and outward. This view is similar to that of Newman, who theorized that health is expanding consciousness and that "unbroken wholeness is what is real—not the fragments we devise with our way of describing things."[18] Using Newman's theory as a framework, Neill[19] studied the personal life stories of women living with rheumatoid arthritis and found that self-transcendence—being able to accept an adverse situation they could not change—could be transformative and contribute to inner growth.

Coward studied self-transcendence both in healthy populations and in people with acquired immune deficiency syndrome (AIDS) and with advanced breast cancer. She found that self-transcendence was related to an increased sense of purpose and self-worth in patient populations, and that it was associated with emotional well-being, hope, a sense of coherence, and high self-esteem in the healthy population.[20] Transcendent awareness, or spiritual transcendence, is the knowledge that one has a spiritual connection to something greater than the self; a fundamental unity with nature.[21] It may be experienced in quiet times of meditation and prayer, or in situations of crisis. It is the type of awareness that may be experienced directly and suddenly, similar to intuitive awareness. Each type of awareness—that is, cognitive, intuitive, and transcendent—contributes to the synthesis of the whole person and is manifest in self-awareness. Each is important in the development of a healthy person. Each of these types of awareness can be fostered through self-reflective strategies that focus on thoughts (cognitions), feelings and intuitions, and self-transcendent experiences or ideas.

Researchers have shown that cognitive–perceptual factors are related to health-promoting behaviors and healthy outcomes.[22] Just as educational interventions can increase clients' knowledge about their bodies and physiologic processes, cognitive awareness can be improved and is related to better health outcomes. For example, in a meta-analysis of the effects of psychoeducational approaches in caring for adults with hypertension, nurse researchers found that education had statistically significant beneficial effects on blood pressure.[23] Little research exists, however, regarding the relation of intuitive and transcendent awareness in relation to health. Self-reflection, or introspective skills, combines the linear analysis of cognitive awareness with the intuitive, nonlinear, and more direct ways of knowing.[24] As these two aspects of knowing and perceiving are synthesized, changes in the bodymind, bodyspirit, and mindspirit occur.

Body-Mind-Spirit Connections

Researchers have provided ample evidence of the connections between body, mind, and spirit.[25,26] The burgeoning disciplines of psychoneuroimmunology and neuropsychology have shed much light on the holistic nature of human belief, thought, and behavior. Once the domain of philosophers and theologians, the realities of beliefs, conscious thought, and spiritual experience now have found their rightful places within new sciences that connect these abstract realities with chemistry and biology. For example, Pert's pioneering work in biochemistry revealed the presence of chemical messengers

known as neuropeptides that, along with their corresponding receptors in cells, form a network for information processing between the body and the mind.[27,28] The presence of such a network literally allows various parts of the body to communicate with others through a mind no longer limited to a space within the brain. Furthermore, there is increasing evidence that engaging in relaxation, guided imagery, and artistic endeavors changes physiology and results in altered immune function with consequent healing.[29]

Spiritual healing, which historically has been a part of many primitive medical systems, now is being explored seriously in scientific circles. Its effectiveness may be due in part to hypnosis, which mimics the focused attention and altered state of consciousness that is found in some ritualistic spiritual healing practices.[30] Scientific theoretical models also are being developed and tested to explain the healing effects of prayer.[31] These and other findings (see, for example, the discussion of the psychophysiology of healing in Chapter 4) emphasize the interdependence of the body-mind-spirit dimensions of human beings and provide an important part of the framework for self-reflection interventions.

HOLISTIC CARING PROCESS

Assessment

In preparing to use self-reflection interventions, the nurse assesses the following parameters:[32]

- **the client's belief system:** Is it congruent with planned interventions?
- **the client's ability to read and write:** If the client cannot read or write, can family members or friends assist with audiotape recordings?
- **the client's experience with similar techniques:** Has the client ever kept a diary or discussed his or her dreams with others?
- **the client's personal goals and motivation for reaching them:** Are they clear to the nurse, and can the nurse respect them if they are different from her own?
- **the client's understanding of the purpose of the intervention:** Does the client understand that the purpose is not to invade his or her privacy, but to enhance self-understanding?

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with the interventions for self-reflection that are related to the 13 domains of Taxonomy II of the Unitary Person framework (see Chapter 14):

- Altered communication: impaired verbal communication
- Impaired social interaction; altered family processes; social isolation
- Spiritual distress; disruption of person–environment pattern of the whole
- Impaired adjustment; ineffective family coping; ineffective individual coping
- Activity intolerance: fatigue; sleep pattern disturbance; deficit in diversional activity
- Altered self-concept; body image disturbance; hopelessness; powerlessness
- Altered thought processes
- Anxiety; grieving: anticipatory and dysfunctional

Outcomes

Exhibit 17–1 guides the nurse in client outcomes, nursing prescriptions, and evaluation for the use of self-reflection as a nursing intervention.

Therapeutic Care Plan and Interventions

Following the client assessment, the nurse works with the client to establish goals for self-reflection. The plan should include self-reflection techniques that the client

Exhibit 17–1 Nursing Interventions: Self-Reflection

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client will demonstrate more effective coping skills as evident in weekly journal entries and clustering maps.	Guide the client in journal keeping and clustering to identify patterns of ineffective and effective coping skills.	The client demonstrates active problem solving and decreasing reliance on food and drugs.
The client will seek situations in which he or she interacts with others and will record feelings of belonging to a group through diary entries.	Guide the client to write daily about feelings and thoughts about the client and his or her relationships with others. Encourage the client to engage in lucid dreaming to imagine himself or herself interacting competently with others.	The client increases participation in social and family events and describes feelings of being more connected with others.
The client will reminisce about life through a life-review process and will verbalize a sense of meaning or purpose in life.	Facilitate six to eight sessions of reminiscence and life review in a support group setting. Encourage presentation of photographs and memorabilia.	The client states that, in addition to feeling sad about dying, he or she has come to realize that life has meaning and purpose and that he or she will be missed by family and friends.

finds most appealing, and that both nurse and client agree will have the highest likelihood in helping to reach the goals.

Although most of these interventions require little technical skill on the part of the nurse, they do require a thorough assessment and a collaborative relationship with the client.

Before the Session

- To be fully present with the client and with the intention to facilitate healing, begin with centering. This is done by engaging in deep breathing and systematic relaxation, letting go of other issues and concerns, and allowing yourself to be fully present in the moment with the client.
- Complete other physical treatments for the client and ensure the client's physical comfort prior to beginning a self-reflection intervention, so that the client may also be fully present in the moment and will not be distracted by physical sensations such as hunger or pain.
- Maintain privacy.
- Collect any special supplies required, such as paper, pencils, photograph albums, tape recorders, or music tapes, prior to initiating the intervention.[33]

At the Beginning of the Session

- Begin the intervention by describing what is to be done and what the client may expect to achieve as a result of participating in the activity.[34]
- Begin with a relaxation exercise, including deep breathing and sys-

tematic muscle relaxation (see Chapter 21 for details).
- Encourage the client to quiet any inner chatter or dialogue that he or she may be experiencing, and to listen to his or her inner wisdom for guidance.
- If this is a second or subsequent session, review with the client events and situations that have transpired since the previous session before starting the relaxation exercise.

During the Session

- Support the client through physical presence and encouragement.
- If the client requests solitude, respect this need and encourage the client to indicate when he or she is ready for further interaction.
- Encourage the client to ask questions, and clarify for the client the purpose and process involved in looking inward for wisdom and understanding.
- Monitor the environment to reduce stimuli in the form of noise, light, and odors that may distract the client from concentrating on the task at hand.
- Ensure that ample time and supplies are provided for the client to complete the strategies and obtain the maximum benefit from them.

At the End of the Session

- Before leaving the client, bring the client's focus back to the present time and place, reorienting the client as needed.
- Review what has been done and what goals have been met.
- Encourage the client to continue with homework, if needed, and provide for a mutually convenient time to review this homework.
- Assess the client's ability to continue reflective work on his or her own, and continue discussion if the client has difficulty in interpreting what has happened.

Specific Interventions: Self-Reflection

The purpose of self-reflection interventions is to help the client make sense of life events and circumstances that may be bewildering or discomforting. Many experiences in life lead to feelings of emptiness and disharmony because of the client's inability to connect the experience with thoughts, feelings, actions, and physiologic responses. Using the following strategies with clients empowers them, and enables them to make new connections and to reframe and reinterpret their experiences in light of inner strengths and wisdom.

Keeping Diaries or Journals

Keeping a diary or journal is a simple way to begin the process of self-reflection. Notes may be kept in a variety of forms, but a notebook or journal that keeps notes together in a single-bound format facilitates the use of these documents for review and for discerning patterns of response to life's events. Diaries may be structured or unstructured. Structuring diaries often facilitates the recording of information such as eating patterns, or patterns of pain and its management. Keeping a chart of symptoms, such as those associated with headache pain, may be useful in identifying interpersonal or environmental triggers for such symptoms.[35] Unstructured diaries or journals provide the space to record thoughts and feelings about those situations that create anxiety or symptoms of illness. There is no correct or incorrect way to make entries in such a diary or journal; clients should be encouraged simply to allow themselves to follow their stream of consciousness and to play as they begin to write or draw in

this format.[36] The purpose is to release feelings, capture lessons learned in the past, apply those lessons to the present, and then connect the released feelings with thoughts, memories, beliefs, behaviors, and expectations about the future.

Diaries and journals also may be used as an arena in which to practice dialogues with personal body parts, other people, or groups. They may be used to log dreams and to record various interpretations of these dreams. These strategies also may be used with children, who may enjoy adding stickers to express feelings or to stimulate the imagination in helping them to deal with painful or frightening procedures or past events.

Because the results of keeping a journal or a diary are very tangible, the selection of an appropriate style of documentation is important. Many fabric-covered blank books are available for this purpose, as are commercially produced daily diaries with dates. The importance of selecting writing or drawing instruments should be addressed, and the client should be assisted in choosing one or several that are pleasurable to use. Reviewing with the client the selection of the diary or journal and writing or drawing instruments may also enhance the experience of self-reflection as the client explains why these particular supplies are appealing.

Creating Works of Art

Creating works of art, using methods such as drawing, sketching, painting, sculpting, weaving, sewing, or knitting, can be used to explore beliefs and shape outcomes.[37] To use one of these strategies for self-reflection, the client, with the nurse's help, identifies the purpose of the activity in terms of *process* rather than *product*. The purpose is to examine values and beliefs that may be hidden from conscious awareness, but that are influencing the client's experience of illness or disharmony. Images that emerge during the creative process are authentic and allow the individual to tap into wisdom that may lie beyond the client's usual ability to access. It is important to stress that this type of activity focuses on process, because the client may put up barriers to engaging in artwork because of a sense that the product or outcome will not be very good. A stimulating question to begin the activity might be, "What would you paint (draw, sculpt, etc.) if you were not trying to impress anybody with the result?"[38]

Writing Letters

Writing letters is a way to express a variety of feelings. While clients already may be writing letters to express positive feelings to others (e.g., by writing a thank you note), they may be unaware of its usefulness as a strategy to express negative feelings such as anger and disappointment. The process of writing a letter is healing because it gives tangible expression to thoughts and feelings that are sometimes kept out of awareness. Letters that express negative emotions may be read aloud to another person, such as the nurse, who acts as a sounding board, or may be read for audio recording. After listening to the letter, the nurse may provide objective feedback, or the client may wish to listen to himself or herself on a tape recording. The letter then may be rewritten to clarify an expression of feelings.

The first draft of such a letter should be completed without editing, and should be written as if it would not be sent to the person addressed. If the letter is to be used for catharsis only, and not for direct communication between client and another person, this should be made clear prior to beginning the intervention. However, the goal may be changed as the client gains self-understanding, and later drafts may be edited and sent if the client determines that this would be helpful.

The process of writing and rewriting a letter should continue until the strength of the emotion has diminished or the client feels at peace with the issue of concern. The letter may then be torn up, placed in a journal, burned, buried, or sent to the intended recipient.[39]

Beginning an Intuition Log

Intuition is a way of direct knowing that is not based on the usual linear method or rational analysis of sensory data.[40] Sudden flashes of insight that are unexpected are common experiences, but few people have learned to trust them as sources of truth or wisdom. Learning to trust such truths, however, contributes to healing and spiritual growth.[41] Some clients may benefit from carrying a personal intuition log with them. Each time they hear their inner voice, have a vague hunch, or experience a sudden "aha!" they can record it in the log book.[42] These entries then can be reviewed with the nurse to sort out the truths from the mere hunches. With validation, clients begin to trust their intuitions, and this intuitive awareness then empowers them with new solutions and deeper understandings that promote healing.

Using Metaphors

A metaphor is a word, phrase, or concept denoting one kind of idea that is used in place of another to suggest an analogy or similarity between the two.[43] This intervention helps clients deal with the questions "Who am I?" and "What is my life all about?" The purpose is to examine the meaning of a problem situation or of one's life in general by using a metaphor to describe some aspect of one's past, present, or future. Using an object to represent their life or an illness, clients are instructed to write or talk about themselves. For example, a client may describe himself or herself as a banana that started out green but ended up mushy and sweet.[44] Clients may be instructed to complete the statement, "Right now my life feels like a ____." Once the metaphor is identified, clients are encouraged to describe it as fully as possible (e.g., size, color, weight, relation to other objects, etc.). After recording or relating the metaphor, clients may wish to change to a different metaphor to symbolize growth in the future.

Learning from Dreams

Most of the dreams that people remember take place during the stage of sleep in which they experience rapid eye movements (REM). Periods of REM sleep occur approximately every 90 minutes after one first falls asleep and are essential for health. People deprived of this stage of sleep may experience memory loss, irritability, fatigue, and lack of concentration.[45] Dreams come from three different levels of consciousness: (1) the preconscious, which is the most readily accessible and contains material easily called into consciousness during the time one is awake; (2) the personal unconscious, which includes those memories that are generally hidden or repressed from waking consciousness, such as childhood traumas and fears; and (3) the collective unconscious, which includes the inherited aspects of mind that spawn the recurrent themes common in the mythology and legends of all cultures.

In his book *Teach Yourself to Dream*, David Fontana offers a practical guide to harnessing the power of the mind and regaining wholeness.[46] He provides a variety of techniques based on Jungian psychology to help people discover the personal meanings of dreams, make dreams more vivid, use dreams to solve practical problems, and engage in lucid dreaming. For example, Fontana suggests that the client be directed to perform a brief ritual before falling asleep, in which dreams are allowed full reign. Creating a

framework based on music, drumming, gesturing, or chanting may facilitate dreaming. Thinking about one's dreams during the day and making imaginative connections between the dreams and actual events may help one to gain insights and facilitate meaningful interpretations of subsequent dreams. Reviewing the day's events prior to falling asleep will facilitate the recall of dreams and help one to build these meaningful connections.

The client also may be instructed to keep a dream diary and pen next to his or her bed, so that dreams can be recorded while they are fresh, and most vivid, in the client's mind. By capturing as much detail as possible from the dreams, the client can learn the most from them. As in writing any diary, the date of the dream should be noted and plenty of room should be left for interpretation. Fontana suggests always recording dreams in the present tense and making notes of the emotions that accompany the recording of the dream, as well as drawing sketches, which may be of either symbolic or real figures.[47] Recording the dream in the present tense brings the material directly into awareness, where the client then can deal with it.

Mind Maps and Clustering

Mind maps are a method for brainstorming by oneself. The purpose of this activity is to clarify one's thinking about a particular issue. As in group methods of brainstorming, four principles are involved: (1) judgment or evaluation of ideas should be suspended; (2) any idea or thought, no matter how illogical or absurd, is allowed; (3) the more ideas or thoughts generated, the better; and (4) all combinations or modifications of existing ideas are allowed.

The mapping of concepts, also known as clustering, begins with a key concept that comes to mind as one reflects on a problem or concern. This word, phrase, symbol, or sketch is placed in the center of a piece of paper and is circled. By connecting words or phrases to this central thought or idea, one can examine belief systems and integrate ideas. The process of writing down an idea, symbol, or picture and then circling it and connecting it to other words continues until an intuitive connection or insight is realized.[48] Using colors and following the natural shapes of plants, such as the roots, trunk, and branches of a tree, helps in expressing and exploring emotions and in examining the connections of these emotions with each other and with behaviors.[49] Figure 17–2 illustrates the use of clustering by a client examining anxiety about an invasive diagnostic procedure. The concepts in the figure are numbered to demonstrate the sequence of thinking and exploring done by the client; however, numbering is not necessary.

One type of mapping that is beneficial in self-reflection is to search the inner guides that Jung referred to as archetypes.[50] Jung conceptualized archetypes as patterns that are deeply imprinted in the human psyche and that exist in the "collective unconscious" of all people throughout history. These are the patterns or themes that recur in dreams, myths, and legends. These archetypal patterns also serve as inner guides to the tasks or crises of growth and development. Two examples of archetypes and the corresponding tasks they help one to achieve are the Innocent, which assists in the attainment of happiness, and the Warrior, which assists in proving one's worth.[51] The Innocent archetype represents the natural state of dependency characteristic of infants and small children. Focusing on this aspect of oneself leads to fantasies of paradise and living life somewhat passively, waiting to be cared for and rescued. One limitation of seeing oneself as an Innocent is that pain and suffering may be ignored. A strength of the Innocent archetype, however, is that it can attract

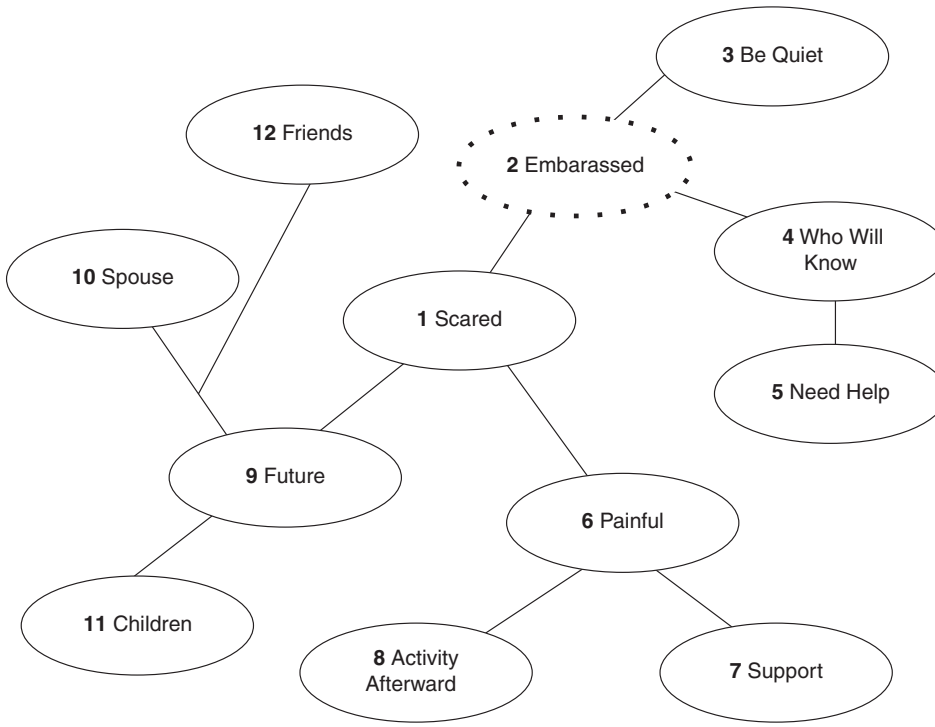


Figure 17–2 Clustering or Mind Mapping a Client's Anxiety.

and activate positive energy in social relationships so that change and growth can occur. The nurse who elects to use archetypes to help clients explore personal growth must be well-acquainted with Jung's work and the collective meaning of these archetypes.

Using the Mandala and Focusing

The mandala, from the Sanskrit word meaning *circle*, is a ritualistic device used in Buddhism as a focus for meditation. Any circular geometric design can be used to focus the attention and quiet the inner dialogue. Focusing on such a harmonic symbol may serve as preparation for listening to the wisdom within.[52] Focusing may then be used to stimulate self-awareness and emotional healing by drawing attention to physical symptoms of illness or other bodily sensations. Focusing may begin by using a physical symbol such as the mandala or by using directed imagery. The purpose is to direct the awareness of the client so that the body is sensed in a systematic manner.[53] In this technique, the internal dialogue that is constantly part of one's inner experience is first quieted, and then awareness is allowed to turn directly to the meaning of a problem or symptom.

Sharing Stories

Each person's life is composed of stories. By telling stories about themselves, people can recreate who they are and who they will become. By sharing and hearing stories, people may develop a deeper understanding of themselves and the meaning of their lived experiences.[54] To make sense of the world, humans create

internal models or frames of reference based on a story line that connects experiences with thoughts, feelings, and beliefs. Telling one's personal story is empowering, but writing it is stronger and more permanent than simply speaking it.[55] Stories that are based on the facts of a client's life, or that represent dreams and goals for the future, may be shared between client and nurse or among a group of clients. Telling his or her story in a variety of settings to various audiences allows the client to incorporate the details of events that may otherwise be emotionally draining. Children, in particular, benefit from telling about their traumatic or frightening experiences. Writing a story allows the client the opportunity to revisit and revise the story as new insights are gained. The powerful impact of gaining insight from storytelling may be enhanced by encouraging the client to use the present tense. Visual images that arise during the telling or writing of the story also can be used to enhance the healing process associated with this intervention.[56]

Fictional story writing may be used in conjunction with the keeping of a diary or journal. Summarizing the theme of a series of events may help the client bring closure to circumstances that have challenged the sense of self. For example, after keeping a journal about the daily feelings and sensations associated with having a mastectomy, a client may write a story that identifies the fears and strengths of an imaginary woman with the same diagnosis. The story, which may incorporate elements of truth and fantasy, may then be read aloud into a tape recorder or to a support group.

Reminiscing and Embarking on a Life Review

Life review is the process of consciously returning to past experiences, often including traumatic life events, that can be surveyed, resolved, and reintegrated into the self.[57] The goal of this integration is the personal realization that life has been unique and has some kind of meaning.[58]

McDougall and colleagues studied this process in 80 adults over the age of 65 who had been diagnosed with depression.[59] Research participants received follow-up care in their homes from an advanced-practice gerontopsychiatric nurse. During each of three sessions per week for 60 days, the nurse used life review to elicit issues about past experiences from the clients, who were formerly hospitalized for their symptoms of depression. These issues included negative life events, unresolved conflicts, and feelings of guilt. The researchers concluded that being in familiar surroundings—their homes—enabled these older adults to discuss topics that might otherwise have remained unexplored and unresolved in this population. As a result of this intervention, the subjects showed a decrease in feelings of anxiety, denial, isolation, and despair.

Various self-help books are available commercially to use with clients who are self-directed, or who might benefit from additional homework exercises. Many of these are in workbook format and have inviting prompts to encourage completion of the activities. Some are meant specifically for women. Borysenko provides 52 exercises specifically for busy people who seek inner peace.[60] A sampling of such books can be found at the end of this chapter under "Suggested Reading."

Case Studies

The two case studies that follow demonstrate the use of self-reflection strategies to aid a man who is dying and an adolescent who has an eating disorder.

Case Study No. 1

Setting:	Community-based AIDS support group
Client:	K.H., a 47-year-old man
Patterns/ Challenges/ Needs:	1. Anticipatory grieving 2. Altered comfort 3. Powerlessness 4. Social isolation, related to family's response to his diagnosis

Ten years ago, K.H. divorced his wife of 15 years when he decided to acknowledge his homosexuality. At the time, K.H. and his wife had three children ranging in age from 5 to 10 years. They had been a close-knit family and had been active in their community. K.H.'s wife won custody of the children but agreed that K.H. could retain weekly visitation rights. Shortly after the divorce, K.H. moved into an apartment with another man in the same city where his ex-wife and children lived. Over the next year, relations among the family members were strained, but K.H. was determined to be involved in raising his children. Approximately five years ago, K.H. learned that he and his partner were both positive for human immunodeficiency virus (HIV), although asymptomatic.

Now K.H. has full-blown AIDS, and although he is receiving treatment he understands that his condition is fatal. His children are now 15, 18, and 20 years old. In the support group that he attends with his partner (who remains asymptomatic), K.H. engages in reminiscing and life review. He also has begun keeping a daily journal in which he records his physical sensations as the symptoms of his disease progress, his emotional feelings of sadness and regret, and his spiritual development as he becomes aware that life includes more than just the physical–emotional dimensions. With the guidance of the holistic nurse, and by sharing stories with other group members, he works through issues of conflict and guilt, particularly those related to raising his children. As a result of this process of self-reflection and increased understanding, K.H. writes a personal letter to each of his children. In each letter he reveals his deepest feelings of love and concern about the child's welfare and shares his experiences of growth and development as a whole person who is willing and ready to die in peace and harmony.

Case Study No. 2

Setting:	Outpatient psychiatric unit
Client:	R.D., an 18-year-old female with anorexia nervosa
Patterns/ Challenges/ Needs:	1. Altered nutrition: less than body requirements 2. Altered family process 3. Ineffective individual coping 4. Disturbance in self-concept

R.D. is in her final year of high school and is making plans to attend an out-of-state college in less than a year. Her senior year is marked by an increasing withdrawal from her parents and younger brother. During family celebrations she refuses to participate in special meals and frequently retires to her room before dessert is served. She admits that she is engaging in an intense diet and exercise program to control her weight so that she will not be teased about being fat when she goes away to college.

R.D. finally agrees to visit her family physician when she begins to experience a persistent cough and finds it difficult to concentrate on her schoolwork. Her disordered eating is diagnosed and treated aggressively. Following a period of hospitalization in which she gains 15 pounds,

she begins to attend outpatient group meetings for young women with various eating disorders. In this setting, she learns about techniques for self-reflection and begins to understand her own behavior and its connections to her deepest fears and needs. She finds that clustering is helpful in sorting out her fears about being out of control. Through this process she begins to understand that her eating behaviors have been ineffective in solving her problems with family members. R.D. also keeps a dream diary and is surprised to find some recurrent themes that enable her to confront her anxiety about growing up and leaving home.

Evaluation

With the client, the nurse determines whether the client outcomes for self-reflection (see Exhibit 17–1) were successfully achieved. To evaluate the session further, the nurse may again explore the subjective effects of the experience with the client using the evaluation questions in Exhibit 17–2. Periodically, the nurse and the client review the progress made toward achieving the goals or outcomes identified before beginning the self-reflection interventions. Many of the interventions described here take place over relatively long periods of time. Throughout the process, the nurse must monitor the client's progress and provide both presence and encouragement to continue the process of self-understanding and acceptance. If specific techniques are used in a formal session, the nurse should encourage the client to evaluate each session as it ends.

Exhibit 17–2 Evaluation of the Client's Subjective Experience of Self-Reflection

1. Was this a new experience for you? Can you describe it?
2. Did you have any physical or emotional responses to the experience? Can you describe them?
3. Were there any distractions?
4. Did this exercise change the way you see yourself or your experiences?
5. Did the experience help you recall any memories or details of your life? Was this a surprise?
6. Was anything about the experience frightening or troubling to you in any way?
7. What are your thoughts and feelings when you review your journal, diary, log, or other self-reflection tool?
8. Would you like to try this again?
9. What would make this experience more meaningful for you?
10. Do you see yourself using this exercise on a regular basis in your life?

DIRECTIONS FOR FUTURE RESEARCH

1. Evaluate the effectiveness of self-reflection interventions in achieving the desired client outcomes.
2. Use qualitative methods to facilitate an understanding of how these interventions affect clients' experiences of healing.
3. Use qualitative methods to develop grounded theory to support the use of these strategies in achieving specific outcomes.
4. Conduct quantitative research to document relationships between the use of specific techniques and a variety of physiologic, behavioral, emotional, and spiritual outcomes for clients and for nurses themselves.
5. Develop appropriate instruments to provide objective evidence that self-

awareness and self-understanding have taken place.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin the process of answering the following questions:

- What inner knowledge and awareness can be created by keeping a personal journal or dream diary?
- How can personal creativity and problem solving be enhanced by self-reflective techniques such as lucid dreaming or meditation?
- How can the life review process be used to ease the pain of death in clients?
- How can I learn to trust intuition in working with clients?

NOTES

1. E.B. Clarke and J.A. Spross, Expert Coaching and Guidance, in *Advanced Nursing Practice: An Integrative Approach*, eds. A.B. Hamric, J.A. Spross, and C.M. Hanson (Philadelphia: W.B. Saunders Co., 1996), 148–153.
2. W. James, *The Principles of Psychology*, vol. 1 (New York: Dover Publications, 1890, 1950).
3. R.A. Wicklund and M. Eckert, *The Self-Knower: A Hero Under Control* (New York: Plenum Press, 1992).
4. A.H. Modell, *The Private Self* (Cambridge, MA: Harvard University Press, 1993).
5. J. Kagan, Is There a Self in Infancy? in *Self-Awareness: Its Nature and Development*, eds. M. Ferrari and R.J. Sternberg (New York: Guilford Press, 1998), 137–147.
6. E. Erikson, *Identity: Youth and Crisis* (New York: W.W. Norton & Co., 1968).
7. R. Josselson, The Theory of Identity Development and the Question of Intervention, in *Interventions for Adolescent Identity Development*, ed. S.L. Archer (Thousand Oaks, CA: Sage Publications, 1994), 12–25.
8. J.E. Marcia, Identity in Adolescence, in *Handbook of Adolescent Psychology*, ed. J. Adelson (New York: John Wiley & Sons, 1980), 159–187.
9. S.J. Schwartz, Convergent Validity in Objective Measures of Identity Status: Implications for Identity Status Theory, *Adolescence* 37 (2002):609–625.
10. L. Rew, *Awareness in Healing* (Albany, NY: Delmar Publishers, 1996).
11. Ibid., 4.
12. Ibid.
13. N. Noddings and P.J. Shore, *Awakening the Inner Eye: Intuition in Education* (New York: Teachers College Press, 1984).
14. Rew, *Awareness in Healing*.
15. James, *The Principles of Psychology*.
16. V. Frankl, *Man's Search for Meaning* (New York: Pocket Books, 1963).
17. P.G. Reed, Toward a Nursing Theory of Self-Transcendence: Deductive Reformulation Using Developmental Theories, *Advances in Nursing Science* 13 (4):64–67.
18. M.A. Newman, Experiencing the Whole, *Advances in Nursing Science* 20, no. 1 (1997):34–39.
19. J. Neill, Transcendence and Transformation in the Life Patterns of Women Living with Rheumatoid Arthritis, *Advances in Nursing Science* 24(4):27–47.
20. D.D. Coward, Self-Transcendence and Correlates in a Healthy Population, *Nursing Research* 45, no. 2 (1996):116–121.
21. R.L. Piedmont, Does Spirituality Represent the Sixth Factor of Personality? Spiritual Transcendence and the Five-Factor Model, *Journal of Personality* 67, no. 6 (1999):985–1013.
22. N.J. Pender, C.L. Murdaugh, and M.A. Parsons, *Health Promotion in Nursing Practice*, 4th ed. (Upper Saddle River, NJ: Prentice Hall, 2002).
23. E.C. Devine and E. Reifschneider, A Meta-Analysis of the Effects of Psychoeducational Care in Adults with Hypertension, *Nursing Research* 44, no. 4 (1995):237–245.
24. M. Conti-O'Hare, *The Nurse as Wounded Healer: From Trauma to Transcendence* (Boston: Jones and Bartlett Publishers, 2002).

25. L. Dossey, Who Gets Sick and Who Gets Well? *Alternative Therapies* 1, no. 4 (1995):6–11.
26. K.L. Lawson and K.J. Horneffer, Roots and Wings: A Pilot of a Mind-Body-Spirit Program, *Journal of Holistic Nursing* 20 (2002):250–263.
27. C. Pert, Neuropeptides: The Emotions and Body-Mind, *Noetic Sciences Review* Spring 1987, 13–18.
28. C. Pert, The Wisdom of the Receptors: Neuropeptides, the Emotions, and Body-Mind, in *The Healing Brain: A Scientific Reader*, eds. R. Ornstein and C. Swencionis (New York: Guilford Press, 1990), 147–158.
29. M. Samuels, Art as a Healing Force, *Alternative Therapies* 1, no. 4 (1995):38–40.
30. J. McClenon, Spiritual Healing and Folklore Research: Evaluating the Hypnosis/Placebo Theory, *Alternative Therapies* 3, no. 1 (1997):61–66.
31. J.S. Levin, How Prayer Heals: A Theoretical Model, *Alternative Therapies* 2, no. 1 (1996):66–73.
32. L.G. Kolkmeier, Self-Reflection: Consulting the Truth Within, in *Holistic Nursing: A Handbook for Practice*, 2nd ed., eds. B.M. Dossey et al. (Rockville, MD: Aspen Publishers, 1988).
33. Ibid.
34. Ibid.
35. Ibid.
36. Ibid.
37. P.B. Allen, *Art Is a Way of Knowing* (Boston: Shambhala, 1995).
38. M. Cassou and S. Cubley, *Life, Paint and Passion: Reclaiming the Magic of Spontaneous Expression* (New York: G.P. Putnam's Sons, 1995) 19.
39. Kolkmeier, Self-Reflection.
40. L. Rew, Intuition: Concept Analysis of a Group Phenomenon, *Advances in Nursing Science* 8, no. 2 (1986):21–28.
41. L. Rew, Intuition: Nursing Knowledge and the Spiritual Dimension of Persons, *Holistic Nursing Practice* 3, no. 3 (1989):56–68.
42. Kolkmeier, Self-Reflection.
43. The American Heritage Dictionary of the English Language, 4th ed. (Boston: Houghton Mifflin Company, 2000).
44. R. von Oech, *A Whack on the Side of the Head: How You Can Be More Creative* (New York: Warner Books, 1990).
45. D. Fontana, *Teach Yourself to Dream* (San Francisco: Chronicle Books, 1997).
46. Ibid.
47. Ibid
48. Rew, Intuition: Nursing Knowledge and the Spiritual Dimension of Persons.
49. T. Buzan and B. Buzan, *The Mind Map Book* (New York: Penguin USA, 1993).
50. C.G. Jung, *Man and His Symbols* (New York: Dell Publishing, 1964).
51. C.S. Pearson, *The Hero Within* (San Francisco: HarperSanFrancisco, 1998).
52. Rew, *Awareness in Healing*.
53. A.W. Cornell, *The Power of Focusing: A Practical Guide to Emotional Self-Healing* (Oakland, CA: New Harbinger Publications, 1996).
54. M.G. Nagai-Jacobson and M.A. Burkhardt, Viewing Persons as Stories: A Perspective for Holistic Care, *Alternative Therapies* 2, no. 4 (1996): 54–58.
55. S.W. Albert, *Writing from Life: Telling Your Soul's Story* (New York: Jeremy P. Tarcher/Putnam, 1996).
56. R. Stone, *The Healing Art of Storytelling* (New York: Hyperion, 1996).
57. G.J. McDougall et al., The Process and Outcome of Life Review Psychotherapy with Depressed Homebound Older Adults, *Nursing Research* 46 (1997):277–283.
58. Nagai-Jacobson and Burkhardt, Viewing Persons as Stories.
59. McDougall et al., Process and Outcome of Life Review Psychotherapy.
60. J. Borysenko, *Inner Peace for Busy People* (Carlsbad, CA: Hay House, Inc., 2001).

SUGGESTED READING

Albert, S.W., *Writing from Life: Telling Your Soul's Story* (New York: Jeremy P. Tarcher/Putnam, 1996).

Cassou, M. and Cubley, S., *Life, Paint and Passion: Reclaiming the Magic of Spontaneous Expression* (New York: G.P. Putnam's Sons, 1995).

Chapman, J., *Journaling for Joy: The Workbook* (Van Nuys, CA: Newcastle Publishing Co., 1995).

Dreaver, J., *The Way of Harmony* (New York: Avon Books, 1999).

Fontana, D., *Teach Yourself to Dream* (San Francisco: Chronicle Books, 1997).

Holland, G.B., Connecting Inner Assets, *Noetic Sciences Review* 57 (Sept.–Nov., 2001):30–33.

Larter, R., Life Lessons from the Newest Science, *Noetic Sciences Review* 59 (Mar.–May, 2002), 22–27.

Marty, L., To Dance on Knowing Ground, *Noetic Sciences Review* 50 (Dec. 1999–Mar. 2000), 28–31.

Murdock, M., *The Heroine's Journey Workbook* (Boston: Shambhala, 1998).

Newman, M.A., The Pattern that Connects, *Advances in Nursing Science* 24(3):1–7.

Olson, M., Death and Grief, in *Core Curriculum for Holistic Nursing*, ed. B.M. Dossey (Gaithersburg, MD: Aspen Publishers, 1997), 126–133.

Richardson, C., *Turning Inward: A Private Journal for Self-Reflection* (Carlsbad, CA: Hay House, Inc., 2002).

Nourishing the Bodymind

In large measure, joy and vitality can come from eating well. A wise nurse endeavors to maximize and develop the best nutrition habits and skills both for the self and for the client. As the 21st century begins the ancient Greek ideal of a sound mind in a strong, able body is once again in fashion. A healthy physical body can indeed be the temple for the mind-spirit. The way in which we care for and nourish our bodies not only affects our general physical well-being but also increases our mental and spiritual capacities.

When planned with knowledge and commitment, nutritional intake promotes high-level wellness behavior. Foods have power. Foods transfer their power to human beings when we digest and assimilate them. One of the basic premises behind the view that foods heal is that food comprises organic chemicals, just as we do. As physical organisms, we are composed of millions of biochemicals. Their daily replacement through the ingestion of healthy nutrients is critical to our optimal functioning. Food consumption and physical activity have a direct effect on the body-mind-spirit. Unlike taking medicines, healthy eating enables us to build up or tear down the actual tissues of our bodies. When we eat well, we build strong, healthy bodies; when our diets are defective, we deprive our bodies of the full complement of biochemicals necessary to ensure optimal health. In general, the feeling of well-being that comes from physical health permeates every individual activity, enabling the quickest thinking, permitting a better night's sleep, and perhaps facilitating spirituality.

The lack of proper nutrition is a major risk factor for diseases, such as hypertension, hypercholesterolemia, and obesity. Eating habits affect exercise abilities and vice versa. However, nutrition patterns can be modified when individuals make the decision to move toward wellness. For those who are nutritionally compromised or physically weakened because of illness and disease, or because of mental, emotional, or spiritual ennui, the good news is that anyone with motivation can use the principles of healing nutrition to activate and nourish the bodymind.

Each of us has the capacity to acquire information, not only to prevent disease, but also to achieve a vital, productive life. Nurses can increase their own vigor and vitality and then use the same methods to assist their clients. As a collective whole, nurses can join with other professionals to meet the objective of increased health and vitality for all people.

Chapter 18

Nutrition

Susan Luck

NURSE HEALER OBJECTIVES

Theoretical

- Learn the definitions of terms in this chapter.
- Differentiate between the recommended daily allowance (RDA) and the optimal daily allowance (ODA).
- Develop a plan that combines good nutrition with exercise and body awareness.
- Learn the benefits of healthy eating for health maintenance and disease prevention.

Clinical

- Assess the quality of your food intake and note how it increases or decreases your energy level at work.
- Observe the meaning of foods in different cultural traditions.
- Identify nutritional foods that support your client's healing process.
- Employ strategies to improve nutrition in your workplace environment.

Personal

- Heighten your awareness of the way in which what you eat affects how you feel.
- Examine your eating patterns and the meaning of food in your life.
- Explore new foods and food preparation that support your health.
- Plan a day's menu, asking yourself, "What does my body need to enhance my wellness?"

DEFINITIONS

Antioxidants: substances that limit free radical formation and damage by stabilizing or deactivating free radicals before they attack cells.

Free Radicals: electrically charged molecules with an unpaired electron capable of attacking healthy cells in the body, causing them to lose their structure and function.

Glycemic Index: an index that classifies carbohydrate foods according to their glycemic response (effect on blood glucose levels), which varies with fiber content, starch structure, food processing, and presence of proteins and fats.

HDL: high-density lipoprotein form of cholesterol associated with reduced risk of atherosclerosis.

Homocysteine: an intermediate product of methionine metabolism and a marker for many clinical conditions, including cardiovascular disease.

LDL: low-density lipoprotein form of cholesterol strongly associated with increased risk of atherosclerosis.

Mineral: an inorganic trace element or compound that works in synergy with other compounds and is essential for human life.

Optimal Nutrition: adequate intake of nutrients for health promotion and disease prevention.

Phytochemicals: biologically active compounds found in foods.

Phytoestrogens: family of compounds found in plants that have some estrogenic and/or antiestrogenic activity in humans.

Probiotic: formulation containing beneficial living microorganisms that maintain health as part of the internal ecology of the digestive tract.

Vitamin: an organic substance necessary for normal growth, metabolism, and development of the body; acts as a catalyst and coenzyme, assisting in many chemical reactions while nourishing the body.

Xenoestrogens: synthetic, hormone-mimicking compounds found in certain pesticides, drugs, and plastics.

THEORY AND RESEARCH

Over the last few decades, nutrition has moved into the forefront as a major component in health promotion and disease prevention. The scientific knowledge of nutrition is expanding rapidly. As nutritional science has developed, so have its clinical implications and applications. Understanding of clinical nutrition has broadened, so that it is now included as part of an integrated, comprehensive approach to health care. Today, nutritional assessment and interventions often are prescribed along with conventional medical protocols in the treatment of many health conditions, including heart disease, arthritis, diabetes, obesity, cancer, immune dysfunction, and a variety of women's health problems.

In the past decade, science has vigorously researched the impact of nutrition on health and disease. Food is no longer viewed merely as providing substances whose absence would produce disease, but as having a positive impact on the individual's health, physical performance, and state of mind. Foods, and the nutrients derived from them, are considered to promote health, assist healthy aging, and support complete physical, mental, and social well-being. Modern society makes available an increasingly wide variety of processed, denatured foods that are depleted of nutrients and often contain toxic chemicals. Research implicates these changes in the food supply as contributing to a number of health problems, including atherosclerosis, heart disease, hypertension, diabetes, and various cancers. These diseases were virtually unknown a hundred years ago. Therefore, nutritional requirements are being reevaluated to meet the demands of today's world and the needs of people throughout the various stages of life, beginning with prenatal development and continuing into old age. The individual's metabolism, environment, genetics, emotional health, and life stressors must be considered in evaluating nutritional needs and nutritional goals. Nutrition is becoming an important component of early intervention strategies to improve physiologic, cognitive, emotional, and physical functioning of the individual.

For more than 40 years, the *recommended daily allowances* (RDAs) for various nutrients established by the U.S. Food and Nutrition Board have been the standard guidelines for defining nutritional needs. RDAs specify the levels of nutrients required to prevent overt symptoms of deficiency.[1] Since their inception, the RDA guidelines have been periodically reevaluated and updated based on continuing analysis of science advances in the field. The RDA guidelines have generated con-

troversy, with many governmental and private groups asking questions such as the following:

- Can one get all of the nutrients one needs from the foods available in today's food supply?
- Do the RDAs take into account individual lifestyle, food availability, and individual health needs?
- Do the RDAs consider optimal health and well-being?

Many researchers and practitioners advocate nutrient supplementation, in addition to consumption of healthy foods that conform to nutritional guidelines, to help people meet the growing health challenges confronting our world today. They recommend new standards known as *optimal daily requirements* (ODAs).

Overt symptoms of nutrient deficiency are merely the last event in a long chain of reactions in the body. When a person does not receive adequate nutrients, the initial reactions occur on a molecular level. First, essential enzymes that are dependent on the deficient nutrients become depleted. This depletion then brings about changes in cells themselves. These deficiencies can continue for many years until the body can no longer carry out its normal functions. Eventually, overt signs and symptoms appear, even though the deficiency may still be considered subclinical since routine laboratory tests do not necessarily uncover nutritional deficiencies. Nevertheless, these subclinical deficiencies can lead to a broad range of nonspecific conditions that can diminish an individual's overall quality of life.[2] Undiagnosed, these deficiencies, over many years, leave the body more vulnerable to illnesses to which the individual may be genetically predisposed, and to immune system compromise. Only recently, high levels of homocysteine have been recognized to be associated with increased risk for cardiovascular disease and stroke. Homocysteine is found in low amounts in healthy individuals. Research has shown repeatedly that elevated homocysteine levels result from subclinical deficiencies of B vitamins, including folic acid, vitamin B_6, and vitamin B_{12}.[3] Vigilance for nutrient deficiencies and their potentially life-threatening consequences is slow to become part of routine physical examinations and health assessments. Two articles in the *New England Journal of Medicine* report, "High plasma homocysteine concentrations and low concentrations of folate and Vitamin B_6 through their role in homocysteine metabolism, are associated with an increased risk of extracranial carotid-artery stenosis in the elderly."[4] Attention to the role of nutrients in maintaining health and preventing disease is gradually becoming a recognized component in the provision of comprehensive care.[5]

Nutrient deficiencies can result from a high intake of refined foods. Americans consume approximately 18 percent of their calories as refined sugar, devoid of the vitamins or minerals necessary for its metabolism. It is estimated that an additional 18 percent of a typical American diet consists of refined products. These include white bread, which is deficient in 28 essential nutrients that were contained in the whole grain prior to its processing. Deficiencies in many of these nutrients—especially vitamin B_6, the most commonly deficient B vitamin in the diet—are associated with diabetes, heart disease, depression, and premenstrual syndrome. Many epidemiological studies report strong correlations between Western diseases and dietary habits.[6] Mortality rates for certain cancers, as well as the incidence of cardiovascular disease, are higher among those consuming an American diet than among those consuming Asian, Scandinavian, or Mediterranean diets.[7] (The

Figure 18–1 Mediterranean Diet Pyramid.

Mediterranean diet pyramid is shown in Figure 18–1.)

Nutrient Sources

Carbohydrates

Carbohydrates provide the main source of energy for all body functions, aiding in digestion, assimilation, and metabolism of proteins and fats. Carbohydrates are classified as simple and complex. Simple carbohydrates include refined white flour products, white rice, white table sugar (dextrose), honey, fruit sugars (fructose), and milk sugars (lactose). Complex carbohydrates are found in whole grains, legumes, and vegetables and contain protein, vitamins, minerals, and fiber. They have been an important staple of the diet in diverse cultures throughout human history. Complex carbohydrates supply the body with essential nutrients and provide longer lasting energy than simple carbohydrates.[8]

Fiber

Fiber contains polysaccharides and can be subdivided into insoluble fiber and soluble fiber, each with a different mixture of compounds. ***Insoluble*** fiber includes pectin and cellulose, hemicellulose, and lignins. Insoluble fiber is present in fruits, leafy vegetables, whole grains and brans, and beans. ***Soluble fiber*** is identified as gelatinlike substances, including the mucilage qualities found in oatmeal and legumes. Research clearly documents that the modern Western diet, with its low fiber

content, has led to an increase in digestive problems, including diverticulitis, constipation, colon cancer, gallstone formation, and other gastrointestinal disturbances. Although dietary fiber is not digested and provides no caloric contribution, it increases fecal bulk and weight, making the passage of waste products more efficient so that toxins and cancer-causing substances are eliminated quickly from the system. Fiber also is important in modulating insulin response and thereby stabilizing blood sugar levels. In recent years, research into the benefits of dietary fiber has led many practitioners to recommend a low-fat, high-fiber diet for prevention of heart disease, diabetes, obesity, digestive disorders, and cancer. According to Seymour Handler, of the North Memorial Medical Center in Minneapolis, most of the serious diseases of the colon, including appendicitis and diverticular disease, are linked etiologically to the high-saturated-fat, low-fiber Western diet. A diet high in saturated animal fat and low in fiber increases the risk of colon cancer. Guidelines for minimizing risk include reducing consumption of saturated fats and increasing consumption of complex carbohydrate foods offering protein, vitamins, minerals, and fiber.[9]

Protein

Protein is the second most plentiful substance in the body (after water), and constitutes approximately one-fifth of body weight. Protein is the basic building block of the body and makes up the rigid structures such as bone, solid organs, and blood vessels. It is essential for the growth and maintenance of all body tissues, including muscle, skin, hair, nails, and eyes. Hormones, chemicals such as antibodies, and enzymes are composed of protein. Protein molecules, essentially comprising amino acids, form long chains and branched structures. Amino acids contain nitrogen, carbon, hydrogen, and sometimes sulfur. Twenty-two amino acids are required to build protein; half of these are produced in the body when adequate nutrients are available, and eight are considered essential. Excessive protein consumption taxes the kidneys and digestive system. Since the majority of Americans consume most of their protein through animal products—a source of saturated fat as well—consumption of a large quantity of animal protein is associated with increased risk of cardiovascular disease and breast, colon, and prostate cancers. Plant foods such as whole grains, legumes, seeds, and nuts provide excellent protein, but this protein is incomplete, and these foods must be combined to provide all of the essential amino acids. Protein requirements depend on the individual's activity level, energy requirements, age, and digestive health. The recommended protein allowance for health maintenance in the United States is 0.8 gram per kilogram of body weight per day. Men and women who body-build require up to 1.2 grams per kilogram of body weight.

Lipids

Lipids are a group of fats and fatlike substances, including essential fatty acids, that account for more than 10 percent of body weight in most adults. The principal function of fats is to serve as a source of energy. Stored fats also act as a thermal blanket, insulating the body and providing a protective cushion for many tissues and organs. According to the third National Health and Nutrition Examination Survey, Americans are eating less fat than they were 10 years ago. Americans now average 34 percent of their total daily calories (82 grams) from fat, with approximately 12 percent (29 grams) from

saturated fats. Current dietary recommendations call for 20 percent of total calories from fat and less than 10 percent from saturated fats. The RDA for dietary fat suggested by the National Academy of Sciences to ensure the intake of essential fatty acids is 25 grams. Unsaturated fats are usually liquid at room temperature and are derived from vegetables, nuts and seeds, soybeans, and olives. Saturated fats—found in animal products, including meat and dairy products—are generally associated with increased risk of cancer and cardiovascular disease. Foods often contain a mixture of saturated and unsaturated fatty acids. Fats are calorie rich and contain approximately 9 calories per gram, almost twice the calories of carbohydrates and proteins.[10]

Essential fatty acids are found in both monosaturated and polyunsaturated fats. Monosaturated fats include olive, peanut, avocado, and canola oils. Polyunsaturated fats (PUFAs) are found in safflower, sunflower, corn, sesame, and soy oils. Fats can be further divided into two main classes: Omega-3 fatty acids and omega-6 fatty acids. Essential fatty acids form a structural part of all cell membranes. They hold proteins in the membrane, maintain fluidity of the membrane, and create electrical potentials across the membrane, facilitating the generation of bioelectrical currents that transmit messages. Certain essential fatty acids substantially shorten the time required for the recovery of fatigued muscles after exercise by facilitating the conversion of lactic acid to water and carbon dioxide. Essential fatty acids act as precursors for a family of hormonelike substances called prostaglandins, which regulate many functions in the body, including inflammatory processes and immune responses. Essential fatty acids contain no cholesterol. They must be supplied through the diet because they cannot be synthesized by the body, although they are essential to health. Omega-3 essential fatty acids are immune enhancing and are often deficient in the modern diet. They contain high concentrations of linoleic acid and are necessary for normal growth and development throughout the life cycle. Omega-3 essential fatty acids are found in high concentrations in fish, fish oils, flax seeds, and pumpkin seeds. Research has shown that these essential fatty acids can lower blood pressure, lower cholesterol and triglyceride levels, and reduce the risk of heart disease, stroke, and immune dysfunction.[11] These essential fatty acids are found in high concentrations in the brain. Japanese researchers concur that a deficiency of these essential fatty acids can lead to impaired ability to learn and decreased cognitive function. Researchers believe that many of today's health problems are the manifestations of Omega-3 essential fatty acid deficiency. Deficiency symptoms include poor immune response, dry skin and hair, behavioral changes, menstrual irregularities, arthritislike conditions, and cognitive difficulties.[12] Table 18–1 serves as a guide for general dietary goals and recommendations.

Vitamins

Vitamins are nutrients essential to life. They contribute to good health by regulating the metabolism and assisting in biochemical processes that release energy from digested food. Vitamins function mostly as coenzymes that activate the chemical reactions continually occurring in the body. Vitamins are the foundation for all aspects of body function, from nervous system transmission to proper composition of bodily fluids. Vitamins are divided into two major groups: water soluble and fat soluble. Water-soluble vitamins must be taken into the body daily

Table 18–1 Dietary Goals and Recommendations

Dietary Goal	*Food Group*	*Recommendation*
Reduce fat	Meat (beef, chicken, pork, turkey, lamb)	Avoid high-fat meats Lean meat—trim fat Bake, broil, steam Increase fish intake Remove skin from poultry
	Dairy	Skim milk, low-fat yogurt, goat (feta) cheese, low-fat cheeses (mozzarella, cottage), low-fat sorbet or sherbet
	Fats/oils	Avoid fried foods Avoid margarine, hydrogenated fats Use olive, flaxseed, canola oil (cold pressed)
	Eggs	2–3 whole eggs/week (boil, poach) Eggs whites—as desired
Reduce refined sugar	Soft drinks, pastries, white sugar	Avoid sodas, cookies, pastries, table sugar Increase fruits
Increase complex carbohydrates	Whole grains, beans, seeds, nuts	Increase beans, whole grains: lentils, tofu, brown rice, oats, whole-grain breads, fiber cereals, almonds, sunflower seeds
Reduce sodium	Salt	Eliminate processed foods high in salt Substitute condiments for flavoring (garlic, onions, spices)
Reduce caffeine	Coffee, soda, chocolate	Coffee substitutes—caffix, postum, decaffeinated coffee Eliminate soda and diet soda, fruit juices, iced herbal teas
Reduce alcohol	Alcohol	Limit (reduce) intake

*Read ingredients on labels

and are excreted within one to four days. They include vitamin C and the B-complex vitamins. Because excessive quantities are excreted rather than stored, water-soluble vitamins are seldom associated with toxicity problems. Fat-soluble vitamins are absorbed into the blood along with dietary fats. Because they are insoluble in water, they are transported via the lymphatic vessels of the blood and are stored in the body's adipose tissue and in the liver. Fat-soluble vitamins include vitamins A, D, E, and K.

Table 18–2 provides more information about vitamins and their food sources.

Minerals

Minerals are naturally occurring elements or compounds found in the earth. They are passed from soil to plants and are then consumed by animals and humans. Minerals are essential components of all cells and function as coenzymes. They are necessary for proper composition of body fluids, formation of blood and bone, and maintenance of healthy nerve function.

Table 18–2 Fat-Soluble and Water-Soluble Vitamins

Vitamin	*Function*	*Food Source*
Fat-Soluble Vitamins		
Vitamin A (retinol)	Antioxidant. Aids in maintenance and repair of mucous membranes and epithelial tissue. Assists in growth and development of bones.	All orange and yellow fruits and vegetables: sweet potatoes, squash, yams, carrots, pumpkin, parsley, mango, apricots. Dark leafy greens: kale, spinach, broccoli, salmon, fish oils
Carotenoids (carotenes, lycopenes)	Antioxidant. Enhances cell communication and immune competence.	Orange, yellow, and dark green fruits and vegetables.
Vitamin D	Aids in transport of calcium. Promotes intestinal and renal absorption of phosphorus. Aids in growth of bones and teeth.	Liver, oils, egg yolk, alfalfa, dairy products, fish, especially fatty fish such as halibut, salmon, sardines.
Vitamin E	Antioxidant. Promotes wound healing. Protects cell membranes against lipid perioxidation and destruction. Improves circulation.	Cold-pressed vegetable oils, whole grains, dark leafy green vegetables, nuts, seeds, legumes, wheat germ, oatmeal.
Vitamin K	Aids in blood clotting. Promotes formation and maintenance of healthy bone.	Green leafy vegetables, egg yolks.
Water-Soluble Vitamins		
Vitamin B_1 (thiamine)	Coenzyme in oxidation of glucose. Assists in production of hydrochloric acid.	Dried beans, brown rice, egg yolks, fish, chicken, peanuts.
Vitamin B_2 (riboflavin)	Assists in red blood cell formation. Aids in metabolism of carbohydrates, fats, and proteins.	Beans, eggs, fish, poultry, meat, spinach, yogurt, asparagus, avocado.
Vitmain B_3 (niacin)	Promotes healthy skin and nervous system. Lowers cholesterol, improves circulation.	Fish, eggs, beef, cheese, potatoes, whole wheat.
Vitamin B_5 (pantothenic acid)	"Antistress" vitamin. Aids in production of adrenal hormones. Assists in formation of antibodies and protein metabolism.	Beans, beef, eggs, mother's milk, fresh vegetables, whole wheat, pork, saltwater fish.
Vitamin B_6 (pyridoxine)	Acts as coenzyme in metabolism of amino acids and essential fatty acids necessary for production of serotonin and other neurotransmitters. Essential for healthy nervous system. Assists in converting iron to hemoglobin.	Eggs, fish, spinach, peas, meat, nuts, carrots, poultry, soybeans, bananas, avocado, whole grain cereals, prunes.
Vitamin B_{12} (cobalamin)	Aids in synthesis of red blood cells. Required for proper digestion and absorption of foods. Prevents nerve damage.	Beef, herring, cheese, sardines, salmon, shellfish, tofu, eggs, dairy products.
Folic acid	Participates in amino acid conversion, manufacture of neurotransmitters.	Dark green vegetables, kidney beans, asparagus, broccoli, whole grains, cereals.
Vitamin C (ascorbic acid)	Antioxidant. Aids in collagen formation, absorption of iron, interferon production. Promotes capillary integrity. Aids in release of stress hormones.	Citrus fruits, papaya, parsley, watercress, berries, tomatoes, broccoli, brussels sprouts.

Once a mineral is absorbed, it must be carried from the blood to the cells and then must be transported across the cell membrane in a form that can be utilized by the cell. Minerals, like vitamins, work in combination with other nutrients and have both synergistic and antagonistic effects. Some minerals compete with one another for absorption, while others enhance the absorption of other minerals. For example, too much calcium can decrease the absorption of magnesium; therefore these minerals should be consumed in the proper ratio to maintain balance.

Minerals are classified as either major minerals or trace minerals; however, this classification does not reflect their importance. A deficiency of either type of mineral can have a deleterious impact on health. To be classified as a major mineral, the mineral must make up no less than 0.01 percent of body weight. Major minerals include calcium, magnesium, phosphorus, potassium, sodium, and chloride. Trace minerals include arsenic, boron, chromium, cobalt, copper, fluoride, iodine, iron, manganese, molybdenum, nickel, selenium, silicon, tin, vanadium, and zinc.

Although normal dietary intake of trace nutrients poses no threat to human health, long-term therapeutic doses of one or more minerals at the expense of other minerals might result in secondary deficiencies that could impair immunological or antioxidant processes. Reduced bioavailability is aggravated by marginal dietary intake of the unsupplemented mineral. Even borderline levels of certain minerals can suppress a variety of immune functions. Cell-mediated immunity, antibody response, and other immune responses may be impaired by marginal deficiencies in trace minerals.[13] For example, borderline zinc deficiency is associated with depletion of lymphocytes and lymphoid tissue atrophy. Excessive long-term consumption of competing minerals, such as iron, might suppress immune response by producing a secondary deficiency of zinc.[14]

Bioavailability and supplementation are some of the most controversial areas in nutrition research and practice. Nutrient intake through food consumption depends on many factors, including the quality of the soil in which the foods were grown, use of fertilizers, and genetic engineering of foods, to name a few. Consumption of a wide variety of fresh fruits and vegetables and unprocessed whole foods is recommended.

Table 18–3 provides further information on minerals and their food sources.

Antioxidants

Some vitamins and minerals function as antioxidants. These include vitamins C and E, beta-carotene (a precursor of vitamin A), coenzyme Q10, alpha lipoic acid, and the trace mineral selenium. ***Antioxidants*** protect the body from the formation of free radicals. Free radicals are electrically charged molecules that have an unpaired electron. Free radicals can cause damage to healthy cells. They can also stress the immune system and suppress its ability to defend the host adequately against organisms, toxins, and metabolic by-products, all of which can lead to degenerative or infectious disease states.[15] Antioxidants can stabilize or deactivate free radicals before the latter attack cells. Antioxidants are absolutely critical for maintaining optimal cellular and systemic health and well-being.[16]

The body can also manufacture its own antioxidant, glutathione. Glutathione is a powerful antioxidant composed of the amino acids cysteine, glycine, and glutamic acid. It is potentized and recycled by other antioxidants, including vitamin C, selenium, and coenzyme Q10. It is produced by and is most concentrated in the liver, where it is involved in detoxification pathways and protects against free-radical damage. Glutathione helps to recycle other antioxidants.[17] Glutathione is

Table 18–3 Major Minerals and Trace Elements

Mineral	*Function*	*Food Source*
Calcium	Formation of strong bones, transmission of nerve impulses, muscle growth and movement. Blood clotting. Prevention of hypertension.	Dairy products, salmon, sardines, green leafy vegetables, seeds and nuts, tofu, blackstrap molasses, seaweed.
Chromium	Metabolism of glucose. Stabilization of blood sugar levels. Synthesis of cholesterol, fats, and proteins.	Brewer's yeast, brown rice, cheese, whole grains, beans, mushrooms, potatoes.
Copper	Formation of bone, hemoglobin, red blood cells. Healing process.	Whole grains, avocado, oyster, lobster, dandelion greens, mushrooms, blackstrap molasses, nuts, seeds, soybeans.
Iodine	Energy production. Body temperature regulation, thyroid gland health.	Seaweed, iodized salt, dairy products, seafood, saltwater fish, garlic, swiss chard, summer squash.
Iron	Hemoglobin production. Stress and disease resistance. Energy production. Immune system health.	Eggs, fish, poultry, dark leafy greens, blackstrap molasses, almonds, seaweed.
Magnesium	Formation of bone. Carbohydrate and mineral metabolism. Maintenance of proper pH balance. Immune function.	Dairy products, fish, seafood, blackstrap molasses, garlic, whole grains, seeds, tofu, green leafy vegetables, nuts.
Manganese	Enzyme activation. Sex hormone production. Nerve health. Energy production.	Avocados, nuts, seeds, seaweed, whole grains.
Phosphorus	Bone and teeth formation. Cell growth. Contraction of heart muscle. Kidney function.	Asparagus, brewer's yeast, fish, dried fruits, garlic, legumes, seeds and nuts.
Potassium	Healthy nervous system. Regulation of body fluids with sodium. pH balance.	Apricots, bananas, potatoes, sunflower seeds, blackstrap molasses, sprouts, broccoli.
Selenium	Antioxidant function. Immune system protection, cancer prevention.	Brazil nuts, brewer's yeast, brown rice, dairy products, garlic, onions, whole grains.
Sodium	With potassium, regulation of body fluids necessary for nerve and muscle function.	Table salt, seaweed.
Zinc	Burn and wound healing. Carbohydrate digestion. Prostate gland function, reproductive organ growth and development. Immune system health, production of antibodies.	Sardines and other fish, legumes, poultry, meat, egg yolks, beans, pumpkin seeds, sunflower seeds.

involved in the synthesis and repair of DNA. Decline in glutathione concentrations in intracellular fluids correlates directly with indicators of immunological function and longevity. Liver stores of glutathione can be depleted by disease processes, malnutrition, or poor-quality nutrient intake. Dietary amino acids are essential to glutathione synthesis. Lifestyle factors that affect efficient utilization of glutathione include stress, alcohol, cigarette smoking, and illicit drug abuse.[18]

Digestion

Diet is the food we eat. *Nutrition* is the study of what happens after we eat it. Optimal absorption of nutrients depends on the integrity of the digestive system. The process of digestion begins in the mouth

with chewing. Food is ground up into small particles and mixes with salivary enzymes. The entire gastrointestinal tract is lined with mucosal tissue that secretes enzymes and protective antibodies known as IgA molecules, an important part of our immune defense. The gastrointestinal tract also contains billions of friendly microflora. These microorganisms assist in metabolic processes while maintaining the integrity of the mucosal lining.[19]

Digestion in the stomach occurs as food is churned and mixed with hydrochloric acid and various enzymes, which prepare it for entry into the small intestine via the duodenum. In the small intestine, digestive enzymes from the liver, gallbladder, and pancreas are added to the partially digested food. The pancreas secretes amylase, lipase, and chymotrypsin, while the liver and gallbladder secrete bile to aid in the digestion of fats and the absorption of essential fatty acids and fat-soluble vitamins. Food spends one to four hours in the small intestine, which is approximately 25 feet long. As food is digested, it is absorbed into small blood vessels in the lining of the intestine. Toxins and waste products enter the large intestine to be excreted as fecal matter. The large intestine processes primarily fiber and water. The proper absorption and utilization of nutrients depends on a complex orchestration of processes in the digestive tract, and therefore it is essential to maintain the health and balance of this system. Colorectal cancer is the third leading cause of cancer deaths in adults in the United States. Researchers are focusing their attention on prevention and nutrition. For example, a recent study reports that women with diets high in folate reduced their risk of developing colorectal cancer. In the well known Nurses Health Study, reported in the April 2001 issue of *Harvard Women's Health Watch*, women who took multivitamins containing folic acid for at least fifteen years were 75 percent less likely to develop colon cancer than those who did not.

The friendly bacteria that live in the gastrointestinal tract, including strains of *Lactobacillus* and *Acidophilus*, have many beneficial effects on health. They assist in synthesizing B vitamins, digesting proteins, balancing intestinal pH, reducing serum cholesterol, strengthening the immune system in the gut, eliminating parasites and preventing overgrowth of yeast, and maintaining regularity. The most common reason for the destruction of friendly bacteria is the use of antibiotics. Studies indicate that beneficial bacteria must be replaced (by probiotic supplementation) when antibiotic therapy is administered. Symptoms of dysbiosis include fatigue, bloating, gas, diarrhea, constipation, food allergies, inflammatory disorders, migraine headache, and weight gain.

Dietary modification, including elimination of fried foods, sugars, and foods that stress an individual's digestive system, also can aid in the treatment of gastrointestinal problems. Keeping a food journal and then following an elimination diet is helpful. Identifying foods that may trigger digestive disorders, food allergies, and autoimmune responses, and then removing them from the diet for a minimum of 21 days can be an important dietary intervention for those with food sensitivities.[20] The individual can slowly reintroduce the food item and observe if symptoms return. Each person has a unique relationship with food and its chemical properties, and therefore nutritional assessment and dietary recommendations are based on individual biochemistry.

EATING TO PROMOTE HEALTH

Increasing awareness of how one's diet can affect one's health and well-being is essential to nutrition education. The fol-

lowing questions can be used as a guideline. Sit down in a quiet place and plan a day's menu by asking yourself:

- What does my body need to enhance wellness?
- What are my past eating patterns? Which do I want to keep? Which do I want to change?
- What are my activity levels and how should I include foods that meet my needs?
- How do I need to plan for psychological factors?
- What factors, unique to me, influence my food planning?

As nutrition is integrated into clinical care, assessing the unique needs of each individual while offering health education and self-care tools can impact the health and well-being of the individual over time. Nutrition offers a holistic approach and takes into account the individual's physiologic, psychologic, social, genetic, cultural, religious, economic, and environmental needs. The individual's eating patterns, food preferences, motivation, attitudes, and beliefs are all part of nutrition counseling and education.

In today's world, the consequences of stress in our lives and its impact on our health can be mediated through increasing our nutrient intake to support normalization of stress-induced biochemical changes and increase natural resistance to stress responses. Research increasingly supports the critical role that stress and stress molecules can play in obesity, diabetes, osteoporosis, hypertension, cardiovascular disease, infectious disease, gastric ulcer, cancer, and gastrointestinal, skin, endocrine, and neurologic disorders, as well as a host of disorders linked to immune system disturbances. Chronic stress has been shown to affect behavior and has been linked to anxiety states and depression. The vulnerability of a particular bodily system to stress varies from one individual to another and is determined by genetic and constitutional makeup and may be influenced by environmental factors. A healthy diet rich in whole foods containing antioxidants, vitamin Bs, essential fatty acids, and trace minerals can mediate the stress response and support overall health and well-being throughout life.

Cardiovascular Disease and Cancer

Cardiovascular disease and cancer are the two leading causes of death among women in the United States. Heart disease is responsible for 45 percent of all deaths among women, and nearly 40 percent of all females are expected to develop cancer at some point in their lifetime. A substantial body of research suggests that both heart disease and cancer are strongly related to dietary habits and nutrient status. Helping women to maintain optimal health with diet and healthy lifestyle choices can have a significant, positive impact on society by reducing the prevalence of disease among women. Recent research demonstrates the cardioprotective effects of several dietary nutrients, including fiber (both soluble and insoluble), antioxidants (vitamins C and E, beta-carotene, selenium, coenzyme Q10), folic acid (homocysteine levels are highest among those with low folic acid levels), and essential fatty acids (omega-3 fish oil).[21] According to several recent studies, women can lower their risk of heart disease and heart attacks by improving blood lipid and fatty acid profiles with a combination of essential fatty acids derived from fish oils including EPA, DHA, and GLA. Researchers estimate this combination produced a 43 percent risk reduction over a ten-year period.[22]

Breast cancer is the second most common cause of cancer-related deaths in women in the United States. Two important environmental risk factors for breast cancer are diet and exposure to xenotox-

ins.[23] An estimated 80 percent of cancers are thought to be related to environmental factors; diet alone is estimated to play a role in at least 35 percent of all cancers. It has been estimated that as much as 50 percent of breast cancer might be prevented by dietary changes.[24] Environmental xenoestrogens—synthetic hormone-mimicking compounds found in certain pesticides, drugs, and plastics—may play a role in the etiology of breast cancer. Women with breast cancer often have higher concentrations of pesticides in their blood and fatty tissue.[25] Xenoestrogens accumulate in the fatty tissues of the body and may interact with estrogen receptor sites in the breast, enhancing breast cell proliferation.[26]

Many epidemiological studies have associated a high-fat, low-fiber diet with an increased risk of developing cancer of the colon, prostate, and breast. A review of the literature also suggests an inverse relationship between the quantity of fresh fruits and vegetables consumed and the incidence of cancer. Fruits and vegetables are rich in fiber, antioxidants, and other plant-derived substances, or phytonutrients, that are believed to have cancer-protective properties.[27] Fiber is thought to influence hormone levels by facilitating the fecal excretion of estrogen metabolites, which at high levels can pose a risk for many women.[28]

Fat intake and obesity appear to be primary risk factors associated with cardiovascular disease, diabetes, and endometrial and ovarian cancers. Weight loss plans that support a low-fat, high-fiber diet, stress reduction, and exercise are part of a comprehensive health approach for the prevention of cardiovascular disease and breast cancer in women.[29]

Other dietary ingredients shown by research to have anticancer properties include soy-based products (tofu, miso, tempeh, soybeans) and cruciferous vegetables (broccoli, cauliflower, brussel sprouts). Soy products contain natural plant phytoestrogens (genistein and daidzen) called isoflavones that play a significant role in the prevention, and possibly treatment, of some hormone-related diseases. These phytonutrients appear to be protective against both breast cancer and prostate cancer.[30] Asian women, who consume approximately 30 to 50 times as much soy as American women, have low rates of breast cancer.[31] Cruciferous vegetables are rich in indoles and isothiocyanates. These substances may help in liver detoxification and aid in the removal of carcinogens, and appear to play a role in the prevention of cancer.[32]

According to a report released in September 1998 through the Harvard School of Public Health, 40 percent of all cancers could be avoided by changes in lifestyle and diet. Walter C. Willett, a Harvard researcher, spent 14 years reviewing 4,500 studies from around the world on nutrition and cancer and compiled a 650-page report sponsored by the American Institute for Cancer Research. The recommendations in this report are as follows:

- Choose a predominantly plant-based diet rich in a variety of vegetables and fruits.
- Avoid being underweight or overweight, and limit weight gain in adulthood to less than 11 pounds.
- Eat 8 or more servings per day of cereals and grains (e.g., brown rice, whole-grain breads), legumes (e.g., lentils, soy), tubers (e.g., potatoes), and roots (e.g., beets).
- Eat five or more servings per day of other fruits and vegetables.
- Limit consumption of white sugar.
- Limit alcoholic drinks.
- Limit intake of red meat to less than 3 ounces a day, if it is eaten at all. In place of red meat, eat fish, poultry, or soy products.

- Limit consumption of fatty foods, particularly those of animal origin.
- Limit consumption of salted foods. Use herbs and spices to season foods.
- Do not eat charred foods.
- Do not smoke or chew tobacco.

*Additional recommendation: Choose organic produce whenever possible.

Osteoporosis

Many older adults are concerned about osteoporosis, a metabolic bone disorder characterized by a reduction in the amount of bone mass, which leads to bone fragility. A decrease in bone density results in loss of bone strength and increased risk of fractures of the spine, hip, and wrist. Osteoporosis has become a major health problem in the United States, although it often goes undetected until an accident or a fall results in a fracture. Osteoporosis primarily affects women. It is responsible for 1.5 million fractures annually, including more than 300,000 hip fractures. Peak bone mass is achieved at about 35 years of age; as estrogen levels decrease with age, the risk of decreased bone density rises. Women who have a strong family history of osteoporosis, have a small body frame, and are of Caucasian or Asian descent have a high risk for the disease.[33] Research suggests that, for those at risk, age-related bone loss may be reduced or even reversed through a comprehensive approach that combines nutrient supplementation, dietary adjustments, and lifestyle changes, including participation in a regular exercise program. The earlier in life a woman begins to integrate an osteoporosis prevention program, the more she will reduce the risk of bone loss later in life. Bone is a dynamic tissue, and adequate nutrition is essential for its maintenance and growth.[34]

In the body's essential metabolic processes, there is a continuous exchange of calcium between bone and plasma. Plasma levels are given priority over bone density. If the body needs additional calcium for essential functions and calcium is not readily available, it is taken from the bones to meet these metabolic needs. When this occurs, bone strength is compromised and bones are weakened. A recurrent theme in nutritional medicine is that degenerative diseases are the result of our modern diet. Considering that bone is living tissue, it is susceptible to both dietary excess and deficiencies. One study found that two-thirds of women in the United States between the ages of 18 and 30 ingest less calcium than the RDA. Several studies have also linked high animal protein diets to loss of calcium from bone, concluding that individuals who consume a balanced vegetarian diet have stronger bones later in life than those who eat high amounts of animal flesh.

Osteoporosis often is the result of deficiencies of several key nutrients, of which calcium is but one. Statistics show that only 25 percent of women with osteoporosis are calcium deficient. Research has demonstrated that other essential nutrients, including magnesium, boron, vitamin D_3, and other trace minerals, must be available in the proper balance to facilitate calcium resorption and uptake into the bone. Vitamin D_3 supplementation has been shown in two studies to be effective in preventing fractures from osteoporosis in both men and women. Studies have correlated long-term, low-calcium diets with the development of osteoporosis later in life. The best treatment for osteoporosis is prevention.[35]

Common Risk Factors for Osteoporosis

- low intake of calcium, magnesium, vitamin D, and trace minerals
- high intake of animal protein
- high caffeine intake
- excessive intake of carbonated beverages
- high sodium intake
- high refined sugar intake
- lack of exercise

- lack of sunlight exposure
- excessive alcohol intake
- smoking
- use of certain medications, including antacids, steroids, thyroid replacement drugs, chemotherapy agents
- hypochlorhydria (low HCL)

Guidelines for Healthy Bones

- Increase consumption of calcium-rich foods, including green leafy vegetables, whole grains, beans, tofu, dairy products, nuts and seeds.
- Increase weight-bearing exercise, such as walking.
- Decrease consumption of soda, caffeine, and alcohol.
- Spend 15 minutes a day exposed to direct sunlight.

Supplement Recommendations for Healthy Bones. The current RDA for calcium is 800–1200 milligrams per day of elemental calcium. Magnesium and calcium function in balance. The recommended ratio of calcium to magnesium is 2:1; thus, the recommended dosage of magnesium is 400–600 milligrams per day. Vitamin D reduces bone loss. Daily dose should not exceed 800 international units (IU) (RDA 400 to 600 IU). These nutrients work together to enhance each other's absorption and utilization in the body. Other nutrients that help maintain bone mass include vitamin K, boron, vitamin B_6, manganese, folic acid, vitamin C, and zinc.[36]

Regardless of a person's age, calcium and trace nutrients are essential for maintaining bone mass and overall good health.

Obesity

One of the most common nutritional problems is obesity. Obesity has been defined as weighing in excess of forty pounds above ideal body weight. Being overweight predisposes an individual to high blood pressure, elevated blood cholesterol levels, diabetes, stroke, heart attack, gallbladder disease, cancer, and musculoskeletal problems. Contributing factors include excessive intake of calories (especially from fat), excessive consumptions of refined sugar, vitamin and mineral deficiencies, maldigestion, insufficient exercise, hypothyroidism, and hereditary factors.

Limiting caloric consumption, even moderately, may be a key to cancer prevention according to a National Cancer Institute study.[37]

Individual diet–nutrition counseling includes exercise planning and behavior modification education. Decreasing caloric intake, increasing exercise, and developing a healthy relationship with food are essential to long-term weight-loss strategies. Successful weight loss is gradual and highly individualized.

The following are some general guidelines for weight management:

- Recognize management of obesity as a lifelong commitment that requires lifestyle changes.
- Set realistic goals for weight loss.
- Do meal planning with daily menus.
- Serve smaller portions (use smaller plates).
- Avoid keeping ready-to-eat snack food around the house.
- Do grocery shopping from a list and not on an empty stomach.
- Do all eating in one room and focus on eating without distractions.
- Increase intake of vegetables ("free" foods).
- Leave a small amount of food on the plate.
- Increase activity level.
- Avoiding skipping meals.
- Avoid late-night eating.
- Drink at least six glasses of water daily.
- Try a food allergy elimination diet.
- Eliminate all junk foods (processed, refined foods) from the diet.

Weight loss is achieved and maintained with a regular exercise program, psychological support, and a personal commitment to wellness.

Nutrition and Aging

Lifestyle and nutrition practices are recognized to play a fundamental role in healthy aging. Health benefits from optimal nutrition in the older years can prevent much of the decline seen with aging. The National Health and Nutrition Surveys conducted by the Department of Health and Human Services reveal that the nation's older citizens remain at high risk of macronutrient and micronutrient deficiencies. Untreated and often undiagnosed deficiencies have taken a heavy toll among older people, resulting in an accelerated aging process.[38] Research studies over the past decade clearly show that many of the ailments previously thought to be an inevitable result of old age can be prevented by aggressive detection and treatment of subclinical nutrient deficits. Cognitive impairment, depression, lethargy, anemia, and poor response to medical and surgical interventions may be the expression of nutrient deficiencies.[39] Laboratory findings have suggested that oxidative stress may contribute to the pathogenesis of Alzheimer's disease. Therefore, the risk of Alzheimer's disease may be reduced by intake of antioxidants that counteract the detrimental effects of oxidative stress.[40]

While patients must be evaluated individually, many psychosocial factors should be considered when addressing nutrition needs and goals, including economics, the person's ability to shop and prepare meals, and social support. As many as 50 percent of elderly people suffer from atrophic gastritis, a condition that impairs absorption of micronutrients, especially of vitamin B_{12}.[41] Often, elderly people have undetected hypochlorhydria, a deficiency of hydrochloric acid in the stomach that leads to bacterial overgrowth in the stomach and small bowel, and results in impaired digestion and absorption of essential nutrients, including vitamins B_6 and B_{12}. Americans over the age of 65 consume 30 percent of the over-the-counter and prescription drugs sold in the United States. Many of these medications are known to impair food intake, absorption, and metabolism of nutrients. Some drugs, such as phenobarbital, are specific nutrient antagonists. The most commonly used over-the-counter drugs among elderly people are laxatives, which can impair the status of the fat-soluble vitamins A, E, D, and K. Other problems that interfere with nutrient intake include chewing difficulties, impaired cognitive function and forgetting to eat, social isolation and apathy in food preparation, and inability to shop or carry packages. Impaired memory in elderly people is often related to the effect of B-vitamin, antioxidant, and essential fatty acid deficiencies.

One of the hallmarks of biologic aging is decreased ability to manage glucose metabolism. This imbalance is a contributing factor in many age-related diseases, including heart disease, inflammatory disorders, dementia, and diabetes. The physiologic control of glucose metabolism is one of the central regulatory activities, along with control of electrolyte levels, intracellular pH, oxygen and carbon dioxide concentrations, and membrane polarity.[42] It is estimated that 10 million Americans are at risk for diabetes.

Many substances affect glucose metabolism, including insulin, hormones, and specific nutrients. Nutrients such as amino acids, fatty acids, trace minerals, and vitamins potentiate the effects of glucose by modifying insulin production and secretion. Increased levels of glucose activate inflammatory immune responses, increase oxidative stress, and accelerate biologic aging. Research indicates that many nutritional substances can help modulate glucose reg-

ulation, including selenium, chromium, magnesium, other trace minerals, alpha lipoic acid, vitamin B complex, vitamin C, and essential fatty acids. Insulin resistance syndrome, also called Syndrome X, is a common abnormality of metabolism, affecting more than 20 percent of Americans. It is characterized by hypertriglyceridemia, low levels of HDL cholesterol, obesity (particularly in the abdominal region), hypertension, and moderate hyperglycemia. People with this metabolic syndrome are at increased risk of developing heart disease and diabetes.[43]

Hypoglycemia and carbohydrate cravings are common syndromes that affect a large portion of the population. A refined-food diet high in simple sugars and low in fiber and nutrients often manifests as glycemic dysregulation and can lead to hyperglycemia and diabetes with aging. Recommendations for stabilizing blood sugar level at any age include eating several smaller meals daily that consist of protein and complex carbohydrates, and avoiding soda, caffeine, and refined or processed foods devoid of nutrients and fiber (see Exhibit 18–1 for a hypoglycemic diet plan). Vitamin deficiencies remain subclinical in elderly people and are the result of inadequate nutrient stores over many years. Establishing a reservoir of nutrients beginning in the younger years is an essential component of disease prevention and health maintenance for healthy aging.

HEALTHY CHOICES IN NUTRITION

High-Fiber Diet

- whole grains: oatmeal, brown rice, millet, whole wheat, enriched pasta
- beans: lentils, tofu, split peas, garbanzo beans, black beans, tempeh
- vegetables: green, yellow, orange—steamed, raw, or stir-fried
- nuts and seeds: sunflower seeds, Brazil nuts, almonds, sesame seeds, pumpkin seeds, nut butters
- fruits: local and in season, such as papaya, melon, mango, grapefruit, berries

Note: Grains + beans = complete protein.

Low-Fat Diet

- Limit meats.
- Eliminate sandwich meats (ham, salami, bacon, sausage).
- Increase fish, chicken, turkey.
- Use cold-pressed, unprocessed oils—olive, canola, sesame.
- Use butter instead of margarine.
- Use low-fat dairy products.
- Bake, broil, steam, or poach food.

Foods To Avoid

- sugars—cookies, soda, candy, jelly, syrup
- processed foods—additives, preservatives, artificial colorings and flavorings
- canned foods—fresh is best, frozen is next best
- refined hydrogenated oils (Crisco, palm oil, cottonseed oil)
- fast foods and junk foods

Other Important Health Factors

- Drink four to six glasses of liquid daily—spring or filtered water, herbal teas.
- Cook and prepare food in cast-iron or stainless steel cookware (avoid aluminum).
- Chew foods slowly and thoroughly.
- Eat smaller, simpler meals.
- Include fiber with each meal.
- Exercise daily—walk, bicycle, jog, dance, swim, stretch.

Exhibit 18–1 Hypoglycemic Diet Plan

GUIDELINES—LOW FAT/LOW REFINED CARBOHYDRATES/HIGH PROTEIN DIET

- Eliminate caffeine, soda, fruit juice, white sugar, white flour, white rice, white bread.
- Limit fruits—2 per day and divide into 4 portions. Avoid grapes and bananas (high in sugar).
- Throughout the day, consume several small meals consisting of protein with complex carbohydrate if needed.
- Vegetables—*Unlimited*—raw or cooked depending on your preference (and digestion); limit beets and carrots.

SAMPLE MENU CHOICES

Protein

Fish	canned tuna, sardines, broiled, baked, steamed fish
Chicken	baked, broiled, remove skin
Turkey	fresh turkey, white meat
Beans	soy (tofu), black, lentil, red, garbanzo, etc.
Whole Grains	brown rice, oatmeal, quinoa, millet, buckwheat (kasha), barley, whole wheat
Eggs	boiled, poached
Dairy	low-fat cheese—mozzarella, goat, yogurt (plain)
Vegetables	salads, steamed vegetables; fresh or frozen; avoid canned

- **Whole Grains + Beans (Complex Carbohydrates) = Complete Protein**

SAMPLE MENU SERVINGS

Breakfast

- 1 boiled egg (or egg white) with whole wheat bread; **or**
- 1 cup cooked old-fashioned oatmeal; **or**
- Cold cereal with low-fat milk, plain low fat yogurt, or milk substitute (soy, rice, or almond milk)

Lunch/Dinner

- Salad with grilled chicken or fish
- Tuna in whole-wheat pita
- Lentil soup with whole-wheat crackers
- Grilled chicken breast with ½ cup brown rice and steamed vegetables
- Tofu or black beans with brown rice and steamed vegetables
- Grilled fish with ½ baked potato and salad

Snacks (small meals)

Low-fat plain yogurt with ½ fresh fruit, whole-wheat cracker with tuna salad, hummus with whole-wheat pita, 1 tablespoon almonds or sunflower seeds, or nut butter, almond or sesame tahini on whole-wheat cracker, leftover lunch portion.

Helpful Hints: Exercise and physical activity can be an important part of weight loss and blood sugar control. Check with your physician or physical therapist.

- Reduce stress through yoga, meditation, deep breathing, relaxation practice, visualization.
- Avoid alcohol, caffeine, smoking, recreational drugs, over-the-counter drugs.
- Get sufficient rest and sleep.

HOLISTIC CARING PROCESS

Assessment

In preparing to use nutrition interventions, the nurse assesses the following parameters:

- the client's relationship to nutrition and diet: biochemical, genetic, cultural, social, emotional, religious, economic, environmental, and physiologic components
- the client's eating habits, food preferences, and nutritional needs
- the client's motivation and ability to make the necessary dietary and lifestyle changes
- the client's understanding that changing food and eating patterns is part of a wellness process

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with nutrition interventions that are related to the 13 domains of Taxonomy II of the Unitary Person framework (see Chapter 14):

- Altered nutrition
- Altered circulation
- Altered oxygenation
- Altered coping
- Altered physical mobility
- Sleep pattern disturbances
- Altered patterns of daily living
- Disturbance in body image
- Disturbance in self-esteem
- Potential hopelessness
- Potential powerlessness
- Knowledge deficit
- Pain
- Anxiety
- Grieving
- Depression
- Fear

Outcomes

Exhibit 18–2 guides the nurse in client outcomes, nursing prescriptions, and evaluation for the use of nutrition as a nursing intervention.

Therapeutic Care Plan and Interventions

Before the Session

- Create an environment in which the client feels comfortable discussing physical and nutritional needs.

Exhibit 18–2 Nursing Interventions: Nutrition

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client will be motivated to improve nutrition.	Assist the client in a personal self-assessment. Encourage the client to participate with the nurse to develop goals and action plans. Prepare the client to follow through with the nurse on evaluation and formulation of new goals.	The client completed a self-assessment form. The client participated with the nurse to develop a personalized program. The client met with the nurse for program evaluation.
The client will demonstrate knowledge of healthful nutrition.	Motivate the client to contribute to discussions about his or her program. Encourage the client to learn more about healthful behaviors as he or she works with the nurse.	The client participated in the session discussion. The client demonstrated new knowledge.

- Prepare assessment tools and educational materials.
- Focus on the client's nutritional and physical needs.
- Use relaxation techniques to assist the client before the session begins.

At the Beginning of the Session

- Take and record the necessary physical assessment data (e.g., weight, skin fold and thickness measurements).
- Guide the client to disclose past habit patterns that affect eating behavior.
- Have the client document food intake and association between food and feelings of well-being or distress.
- Assist the client in creating a sample menu.
- Encourage the client to participate in setting nutritional goals and action plans.
- Present specific nutritional guidelines for the client to follow.
- Direct the client to keep a food journal to present at follow-up session.

During the Session

- Have the nurse serve as a guide.
- Emphasize the connection between nutrition and whole-person health.
- With the nurse's guidance, have the client develop strategies for changing nutrition habits, nutrient intake, and eating patterns.
- Have the nurse assist the client in optimizing diet and nutrition by:
  - —Creating an image for food as a healing medicine
  - —Reframing the nutrition process into a positive action
  - —Reframing nutrition and food as an empowerment tool
  - —Illustrating how external nutrition changes promote internal healing responses
  - —Reinforcing the client's positive changes in nutrition as part of the healing process
  - —Ending sessions with images of desired state of well-being.

At the End of the Session

- Have the client identify the options presented that best fit with his or her own lifestyle.
- Work together with the client to write down goals and target dates.
- Give the client specific affirmations to use to support these goals.
- Give the client handout material to reinforce the teaching.
- Use the client outcomes that were established before the session (see Exhibit 18–2) and the client's subjective experiences (see Exhibit 18–3) to evaluate the session.
- Schedule a follow-up session.

Exhibit 18–3 Evaluation of the Client's Subjective Experience with Nutrition

1. Is this the first time you have considered the effects of healing nutrition from a holistic perspective?
2. Have you discovered ways you can eat for increased vitality and vibrant living?
3. Do you think there are any links between your food intake and the potential for development of a chronic disease in your life?
4. Is your life filled with healing foods? Do you want it to be?
5. What support systems would help you develop and adhere to a lifestyle that includes healing foods?
6. Can you think of anything else that would help you to maintain a routine that includes healing nutrition?
7. What is your next step (or your plan) to integrate these experiences on a daily basis?

Specific Interventions: Ensuring Optimal Nutrition

To optimize nutrient intake, the nurse may advise the client to

- adhere to recommended healthy diet
- practice relaxation techniques
- increase exercise following evaluation by a trained professional

The nurse can share information and research data on health benefits of antioxidants and other nutrients known to assist in the health and healing process.

A daily menu plan can be created to fit the client's particular needs. The following should be considered:

- daily activity status
- current health status
- any physical limitations
- economic considerations
- social and cultural influences
- emotion state of being
- individual differences, including food preferences and religious dietary customs

To motivate and assist the client, the nurse can

- encourage the client to write a food journal daily
- demonstrate the daily practice of asking the body what it needs to be healthy
- create daily menus using healthy choices that are mutually agreed upon
- teach the client to self-assess health changes that occur with dietary interventions
- encourage the client who is currently using nutritional supplementation to organize a routine to optimize compliance and benefits

Open-ended questions, images, journal writing, drawing, and other creative strategies to integrate nutrition into the client's daily life can be used to close the session.

Case Study

Setting:	A nurse-based wellness center
Client:	B.V., a 40-year-old married woman who seeks counseling for weight loss
Patterns/ Challenges/ Needs:	1. Altered nutrition (more than body requirements) related to improper eating and lack of exercise 2. Altered self-esteem related to obesity 3. Ineffective reversal/ prevention of coronary artery disease risk factors (hypertension, hypercholesterolemia, obesity) related to stress and low self-esteem

B.V. came to the wellness center after having a physical examination by a physician and being told for the sixth straight year that she needs to lose weight. Her total cholesterol is 340 milligrams per deciliter, blood pressure is 180/100, height is 5 feet, 7 inches, and weight is 220 pounds. She is a nurse and seeks help from a nurse colleague at the wellness center because her elevated cholesterol level has finally motivated her to lose weight. Her husband has been encouraging this for years, but she just cannot seem to make it happen.

During the initial session, the nurse takes an eating and diet history. Like most self-referrals for weight loss, B.V. is knowledgeable about various diet programs and has tried different plans for several years. She has a pattern of losing and then regaining up to 50 pounds on each attempt. At this point, she is willing to try anything.

The nurse discovers during the interview that B.V. has been on numerous antihypertensive drugs for 10 years without attaining consistent control. The assessment shows that, in general, B.V. is physically out of shape and emotionally depressed and discouraged. She is a fellow health care professional who has reached burnout.

After establishing 6-week and 6-month goals, B.V. and the nurse schedule weekly sessions. B.V. is given a standard form of a weekly diet, exercise, and emotion and attitude recording sheet. She is instructed to write down everything she eats, as well as the feeling that she has before, during, and after the eating periods during the next week.

In the second session, B.V. and the nurse review the eating/feeling diary and discuss where significant relationships between feelings and eating are observed. During this and subsequent sessions, it is important to examine and try to understand the client's feelings, for they are closely tied to the eating behavior. In addition, the physical parameters of weight and body fat calibration measurements are recorded.

Goals that are too difficult to achieve can discourage the client altogether. Therefore, during each session, several small attainable goals are set for the following week. Both exercise and eating patterns gradually improve.

B.V. meets with the nurse on a regular basis for 6 months. During that time, she reduces her weight to 160 pounds, works out in a regular aerobic exercise program four times a week, and increases her knowledge and interest in healthful food consumption. At the end of this period, B.V. and the nurse agree to move to monthly visits for the next three sessions and plan for termination of the appointments at that time.

Evaluation

With the client, the nurse determines whether the client outcomes for nutrition (Exhibit 18–2) were successfully achieved. To evaluate the session further, the nurse may again explore the subjective effects of the experience with the client using the evaluation questions in Exhibit 18–3.

Nurses should chart all information they impart to the client, as well as an evaluation of the session. When the nurse works in an inpatient facility, other staff need to be appraised of the program and its progress. Nurses who work in wellness centers, in centers using integrated models, and in private practice should also keep records for each client and should state nursing diagnosis, type of counseling employed, and the effectiveness of each session.

The nurse is in a prime position to model the effects of healthy nutrition and lifestyle by integrating these elements into daily life and practicing self-care.

DIRECTIONS FOR FUTURE RESEARCH

1. Investigate the hypothesis that those who eat a nutritionally balanced diet live longer.
2. Continue the investigation on how healthy behaviors in nutrition affect a person's general sense of well-being.
3. Study the relationship of vitamin and mineral supplementation to disease prevention and high-level wellness.
4. Study the specific factors for tailoring a nutrition program to different cultural and ethnic groups.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin the process of answering the following questions:

- What sensations accompany physical well-being because of my improved nutrition?
- What comprises healthy eating for both myself and my clients?
- How can I model healthy nutrition practices?

NOTES

1. National Research Council, *Recommended Daily Allowance*, 10th ed. (Washington, DC: National Academy Press, 1989).
2. A.G. Motulsky, Nutrition and Genetic Susceptibility with Common Diseases, *American Journal of Clinical Nutrition* 5, supplement (1992):1244S–1245S.
3. K.A. Math, Homocysteine Athrothrombosis, *New England Journal of Medicine* 399, no. 7 (1998):478–479.
4. J.C. Deutch et al., Plasma Homocysteine Levels and Folic Acid Supplementation, *New England Journal of Medicine* 339, no. 7 (1998):475.
5. R.H. Fletcher and K.M. Fairfield, Vitamins for Chronic Disease Prevention in Adults: Clinical Applications, *Journal of the American Medical Association* 287 (2002):3127–3129.
6. B. Posner et al., Diet and Heart Risk Factors in Adult American Men and Women, *International Journal of Epidemiology* 22 (1993):1014–1025.
7. K.H. Thompson and D.V. Goodin, Micro Nutrients and Antioxidants in the Progression of Diabetes, *Nutrition Research* 15, no. 9 (1995):1377–1410.
8. D. Jenkins and T. Wolever, Slow Release Carbohydrate and the Treatment of Diabetes, *The Proceedings of the Nutrition Society* 40 (1981):227–234.
9. S. Handler, Dietary Fiber: Can It Prevent Certain Colon Diseases? *Postgraduate Medicine* 73 (1983):301–307.
10. C. Lafante and N. Ernst, Daily Dietary Fat and Total Food Energy Intakes—NHANES 111.
11. M.L. Daviglus et al., Fish Consumption and the 30 year risk of myocardial infarction, *N Engl J Med* 336 (1997):1046–1053.
12. E. Soyland et al., Effect of Dietary Supplementation with Very Long Chain n-3 Fatty Acids in Patients with Psoriasis, *N Engl J Med* 328 (1993):1812–1816.
13. R. Chandra, Trace Element Regulation of Immunity and Infection, *Journal of the American College of Nutrition* 4 (1985):5–16.
14. S. Solomon and R. Jacob, Studies on the Bioavailability of Zinc in Humans: Effects of Heme and Non Heme Iron on the Absorption of Zinc, *American Journal of Clinical Nutrition* 4 (1985):5–16.
15. H. Sies et al., Antioxidant Function of Vitamins, *Annals of the New York Academy of Sciences* 669 (1992):7–20.
16. O.I. Arumoa et al., Free Radicals, *Bio Med* 6 (1989):593–597.
17. B. Halliwell, Free Radicals, Antioxidants, and Human Disease: Curiosity, Cause or Consequence? *Lancet* 344 (1994):721–724.
18. J. Bland, Antioxidants in Nutritional Medicine: Tocopherol, Selenium, and Glutathione, in *Yearbook of Nutrition Medicine 1984–1985* (New Canaan, CT: Keats Publishing), 213–237.
19. R. Fuller, Probiotics in Human Medicine, *Gut* 32 (1991):439–473.
20. H. Sampson et al., Food Allergy, *Journal of the American Medical Association* 258, no. 20 (1987):2886–2890.
21. D. Hunter et al., A Prospective Study of the Intake of Vitamins C, E, A and the Risk of Breast Cancer, *New England Journal of Medicine* 339 (1993):234–240.
22. M. Laidlaw et al., Effects of Supplementation with Fish Oil Derived n-3 Fatty Acids Gamma-Linolenic Acid on Circulating Plasma Lipids and Fatty Acid Profiles in Women, *American Journal of Clinical Nutrition* 77 (2003):37–42.
23. E. Dewailly et al., High Organochlorine Body Burden in Women with Estrogen Receptor Positive Cancer, *Journal of the National Cancer Institute* 85, no. 8 (1993):598–599.
24. A. Diplock, Antioxidant Nutrients and Disease Prevention: An Overview, *American Journal of Clinical Nutrition* 53 (1991):189S–193S.
25. P. Martin et al., Phytoestrogen Interaction with Estrogen Receptors in Human Breast Cancer Cells, *Endocrinology* 100, no. 5 (1978):1860–1867.
26. D. Hunter and T. Kelseyk, Pesticide Residues and Breast Cancer: The Harvest or the Silent Spring? *Journal of the National Cancer Institute* 85, no. 8 (1993):598–599.
27. G. Block, The Data Supports a Role for Antioxidants Reducing Cancer Risk, *Nutrition Reviews* 50 (1992):207–213.
28. D. Rose et al., High Fiber Diet Reduces Serum Estrogen Concentrations in Premenopausal Women, *American Journal of Nutrition* 54 (1991):520–527.

29. R.J. Herscopf, Obesity, Diet, Endogenous Estrogens, and the Risk of Hormone-Sensitive Cancer, *Journal of Clinical Nutrition* 45 (1987):283–289.
30. T.B. Clarkson et al., Estrogenic Soybean Isoflavones and Chronic Disease Risk Factors and Benefits, *Trends in Endrocrinology and Metabolism* 6 (1995):11–16.
31. D. Ingram et al., Case Study of Phytoestrogens and Breast Cancer, *Lancet* 350 (1997):990–994.
32. B.R. Goldin et al., The Relationship Between Estrogen Levels and Diets in Caucasian and Oriental Immigrant Women, *American Journal of Nutrition* 44 (1986):945–953.
33. V.W. Bunker, The Role of Nutrition in Osteoporosis, *British Journal of Biomedical Science* 51, no. 3 (1994):228–240.
34. E.L. Smith et al., Calcium Supplementation and Bone Loss in Middle Aged Women, *American Journal of Clinical Nutrition* 50, (1989):833–842.
35. D. Trivedi et al., Effect of Four Monthly Oral Vitamin D3 (Cholecalciferol) Supplementation on Fractures and Mortality in Men and Women Living in the Community: Randomized Double Blind Controlled Trial, *British Medical Journal* 2003: 326:1–6.
36. J. Wright and J. Gaby, *Preventing and Reversing Osteoporosis* (Rocklin, CA: Prima Publishing, 1994), 21–93.
37. P. Mukherjee et al., Dietary Restriction Reduces Angiogenesis and Growth in an Orthotopic Mouse Brain Tumor Model, *Br J Cancer* 86, no. 10 (2000):1615–21.
38. J. Morley, Nutrition and the Older Female: A Review, *Journal of the American College of Nutrition* 12 (1993):337–343.
39. C. Jeandel et al., Antioxidant Status in Alzheimer's Patients, *Gerontology* 35 (1989):275–282.
40. M.J. Engelhart et al., Dietary Intake of Antioxidants and Risk of Alzheimer Disease. *Journal of the American Medical Association* 287 (2002):3223–3229.
41. J. Prendergast, *Nutritional Intervention in the Aging Process* (New York: Springer Publishing Co., 1984), 265–280.
42. G. Reaven, Pathophysiology of Insulin Resistance in Human Disease, *Physiological Reviews* 75, no. 3 (1995):473–485.
43. F. Guerrero-Romero et al., Low Serum Magnesium Levels and Metabolic Syndrome, *Acta Diabetol* 39 (2002):209–213.

SUGGESTED READING

Adlercreutz, A., et al., Dietary Phyto-Estrogens and the Menopause in Japan, *Lancet* 339 (1992):1233.

Amimoto, T., et al., Acetaminophen-Induced Hepatic Injury in Mice: The Role of Lipid Peroxidation and Effects of Pre-treatment with Coenzyme Q10 α-Tocopherol, *Free Radical Biology and Medicine* 19 (1995):169–176.

Anderson, K., and Arrallah, K., Dietary Regulation of Cytochrome P450, *Annual Review of Nutrition* 11 (1991):141–167.

Balieu, E., Dehydroepiandrosterone (DHEA): A Fountain of Youth? *Journal of Clinical Endocrinology and Metabolism* 81 (1996):3147– 3151.

Barringer, T., Kirk, J.K., Santanieloo, A.C., Foley, K.L., and Michielutte, R., Effect of a Multivitamin and Mineral Supplements on Infection and Quality of Life. A randomized, double-blind, placebo-controlled trial, *Annals of Internal Medicine 2003 Mar 4*; 138(5):365–71.

Baum, M.K., et al., Micronutrients and HIV-1 disease progression, *AIDS* 9 (1995):1051–1056.

Bliznakov, E.G., Coenzyme Q in the Immune System and Aging, in *Biochemical and Clinical Aspects of Coenzyme Q10*, vol. 3, eds. K. Folkers and Y. Yamamura (New York: Elsevier Science, 1991), 331–336.

Boris, M., and Mandel, F.S., Foods and Additives Are Common Causes of the Attention Deficit Hyperactive Disorder in Children, *Annals of Allergy* 72 (1994):462–468.

Bunker, V.W., The Role of Nutrition in Osteoporosis, *British Journal of Biomedical Science* 51 (1994):228–240.

Chen, H., and Tappol, A.L., Vitamin E, Selenium, Trilox C, Ascorbic Acid Palmitate, Acetylcysteine, Coenzyme Q, B-Carotene, Canthaxanthin and (+)-Catechin Protect against Oxidative Damage to Kidney, Heart, Lung and Spleen, *Free Radical Research* 22 (1995):177–186.

Coconnier, M.H., et al., Inhibition of Adhesion of Enteroinvasive Pathogens to Human Intestinal Caco-2 Cells by Lactobacillus acidophilus Strain LB Decreases Bacterial Invasion, *FEMS Microbiology Letters* 110 (1993):299–306.

Dela Fuente, M., and Victor, V.M., Anti-Oxidants as Modulators of Immune Function. *Immunology and Cell Biology* 2003 Feb.; 78(1):49–54.

Dubena, K., and McMurray, D.N., Nutrition and the Immune System: A Review of Nutrient–Nutrient Interactions, *Journal of the American Dietetics Association* 96 (1996):1156–1164.

Ernster, L., and Dallner, G., Biochemical, Physiological and Medical Aspects of Ubiquinone Function, *Biochimica et Biophysica Acta* 1271 (1995):195–204.

Folkers, K., et al., The Activities of Coenzyme and Vitamin B6 for Immune Responses, *Biochemical and Biophysical Research Communications* 193 (1993):88–92.

Folkers, K., and Simonsen, R., Two Successful Double-Blind Trials with Coenzyme Q10 (Vitamin Q10) on Muscular Dystrophies and Neurogenic Atrophies, *Biochim Biophys Acta Mol Basis Dis* 1271 (1995):281–286.

Fuller, R., and Gibson, G.R., Modification of the Intestinal Microflora using Probiotics and Prebiotics, *Scandinavian Journal of Gastroenterology* 222, supplement (1997):28–31.

Greenberg, S., and Frisshman, W.H., Coenzyme Q10: A New Drug for Cardiovascular Disease, *Journal of Clinical Pharmacology* 30 (1990):596–608.

Harbige, L.S., Nutrition and Immunity and Emphasis on Infection and Autoimmune Disease, *Nutrition and Health* 10, no. 4 (1996):285–312.

Hoyumpa, A.M., and Schenker, S., Drugs and the Liver, in *Gastroenterology and Hepatology: The Comprehensive Visual Reference*, ed. W.C. Maddrey (Philadelphia: Current Medicine, 1996), 6.1–6.22.

Ingram, D., et al., Case-Control Study of Phytoestrogens and Breast Cancer, *Lancet* 350 (1997):990–994.

Jenner, P., Oxidative Damage in Neurodegenerative Disease, *Lancet* (September 17, 1994):796–798.

Kaminski, Jr., P., et al., AIDS Wasting Syndrome as an Entero-Metabolic Disorder: The Gut Hypothesis, *Alternative Medicine Review* 3, no. 1 (1998):40–53.

Lang, C.A., et al., Low Blood Glutathione in Healthy Aging Adults, *Journal of Laboratory and Clinical Medicine* 120 (1992):720–725.

Lockwood, F., et al., Progress on Therapy of Breast Cancer with Vitamin Q10 and the Regression of Metastases, *Biochemical and Biophysical Research Communications* 212 (1995):172–177.

Lomaestro, B.M., and Malone M., Glutathione in Health and Disease: Pharmacotherapeutic Issues, *Annals of Pharmacotherapy* 29 (1995):1263–1273.

McCoy, H., and Kenney, M.A., Magnesium and Immune Function: Recent Findings, *Magnesium Research* 5, no. 4 (1992):281–293.

Messina, M., et al., Photoestrogens and Breast Cancer, *Lancet* 350, no. 9083 (1997):990–994, 971–972.

Morales, A.J., et al., Effects of Replacement Dose of Dehydroepiandrosterone in Men and Women of Advancing Age, *Journal of Clinical Endocrinology and Metabolism* 78 (1994):1360–1366.

MRC Social Public Health Sciences Unit, London, UK, Fruits, Vegetables, and Antioxidants in Childhood and Risk of Adult Cancer: The Boyd Orr cohort, *Journal of Epidemiology and Community Health* 57, no. 3 (2003):218–25.1367.

Morris, M.C., Evans, D.A., Beinias, J.L., Tangney, C.C., Bennett, D.A., Wilson, R.S., Aggarwal, N., and Schneider, J., Consumption of Fish and n-3 Fatty Acids and Risk of Incident Alzheimer Disease, *Archives of Neurology* 60, no. 7 (2003):923–4.

Phipps W.R., et al., Effect of Flax Seed Ingestion on the Menstrual Cycle, *Journal of Clinical Endocrinology and Metabolism* 77 (1993):1215–121.

Sofrizzi, V., Panza, F., and Capurso, A., The Role of Diet in Cognitive Decline, *Journal of Neural Transmitters* 110, no. 1 (2003):95–110.

Smith, E., et al., Deterring Bone Loss by Exercise Intervention in Premenopausal and Postmenopausal Women, *Calcified Tissue International* 44 (1998):312–321.

Steward, H., and Bethea, M., *Sugar Busters* (Ballantine Books, 2003).

Stoll, B.A., Essential Fatty Acids, Insulin Resistance, and Breast Cancer Risk, *Nutrition and Cancer* 31, no. 1 (1998):72–77.

U.S. Preventive Services Task Force. Routine Vitamin Supplementation to Prevent Cancer and Cardiovascular Disease: Recommendations and Rationale, *Annals of Internal Medicine*, 139, no. 1 (2003):51–55.

Werbach, M. *Foundations of Nutritional Medicine: Sourcebook of Clinical Research*. (Firstline Press, 1997), 330.

Willcox, J.K., Catignani, G.L., and Lazarus, S., Tomatoes and Cardiovascular Health, *Critical Review of Food Science Nutrition* 43, no. 1 (2003):1–18.

VISION OF HEALING

Moving Through Strength

It is remarkable how much better we can feel from the simple acts of exercising regularly and moving creatively to the rhythm of life. Holistic nurses endeavor to maximize and develop the best of exercise and movement skills for the self, for the individual client, and for groups. It is through various kinds of movement that we begin to strengthen and maximize the abilities of the physical body.

As we begin the new millennium, the ancient Greek ideal of a sound mind in a strong, able body is once again in fashion. A healthy physical body is indeed the temple for the mind-spirit. The way in which we care for our body permeates all aspects of our being, including such things as our self-esteem and self-care practices. It even affects longevity and the ability to care for and be of service to others.

Holistic nurses will want to learn about various movements in order to personally and professionally use them with knowledge. A program of conscious, controlled, regular body movement promotes physical power. Unlike medicines, active movement enables us to build up the actual tissues and muscle mass of our bodies. When we exercise, we build strong, healthy bodies; when we are sedentary and slothful, we deprive ourselves and set up an internal environment for physical deterioration.

The feeling of well-being that comes from physical health permeates every individual activity, enabling the quickest thinking, permitting a better night's sleep, and perhaps facilitating spirituality. The lack of proper exercise and movement can even contribute to the risk of developing major diseases, such as hypertension, hypercholesterolemia, and obesity.

Both movement and exercise patterns are modifiable when individuals make the decision to move toward wellness. For those who are physically weakened because of illness and disease, or because of emotional, mental, or spiritual ennui, the good news is that anyone with motivation can begin a personally tailored exercise program to activate healing of the bodymind.

Now is the ideal time for making new personal beginnings. Think about why you want to make a new commitment to acquiring the knowledge and skills necessary for an effective movement program, and how you will go about achieving your goals. Choose a program of strengthening exercises or movement routines, and then join with others for the support and motivation it takes to successfully carry through on your new program. It is when we become individually strong that we can best join with other like-minded nurses to demonstrate ways of moving through strength. When we believe and model the fact that physical strength is an important ingredient in optimum health, we are in the best position to help our clients achieve their goals.

Chapter 19

Exercise and Movement

Beryl H. Cricket Rose and Lynn Keegan

NURSE HEALER OBJECTIVES

Theoretical

- Learn the definitions of terms in this chapter.
- Differentiate among exercise, fitness, and movement.
- Develop a fitness plan that combines movement and exercise.
- Learn the benefits of exercise and movement both in illness and in health.

Clinical

- Develop an awareness of body mechanics (movement and posture) during both clinical and physical activity and stationary desk or phone work.
- Employ strategies to improve exercise and movement in the workplace.
- Involve clients in self-assessment of their movement and exercise patterns as a routine part of health promotion, and as a strategy for management and recovery from illness.
- Include exercise and movement assessments of children in health care of a family.
- Seek current clinical research regarding special health concerns and the recommendations for therapeutic exercise and movement, and make the information available to clients.
- Consider ways in which the nurse can initiate or promote community-based health programs supporting exercise and movement.
- Consider ways in which the nurse serves as a role model during the workday.
- Learn the value of kinetic energy at work, and become an exercise leader in the clinical setting.

Personal

- Become aware of your current activities of exercise and your patterns of movement.
- Assess your physical habits related to both exercise and movement.
- Begin to experiment with new patterns of exercise and movement.
- Become increasingly sensitive to nuances of feeling as you gradually refine your skills in these physical activities, increasing kinesthesia.
- Attend to the mind/body/spirit responses you feel and evaluate the results.

DEFINITIONS

Aerobic Exercise: sustained muscle activity within the target heart range that challenges the cardiovascular system to meet the muscles' needs for oxygen.

Anaerobic Exercise: exercise that is fueled by the energy within the muscles used.

Endurance: the period of time the body can sustain exercise or movement.

Fitness: the ability to carry out daily tasks with vigor and alertness, without undue fatigue, and with ample reserve to enjoy leisure pursuits; the ability to respond to physical and emotional stress without an excessive increase in heart rate and blood pressure. Fitness is increased with endurance exercises.

Flexibility: the ability to use a joint throughout its full range of motion and to maintain some degree of elasticity of major muscle groups.

Kinetic Energy: energy associated with motion, energizing, or dynamic energy.

Maximal Heart Rate: the rate of the heart when the body is engaged in intense physical activity.

Movement: changes in the spatial configuration of the body and its parts, such as in breathing, eating, speaking, gesturing, and exercising; motion away from mental, physical, emotional, or spiritual stasis.

Nonaerobic Exercise: sustained physical activity above the normal resting state that uses one or more major muscle groups, but that is not intense enough to cause an increased muscle oxygen uptake.

Posture: pose, or placement of parts of the body in spatial relationships.

Resistance Training: the use of weights or opposing forces to exercise (strengthen) muscle groups.

Resting Heart Rate: the rate of the heart when the body is in deep rest.

Strength: the power of muscle groups.

Target Heart Rate: the safe rate for the heart during exercise.

Training: repetitive bouts of exercise over a period of time with the intention of developing fitness.

THEORY AND RESEARCH

Exercise

Traditionally, regular exercise programs were thought to be necessary only for athletes in training. We now know that vigorous aerobic exercise is good for everyone. The 1998 guidelines issued by the American College of Sports Medicine (ACSM) note that body composition, strength, endurance, and flexibility are joined with cardiorespiratory vigor in supporting fitness.[1] Today, less than 1 percent of all the energy used in factories, workshops, and farms comes from human muscles. During the next few years, continued growth will be seen in information and technology occupations, which are increasingly sedentary and, hence, potentially unhealthy, reducing the fitness of many people.

Exercise is any form of movement in a continuum from active physical exertion to subtle motions that are only slightly perceptible. In a CDC report based on 68,000 household interviews regarding adult leisure-time activity, 61.7 percent of adults engaged in some physical activity, 30.6 percent of them were regularly active, and only 22.9 percent were active in strengthening activities.[2] The 2001 ACSM Position Stand on Weight Loss states that more than 55 percent of adults in the US are either overweight or obese.[3] Thus, even though the number of adults who exercise regularly is increasing, most are not exercising at the intensity or frequency necessary to obtain maximal health benefits.

Physical activity is positively associated with a vigorous life and fitness. According to the 1998 guidelines from the ACSM,

walking briskly every day substantially increases stamina, prevents obesity, and improves general fitness. A variety of clinical trials support the contention that regular participation in physical activity either delays the onset or reduces the severity of several chronic diseases, including obesity and coronary heart disease.[4–6]

Eastern approaches to exercise and movement, such as Ayurveda and yoga practices, are distinctly different from Western medical approaches; these Eastern practices advise movements and exercises for health promotion and restoration. Ayurvedic medicine prescribes daily exercises that, although specific to the individual, are generally designed to be performed at 50 percent of maximum heart rate and are balanced with breathing exercises and yoga postures and stretching. In Ayurveda practice, daily physical exercise balanced with mental and spiritual exercises is essential, but exercise is performed at submaximal levels designed to slowly increase capacity and endurance and provide positive self-reinforcement for the behavior. Thus, Ayurveda exercises are achievable by persons whose goal is not to develop athletic ability but rather to gain a healthy vitality.[7,8]

Exercise Needs in Special Situations

Acquired Immunodeficiency Syndrome. In a study to determine if progressive resistance exercise could improve muscle function in patients with acquired immune deficiency syndrome (AIDS), the experimental group who engaged in such exercise three times a week for six weeks improved significantly in 13 of 15 study variables. Thus, when patients are in the nonacute stage of AIDS, exercise can produce physiologic adaptation that improves muscle function and increases body dimensions and body mass.[9,10]

Cardiovascular Disease. In acute heart failure, rest is a useful adjunct to pharmacologic treatment. In chronic heart failure, however, avoidance of exercise can lead to deconditioning changes in skeletal muscle and in the peripheral circulation, which can actually impair exercise tolerance. Although some controversy still exists as to whether training improves the prognosis for patients with chronic heart failure and how soon after myocardial infarction they can safely commence training, exercise is likely to become an increasingly popular and useful adjunct in the care of patients with chronic heart disease.[11,12]

The cardiovascular effects of aerobic exercise include a decrease in the resting heart rate and the heart rate response to submaximal exercise, an increase in resting and exercise stroke volume, an increase in maximal cardiac output, an increase in maximum oxygen consumption, and an increase in arteriovenous oxygen difference. These effects of cardiovascular fitness have a beneficial effect on the coronary artery disease risk profile. An inverse relationship exists between physical fitness and resting heart rate, body weight, percentage of body fat, systolic blood pressure, and serum levels of cholesterol, triglycerides, and glucose. In addition, exercise increases the high-density lipoprotein fraction of total cholesterol.[13] To develop and maintain cardiovascular fitness, an individual should engage in aerobic exercise 3 to 5 days per week at an intensity of 55 to 90 percent of heart rate maximum, or 40 to 85 percent of heart rate maximum reserve for 30 to 60 minutes (or a minimum of three 10-minute bouts accumulated throughout the day).[14,15] In addition, stretching and resistance training for the major muscle groups should be carried out 2 or 3 days a week. For resistance training, using one set of 8 to 10 exercises with 8 to 12 repetitions per exercise is recommended. Studies of stretching routines suggest that any of several techniques is beneficial. Four repetitions should be performed with

each major muscle/tendon group. Therapists generally recommend stretching exercises for warm-ups and cool-downs during aerobic exercise, but isolated stretching or nonaerobic exercises such as yoga and T'ai Chi exercises are beneficial as well.[16–18]

Studies suggest that clinically stable, aerobically trained cardiac patients may perform resistance exercises like circuit training comfortably.[19] A carefully supervised, long-term program of low-resistance training appears to be safe with regard to blood pressure and beneficial in terms of strength gain.[20,21]

Age does not seem to influence the results in cardiac rehabilitation programs. One study found that improvements in exercise capacity, obesity indexes, and lipid levels were very similar in older and younger patients enrolled in cardiac rehabilitation and exercise programs.[22] Because nurses play a key role in the development and implementation of these programs, they should be aware of research findings in this area so that they can personalize programs to meet the needs of different types of patients.[23]

Diabetes. Control of diabetes is enhanced with control of stress (related to the fact that catecholamine or adrenalin production causes elevations in blood sugar). Yoga and therapeutic movement (dance) are recommended for stress management in diabetic individuals. Regular aerobic exercise, particularly bicycling and swimming, are beneficial for the diabetic individual in order to control weight, increase tissue oxygenation, and maintain energy levels. General health, glucose control, and other risk factors must be assessed before specific exercise prescriptions can be advised.[24,25]

Neuromuscular Conditions. In several small studies, patients with slowly progressive neuromuscular diseases (e.g., muscular dystrophy) were trained with moderate resistance exercise programs, to study the safety and efficacy of strength training programs. Results provide evidence that a supervised submaximal strength training program is practical and safe for these individuals and can produce moderate improvement in measured strength.[26]

Low Back Pain. To determine whether graded physical exercise could restore occupational function in industrial blue-collar workers who were sick-listed for 8 weeks because of subacute, nonspecified, mechanical low back pain, 103 subjects were randomly assigned to either an activity group or a control group. Subjects in the graded activity group became occupationally functional again, as measured by their earlier return to work, and their time on long-term sick leave was significantly reduced.[27] Another group of researchers explored the effect of a weekly exercise program on the amount of short-term sick leave (50 days or less) attributable to back pain, and the possible correlation between changes in absenteeism and changes in cardiovascular fitness. They found that, during the intervention period, the number of episodes of back pain and the number of sick leave days attributable to back pain decreased by more than 50 percent in the exercise group.[28] Overcoming inactivity is key to rehabilitation and recovery with low back pain.[29,30]

Osteoporosis. Weight-bearing, bone-jarring exercise and resistance training builds bones. For this purpose, dancing is better than swimming. One study reported that 30 women increased their spinal bone mass by 0.5 percent in 1 year by performing 50 minutes of vigorous walking four times per week, irrespective of calcium consumption, while nonexercisers lost 7 percent of spinal bone mass.[31] Epidemio-

logical studies show that women who are able to maintain a high level of physical activity have a lower incidence of hip fractures, which may be an indirect result of postural stabilization, improved coordination, strength, and flexibility enabled by regular exercise.[32]

Asthma. Sixty-seven asthmatic adults participated in a 16-week program and randomly were assigned to a deep diaphragmatic breathing training group, a physical exercise training group, or a waiting list control group. Deep diaphragmatic training produced significant reductions both in medication use and in the intensity of asthmatic symptoms. Importantly, diaphragmatic training also made possible a nearly 300 percent increase in time spent in physical activities.[33]

Cystic Fibrosis. The 2002 Cochrane Review of physical training for cystic fibrosis (CF) looked at six clinical trials testing exercise tolerance for acute CF hospitalizations. Results indicate that, in some cystic fibrosis patients, exercise therapy (physical training) is an effective substitute for at least part of the standard protocol of bronchial hygiene therapy.[34]

Fibromyalgia. Strenuous exertion may exacerbate the symptoms of fibromyalgia, but specific low-intensity exercises such as walking, biking, and swimming with a kick board have been observed to aid patients in their physical fitness achievements. Aerobic exercise is contraindicated, according to anecdotal evidence from therapists working with fibromyalgia patients.[35]

Rheumatoid Arthritis. Although patients with rheumatoid arthritis are not expected to maintain high levels of physical fitness, a 1975 study evaluated 34 patients who participated in a 6-week training program of physical therapy. Patients in the control group (n = 11) were given only physical therapy. Patients in the experimental group (n = 23) also were given cycle ergometer workouts five times a week. The training group showed significant improvement in a walk test and an oxygen uptake test, with no change in joint status as judged by pain and swelling. A 6-month follow-up showed that 18 of the 23 patients in the training group continued exercising at least twice a week. After 8 years, those in the training group were three times more physically active, experienced less stiffness, and had fewer sick days and fewer hospitalizations than the control group. Several other studies support the prescription of moderate exercise (at 50–70 percent of maximal heart rate) and some resistance training for patients in a moderate phase of rheumatoid arthritis.[36]

Psychiatric Conditions. The effects of exercise on clients in a psychiatric rehabilitation program were investigated in three studies. Results indicate that, the higher the level of aerobic fitness, the lower the level of self-reported depression.[37,38] Nurses may want to act on such data by establishing exercise programs in psychiatric settings.

Aging Adults and Exercise

Loss of lower-extremity strength increases the risk of falls in older persons.[39] One exercise program study involving elderly male nursing home residents demonstrated that an appropriately designed high-intensity exercise program can result in significant, albeit limited, improvements in clinical mobility scores, strength, muscular endurance, and certain gait parameters.[40] In another study, a 12-week randomized clinical trial used an exercise program that focused on strength and balance to achieve a clinically significant improvement in gait velocity.[41] Exercise also was found to improve balance in elderly women. Postural stability, cardiovascular toning, increased muscle mass and strength, added bone density, and psychological

boost are all advantages of physical activity in the aging person. Running, walking, swimming, cycling, dancing, stretching, or other movement programs can add vigor to the life of an elderly person.[42]

Movement

Various aspects of movement, such as dance, theater, and sport, have been used in ritual, celebration, and healing rites since humans first organized into collective tribes and families. For thousands of years, Eastern cultures and philosophies have considered symbolic physical motion to be essential for physical and mental well-being. Yoga and T'ai Chi, for example, are two ancient physical movement forms that are still practiced today to enhance overall health. T'ai Chi, a traditional Chinese exercise, is a series of individual dancelike movements linked together in a continuous, smooth-flowing sequence. Movements within such disciplines are based on concepts of total concentration, strength, relaxation, and symbolic motion.

Movement ranges from the rapid motions of active dance or acrobatics, to the subtle rhythm characterized by breathing and choral singing, to the slow, careful movements of T'ai Chi. It includes the way that individuals hold and carry their bodies (i.e., posture) and the way that groups communicate nonverbally (i.e., body language). Movement also includes dancing, swimming, and other leisure sports. Exercise is the form of movement to which we give the most attention because of its known benefits to health maintenance. In health care, movement is used for a number of therapeutic purposes: range-of-motion exercises, water exercises, and specific physical therapy movements are incorporated into a variety of rehabilitative programs.[43]

The use of bodywork and movement to influence physiologic functioning is evident in several therapies emerging in alternative medicine: the Alexander technique, Feldenkrais method, rolfing movement integration, Aston-patterning, Hellerwork, and Trager approach. Most of these therapies are holistic approaches to reeducating body mechanics, balance, and postural alignments, that are used by many nontraditional physical therapists and healers. The Alexander technique was developed by an actor who kept losing his voice and found his body movements and postures to be at fault.[44] In the Trager approach, the mindfulness of patterns of movement assists in improving balance in the frail elderly, easing tension in myofascial pain syndrome, and promoting recovery from surgeries in which movement is restricted for a time (mastectomy, surgery of the back, knee, or shoulder).[45]

In one study to determine the potential value of T'ai Chi in promoting postural control in healthy elderly people, the performance of nine T'ai Chi practitioners on five balance tests was compared to the performance of nine nonpractitioners. Statistical analysis demonstrated that, in three of the tests, the T'ai Chi practitioners had significantly better postural control than did the sedentary nonpractitioners. Men performed significantly better on the same three tests than did women in both the practitioner and nonpractitioner groups.[46] T'ai Chi also has been found to be a safe movement therapy for clients with rheumatoid arthritis.[47,48]

Because we all use movement continually, we usually take it for granted. However, for many who have disabilities or are in rehabilitative programs, the design of creative movement plans can make the difference between partial and full development of their physical potential. Others can use movement therapies to improve body mechanics and help cope with the sedentary workplaces of our era. Although occupational or physical therapists often design and teach movement programs,

new types of therapists have emerged with an increased emphasis on wellness programs. Dance therapists and T'ai Chi instructors are now more widely consulted, particularly by those seeking high-level wellness. Creative movement programs are taught in group sessions, at wellness centers, and in continuing education classes, and may be led by nurses.

Creative movement, including dance, T'ai Chi, and other expressive movements, is a health-promoting behavior that is appropriate for a variety of populations and age groups. Movement can be a nursing intervention with independent, active people, as well as with those who have mobility deficits.[49] Dance, which is one of the major movement therapies, emphasizes the holism of human beings. In dance, one can externalize concepts created in the mind, thus making possible another bodymind experience.

HOLISTIC CARING PROCESS

Assessment

In preparing to use exercise and movement interventions, the nurse assesses the following parameters:

- the client's financial and religious restrictions, as well as habit patterns formed during childhood, and cultural approaches to exercise and movement
- the client's nonverbal movement patterns and known movement limitations
- the client's motivation, desire, and ability to make the necessary lifestyle changes in the areas of exercise and movement

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with the interventions for exercise and movement that are related to the 13 domains of Taxonomy II of the Unitary Person framework (see Chapter 14):

- Altered nutrition
- Altered circulation
- Altered oxygenation
- Altered coping
- Altered physical mobility
- Sleep pattern disturbance
- Altered activities of daily living
- Disturbance in body image
- Disturbance in self-esteem
- Potential hopelessness
- Potential powerlessness
- Knowledge deficit
- Pain
- Anxiety
- Grieving

Outcomes

Exhibit 19–1 guides the nurse in client outcomes, nursing prescriptions, and evaluation for the use of exercise and movement as nursing interventions.

Therapeutic Care Plan and Interventions

Before the Session

- Create an environment in which the client feels comfortable discussing the needs of his or her physical body from a physical movement perspective.
- Clear your mind of other client or personal encounters in order to be fully present when meeting with the client.
- Gather input data forms and teaching charts.
- Prepare all necessary assessment equipment.
- Prepare handouts or between-session worksheets to give to the client during the session.

Exhibit 19–1 Nursing Interventions: Exercise and Movement

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client will be motivated to improve exercise and movement practice.	Assist the client in a personal self-assessment.	The client completed a self-assessment form.
	Encourage the client to participate with the nurse to develop goals and action plans.	The client participated with the nurse to develop a personalized program of exercise and movement.
	Prepare the client to follow through with the nurse on evaluation and formulation of new goals.	The client met with the nurse to evaluate program results.
The client will demonstrate knowledge of healthful exercise and movement programs and resources.	Motivate the client to contribute to discussions about his or her program.	The client participated in the session discussions.
	Encourage the client to learn more about healthful behaviors as he or she works with the nurse.	The client demonstrated content knowledge and resource acquisition for using new behaviors in exercise and movement programs.

At the Beginning of the Session

- Take and record the necessary physical assessment data (e.g., height, weight, skin-fold thickness measurements, body contour measurements, blood pressure, data on range of motion and mobility limitations).
- Guide the client as he or she discloses past habit patterns that affect exercise behavior.

During the Session

- Review with the client current weekly exercise patterns.
- Be alert to psychologic clues that may relate to exercise behavior or extremes (exhaustion versus training versus sedentariness).
- Following data collection, work with the client to develop an individualized exercise and movement program.
- Make certain that teaching is at the client's intellectual and emotional level.

At the End of the Session

- Have the client identify the options presented that best fit his or her lifestyle.
- Work with the client to write down goals and target dates.
- Give the client specific affirmations to use to support these goals.
- Give the client handout material to reinforce the teaching.
- Use the client outcomes that were established before the session (see Exhibit 19–1) and the client's subjective experiences (see Exhibit 19–2) to evaluate the session.
- Schedule a follow-up session.

Specific Interventions: Exercise and Movement

Exercise (Basic)

A new paradigm of fitness is emerging. Its orientation is broader and it focuses more on enjoyment. As the new paradigm gains

Exhibit 19–2 Evaluation of the Client's Subjective Experience with Exercise and Movement Interventions

1. Is this the first time you have experimented with your exercise routine?
2. Have you experienced any sense of release during the changed physical activity?
3. Has your vitality increased since beginning regular exercise?
4. Does exercise give you a sense of reduced stress in your life?
5. Do you find time during your normal day to integrate special movement techniques?
6. If not, would you like to learn more ways to improve your movement periods at work?
7. What support systems have you discovered that assist you with maintaining and developing your exercise regimen?
8. Is there some other support that you need to assist you in adhering to your new exercise regimen?
9. What is your next step for integrating exercise and therapeutic movement into your daily life?
10. Do you need help in obtaining more resources for this final step?

strength, both the number of people exercising and those exercising at the level of vigor necessary to achieve improved vitality and health promotion will probably increase. Table 19–1 depicts the old and new fitness paradigms.

The primary purpose of exercise is to produce fitness. The basic components of fitness are:

1. Flexibility—the ability to use a joint throughout its full range of motion and to maintain some degree of elasticity of major muscle groups. It is important because
   - it provides increased resistance to muscle and joint injury
   - it helps prevent mild muscle soreness if flexibility exercises are done before and after vigorous activity
2. Muscle strength—the contracting power of a muscle. It is important because
   - daily activities become less strenuous as muscles become stronger
   - strong abdominal and lower back muscles help prevent lower back problems
   - appearance improves as muscles become firmer
3. Cardiorespiratory endurance—the ability of the circulatory and respiratory systems to maintain blood and oxygen delivery to the exercising muscles. It is important because
   - it increases resistance to cardiovascular diseases

Table 19–1 Old and New Fitness Paradigms

Old Fitness Paradigm	*New Fitness Paradigm*
Physical education, athletics programs	Bodymind integration, kinetic energy
Competition and comparison with others	Noncompetition, self-comparison only
Regulated calisthenics, aerobics, sports	Technology, feedback, and mechanical advantages to motivate and inspire action
Rigorous and punitive	Exhilirating and fun
Muscle building, body building, shape orientation	Integration of body-mind-spirit in temporal physicality

- it improves the ability to maintain activity levels
- it allows for a high energy return for daily activities

4. Postural stability—the body's ability to balance and stay balanced during dynamic action. This ability declines naturally with age; exercise continuation assists with preventing falls through integration of neuromuscular and sensory responses.

Beginning the regimen in a disciplined manner increases the chances of maintaining the program. Thus, before beginning an exercise program, an individual should be encouraged to follow these basic guidelines:

- Learn about the different types of exercise programs available in your area.
- Consult your physician or exercise authority. If you are over 35, have never seriously exercised, or have a disability or chronic illness, obtain guidance to avoid injuries or complications.
- Establish an exercise routine. Choose exercises or sports you will enjoy. Decide on a place and time of day to exercise. Ask a friend to join you or meet some new people at the jogging trail or health club. Create or join an exercise class before, during, or after work. There are endless possibilities.
- Warm up and cool down. Stretching exercises are essential before and after each aerobic or nonaerobic exercise period.
- Set realistic goals and work toward them. Some benefits of exercise may not be immediately apparent. Be patient. Build up slowly to your long-term goals.
- Evaluate your program periodically. Determine if you are making progress. If you want to go further, set new goals.
- Create competition for yourself only if it benefits you. If you have allowed too much competition, exercise may become more of a burden than a joy.

Many rewards of exercise and physical activity do begin immediately. Mental and spiritual improvements include beneficial changes in your

- mental attitude toward your work, yourself, and life in general
- ability to cope with stress
- ability to avoid or control mild depression
- sleep patterns
- strength and endurance
- eating habits
- appearance and vitality
- posture
- physical stamina as you age

To reduce risks associated with exercise, you must know not only how often and how long to exercise but also how vigorously to exercise. Although the target pulse range allows for a heart rate within 60 to 80 percent of maximal capacity, the American Heart Association guidelines state that regular exercise of a moderate level, or from 50 to 75 percent of maximal capacity, appears to be sufficient. Maintaining the target pulse rate during physical exercise for 15 to 30 minutes three to five times per week reduces the risk of overexertion, enhances enjoyment, and results in cardiovascular fitness. Because uncontrolled exercising may result in injury, it is wise to follow these guidelines:

- Always warm up for a minimum of 10 minutes.
- If you are tired, stop.
- If something hurts, stop.
- If you feel dizzy or nauseated, stop.

- Take your pulse at regular intervals.
- Cool down after exercising.

To ease your heart rate into the training range, begin with 10 minutes of low-intensity, warm-up exercise. To cool down, do 10 minutes of the same slow activity.

Adherence rates for nurse-led exercise programs are considerably higher than are those for other programs. Women tested at 3- and 6-month intervals after exercise intervention stated that they tried many fitness clubs and spas in the area but could find no exercise programs that were tailored to their age and fitness level, or that took into consideration their individual health needs. Nurses interested in and knowledgeable about the changes associated with aging are in an ideal position to develop and lead exercise programs for older individuals, particularly those with chronic, nondisabling physical problems.[50] Technological advances that may help in the provision of educational services include videocassettes and interactive computer programs.[51]

Movement (Basic)

There are four components of creative movement: centering, warm-up, exploration of surrounding space, and stretching.[52]

1. Centering is the inward focusing on one's own physical reality. The duration of this process varies, but it usually lasts 3 to 10 minutes.
2. The stretching, breathing warm-up exercises follow the centering exercise and are designed to "wake up" the muscles while maintaining the harmonious integration of psyche and soma that was begun through centering.
   - Musical accompaniment has a positive effect on one's ability to perform. Music seems to bypass the psychological feedback of the sensations of exertion and fatigue and instead produces feelings of exuberance and strength.
   - Exercises are done to synchronize breathing and symbolic imagery slowly and rhythmically. The individual uses images in concert with motion.
   - Social involvement during warm-up adds another dimension to creative movement. Initially, people may be shy with one another, but relaxation and enjoyment increase as the movement accelerates.
   - Additional warm-up techniques allow people to delve deeper into their own personal inward life before proceeding further into group activities, if they wish.
3. Exploration of surrounding space occurs as movement proceeds and there is an awakened sense of self-awareness. With this discovery of new physical capacities comes increased kinetic and spatial awareness. During this time, there may be swinging, swaying, and laughter.
4. Stretching concludes a dance movement, allowing for relaxation as it brings one to a resting state. At the conclusion, one should savor the feeling of energetic relaxation.

Case Study

Setting:	Public health clinic
Client:	E.J., a 55-year-old Hispanic widow with diabetes, living with a partially blind adult son.
Patterns/ Challenges/ Needs:	1. Altered nutrition (more than body requirements) related to excessive intake, improper eating patterns, and lack of exercise

2. Alteration in tissue perfusion related to decreased cellular exchange
3. Ineffective management of therapeutic regimen related to health beliefs

E.J. came for a routine checkup after years of uncontrolled diabetes mellitus. Oral hypoglycemic drugs had been prescribed for her several years earlier, but due to financial circumstances she did not continue to obtain health care and neglected her prescription for over 6 months. Worried because of increasing symptoms, she found the health department services and made an appointment with the family practice clinic. Her blood glucose level (fasting) was 240 mg/dl; her blood pressure was 150/88; she weighed 168 pounds and was 5 feet tall. She had not worked for the past 6 months. Her son lives with her and helps her financially as much as he can, working at nonskilled jobs. She has some friends and relatives that are nearby and who encouraged her to obtain treatment at a clinic.

Through the intake interview and history, the nurse learned that E.J. used to dance every weekend when her husband was alive and that she lives in a beautiful country setting in a trailer park. E.J. reported no meaningful activities outside of her church, for which she sometimes cleans and cooks. She had become more sedentary over the past 6 months, watching TV most of the day.

Willing to gain some control over her diabetes, E.J. agreed to follow a diet and exercise plan along with taking her prescriptions. She arranged to record her activities every day, to include daily walks in her neighborhood, and to begin using her record player at home to dance for 20 to 30 minutes three or four times a week. Together with the nurse, she designed an exercise program for a trial period of 6 weeks. She was given follow-up appointments with the nutritionist, the nurse, the physician, the laboratory, and a social worker. Because her plan for exercise and movement included keeping a daily journal of her activities, she was instructed to bring this journal back to review with the nurse in 2 weeks during a short visit.

After 6 weeks, the nurse and the social worker introduced E.J. to a senior citizen group that holds regular dances each month and an exercise class located in a church basement. E.J. met several other middle-aged women who walk in her neighborhood and formed a loose group of walkers. She reported only occasional lapses in exercise, usually due to her son's health or the weather. Together E.J. and the nurse discussed strategies for dealing with the changing weather and her daily walks. Overall, E.J. felt successful and energetic, and appeared to have recovered from the gloomy withdrawal she felt earlier.

Ongoing assessments of her activity level were to be scheduled according to her needs, but at least annually. E.J. revealed great joy in the experience of keeping a journal, as she felt she could show her son what she was doing and be proud of her smallest accomplishments regarding exercise and movement. Her ability to control this element in her self-care contributed both to her self-esteem and to the management of her diabetes. She also lost 8 pounds. In general, she experienced many benefits from establishing an exercise and movement program.

Evaluation

The nurse determines with the client whether the client outcomes for exercise and movement (Exhibit 19–1) were successfully achieved. To evaluate the session further, the nurse may again explore the subjective effects of the experience with the client using the evaluation questions in Exhibit 19–2.

Nurses should chart the information they impart to the client as well as the evaluation of the session. When the nurse works

in an inpatient facility, other staff must be apprised of the program and the client's progress. Nurses who work in wellness centers, independent practice, or other areas in which counseling sessions are the primary care modality should keep records for each client that state the nursing diagnosis, type of counseling employed, and effectiveness of each session.

Attention to exercise and movement can lead to a general improvement of health and decrease the risk factors of major diseases. The nurse is in a prime position to model the effects of healthy exercise and movement behaviors.

DIRECTIONS FOR FUTURE RESEARCH

1. Investigate the hypothesis that those who exercise feel better and live longer.
2. Continue investigating ways in which the lifestyle behaviors of exercise and movement affect a person's general sense of well-being.
3. Investigate the determinants that allow or encourage exercise in unstructured or spontaneous situations.
4. Study the specific factors that are important in tailoring exercise programs to ethnic and cultural groups.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin the process of answering the following questions:

- How would I describe the place of movement and exercise in my life today?
- What mental or spiritual sensations accompany my physical sensations because of my improved exercise and movement status?
- How should I feel when I am physically fit?
- What exercise and movement changes can I incorporate in my daily life to improve my fitness?
- How can I learn, practice, and model healthy exercise and movement?

NOTES

1. American College of Sports Medicine, Position Stand, The Recommended Quantity and Quality of Exercise for Developing and Maintaining Cardiorespiratory and Muscular Fitness, and Flexibility in Healthy Adults, *Medicine and Science in Sports and Exercise* 30, no. 6 (1998):975–991.
2. C. Schoenborn and P. Barnes, Leisure-time Physical Activity among Adults: United States, 1997–98, (CDC Publication, Advance Data No. 325, April 7, 2002). Washington, DC: U.S. Department of Health and Human Services.
3. J. Jakicic et al., American College of Sports Medicine, Position Stand, The Appropriate Intervention Strategies for Weight Loss and Prevention of Weight Regain for Adults, *Medicine and Science in Sports and Exercise* 33, no. 12 (2001):2145–2156.
4. Burton Goldberg Group, *Alternative Medicine: The Definitive Guide* (Puyallup, WA: Future Medicine Publishing, 1994), 721, 729.
5. American College of Sports Medicine, Position Stand, The Recommended Quantity and Quality of Exercise.
6. Jakicic et al., The Appropriate Intervention Strategies for Weight Loss and Prevention of Weight Regain for Adults.
7. H. Sharma and C. Clark, *Exercise in Contemporary Ayurveda: Medicine and Research in Maharishi Ayur-Veda* (New York: Churchill Livingstone, 1998), 117–126.
8. Burton Goldberg Group, *Alternative Medicine*, 69.
9. S. Bhasin et al., Testosterone Replacement and Resistance Exercise in HIV Men with Weight Loss and Low Testosterone Levels, *Journal of the American Medical Association* 283 (2000):763–770.
10. L. Goldberg and D.L. Elliot, *Exercise for Prevention and Treatment of Illness* (Philadelphia: F.A. Davis Co., 1994), 301, 308.

11. Goldberg and Elliot, *Exercise for Prevention and Treatment of Illness*, 49.
12. A.J. Coats, Exercise Rehabilitation in Chronic Heart Failure, *Journal of the American College of Cardiology* 22, no. 4 (1993):172A–177A.
13. L.T. Braun, Exercise Physiology and Cardiovascular Fitness, *Nursing Clinics of North America* 26, no. 1 (1991):135–147.
14. American College of Sports Medicine, Position Stand, The Recommended Quantity and Quality of Exercise.
15. National Guideline Clearinghouse (NGC), Physical Activity in the Prevention, Treatment, and Rehabilitation of Diseases [online], Available: http://www.guidelines. gov/, 2002.
16. J. Lasater, Untying the Knot: Yoga as Physical Therapy, in *Complementary Therapies in Rehabilitation: Holistic Approaches for Prevention and Wellness*, ed. C.M. Davis (Thorofare, NJ: Slack, 1997), 125–131.
17. R.K. Ng, Cardiopulmonary Exercise: A Recently Discovered Secret of T'ai Chi, *Hawaii Medical Journal* 51 (1992): 216–217.
18. J.S. Lai et al., Two-Year Trends in Cardiorespiratory Function among Older T'ai Chi Chuan Practitioners and Sedentary Subjects, *Journal of American Geriatric Society* 43 (1995):1222–1227.
19. American College of Sports Medicine, Position Stand, Exercise for Patients with Coronary Artery Disease, *Medicine and Science in Sports and Exercise* 26, no. 3 (1994):i–v.
20. American College of Sports Medicine, Position Stand, Exercise and Physical Activity for Older Adults, 992–1008.
21. Scottish Intercollegiate Guidelines Network (SIGN) and National Guideline Clearinghouse (NGC), Cardiac Rehabilitation. A National Clinical Guideline [online], Available: http://www.guidelines.gov/, 2002.
22. C.J. Lavie et al., Benefits of Cardiac Rehabilitation and Exercise Training in Secondary Coronary Prevention in the Elderly, *Journal of the American College of Cardiology* 22, no. 3 (1993):678–683.
23. National Guideline Clearinghouse (NGC), Physical Activity in the Prevention, Treatment, and Rehabilitation of Diseases.
24. Goldberg and Elliot, *Exercise for Prevention and Treatment of Illness*, 181.
25. Burton Goldberg Group, *Alternative Medicine*, 652–653.
26. Goldberg and Elliot, *Exercise for Prevention and Treatment of Illness*, 121.
27. I. Lindstrom et al., The Effect of Graded Activity on Patients with Subacute Low Back Pain: A Randomized Prospective Clinical Study with an Operant-Conditioning Behavioral Approach, *Physical Therapy* 72, no. 4 (1992):279–293.
28. K.M. Kellett et al., Effects of an Exercise Program on Sick Leave due to Back Pain, *Physical Therapy* 71, no. 4 (1991):283–291.
29. National Guideline Clearinghouse (NGC), Adult Low Back Pain [online], Available: http://www.guidelines.gov/, 2002.
30. Goldberg and Elliot, *Exercise for Prevention and Treatment of Illness*, 165–167.
31. L.A. Pruitt et al., Weight-Training Effects on Bone Mineral Density in Early Postmenopausal Women, *Journal of Bone and Mineral Research* 7, no. 2 (1992): 170–185.
32. American College of Sports Medicine, Position Stand, Osteoporosis and Exercise, *Medicine and Science in Sports and Exercise* 27, no. 4 (1995):i–vii.
33. M. Girodo et al., Deep Diaphragmatic Breathing: Rehabilitation Exercises for the Asthmatic Patient, *Archives of Physical Medicine and Rehabilitation* 73, no. 8 (1992):717–720.
34. The Cochrane Library, Issue 3, 2003, Physical Training for Cystic Fibrosis [online]. Available: http://www.imbi.uni-freiburg.de/cochrane/revabstr/AB002768.htm.
35. Goldberg and Elliot, *Exercise for Prevention and Treatment of Illness*, 99.
36. Goldberg and Elliot, *Exercise for Prevention and Treatment of Illness*, 89–90.
37. T.W. Pelham et al., The Effects of Exercise Therapy on Clients in a Psychiatric Rehabilitation Program, *Psychosocial Rehabilitation Journal* 16, no. 4 (1993):75–84.
38. T.W. Pelham and P.D. Campagna, Benefits of Exercise in Psychiatric Rehabilitation of Persons with Schizophrenia, *Canadian Journal of Rehabilitation* 4, no. 3 (1991):159–168.
39. R.S. Mazzeo et al., Exercise and Physical Activity for Older Adults, *Medicine and Science in Sports and Exercise* 30, no. 6 (1998):992–1008.
40. L.R. Sauvage et al., A Clinical Trial of Strengthening and Aerobic Exercise To Improve Gait and Balance in Elderly Male Nursing Home Residents, *American Journal of Physical Medicine and Rehabilitation* 71, no. 6 (1992):333–342.

41. J.O. Judge et al., Exercise To Improve Gait Velocity in Older Persons, *Archives of Physical Medicine and Rehabilitation* 74, no. 4 (1993):400–406.
42. Mazzeo et al., Exercise and Physical Activity for Older Adults.
43. Burton Goldberg Group, *Alternative Medicine*, 97–108.
44. D. Zuck, The Alexander Technique, in *Complementary Therapies in Rehabilitation*, ed. C. Davis (Thorofare, NJ: Slack, 1997), 161–187.
45. A.R. Stone, The Trager Approach, in *Complementary Therapies in Rehabilitation*, ed. C. Davis (Thorofare, NJ: Slack, 1997), 199–212.
46. S. Tse and D.M. Baily, T'ai Chi and Postural Controls in the Well Elderly, *American Journal of Occupational Therapy* 46, no. 4 (1992):295–300.
47. A.E. Kirsteins et al., Evaluating the Safety and Potential Use of a Weight Bearing Exercise, Tai Chi Chuan, for Rheumatoid Arthritis Patients, *American Journal of Physical Medicine and Rehabilitation* 70, no. 3 (1991):136–141.
48. Goldberg and Elliot, *Exercise for Prevention and Treatment of Illness*, 84.
49. S. Boots and C. Hogan, Creative Movement and Health, *Topics in Clinical Nursing* 3, no. 2 (1981):21–31.
50. P.A. Gillett et al., The Nurse as Exercise Leader, *Geriatric Nursing* 14, no. 3 (1993):133–137.
51. N.K. Wenger, Modern Coronary Rehabilitation, *Postgraduate Medicine* 94, no. 2 (1993):131–136, 141.
52. Boots and Hogan, Creative Movement and Health, 21–31.

Releasing the Energy of the Playful Child

The joys of playing and playfulness are gifts that can be lost as we grow out of childhood and take on adult responsibilities. Illness may further deplete our ability to see the lighter side of life and take advantage of healthy hilarity. We must search out ways to reconnect with the joyful child within and use that energy to move to a higher level of wellness. When we laugh, our perception shifts. We release feelings of judgment, blame, and self-pity to embrace a more extended knowing of ourselves and others. Deliberately taking the time to amuse and be amused allows us to endure a great deal of change that otherwise would be overwhelming.[1]

Play is part of the richness of life; it enables us to live and grow. As infants and children, we play to learn. As adults, we play to relax, to enjoy interaction with others, to grow, and to gain a different perspective on our lives. Our play can be a variety of activities, from the simple experience of skipping or dancing for the joy of movement, to the excitement of "playing to win" in a tournament or game.

Most animals play for at least some portion of their lives. The animals that play are those that can benefit from experience, those that can learn both step by step and on occasion by leaps of the imagination. The ones that play are those that must learn by discovery and practice, acquiring through trial and error (and trial and success) the skills they need to survive.[2]

> *There is more honest "belly laughter" in a Zen monastery than surely in any other religious institution on earth. To laugh is a sign of sanity; and the comic is deliberately used to break up concepts, to release tensions and to teach what cannot be taught in words. Nonsense is used to point to the beyond of rational sense.*[3]
>
> *Christmas Humphries*

NOTES

1. J. Segal, *Feeling Great* (Van Nuys, CA: Newcastle Publishing Co., 1981), 68.
2. M. Piers and G. Landau, *The Gift of Play* (New York: Walker and Co., 1980), 19.
3. T. Quereau and T. Zimmerman, *The New Game Plan for Recovery: Rediscovering the Positive Power of Play* (New York: Ballantine Books, 1992), 261.

Chapter 20

Humor, Laughter, and Play: Maintaining Balance in a Serious World

Patty Wooten

NURSE HEALER OBJECTIVES

Theoretical

- Define humor, laughter, and play and explain how they interrelate.
- Describe the psychosocial and physiologic benefits of laughter and play.
- Explain how humor, laughter, and play can aid in stress reduction.

Clinical

- Organize and integrate playful activities into your clinical practice.
- Document the psychophysiologic changes that occur in clients as they allow themselves to laugh and engage in playful activities.
- Develop a collection of humorous books, cartoons, games, and comedy DVDs, videos, and audio cassettes that are appropriate for use in your area of nursing practice.

Personal

- Describe strategies for integrating a humorous perspective and playful activities into each day.
- Clarify and expand awareness of your personal humor preferences and favorite playful activities.
- Develop a heightened awareness of opportunities to insert humor and encourage playfulness.

DEFINITIONS

Humor: a quality of perception and attitude toward life that enables an individual to experience joy even when facing adversity; a perception of the absurdity or incongruity of a situation.

Laughter: a physical behavior that occurs in response to something that is perceived as humorous, amusing, or surprising. This behavior engages most of the muscle groups and organ systems within the body. Laughter is often preceded by physical, emotional, or cognitive tension.

Play: a spontaneous or recreational activity that is performed for sheer enjoyment rather than to reach a goal or produce a product. Playfulness is a mood or attitude that infuses the individual with a sense of joy and positive emotions.

THEORY AND RESEARCH

Humor is a complex phenomenon that is an essential part of human nature. Anthropologists have never found a culture or society, at any time in history, that was completely devoid of humor. A sense of humor is both a perspective on life—a

way of perceiving the world—and a behavior that expresses that perspective. As Moshe Waldoks declared, "A sense of humor can help you overlook the unattractive, tolerate the unpleasant, cope with the unexpected and smile through the unbearable."[1]

Humor is a word of many meanings. It is derived from the Latin word *umor,* meaning liquid or fluid. In the Middle Ages, humor referred to an energy that was thought to interact with a body fluid and an emotional state. This energy was believed to influence health and disposition (e.g., 'he's in a bad humor'). A sanguine humor was cheerful and associated with blood. A choleric humor was angry and associated with bile. A phlegmatic humor was apathetic and allied with mucus. A melancholic humor was depressed and related to black bile.[2] This belief system was an early recognition of the energy links between the mind and the body.

One of the earliest and most extensive reviews of humor and its use by health professionals was compiled in the early 1970s by nurse-educator Vera Robinson as part of her doctoral thesis.[3] First published in 1977, her work was updated and released again in 1991. Today, almost 30 years later, it continues to be one of the most comprehensive studies of humor and its importance in nursing practice. Her review of the theories of humor is both comprehensive and concise. Her findings are summarized here.

Humor from Different Perspectives

The humanities and the literature of the world, from the time of the ancient Greeks to the present, have been concerned with the nature of comedy and laughter. Comedy reveals people's imperfections, gives them courage to face life, and leaves them more tolerant. Tragedy is idealistic and expresses "the pity of it," while comedy tends to be more skeptical and expresses "the absurdity of it."[4]

Early philosophers were concerned with the nature of humor in relation to the issues of good and evil and the nature of humans. Both Plato and Aristotle felt that laughter arose from enjoyment of the misfortunes of others and that comedy was an imitation of people at their worst. Other philosophers viewed laughter as a valuable asset in correcting the minor follies of society.

According to the psychoanalytic view of humor set forth by Sigmund Freud, civilization has led to repression of many basic impulses, and joking is a socially acceptable way of satisfying these repressed needs. Freud described four major types of joke: the sexual joke, the aggressive and hostile joke, the blasphemous joke, and the skeptical joke. This joking activity serves to preserve psychic energy. Freud differentiated between wit, the comic effect, and humor. The pleasure of wit comes from an economy of inhibition; the pleasure of the comic, from an economy of thought; and the pleasure of humor, from an economy of feelings.[5]

Psychologists go beyond Freud's interpretation to assert that humor is not simply determined by the present stimulus situation but also depends on recollections of the past and anticipation of the future. A collective process is important in generating the pleasure of humor. Humor is cognitively based and involves information-processing and problem-solving abilities. Psychologist Harvey Mindess proposed the liberation theory of humor. He viewed humor and laughter as the agents of psychologic liberation. They free us from the constraints and restrictive forces of daily living and, in doing so, make us joyful.[6]

Anthropologists have described the use of humor within various cultures or ethnic groups. They have identified a joking relationship that is a kind of "permitted disrespect," in which one person is required to

tease or make fun of another, who is in turn required to take no offense. This kind of social relationship is widespread in different societies and provides a basis for comparative studies of social structures.[7] One of the first cross-cultural studies of humor found that humor is the result of cultural perceptions, both individual and collective; it is a cognitive experience that must have a cultural niche and cannot occur in a vacuum.[8] Humor is universal, but the culture, society, or ethnic group in which it occurs influences the style and content of humor and the situations in which humor is used and is considered appropriate.[9]

Many sociological studies have explored exactly how humor is used within society. Humor is a social relationship and occurs in a social environment. Research has shown that it promotes group cohesion, initiates relationships, relieves tension during social conflict, and can be a means of expressing approval or disapproval of social action. Joking relationships within organizations serve to minimize stress and release antagonism.[10,11]

The three major theories of humor are (1) the superiority theory, (2) the incongruity theory, and (3) the release theory. The *superiority theory* asserts that people laugh at the inferiority, stupidity, or misfortunes of others so that they may feel superior to them. This type of laughter can be cruel and scornful, or can reflect warmth and empathy. For example, people watch the foolish actions of beloved comics such as Lucille Ball or Charlie Chaplin and feel smart and dignified compared to them. Essentially, people are laughing at themselves, at their own imperfections. For the moment, they feel superior. What they are laughing at did not happen to them, but it could have. This type of comedy demonstrates that "man is durable, even though he may be weak, stupid, and undignified."[12] In the superiority theory, humor can be viewed as a continuum: from laughing at no one (nonsense jokes), to laughing at a specific person or group (jokes about morons or ethnic groups), to laughing with others in general at people's foibles (Charlie Chaplin's humor), to laughing at oneself, the most therapeutic of all.

The *incongruity theory* of humor holds that a sudden shock or unexpectedness, an incongruity, ambivalence, or conflict of ideas or emotions, is necessary to produce the absurdity provoking a burst of laughter.

The *relief* or *release theory* of humor proposes that humor and laughter provide a release of tension. The relief can be cognitive—an escape from reality, from seriousness, from reason. The relief can be an emotional release of anxiety, fear, anger, or embarrassment from social conflict. It also can be a release of nervous energy and physical tension.

Many of these theories of and perspectives on humor obviously overlap. Some describe the *nature* of humor, while others describe the *function* of humor. However, this diversity of perspectives shows that humor, laughter, and play are very complex phenomena that serve people in many ways. The possibilities for the study of humor are endless. The importance and influence of humor have been examined from the perspectives of anthropology, psychology, literature, sociology, linguistics, religion, and so on. More information about the influence of humor in people's lives can be obtained from the International Society for Humor Studies (see the Resources section at the end of the chapter). A discussion of the therapeutic value of humor and its beneficial influence on the body-mind-spirit follows.

Therapeutic Humor

Modern dictionaries define humor as the quality of being laughable or comical, or as a state of mind, mood, and spirit. Our sense of humor gives us the ability to find delight and experience joy even when fac-

ing adversity. Humor, then, is a flowing energy, involving and connecting the body, mind, and spirit.

Humor can take many forms: jokes, cartoons, amusing stories, outrageous sight gags, funny songs, whimsical signs, bloopers, "daffynitions," and physical slapstick antics. These humorous techniques stimulate the auditory, visual, or kinesthetic senses.

Therapeutic humor can be divided into three basic categories: hoping humor, coping humor, and gallows humor. *Hoping humor* gives the individual the courage to face challenges. *Coping humor* offers a release for physical and emotional tension. *Gallows humor* provides protection from the emotional impact of witnessing tragedy, death, and disfigurement. Sharing humor and laughter with clients and colleagues can have profound healing potential. Finding a humorous perspective on one's problems, or experiencing the relaxing effects of laughter, can be an effective stress management technique that helps one stay healthy.

The term *to heal* comes from the Anglo-Saxon word *haelen*, which means to bring together and make whole. Bringing together the body, mind, and spirit can be healing. Humor, laughter, and the resulting emotion, mirth, unite the body, mind, and spirit. Humor is a cognitive activity engaging the mind. Laughter is a physical activity involving the body. Mirth is an emotional state that lifts the spirit.[13]

Hoping Humor: The Courage to Face Challenges

The ability to hope for something better enables human beings to cope with difficult situations. Hoping humor laughs in spite of the overwhelming circumstances. It reflects an acceptance of life with all its dichotomies, contradictions, and incongruities. This type of humor is usually warm and gentle and accepts the reality of the situation. Consider the following example of hoping humor.

Janet Henry had breast cancer. After her mastectomy, she received chemotherapy. First she lost her breast, and then she lost her hair, but Janet never lost her sense of humor. She wrote a little poem to describe her ritual as she prepared for bed each night.

> ***The Nightly Ritual***
> I prop my wig up on the dresser
> And tuck my prosthesis beneath
> And I thank God
> I still go to bed
> With my man and my very own
> teeth.

With whimsy and gratitude, Janet remembered the blessings in her life in spite of her losses.[14]

Hoping humor can also be used to sustain the spirit during the shock and trauma of natural disasters. People create humor to literally laugh in the face of their loss. Both disaster victims and those who offer professional assistance use humor to provide hope and courage as they deal with the overwhelming task of recovery. As Charlie Chaplin once noted, "To truly laugh, you must be able to take your pain and play with it."[15]

Sandy Ritz, a nurse from Hawaii, completed her doctoral thesis in public health on the topic of humor and disaster recovery.[16,17] Her research showed how humor changed as the stages of recovery progressed. After the devastating floods in the Midwest during 1997, a large billboard announced: "Concerned about the weather? Call 1-800-NOAH." After a tornado destroyed a house in Texas, the family moved across town to live with relatives. They placed a sign on their front lawn: "Gone with the wind." After an earthquake in Los Angeles, one house that had completely collapsed had this sign in front: "House for Rent. Some assembly required."

Nurses and other professional caregivers use hoping humor to acknowledge

their own reality and to laugh in spite of the pressure and demands. For example:

> *How You Know It's Going To Be a Long Shift*
>
> 1. You step off the elevator and emergency room gurneys are lined up in the hall.
> 2. The crash cart is not in its usual location.
> 3. There are too many people in the nursing station.
> 4. There is nobody in the nursing station.
> 5. Housekeeping is scrubbing a large area of the floor.
> 6. You get two admissions during report.[18]

Coping Humor: A Release for Tension

Illness and trauma cause stress and suffering. They disrupt our ability to function smoothly and present many challenges. Coping describes what people do to minimize this disruption and attempt to regain some control. To cope effectively, people must change how they think and how they behave. Humor often is used as a coping tool to change perspective, release tension, and regain a sense of control. As Freud noted, "Humor has a liberating element, it is the triumph of narcissism. It is the ego's victorious assertion of its invulnerability. It refuses to suffer the slings and arrows of reality."[19] Clients use coping humor to laugh about uncomfortable and embarrassing moments. While they may not always be able to control their external reality, they can use humor to control how they perceive their situation and use their ability to laugh about it to provide some sense of empowerment,[20,21] as shown by the following example.

> The nurse was caring for Barbara during her weeklong hospitalization for chemotherapy. The drugs were powerful, with many uncomfortable side effects. Fortunately, the nurse had been successful in managing Barbara's nausea with antiemetic medications. However, when the nurse entered the patient's room on Thursday, she found her bending over the toilet bowl vomiting profusely. The nurse was surprised and, without thinking, blurted out, "What are you doing?" Barbara wiped her chin, looked up at the nurse, and said, "Well, I had a tuna sandwich for lunch and I began feeling sorry for the tuna, so I thought I'd return it to its natural habitat."

Barbara used humor to redefine her uncomfortable situation, took control of her perceptual process, and changed her attitude about the event.[22]

Coping humor often expresses anxiety or frustration about things that are out of one's control. Consider the following:

> *Handy Exercises You Can Do To Prepare for Hospitalization*
>
> 1. Lie naked on the front lawn, covered with a napkin, and ask people to poke you as they go by.
> 2. Practice inserting your hand in a running garbage disposal and smile, saying "Mild discomfort."
> 3. Set your alarm to go off every 10 minutes between 11 P.M. and 7 A.M., at which times you will awaken and stab yourself with a screwdriver.
> 4. Learn to urinate into an empty lipstick tube.[23]

Caregivers also create humor to help release feelings of hostility or frustration created by patients or other professionals.[24–30] Sometimes nurses enjoy making jokes about physicians. For example:

> What do you call two orthopedic surgeons reading an electrocardiogram?

A double-blind study.

Why is a neurosurgeon just like a sperm?

One in 200,000 becomes a human.

What does it mean when a physician writes WNL on the History and Physical?

We Never Looked.

Sometimes, caring for patients who are noncompliant, combative, demanding, or ungrateful can be frustrating. These patients are sometimes referred to as gomers, an acronym created by a physician writing about his internship experience.[31] GOMER is an acronym for Get Out of My Emergency Room. Over the years, several versions and additions to the gomer criteria list have evolved.

You know your patient is a gomer if

1. his old chart weighs more than 5 pounds.
2. his previous address was the VA hospital.
3. he keeps tying his pajama strings in with the Foley catheter.
4. he can have a seizure and never drop his cigarette.
5. he asks for a cigarette in the middle of his pulmonary function test.
6. his blood urea nitrogen level is higher than his IQ.

Coping humor is a socially acceptable form of expressing hostility, but it should be used with caution. It can be viewed as disrespectful and hurtful if overheard by someone who either identifies with the person being laughed at or feels that this type of humor is offensive and inappropriate for health professionals. Sharing any form of humor is always a risky venture because people vary greatly in what they find funny, and which topics they consider too serious to laugh about. What is funny to one person may be viewed as offensive by another.[32] Exhibit 20–1 shows guidelines for appropriate use of humor.

Gallows Humor: Protection from Pain

Gallows humor often is used by professionals who work in situations that are horrifying or tragic. Every day these people cope with the reality and horror of illness, suffering, and death. In this group are doctors, nurses, police officers, newspaper journalists, social workers, hospice workers, and many others. These professionals, because of their caring and compassion, are more likely to feel the impact of the suffering they witness. Caregivers often use humor as a means of maintaining some distance from the suffering to protect themselves from empathic pain.[33,34] Gallows humor acknowledges the disgusting or intolerable aspects of a situation and then attempts to transform it into something lighthearted and amusing. People's ability to laugh in this type of situation provides them with a momentary release from the intensity of what might otherwise be overwhelming. They are able to maintain their balance and professional composure so that they may continue to offer their therapeutic skills.

Consider the following example: One night, in the emergency room at a county hospital, an ambulance brought in a homeless person who had been found unconscious in an alley. The man was filthy, his breath reeked of alcohol, and he had lice crawling on his body. It took two nurses more than an hour just to clean the man up enough for admission. It was difficult work, and the nurses' senses were overwhelmed with unpleasant sights and smells. One of the nurses read the intern's admission note on the way up in the elevator. It said, "Patient carried into emergency room by army of body lice, who

Exhibit 20–1 Concerns and Cautions about Using Humor in Health Care Settings

Concerns

- ***Will clients or colleagues consider the use of humor unprofessional?***
  Offer a brief explanation of the health benefits of humor to counter this. You can maintain your professionalism and still adopt a lighter style of interaction with patients and staff.
- ***Will I be seen as incompetent?***
  Establish your competence first (especially among other staff), then let your sense of humor emerge. Clients usually welcome a lighter style of interaction.
- ***Will clients misinterpret humor as indifference about their condition?***
  Shared humor does not replace concern, care, and respect. It makes those qualities more personal and believable.
- ***What should I do if I really don't think the client's humor is funny?***
  Don't laugh, but smile and acknowledge the joke.
- ***What should I do if the client's humor is offensive?***
  Be honest and tell the client that you really don't enjoy that kind of humor. Be flexible, open, and supportive of the client's humor generally. There are limits to joking as with any other behavior.

Cautions

- Be sensitive to whether the client is responding positively or negatively to humor. Don't force your humor on the client if the client is not receptive. Think of humor as a medication. You must administer the right medicine, in the right dosage, at the right time for a therapeutic benefit to occur. Two clients with the same symptoms do not always get the same medication. Some clients have allergic reactions. Be sensitive to the client's humor allergies.
- Remember that clients may not respond to humor until they have come to accept the reality of their disease. Do not try to use humor to subdue their depression or anger. The time may come, however, when humor can help them turn the corner of acceptance.
- Remember that sometimes clients don't feel like laughing. They may be nauseated, in pain, or just not in the mood.
- Remember that many clients have no history of using humor under stress. It may be unrealistic to expect them to react favorably to humor when their health is threatened. People generally use the same coping mechanisms in the hospital that they have used in other stressful situations. This may include becoming angry, depressed, withdrawn, anxious, assertive, or demanding. Each of these coping styles is compatible with humor once you know the client well. Always be sensitive to how the client is responding to your playful style.
- Remember that some clients may have religious convictions that stress reverence for the seriously ill. This may be incompatible with any form of humor or light-hearted interaction.
- Humor is inappropriate when
  1. the patient needs time to cry.
  2. the patient needs quiet time to rest, contemplate, or pray.
  3. the patient is trying to come to grips with any emotional crisis.
  4. the patient is trying to communicate something important to you.
  5. the person in the adjacent bed is very sick or dying.
- Avoid humor that is
  1. ethnic, sarcastic, mocking.
  2. at the expense of another person (laugh with, not at).
  3. joking about any client or that client's condition.

were chanting, 'Save our host. Save our host.'" The nurse laughed heartily at this amusing picture. Suddenly the struggles of the last hours were put into a humorous perspective, and she felt a lot less anger and a lot more compassion.

One study of the use of humor among hospital staff in emergency rooms and critical care units described how gallows humor was used as a coping tool:

> There is a goodness of fit between how the provision of care induces stress in the emergency care environment and how the use of humor intervenes in that process.

> Emergency personnel experience a wide spectrum of serious events—trauma, life-threatening illness, chaotic emotional situations—often all at the same time. There is no time to emotionally prepare for these events, and little time to ventilate afterwards or "decompress." The spontaneous way in which humor can be produced in almost any situation, and it's instantaneous stress-reducing effects are well suited to the emergency care experience.[35,36]

It is important to note that gallows humor, so therapeutic for staff, may not be appreciated by clients or their families. One group of nurses hung the following sign in the visitor waiting room to reassure visitors that the staff's use of humor actually helped them provide better care for their loved ones:

> You may occasionally see us
> laughing,
> or even take note of some jest.
> Know that we are giving your
> loved one
> our care at its very best.
> There are times when the tension
> is highest.
> There are times when our systems are stressed.
> We've discovered humor a factor
> in keeping our sanity blessed.
> So, if you're a patient in waiting,
> or a relative, or a friend of one
> seeing,
> don't hold our smiling against us,
> it's the way we keep from
> screaming.[37]

Cathartic Laughter

Laughter is a smile that engages the entire body. At first, the corners of the mouth turn up slightly. Then the muscles around the eyes engage and a twinkling can be seen in the eyes. Next the person begins to make noises, ranging from controlled snickers, escaped chortles, and spontaneous giggles to ridiculous cackles, noisy hoots, and uproarious guffaws. The chest and abdominal muscles become activated. As the noises get louder, the person begins to bend the body back and forth, sometimes slapping the knees, stomping the feet on the floor, or elbowing another person nearby. As laughter reaches its peak, tears flow freely. All of this continues until the person feels so weak and exhausted that he or she must sit down or fall down. Very strange behavior!

Of course, not everyone experiences such intense laughter every time they are amused. For example, people may struggle to contain themselves if they are concerned about how others might judge this behavior; if they are concerned with maintaining a dignified image; if they feel others might be offended by their robust laughter; or if the culture places strong taboos on such behavior.[38,39]

Sounds of Laughter

If we listen to the sound of someone laughing, we hear that the laughter has different tones and rhythms, almost as if the laughter were coming from different parts of the body. These sounds can give us a clue as to why the person is laughing. A "tee hee" laugh is often a high-pitched titter that seems to come from the top of the head. This laugh arises when a person is very nervous and tries to disguise his or her anxiety with laughter. Like the valve atop a pressure cooker, this laughter acts as a safety valve and allows the person to release a little steam before he or she explodes from built-up pressure. A "heh heh" laugh is a shallow, almost hollow sound that comes from the throat area.

This laugh occurs when a person feels socially obligated to laugh at a joke that is not really considered funny. A "ha ha" laugh emanates from the heart space with a warm resonance and palpable sincerity. This laugh occurs when someone is truly amused or delighted by the humorous stimuli. It is also the kind of laugh that occurs during deep insight or peaceful, joy-filled moments, such as during meditation. A "ho ho" laugh is the deep belly laugh, the kind in which a person really begins to let go of control and surrender to the experience of deep joy and amusement. The whole body is engaged in movement, which usually continues until exhaustion. The person must put down whatever is being held, and must sit down to avoid falling down. Sometimes the laughter is so deep and so prolonged that the person is left gasping for air and exhausted from the activity. After the laughter, as the person becomes quiet, a warm glow fills his or her body. The person feels lighter, almost buoyant, and his or her mind is clear of worry, fear, and anger. His or her body feels energized yet relaxed. Usually, the person is no longer aware of any pain that was previously felt. If this laughter was shared with others, the person feels a sense of connection and trust. During these moments one's problems do not feel oppressive; one feels safe and at peace with the world. The body is listening to this emotional weather report and making subtle, or sometimes profound, changes at a molecular level. These changes have a powerful impact on the immune system and can enhance the ability to heal. As Barry Sultanoff, a holistic physician, explained: "Laughing together can be a time of intimacy and communion, a time when we come forward, fully present and touch into each other's humanness and vulnerability. By joining in humor and acknowledging our oneness, we can have a profound experience of unity and cooperation. That in itself maybe one of the most profound expressions of healing energy of which we are capable."[40]

What *is* this healing energy? Where does it come from? What does it do? For thousands of years we have extolled that "laughter is the best medicine." In many cultures, religions, and societies, people speak of the healing power of humor. The Old Testament says, "A merry heart does good like a medicine, but a broken spirit dries the bones" (Proverbs 17:22). This universally accepted truth is just now being explained by scientific research. Norman Cousins enlightened the medical community about the healing potential of laughter in his book *Anatomy of an Illness*.[41] In 1968, Cousins was diagnosed with ankylosing spondylitis, a potentially life-threatening, degenerative disease involving the connective tissue of the body, which is essential in holding together the cells and larger structures of the body. Cousin's case was so extreme that he soon experienced great difficulty and pain in moving his joints. He was told that his prospect for recovery was very bleak. Because of discomfort and fatigue, he was unable to travel or play tennis, activities that brought him great joy and satisfaction.

Cousins refused to accept his grim prognosis and decided to take charge of his own treatment, working in partnership with his physician. He remembered reading about the adverse consequences of negative emotional states on the chemical balance of the body. He reasoned that, if negative emotions had played any part in predisposing him to illness, then perhaps positive emotions could aid in his recovery. He sought activities that increased his positive emotions, such as faith, hope, festivity, determination, confidence, joy, and a strong will to live. He knew that laughter helped create positive emotions. With this in mind, Cousins watched films of the Marx brothers and Candid Camera. He had nurses read to him from humorous

books. He played practical jokes and told jokes. He began feeling better. Blood tests showed that his sedimentation rate (an index of the degree of infection or inflammation in the body) decreased after his laughter sessions, and they continued to fall as he gradually recovered.

After several months of this "humor therapy," his illness resolved and never returned. One could argue that Cousins would have recovered anyway, even without the laughter. Or one could comment that the results are not scientifically significant and represent the observations of a single case. However, Cousins continued his quest to understand just how his healing occurred.

Cousins spent the remaining 12 years of his life as an adjunct professor at the University of California at Los Angeles Medical School, where he established a "humor task force" to coordinate and support clinical research into laughter. Today, 25 years after Cousins' self-healing experience with laughter, there is scientific research providing evidence for the specific physiologic changes that his individual story suggested.[42–45] Cousins declared:

> Each human being possesses a beautiful system for fighting disease. This system provides the body with cancer-fighting cells—cells that can crush cancer cells or poison them one by one with the body's own chemotherapy. This system works better when the patient is relatively free of depression, which is what a strong will to live and a blazing determination can help to do. When we add these inner resources to the resources of medical science, we're reaching out for the best.[46]

Physiologic Response to Laughter

The behavior called laughter creates predictable physiologic changes within the body. In the 1950s, William Fry, Jr., Professor Emeritus of medicine at Stanford University, began his research into the physical effects of laughter.[47] As with other exercise, the body's response has two stages: the arousal phase, in which the physiologic parameters increase, and the resolution phase, in which they return to resting values or lower. With vigorous, sustained laughter, the heart rate is stimulated, sometimes reaching rates of above 120 beats per minute. The normal respiratory pattern becomes chaotic; respiratory rate and depth are increased, while residual volume is decreased. Coughing and hiccups are often triggered due to phrenic nerve irritation or the dislodging of mucus plugs. Oxygen saturation of peripheral blood does not significantly change during the increased ventilation that occurs with laughter. Conditions such as asthma or bronchitis may be irritated by vigorous laughter. Peripheral vascular flow is increased due to vasodilatation. A variety of muscle groups become active during laughter, including diaphragm, abdominal, intercostal, respiratory accessory, and facial muscles, and occasionally muscles of the arms, legs, and back.[48–51]

Some of the most exciting research exploring the potential healing value of laughter is in the area of psychoneuroimmunology.[52] Psychoneuroimmunology studies the connections and communication patterns linking the nervous, endocrine, and immune systems. Candace Pert, one of the most respected researchers in the area of mind-body medicine, notes that emotions, which are registered and stored in the body in the form of chemical messages, are the most influential connection between the mind and the body. The emotions one experiences in connection with one's thoughts and daily attitudes—and, more specifically, the neurochemical changes that accompany these emotions—have the power to influence health.[53–55]

The key, according to Pert, is found in complex molecules called neuropeptides, which are formed from amino acids. Pep-

tides are found throughout the body, including in the brain and immune system. The brain contains more than 60 different neuropeptides. These neuropeptides carry messages between the brain and the body as well as within the brain and within the body. Individual cells, including brain cells, immune cells, and other body cells, have receptor sites that receive neuropeptides. As our emotions change throughout the day, the neuropeptides available to cells reflect these variations. Receptor sites are important as a communication link between the brain and the immune system. Emotions can trigger the release of neuropeptides from the brain. These chemicals then enter the bloodstream and plug into receptor sites on the surfaces of immune cells. When this occurs, the cells' metabolic activity can be altered in either a positive or a negative direction. The kind and number of emotion-linked neuropeptides available at receptor sites of cells influences the probability of staying well or getting sick.[56] As Pert explains, "Viruses use these same receptors to enter into a cell, and depending on how much of the natural peptide for that receptor is around, the virus will have an easier or harder time getting into the cell. So our emotional state will affect whether we'll get sick from the same loading dose of a virus."[57]

One of the first research teams to join Norman Cousins' humor task force was Lee Berk and Stanley Tan from Loma Linda University Medical Center. Berk, a psychoneuroimmunologist, and Tan, an endocrinologist, have measured changes in immune function stimulated by the experience of mirthful laughter. In an interview, Berk noted:

> Essentially, we found that mirthful laughter serves to modulate specific immune system components. By modulate, we mean that chemicals released during the emotional experience of mirth can connect to receptors on the surface of the immune cells. This connection stimulates a change in the molecular machinery inside the cell. Specific molecules known as immunoregulators are like plugs that fit into receptors and subsequently increase or decrease the immune cell activity. One metaphor for modulation of immune activity is the conductor of an orchestra. Although the conductor does not actually play an instrument, he influences the tempo, harmony and volume of the music produced by the orchestra. Mirthful laughter would be like the conductor who enhances sonic integration and brings out melodious harmony. Whereas distressful emotions would be like the conductor who brings out harsh, disharmonious sounds. Emotion, like a conductor, modulates the activity and effectiveness of the immune cells although it does not directly protect the body from insult or infection.[58]

The findings of Berk and Tan during more than 10 years of research can be summarized as follows. Mirthful laughter has been shown to

1. increase the number and activity of natural killer cells, which attack viral-infected cells and some types of cancer cells.
2. increase the number of "activated" T cells; these cells are "turned on and ready to go."
3. increase the level of the antibody IgA, which fights upper respiratory tract infections.
4. increase the levels of gamma interferon, a lymphokine that activates many immune components.
5. increase levels of complement 3, which helps antibodies to pierce infected cells.

In addition to measuring specific immune system changes, the research of

Berk and Tan also shows that levels of stress hormones, which constrict blood vessels and suppress immune activity, actually decrease in response to mirthful laughter. Levels of epinephrine, dopamine, and cortisol, which usually rise in response to stress, were all lowered with laughter.[59–65]

Stress has been shown to create unhealthy physiologic changes. The connection between stress and blood pressure elevation, muscle tension, immunosuppression, and many other changes has been known for years. There is now proof that laughter creates the opposite effects. It appears to be the perfect antidote for stress.

This research helps us to better understand the mind-body connection. The emotions and moods we experience directly effect our immune system. If we have a well-developed sense of humor we are more likely to appreciate the amusing incongruities of life, and experience more moments of joy and delight. These positive emotions can create neurochemical changes that buffer the immunosuppressive effects of stress.

The Power of Playfulness

The key to improving our sense of humor is the rediscovery of the playfulness we had as children. The joyous laughter that accompanies children's play leaves no doubt that they are happy. When we become more playful, we automatically become more spontaneous and enjoy whatever we are doing more than we otherwise would. The dictionary defines *play* as activities that are amusing, fun, or otherwise enjoyable in their own right.[66] When we truly play, we seek to impress no one, and we produce no product—we just enjoy being in the moment. Playing is as old as humankind, as evidenced by the remains of toys found in the ancient ruins of Egyptian, Babylonian, Chinese, and Aztec civilizations. When children play, they use their imagination to invent a reality that meets their needs. If we allow ourselves to be children and distort or exaggerate a situation to its most absurd limits, we create an opportunity for laughter. As we grow older, our ability to open ourselves to moments of playfulness becomes constrained. Serious attention to the business at hand may replace a willingness to laugh and play, subsequently reducing our health-promoting behaviors. Sometimes it is difficult to incorporate play into our lives again because it does not always fit our image of what is necessary and proper for an adult. Erickson noted that through the ages, some adults have been inclined to judge play to be neither serious nor useful, and thus unrelated to the center of human tasks and motives, from which the adult, in fact, seeks recreation when he plays.[67]

Yet recent research on animals shows that play makes a crucial contribution to brain development. Natalie Angier recently summarized this research as follows: "An animal plays most vigorously at precisely the time when its brain cells are frenetically forming synaptic connections, creating a dense array of neural connections that can pass an electrochemical message from one neighborhood of the brain to the next. . . . Scientists believe that the intense sensory and physical stimulation that comes from playing is critical to the growth of these cerebral synapses and thus to proper motor development."[68] Play, then, is essential for survival in the animal world. Early childhood play is one way that humans practice socialization skills and mimic cultural rituals. It is a way that people create connections with others and build trust. Creative people are playful, experimental, and willing to take risks. Therefore, in serious situations like illness, which may require a change in lifestyle or other adaptation, creative problem solving can be a great help. Creative solutions seldom emerge when peo-

ple are concentrating on something in a solemn, practical mood; they are more likely to come when people are in a relaxed, even playful mood.

Humor and Stress Management

If play serves to build up skills that are essential to effective adaptation as an adult, how then does humor help one adapt? Why does humor exist? One of the main reasons humor exists may be that it helps people adapt to the stresses in their lives. It is because of a human being's superior intellectual capacities that they have such high stress in their lives. As Hans Selye noted, stress is not the *event*, but rather our *perception* of the event.[69] In other words, it is people's interpretation of events that causes stress, not the events themselves. A sense of humor helps people to view difficult circumstances in a less stressful way.

Because different people respond differently to the same environmental stimuli, some people seem to cope with stress better than others.[70,71] Sociologist Suzanne Kobassa defined three "hardiness factors" that can increase a person's resilience to stress and prevent burnout: commitment, control, and challenge.[72,73] If one has a strong commitment to oneself and one's work, if one believes that one is in control of the choices in one's life (internal locus of control), and if one views change as challenging rather than as threatening, then one is more likely to cope successfully with stress.[74] A theme that is becoming more prominent in the literature is the idea that a sense of powerlessness is a causative factor in burnout.

In this context, humor can be an empowerment tool. Humor gives people a different perspective on their problems, and with an attitude of detachment, they feel a sense of self-protection and control in their environment. As comedian Bill Cosby is fond of saying, "If you can laugh at it, you can survive it." It is reasonable to assume that, if the locus of control is strongly internal, a person will feel a greater sense of power and thus be more likely to avoid burnout.[75,76]

Humor and Locus of Control

This author's research, presented in 1990 at the Eighth International Conference on Humor Studies in England, documented changes in locus of control and appreciation of humor related to a humor training course.[77] Using the Adult Nowicki-Strickland Scale,[78] which has proven reliability and validity, the research team assessed the locus of control in 231 nurses in Pennsylvania, Kentucky, and California. The team then separated the nurses into two groups and administered Svebak's Sense of Humor Questionnaire, using only the subscales that have proven to be reliable and valid.[79,80] The experimental group completed a 6-hour humor training course, in which they were given permission and techniques for appropriate use of humor with patients and coworkers. The control group had no such humor training. The same survey tools were readministered to each group 6 weeks later to determine changes in locus of control and appreciation of humor.

Using the Wilcoxon Matched Pairs Signed-Ranks Test, the team found that there was a significant decrease in the score for external locus of control in the experimental group ($P = .0063$, two-tailed). Using the same analysis for the control group, the team found no significant change. No significant differences were found in the initial locus of control scores for the experimental and the control groups when tested using the Mann-Whitney U and Kolmogorov-Smirnov tests. This study indicates that, if people are encouraged and guided in using humor, they can gain a sense of control in their lives. The use of humor represents what Kobassa

calls cognitive control. We cannot control events in our external world, but we can control how we view these events and our emotional response to them.[81] Further research is needed to determine how long these effects persist.

Ho Ho Holistic Health

Humor, laughter, and play contribute to our health and well-being in many ways. Each touches our body-mind-spirit in its own way. Humor, as a cognitive process, is primarily a mental activity. The behavior of laughter affects the whole body, from cells to entire organ systems. Play and a playful spirit fill us with joy, connect us with others, and keep us focused on the present moment. The interaction of body-mind-spirit with humor, laughter, and play forms the "Aha, Ha Ha, Ahhhh" continuum. The mind says, "Aha! I get the joke." The body says, "Ha Ha!" And the spirit says, "Ahhhh, everything feels much better now."

HOLISTIC CARING PROCESS

Assessment

In preparing to use humor, laughter, and play interventions, the nurse assesses the following parameters:

- the client's ability and willingness to smile and laugh
- the client's attitude toward using laughter and play in the current situation
- the client's history of using humor, laughter, and play in other circumstances
- the client's visual, auditory, cognitive, and physical limitations
- the client's preferred style of humor (i.e., jokes, cartoons, stories, comedy movies, animated cartoons, stand-up comedy, funny songs)[82]
- the client's favorite comedy artists—performers, writers, cartoonists, and so on
- the client's feelings about previous experiences with humor and play
- the client's preferred playful activities

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with the interventions for humor, laughter, and play that are related to the 13 domains of Taxonomy II of the Unitary Person framework (see Chapter 14):

- Altered parenting, actual or potential
- Social isolation
- Ineffective individual and family coping
- Activity intolerance, actual or potential
- Deficit in diversional activity
- Impaired physical mobility
- Powerlessness
- Disturbance in self-concept: altered self-esteem, role performance, personal identity
- Altered sensation/perception: visual, auditory, kinesthetic, gustatory, tactile, olfactory
- Altered thought processes
- Anxiety
- Pain
- Fear
- Potential for violence: self-directed or directed at others

Outcomes

Exhibit 20–2 guides the nurse in outcomes, nursing prescriptions, and evaluation for the use of humor, laughter, and play as a nursing intervention.

Therapeutic Care Plan and Interventions

Before the Session

- Assess your own ease and comfort with using humor and play as a therapeutic intervention.

Exhibit 20–2 Nursing Interventions: Play and Laughter

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client will smile and/or laugh in response to humorous stimuli.	Introduce the client to the concept that humor, laughter, and play benefit health. Guide the client in identifying his or her own preferred humor style. Help the client to clarify any blocks to using humor, laughter, or play.	The client requested some humor resources from family or friends. The client laughed in response to a selected humorous intervention. The client laughed at a joke, story, or cartoon provided by the nurse. The client shared a joke or story with the nurse or family. The client sees some absurdity in a personal incident and shares with staff or family.
The client will engage in playful activities.	Guide client to select a playful activity that matches his or her preference and ability	The client was observed amusing self with toy. The client plays game with family during visiting hours. The client wears amusing item to greet staff or family.
The client will experience decrease in subjective severity of target symptom as a result of humor or playful intervention.	Guide client in grading the severity of a symptom on a scale of 1 to 10 before and after intervention.	Patient rated pain at 6 before humor intervention and graded pain at 3 after intervention.

- Practice smiling in front of a mirror. First scowl, then smile. Feel the difference.
- Evaluate your ability to respond to humor or engage in playful activity for your own personal pleasure.
- Increase awareness of your own preferred humor style, artist, writer, performer.
- Allow yourself to laugh with abandon at things you find funny.
- Become familiar with the content and variety of humorous items and playful activities that are available for you to use.
- Ensure that all supplies and equipment are in working condition.
- Improve your ability to tell a good joke. Remember these tips: Keep it short—less than 2 minutes. Be sure you can remember the whole joke before you start. Let your body, face, and voice become animated as you tell the joke. Pause occasionally as you deliver the material; create a brief and concise setup for the punch line; pause before delivering the punch line; speak the punch line clearly and with punch!
- Review the client's chart or consult with others to assess changes in the client's situation since you last met.
- Sense your own needs and stress level. Give yourself permission to be silly and playful.

At the Beginning of the Session

- Assess the client's status according to the assessment parameters.
- Record vital signs and ask the client to assess pain, anxiety, tension, or other target symptoms on a numerical scale (1 = comfortable, 10 = extremely uncomfortable).

- Describe to the client the benefits that humor, laughter, and play have on the body (physiologic), mind (psychologic), and spirit (emotional and energy level).
- Provide the client with appropriate materials to match his or her preference and some instructions for use.

During the Session

- Use all interventions with sensitivity to the client's needs, response, and difficulties.
- Provide support for the client through your physical presence, encouragement, or time alone if the client wants to read or watch a videotape.
- Remember that humor is contagious and social. Interventions may be most effective if used within a group (e.g., family and friends) rather than individually.
- Remember that humor and play are spontaneous and therefore are most successful when not precisely planned.
- Continue to evaluate the mood and response of the client and adapt the humor and play intervention to meet the client's perceived needs.

At the End of the Session

- Record vital signs and ask the client to reevaluate the pain, tension, or target symptom on a scale of 1 to 10.
- Discuss the intervention with the client and obtain feedback for future sessions.
- Answer any questions the client may have.
- Encourage the client to continue using the intervention at home and to explore other possible variations.
- Use client outcomes (Exhibit 20–2) and the client's subjective experiences (Exhibit 20–3) to evaluate the session.
- Schedule a follow-up session.

Exhibit 20–3 Evaluation of the Client's Subjective Experience with Humor, Laughter, and Play

1. Was this a new experience for you? Can you describe it?
2. Can you describe any physical or emotional shift that occurred during the exercise?
3. Were there any distractions or uncomfortable moments during the exercise?
4. How long has it been since you had this kind of experience?
5. How was this exercise different for you from the last time you took part in a similar one?
6. Would you like to try this again?
7. How could the experience be made more meaningful for you?
8. What are your plans to integrate this exercise into your daily life?

Specific Interventions: Humor, Laughter, and Play

Humor interventions can be packaged in many different ways—as humor rooms, comedy carts, humor baskets, laughter libraries, or caring clown programs. The individual caregiver can adapt these programs to meet the specific needs of clients. Several suggestions for starting a humor program follow.

- Create a scrapbook of cartoons. Place the cartoons in a photo album with peel-back pages to protect them and keep them clean. Consider the audience that will read this scrapbook. Try to find humor about situations or problems your clients will be facing. Be careful not to add any potentially offensive or shocking items to the scrapbook. Include a variety of cartoon artists.
- Develop a file of funny jokes, stories, cards, bumper stickers, poems, and songs. When you hear something

funny, write it down immediately, before you forget! Many humorous resources are available on the Internet. Books of jokes are available in stores and libraries, but these are rather unreliable resources for usable material. The jokes are often offensive, outdated, or just not funny. A better method of building a collection is to write down jokes you hear from friends, see on television, or read in magazines.

- Collect or borrow funny books, DVDs, videos, and audio cassettes of comedy routines. These can be found in libraries, humor sections of bookstores, mail-order catalogs, or at humor conferences. (See the Resources section at the end of the chapter.) Create a lending library.
- Keep a file of local clowns, magicians, storytellers, and puppeteers. Invite them to entertain at your facility, at the patient's home, or at a group function.
- Collect toys, interactive games, noisemakers, and costume items. Keep them available for play. Small wind-up toys can be enjoyable. The author has a pair of little shoes that walk around when wound up and a large nose that does the same—it is called the "runny nose." If you will be sharing such toys with a client, keep in mind safety and infection precautions. (See Exhibit 20–4.)
- Create a humor journal or log to record funny encounters or humorous discoveries. On days when you really need a laugh but cannot seem to find anything funny, you will have a collection of amusing stories at your fingertips. A nurse in one of the author's workshops recounted that she had created a journal for the operating room where she worked. She called the book *The Days of Our Knives*.
- Establish a bulletin board in your facility or on your refrigerator at home. Post cartoons, bumper stickers, and funny signs. If the display is public, you must consider the sensitivities of the audience and be careful to exclude potentially offensive (e.g., ageist, sexist, ethnic) material.
- Subscribe to a humorous newsletter or journal to collect new ideas and inspiration. See the Resources section at the end of the chapter for a list of resources.
- Educate yourself about therapeutic humor. Attend conferences, workshops, and conventions. New techniques are developed daily. New research is published, and better resources become available on a regular basis. Stay up to

Exhibit 20–4 Supplies for Humor Programs

Joke books	Kaleidoscopes	Wind-up toys
Large sunglasses	Goofy hats	Rubber noses
Giant pacifier	Clown nose	Magic wand
Puppets	Rubber chicken	Smile on a stick
Funny buttons	Funny pictures	Groucho glasses
Squirt guns	Hand-held games	Cartoon books
Bubbles	Funny Post-It notes	Stickers

date in this rapidly growing field. (See the Resources section.)

Communication studies have shown that people take in 7 percent of other people's words, 38 percent of their vocal characteristics, and 55 percent of their nonverbal signals.[83] Applying these concepts in the creation and communication of humor can make your efforts even more effective. Because the client will notice less than 10 percent of your words, choose them carefully. Develop a collection of zingy one-liners, clever riddles, funny stories, and brilliant jokes for every occasion.[84,85] Vocal characteristics are five times more important than words alone. Try to change the pace and tone of your voice, or speak with an accent, and your words will have more impact. The most powerful communication tool we have is the ability to communicate nonverbally. Facial expressions, physical gestures, costuming, props, and the way we walk or stand or reach for something are nonverbal communication techniques that provide the greatest impact on our audience. Clowns and other physical-comedy artists have perfected these skills and use their body language to deliver the humorous message.[86,87] Some suggestions for humor program packages follow.

- Laughter libraries offer a selection of funny and informative books about humor and health. Audio cassettes, DVDs, and videos are usually a part of this collection. These resources can be used either at home or within a facility. There are literally hundreds of books that can be included in a laughter library.
- A humor room is a place where clients, their families, and staff can gather to laugh, play, and relax together. These rooms are decorated with comfortable furniture, plants, and artwork. The furniture is arranged in clusters so that groups of three to five people can gather around a game table, television, or reading area.[88]
- A comedy cart is a mobile unit with many of the same supplies available in a humor room. It can be wheeled into a client's room to bring mirth aid alongside the frightening medical equipment and monitoring devices. These carts often have clever names such as Laughmobile, Jokes on Spokes, Humor on a Roll, or Humor à la Cart.[89]
- A humor basket is probably the easiest therapeutic humor program to create, and is an appropriate place to start if time and resources are limited. This basket is a smaller collection of comedy toys, gadgets, and props. Hospital staff find that humor baskets provide quick and easy access to items with humor potential, stimulate their own creativity, and enhance their spontaneity. (See Exhibit 20–4.)
- Bedside clowning attempts to distract patients from their problems to help them forget their pain. Patients are given a chance to watch or participate in some fun and silliness. Clowns offer a momentary release from personal burdens, inspire joy, and stimulate the will to live.[90–92] The *Hospital Clown Newsletter* advises performers on routines and precautions that will enhance their bedside skills. (See the Resources section.)
- Scan your local TV program schedule and create a list of humorous entertainment options. Post this list in a common area.
- When using closed-circuit video, be sure to obtain permission for use if the material is copyrighted. In some situations, a license must be purchased to show these films to large audiences.

Case Studies

Case Study No. 1

Setting: Hospital room
Client: R.T., a 52-year-old man awaiting open heart surgery

Patterns:	1. Anxiety
Challenges/ Needs:	2. Coping, ineffective individual
	3. Powerlessness
	4. Social isolation

R.T. lay quietly in his hospital bed. The doctors had visited and left, the nurses were finished with their morning care. It was quiet. He was alone and feeling lonely. His wife Sally and the kids would not be able to visit until later that evening. What could he do until then? It was hard not to worry about his surgery scheduled for the next day. The more he worried, the more he felt agitated, depressed, and simply scared to death. The next moment, he was given the perfect solution. Evelyn, a smiling hospital volunteer, entered his room pushing a decorated cart. She wore a colorful smock and a funny hat labeled, "Humor Patrol—Department of Energy." R.T. smiled for the first time that day. "Looks like you could use some mirth aid, and we've got a wonderful selection today." R.T. was skeptical but curious. He asked for an explanation. "Well," she replied, "it's difficult for patients to lie around all day waiting for the next medical procedure. They worry and get depressed. These emotions have been proven to inhibit healing, so to prevent them, we provide a therapeutic humor program for our patients. It's part of the hospital's mission statement, to offer care and attention to the whole patient—body, mind, and spirit."

R.T. agreed that his spirits needed a lift and his mind could use some distraction. He asked to see more. First, Evelyn opened the "Yuk-a-Day Vitamin" jar and read a few jokes, riddles, and funny one-liners. Then she opened a drawer and pulled out a few wind-up toys and started them running on his over-bed table. She continued to pull out toys, games, props, puppets, cartoon books, puzzles, and costume items. Soon both of them were laughing, joking, and playing around like small children. After performing a few magic tricks, Evelyn gave R.T. a list of the humorous audio cassettes, videotaped programs, and books that were available from the hospital's laughter library. R.T. chose an audio cassette of Bob Newhart, his favorite comedian, and arranged for a comedy video to be delivered when his family arrived that evening. He selected a few toys to borrow, as well as some rubber vomit to tease the nurses and a squirt gun to defend himself against unwanted interruptions.

R.T. felt like a kid again, filled with enthusiasm and ready to have fun. He looked forward to the fun and laughter he would experience and share with his family. As Evelyn left, she offered one more answer to a problem he had not yet solved: "If you like, we can schedule a clown to visit with you while you're in the hospital." "Great idea," he thought. His son's birthday was on Saturday, and instead of missing his party, now they could share a special celebration right there in the hospital. He scheduled the clown visit. Because of the therapeutic humor program, R.T. was now feeling energized, optimistic, and relaxed. Laughter *is* the best medicine!

Case Study No. 2

Setting:	Outpatient clinic
Client:	J.B., a 45-year-old woman
Patterns/ Challenges/ Needs:	1. Activity intolerance
	2. Anxiety
	3. Breathing pattern, ineffective
	4. Fear
	5. Powerlessness
	(All related to adult-onset intrinsic asthma)

J.B. had visited the clinic for treatment of her asthma over a period of several months. Her bronchodilator medications had been adjusted, she was using a cool mist to thin secretions, her activity level had increased, and she had returned to full-time employment. In the process of teaching breathing techniques to J.B., the

nurse noted that she had difficulty in maintaining prolonged exhalation. She was able to lengthen her expiratory time between attacks but would forget the intervention when under the stress of wheezing and shortness of breath.

J.B. arrived at the clinic in mild distress after using an inhaler to open her airways with only partial success. After sitting J.B. in a straight chair, the nurse began coaching her in her breathing pattern while applying gentle pressure on her shoulders with each exhalation. As her breathing became easier, the nurse opened a bottle of bubble solution and invited J.B. to blow bubbles. Although J.B. felt that this was a rather nontraditional approach to her condition, she agreed to participate.

In order to blow bubbles successfully, one must exhale slowly and for a long period of time. J.B. remembered this from her own childhood and from playing with her children. She was soon blowing long streams of fragile bubbles, and her wheezing disappeared as she did so. As the attack eased, the nurse coached J.B. to visualize the bubbles as carrying away her tension triggers. J.B. expressed her delight with her new application of an old skill. Her tension decreased, and she returned to work confident in her ability to apply her skill during stressful situations. Linking the skill with an unusual and playful activity made the breathing strategy stand out in her memory, and made it easier to recall under stress.

Evaluation

With the client, the nurse determines whether the client outcomes for humor, laughter, and play (see Exhibit 20–2) were successfully achieved. To evaluate the session further, the nurse may again explore the subjective effects of the experience with the client using the evaluation questions in Exhibit 20–3.

DIRECTIONS FOR FUTURE RESEARCH

1. Determine the impact of humor and laughter programs on quality of life, pain control, and symptom management.
2. Examine the cost effectiveness of humor programs in increasing patient satisfaction, decreasing length of stay, and achieving compliance with treatment plan.
3. Analyze the impact of laughter and play programs on the immune-compromised patient and the patient at risk for developing infection.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin the process of answering the following questions:

- What is my inner sense of joy when I hear myself or another laugh?
- Do I nurture my ability, and the ability of my patients, to be playful?
- Can I laugh and play with a sense of freedom and without guilt, even when my work is not yet finished?
- Can I experience playful activities without competing, or feeling that I must accomplish a particular goal?

NOTES

1. A. Klein, *Quotations to Cheer You Up When the World Is Getting You Down* (New York: Sterling Publishing Co., 1991).
2. R. Moody, *Laugh after Laugh* (Jacksonville, FL: Headwaters, 1978).
3. V. Robinson, *Humor and the Health Professions* (Thorofare, NJ: Slack, 1991).
4. L. Kronenberger, *The Thread of Laughter* (New York: Alfred A. Knopf, 1952).
5. S. Freud, Jokes and Their Relation to the Unconscious, in *The Complete Psychological Works of Sigmund Freud*, vol. 8 (London: Hogarth Press, 1905/1961).
6. H. Mindess, *Laughter and Liberation* (Los Angeles: Mansh Publishing, 1971).
7. A.R. Radcliffe-Brown, On Joking Relationships, in *Structure and Function in Primitive Society* (New York: Free Press, 1952).
8. M.L. Apte, *Humor and Laughter: An Anthropological Approach* (Ithaca, NY: Cornell University Press, 1985).
9. A. Ziv, *National Styles of Humor* (Westport, CT: Greenwood Publishing Group, 1988).
10. K. Buxman, Today's Health Crisis: A Laughing Matter? *Neonatal Network* 8 (2001):63–4.
11. J. Boskin, *Humor and Social Change in Twentieth Century America* (Boston: Trustees of the Public Library, 1979).
12. C. Hyers, *The Spirituality of Comedy* (New Brunswick, NJ: Transaction Press, 1996), 24.
13. A. Klein, *Healing Power of Humor* (Los Angeles: Jeremy P. Tarcher, 1989).
14. Personal communication.
15. A. Goodheart, *Laughter Therapy* (Santa Barbara, CA: Stress Less Press, 1994).
16. S. Ritz, Survivor Humor and Disaster Nursing, in *Nursing Perspectives on Humor*, ed. K. Buxman (Staten Island, NY: Power Publications, 1995), 197–216.
17. P. Wooten, *Compassionate Laughter,* 2nd ed. (Santa Cruz, CA: Jest Press, 2000), 15.
18. C. Edson, You Know It's a Long Shift When . . . , in *Whinorrhea and Other Nursing Diagnoses*, ed. F. London (Mesa, AZ: JNJ Pub., 1995), 56–57.
19. Freud, Jokes and Their Relation to the Unconscious.
20. K. Buxman, Humor in Critical Care: No Joke, *AACN Clinical Issues* 11, no. 11 (2000):120–127.
21. H. Olsson, H. Backe, S. Sorensen, and M. Kock, The Essence of Humour and Its Effects and Functions: A Qualitative Study, *Journal of Nursing Management*, 10, no. 1(2002):21–6.
22. J.S. Dowling, Humor: A Coping Strategy for Pediatric Patients, *Pediatric Nursing* 28, no. 2 (2002):123–31.
23. K. Hammer, *And How Are We Feeling Today* (Chicago: Contemporary Books, 1993).
24. J.C. Scholl and S.L. Ragan, The Use of Humor in Promoting Positive Provider-Patient Interactions in a Hospital Rehabilitation Unit, *Health Communication* 15, no. 3 (2003):321–30.
25. F. London, ed., *Whinorrhea and Other Nursing Diagnoses* (Mesa, AZ: JNJ Pub., 1995).
26. C. Kenefick and A. Young, eds., *The Best of Nursing Humor*, Vol. 2 (Philadelphia: Hanley and Belfus, 1999).
27. J. Cocker, ed., *Stitches* (Toronto: Stoddart Publishing Co., 1993).
28. C. Prasad, *Physician Humor Thyself* (Winston-Salem, NC: Harbinger Medical Press, 1998).
29. G. Bosker, *Medicine's the Best Laughter* (St. Louis, MO: Mosby, 1995).
30. J. Wise, *Tales from the Bedside* (St. Louis, MO: Mosby–Year Book, 1994).
31. S. Shem, *House of God* (New York: Dell Publishing, 1978).
32. P. Johnson, The Use of Humor and Its Influences on Spirituality and Coping in Breast Cancer Survivors, *Oncology Nursing Forum* 29, no. 4 (2002):691–695.
33. A. Klein, *Courage to Laugh* (Los Angeles: Jeremy P. Tarcher, 1998).
34. Robinson, *Humor and the Health Professions*, 87.
35. L. Rosenberg, A Qualitative Investigation of the Use of Humor by Emergency Personal as a Strategy for Coping with Stress, *Journal of Emergency Nursing* 17, no. 4 (1991):197–203.
36. L. Rosenberg, Sick, Black, and Gallows Humor among Emergency Caregivers, or—Are We Having Any Fun Yet?, in *Nursing Perspectives on Humor*, ed. K. Buxman (Staten Island, NY: Power Publications, 1995), 39–50.
37. Wooten, *Compassionate Laughter*, 26.
38. Goodheart, *Laughter Therapy*, 86.

39. E. Foley, R. Matheis, and C. Schaefer, Effect of Forced Laughter on mood, *Psychological Reports* 90, no. 1 (2002):184.
40. Personal communication.
41. N. Cousins, *Anatomy of an Illness* (New York: W.W. Norton & Co., 1979).
42. Ibid.
43. N. Cousins, *Head First—the Biology of Hope* (New York: E.P. Dutton, 1989).
44. N. Cousins, Intangibles in Medicine: An Attempt at Balancing Perspective, *Journal of the American Medical Association* 260, no. 2 (1988):1610–1612.
45. N. Cousins, Anatomy of an Illness, *New England Journal of Medicine* 295 (1976):1458–1463.
46. Cousins, *Head First*.
47. P. Wooten, Interview with William Fry, *Journal of Nursing Jocularity* 4, no. 4 (1994):46–47.
48. Wooten, Interview with William Fry.
49. W. Fry, Humor, Physiology and the Aging Process, in *Humor and Aging*, ed. L. Nahamow (Orlando FL: Academic Press, 1986), 81–98.
50. W. Fry, Mirth and Oxygen Saturation of Peripheral Blood, *Psychotherapy and Psychosomatics* 19 (1971):76–84.
51. W. Fry, Mirth and the Human Cardiovascular System, in *The Study of Humor*, ed. L. Mindess (Los Angeles: Antioch University Press, 1979).
52. R.M. Caine, Psychological Influences in Critical Care: Perspectives from Psychoneuroimmunology, *Critical Care Nurse* 23, no. 2 (2003):60–70.
53. R. DeKeyser, Psychoneuroimmunology in Critically Ill Patients, *American Association of Critical Care Nursing Issues* 14, no. 1 (2003):25–32.
54. C. Pert, *Molecules of Emotion* (New York: Charles Scribner's Sons, 1997).
55. J.K. Kiecolt-Glaser, T.F. Robles, K.L. Heffner, T.J. Loving, and R. Glaser, Psycho-oncology and Cancer: Psychoneuroimmunology and Cancer, *Annals of Oncology* 13, no. 4 (Suppl) (2002):165–9.
56. P. McGhee, *Health, Healing and the Amuse System* (Dubuque, IA: Kendall-Hunt Publishing, 1997), 13.
57. S. Maes, Nurses Explore Relationships among Mind, Body, and Spirit, *Oncology Nursing Society News* 16, no. 9 (2001):1, 4–5.
58. P. Wooten, Interview with Dr. Lee Berk, *Journal of Nursing Jocularity* 7, no. 3 (1997):46–48.
59. M. Bennett, J. Zeller, L. Rosenberg, and J. McCann, The Effect of Mirthful Laughter on Stress and Natural Killer Cell Activity, *Alternative Therapy Health Medicine* 9, no. 2 (2003):38–45.
60. K. Takahashi, M. Iwase, K. Yamashita, Y. Tatsumoto, H. Ue, H. Kuratsune, A. Shimizu, and M. Takeda, The Elevation of Natural Killer Cell Activity Induced by Laughter in a Crossover Designed Study, *International Journal of Molecular Medicine* 8, no. 6 (2001):645–50.
61. L. Berk and S. Tan, Neuroendocrine and Stress Hormone Changes during Mirthful Laughter, *American Journal of the Medical Sciences* 298 (1989):390–396.
62. L.S. Berk, D.L. Felten, S.A. Tan, B.B. Bittman, and J. Westengard, Modulation of Neuroimmune Parameters during the Eustress of Humor-Associated Mirthful Laughter, *Alternative Therapies Health Medicine* 7, no. 2 (2001):62–72, 74–6.
63. H. Lefcourt, K. Davidson-Katz, and K. Kueneman, Humor and Immune System Functioning, *International Journal of Humor Research* 3, no. 3 (1990):305–321.
64. S. Yoshino, Effects of Mirthful Laughter on Neuroendocrine and Immune Systems in Patients with Rheumatoid Arthritis, *Journal of Rheumatology* 23 (1996):793–794.
65. T. Kamei, H. Kumano, and S. Masumura, Changes of Immunoregulatory Cells Associated with Psychological Stress and Humor, *Perceptual Motor Skills* 84 (1997):1296–1298.
66. S. Sarra and E. Otta, Different Types of Smiles and Laughter in Preschool Children, *Psychological Reports* 89, no. 3 (2001):547–58.
67. E. Erickson, *Toys and Reasons* (New York: W.W. Norton & Co., 1977), 17.
68. A.M. Okimoto, A. Bundy, and J. Hanzlik, Playfulness in Children with and without Disability: Measurement and Intervention, *American Journal of Occupational Therapy* 54, no. 1 (2000):73–82.
69. H. Selye, *The Stress of Life* (New York: McGraw-Hill, 1956).
70. C. Maslach, *Burnout—The Cost of Caring* (Englewood Cliffs, NJ: Prentice-Hall, 1982).
71. P. Balevre, Professional Nursing Burnout and Irrational Thinking, *Journal of Nursing Staff Development* 17, no. 5 (2001):264–71.
72. S.C. Kobassa, Personality and Social Resources in Stress Resistance, *Journal of Personality & Social Psychology* 45 (1983):839.

73. J.H. Larrabee, M.A. Janney, C.L. Ostrow, M.L. Withrow, G.R. Hobbs, Jr., and C. Burant, Predicting Registered Nurse Job Satisfaction and Intent to Leave, *Journal of Nursing Administration* 33, no. 5 (2003):271–83.
74. P. Griffiths, The Relationship of Internal Locus of Control, Value Placed on Health, Perceived Importance of Exercise and Participation in Physical Activity During Leisure, *International Journal of Nursing Studies* 40, no. 5 (2003):461–2.
75. Kobassa, Personality and Social Resources in Stress Resistance.
76. P. Wooten, Humor: An Antidote for Stress, *Holistic Nursing Practice* 10, no. 2 (1996):49–55.
77. P. Wooten, Does a Humor Workshop Effect Nurse Burnout?, *Journal of Nursing Jocularity* 2(2) (1992):42–43.
78. S. Nowicki, A Locus of Control Scale for College as Well as Non-College Adults, *Journal of Personality Assessment* 38 (1974):136–137.
79. S. Svebak, Revised Questionnaire on the Sense of Humor, *Scandinavian Journal of Psychology* 15 (1974):328–331.
80. H. Lefcourt and R. Martin, *Humor and Life Stress* (New York: Springer-Verlag, 1986).
81. J.W. Henderson and R.J. Donatelle, The Relationship Between Cancer Locus of Control and Complementary and Alternative Medicine Use by Women Diagnosed with Breast Cancer, *Psychooncology* 12, no.1 (2003):59–67.
82. S.M.I.L.E. (Subjective Multidimensional Interactive Laughter Evaluation) is a computer software program that obtains answers to questions about a person's humor preferences, attitudes, and history. It then accesses a database that will match a person's stated preference with the audio, video, or book source that is most likely to make the person laugh. The questionnaire can be viewed or the software ordered through the website *www.touchstarpro.com* (see Resources section).
83. J. Sherman, *The Magic of Humor in Caregiving* (Golden Valley, MN: Pathway Books, 1995), 70.
84. M. Helitzer, *Comedy Writing Secrets* (Cincinnati, OH: Writer's Digest Books, 1987).
85. R. Bates, *How To Be Funnier, Happier, Healthier and More Successful Too!* (Minneapolis, MN: Trafton Publishing, 1995).
86. F. Fife, *Creative Clowning* (Colorado Springs, CO: Java Pub., 1988).
87. M. Stolzenberg, *Clown for Circus and Stage* (New York: Sterling Publishing, 1981).
88. K. Buxman, Make Room for Laughter, *American Journal of Nursing* 91, no. 12 (1991):46–51.
89. L. Gibson, Carts, Baskets and Rooms, in *Nursing Perspectives on Humor*, ed. K. Buxman (Staten Island, NY: Power Publications, 1995), 113–124.
90. P. Adams, Humour and Love: The Origination of Clown Therapy, *Postgraduate Medicine Journal* 78, no. 922 (2002):447–48.
91. S. Shobhana and P. Wooten, *Hospital Clowns—A Closer Look* (Santa Cruz, Jest Press, 2000).
92. R. Snowberg, *The Caring Clown* (La Crosse, WI: Visual Magic, 1997).

RESOURCES

Associations

Association for Applied and Therapeutic Humor
1951 W. Camelback Rd. Suite 445
Phoenix, AZ 85015
Phone: 602-995-1454
Fax: 602-995-1449
Website: www.aath.org

International Society for Humor Studies
Don Nilsen, Arizona State University
Department of English
Tempe, AZ 85287-0302
Website: www.uni-duesseldorf.de/WWW/MathNat/Ruch/SecretaryPage.html
Email: don.nilsen@asu.edu

Publications

Fellowship of Merry Christians, Inc.
PO Box 895
Portage, MI 49081-0895
Phone: 800-877-2757
Website: www.JoyfulNoiseletter.com
Email: JoyfulNZ@aol.com

Funny Times
PO Box 18530, Department 2AAM
Cleveland Heights, OH 44118
Phone: 216-371-8600, ext. 8002
Website: www.funnytimes.com

Hospital Clown Newsletter
PO Box 8957
Emeryville, CA 94662
Phone: 510-420-1511
Email: ShobiDobi@aol.com

Supplies

Jest for You Catalogue
Patty Wooten
PO Box 8484
Santa Cruz, CA 95062
Phone: 888-550-5378
Website: www.jesthealth.com
Email: pwooten@jesthealth.com

Clown Supplies
The Castles, Tre. 101, Suite C-7C
Brentwood, NH 03833
Phone and fax: 603-679-3311

Too Live Nurse
PO Box 58
Columbiaville, NY 12050-0058
Phone: 518-828-3271
Website: www.toolivenurse.com
Email: efiebke@toolivenurse.com

Websites

Brownson's Humor Page
http://members.tripod.com/~DianneBrownson/humor.html

Nurse Cartoons
http://www.nurstoon.com

The Onion
http://www.theonion.com

Political Humor
http://www.politicalhumor.about.com

Cartoons
http://cagle.slate.msn.com

Creating Receptive Quiet

Be still and know that I am God.
Psalm 46

Moments of inner and outer quiet are the spaces and places in which we are most deeply in touch with ourselves and our true nature of being, and with nature's true gift of restoring and renewing. As nurses of the twenty-first century, we need to preserve and create sacred spaces of quiet, within ourselves and in our health care environments.

Quiet spaces help us to learn and deepen our practice of relaxation and meditation; to be present right here, right now, in this moment.

Breathing In, I Calm.
Breathing Out, I Smile.
Dwelling in this present moment
I know this is a wonderful moment.
Thich Nhat Hanh

Deceivingly simple, being in this moment offers a profound message that is increasingly important in the face of events of the last few years: There is peace to be found in each moment, in any moment, in any circumstance.

During times of calm, but most especially during times of crisis and fear, it is possible to experience comfort, calm, quiet, and relaxation as we practice stopping and breathing; as we watch the sun set, a wave reach the shore, a baby sleep, or the wind blowing the leaves of a tree.

These simple acts of being with life restore and renew our spirits as nurses and as healers, and remind us of what truly inspires and nurtures us.

In the beginning
We attempt to cultivate Loving Kindness
Later Loving Kindness cultivates us.
Stephen Levine

We need to continuously find ways to renew our spirit as our world faces war, terrorism, and global health crises, to remind us that we also have unprecedented opportunities for peace, understanding, and healing.

I have learned that humankind is brave and resilient, and that people are full of hope and kindness even in the most challenging situations. I have learned that nursing is often not about fancy procedures but listening, caring and being organized. I am moved beyond words by the love and compassion of my professors. I am proud to live in New York City. Most of all, I am honored that, in seven months, I will be a nurse.

Faith Fisher
Student, NYU Division of Nursing
Ground Zero Volunteer

Cultivating a peaceful, compassionate heart, and making time to relax and tend to our own well-being, are gifts we give ourselves. They impact everything we do, and every life we touch. Our lives, our spiritual path, our nursing practice, and this world call for nothing less.

Chapter 21

Relaxation: The First Step to Restore, Renew, and Self-Heal

Jeanne Anselmo

NURSE HEALER OBJECTIVES

Theoretical

- Learn the definitions of relaxation and self-regulation.
- Compare and contrast different relaxation exercises.
- List the body-mind-spirit changes that accompany profound relaxation.

Clinical

- Describe three different types of relaxation exercises and their appropriate clinical application.
- Describe indications and contraindications for two forms of relaxation practice.
- Identify a commonly used piece of equipment in your practice and describe how it can be used as a biofeedback device.
- Use breathing strategies with a client and record the subjective and clinical changes that occur with relaxed breathing.

Personal

- Pick one or a combination of relaxation and meditation practices and apply them to a stressful moment.
- Identify through focused awareness the places where you most often accumulate tension.
- Identify three personally meaningful therapeutic suggestions and use them as reminders to support your self-care relaxation practice and well-being.

DEFINITIONS

Autogenic Training: self-directed therapy that focuses on repetition of phrases about desired states of the body (e.g., heaviness and warmth).

Biofeedback: the use of external equipment which mirrors psychophysiologic processes which normally are not perceived by the individual and may be brought under voluntary control; allows the person to be an active participant in health maintenance.[1]

Note: The author would like to acknowledge previous contributions of Leslie Gooding Kolkmeier as the originator of this chapter in its first edition, as well as being co-author in previous editions.

Hypnosis: a process for focused awareness and expanded consciousness with diminishing perception of peripheral sensations, thoughts, and feelings.

Mantra: a word, short phrase, or prayer that is repeated either silently or aloud as a focus of concentration during the practice of meditation.

Meditation: originally based in spiritual traditions, the practice of focusing and concentrating one's attention and awareness while maintaining a passive attitude; evolves with discipline and practice and is known for providing health benefits as well as being a road to spiritual transformation.

Pain (Medical Definition): localized sensation of hurt, or an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

Pain (Nursing Definition): a subjective experience including both verbal and nonverbal behavior.[2]

Power: Barrett's Theory of Power as knowing participation in change is being aware of what one is choosing to do, feeling free to do it, and doing it intentionally.[3]

Progressive Muscle Relaxation: the process of alternately tensing and relaxing muscle groups to become aware of subtle degrees of tension and relaxation; originally developed by Edmund Jacobson.

Relaxation: a psychophysiologic experience characterized by parasympathetic dominance involving multiple visceral and somatic systems; the absence of physical, mental, and emotional tension; the opposite of Canon's "fight or flight" response and Selye's general adaptation syndrome.[4]

Relaxation Response: an alert, hypokinetic process of decreased sympathetic nervous system arousal that may be achieved in a number of ways, including through breathing exercises, relaxation and imagery exercises, biofeedback, and prayer. A degree of discipline is required to evoke this response, which increases mental and physical well-being.

Self-Hypnosis: an approach for voluntarily fostering a consciousness process for the purpose of influencing one's thoughts, perceptions, behaviors, or sensations.

Stress (Psychophysiologic Definition): the felt experience of overactivity of the sympathetic nervous system.

THEORY AND RESEARCH

People are frequently told to "just relax," or "take it easy," as part of their recovery from illness, as if everyone knew how to practice this skill. Yet the ancients knew that relaxation is a paradox: it is and is not that simple. Throughout the ages, in cultures around the world, practitioners of the sacred healing arts and sciences developed and practiced stopping, quieting, and calming on a disciplined and regular basis, offering themselves deep rest to still the body-mind-spirit and emotions. They did this not only to access their natural ability to heal, restore, and renew their body-mind-spirit, but also to open themselves to the divine, the oneness of being, the numinous. This oneness of being offered itself to these ancient spiritual voyagers as the waves of the mind stilled, and as the activity of the body quieted into deep rest and relaxation found within their meditative refuge and relaxation practice.

Today we continue this voyage to touch shores beyond our unhealthy habit patterns and belief systems through the practice of the ancient arts of relaxation, meditation, yoga, Qi Gong, and breathing, and their modern counterparts: autogenic training, progressive muscle relaxation,

hypnosis, biofeedback, self-regulation, the relaxation response, and body scanning.

We now understand relaxation to be an ancient art with many modern interpretations, which has been anchored throughout nursing practice from childbirth education to pre- and postoperative teaching. Relaxation has been defined in medical and scientific terms as "a psychophysiologic state characterized by parasympathetic dominance involving multiple visceral and somatic systems; the absence of physical, mental, and emotional tension; the opposite of Canon's fight or flight response."[5]

Relaxation also can be described as an experience or process of calm, comfort, deep rest, natural nurturing, inner connectedness, renewal, and openness that every living creature, from slumbering infants to creatures of the wild, instinctively and intuitively knows how to access. Unfortunately, this activity can be conditioned to become more the exceptional experience than the norm, thereby leading to the development of stress-related illnesses (which account for 75 to 80 percent of illness in modern life).

Therefore, the benefits of relaxation practice are great, especially for our hectic, modern, overscheduled lives. Relaxation interventions are useful for people in all stages of health and illness: the critically ill, expectant parents attending childbirth preparation classes, or bus drivers learning to regulate blood pressure while weaving through city traffic. Even in the acute phase of recovery from a myocardial infarction, or during an examination in an emergency room after an accident, clients can derive the clinical benefits of relaxation by learning basic breathing and muscle relaxation exercises (Exhibit 21–1).

Modern nurses in all areas of practice can be found who offer relaxation and breathing techniques and some form of meditation to clients over the past four decades. Yet this is not new to nursing. Florence Nightingale counseled her nurses to support patients' rest and well-being by reducing unnecessary noise, not awakening patients out of their first sleep, and protecting patients from unnecessary disturbances such as conversations of doctors or friends within earshot and the disturbing rustling of crinolines. She advised that "all hurry or bustle is peculiarly painful to the sick."[6] One wonders what Nightingale would say if she were to visit hospitals and health care settings today and witness our efforts to follow her legacy in the chaos of our times.

These days, nurses offer relaxation practices in self-care circles for themselves and their colleagues, as well as for clients in hospitals, community and adult education programs, outpatient clinics, and homeless shelters, to promote a variety of personal benefits (Exhibit 21–2); they offer these practices to individuals, families, and groups; to children in classrooms,

Exhibit 21–1 Clinical Benefits of Relaxation

Relaxation training has the following clinical benefits:

- decreasing the anxiety accompanying painful situations, such as debridement or dressing changes
- easing the muscle tension pain of skeletal muscle contractions
- decreasing fatigue by interrupting the fight or flight response
- providing a period of rest as beneficial as a nap
- helping the client fall asleep quickly
- increasing the effect of pain medications
- helping the client dissociate from pain

Exhibit 21–2 Whole Self Benefits of Relaxation

Relaxation has the following benefits to self:

- decreasing pain
- decreasing anxiety
- improving immune system function
- quieting the fight or flight sympathetic response
- facilitating sleep
- providing rest
- increasing efficacy of pain medications
- reducing muscle tension, increasing blood flow
- improving sense of well-being
- offering insight and creativity

to clients and families in home care and hospice, and to workers and executives in workplaces and corporations.

Cross-Cultural Context

Relaxation practices are found throughout time in all cultures around the world. Whether these practices are mediated through the use of herbs, acupuncture, movement, or prayer, evidence of the power, impact, and importance of relaxation and the use of breath can be seen in shamanic healing, yoga, meditation, Chinese medicine, and other traditions across the globe. Modern research exploring the area of psychoneuroimmunology demonstrates the vital importance of relaxation in improving immune system function. Thus, psychoneuroimmunologic research suggests the importance of this ancient practice for our modern scientific world. (See Chapter 6 for further information.) Modern psychology uses relaxation as a dimension of systematic desensitization, in which clients learn to relax in the face of mild, then moderate, and then intense stressors. Practitioners of biofeedback include relaxation practice with their therapy to help clients learn to self-regulate their peripheral temperature, muscle activity, and brain wave frequencies.

Jon Kabat-Zinn of the University of Massachusetts found relaxation breathing and body scanning to be a vital dimension of a mindfulness-based stress reduction practice used for dealing with pain and depression.[7] Dean Ornish includes relaxation, meditation, breathing, and yoga in his program to reverse heart disease.[8] Dolores Krieger and Dora Kunz guide nurses to perform sustained centering, a practice of meditative inner connection and relaxed awareness, before entering into therapeutic touch practice with a client.[9,10]

These modern pioneers all continue to validate the importance of the ancient practice of relaxation through the use of its modern counterparts.

Caring for Ourselves, Caring for Others: A Spiritual Journey

These days the practice of relaxation in its many forms is even more important for nurses. These challenging times of constant change and global uncertainty require nurses to walk a wellness path of self-care, self-healing, and spiritual awareness. Finding a personal relaxation practice can help nurses restore and renew, and avoid burnout, as well as model a personal wellness path for their clients. Living this path and sharing by example give nurses an inner understanding and appreciation for the challenges their clients face as clients start to integrate complementary practice into everyday lives.

Relaxation practice offers nurses an important refuge; a self-awareness foundation for deepening their spiritual journey as holistic caregivers. Whether individuals are being with themselves and with All That Is in meditation; exploring their own past issues, traumas, or painful life experiences in counseling and psychotherapy; or expanding their awareness in intuitive practices and energy

healing, a foundation in deep relaxation of the body-mind-spirit is a fundamental step on the path. Long-time practitioners of healing arts continue to loop back, reconnect, and deepen their abilities to relax and renew with each step of their path (Exhibit 21–3).

The American psyche, poised to do everything with intensity and competitiveness, also enters with us into self-healing and spiritual practices. This intensity and competitiveness can be our undoing, especially if we forget the importance to our body-mind-spirit of nondoing, which is different that "doing nothing." Holistic practice, whether offered within the biomedical health care system or explored in a retreat setting, offers health and healing benefits with clinical implications but remains in its essence an avenue of spiritual renewal.

Exhibit 21–3 Benefits of Relaxation for the Nurse and Holistic Nursing Practice

Relaxation

- is an essential element of self-care
- cultivates a centered, calm presence
- as a self-care practice offers insights into challenges and benefits clients will experience
- offers a vehicle to modulate and self-regulate the nurses' own stress response within stress-filled work settings
- supports a therapeutic energetic bond and connectedness when practicing along with clients and/or colleagues
- creates opportunity for intuitive exploration, insight, and understanding of self and others, issues, and problems
- is an excellent vehicle for beginning professional gatherings and staff meetings; offers opportunity to be present, creative, open, and connected
- can be done anywhere, without any cost or equipment, is easily teachable, and easily practiced
- can be a spiritual practice for opening ourselves to deeper ways of being

Do everything with a mind that lets go,
Do not expect any praise or reward.
If you let go a little, you will have a little peace.
If you let go a lot, you will have a lot of peace.
If you let go completely, you will know complete peace and freedom.
Your struggles with the world will have come to an end.[11]

Achaan Chah*

Nurses must reclaim their legacy of caring by cultivating their compassion, wisdom, spirit of service, and heart-centered health care in their culture. Relaxation is a first step along this path. It is easy to learn and practice; its benefits are demonstrated quite readily; and it offers nurses an easy entree to a self-care plan for themselves, their colleagues, and their clients.

The Stress Response

The last few years have brought new awareness to what constitutes an emergency response, both for individuals and for society. Whether we are dealing with a national orange alert or the everyday intense internal reactions we experience when faced with a truck cutting in front of us on the highway, a "code blue" coming over the loudspeaker, or a child darting into the street, we experience what some researchers refer to as an "adrenaline rush," the familiar fight or flight response. This response is actually a complex series of psychophysiologic processes that prepare us to deal with the real or perceived

*Source: Achaan Chah, as quoted in *The Fine Arts of Relaxation, Concentration, and Meditation: Ancient Skills for Modern Minds*, copyright Joel and Michelle Levey, 2003. Reprinted with permission of Wisdom Publications, 199 Elm St., Somerville, MA 02144 USA, www.wisdompubs.org.

emergency. It is important to note that people respond to an imagined threat in the same way that they respond to an actual threat to their well-being. That is why in times of personal threat, such as facing a possible health crisis or the fear of potential terrorism, these practices help us keep balanced or self-regulated.

The generalized stress response of the body, mind, and energy field is to

- constrict the blood flow to the hands and feet (cool extremities)
- tighten muscles
- constrict the energy field (closing down or blocking flow)
- increase heart rate
- increase oxygen consumption
- increase brain wave activity
- increase sweat gland activity
- increase blood pressure
- increase anxiety

This stress response readies the body-mind-spirit through this instinctive response pattern to prepare for a stress, shock, or trauma. In modern-day life, the body alerts or readies itself physically far beyond what is needed in order to deal with a fast-paced stressful life. Most people know how to turn on this stress response but have little familiarity with how to relax or turn it off. Not only do people not know how to relax, but our society typically has a negative view of relaxed people.

The paradox is that masters of ancient practices have learned that, while instinctive responses such as the fight or flight response can put one on alert to help protect one in an emergency or a crisis, a more conscious relaxation discipline, practice, and philosophy offer deeper possibilities.[12]

An example for understanding this philosophy is the ancient Chinese hexagram for *crisis*. The two Chinese characters for crisis are *danger* and *opportunity*. Hidden within each crisis is an opportunity, not just a danger. People must learn to face the danger and seize the opportunity. Relaxation in practice offers people that possibility of turning a difficult situation around for the better.

Exercise. Imagine a relaxed person. Write as many words as you can to describe that image. After making your list, note how many of those words (1) you consider to represent a positive quality in a person, (2) society considers to represent a positive quality, and (3) work environments consider to represent a positive quality in a person. Log any awareness or insights you gain from this exercise in a journal. See if these insights help you when you are discussing relaxation practice with clients, colleagues, family members, and others. This exercise may help you to become aware of conscious or unconscious positive and/or negative attitudes that can impact clients' interest and motivation to learn to relax. (See the Suggested Reading section at the end of this chapter for further insight.)

MEDITATION

Relaxation Response Meditation

Though many people call the body-mind-spirit effects of relaxation the *relaxation response*, this phrase is attributed to Herbert Benson and his colleagues at Harvard University, who used a nonreligious form of meditation that is similar to transcendental meditation to produce the opposite of the fight or flight response. Their relaxation response meditation has been introduced into many health care settings and has been applied in a variety of studies that demonstrate its efficacy in treating hypertension and anxiety.[13,14] Both transcendental meditation and relaxation response meditation offer a practice consisting of 20 minutes of daily passive concentration focused on a neutral word, such as the Sanskrit word *OM* in transcendental meditation or *ONE* in relaxation

response meditation. In relaxation response meditation, slow repetition of the word with each exhalation has been shown to bring about the same psychophysiologic responses as other deep relaxation processes (see below). Further studies have documented a deep relaxation response when the client focuses on a short, personally meaningful religious statement or quotation, as was found in what Benson termed the "faith factor."[15]

The changes that occur when an individual reaches a deep level of relaxation are exactly the opposite of those that occur in the fight or flight response. Alterations take place in the automatic, endocrine, immune, and neuropeptide systems as follows:

- Deep relaxation increases
  - —peripheral blood flow (warm extremities)
  - —electrical resistance of skin (dry palms)
  - —production of slow alpha waves
  - —activity of natural killer cells (improved immune function)
- Deep relaxation decreases
  - —oxygen consumption
  - —carbon dioxide elimination
  - —blood lactate levels
  - —respiratory rate and volume
  - —heart rate
  - —skeletal muscle tension
  - —epinephrine level
  - —gastric acidity and motility
  - —sweat gland activity
  - —blood pressure, especially in hypertensive individuals[16]

Benson calls relaxation response meditation "a very simple technique."[17] For centuries, many elements of the relaxation response have been elicited within a religious context in cultures around the world.

Benson cites four basic elements that are common to all relaxation response practices: a quiet environment, a mental device, a passive attitude, and a comfortable position.[18] To incorporate these four factors, Benson recommends that the practitioner first create a quiet environment devoid of all noises and distractions. Next, the meditator is asked to choose a mental device, that is, the "constant stimulus of a single-syllable sound or word."[19] This word is repeated silently or in a low, gentle tone. To allow rest and relaxation, the person is invited to adopt a passive attitude, not forcing the relaxation response. The meditator also is counseled to simply disregard any distracting thoughts that enter the mind.[20] To reduce any stress or muscular effort, the meditator should assume a comfortable position on the floor or use a chair. Incorporating these elements and focusing on the mental device of the word *ONE* for 20 minutes each day facilitates the relaxation response.

The holistic nurse may wish to explore and experience each of the relaxation practices presented in this chapter and write his or her insights and experiences in a journal. See the Notes and Suggested Reading sections at the end of the chapter for further references on relaxation response meditation and other nonreligious meditation practices.

Breathing In and Breathing Out

One of the simplest and deepest relaxation practices is right under our noses every moment of every day: breathing. We have special breathing practices to assist childbirth and we recognize special breathing patterns when we are dying. In between, we breathe each moment, and our breathing patterns reflect our lives' peaks and valleys, our stresses, and our relaxing moments.

Beyond the unconscious breathing pattern that most people are involuntarily practicing is a conscious breathing practice described long ago in the ancient sacred texts of yoga, the Buddha's Four Foundations of Mindfulness, Taoist Qi Gong practice, native shamanic practices,

and spiritual teachings and practices from around the world.

Conscious awareness of breathing—whether the slow, deep, diaphragmatic breaths of hatha yoga or the mindful awareness of breathing in and out of mindfulness meditation—can be practiced in formal sessions of 20 to 45 minutes once or twice a day. Conscious awareness of breathing also can be practiced informally by breathing with mindfulness during everyday activities.

Jon Kabat-Zinn developed a mindfulness-based stress-reduction program that demonstrated how conscious awareness of breathing can help to relieve chronic pain, depression, and anxiety.[21] Participants in the 8-week program practice mindfulness meditation every day; they also practice body scanning (systematically bringing attention to each part of the body, letting the attention rest there, letting go of any judgment about how it is "supposed to feel" and just being with this part of the body, then moving on to the next place in the body), and yoga (performance of meditative asanas or postures combined with breathing to create a union of body, mind, and spirit). Several studies in clinics, communities, and prisons have demonstrated that Kabat-Zinn's program, as well as other modern forms of meditation, can improve quality of life and reduce symptoms (see Table 21–1).

Breathing and Energy Healing Practice

Breathing practice also is an integral dimension of yoga and Qi Gong. The breath or life force, called *prana* in yoga and *qi* (or chi or ki) in Chinese energy practice, is the vital force or energy that animates life. Nurses practicing therapeutic touch center themselves through conscious meditation on their intention to help or to heal, by letting go of outside distractions, and by opening themselves to allow the universal life force or prana to flow through them to their clients. They can use their breathing practice to help enhance this sustained centeredness and their openness to this healing life force.[40,41]

The ancient Yogis knew that by learning to consciously control their breathing and their bodies through practicing a series of yoga postures (asanas), they could open and ready themselves for transcendent awareness. As mentioned previously, yoga practices also have been demonstrated to have great health benefits in the work of Kabat-Zinn[42] and Ornish.[43]

Qi Gong practices date back to about 5000 B.C.E. Taoist and Buddhist Qi Gong masters channeled the flow of qi from nature and the universe through their bodies by practicing simple movements, combined with an awareness of breathing and meditation.

These ancient Chinese practices, which are one of the dimensions of traditional Chinese medicine, have long been renowned for producing health benefits and slowing the aging process. These effects are now being researched and documented in the scientific literature (see Table 21–1).

Yoga and Qi Gong practitioners consider these disciplines essential self-care practices for the unitary body-mind-spirit. These practitioners offer a living legacy of self-care that not only offers healing to their patients, but is the fundamental requirement for development of a healer and/or teacher. In contrast, the Western scientific course of study does not emphasize the cultivation of one's own personal wellness and spiritual development as a prerequisite for becoming a licensed health care professional.

Other Forms of Meditation

As illustrated by transcendental meditation and the works of Benson and Kabat-Zinn, there are many forms of

Table 21–1 Research-Based Outcomes of Meditation

Practice	*Modern Forms*	*Adapted by*	*Clinical Benefits*	*Researcher*
Meditation	Mindfulness, insight meditation, vispassana		See list of deep relaxation changes in Relaxation Responses section	
	Transcendental meditation (TM)	Maharashi Mahesh Yogi		
	Clinically standardized meditation	Patricia Carrington (1975)		
	Relaxation response meditation	Herbert Benson (1975)	Decreased hypertension	Benson et al. (1974)[22,23]
	Mindfulness-based stress reduction	Jon Kabat-Zinn (1977)	Decreased anxiety	Kabat-Zinn et al. (1992)[24] Miller et al. (1995)[25]
			Decreased chronic pain	Kabat-Zinn (1982)[26] Kabat-Zinn et al. (1987)[27]
			Improved psoriasis (as an adjunct to phototherapy and photochemotherapy)	Bernhard et al. (1988)[28]
			Decreased number of primary care visits of urban participants with chronic illness	Roth and Stanley (2002)[29]
Prayer			High frequency of prayer in older adults with poorer physical health experienced better mental health	Meisenhelder et al. (2000)[30]
Moving meditation	Yoga, meditation, stress reduction, nutrition, lifestyle	Dean Ornish	Reversal of heart disease	Ornish (1990)[31]
			Improved non-insulin-dependent diabetes mellitus	Ornish (1990)[32] Ornish (1990)[33]
	Yoga		Improved well-being, symptom management and physical functioning in women with breast cancer in urban multiethnic cancer center	Moadel et al. (2003)[34]
	Qi Gong, Chi Kung		Improved atherosclerotic vascular disease	Ankun and Chong zing (1991)[35] Lim and Boone (1993)[36]
			Lowering of blood glucose levels	McGee et al. (1996)[37]
			Reduced stress	Ryu et al. (1996)[38]
			Shortened detoxification period and reduced craving and discomfort during heroin detoxification	Li et al. (2002)[39]
	Therapeutic touch	Delores Krieger/Dora Kunz		See Chapter 24

meditation. Some say that hundreds of practices can be listed under the heading of meditation. Each practice cultivates a qualitative state of mind that can induce a deep experience of relaxation and calm. In some meditative practices, such as transcendental meditation and relaxation response meditation, the individual focuses on an object of meditation in order to move away from and minimize thoughts. Other traditions, such as mindfulness meditation, insight meditation, and vispassana meditation, invite practitioners to cultivate greater awareness by returning to the breath as awareness of sensations, thoughts, and feelings are present.

Centering prayer, a Christian meditation practice developed by Father Thomas Keating, focuses on words or sounds in somewhat the same way that transcendental meditation uses mantras (sacred Sanskrit syllables and words such as *OM*). Other meditation practices invite meditators to gaze at the flame of a candle, a sacred image, or a mandala; to chant aloud; or to concentrate on an unanswerable question (or Koan), as in Zen practice.

Janet Macrae calls therapeutic touch a moving meditation.[44] Sufi dancing is another form of moving meditation, as are Native American and shamanic ritual dances, which may continue for many hours or many days. The purpose of spiritually-focused meditation is to awaken to a higher consciousness, to be at one with the sacredness of the All, to become one with the Divine. Individuals practice such meditation to open the body-mind-spirit to the qualities of compassion, wisdom, skillfulness, fearlessness, stillness, openness, and interconnectedness.

The healing arts are the underpinning of many culture's healing traditions. For example, Tibetan healers begin their education at an early age, studying sacred texts on healing and herbs as well as meditating and praying each day to cultivate a heart of compassion and loving kindness, to become one with the compassionate, healing energy and wisdom of the limitless realms. After years of study and apprenticeship (some healers apprentice from childhood), they practice their healing art and science of body-mind-spirit.

What would health care be like if nurses, physicians, and other health care practitioners began by cultivating a heart of compassion and service? What would the health care system be like? Would burnout exist? (See the Loving Kindness Meditation section below.)

Meditation Practices

This era will give birth to many distillations of ancient meditative practices, including intricate Tibetan meditative practices, because of their health benefits.

Finding a meditation practice and learning to explore it deeply offers healing and insight, a gift only committed practice can provide.

Mindful Breathing During Nursing Practice

Nurses who wish to be more present with their clients, to practice self-care, and to awaken to the simple sacredness of everyday nursing practice (e.g., hanging an intravenous bag, writing nursing notes, eating, walking down a hall, or feeding a patient) may want to practice mindful breathing each moment, as in the following exercises.

Breathing Exercise I

Script: *Breathing In, I am aware of Breathing In.*
Breathing Out, I am aware of Breathing Out.
Breathing In, I am aware of introducing this healing medication through this intravenous line.

Breathing Out, I send my healing intentions along with the medication to help support this patient's healing.

Breathing Exercise II

Script: *Breathing In, I am walking down this hall.*
Breathing Out, I smile, enjoying my steps.
Breathing In, I am fresh.
Breathing Out, I celebrate my aliveness.

Being with the breath, reminding oneself to offer self-care in each moment by consciously breathing with each activity, is a gift of self-renewal, freshness, and aliveness that deepens with practice. It is a gift nurses can give to themselves every moment.

Mindful Breathing Meditations

Exploring and practicing relaxation and meditation not only helps the nurse gain insight into specific methods and into the issues that clients may face as they work to integrate these techniques into their daily lives, but it also offers the nurse an opportunity for personal wellness, self-care, and spiritual development.

When choosing a meditation practice to explore, the nurse should commit to that practice for at least 4 to 6 weeks before trying another, while keeping a journal of his or her reflections along the way.

Mindfulness of the Breath Exercise I (Lying Down). Lie on the floor with your hands on your abdomen. Close your eyes, and feel the movement of your body with every rise and fall of the breath. Follow the inhalation fully and the exhalation fully. With each inhale, repeat, in your mind, "*Breathing in, I am aware of breathing in*," and on each exhale, "*Breathing out, I am aware of breathing out*." As you continue, you may shorten the phrase by repeating gently in your mind *"In"* on the in breath and *"Out"* on the out breath. As you are breathing and lying comfortably with your hands on your abdomen, allow a gentle smile to bloom on your lips and at the corners of your eyes. (After all, this is supposed to be an enjoyable practice.) Try this practice for 15 to 20 minutes. Observe and note any awareness, reflections, and insights in your personal journal.

To extend this practice during the next week, you may wish to continue lying down in a comfortable position, or you may choose a sitting meditation practice, as described below.

Mindfulness of the Breath Exercise II (Sitting). In a quiet place, find a comfortable position sitting. Either sit on a chair with your feet on the floor and your back supported and straight, or sit on the floor using a meditation cushion (zafu) or a regular pillow folded in half to create a supportive lift under your buttocks. If you are sitting on the floor, find a comfortable way to place your legs, either (1) crossed in lotus or half-lotus position with or without pillows under your knees, (2) Indian style, or (3) straight out in front of you, with a pillow under your knees and your back supported against a back jack or against the wall.

Focus on a point on the floor in front of you and gently lower your lids until they are almost closed. Gently bring your attention to your breath.

Script: *Breathing In, I am aware of Breathing In.*
Breathing Out, I am aware of Breathing Out.
In.
Out.
Breathing In, I am calm.
Breathing Out, I smile.[45]
Thich Nhat Hanh

Continue to bring your attention to your breath, allowing any thoughts, feelings, or awareness to pass through, then gently bring your attention back to the breath and the repeated phrase.

Practice for approximately 15 to 20 minutes. After your practice, note your experience in your journal.

This practice is an example of using meditation to become aware of our minds and to practice just *being*, just being present and relaxed, and practicing nondoing rather than "doing nothing." We get so caught up in believing that we always have to be "doing" or multitasking that we lose the essence of what is of true value. Mindfulness helps us to get back in touch with what is truly healing within and around us.

As you continue, you may want to note Kabat-Zinn's attitudinal foundations of mindfulness practice, which are relevant to all relaxation practice (Exhibit 21–4).

Walking Meditation

Walking as if one were planting peace with each step—this is the essence of walking meditation.[46] This practice has been especially helpful during times of trauma and crisis and can be done to center oneself in the most challenging and traumatic of circumstances.

To practice, start with the left foot and begin walking slowly by synchronizing the breathing meditation practice of *In*/*Out* with each step. Sometimes you may take three steps to the *In* breath and three steps to the *Out* breath. Play with your

Exhibit 21–4 The Attitudinal Foundation of Mindfulness Practices

- **Nonjudging:** Learning to become aware of judging and reacting to inner and outer experiences and develop an observing stance. Learning to witness or observe the judging mind and then return to the breath.
- **Patience:** Allowing each moment to unfold with its own fullness, at its own rate and pace. Discovering that each moment is a special moment to be with rather than rushing through it to get to a "better" one.
- **Beginner's mind:** Cultivating the freshness of seeing for the first time. Being receptive to new possibilities in every moment, experiencing well-worn practices as though they have never been experienced before. This is beginner's mind or don't know mind.
- **Trust:** Learning to cultivate trust in one's own basic wisdom, intuition, and goodness. Learning to listen first to one's own inner voice and trust its insights and awareness, even while being open and receptive to learning from other sources.
- **Nonstriving:** Nondoing, practicing without a goal other than for one to be oneself. The irony is that one already is. Nonstriving is trying less and being more by intentionally cultivating the attitude of nonstriving. Learning to be present with whatever emotion, experience, or sensation one is experiencing without trying to do anything either to enhance it or to reduce it. Nonstriving invites one to be with one's awareness and experience.
- **Acceptance:** Not denying or resisting what is, but cultivating being present with one's reality. Acceptance does not mean being satisfied with how things are or being resigned to this situation. Acceptance is a willingness to see things as they are.
- **Letting go:** Nonattachment to one's thoughts, experiences, feelings, and sensations. As we practice, we recognize our desire to hold onto certain types of feelings and experiences we deem pleasurable and to rid ourselves of those viewed as unpleasant and painful. Practicing letting go allows us to cultivate being with all our experience as it is and observing it moment to moment.

Source: From FULL CATASTROPHE LIVING by Jon Kabat-Zinn. Copyright © 1990 by Jon Kabat-Zinn. Used by permission of Dell Publishing, a division of Random House, Inc.

practice, exploring how carefully you can become aware of the subtle sensations of slowly lifting, moving, and placing each step as you continue your awareness of breathing.

This practice can be interspersed between sitting practice sessions: 20 minutes of sitting, 10 minutes of walking, 20 minutes of sitting, 10 minutes of walking. This also is a wonderful meditation to practice at a more normal pace of walking at work, as well as going to and from work. *"Walking down the hall, I am aware of my footsteps and my breathing. Being in this present moment, I know this is the only moment."*

Practicing walking meditation often allows the practice to *be in our bones*, so that it is there for us when we need it most.

Cultivating the Heart of Compassion Meditation

Loving Kindness Meditation. This meditation* for helping professionals is adapted from Thich Nhat Hanh's Loving Kindness Meditation in *Teachings on Love*.[47]

Sitting peacefully, begin as in sitting meditation practice, then plant each phrase like a healing seed within your heart, following your breath and focusing on your intention to cultivate compassion. Say each line to yourself in your mind, or ask a friend to read this meditation aloud to you, pausing after each line so that you can slowly repeat it silently to yourself.

Part I: *May I be peaceful.*
May I be happy.
May I look to myself with the eyes of compassion and love.
May I be safe.
May I be free from accidents.
May I be compassionate with my anger and gentle with my fear.
May I be spacious and compassionate to the depths of my true heart.
May I be whole.
May I be well.
May I be free.
May I be peaceful.
May I be happy.

In Part II of this meditation, repeat the same meditation while imagining that someone you care about and/or are having difficulty with is sitting in front of you, and center your attention on cultivating and offering compassion while repeating silently in your mind:

Part II: *May you be peaceful.*
May you be happy.
May you look to yourself with the eyes of compassion and love.
May you be safe.
May you be free from accidents.
May you be compassionate with your anger and gentle with your fear.
May you be spacious and compassionate to the depth of your true heart.
May you be whole.
May you be well.
May you be free.
May you be peaceful.
May you be happy.

Then, in Part III, imagine offering compassion to all beings on earth, to the earth, to all the planets, and to all beings throughout the universe and beyond time and space:

Part III: *May all beings be peaceful.*
May all beings be happy.

**Source:* Adapted from a loving kindness meditation in *Teachings on Love* (1997) by Thich Nhat Hanh with permission of Parallax Press, Berkeley, California.

May all beings look to themselves with the eyes of compassion and love.
May all beings be safe.
May all beings be free from accidents.
May all beings be compassionate with their anger and gentle with their fear.
May all beings be spacious and compassionate to the depths of their true heart.
May all beings be whole.
May all beings be well.
May all beings be free.
May all beings be peaceful.
May all beings be happy.

For other heart-opening meditations, see the St. Francis Prayer and *www.Beliefnet.com* in the Resources section at the end of the chapter.

Quiet Heart Prayer

One of the most frequently used traditional nursing spiritual therapies is prayer.[48] Prayer is a way of eliciting the relaxation response in the context of one's deeply held personal, religious, or philosophic beliefs. Benson refers to this as incorporating the "faith factor" into relaxation. Many people are comfortable with prayer as meditation, and it requires only seconds to minutes. In health care settings, nurses need to accommodate the client's spiritual needs, either by calling on his or her personal spiritual/religious background and resources or by enlisting the help of appropriate family of the client, clergy, or chaplaincy staff.

MODERN RELAXATION METHODS

Progressive Muscle Relaxation

In 1935, Edmund Jacobson detailed a strategy leading to deep muscle relaxation.[49] The body responds to anxious thoughts and stressful events with increased muscle tension. This body-mind-spirit tension further provokes subjective sensations of anxiety. In progressive muscle relaxation, the practitioner deliberately tenses muscle groups, focusing on the tightening sensations, and then slowly releases that tension. In this way, the individual learns to manage levels of muscle tension. Progressive muscle relaxation allows the client to deepen the experience of comfort.

Several studies have demonstrated that progressive muscle relaxation reduces subjective feelings of anxiety and increases peak expiratory flow rates in asthmatic clients; it also helps clients with insomnia, headaches, ulcers, hypertension, and colitis (see Table 21–2).

In the original form of progressive muscle relaxation, clients learn to relax 16 of the body's muscle groups. They inhale while tensing their muscles and then exhale and relax their muscles very slowly. Variations on progressive muscle relaxation, or modified progressive muscle relaxation, are integrated into many relaxation practices.

Progressive Muscle Relaxation Exercise: Tension Awareness

The purpose of a tension awareness exercise is to help the client identify subtle levels of mental tension and anxiety and the physical tension that accompanies these mental and emotional states. The client who is aware of the internal differences induced by this exercise can move to threshold levels of tension, holding just enough tightness in the muscle group to be aware of beginning tension and then relaxing the group. By moving from strong contractions to very subtle ones, the client becomes aware of the ability to fine-tune the relaxation process. Read through this script first because you will be required to insert other areas into the text as you go. This exercise requires 10 to 30 minutes depending on how many areas of the body you include.

Script: *First take a few moments to focus on your breathing. This*

Table 21–2 Research-Based Outcomes of Relaxation

Modern Form of Relaxation Practice	*Developed by*	*Clinical Benefits*	*Researcher*
Progressive muscle relaxation (PMR)	Jacobson	Chemotherapy symptoms: reduced pretreatment nausea and anxiety, lowered blood pressure, lowered post-treatment anxiety, depression, nausea (practiced once daily)	Lyles et al. (1982)[50]
		Immunocompetence in geriatric population: those practicing PMR demonstrated better immunocompetence (increased natural killer cell count and herpes antibodies) and decreased stress	Keicolt-Glaser et al. (1985)[51]
PMR and music		Myocardial infarction (acute): reduced apical pulses, increased peripheral temperatures, reduced incidence of cardiac complications (congestive heart failure, pericarditis, persistent chest pain)	Guzzetta (1989)[52]
PMR and meditation		Cardiac catheterization: reduced STAI scores and diazepam use	Wagner et al. (1992)[53]
Autogenic training	Schultz and Luthe	Reduced muscle tone, blood pressure, and skin resistance	Schultz and Luthe (1959)[54]
		Increased theta activity, decreased beta activity on electroencephalogram	Dierks et al. (1989)[55]
Autogenic biofeedback therapy		Reduced classical and common migraine	Blanchard et al. (1985)[56]
		Reduced idiopathic essential hypertension	Fahrion (1991)[57]
		Improved Raynaud's disease	Freedman (1987)[58]
Hypnosis		Preoperative hypnosis reduced postoperative vomiting after breast surgery	Enquist et al. (1997)[59]
		Self-hypnosis reduced anxiety following coronary artery bypass surgery	Ashton et al. (1997)[60]
Hypnosis/meditation		Improved quality of life in women with osteoporosis (phenomenologic study)	La Vorgna-Smith (1997)[61]
Biofeedback		Improved fecal incontinence and pelvic floor dyssynergia	Whitehead et al. (1996)[62]
Biofeedback-assisted relaxation		Lowered blood glucose levels, percentage of fasting blood glucose levels at target in type I diabetes	McGrady et al. (1991)[63]

will help you to focus better on internal cues of muscle tension and then relaxation. I will guide you as we begin to move through the muscles of your body. Become aware of how you can gain control over the tension found in those muscles. This process involves alternately tightening and relaxing muscle groups. Let yourself tighten each muscle group, hold the tension for 5 to 10 seconds or until mild fatigue is felt in the area, and then release the tension. . . . Begin with the muscles in your feet and calves; tighten that area as much as you can. Pull your toes up toward your head and become aware that, as the muscles tighten and as you continue to hold that tightness, your legs will perhaps tremble or shake a bit as they fatigue. . . . Now, let the

tension slowly dissolve and feel the difference in your lower legs and feet. . . . Let your attention move up to your knees and thighs; tense those muscles by pressing your legs into the surface of the bed (couch, floor, chair). . . . When you are aware of how they feel, then allow the tension to drift away as you exhale.

The exercise then proceeds to the following areas: hips and buttocks, abdomen and lower back, chest and upper back, shoulders and biceps, forearms and hands, neck and shoulders, jaw and tongue, and finally facial muscles. Insert these areas into the script to continue the exercise.

If the client is experiencing pain or difficulty with a particular part of the body, the exercise should begin as far away from the involved area as possible and conclude with the primary area of difficulty.

Clients should be coached to breathe throughout the session, thereby avoiding the temptation to hold their breath as they tighten their muscles. Clients may learn to exhale as they tighten muscle groups. Tension in muscles should be held short of true discomfort.

Progressive muscle relaxation is particularly effective for clients who are feeling physically tense, anxious, and perhaps agitated. Because it is an active intervention, it may be preferable to other passive exercises, especially early in client training. It should be used with caution for clients with ischemic myocardial disease, hypertension, and back pain, however.

Autogenic Training

In 1932, Johannes Schultz and his student, Wolfgang Luthe, developed a series of brief phrases designed to focus attention on various parts of the body and induce a bodymind shift in those parts.[64] The phrases that were developed are called *autogenic* because of their ability to assist a person in inducing self (auto) change from within. This approach to health care was rather new in the 1930s.

Although similar to self-hypnosis, autogenic strategies are a specific present-time-oriented means of gaining access to the natural restorative mechanisms of the mind. Autogenic training has been found to be effective in managing disorders in which cognitive involvement is prominent (see Table 21–2). These self-healing phrases can be combined with progressive muscle relaxation as an integrative approach to relaxation to help a broader spectrum of clients. Autogenic training is one of the most widely used approaches in teaching clients to warm their hands during biofeedback temperature training.

Autogenic Training Exercise

Clients may find autogenic training helpful to consciously rebalance the internal homeokinetic mechanisms of the cardiovascular and respiratory systems, which simultaneously affect the autonomic, endocrine, immune, and neuropeptide systems. The exercise generally lasts 10 to 20 minutes.

Script: *Slowly and silently repeat the following phrases to yourself as I say them out loud to you* [repeat each phrase two to four times, pausing a few seconds between each repetition]: *"I am beginning to feel quiet. . . . I am beginning to feel relaxed. . . . My feet, knees, and hips feel heavy. . . . Heaviness and warmth are flowing through my feet and legs. . . . My hands, arms, and shoulders feel heavy. . . . Warmth and heaviness are flowing through my hands and arms. . . . My neck, jaw, and forehead feel relaxed and smooth. . . . My whole body*

feels quiet, heavy, and comfortable. . . . I am comfortably relaxed. . . . Warmth and heaviness flow into my arms, hands, and fingertips. . . . My breathing is slow and regular. . . . I am aware of my calm, regular heartbeat. . . . My mind is becoming quieter as I focus inward. . . . I feel still. . . . Deep in my mind I experience myself as relaxed, comfortable and still. . . . I am alert in a quiet, inward way. As I finish my relaxation, I take in several deep, reenergizing breaths, bringing light and energy into every cell of my body."

Autogenic training should begin in a warm (75° to 80°F) room to facilitate sensations of warmth. Clients can progress to cooler environments to generalize their training (to simulate being outside). Using the phrases while the mind is relaxed and receptive allows the peripheral circulation to increase and cardiac and respiratory rates and rhythms to slow and stabilize. Several weeks may be required for the client to feel sensations of heaviness and warmth, although the client usually achieves restful heart rate and respiratory patterning much sooner.

Effects of Relaxation Therapies

Over the past three decades, practitioners involved in stress reduction, relaxation training, and biofeedback have questioned whether all the various techniques elicit a single relaxation response, as hypothesized by Herbert Benson in 1975, or whether specific practices render specific effects.[65] The latter view proposes that specific cognitive effects are produced by the use of cognitively oriented methods (see the Autogenic Training section), autonomic effects are produced by autonomically oriented methods, and muscular effects are produced by muscularly oriented methods (see the Progressive Muscle Relaxation section). (See Table 21–3.)

Holistic Nurse Learning Experiment I

One of the most effective tools for understanding relaxation is self-exploration and self-experimentation. Within him- or herself, the nurse is a minilaboratory able

Table 21–3 Hypothesized Effects of Relaxation Techniques

Relaxation Technique	*Hypothesized Effect*	*Researcher*
Progressive muscle relaxation (PMR)	Modified PMR might be expected to develop muscular skill.	Davidson and Schwartz (1976)[66]
Autogenic training (AT)	AT might generate both cognitive and somatic effects because it emphasizes body awareness through repeated self-suggestion.	Linden (1993)[67]
AT vs. PMR	AT is particularly effective in cultivating specific sensations suggested in the self-suggestion statements and has much greater effects in that realm than does PMR.	Lehrer et al. (1980)[68] Shapiro and Lehrer (1980)[69]
Relaxation response meditation	Relaxation response elicited is hypothesized to be universal (i.e., all relaxation techniques are considered equivalent).	Benson (1975)[70]

to explore these various methods and do his or her own inner research. All that is needed is a journal and the commitment to inner exploration and personal and professional self-development.

A commitment must be made to practice the method for at least 4 to 8 weeks to explore beyond initial positive or negative reactions. Practice each day following your script or tape and keep a journal of your awareness observations: how you felt in your body before and after the session, any areas of comfort or discomfort you noted before or after the session, and so on (see Exhibit 21–5).

After practicing, exploring, and writing a journal about your selected practice, you may want to explore another practice in a similar fashion and compare and contrast their effects.

Another method of exploration is to invite others to join you in experimenting with the same practice or different ones. Holding periodic group meetings to review your observations and your inner laboratory journals can help you to explore variations in experiences with the same practice and compare and contrast differences in and preferences for various practices.

Selecting Relaxation Interventions for Clients

No formula exists for determining which relaxation intervention is best for which client. The approach must be tailored to the individual based on his or her condition, personal preferences, and available time. A few clients may initially resist the idea of relaxation practice in spite of the nurse's best efforts to present it in a positive manner. In this situation, the issue need not be forced, for the client may accept the intervention at a later time. Taking some time to explore the client's experience and the source of the resistance may reveal misconceptions or myths that further dialogue can dispel. Recall your list of descriptors of a relaxed person from the beginning of this chapter and its implications for motivation and client participation.

The use of audio and video relaxation tapes, CDs, or DVDs present relaxation instructions in a nonthreatening gentle manner. Often accompanied by soothing music (and images) this format can be offered over hospital closed circuit television or become part of a comfort cart on each floor and may hasten acceptance of this intervention. Relaxation tapes and CDs also can be played on the home or business audio system as gentle background for daily activities. The following are guidelines for the client in the use of relaxation tapes:

1. Listen to an exercise at least once a day, preferably twice a day.
2. Never listen to a tape when you are driving or operating a vehicle.
3. Arrange to have uninterrupted privacy while you listen to the tape.
4. Listen with headphones to help block out distracting noises from the environment.
5. Listen to the tape in a relaxing position in which your body is supported.

Hypnosis and Self-Hypnosis

Most people misunderstand the use of trance and hypnosis, and associate it with stage professionals and entertainment. However, hypnosis and trance have been used for healing and therapeutic purposes from the times of ancient Egypt and Greece. In these ancient societies, priest/healers in healing temples helped their patients evoke a healing process of awareness or trance. Native shamans evoke a trance to seek healing guidance and wisdom for themselves and members of their tribes. In the late eighteenth century, Viennese physician Franz Mesmer offered "magnetic" treatments to his patients that included hypnosis. The word *mesmerized* is

Exhibit 21–5 Inner Laboratory Journal

Name_____

Date _____ Practice method _____

Session no. _____ _____

Place of practice_____

Method of practice:

CD/DVD/Tapes ❑ _____

Script ❑ _____

Read aloud ❑ _____

Memorized ❑ _____

Other ❑ _____

Pre-Session Awareness

High comfort, high well-being — **Low comfort, low well-being**

10 ——— 0

Describe areas of comfort:

_____

_____

_____

No pain — **High pain**

0 ——— 10

Where? (Describe) _____

Post-Session Awareness

Note areas of:

_____ Tingling
_____ Pulsing
_____ Throbbing
_____ Warmth
_____ Numbness

_____ Heaviness
_____ Lightness
_____ Calm
_____ Inner Peace
_____ Energy Flow

_____ Arms
_____ Hands
_____ Legs
_____ Feet
_____ Hips

_____ Head
_____ Neck
_____ Face
_____ Jaw
_____ Eyes

_____ Abdomen
_____ Back
_____ Chest
_____ Shoulders
_____ Pelvis

continues

Exhibit 21–5 Continued

Describe any images, thoughts, feelings:

_____

_____

_____

_____

_____

_____

_____

_____

High comfort, high well-being — **Low comfort, low well-being**

10 — 0

Describe areas of comfort:

_____

_____

_____

No pain — **High pain**

0 — 10

Where? (Describe) _____

now part of our language—an indication of the impact of Mesmer's work.

Hypnosis has been defined in many ways. Nursing expert Dorothy Larkin, PhD, describes hypnosis as "a process of therapeutic communication, awareness and behavior within the context of a therapeutic relationship."[71] In hypnosis, attention can be more focused or more mobile, and there is a tendency for greater responsiveness to suggestion. Once the visual, behavioral, and thinking processes and cues associated with hypnosis are understood, they may be seen to occur spontaneously under a variety of circumstances. According to David Cheeks, an expert in the study of trance and hypnosis, "hypnotic states may occur when people are frightened, disoriented in space, unconscious, very ill, or stammering."[72] These experiences are experiences that nurses' patients and clients experience every day, and thus most nurses first encounter their clients and patients in an already altered process of hypersuggestibility. This naturally occurring trance opens up the client to the influence of nurses' therapeutic presence and therapeutic suggestions.

Recall Cheeks's description of the hypnotic trance of frightened and ill patients,

and consider how clients and patients are given the news of their diagnosis and prognosis by their physicians while they are in that state of fear and hypersuggestibility. Many patients today still are told that they have only a few months to live or that nothing can be done for them. This nontherapeutic suggestion is being instilled in a patient's consciousness in a suggestible moment by one of his or her most trusted authorities, the physician. What outcome could be expected? How might the process differ if the client were offered more positive therapeutic suggestions? Nursing experts have been interested in exploring and integrating hypnosis, trance, and therapeutic suggestions because of the history of hypnosis in healing throughout the cultures of the world, because of its natural availability through client hypersuggestibility during health care crisis, and because of its ease of use and practicality.[73] Larkin and many other nurse experts in hypnosis have explored ways in which therapeutic suggestion can enhance patient cooperation and comfort.[74,75]

Nurses can recognize a hypnotic experience in clients who have a faraway stare, glazed eyes, or fixed attention. Larkin notes that nurses "can utilize this receptive state by offering therapeutic suggestion, reassurance, and health-promoting education. Continual assessment will need to be observed so if the subject's attention suddenly shifts, the nurse can concurrently change the offered therapeutic strategy to meet the patient's needs and altered perceptions."[76]

Learning how to use therapeutic suggestion is not foreign to nurses who have used health education to focus clients on healing and health-promoting phrases in order to help them reframe their experiences. Norman Cousins described an example of reframing an experience and conversational induction in which he supported a man on the street who was having a myocardial infarction. Holding the man's hand, Cousins whispered in his ear that the paramedics were on the way and that the man's body was already beginning to heal itself. He helped the patient begin relaxation breathing and continued to reframe the situation through the use of therapeutic suggestion by introducing simple information about the body's ability to restore, rebalance, and heal during a crisis.[77] Imagine how Cousins' approach contrasts with what usually happens with clients who have heart attacks and do not get any information about their condition, have people speak in terms they can't understand, or have others speak in the room as if they were not present. This form of conversational induction can be most helpful in situations of great crisis or trauma when the patient's capacity for other forms of relaxation may be impeded. "In daily conversations with patients and families . . . these strategies can help . . . maintain their protective defenses while introducing comfort producing approaches."[78] Learning how to use this skill during our usual care will imbed the skill deeply into our awareness so that it can be easily accessed in times of crisis or trauma.

Therapeutic suggestion is also a vital accompaniment in disbursing medication. For example, the nurse might say, "This medication will help to quiet your nervous system so you can relax more comfortably into sleep." Rather than having the nurse say, "This pill is for your insomnia." Suggestion and hypnosis have been used in a wide variety of clinical settings. Hypnosis has been used by nurses in hospice care, palliative care, home care, and critical care, as well as in burn units and oncology, obstetrics, medicine, and surgery units, to name only a few areas (see Table 21–2).

All nurses can learn to use reframing, conversational inductions, and positive therapeutic suggestion, and to recognize an everyday hypnotic trance process of

clients in crisis (also see the Cryptotrauma section later in this chapter). Some nurses may want to pursue hypnosis as an area of expertise by receiving reputable training and exploring the Resources and Suggested Reading sections at the end of the chapter, which offer sources for further information. Nurses can also practice self-hypnosis and therapeutic suggestion as part of their personal self-care, in addition to teaching clients this practice so that they can continue self-care at home.

Biofeedback

Another modern form of the ancient healing art of relaxation uses modern technological equipment that most nurses employ daily to monitor body-mind-spirit changes. This combination of ancient awareness practice and technology is called biofeedback. Biofeedback was termed the "yoga of the West" by Elmer and Alyce Green, researchers and early biofeedback pioneers at the Menniger Institute in Topeka, Kansas.[79] When the devices monitoring the unitary body-mind-spirit are turned so that clients can see their displays, clients learn how to read their bodies' signals more accurately and are empowered to make therapeutic changes. Educating clients about how their bodies respond to stress and teaching them how to react more healthfully is the work of biofeedback.

Recall what has just been explored with regard to therapeutic hypnotic suggestion and reframing and imagine how this new knowledge and awareness might be used to empower clients as they encounter the monitors and other technical equipment in the health care setting. If you can imagine turning your monitors around and teaching clients the positive meaning of the monitor's signals so that they can understand how their bodies respond to thoughts and feelings, then you have already begun to understand the impact and usefulness of biofeedback. Biofeedback machines can measure many functions of the unitary body-mind-spirit. Whether the biofeedback comes from a temperature monitor measuring hand temperature or from Kirlian photography showing the energy field as displayed on a computer, clients are learning something that, prior to the use of this technology, may have been hidden from their perception. With practice, clients can tune their inner awareness to become like the Yogis, and learn to influence and control these previously imperceptible and seemingly uncontrollable signals.

The most widely used biofeedback monitors include temperature-sensing units for measuring vasodilatation of extremities, electromyographs for monitoring motor neuron activity of the muscles, electroencephalographs for measuring brain-wave frequencies and patterns, and electrodermal response units for measuring electrical activation of the sweat glands. Heart rate variability monitors and blood pressure monitors also are widely used in biofeedback (Exhibit 21–6).

Biofeedback has been practiced since the 1960s. Its focus is to teach clients to create "psychosomatic health," as Elmer Green would put it, instead of psychosomatic illness.[80] This goal is accomplished with the assistance of the biofeedback equipment and the nurse therapist. Specialized training and certification in biofeedback is available through the Association for Applied Psychophysiology and Biofeedback and the Biofeedback Certification Institute of America (see Resources section). Both organizations are established multidisciplinary groups that integrate the sciences and arts of engineering, psychology, neuroscience, research, education, healing, meditation, and yoga.

Exhibit 21–6 Clinical Indicators for Biofeedback

Neuromuscular disorders
- Chronic muscle contraction
- Movement disorders
- Spasticity

Central nervous system disorders
- Stroke
- Some epilepsies

Vascular disorders
- Raynaud's disease
- Migraine

Pain
- Headache
- Back pain

Gastrointestinal and genitourinary disorders
- Urinary and fecal incontinence
- Urinary and fecal retention

Stress reduction
- Insomnia
- Anxiety
- Phobias
- Alcoholism/addiction
- Attention-deficit hyperactivity disorder
- Procedure-related anxiety

Holistic Nurse Learning Experiment II

Biofeedback can offer nurses the opportunity for independent professional practice, whether in private practice or in an institutional setting. Many nurses integrate biofeedback into relaxation therapy, stress management, health counseling, and teaching. Other nurses specialize in neurofeedback for the care of insomnia, depression, addictions, and attention-deficit hyperactivity disorder. Another area of particular interest to nurses is heart rate variability, as well as the use of electromyography to help clients manage urinary and fecal incontinence (see Table 21–2). All these areas of specialization require extensive study, practice, and mentoring. However, every nurse can benefit from using simple biofeedback principles and techniques in everyday nursing practice. Learning to understand these biofeedback principles from the inside out is the purpose of the following series of experiments. One or two psychophysiologic monitors, paper, and a pen are required. Any monitors available—pulse oximetry, blood pressure, heart rate, incentive spirometer—can be used, or an inexpensive temperature-sensing unit can be purchased (see Resources section).

Allow 30 minutes for the exercise. Make yourself comfortable. Make sure the environment is relaxing and is as quiet as possible, and that there will be no interruptions. Set up the biofeedback equipment and attach the leads to yourself so you can easily monitor your responses. Pick only one or two types of equipment, such as an extremity temperature monitor and an automatic blood pressure and/or oxygen saturation rate monitor. If you are setting up a temperature unit, begin by attaching the ceramic end of the wire (called the thermister) to the fleshy, palmar surface of your fingertip (see Figure 21–1).

Run the wire down along the length of the finger and attach the thermister with paper tape so the tape covers the end of the ceramic tip. You should begin to see changes in the temperature as the heat of your finger warms the thermister. Do not use plastic tape when attaching a thermister because it creates a greenhouse effect and can alter the accuracy of the readings.

The warmer the hands, the greater the blood flow and circulation to the extremities, indicating quieting of the sympathetic nervous system and quieting of the fight or flight response. Cooling extremities demonstrate the opposite: decrease in blood flow and circulation in the extremities, and an increase in the fight or flight response. Normal hand temperature readings can range from 65° to 99°F.

Sit quietly for 3 to 5 minutes, then notice your readings on the temperature unit and

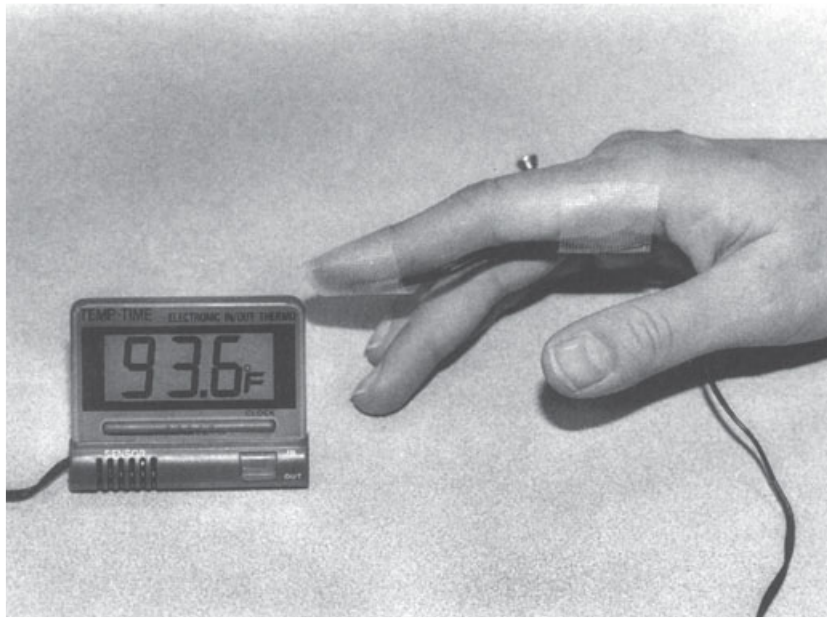


Figure 21–1 Biofeedback Temperature Unit. Finger with thermister attached. Ceramic tip of biofeedback thermal probe (thermister) is attached to palmar tip of finger. Tip of thermister is covered with paper tape and wire is attached to finger as demonstrated in photograph (clear tape is used in the photograph so that placement of thermister is visible).

any other unit you have chosen to monitor. Try to check your readings with as little disturbance to the quiet of the experience as possible. These primary or initial readings are called your *baseline readings*. Write down these baseline readings. If you are comfortable, remain attached to the biofeedback monitors. Make sure that your body is supported and that you can easily see the monitors with as little movement as possible. Next, perform one of your favorite relaxation or meditation practices for 10 to 20 minutes.

Take readings immediately at the end of the session in a quiet, unhurried way so as not to disturb your relaxation. Notice any difference in your readings before and after the practice. What did the readings demonstrate about your practice experience? What change did you experience inside? Were these changes reflected in your biofeedback readings?

If you notice a drop in the temperature of your hands during or after a relaxation practice, check the following:

1. Did you feel hurried?
2. Were you trying too hard to relax?
3. Were you thinking about something other than the relaxation practice or wondering what the monitors would show?
4. Was the room warm enough?
5. Were there any interruptions, expected or unexpected, such as people entering the room, phones ringing, etc.?

Whatever the results are, they can only help to deepen your understanding of the internal awareness and responses in-

volved in these special practices. Remember to adopt the attitude of nonjudgmental observer and explore your inner awareness. Examine Exhibit 21–7 to determine whether any of these factors can help to explain your response. With practice, you may notice an increase from your prerelaxation to postrelaxation temperature reading.

Holistic Nursing Experiment II (Variations)

Variation A: Client Practice

Try the biofeedback experiment described above on a client. Use an abbreviated form of the experiment (5 to 10 minutes), taking readings before and after relaxation practice. Explore and explain the meanings of the readings and invite the client to describe what he or she felt inside and what he or she feels the readings mean.

This technique provides an opportunity for health care teaching and counseling to move from client compliance into client empowerment. Teaching clients how anxiety, worry, and stress can produce higher blood pressure, cooler hands, and tenser muscles, and how relaxation can produce the opposite responses, is an easy way to begin a dialogue providing clients with insight into the stressors of their lives and how they respond to them.

Variation B: Group Self-Care Experiment

Try relaxation/biofeedback in a group (Figure 21–2). Start with a group of colleagues rather than a group of clients. (You can begin to introduce this technique to a group of clients later as you gain experience and knowledge with the practice.) Schedule a relaxation break for your unit. Take 15 minutes at the beginning of a staff meeting, or schedule the relaxation practice during a lunch break every week or month. A relatively quiet room with chairs arranged in a circle, flowers for the center of the circle, and some music will be helpful. Invite each person to bring a small journal and pen and obtain a biofeedback temperature monitor for each person. Small alcohol thermometers are the least expensive temperature monitors; liquid crystal cards, dots, or bands also work. If electronic temperature units or finger alcohol thermometers are used, attach the unit to the palmar surface of the finger with paper tape (see Figure 21–1). Agree as a group to meet on a regular basis, keep a journal of individual progress, and begin and end on time so that people can easily return to work or finish lunch.

Set up the room in advance so that the flowers are in the center of the circle of chairs. Have members of the group attach their temperature monitors. Allow 1 to 2

Exhibit 21–7 Important Factors in Relaxation Practice

- **Passive volition:** Letting go, being without doing or striving, allowing, being with the process as it unfolds rather than making it happen; planting a seed in the mind of wanting to relax and then letting go and watching the process.
- **Attention to the here and now:** Being oriented toward the present, not caught up in what happened or what might happen.
- **Altered perception of time:** Experiencing time as expanded or contracted. Relaxation practice can change the perception of time so that a very short practice session feels like a long time or a long practice session is experienced as a few moments.
- **Enjoyment of practice:** Committing to practice and, even more importantly, enjoying practice. Most traditional healers and teachers of the restorative arts ask their students if they are enjoying their practice. Finding a practice that helps one weather the storms of life and enhances one's inner connection is a joy.

Figure 21–2 Nursing Group Practicing Biofeedback. Nurses practice biofeedback handwarming as part of self-care/patient care as they are led in a guided meditation by their nurse colleague.

minutes before taking the first baseline reading. Next, introduce a relaxation exercise. You can continue to play music or turn the music down or off, while one of the group members offers a relaxation practice. The role of relaxation leader can be rotated. Depending on the interests of the group, the same practice can be carried out at each meeting, or different practices can be offered each week.

After the relaxation practice, group members take another monitor reading and write journal entries on their experiences and responses. A few minutes should be left for group members to explore and share their experiences with one another. Observe what happens over time. Invite group members to track their medication use and observe overall changes in well-being, blood pressure, headaches, pain, anxiety, and so on.

Special Issues for Groups "I don't have time. I'm too busy. I could be/should be catching up on my work, not relaxing." Sandy O'Brien and Jeanne Anselmo developed a staff wellness project using the practices described above.[81] The answer they found to the challenge of "I don't have time to practice" is that we cannot afford *not* to take time to center ourselves and care for ourselves in order to do the best for our own health while offering the best of care to our clients and families.

While relaxation practice does take time and commitment, most groups learn to avoid giving in to the work-and-hurry sick-

ness and begin to enjoy the benefits of stopping, calming, and letting go.

In fact, according to the Nurses' Health Study from Harvard, the more friends and social ties nurses had the less likely they were to develop physical ailments and the more joyous their life would be. Researchers from UCLA demonstrated that women's social ties reduce the risk of heart disease by lowering blood pressure, cholesterol, and heart rate.[82]

Cautions and Contraindications for Relaxation, Meditation, and Biofeedback

Medications. Clients who take insulin, thyroid replacement medication, antihypertensives, cardiac medications, antianxiety agents, and sleep medications must be monitored for a change in their symptoms and medication needs as they learn to deepen their relaxation response. As clients learn to regulate their stress response, their medication requirements may change. Work closely with clients' prescribing providers to ensure that their medications are titrated properly.[83]

Education and Information. Discussing issues and experiences associated with relaxation before and after each session helps to involve the client, positively empower them, and reframe any of the anticipatory anxiety or questions they may have.

Mental Health History. Clients with a history of dissociative experiences, acute psychosis, borderline personality, and post-traumatic stress disorder are best cared for by nurses and professionals skilled in treating such clients. Check your client's mental health history before beginning relaxation practice.[84]

Cryptotrauma. Many patients have experienced undiagnosed physical and/or psychological trauma. Many times patients are reluctant to disclose these problems, and many times health professionals are unskilled in or uncomfortable with exploring these issues. Domino and Haber reported that 66 percent of women at a multidisciplinary pain center with chronic headaches had a prior history of physical and/or sexual abuse (61 percent had experienced physical abuse; 11 percent, sexual abuse; and 28 percent, both physical and sexual abuse). The average duration of abuse was 8 years.[85]

The term *cryptotrauma* indicates that the trauma which is the cause of the patient's pain is hidden or has not been revealed. Signals to watch for in clients with post traumatic stress disorder and/or cryptotrauma include

- hypervigilance
- difficulty falling or staying asleep
- irritability or outbursts of rage
- difficulty concentrating
- exaggerated startle response
- dissociation
- addiction
- flashbacks
- numbing
- panic attacks
- disturbed self-perception, denigration
- isolation
- inability to be comfortable with touch
- nightmares[86]

Even with the most sensitive and careful history taking and preparations, clients with such disorders can have flashbacks related to the underlying trauma. If this occurs, first, do not panic. Remember your intention to help and support, and trust your therapeutic bond with the client. Second, center and ground yourself. Clients in a panic state related to anxiety or flashback are supersensitive to people around

them; centering, calming, and grounding yourself will deeply help them. Third, reassure the client, speak to the client in a calm, soothing voice, and use therapeutic suggestions. Have the client open his or her eyes, feel their feet on the floor, or touch the furniture; if possible, have the client tighten and release their hands and feet and be aware of their body and of being with you in the present. If appropriate, hold the client's hand; use your judgment. Fourth, remember that the information with which the client is getting in touch is important for the client's wholeness and healing. A simple, short statement explaining this to the client helps to reframe the situation and plant therapeutic suggestions during these most open and suggestible moments. Seek appropriate referrals for the client as needed.

PTSD, Cryptotrauma, and Working in Times of Trauma or Major Crisis

Clients who suffer from cryptotrauma or who have sustained one or more major losses around the time of a disaster are at the greatest risk for developing post traumatic stress disorder (PTSD). Nurses and other helping professionals who are aware of the above-mentioned symptoms for cryptotrauma could be the first line of help for assessing, recognizing, and helping a client, colleague, child, or even a neighbor or family member, suffering from traumatic grief or PTSD after any major community trauma or major crisis.

Richard Schaedle, DSW, Director of Crisis Resource Center at LifeNet at The Mental Health Association of NYC, described dealing with trauma in communities post-9/11. Though everyone grieves differently and most people recover without much intervention, "We needed to alert people about a normal reaction to an abnormal event. For the more pathological symptoms, like traumatic grief and PTSD there were psychotherapy and medication." Schaedle described how "there were no boundaries" between the spiritual and religious helpers and professionals and paraprofessionals; all were needed to help and all needed to be trained to deal with the enormous needs of the community after the attack. Volunteers offered massage therapy, yoga, and spiritual counseling along with community counseling and support groups, all of which helped to destress and reduce trauma in the wake of the September 11th attack.[87]

Increased Incidence of PTSD in the Disaster Region

Immediately after September 11th, New York City's mental health/alcoholism/drug addiction 24-hour helpline turned into 1-800-Lifenet, a hotline designed to deal with the emotional and mental health issues of the NYC community. After September 11th, the number of calls to the hotline doubled from the previous year, and almost two years after the attack, the number of calls to the hotline continued to grow another 25 percent by the summer of 2003. Having this helpline already in place was a great resource for the community, and training of five to seven thousand helping professionals offered a future resource to draw on in case of emergency to address the unprecedented levels of need.[88]

Calls related to September 11th continued to come into LifeNet regarding symptoms, reactions, and PTSD long after the event. As the rest of the city and country move on and feel better, those with PTSD actually get worse and feel even more isolated and out of synch with the rest of the community.

According to John Draper, PhD, Director of Public Education and the LifeNet Hotline Network, prior to September 11th, 1 out of 200 people in the New York metropolitan area would be diagnosed with PTSD. After September 11th, 1 out of 3 were diagnosed with PTSD, and during the summer of 2003 that percentage was still high, with 1 out

of 10 being diagnosed with PTSD. The antithetical dimension of PTSD is that, left untreated, with time the symptoms do not get better but actually get worse.

Those people who suffered an additional loss around the time of the disaster (e.g., job loss, financial crisis, illness or death in the family) had a 4 to 5 times higher possibility of developing PTSD than those that did not have any additional loss or trauma. Those who sustained multiple additional losses around the time of the disaster were 47 to 50 times more likely to develop PTSD.[89]

Why is this of any importance to areas outside the regions directly attacked? One reason is to learn from this lived experience in order to build the awareness, personal and professional resources, education, and skills needed to help one's own community in case of a disaster. Second, living in a very mobile society, nurses and helping professionals could be confronted with a client or patient who has moved away from a disaster area, or has friends or family in the disaster and thereby is at risk for PTSD, which may not be recognized, understood, or supported outside of the area where the crisis occurred. Many people have delayed responses and are not immediately diagnosed as demonstrated by the reports of a 25 percent increase in calls to the LifeNet hotline two years after the disaster. The main statement the LifeNet hotline continues to hear is, "I thought I'd be over this by now." The more time that elapses from the time of the event, the more distressing the symptoms and reactions become for the persons with PTSD.[90]

PTSD is characterized by avoidance, numbness, and feelings of helplessness and hopelessness. For those suffering from PTSD, conversational induction and therapeutic suggestion may be even more helpful and appropriate than any form of deep relaxation.[91] As stated earlier, conversational induction helps to support a person's defenses while promoting comfort; important qualities to be cultivated for PTSD sufferers, especially in the immediate time during or after a major trauma. As in any clinical situation, professional experience, clinical judgment, and the client's comfort level with the intervention all will help to determine what is the best approach for that client.

Because rescue or relief workers and professionals involved with trauma work of disaster victims may have to continuously return to the disaster site and reexperience the crisis, they, too, may experience vicarious traumatization and feel stuck and isolated while other colleagues move on. They need personal, workplace, and community healing support as well.

Holistic Nursing Perspectives for Living in a Time of Uncertainty

According to Dr. Elizabeth Barrett, "Power, from a Rogerian perspective, is the capacity to participate knowingly in the nature of change characterizing the continuous patterning of the human and environmental field. The observable, measurable pattern manifestations of power are awareness, choices, freedom to act intentionally, and involvement in creating change."[92] So, what awareness, choices, intentions, and involvement do we want to offer, as holistic nurses, to foster community unitary well-being in times of uncertainty? How do we help to support empowered awareness and choices in times of helplessness or uncertainty?

Our own practices of self-healing, meditation, and relaxation support us during times of illness and stress by helping us to build inner skills, awareness, and resiliency. Similarly, communities also can cultivate their inner resiliency by building their own inner capacities. Increased training of clergy, child care workers, mental health professionals, teachers, and funeral directors, as well as

nurses, social workers, physicians, chiropractors, and nutritionists, to recognize and deal with various forms of trauma and teach self-care practices and group support, would be one example of developing inner resources of a resilient community.

Sandra Bloom, MD, President of CommunityWorks and an expert in dealing with trauma, makes recommendations for organizations as communities. Dr. Bloom recommends that organizations can facilitate healing after trauma by "viewing the problem as a problem for the entire group and not limited to the individual. A trauma sensitive workplace culture reverses the effects of trauma emphasizing safety, emotional management, grief resolution, and a vision of recovery, change, growth and life after trauma." She also states that a "workplace culture that can respond to the need of trauma survivors will end up being a healthier and more productive environment for everyone."[93]

Times of uncertainty provide holistic nurses with an opportunity to address the potential for building healthy resiliency in ourselves, our communities, organizations, and our society. An acronym for *Choice* is offered by holistic nurse Jeanne Campion, MA, RN, CNS: **C**onsciously **H**elping **O**ne **I**ntentionally **C**hange **E**nergy. She continues in a talk inspired by the first anniversary of September 11th: "We always have CHOICES related to our energy/vibration/level of consciousness. One can choose to respond from a place of centered calm: mindful or one can choose to react from a place of confusion and chaos."[94]

Restorative Practices

As explored previously, relaxation practice can help the individual to center and open to loving-kindness, inner awareness, and connectedness in meditation; to cultivate the relaxation response; and to develop self-regulation abilities through biofeedback. Relaxation practice also brings the gifts of restoring, opening, and renewing.

Yoga

In restorative yoga, practitioners open themselves more deeply to the healing energies that flow through them in each posture (asana). They accomplish this by supporting their bodies in yoga poses using bolsters, pillows, and blankets.[95]

Yoga is a philosophy of living that unites physical, mental, and spiritual health. When practiced for the purpose of relaxation, it involves breathing and stretching exercises and postures. The exercises vary greatly in difficulty. Because yoga starts with very gentle stretches and breathing techniques, it is ideally suited for clients with stiff muscles and decreased activity levels who are attempting to begin an active relaxation and exercise program. Clients need not embrace the philosophy to benefit from the activity.

Daily practice of restorative yoga—even 10 to 15 minutes a day—creates energy, restorative rest, and calm. Restorative yoga is a wonderful practice to perform during a break at work. (See the Resources section for more information.)

Qi Gong

Seasonal Qi Gong practices restore and renew, and center and open meridians as the energy field and body changes with the seasons. Some techniques of Chinese Qi Gong have been practiced for at least 5,000 years. Simple movements are combined with breath and meditation in a flow with nature's healing qi. Restoration and healing come from daily practice. Qi Gong practices are a part of Chinese medicine, which includes acupuncture, external Qi Gong (receiving healing energy from a healer or master), herbal medicine, diet, massage, and self-care. (See Resources section.)

Restorative Gardens

"Nature alone heals"[96] is one of Nightingale's most famous quotes. What Nightingale knew, and what gardeners and nature lovers also know, is that nature can heal and cure. Many hospitals and health care centers are creating healing gardens, restorative gardens, greenhouses, meditative gardens, and labyrinths in their plazas, lobbies, rooftops, and other inner and outer spaces, to help cultivate relaxation, renewal, and peace. Bringing nature inside the healing environment is not at all new; it dates back to medieval monastic healing sanctuaries. The medieval architectural designs included low windows so that patients could look out at nature's beauty.

Simply helping clients to be with nature amid the high-tech health care system can improve their well-being, reduce their anxiety, and calm their fears. Nurses themselves can benefit from resting in a garden or creating natural spaces within the health care setting.[97]

HOLISTIC CARING PROCESS

Assessment

In preparing to use relaxation interventions, the nurse assesses the following parameters and lived experiences:

- the client's perception of personal tension levels and need to relax
- the client's readiness and motivation to learn relaxation strategies, because relaxation is a very subjective and personal endeavor
- the client's past experience with the process of relaxation, hypnosis, or meditation
- the client's personal definition and lived experience of what it means to be relaxed
- the client's ability to remain comfortably in one position for 15 to 30 minutes
- the client's hearing acuity, so that the nurse can speak at an appropriate level while guiding the client in relaxation exercises
- the client's religious beliefs, so that the nurse can present the relaxation process in a way that will meld comfortably with the client's belief system
- the client's level of pain or discomfort, anxiety, fear, or boredom
- the client's perception of reality, history of depersonalization states, and locus of control, because deep relaxation may exacerbate the symptoms of psychotic and prepsychotic individuals
- the client's medication intake, particularly of medications that may alter response to relaxation or that may need to be titrated as relaxation progresses

A questionnaire can be used to complete the assessment. The information gathered in the questionnaire provides starting points for discussion and further exploration.

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with relaxation interventions that are related to the 13 domains of Taxonomy II (see Chapter 14):

- Social isolation
- Altered coping; ineffective individual and family
- Activity intolerance, actual or potential
- Deficit in diversional activity
- Powerlessness
- Altered self-concept; disturbance in self-esteem, role performance, personal identity
- Altered sensation/perception: visual, auditory, kinesthetic, gustatory, tactile, olfactory

- Altered thought processes
- Anxiety
- Altered comfort: pain
- Fear
- Potential for violence: self-directed or directed at others

Outcomes

Exhibit 21–8 guides the nurse in client outcomes, nursing prescriptions, and evaluations for the use of relaxation as a nursing intervention.

Therapeutic Care Plan and Interventions

Before the Session

- Become personally familiar with the experience of the relaxation intervention before approaching the client.
- If the client has previous positive experience with a particular relaxation intervention, encourage further practice and use of that intervention.
- Review with the client his or her lived experience and gather information from the chart, diaries, and/or verbal self-report concerning pain, anxiety, and activity levels since the last session.

Preparation of the Environment (Ideal)

- Arrange medical and nursing care to allow for 15 to 45 minutes of uninterrupted time.
- Keep the room warm and ventilated, not cold.
- Shut the door or otherwise decrease extraneous noise and distraction. Place a note on the door indicating a need for privacy until a designated time.

Exhibit 21–8 Nursing Interventions: Relaxation

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client will demonstrate decreased anxiety, tension, and other manifestations of the stress response as a result of the relaxation intervention.	Guide the client in the relaxation exercise. Evaluate for decrease in anxiety, tension, and other manifestations of the stress response as evidenced by heart rate within normal limits, decreased respiratory rates, return of blood pressure toward normal, resolution of anxious facial expressions and mannerisms, decrease in repetitious talking or behavior, and inability to sleep or restlessness.	The client exhibited decreased anxiety, tension, and other manifestations of the stress response as evidenced by normal vital signs; a slow, deep breathing pattern; and decreased anxious behaviors.
The client will demonstrate a stabilization or decrease in pain as a result of the relaxation intervention.	Evaluate for decrease in pain as evidenced by reduction or elimination of pain control medication and increased activities or mobility.	The client's intake of pain medication stabilized and then decreased with relaxation skills practice. The client began to participate in activities previously limited by pain.
The client will link breathing awareness to a commonly occurring cue and use this combination to reduce tension.	Teach awareness of breathing patterns and habitual linking of relaxing breathing to a cue in the environment.	The client used turning in bed as a cue to take a slow, deep breath and relax jaw muscles.

- Unplug the telephone or ask a family member or roommate to answer the telephone should it ring during the relaxation training session.
- Reduce lighting to a low level.
- Use natural or incandescent lighting if possible; fluorescent lighting can cause headaches in some patients.

Client Comfort Measures

- Have the client empty his or her bladder before starting the intervention.
- Help the client find a comfortable sitting or reclining position, with hands resting by the sides or on the thighs.
- Ensure the client's comfort by providing a blanket or by adjusting the thermostat to a comfortably warm setting; have small, soft pillows available for positioning.

Timing of the Session (Ideal)

- Hold the training session before meals or more than 2 hours after the last meal. A full stomach coupled with relaxation may lead to sleep.

Support Tools

- Have available music tapes/CDs and a CD and tape recorder/player.
- If the session is to be followed by drawing, have paper, crayons, or markers available.
- Tell the client that you may ask simple yes or no questions during the session to check the comfort level of the music or to confirm the client's understanding of verbal instructions. The client may answer these questions by raising a preestablished 'yes' finger or 'no' finger or nodding the head.

At the Beginning of the Session

- Review briefly the potential benefits of relaxation intervention and enlist the client's cooperation. Explore the client's lived experience of relaxation and stress.
- Explain to the client that relaxation may be easier if practiced with the eyes closed. The client may drift off to sleep, but this position allows the client to focus attention inward while remaining awake. This may take practice to accomplish, and many times clients fall asleep due to exhaustion or lack of sleep. In such a case, the restorative dimension of relaxation is at work and the nurse has still introduced therapeutic suggestions.
- Explain that one purpose of breathing and relaxation exercises is to experience inward relaxation and become aware of the body-mind-spirit connections associated with relaxation.
- Emphasize that you are merely a guide, and that any therapeutic results obtained from the session are due to the client's involvement, interest, and practice.
- Let go of outcomes. There is an ebb and flow to the learning experience. Encourage the client to practice for comfort and awareness, noting shifts in breathing, anxiety, and sensations.
- Arrive at mutually agreeable goals for the session, such as reduction of pain, decreased time to sleep onset, reduction of anxiety, or enhanced well-being.
- Have the client quantify the level of the parameter to be changed; for example, "My pain or anxiety level right now is 7 on a scale of 0 (none) to 10 (extreme pain)." Record the level before and after the session.
- Record baseline vital signs. If biofeedback equipment is used, record baseline readings.
- Assure the client that sensations of heaviness, warmth, floating, or lightness are naturally occurring indications of deep relaxation; explain that the client can end the experience at any moment he or she desires by opening the eyes, tightening the fists, and/or stretching; this will orient the client and enable the exercise to continue.

- Begin soft background music. (See Chapter 23 for suggestions regarding music selection.)
- Guide the client through a basic breathing relaxation exercise. Breathing exercises may be repeated slowly for several minutes as an introduction to deeper relaxation.
- Start the session with short breathing or relaxation exercises (5 minutes); lengthen the exercises to 10 to 20 minutes as the client becomes better able to relax and attend to inner thoughts and feelings.

During the Session

- Phrase all therapeutic suggestions and self-statements in a positive form. For example, say "I am aware of comfort moving down my arm and into my hand," rather than, "I am not in pain." These therapeutic suggestions enhance the process and reframe the experience.
- Speak in a relaxed manner. Ask the client for feedback concerning the appropriateness of the practice and his or her ability to hear the background music and instructions. Have the client respond with a finger movement (using signals established before the session) or nod of the head, and make adjustments as necessary.
- Pace your instructions according to the following visual cues from the client. Each indicates a deepening of relaxation.
  - —change in breathing pattern: slower, deeper breaths progressing to slow, somewhat shallower breathing as relaxation deepens
  - —more audible breathing
  - —fluttering of eyelids
  - —blanching of the skin around the nose and mouth
  - —easing of jaw tightness, sometimes to the extent that the lips part and the jaw drops slightly
  - —if client is supine, pointing of toes outward rather than straight up
  - —complete lack of muscle holding (ask client's permission to lift arm gently by the wrist; no resistance should be felt and the arm should move as easily as any other object of similar weight)
- Modify your instructions and strategies to fit the situation. Encourage an intubated and ventilated patient who cannot control respiratory rate or volume to drop the jaw and allow the rhythm of the ventilator to soothe tight muscles, for example. Gently placing your hand over the clavicle or holding the person's hand as you speak enhances the therapeutic relationship and supports relaxation.
- Intersperse your instructions with therapeutic suggestions of encouragement that the client can use after the session as cues to recapture aspects of the relaxation experience. Examples of such phrases are:
  - —Perhaps you are noticing a softening of your muscles.
  - —As you take your next breath, become aware of how the warmth is flowing down your arm.
  - —Deep breathing helps to replenish the oxygen and energy of the body and helps the body heal, relax, restore, and renew.
- As the client relaxes, he or she may experience a release of emotional life issues, which can surface in the conscious mind. Be alert for signs of emotional discomfort or letting go, such as tears or a change in breathing to deeper, faster breaths. If such a sign occurs, ask gentle questions (e.g., "Can you put those feelings into

words and express them safely?") and allow time for the client to express and deal with the material before continuing with or concluding the session. (See the earlier section on cryptotrauma/trauma for more information on helping clients stay grounded if they tap into emotion-laden material.) Often, clients in a deeply relaxed state gain insight into how to resolve problems or which directions to take in their lives.

At the End of the Session

- Bring the client gradually into a wakeful state by suggesting that he or she take deep, energizing breaths, begin to move hands and feet, and stretch; orient the client to the room, talking with the client about the comfort he or she created.
- Have the client reevaluate, on the scale of 0 to 10 used earlier, the level of comfort or severity of the parameter previously selected to be changed. Record the level.
- Allow time for discussion of the experience, including discussion of the techniques that seemed especially effective and the client's physical, emotional, and energy awareness. Invite the client to express his or her experience by writing, making a journal entry, or drawing. Different clients will prefer different methods, such as creating an abstract drawing, offering a story, or writing poetry, to express their experience.
- Ensure that medication changes, if indicated, are appropriately monitored.
- Engage the client in continuing practice on an individually assigned basis until the next session.
- Help the client choose supportive measures for practicing his or her relaxation skill.
- Review a log or journal in which the client records relaxation practice, symptoms, medications, time, and results.

Case Studies

Case Study No. 1

Setting:	Outpatient; multidisciplinary holistic health care center
Client:	S.D., a 47-year-old African-American man with family history of stroke
Medical Diagnosis:	Progressive essential hypertension, unresponsive to any antihypertensive therapy
Current Medications:	Catapres, Lasix, Valium, Minipress, potassium chloride
Patterns/ Challenges/ Needs:	1. Altered physical regulation (essential hypertension) 2. Anxiety 3. Fear 4. Powerlessness 5. Ineffective coping related to anxiety, stress of job, and parenting of five children 6. Self-esteem disturbance, situational

S.D. had been diagnosed with severe uncontrollable essential hypertension. He scrupulously took his antihypertensive medications and had an extensive clinical workup to rule out any secondary causes. S.D. was very frustrated, because his father had died of a stroke and S.D. did not want to have a stroke or "die young." He and his wife cared for their five children. He worked at a job that required him to perform physical labor and walk up and down three flights of stairs.

His physician sent him to learn biofeedback-assisted relaxation as an adjunctive therapy. His blood pressure at rest while on medication ranged from 160/100 to 200/120 millimeters of mercury (mm Hg). To reduce S.D.'s fear and feeling of powerlessness, the nurse explored his lived experience of his condition and used health care teaching and stress management counseling to reframe his understanding of what was happening in his body.

The nurse explained to S.D. that his body knew very well how to respond to stress, but that he needed the opportunity and the time to recover from stress and learn less physically distressing ways to respond. S.D. was shown how to use the temperature trainer and a small galvanic skin response unit that indicated sympathetic outflow by measuring sweat gland response. He was taught simple breathing exercises and autogenic phrases while he learned to monitor his body-mind-spirit response on the biofeedback displays.

Because of the urgency and critical nature of his situation, he was invited to participate in three practice sessions a week for one month instead of the usual one session per week. He was asked to practice the relaxation two times a day. Within the first two weeks, he had brought his blood pressure down to 140/100 mm Hg. He continued sessions each week during the second month and then continued practice on his own. After three months, his blood pressure was 140/80 mm Hg while he continued on the same level of medication.

After one year, his medication level was reduced, and blood pressure was maintained at 140/80 mm Hg. The nurse scheduled a meeting with S.D., his wife, and all their children to explore their needs, fears, and concerns about S.D.'s health. The family agreed to help support S.D. in his health care practice by making sure he was not disturbed during his practice time. The opportunity to share their love and support, and to understand how their loved one was working to help himself, offered them a new understanding of their father/husband, his health care issues, and how they could be active in his wellness plan.

Case Study No. 2

Setting:	Home care and hospital preoperative and postoperative care
Client:	M.D., a 76-year-old European-American woman undergoing surgery for renal tumor
Patterns/ Challenges/ Needs:	1. Altered physical regulation (renal tumor) 2. Anxiety 3. Fear 4. Ineffective coping related to renal tumor, possible cancer 5. Powerlessness

M.D. complained of back pain. A sonogram revealed a large renal tumor. The surgeon told M.D. and her husband the results of the sonogram and recommended surgery within the next five days. M.D. and her husband were very upset after their visit to the surgeon and consulted with a nurse in private practice about methods of readying for surgery.

Because of M.D.'s shock and anxiety, and her fear about the possible outcome of the surgery, the nurse discussed with the client, her family, and the surgeon whether or not the surgery had to be performed immediately. The surgeon had determined that the tumor was a slow-growing mass that had been present for at least two years. The surgeon agreed that the surgery could be scheduled two weeks later to give M.D. time to prepare her body-mind-spirit for the experience.

M.D. was taught breathing and meditation exercises, began receiving Reiki energy sessions, and, with preoperative

teaching, began to create visualizations of surgery as a healing experience. The two-week delay gave her a chance to reduce the shock and include her family and her parish in her preparation. Members of her women's group at the church prayed for her and were "breathing toward her," sending spiritual energy, love, and support. Her family from out of town had an opportunity to come and escort her to the hospital. Most importantly, she was able to prepare and practice her relaxation healing surgery experience so that, in the preoperative room, she was so relaxed that she told the nurse she was resting on the "breath of God."

Her relaxation practice included quiet meditation, prayer, deep breathing, and visualization of each of the steps that would occur, from the night before the surgery through the ride to the hospital, the preoperative preparation, surgery, and recovery.

Interspersed throughout her educational preparation were the therapeutic suggestions that there would be very little pain or bleeding and no infection from the surgery, and that everyone who was in contact with her could be a vehicle for sending healing light and energy. Every intravenous line, medication, procedure, and caretaker became a part of her visualization.

M.D.'s holistic nurse went with her into the preoperative area and helped her practice her relaxation strategies; the nurse also informed the rest of the surgical team of M.D.'s plan to practice during the surgery. The staff wanted to know if their other patients could learn these practices, since M.D.'s response was so positive.

M.D.'s surgery went well. She did have cancer, but she continued to use the practices she had learned and extended them into an ongoing wellness plan. These practices improved her well-being, energy, and spirit; enhanced her immune function; and slowed the progression of the disease. She died four years later, practicing relaxation through to the moment of her death. These practices wove together her spiritual life, her desire to be an active participant in her care, and her understanding of her health, wellness, and well-being.

Evaluation

With the client, the nurse determines whether the client outcomes for relaxation interventions (see Exhibit 21–8) were successfully achieved. To evaluate the session further, the nurse may again explore the subjective effects of the experience with the client (Exhibit 21–9). Because the accomplishment of these interventions may take place over a period of days or weeks, they must be reviewed and reevaluated periodically. Continuing support and encouragement are necessary.

Relaxation exercises can be taught to clients under almost any circumstances. They not only reduce the fear and anxiety associated with many medical and nursing interventions but, once learned, may be used in all aspects of a client's life. They increase the overall movement toward wholeness and balance for both

Exhibit 21–9 Evaluation of the Client's Subjective Experience of Relaxation

1. Was this a new experience for you? Can you describe it?
2. Did you have any physical or emotional responses to the relaxation exercises? If so, can you describe them?
3. Do you feel different after this experience? How?
4. How does your bodymind communicate with you when your stress level is at an uncomfortable point?
5. Would you like to do this again?
6. Were there any distractions to your relaxation?
7. What would make this a more pleasant experience for you?
8. How do you see yourself integrating relaxation skills into your daily life?

client and nurse, and they facilitate other interventions by allowing the client to move toward learning and participating more fully in his or her own health promotion.

DIRECTIONS FOR FUTURE RESEARCH

1. Correlate the changes in psychophysiology with the specific relaxation interventions used to determine the most effective interventions and their presentation.
2. Conduct tightly structured studies to evaluate relaxation techniques, using control groups to validate changes brought about by relaxation exercises.
3. Monitor and validate the effect of the "compassionate guide" in the relaxation process.
4. Conduct qualitative studies to explore the meaning of the client's lived experience of phenomena relevant to nursing.
5. Monitor and validate the effect of conversational suggestion and sustained centering for enhancing comfort and calm in crisis situations.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin the process of answering the following questions:

- How does my inner experience of tension or anxiety shift when I release my muscle tightness?
- How do I model relaxation to my family, friends, colleagues, and clients?
- What is my kinesthetic experience of letting go of tension, concerns, and physical and emotional stresses?
- What cues about my inner experience of tension or relaxation do I receive from my breathing pattern?
- How do I cultivate peace of mind as I move through my potentially stressful job activities?
- Am I aware that my attitudes toward my tasks are contagious to my clients?
- What dimensions of resiliency are found/needed in my workplace and/or community?

NOTES

1. G. Fuller, *Biofeedback: Methods and Procedures in Clinical Practice* (San Francisco: The Biofeedback Institute of San Francisco, 1977), 1.
2. N. Meinhart and M. McCaffery, *Pain: A Nursing Approach to Assessment and Analysis* (East Norwalk, CT: Appleton-Century-Crofts, 1983), 377.
3. E.A. Barrett, The Theoretical Matrix for a Rogerian Nursing Practice, *Theoria: Journal of Nursing Theory* (9)4 (2000):3–6.
4. K. Phillips, Biofeedback as an Aid to Autogenic Training, in *Mind and Cancer Prognosis*, ed. B. Stoll (New York: John Wiley & Sons, 1979), 153.
5. M. McCaffery, Relieving Pain with Noninvasive Techniques, *Nursing* 80, no. 12 (1980):57.
6. F. Nightingale, *Notes on Nursing, Commemorative Edition* (Philadelphia: J.B. Lippincott Co., 1992), 28.
7. J. Kabat-Zinn, *Full Catastrophe Living: Using the Wisdom of Your Body and Mind To Face Stress, Pain, and Illness* (New York, NY: Bantam Doubleday Dell Publishing Group, 1990).
8. D. Ornish, *Dr. Dean Ornish's Program for Reversing Heart Disease* (New York: Random House, 1990).
9. D. Kreiger, *Accepting Your Power To Heal: The Personal Practice of Therapeutic Touch* (Santa Fe, NM: Bear and Co. Publishing, 1993), 17–20.
10. D. Krieger, *Characteristics of Integration During The Healing Moment*, Keynote Address at the 5th Annual Holism and Nursing Confer-

ence, Zeta Omega Chapter-at–Large of Sigma Theta Tau International, Inc, Wainwright House, Rye, NY, May 16, 2003.

11. A. Chah, The Fine Arts of Relaxation, Concentration, and Meditation: Ancient Skills for Modern Minds, © Joel and Michelle Levey, 2003. Reprinted with permission of Wisdom Publications, Somerville, MA.
12. Kabat-Zinn, *Full Catastrophe Living*, 248–273.
13. H. Benson et al., Decreased Premature Ventricular Contraction through the Use of the Relaxation Response in Patients with Stable Ischemic Heart Disease, *Lancet* 2, no. 7931 (1975):380.
14. M. Frenn et al., Reducing the Stress of Cardiac Catheterization by Teaching Relaxation, *Dimensions of Critical Care Nursing* 5, no. 2 (1986):108–116.
15. H. Benson, *Beyond the Relaxation Response* (New York: Times Books, 1984).
16. Ibid.
17. H. Benson, Your Innate Asset for Combating Stress, in *Relax: How You Can Feel Better, Reduce Stress, and Overcome Tension*, eds. J. White and J. Fodeman (New York: Confucian Press, 1976), 53–54.
18. Ibid.
19. Ibid.
20. Ibid.
21. Kabat-Zinn, *Full Catastrophe Living*.
22. H. Benson et al., Decreased Blood Pressure in Borderline Hypertensive Subjects Who Practiced Meditation, *Journal of Chronic Diseases* 27 (1974):163–169.
23. H. Benson et al., Decreased Blood Pressure in Pharmacologically Treated Hypertensive Patients Who Regularly Elicited the Relaxation Response, *Lancet* 1 (1974):289–291.
24. J. Kabat-Zinn et al., Effectiveness of a Meditation-Based Stress Reduction Program in the Treatment of Anxiety Disorders, *American Journal of Psychiatry* 149, no. 7 (1992):936–943.
25. J. Miller et al., Three Year Follow Up and Clinical Implication of Mindfulness Meditation-Based Stress Reduction Intervention in the Treatment of Anxiety Disorders, *General Hospital Psychiatry* 17 (1995):192–200.
26. J. Kabat-Zinn, An Outpatient Program in Behavioral Medicine for Chronic Pain Patients on the Practice of Mindfulness Meditation: Theoretical Considerations and Preliminary Results, *General Hospital Psychiatry* 4 (1982):33–47.
27. J. Kabat-Zinn et al., Four-Year Follow Up of a Meditation-Based Program for the Self Regulation of Chronic Pain: Treatment Outcomes and Compliance, *Clinical Journal of Pain* 2 (1987):154–173.
28. J. Bernhard et al., Effects of Relaxation and Visualization Technique as an Adjunct to Phototherapy and Photochemotherapy of Psoriasis [correspondence], *Journal of the American Academy of Dermatology* 19, no. 3 (1988):572–573.
29. Roth et al., Mindfulness-based Stress Reduction and Healthcare Utilization in the Inner City: Preliminary Findings, *Alternative Therapies* 8, no. 1 (2002):60–67.
30. J. Meisenhelder et al. Prayer and Health Outcomes in Church Members, *Alternative Therapies* 6, no. 4 (2000):56–61.
31. D. Ornish et al., Can Lifestyle Changes Reverse Coronary Artery Disease? *Lancet* 336 (1990):129.
32. Ibid.
33. Ornish, *Dr. Dean Ornish's Program for Reversing Heart Disease*.
34. A. Moadel et al., Randomized Controlled Trial of Yoga for Symptom Management During Breast Cancer Treatment, Paper presented at 39th Annual Meeting of the American Society of Clinical Oncology, Chicago, IL (May–June 2003).
35. K. Ankun et al., Research on "Anti-Aging" Effect of Qi Gong, *Journal of Traditional Chinese Medicine* 2, no. 2 (1991):153.
36. Y. Lim et al., Effects of Qi Gong on Cardiorespiratory Changes: A Preliminary Study, *American Journal of Chinese Medicine* 21, no. 1 (1993):106.
37. C.T. McGee et al., Qi Gong in Traditional Chinese Medicine, in *Fundamentals of Complementary and Alternative Medicine*, ed. M.S. Micozzi (New York: Churchill Livingstone, 1996).
38. H. Ryu et al., Acute Effect of Qi Gong Training on Stress Hormonal Levels in Man, *American Journal of Chinese Medicine* 24, no. 2 (1996):193.
39. M. Li et al., Use of Qigong Therapy in the Detoxification of Heroin Addicts, *Alternative Therapies* 8, no. 1 (2002):50–59.
40. Krieger, *Accepting Your Power to Heal*, 17.
41. Krieger, *Characteristics of Integration During The Healing Moment*.
42. Kabat-Zinn, *Full Catastrophe Living*.
43. Ornish, *Dr. Dean Ornish's Program for Reversing Heart Disease*.
44. J. Macrae, *Therapeutic Touch: A Practical Guide* (New York: Alfred A. Knopf, 1987).

45. T. Nhat Hanh, *The Blooming of a Lotus: Guided Meditation Exercises for Healing and Transformation* (Boston: Beacon Press, 1993), 17.

46. T. Nhat Hanh, *The Long Road Turns to Joy: A Guide to Walking Meditation* (Berkeley: Parallax Press, 1996), 8.

47. T. Nhat Hanh, *Teachings on Love* (Berkeley, CA: Parallax Press, 1997), 21.

48. B. Barnum, *Spirituality in Nursing: Form Traditional to New Age*, 2nd ed. (NYC, NY: Springer Publishing, 2003), 165.

49. E. Jacobson, *Progressive Relaxation* (Chicago: University of Chicago Press, 1938).

50. J. Lyles et al., Efficacy of Relaxation Training and Guided Imagery in Reducing the Adverseness of Cancer Chemotherapy, *Journal of Consulting and Clinical Psychology* 50 (1982):509–529.

51. J. Keicolt-Glaser et al., Psychosocial Enhancement of Immunocompetence in a Geriatric Population, *Health Psychology* 4 (1985):25– 41.

52. C.E. Guzzetta, Effects of Relaxation and Music Therapy on Patients in a Coronary Care Unit with Presumptive Acute Myocardial Infarction, *Heart and Lung* 18 (1989):609–616.

53. C.D. Wagner et al., The Effectiveness of Teaching a Relaxation Technique to Patients Undergoing Elective Cardiac Catheterization, *Journal of Cardiovascular Nursing* 6, no. 2 (1992):65–75.

54. J. Schultz and W. Luthe, *Autogenic Training: A Psychophysiologic Approach in Psychotherapy* (New York: Grune & Stratton, 1959).

55. T. Dierks et al., Brain Mapping of EEG in Autogenic Training (AT), *Psychiatry Research* 29 (1989):433–434.

56. E. Blanchard et al., Behavioral Treatment of 250 Chronic Headache Patients: A Clinical Replication Series, *Behavior Therapy* 16 (1985):308–327.

57. S. Fahrion, Hypertension and Biofeedback, *Primary Care* 18 (1991):663–682.

58. R. Freedman, Long Term Effectiveness of Behavioral Treatments for Raynaud's Disease, *Behavior Therapy* 18 (1987):387–399.

59. B. Enquist et al., Preoperative Hypnosis Reduces Postoperative Vomiting after Surgery of Breasts: A Prospective Randomized and Blended Study, *Acta Anaesthesiologica Scandinavia* 41, no. 8 (1997):1028–1032.

60. C. Ashton et al., Self-Hypnosis Reduces Anxiety following Coronary Artery Bypass Surgery: A Prospective, Randomized Trial, *Journal of Cardiovascular Surgery* 38, no. 1 (1997):69–75.

61. M. La Vorgna-Smith, Hypnotherapy/Meditation and Mind/Body Healing: A Phenomenological Study of Women with Osteoporosis [abstract]. Presented at the Second Annual Alternative Therapies Symposium, Orlando, FL, 1997.

62. W. Whitehead et al., Biofeedback for Disorders of Elimination: Fecal Incontinence and Pelvic Floor Dyssynergia, *Professional Psychology: Research and Practice* 27, no. 3 (1996):234–240.

63. A. McGrady et al., Biofeedback-Assisted Relaxation in Insulin Dependent Diabetes: A Replication and Extension Study, *Annals of Behavioral Medicine* 28, no. 3 (1996):185.

64. Schultz and Luthe, *Autogenic Training*.

65. R. Davidson et al., The Psychobiology of Relaxation and Related States: Multiprocess Theory, in *Behavioral Control and the Modification of Physiological Processes*, ed. D.J. Mostofsky (Englewood Cliffs, NJ: Prentice-Hall, 1976).

66. Ibid.

67. W. Linden, The Autogenic Training Method of J.H. Schultz, in *Principles and Practice of Stress Management*, 2nd ed., eds. P.M. Lehrer et al. (New York: Guilford Press, 1993).

68. P. Lehrer et al., Effects of Progressive Relaxation and Autogenic Training on Anxiety and Physiological Measures with Some Data on Hypnotizability, in *Stress and Tension Control*, eds. F.J. McGuigan et al. (New York: Plenum Publishing, 1980).

69. S. Shapiro et al., Psychophysiological Effects of Autogenic Training and Progressive Relaxation, *Biofeedback and Self-Regulation* 5 (1980):249–255.

70. H. Benson, *The Relaxation Response* (New York: William Morrow and Co., 1975).

71. D. Larkin, *Interview*, College of New Rochelle, June 16, 2003.

72. D. Cheeks, Hypnosis, in *The Complete Guide to Holistic Medicine Health for the Whole Person*, eds. A. Hastings et al. (New York: Bantam Books, 1981), 141–156.

73. B. Rogers, Therapeutic Conversation and Posthypnotic Suggestion, *American Journal of Nursing* 72 (1972):714–717.

74. D. Larkin, Therapeutic Suggestion, in *Relaxation and Imagery: Tools for Therapeutic Communication and Intervention*, ed. R. Zahorek (Philadelphia: W.B. Saunders Co., 1988).

75. E. Jacobs et al., Ericksonian Hypnosis and Approaches with Pediatric Hematology

Oncology Patients, *American Journal Clinical Hypnosis* 41:2 (October 1998):139–153.

76. Larkin, Therapeutic Suggestion, 88.
77. N. Cousins, invited address, Institute of Noetic Sciences, New York Chapter, NYU Medical Center Dental School, New York, Fall 1988.
78. Jacobs et al., Ericksonian Hypnosis and Approaches with Pediatric Hematology Oncology Patients.
79. E. Green and A. Green, *Biofeedback the Yoga of the West* (Cos Cob, CT: Hartley Film Foundation, 1970).
80. Ibid.
81. S. O'Brien, Staff Wellness Program Promotes Quality Care, *American Journal of Nursing* 98, no. 6 (1998):16B.
82. S.E. Taylor et al., Female Responses to Stress: Tend and Befriend, Not Fight or Flight, *Psychological Review* 107, no. 3 (2000):41.
83. M. Schwartz, Selected Problems Associated with Relaxation Therapies and Guidelines for Coping with the Problems, in *Biofeedback*, 3rd Ed. eds. M. Schwartz et al. (New York: Guilford 2003).
84. Ibid.
85. J. Domino et al., Prior Physical and Sexual Abuse in Women with Chronic Headaches: Clinical Correlates, *Headache* 27 (1987):310–314.
86. Ibid.
87. R. Schaedle, DSW, Director of Crisis Resource Center at LifeNet at The Mental Health Association of NYC, *unpublished personal interview*, June 25, 2003.
88. J. Draper PhD, Director of Public Education and the LifeNet Hotline Network, *unpublished personal interview*, July 9, 2003.
89. Ibid.
90. Ibid.
91. D. Larkin PhD, RN, CS, Assistant Professor, College of New Rochelle School of Nursing, *unpublished personal interview*, June 16, 2003.
92. Barrett, The Theoretical Matrix for a Rogerian Nursing Practice.
93. S. Bloom, *After 9/11: Living with Grief: Workplace Strategies for Support and Response*, presentation given at NYU Medical Center, New York City, September 24, 2002.
94. J. Campion, *Spirituality and Holism in Nursing Self Care Practice*, presentation given at the 5th Annual Holism and Nursing Conference, Zeta Omega Chapter-at–Large of Sigma Theta Tau International, Inc, Wainwright House, Rye, NY, May 16, 2003.
95. J. Laster, *Relax, Renew: Restful Yoga for Stressful Living* (Berkeley, CA: Rodwell Press, 1995).
96. Nightingale, *Notes on Nursing*, 74.
97. N. Gerlach-Spriggs et al., *Restorative Gardens: The Healing Landscape* (New Haven, CT: Yale University Press, 1998).

SUGGESTED READING

Anselmo, J., Dancing with the chaos: a grassroots approach to transformation and healing in nursing, in *Policy and politics in nursing and health care*, 4th ed., eds. D. Mason and J. Leavitt (Philadelphia: W.B. Saunders Co., 2002).

Anselmo, J., Holistic nursing practice and complementary modalities, in *Psychiatric nursing: an integrative approach of theory and practice*, eds. P. O'Brien and K. Ballard (New York: McGraw-Hill Book Co., 1999).

Goleman, D., *Destructive emotions: how can we overcome them?* (New York: Bantam Books 2003).

Nhat Hanh, T., *The blooming of the lotus, the miracle of mindfulness: a manual on meditation* (Boston: Beacon Press, 1976).

Nhat Hanh, T., *Peace is every step: the path of mindfulness in everyday life* (New York: Bantam Books, 1991).

Nhat Hanh, T., *Teachings on love* (Berkeley, CA: Parallax Press, 1997).

Kabat-Zinn, J., *Full catastrophe living: using the wisdom of your body and mind to face stress, pain, and illness* (New York: Bantam Doubleday Dell Publishing Group, 1990).

Larkin, D., Nursing, in *Medical hypnosis: an introduction and clinical guide*, ed. R. Tames (New York: Churchill Livingstone, 1999).

Lehrer, P., Woolfork, R., *Principles and practice of stress management*, 2nd ed. (New York: Guilford Press, 1993).

Levey, J. Levey, M., *The fine arts of relaxation, concentration, and meditation: ancient skills for modern minds* (Somerville, MA: Wisdom Publications, 2003).

Macrae, J., *Nursing as a spiritual practice: a contemporary application of Florence Nightingale's views* (New York: Springer Publishing, 2001).

Schwartz, M., *Biofeedback: a practitioner's guide*, 3rd Ed. (New York: Guilford Press, 2003).

Snyder, M., Lindquist, R., *Complementary/alternative therapies in nursing*, 4th ed. (New York: Springer Publishing, 2002).

RESTORATIVE PRACTICES

Restorative Yoga

Larson, J., and Howard, K., *Yoga mom, Buddha baby: the yoga workout for new moms* (New York: Bantam Books, 2002).

Lasater, J., *Relax, renew: restful yoga for stressful living* (Berkeley: Rodwell Press, 1995).

Restorative Gardens

Gerlach-Spriggs, N. et al., *Restorative gardens: the healing landscape* (New Haven: Yale University Press, 1998).

Qi Gong

Chia, M., *Chi self massage: the Taoist way of rejuvenation* (Huntington, NY: Healing Tao Books, 1986).

Wang, S., and Liv, J., *Qi gong for health and longevity: the ancient Chinese art of relaxation, meditation and physical fitness*, East Health (Tustin, CA: Development Group, 1995).

RESOURCES

The Relaxation Response

The Mind Body Medicine Institute
Division of Behavioral Medicine
New England Deaconess Hospital
185 Pilgrim Road
Boston, MA 02215
(617) 732-9530

Biofeedback Certification

Biofeedback Certification Institute of America
10200 West 44th Avenue #304
Wheat Ridge, CO 80033
(303) 420-2902

Mindfulness Meditation

Stress Reduction Clinic
University of Massachusetts Medical Center
Worcester, MA 01655
(508) 856-1616

Subtle Energy and Energy Medicine

International Society for the Study of Subtle Energy and Energy Medicine
356 Goldco Circle
Golden, CO 80403
(303) 278-2228

Yoga, Relaxation, Qi Gong

Check local holistic education institutes, universities, continuing education programs, Chinese energy medicine centers, yoga ashrams, and health food stores for resources in your area.

Hypnosis

American Society of Clinical Hypnosis
2200 East Devon Avenue, Suite 291
Des Plaines, IL 60018

The College Of New Rochelle
Department of Nursing
29 Castle Place
New Rochelle, NY 10805
(914) 576-5213

Biofeedback Workshops: Temperature Units, Stress Dots, Alcohol Thermometers, Stress Cards

Call Association for Applied Psychophysiology and Biofeedback for full listing of distributors.

Association for Applied Psychophysiology and Biofeedback
10200 W. 44th Avenue · Suite 304
Wheat Ridge, CO 80033-2840
(t) (303)422-8436
(f) (303)422-8894
AAPB@resourcenter.com

Online Audio/Video Guided Meditations

See *www.Beliefnet.com*.

PTSD and Resilient Communities

See www.sanctuaryweb.com.

Modeling a Wellness Lifestyle

Nurses must first identify their own state of wellness and then model a wellness lifestyle if they are to be effective teachers. Wellness is an evolving process that does not just happen. It requires ongoing self-assessments in all areas of human potential, as well as investigation of one's values and beliefs. Nurses should reflect on these questions about their state of wellness:

- *Do I see wellness as a fluctuating state that I can continuously participate in creating?*
- *Do I see my health as affected and determined by family, friends, job, and environment?*
- *Do I think that I can learn new wellness behaviors?*
- *Is the responsibility for my staying well mine or someone else's?*

Self-responsibility for wellness resides within each of us. The key elements of a wellness program should include all areas of the circle of human potential (see Chapter 15). Through these areas, we focus on maximizing wellness. In planning a wellness program, we must develop and incorporate four basic and critical factors: (1) a positive self-image, (2) a positive attitude, (3) self-discipline, and (4) integration of body-mind-spirit. Each person will develop and incorporate these factors in his or her own unique way.

A positive self-image is a view of oneself as a worthy human being. We must continue to develop keenly all of our senses and see ourselves as well in all respects—physical, mental, emotional, social, and spiritual. A positive attitude means that we like and respect ourselves in all that we do. To thrive in this life, we must learn to respect our body-mind-spirit. We also must learn self-discipline, which embodies the idea of being calm and consistently following positive wellness patterns, such as relaxation, exercise, play, and good nutrition. Body-mind-spirit integration means that we see ourselves as a whole. We learn to "walk our talk" of integration in both the personal and the professional aspects of our lives. We must learn to be more humane to ourselves. We are part of a whole universe, and we must see this relationship in terms of interacting wholes that are different from the sum of the parts. We must feel a keen sense of balance and relatedness between who we are, where we are, and how we interact with everyone.

Application of the wellness model to our own lives can assist us in feeling whole and inspired about life. To apply the model, we need to

- *search for patterns and antecedents or precipitants of stress and anxiety*
- *identify positive feelings and emotions*
- *emphasize our human values*
- *assess any pain and disease as valuable*

signals of internal conflict, not as totally negative events
- *emphasize the achievement of maximal body-mind-spirit wellness*
- *view the elements of the body-mind-spirit as equal factors, with one element never more important than the others*

Chapter 22

Imagery: Awakening the Inner Healer

Bonney Gulino Schaub and Barbara Montgomery Dossey

NURSE HEALER OBJECTIVES

Theoretical

- Define and contrast the different types of imagery.
- Discuss the different theories of imagery.
- Explain different imagery interventions.

Clinical

- Incorporate imagery interventions into your clinical practice.
- Learn techniques to empower your spoken words.
- Train your voice so that your tone of voice and the pacing of selected words and phrases convey the qualities of calmness, reassurance, openness, and trust.

Personal

- Bring awareness of your own imagery process into your daily life.
- Choose a special healing image to focus on throughout the day.
- Learn to trust and interpret the meaning of your images.

DEFINITIONS

Body-Mind Imagery: the conscious formation of an image that is directed to a body area or activity that requires attention or increased energy.

Clinical Imagery: the conscious use of the power of the imagination with the intention of activating physiological, psychological, or spiritual healing.

Correct Biologic Imagery: biologically accurate images that are visualized to send messages to physiologic processes.

End-State Imagery: images that contain specified imagined hopes and goals (e.g., a healed wound).

Guided Imagery: a highly structured imagery technique.

Imagery Process: internal experiences of memories, dreams, fantasies, inner perceptions, and visions, sometimes involving one, several, or all of the senses, serving as the bridge for connecting body, mind, and spirit.

Imagery Rehearsal: an imagery technique designed to rehearse behaviors or prepare for activities or procedures.

Impromptu Imagery: the nurse's introduction of his or her spontaneous, intuitive images or perceptions into the therapeutic intervention.

Packaged Imagery: commercial tapes that have general images.

Relationship Imagery: imagery technique designed to explore relationships.

Spontaneous Imagery: the unexpected reception of an image, as if it "bubbled up," entering the stream of consciousness.

Symbolic Imagery: inner images that represent a person's deeper knowledge. Occurring in the form of metaphors or symbols, that may be immediately translatable to rational verbal thought, or their meaning may slowly emerge over time.

Transpersonal Imagery: images that connect one to expanded (i.e., beyond personality) levels of consciousness, such as imagining one's body as a mountain and beginning to feel an inner quality of immovable strength and solidity.

Visualization: the use of external images (e.g., religious painting, written word, nature photograph) to evoke internal imagery experiences that energize desired emotions, qualities, outcomes, or goals.

THEORY AND RESEARCH

Imagery is an essential aspect of holistic nursing practice, as it brings the natural powers of the mind into the process of health and healing. Distinct from thinking, imagery as a technique interacts with the image-making function of the brain, which in turn acts on the entire physiology. Imagery can be used on its own or in conjunction with therapeutic touch, meditation, biofeedback, reiki, reflexology, and other holistic practices. Imagery is an independent nursing intervention, a nurse-initiated action performed by nurses to bring about patient outcomes falling within the scope of nursing practice.[1]

The research definition of imagery is a perception of a stimulus in the absence of that stimulus. For example, if a person imagines a lemon and begins to taste lemon juice, he or she is having a perception (tasting the juice) of a stimulus (lemon) that is not present. Commonly, in addition to tasting the lemon, the person begins to salivate as well, demonstrating a rapid physiological alteration in response to the imagery suggestion. This "absence of stimuli" definition is relevant to the crucial issue of the placebo effect, a phenomenon in which the patient thinks (imagines) he or she is receiving a potent medicine and experiences the anticipated effects, both positive (placebo) and negative (nocebo), of that medication, when in fact a neutral substance was administered. This effect was demonstrated in a study that followed the progress of 303 patients medicated with a placebo for benign prostatic hyperplasia over a 25-month period. The study demonstrated rapidly significant improvements in urinary output and relief of symptoms of benign prostatic hyperplasia, but some patients also experienced negative side effects of the inert placebo "medication."[2]

In a study on the effect of a placebo in the relief of post-surgical pain, researchers found that the experience of an analgesic effect with the administration of a placebo was most effective with those patients who had prior successful outcomes with opioid exposure. For example, some patients experienced respiratory depression from the placebo if they had previously experienced this effect from the opioid.[3]

A practitioner's suggestions regarding an expected outcome influence the effect of a placebo. In a study where subjects were instructed to place their hands in ice water, one group was informed of the beneficial effect of this practice, one group was told of the possible hazards, and the control group was given a neutral suggestion. The pain

threshold, tolerance, and endurance of the three groups were compared. The tolerance of participants given the positive suggestion was significantly greater than that of the other two groups. In contrast, the group given the negative suggestion had significantly decreased tolerance and endurance of the test condition.[4]

The concept that imagery, or a person's belief, may alter his or her experience of an event is easier to accept than believing that structural or other types of physiological changes can occur as a result of changes in thought. In a study using ultrasound treatment to reduce the pain and jaw tightness and swelling following wisdom tooth extraction, researchers found that tightness and swelling was measurably reduced even when the ultrasound machine was in contact with the patient but not turned on to produce ultrasound.[5]

This information challenges the holistic nurse to understand and work with the power of a patient's imagination when providing care. The expectation of sickness, and the feelings of fear associated with this expectation, may actually contribute to illness.[6] Therefore, the interpersonal skills of the nurse, his or her self-awareness and focus, and positive outlook are all factors that help the patient imagine well-being and healthy outcomes.[7]

If a patient can physically benefit from imagining good results, then the imagination is a powerful healing tool in health care. Clinical imagery is the application of the conscious use of the power of the imagination with the intention of activating physiological, psychological, or spiritual healing. The key word in this definition is *conscious*. The power of the imagination, for good or bad, is always affecting people. People imagine negative futures and employ their intelligence to worry about that negative future. Their life becomes focused around a negative future that they imagine to be true. Imagery's clinical focus is to use the imagination to promote life-affirming behaviors and goals.

The effectiveness of imagery in healing has been recognized and used cross-culturally for thousands of years.[8,9] As more nurses gain an understanding of the benefits of imagery and use it to complement traditional nursing interventions, it will revolutionize the practice of nursing. It will change nursing because it engages the nurse and the client/patient at a higher level of consciousness than traditional nursing does. With imagery, the nurse introduces proven ancient methods of healing into modern health care. This cross-fertilization of ancient and modern methods is creating a new form of practical spirituality in U.S. health care.[10] In assisting this development, nurses play a key role in contributing to the scientific basis for imagery.

Imagery and States of Consciousness

Several important psychology research findings about the ongoing imagery process, or "stream of consciousness," have implications for the nursing care of patients and clients. Sensory deprivation research in the early 1960s spurred the study of the ongoing imagery process. Initially, the purpose of this research was to examine the functioning of the brain in the absence of sensory input. Much of this research resulted from the space program's need to understand the impact on astronauts of the sensory deprivation, isolation, and confinement of space travel.[11] These studies indicated that an ongoing imagery process is a vital element in human mental experience, particularly when perceptual stimulation is reduced as

it is in those who have a sensory impairment, those who are dealing with the monotony of hospitalization—particularly those in intensive care units, and those who work in monotonous environments.

Research conducted on the process of daydreaming also has provided nurses with insights helpful in their work with imagery. Foulkes and Fleisher applied a simple technique, previously used in sleep research, to study waking mental activity.[12] Subjects reclined in moderately lit rooms in bed but stayed awake. They were isolated from the researchers, and electroencephalogram (EEG) monitors were used to make sure they did not fall asleep. At randomly selected times, subjects were asked to describe their mental activity. In 84 of 120 "arousals," subjects reported awareness of imagery; in more than a quarter of these instances, the images were extremely vivid. The researchers concluded that relaxed, waking thought is fairly susceptible to momentary intrusions of extremely vivid and at times unusual content. The research of Foulkes and Fleisher, along with that of Singer and Antrobus,[13,14] point to the richness and variety of imagery content in mentally healthy subjects. This information can allow the nurse to be comfortable with the wide variety of material evoked during an imagery session. It is the value and nature of working with imagery to encounter creative and novel perspectives on the issues being explored.

Preliminary evidence that the vividness of a person's imagery is affected by ultradian and circadian cycles[15] has implications for effectiveness of imagery interventions, and points to the need for clinical research in this area.

Another significant aspect of imagery work is its potential to tap into memory at very deep levels. Wilder Penfield, a Canadian neurosurgeon working in the middle of the twentieth-century, did extensive experimentation with direct electrical stimulation and mapping of the brain during surgery. In his research on locally anesthetized, conscious subjects, he identified an area of the brain he labeled the "interpretive cortex." Upon electrostimulation of this region, he discovered that there is a brain mechanism "capable of bringing back a strip of past experience in complete detail without any of the fanciful elaborations that occur in a man's dreaming . . . a record that has not faded but seems to remain as vivid as when the record was made."[16] Penfield went on to indicate that, although the memories recalled in this manner were predominantly visual or auditory, the memory record included all the sensory information that had entered consciousness (e.g., smells, tastes, sounds, tactile sensations). In addition, there was a sense of familiarity about the event. Simultaneous with the experience of these memory records, Penfield's subjects retained an awareness of their present situation, namely that they were on an operating table having their brain probed by a surgeon.

Penfield's studies illustrate the capacity of consciousness to be absorbed in multiple activities at the same time. Penfield's patients were conscious of complete sensory recall of memories, were conscious of being on an operating room table, and were able to verbalize their experiences to Penfield and his staff. Appreciating the potentials of human consciousness is a key element in imagery work.

Clinical Effectiveness of Imagery

In a comprehensive review of the research on the physiologic effects of imagery,[17] Graham cited studies demonstrating the impact of mental imagery on a wide range of systems:

- Vasomotor activity resulting in alterations in skin temperature

- Increasing internal blood flow, demonstrated by increased temperature in specific skin areas
- Decreased external bleeding in hemophiliacs during oral surgery
- Increases in heart rate resulting from imaging sexually or emotionally arousing situations
- Heart rate reduction in response to images of relaxation
- Increases in systolic blood pressure in response to images of fear and anger

Other physiologic responses to imagery include salivary gland activation, changes in blood sugar, gastrointestinal activity, and blister formation.[18]

Jacobson demonstrated imagery's effect on motor responses in 1929, when he showed that subtle tensions of small muscles or sense organs result from imagining movement (see Chapter 21).[19] In addition, imagined activity stimulates the appropriate motor neurons. A recent study demonstrated the effectiveness of imagery rehearsal as practice in the learning of motor skills.[20] This is the "ideo-motor" aspect of imagery that has been applied in the use of imagery rehearsal for improving athletic performance.[21] In fact, the research on motor responses has been extensively applied in athletic training,[22–24] but it also holds rich possibilities for application in rehabilitation nursing and in any setting where people are experiencing limitations in movement and activity. This aspect of imagery was applied in working with patients affected with Parkinsonism. Mental images of movement were used to help in freeing movement in "frozen" body parts.[25] Mental imagery practice of movement also was applied in post-stroke rehabilitation.[26] Patients were requested to perform a simple arm movement sequence. They were then asked to practice the same sequence without any actual movement. The mental rehearsal activated brainwave responses consistent with sensorimotor learning, suggesting the potential benefit of imagery in post-stroke rehabilitation.

Simonton and associates explored the effect of imagery on immune function and the application of this information in the treatment of cancer,[27] as did Achterberg and Lawlis.[28,29] Hall studied the effect of hypnosis and imagery on immune modulation, noting increases in the number of lymphocytes and general increased immune system responsiveness.[30,31] Schneider and associates demonstrated enhanced immune responsiveness in subjects working with imagery of "white blood cells attacking germs."[32] Schneider and associates also successfully used imagery to increase adherence, or "stickiness," of neutrophils.[33] Two factors affected the successful use of imagery in these studies: First, the biologic accuracy of the imagery appeared to be significant. Second, the ability to work with the imagery without straining at it played a part in significant outcomes.

In yet another study, healthy subjects were able to reduce the release of the "stress hormones" (corticosteroids) that reduce immune function when using images of relaxation.[34] In a community-based nursing study, patients with advanced cancer who were experiencing anxiety and depression were taught progressive muscle relaxation and guided imagery meditations.[35] One group of patients was taught just progressive muscle relaxation, one group was taught guided imagery for anxiety depression and quality of life, one group was taught both treatments, and there was one control group. The group that learned both techniques showed significant positive changes for depression and quality of life, although there was no significant change in anxiety.

Clinical imagery has been applied for pain reduction during cancer treatment.[36] In one study, a group of women undergoing radiation for early breast cancer were

given guided imagery tapes specifically designed to increase the comfort of women with their condition.[37] The women were instructed to listen to the tape on a daily basis for the duration of their radiation treatment. The researchers found a very significant increase in comfort level for the women in the group who received the imagery treatment.

Imagery interventions alone were found to be as effective as the combination of imagery and teaching of cognitive behavioral skills to reduce anxiety during magnetic resonance imaging (MRI) diagnostic procedures.[38] In another study, patients undergoing nonemergency MRI scans listened to a guided imagery/relaxation tape before their scan, and were taught to use the guided imagery during the procedure. A significant reduction in anxiety was reported by the treatment group in comparison with the control group, as well as less movement during the procedure as reported by both the operator and patient self-reports.[39]

A clinical study on the use of imagery as a coping strategy for perioperative patients had participants listen to imagery tapes for three days preoperatively; during anesthesia induction; during surgery; in postanesthesia care; and for six days post surgery. Patients treated with guided imagery required 50 percent less narcotic medication and experienced significantly lower levels of anxiety and perception of pain.[40]

An interesting study compared the effectiveness of two different types of imagery in the reduction of daily fibromyalgia pain. In the study, women were assigned to one of three groups: Group one received relaxation training and guided instruction in "pleasant imagery" in order to distract from the pain experience; group two received relaxation training and "attention imagery" instruction, encouraging the "active workings of the internal pain control systems"; group three, the control group, received treatment as usual without any imagery. All the patients in the study were also randomly assigned to treatment with either 50 mg per day of amitriptyline or a placebo pill. The results showed a significant difference in the reduction of pain in the group receiving the pleasant imagery, but not in the attention imagery group when compared with the control group. In addition, it was found that amitriptyline had no significant advantage over the placebo in reducing fibromyalgia pain during the course of the study.[41] This information also reflects the fact that if a particular imagery intervention does not prove to be helpful for a particular patient, the practitioner should not be discouraged, but instead should use creativity and try other imagery approaches. The attention imagery may have worked for some, just as the pleasant imagery was not effective with everyone. Statistical significance is helpful and points to a general understanding of effects, but does not give us the final word on what works for an individual, or even what works for an individual under one set of conditions, but not other circumstances.

In other research examining the effectiveness of imagery in the treatment of chronic pain, two hundred and sixty chronic tension-headache patients being treated at a specialty clinic participated in a study over a one-month period. In addition to individualized headache therapy, one hundred twenty-nine subjects were given guided imagery audiocassette tapes and instructed to listen to them on a daily basis for the duration of a month. The remaining patients received only their individualized therapy without any imagery. Post-testing of the subjects reflected a significant degree of decrease in bodily pain, an increase in a sense of vitality, and overall improvement in mental health in the imagery treatment patients.[42]

In a review of the application of imagery in cardiovascular disease, Luskin and

associates cited imagery as a helpful tool in several issues: altering behaviors associated with cardiac risk, such as bringing about smoking cessation; reducing heart rate reactivity over a 28-week follow-up period; and decreasing anxiety responses in male automatic defibrillation recipients.[43] In another study, outcomes of cardiac surgery patients who had participated pre- and postoperatively in a guided imagery program were compared with a group receiving no imagery. The imagery recipients experienced a significant degree of reduced anxiety, less pain, and shorter length of stay. Of great significance in establishing acceptance of imagery interventions in the hospital setting, the researchers were able to document to the hospital administration that the treatment, in addition to resulting in shorter average length of stay, reduced average direct pharmacy costs, reduced direct pain medication costs, and maintained a high level of patient satisfaction in their care and treatment.[44]

As we see, many studies have demonstrated imagery's therapeutic effect in reducing anxiety and improving quality of life.[45–48] People can learn to produce positive healing results through imagery processes. The effectiveness of imagery in reducing anxiety was found to be positive even if the imagery recipients were not vivid imagers.[49] Research has demonstrated that even congenitally totally blind people are able utilize visual imagery.[50] Nursing students who were taught imagery-based stress management interventions were able to apply the imagery techniques successfully for their self-care, as well as to use them in their medical/surgical, maternity/gynecology, community, home care, and psychiatric clinical rotations.[51]

In summary, research findings on imagery and physiology include the following:

- Images relate to physiologic states.
- Images may either precede or follow physiologic changes, indicating that they have both a causative and a reactive role.
- Images can originate in conscious, deliberate behaviors, as well as in subconscious acts (e.g., electrical stimulation of the brain, reverie, dreaming, brain wave biofeedback).
- Images can be the hypothetical bridge between conscious processing of information and physiologic change.
- Images can influence the voluntary (peripheral) nervous system, as well as the involuntary (autonomic) nervous system.
- Imagery is not about mental pictures, but is a resource for gaining access to the imagination and more subtle aspects of inner experience. It may involve all sensory modalities: visual, olfactory, tactile, gustatory, auditory, and kinesthetic.[52]

Our access to our imagination, our inner wisdom, and our inner healing resources are all elements of imagery work. Because anyone's experience of imagery is deeply subjective, imagery is a challenge to quantify and objectify through a process of quantitative research. While research is a vital element in gaining recognition of the clinical value of this exciting and effective tool, by its nature research necessitates reducing the questions asked into dichotomous frameworks. Do we even know if it is the image, per se, that is effecting the change? Or is it the focus, intentionality, and empowerment that we elicit in our patients when we provide them with education about inner skills and potentials that are ultimately creating the therapeutic effect? Imagery researcher Braud states; "Perhaps images are simply clothed intentions—specific intentions or focused intentions that have been dramatized or personified in imagery forms?"[53]

Clinical Imagery Theories

Eidetic Psychotherapy

Ahsen developed a theory of imagery called *eidetics*.[54] He posited that there are three unitary, interactive modes of awareness available:

1. Image (I)
2. Somatic response (S)
3. Meaning (M)

This triad of image–somatic response–meaning (ISM) defines the eidetic image that is stored in the mind as an experiential unit. The somatic response and meaning components are repressed in the image, constituting what Ahsen labeled "the consciousness–imagery gap." Ahsen theorized that alterations in the image alter the corresponding somatic responses and meanings of past events. This theory can be related to the previous cognitive and biologic explanations of imagery. Ahsen developed an elaborate and broadly applicable theory for working with eidetic images in the clinical setting. The implication of this theory is that any work at the somatic level (e.g., therapeutic massage) or work at the meaning level (e.g., counseling) must include awareness of the images evoked by these practices.

Psychosynthesis

Roberto Assagioli was an Italian psychiatrist who introduced meditation and imagery into clinical practice beginning in 1909.[55,56] His theory of the wholeness of human consciousness, called psychosynthesis, has been extensively applied in the helping professions since 1965. He was personally most interested in developing a science of the higher self, a term that he used to describe the aspect of each person that holds inner wisdom and connection with life purpose. He saw the higher self as a developmental step latent inside each person.

Assagioli used imagery in three forms:

1. Inner images, to explore the various levels of human experience, including biologic, social, and transpersonal experience.
2. Inner images, to represent the intentions and goals of the patient.
3. External images—the actual paintings and statues of his city, Florence, Italy—to help encourage transpersonal feelings in his patients. He often suggested that his patients go to a particular museum or church to meditate on a particular work of art because of the spiritual insights and feelings that the artist expressed in the work.[57]

Assagioli viewed imagery within a body-mind-spirit context. He developed a set of principles that he referred to as "psychological laws" to describe the interactive effects among images, ideas, emotions, physical responses, behaviors, attitudes, and impulses. According to one such law, "Images or mental pictures tend to produce the physical conditions and the external acts that correspond to them." According to a second law, "Attitudes, movements, and actions tend to evoke corresponding images and ideas; these, in turn, evoke or intensify corresponding emotions."[58] In these and other laws, Assagioli was seeking to outline the ability of the mind through imagery and intention to interact with, and positively affect, the body/mind for healing and growth.

In a recent study that follows the spirit of Assagioli's work, researchers began with the observation that directing attention to the body is part of the effectiveness of techniques such as imagery and meditation in producing psychophysiologic harmonious states.[59] They wondered what the measurable effect would be of directing attention to particular body organs. Their studies focused specifically on the heart. When simultaneously measuring heart rhythm

by electrocardiogram (ECG) and brain wave rhythm by EEG, they instructed subjects to focus attention on their heart beat. In doing this, they discovered a state of heart–brain electrical wave synchronization. They then postulated that a process emerges as a result of the synchronization occurring from this focused direction of consciousness: self-attention—connection—self-regulation—order—ease. They proposed that this existed in contrast to a process of disattention—disconnection—disregulation—disorder—disease. It was also observed that the synchronization was more effective when participants practiced with eyes closed.

CLINICAL TECHNIQUES IN IMAGERY

It is clear that imagery affects our general physical state and our sense of emotional well-being. Patients with negative imagery will go into physical states of fear and nervous vigilance. If instead they choose to focus their minds on specific positive imagery, all of their physical systems will move toward states of ease and harmony. Imagery interacts with physiologic processes, sending messages and information from the right brain to the central nervous system.

Nurses may use specific, highly structured, guided body/mind, correct biologic, and end-state imagery techniques. The use of symbolic drawing can be introduced in the exploration process. Perhaps the most available use of imagery is the nurse's own impromptu imagery. Impromptu imagery is the nurse's unplanned use of an image that arises in her own imagery process during a clinical interaction. For example, an emergency room nurse, caring for a woman who had badly injured arms as a result of a car accident, was unable to establish an intravenous (IV) line because the woman's veins were collapsing. The situation was urgent, and there was discussion about the possible need to amputate an arm. The nurse, who had recently started studying clinical imagery, suddenly had an image of this woman holding a baby. She immediately suggested that the woman take a few moments and embrace her injured arm as if it were a tiny baby. She said, "Hold your arm, and send it loving energy." Within moments, the woman was calm, and the nurse was able to start the IV infusion.

Another nurse became aware of a patient's anxiety as she was preparing to administer a transfusion of packed cells. The woman had recently experienced a number of transfusion reactions and was very fearful about the procedure. The nurse, who was meeting the patient for the first time, noticed that the cells had come from a source in Florida. She had an image of the blood donor basking on a warm Florida beach. The nurse told the woman where the blood supply had originated and suggested that she imagine these cells bringing the healing energy of the Florida sun and the gentle breeze of the beach to soothe and calm her. The patient immediately responded favorably to this suggestion, happy to have a calming image with which to engage her mind. The transfusion was a success.

Imagery in Holistic Health Counseling

Imagery clearly taps a deeper level of self-knowledge in the patient. One example of this occurs in relationship imagery. In one instance, when a patient was asked to describe his relationship with his father, he offered a few familiar comments. But when he was asked to get an *image* of his father, the patient suddenly got in touch with the feelings of sadness and hopelessness that his father stimulated in him. This deeper level of self-knowledge allowed the patient to appreciate why he struggled with hopelessness in himself.

The remarkable ability of imagery to offer intimate information to the patient, immediately and directly, is its special contribution to holistic health counseling. Such information may be helpful in making health decisions, in rehearsing new behaviors, in understanding relationships, and in making life choices.

Values and Spirituality

Nurses often are caring for patients at a stage in their lives when values and spirituality have become a central concern. Illness, divorce, ethical dilemmas, deaths, or other life crises often cause people to slow down and ask basic questions about how they are going to conduct their lives. Changes in physical capacities, the need to find different employment, decisions about education and lifestyle, and retirement all call upon people to reassess their deepest values and their sense of spiritual purpose in life. Such a stage of life is a time of "crossroads decisions," in which there is a need to have a larger vision of life's path. Immediate reasons for one decision or another are only relatively helpful. People know that their "crossroads decision" will affect them for a long time, and they need to be aware of their values and spiritual perspective to help with decisions.

At these times, rational thought processes are not enough, because they do not reveal the big picture. Imagery allows someone to imagine the actual results of a decision. For example, a nurse counseling a 59-year-old elementary school teacher struggling with a decision about retirement suggested that she close her eyes, focus on her breath, and imagine herself retired. After a few moments, the woman experienced an image of herself at home, looking bored and unhappy. She was frustrated with this image. She then tried to imagine her retirement as a time of new growth. She went back into the imagery, trying to imagine herself retiring and going back to school to study something new—but she was unable to do so. Her imagination literally refused to see it. She then imagined herself doing service work in the community. Suddenly, during this imagery, she felt a peace and an ease settle into her experience.

Imagining pictures of the future makes specific behavioral and emotional information available. This information is invaluable for decision making because it provides a holistic level of information that is not available at the purely verbal level.

Transpersonal Use of Imagery

The transpersonal (beyond personality) level of human nature is a fact. Cultures throughout the world have used prayer, meditation, imagery, diet, physical training, study, ritual, art, and many other methods to experience transpersonal states of consciousness. People seek these states because they tend to provide a subtler understanding of the universal patterns of reality and a more peaceful perspective on the "little self" living in the immensity of creation. Holistic nurses frequently cite their own transpersonal experiences as one of the reasons they became interested in introducing holistic methods into their work. Motivated by their own development through such experiences, they desire to pass the potentials of transpersonal experiences on to others.

The role of imagery in transpersonal experience is a crucial one. Holistic nurses can use transpersonal imagery to introduce patients safely to the transpersonal level of consciousness.[60–62] This imagery is referred to as transpersonal because it links and identifies the individual experience to universal processes. Transpersonal imagery taps into an expanded

experience of the self, an experience that draws on human beings' capacity to connect deeply with the flow of life energy and creation. This connection, and the imagery that emerges from it, can be interpreted as a connection with God, with all of humanity, with a higher power, with the wonder of the universe and nature, or a connection with the mysterious, nonverbal communication that occurs between people at the level of intuitive knowing and caring (see Chapters 2, 3, 7, 8, and 10).

Visualization practice can be helpful for energizing and eliciting transpersonal experiences.[63] Art images, photographs, and picture postcards are all sources for images that can be used in work with transpersonal symbols. The nurse can begin to collect art cards and other images that can be used to help patients. For example, one elderly woman hospitalized with advanced heart disease was feeling very lonely, depressed, and fearful. She expressed fear that she was going to die. In sharing this with the nurse, she said she was confused by spirituality and did not know what she believed. The nurse asked if she would like to explore these feelings with imagery, and the woman agreed. The nurse led her in a brief relaxation and then suggested that she experience herself in a place that she felt was sacred. The woman was silent for a long time. The nurse sat silently with her. After a while, the woman opened her eyes. She was very surprised by her imagery. She felt herself in Florence, Italy, a place she had never visited. She imagined walking the streets, looking at the beauty of the churches and feeling deeply connected to the sacredness of the art. She said she always imagined Florence as a sacred place. She deeply loved Renaissance art and imagined the magic of a place where so much beauty had been created. She realized that her love of art was the closest thing she could identify as a spiritual feeling. Recognizing the importance of this imagery for the patient, the nurse said she would bring her a postcard of Florence. This pleased the woman, and the nurse told her that it would be important to honor this inner experience by keeping a reminder of it where she could connect with it over the course of the day.

Working with metaphors and symbols of transcendent experiences is an effective way to help a patient who is experiencing spiritual distress, hopelessness, and helplessness. Bringing a client into deep relaxation and then introducing one of these metaphors in an open-ended, exploratory way can be deeply meaningful. The patient can choose the symbol that he or she wants to explore, or the nurse can create the journey based on information from the patient. In times of illness and crisis, people may have spontaneous spiritual experiences and images. It is advisable to learn about these images so that patients can be supported and derive benefit from their experience (Table 22–1).

Imagery with Disease/Illness

Much emphasis is placed on treating disease, the pathologic changes in organic form either observed or validated by laboratory tests. There is also a great need to address the individual's personal experience of his or her illness, general state of being, anxiety level, state of hopefulness or despair, and the meaning attributed to the situation. The nurse, using imagery, can promote a sense of well-being in clients and help them change their perceptions about their disease, treatment, and their inner resources and innate healing ability.

Fear and negative imagery are not unusual in an individual with an undiagnosed or even a known illness. For example, a woman who discovers a palpable breast lump may conjure up frightening

Table 22–1 Symbols and Metaphors of Transformation

Symbol or Metaphor	*Transformative Experience*
Introversion	Exploration of the true self; self-knowledge; inner journey to the soul, to beingness
Deepening/descent	Journey to the underworld of the psyche; confronting the difficult aspects of the self, the shadow; entering a cave; the heroic journey of facing fears
Ascent/elevation	Climbing a mountain to reach a higher plane of awareness
Expansion/broadening	Enlarging perspective; taking in the wholeness and seeing beyond one's small, individual perspective
Awakening	Awakening from the dream or from illusions; opening to the truth or reality of what really matters
Illumination	Bringing in the light of the human soul; spiritual light to transform or "enlighten" a situation; moving from darkness to light; bringing in life energy
Fire	Purification; spiritual alchemy; candles, lanterns, bonfires, ceremonies of transformation
Development	Growth, blossoming; potentials waiting to become real
Love	Opening the heart; compassion and generosity, forgiveness
Path/pilgrimage	"Mystic way;" the journey of outward exploration; seeking to be changed by new experience or knowledge
Rebirth/regeneration	Birth of the new being; resurrection
Freedom/liberation	Liberation of psychic, physical, and spiritual energy to align with creation and creativity

Source: Adapted by permission of Sterling Lord Literistic, Inc. Copyright © 1965 by Robert Assagioli.

images before any tests or diagnoses. These images may include cancer, mastectomy, chemotherapy, radiation, hair loss, nausea/vomiting, severe pain, metastatic disease, the deathing process, funeral, and the actual moment of dying. This process may be conscious or preverbal. It may be noticed in dreams, daydreams, spontaneous images, and kinesthetic sensings.

Concrete Objective Information

Nursing research has been conducted over the last 20 years in the use of imagery in preparing patients for difficult procedures. This technique, referred to as concrete objective information, is broadly applicable in nursing practice.[64] It is a form of imagery rehearsal, and its effectiveness lies in the importance of the "prepared mind." People are fearful of the unknown and of feeling out of control. This technique addresses both these fears.

Concrete objective information explores the client's subjective and objective experiences of the upcoming event. Clients who receive information about both subjective and objective components of tests, procedures, and surgery recover more quickly. They are able to plan and use more effective coping strategies than clients who receive only one of the components. A surgical patient's subjective experience includes what will be felt, heard, seen, smelled, or tasted before, during, and after the procedure. In addition, it includes the sensory experiences of a postsurgical healing incision (e.g., pressure, smarting, tingling), as well as sensations over time (e.g., fleeting sharp sensations from the incisional area when

turning in bed or when coughing). Table 22–2 lists sensations evoked by selected procedures.

Objective experiences are observable and verifiable by someone other than the person going through the procedure. Thus, for the surgical patient, an objective experience may include the time and place of the presurgery nurse's visit, the matters to be discussed in the visit, the preoperative preparation of the skin, placement on the stretcher to go to surgery, awakening in the recovery room, and expected sensations. This process reduces the likelihood that the patient will interpret normal sensations or events as signs that "something's wrong." It also allows the nurse and patient to plan specific ways for the patient to handle difficult parts of the event.

The following procedural points related to the use of concrete objective information originate in science-based nursing practice:

- Identify the sensory features of the procedure to be used.
- Determine the individual's perception of the procedure/treatment/test to be experienced.
- Choose words that have meaning for the person.
- Use synonyms that have less emotional impact, such as "discomfort" instead of "pain."
- Select specific experiences when giving examples, rather than abstract experiences (see Table 22–2).
- Help individuals reframe any negative imagery. For example, patients often fear chemotherapy and think of it as a poison because of all the precautions and side effects associated with it. It is very important to have a way of framing the experience that is positive and focuses on healing. For example, the nurse may say, "Chemotherapy is powerful and effective in fighting the most vulnerable cells, the confused and incomplete cancer cells. The healthy cells—most of the cells in your body—are strong and protected."
- Plan specific strategies to be used at different stages of the procedure, such as using a breathing technique while waiting for the procedure to begin, and using imagery of a safe place during the procedure as a distraction from uncomfortable sensations.

Fears in Imagery Work

There are three predictable and understandable fears encountered in imagery work: (1) nothing will happen; (2) too much will happen; or (3) it will be done wrong.

Nothing will happen. Patients fear that they will not be able to imagine anything in response to the nurse's imagery suggestion. Coincidentally, the nurse may share the same fear. The nurse may be afraid that the imagery method will produce nothing of worth for the patient.

The answer to this fear is to be curious about any experience that occurs during the course of the imagery. If, for example, the patient reports that her breathing became faster as soon as she heard the nurse's suggestion to relax, the nurse should be curious about why the patient believes her breathing became faster. The patient may respond that she was afraid of relaxing. On the surface, this may seem a strange statement. How can anyone be afraid of relaxing? In fact, relaxation can be frightening. For example, it can be frightening for someone who has experienced trauma in childhood and feels the importance of maintaining vigilance. Such information can be invaluable in actually helping the patient to enter states of relaxation safely and to engage in imagery work.

Too much will happen. Patients fear that the imagery will evoke difficult or even overwhelming thoughts and feelings. Coincidentally, the nurse may share the same fear. The nurse may fear the imagery

Table 22–2 Documented Subjective Experience Descriptors by Stressful Health Care Event

Stressful Event	*Descriptors*
Gastroendoscopic examination	Intravenous medication; feel needle stick, drowsiness As air is pumped into stomach, feeling of fullness like after eating a large meal Feel physician's finger in mouth to guide tube insertion
Nasogastric tube insertion	Feeling passage of tube Tearing Gagging Discomfort in nose, throat, mouth Limited mobility
Cast removal	Hear buzz of saw Feel vibrations or tingling See chalky dust Feel warmth on arm or leg as saw cuts cast; will not hurt or burn Skin under padding looks and feels scaly and dirty Arm or leg may feel a little stiff when first trying to move it Arm or leg may feel light because cast was heavy
Barium enema	Lying on hard table Table feels hard Feel fullness Feel pressure Feel bloating Feel uncomfortable Feel as if might have a bowel movement
Abdominal surgery	Preoperative medications: feel sleepy, light-headed, relaxed, free from worry, not bothered by most things, dryness of mouth Feel incision: tenderness, sensitivity, pressure, smarting, burning, aching, sore Sensations might become sharp and feel like they are traveling along incision when moving Arm with intravenous tube feels awkward and restricted but not painful Feel tired after physical effort Feel bloating in abdomen Cramping due to gas pains Pulling and pinching when stitches are removed
Tracheostomy	When moving about, swallowing, or during suctioning: feel hurting, pressure, choking
Mastectomy—mean of 5.5 years postoperative	Arm or chest wall pain, "pins and needles," numbness, weakness, increased skin sensitivity, heaviness Phantom breast sensations, such as twinges, itching
4-vessel arteriography	Before contrast medium: table is hard, head taping is uncomfortable, cleansing solution is cold After contrast medium: hot, burning sensation in face, neck, chest, or shoulders

Source: Adapted from *Nursing Interventions: Essential Nursing Treatments*, 2nd ed., by G. Bulechek and J. McCloskey, p. 145, with permission of W.B. Saunders Company, © 1992.

method will be too evocative and will have negative consequences for the patient.

The answer to this fear is that imagery does not take away a person's defenses. If the imagery suggestion is too evocative, the patient will simply fail to hear it, will ignore it, will change it into a suggestion that is easier to work with, or will simply open his or her eyes and stop the process. If a patient does have difficult thoughts and feelings in response to the imagery suggestion, these thoughts and feelings will develop because the patient is ready to receive them.

These statements presuppose that the nurse is skilled in imagery and is not imposing a manipulative imagery practice. Each patient has the potential for important new knowledge and new feeling. The nurse is not using imagery to make something happen. Rather, the nurse is using imagery to evoke what is already present in the patient. Carried out in this spirit, the nurse will not evoke any experiences for which the patient is not ready. The imagery suggestion will instead open the patient to the interior world of latent intuition, knowledge, and creative problem solving already present in the patient's imagination.

It will be done wrong. Anxious to please the nurse, patients fear they cannot do imagery the "right way." Coincidentally, the nurse may also harbor the fear that there is a "right way" to do imagery, and that his or her personal skills are inadequate for the "right way."

The answer to this fear is to realize that there is no right way. The processes of the imagination are unique to each person; thus, each imagery experience is unique. Furthermore, a nurse may use the same imagery suggestion twice, and the same patient may experience two totally different responses to the imagery. It is very important to realize that the patient's experience is the center of all imagery work. The nurse may suggest imaging a walk in an open field, and the patient may respond by imaging the atmosphere in a dark room. The dark room becomes of importance. The original suggestion of an open field is no longer significant. The meaning of the dark room for the patient becomes the source of interest and new learning. The nurse's imagery suggestion is simply that—a suggestion—to evoke the latent powers and intelligence of the imagination into the service of the patient. Imagery techniques can be studied for many years, imagery skills can be honed, and yet it remains the unique response of the patient that is central to the work.

HOLISTIC CARING PROCESS

Assessment

In preparing to use imagery as a nursing intervention, the nurse assesses the following parameters:

- the client's potential for organic brain syndrome or psychosis in order to determine if general relaxation techniques should be used instead of imagery techniques.
- the client's anxiety/tension levels in order to determine which types of relaxation inductions will be most effective.
- the client's hopes in regard to the session and reason for seeking help.
- the client's wants, needs, desires, or recurrent/dominant themes.
- the client's understanding that it is not necessary to literally hear, see, feel, touch, or taste when working with imagery; that it is best to trust the inner experience in whatever form the information comes.

- the client's primary sensory modalities when they experience their imagination—visual, auditory, kinesthetic, and so forth.
- the client's understanding that imagery is basically a way in which we communicate with ourselves at a deep level.
- the client's understanding that imagery can bring us into contact with our body and find out what it needs.
- the client's previous experiences with the imagery process.
- the client's emotional comfort level with closing eyes, bringing attention inside, and opening to states of internal awareness. If the client is not comfortable with closing the eyes, the nurse can suggest just lowering the eyes and gazing at a point on the floor approximately one or two feet in front of him or her. This will cause the client's peripheral vision to blur, eyelids will usually get heavy, and then the eyes will close effortlessly. Some clients need to learn to trust that it is safe to relax, that they are experiencing a natural phenomenon.
- the client's knowledge of relaxation skills. If not skilled in relaxation, the client may need an explanation of what the normal sensations will be and time to shift to the "letting go" state. Once the client becomes skilled at entering a relaxed state, a selected word, phrase, or hand posture can become a signal to relax.
- the client's ability to maintain attention and not drowse off in the session.

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with imagery interventions that are related to the 13 domains of Taxonomy II (see Chapter 14):

- Social isolation
- Role performance
- Caregiver role strain
- Parental role strain
- Spiritual well-being
- Spiritual distress
- Altered effective coping
- Impaired adjustment
- Ineffective denial
- Potential for growth
- Decisional conflict
- Health-seeking behaviors
- Sleep pattern disturbance
- Relocation stress syndrome
- Altered self-concept
- Disturbance in body image
- Disturbance in self-image
- Potential hopelessness
- Potential powerlessness
- Pain
- Anxiety
- Fear
- Post-trauma response
- Grief

Outcomes

Exhibit 22–1 guides the nurse in client outcomes, nursing prescriptions, and evaluations for the use of imagery as a nursing intervention.

Therapeutic Care Plan and Implementation

Before the Session

- Become calm and centered. Let your bodymind release any tension and tightness. Prepare to guide the client with relaxation and imagery.
- Focus on the client's baseline feelings/emotions as revealed during the assessment process.

Exhibit 22–1 Nursing Interventions: Imagery

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client will demonstrate skills in imagery.	Following an assessment, guide the client in an imagery exercise.	The client participated in imagery exercise by choice.
	Assess the client's levels of anxiety with this new process.	The client demonstrated no signs of anxiety with imagery process.
	After the imagery process experience, assess effectiveness through client dialogue.	The client stated that the imagery experience was helpful.
	Encourage the client to recognize daily self-talk and the images that lead to balance and inner peace.	The client reported using self-dialogue with imagery.
	Help the client to create images of desired health habits, feelings, desires for daily living.	The client reported creating images of desired health habits, feelings, and desires for daily living.
	Teach the client coping, power over daily events, ability to move toward healthy lifestyle.	The client reported increased coping with daily stressors.
	Teach the client to recognize images leading to self-defeating lifestyle habits.	The client reported recognition of negative images leading to self-defeating behavior; the client created positive images.
The client will participate in drawing, if appropriate.	Encourage the client to draw images and symbols as a communication process with self.	The client used drawing as a communication process with self.

- Prepare the room to ensure the client's comfort and minimize distraction from noise.
- Have the client empty his or her bladder before the session begins.
- Place a sign on the door stating that the session is in progress, in order to avoid interruptions.
- Have the client sit, recline, or lie down, depending on client preference and clinical situation.
- Have a selection of music tapes available from which the client can choose (see Chapter 23).
- Have a light blanket available in case the client should feel cool.
- Have blank paper, crayons, and colored markers available should the client wish to draw before or after the session.

At the Beginning of the Session

- Give the client a general definition of imagery: "Imagery is a natural way to connect body-mind-spirit by quieting the busy mind and body. This helps you tap into the power of the imagination."
- Have the client develop a positive expectation of what is to occur using bodymind and/or end-state imagery directed toward a successful outcome. Help the client clarify his or her intention and focus on the healing efforts.

- Assist the client in experiencing the imagery process and making friends with the experience of inner wisdom. This process is a key aspect of self-empowerment and creativity.
- Have the client center awareness on the present moment, focusing on breath or other sensory experience, in order to facilitate the imagery process.
- Instruct the client to let spontaneous images emerge from the inner self without judging or analyzing them, allowing the stream of consciousness to flow. Release expectations of logically working the images through to resolving conflicts at this time. Help the client to trust inner experience and to approach it with curiosity and compassion.
- Tell the client that, in experiencing guided relaxation and imagery suggestions, different images will appear. If any images appear that the client is unwilling or unready to deal with, it is perfectly all right to open his or her eyes and discuss it. This is valuable information to understand and clarify. When the client is ready, the session can proceed.
- After giving an induction, and a state of deep relaxation is demonstrated, the nurse can suggest to the client that he or she "allow images to emerge from this relaxed state."

During the Session

- With your guidance, let the client create his or her own images.
- Assess the state of relaxation throughout the session. Notice decreased tension in the face, chest, torso, and legs. The changes can range from subtle to dramatic. Respirations become deeper, with more space between the breaths. The eyelids may flicker (especially with very vivid imagers), and the lips and face may change to a paler color.
- Determine if the client is following the imagery process. The nurse may instruct the client, "If you are following the imagery, raise a finger to indicate yes." Similarly, the nurse may ask if the client needs a slower pace or would like to get more comfortable. Clients who are used to working with inner imagery can usually focus more easily than novices. If the client cannot clear the mind, suggest returning to breath awareness.
- Determine the length of the session based on the client's needs, body responses, and session outcomes. The sessions can last from 10 or 15 minutes to an hour or longer.
- Allow your personal intuition to emerge while guiding the client. It helps you to recognize subtle cues from the client that something special is present in the imagery process.
- Continually assess the client's body language and facial expressions for resistance to the imagery process. If there is resistance, the imagery should be kept simple and more directed: "Focus on your right hand . . . and notice sensations in your right hand. . . ." At other times, a less direct guided imagery approach is needed, such as "At your own pace . . ." "In your own way. . . ." Resistance to, or blocking the experience, is not failure. It becomes useful information to help the client to recognize that the body-mind-spirit needs some healing.

At the End of the Session

- Bring the client to an alert state gradually, allowing time for silence before discussion. Observe and take cues from the client as to the appropriate time to begin the discussion. The moments following a session are a time for personal insight. This opportunity may be lost if talking begins too soon. Both the client and the guide need to be

immersed in the healing of silence, even if only for 20 to 30 seconds.
- If appropriate, have the client finish the session by drawing or writing down some impressions.
- Discuss the experience with the client, and encourage the client to interpret the imagery. The nurse can facilitate the interpretation by weaving imagery questions into conversational interaction and asking open-ended questions that guide the client in further contemplation.
- Provide the client with appropriate educational materials. Give written guidelines for integrating imagery skills and bodymind communication into daily life.
- Encourage the client to integrate relaxation and imagery daily. Instruct the client to notice patterns of tension at different times during the day. Then show the client how to replace tension patterns with relaxation and different types of imagery.
- Encourage the client to notice constant inner self-talk, focusing on introducing positive images and statements into this inner dialogue.
- Introduce the idea of "constant instant practice," using some frequent activity of daily life (e.g., telephone calls) as a reminder to practice imagery.
- Have the client use the images that come forth from inner awareness as guides for practice. Suggest the use of a journal or diary for recording images and their interpretation.
- Emphasize that practice is the key to successful imagery interventions. Have the client establish a scheduled time to practice, just as he or she takes medication on a schedule.
- Experiment with different exercises.
- Use the client outcomes (see Table 22–3) that were established before the imagery session and the questions shown in Exhibit 22–1 on page 583 on the client's subjective experience with imagery to evaluate the session.
- Schedule a follow-up session.

Specific Interventions

Facilitation and Interpretation of the Imagery Process

It is essential for nurses to become aware of their own imagery process and familiarize themselves with the rich variety and individuality of imagery experiences. When nurses come together in a group to listen and share personal and professional stories, they hear many perspectives. They can train themselves to listen to the use of metaphors and images and learn from the different types of imagers.

In order to facilitate the imagery process, the nurse serves as a guide. There is absolutely no way to predict what will surface in a client's imagination. Every experience is different, even when the same script is used.

Nurses who are unfamiliar with imagery and guiding should learn a few basic relaxation and imagery scripts, and practice on themselves by making tapes of their own voice and following their own guiding. This will help build confidence with the intervention. It is helpful to learn a variety of scripts pertaining to common problems in clinical practice, such as preoperative anxiety, recovery from surgery, postoperative coughing, effective wound healing, fear, anxiety, pain, and relationship problems. For scripts not frequently used, some nurses keep a notebook or reference book handy. In studying clinical imagery, the nurse needs to be willing to open up and learn it from the inside out, using imagery for personal change and development.

Each individual is the best interpreter of his or her own imagery process.[65] Symbolic information that surfaces in the imagination is rich with personal meaning. Many people have been closed off from or afraid

of their imagination. Nurses should encourage clients to record their images in a diary or journal for further exploration. It is easy to lose symbolic imagery in the conscious thoughts that dominate someone's attention during a busy day.

When teaching imagery, the nurse listens to the way that a client tells his or her story to get a sense of the client's outlook and orientation to the world. Does the client have a materialistic, concrete outlook on problem-solving and life in general, or a more intuitive, spontaneous perspective? For the logical, concrete thinker, written information is useful. For example, if using imagery for hand warming, the nurse may prepare an imagery teaching sheet that includes specific physiologic information and instructions such as

- An explanation of normal blood flow physiology.
- A drawing of blood flow to the hands via radial and ulnar arteries that branch into intricate blood vessel networks of the hands and the fingers.
- Examples of images that warm the hands.

Less structure is necessary for the more intuitive patient. The nurse can go directly to working with imagery and use the teaching sheets to support what the vivid imager has learned.

There is no need to follow teaching sheets explicitly. Suggested images are adapted to fit what feels right to the client. Teaching sheets refresh and reinforce the teaching–learning session and provide additional information to be mastered. Clients can add their own notes about specific images and personalize their practice. The nurse can help clients rework weak or erroneous imagery so that it more accurately reflects healthy outcomes (e.g., images focusing on weak, confused, cancer cells and a strong immune system instead of vice versa).

Guided Imagery Scripts

The guidelines that follow will help the nurse in the effective implementation of imagery scripts as nursing interventions:

- Start the session with an induction, a general relaxation—focusing on breath, shortened passive progressive relaxation, or body awareness, for example (also see Chapter 21).
- Reaffirm that there is no right or wrong way for the client to do imagery, that whatever occurs is useful information, and that the client has complete control over the process (e.g., deciding whether to go further or to stop).
- Follow the induction instructions for yourself so that you communicate a calming presence.
- Personalize the imagery by using the client's name or other specific references several times during the process.
- Speak slowly and smoothly, allowing for pauses and silence after each suggestion.
- Observe the client's body language and breathing rhythm to assess responses to suggestions.
- If there are signs of tension such as shallow breathing, tightness of muscles, or tense facial muscles in response to an imagery suggestion, ask, "What are you experiencing now?"
- If the client appears to be struggling to get into the imagery, pause in the script and suggest that the client reconnect with the breath and go more deeply into relaxation.
- Avoid saying "yes" or "right" or other words that communicate evaluative reactions to the client's experience. A more supportive comment such as "stay with your experience" can be made.
- Provide encouragement and guidance for those with less vivid imagery. Vivid imagers, on the other hand, prefer more silence: words may

be distracting or intrusive to them. Extremely vivid imagers may prefer to keep their eyes partially open to prevent feeling overwhelmed.

- End the session by bringing the person's awareness back to the room (e.g., "At the count of 5, you will be fully awake and alert . . . 1 . . . 2 . . . 3 . . . 4 . . . 5").

Induction for Imagery. A simple breathing technique or other relaxation technique may be useful to focus the client's mind inward and induce imagery. This allows awareness of subtler aspects of experience to become available to the person. This inward focus can be thought of as reducing external stimuli so that the inner awareness is enhanced.

The following induction script can be used as a preparation for most imagery interventions. It is especially appropriate for a person who needs assistance quieting the body. Resting the hands on the lower abdomen and breathing into the belly (diaphragmatic breathing) is an effective calming posture. In this position, the palms of the hands are resting on the body's energy center. By noting the slowing of breathing, relaxation of facial muscles, and changes in skin color, the nurse can assess the effectiveness of the relaxation technique. The induction for imagery can take 5 to 10 minutes. The most common mistake that new imagery practitioners make is to move too quickly through the suggestions. *Go slowly.* Allow your client time to connect with a subtler awareness. Learn to become comfortable with silent pauses.

> ***Script:*** *Make yourself comfortable and close your eyes. . . . Put your hands gently on your lower abdomen, just below your navel. . . . Bring all your attention to the sensations in your hands. . . . Notice the slight rise and fall of your hands as they move with your breathing. . . . Notice the tactile sensations of the surfaces of your hands and fingers. . . . Bring all your awareness into these sensations. . . .* [Pause.] *Now notice the temperature of your hands. . . .* [Pause.] *Notice their weight. . . .* [Pause.] *Now notice any sensations inside the skin, perhaps tingling or pulsing. . . .* [Pause.] *Now bring your attention to the center of your chest and be aware of the sensations . . . noticing the movement of your chest with each breath . . . the passage of breath into your lungs . . . the tactile sensations of your skin . . . perhaps an awareness of your heartbeat. . . .* [Pause.] *Now bring your awareness to your nose and be aware of breath passing through your nostrils. . . . Notice the slight cool sensations of the air touching the inside of your nose. . . .*

Connecting with Life Energy Imagery. This imagery, which draws upon a person's sense of his or her inner energy, focuses on the fact that the body is not just sick. The life force is operating without any conscious effort. This awareness can reframe a person's attitude, bringing a connection with inner healing mechanisms and with what is functioning healthfully, as opposed to focusing on the disease process.

> ***Script:*** *Bring your awareness to your imagination and take a moment to reflect on all the systems that are functioning in your bodymind at this moment*

. . . your heart and your circulatory system . . . [pause] *your immune system . . .* [pause] *your respiratory system . . .* [pause] *your senses. . . .* [Pause.] *Be aware of all of these. . . .* [Pause.] *Realize that you don't need to do anything to make these systems function. . . . They are part of your body's wisdom. . . .* [Pause.] *And now be aware that deep within you is a source of life energy . . . a vital spark that has been a part of you since the moment of your conception. . . . It has always been a part of you . . . guiding and energizing your body and mind. . . . Use your imagination to get in touch with this source of life energy. . . . Trust whatever information your imagination gives you. . . . Locate this source in your body. . . . Feel its strength and energy. . . .* [Pause.] *Allow your intuition to give you an image or symbol for this source and when you have the image, spend some time with it. . . .* [Pause.] *If it feels right, communicate with it . . . What does it need from you? . . .*[Pause.] *If there is anything else that needs to happen in relation to this image, let it happen. . . . Take your time. . . . When you feel ready, bring your awareness back to the room. . . .*[66]

Special/Safe Place Imagery. Clients need to identify a special place that is a safe retreat. This is an easy place for novices to start. It takes 10 to 20 minutes. Several different approaches can be useful. The first script is more open-ended and less specific. The ones that follow are more descriptive. People have different preferences as to what is most helpful.

Scripts:

- *Let your imagination choose a place that is safe and comfortable . . . a place where you can retreat at any time. This is a healthy technique for you to learn. . . . This place will help you with your daily stressors.* [If the client is in the hospital, . . .] *This safe and special place is very important, particularly while you are in the hospital. . . . Any time that there are interruptions, just let yourself go to this place in your mind.*
- *Form a clear image of a pleasant outdoor scene, using all of your senses. . . . Breathe . . . smell the fragrances around you . . . Feel . . . feel the texture of the surface under your feet. Hear . . . hear all the sounds in nature, birds singing, wind blowing. See . . . see all the different sights around as you let yourself turn in a slow circle to get a full view of this special space.* [Include taste, if appropriate.]
- *Let a beam of light, such as the rays of the sun, shine on you for comfort and healing. Allow yourself to experience the warmth and relaxation. Form an image of a meadow. Imagine that you are in the meadow. . . . The meadow is full of beautiful grass and flowers. In the meadow, see yourself sitting by a stream . . . watching the water . . . flowing by . . . slowly and gently.*
- *Imagine a mountain scene. See yourself walking on a path toward the mountain. You hear the sound of your shoes on the path . . . smell the pine trees and feel the cool breeze as you approach your campsite. You have now reached the foothills of the mountain. You are now higher up the mountain . . . resting in your*

campsite. Look around at the beauty of this place.

- *Imagine yourself in a bamboo forest. . . . You are walking in a large bamboo forest. The bamboo is very tall. . . . You lean against a strong cluster of bamboo . . . hear the swaying . . . and hear the rustling of the bamboo leaves, gently moving in the wind. . . . Look into the sky of your mind. . . . See the fluffy clouds. A cloud gently comes your way, . . . and the cloud surrounds your body. You climb up on the cloud and lie down. Feel yourself begin to float off gently in a gentle breeze.*

Worry and Fear Imagery. Some images can help clients change the internal experience of worry and fear. Clients should set aside 10 to 20 minutes a day to worry, preferably in the morning before they start their daily routines. This approach reassures the subconscious that it *has* worried, and the person has greater success at stopping the habitual worry during the rest of the day.

Script: *Let worries come one by one . . . just watching as one replaces the other. As you do this for a short period of time, feel the experience that occurs with each of those worries and fears. Notice how just having a worry or fear changes your state right now.*

Stop the images. Focus on your breathing . . . in . . . and out. . . . Allow yourself to have three complete cycles of breathing before continuing. . . . In your relaxed state, become aware of these feelings of relaxed bodymind. This time, take your relaxed state with you into your imagination. Let one worry come to your mind right now. See and feel it. . . . See yourself in that situation relaxed and at ease.

Right now, just say to yourself, "I can stop this worry." Imagine yourself functioning without that worry or fear. See yourself waving good-bye to that worry and fear. See yourself completely free of that worry and fear. Look at the decisions that you can make for your life that will lead you in new directions. Feel your energy as you breathe in. As you exhale, let go of all of the worry, fear, tension, and tightness.

Experience your comfortable bodymind. Know that you can work with many of your worries and fears that surface daily. Whenever they come, let the dominant worry surface. . . . Then feel what it is like as you gradually give up portions of the worry . . . until it is completely gone. If that seems impossible right now, decide which part of that worry and fear you need to keep and which part you can let go. And now, see yourself waving good-bye to the part that you can let go.

Now, feel what it is like in your mind with part of that worry or fear gone. Experience that and feel the changes within the body. Assess the part of the worry or fear that remains. Again, allow a portion of that worry or fear to move away. See yourself waving good-bye. Feel the change inside as more is released.

Let yourself now be in a place where the worry and

fear are diminished. Assess what part remains and see if you can now begin to give up that part. Pay attention to the experiences inside your body as you do this.

This script has many variations: writing worries/fears on a seashell and watching a seagull pick up the shell and drop it into the sea; running along a road, dropping the worries/fears by the road, and watching the wind blow them away; letting a picture of worries and fears flow forward in a moving stream. This basic script can also be individualized by putting into words what the client revealed before the session.

Inner Guide Imagery. The nurse can assist the client in creating purposeful self-dialogue that gains access to inner wisdom and personal truth that naturally reside within each of us. It is advisable to allow 10 to 20 minutes for this exercise.

Script: *As you begin to feel even more relaxed now . . . going to a deeper place within . . . feeling deeply relaxed . . . peaceful and safe . . . let yourself become aware of a sense of not being alone. With you right now is a guide . . . who is wise and concerned with your well-being. Let yourself begin to see this wise being with whom you can share your fears or your joys. You have a trust in this wise being.*

If you do not see anyone, let yourself be aware of hearing or feeling this wise being, noticing the presence of care and concern. In whatever way seems best for you, . . . proceed to make contact with this wise inner guide. Let yourself establish contact with your guide now . . . in any way that comes. Your guide may appear to you in any form, such as a person, an animal, an inner presence/peace . . . or as an image of the very wisest part of you.

Notice the love and wisdom with which you are surrounded. This wisdom and love are present for you now. . . . Let yourself ask for advice . . . about anything that is important for you just now. Be receptive to what emerges. . . . Let yourself receive some new information. This inner guide may have a special message to share with you. . . . Listen with openness and pure intention to receive.

Allow yourself to look at any issue in your life. It may be a symptom, a choice, or a decision. . . . Tell your wise guide anything that you wish. . . . Listen to the answers that emerge. Imagine yourself acting on the answers and directions that you received. . . . Imagine yourself calling upon the wisdom and love of this wise guide to help you in the days to come. Now in whatever way is best for you . . . bring closure to the visit with this inner guide. You can come back here any time that you wish. All you have to do is take the time.

This script helps clients gain an awareness of their own inner wisdom. It is best to introduce this exercise after a client has done several imagery sessions. Word choices should take into account the client's dominant sense. If a client prefers the visual, for example, the nurse uses the word *see*; if the client prefers the auditory,

the word *hear*; if the client prefers the kinesthetic, the word *feel*.

Seeking an inner guide can be done over many sessions. The client should be aware that many different guides or advisors will surface over time. The guide may also appear as a traditional religious figure such as a shaman, the Virgin Mary, a saint, Moses, or Buddha. It can be interesting and surprising when someone meets a spiritual figure not from their own religious tradition. The guide may also emerge as an admired historical or living person such as a favorite author or artist, a philosopher, or a heroic leader such as Martin Luther King, Jr.

There are many versions of this script, so the nurse can add, invent, and explore. Much detail can be added to this imagery script to lengthen the session. When time is extended, a wealth of insight can emerge for the client. The nurse should pause frequently and let a few moments pass in silence during the guiding, as indicated by his or her intuition.

Pain Reduction Imagery—*Red Ball of Pain.* To decrease psychophysiologic pain, clients can learn to use distraction. This kind of imagery is good for both acute and chronic pain, as well as for the discomfort or pain of procedures. It takes 10 to 20 minutes.

Script: *Scan your body. . . . Gather any pains, aches, or other symptoms up into a ball. Begin to change its size. . . . Allow it to get bigger. . . . Just imagine how big you can make it. Now make it smaller. . . . See how small you can make it. . . . Is it possible to make it the size of a grain of sand? Now allow it to move slowly out of your body, moving further away each time you exhale. . . . Notice the experience with each exhale . . . as the pain moves away.*

Give suggestions to the client to change the size of the ball several times in both directions. This serves as a distraction and an exercise in manipulating the pain experience rather than being trapped or overwhelmed by it. This imagery provides a tremendous sense of control as well as pain relief for the client. The person's body cues indicate how many times to go in each of the opposite directions.

Pain Assessment Imagery. Imagery helps access and control both acute and chronic psychophysiologic pain. The following exercise can be done in 10 to 20 minutes.

Script: *Close your eyes and let yourself relax. . . . Begin to describe the pain in silence to yourself. Be present with the pain. . . . Know that the pain may be either physical sensations . . . or worries and fears. Let the pain take on a shape . . . any shape that comes to your mind. Become aware of the dimensions of the pain. . . . What is the height of the pain? . . . The width of the pain? . . . And the depth of the pain? Where in the body is it located? . . . Give it color . . . a shape. . . . Feel the texture. Does it make any sound?*

And now with your eyes still closed, . . . let your hands come together with palms turned upward as if forming a cup. Put your pain object in your hands. [Once again, the nurse asks these questions about the pain, preceding each question with this phrase, "How would you change the size, etc.?"]

Let yourself decide what you would like to do with the pain. There is no right way to finish the experience. . . . Just

accept what feels right to you. You can throw the pain away . . . or place it back where you found it . . . or move it somewhere else. Let yourself become aware . . . of how pain can be changed. . . . By your focusing with intention, the pain changes.

It is not unusual for the pain to go completely away, or at least lessen after this exercise. The client also learns to manipulate the pain so that it is not the controlling factor of his or her life. The exercise is also effective with severe pain. After giving pain medication, the nurse can have the client relax during the imagery process.

Correct Biologic Imagery Teaching Sheets and Scripts

Clients who are given specific information about the role of bodymind connections, correct biologic healing images, and stress management strategies have fewer complications and shorter recovery times.[67–69] The nurse elicits from a client/patient images and symbols that have special healing meaning and value, then makes an audiocassette for the client/patient that includes correct biologic images, specific concrete objective information, specific symbols, and specific types of imagery. (See Chapter 23 for guidelines on making an audiocassette tape and establishing an audio/video library.)

It may seem that the following scripts are suitable only for well-educated, sophisticated individuals, but this is not the case. It is necessary, however, for the nurse to assess the individual's education level and adapt these scripts to fit the person's needs and cultural beliefs. Imagery is an important tool, particularly for those clients who do not read.

Bone Healing Imagery. An imagery exercise for bone healing[70] may be done in 20 to 30 minutes. Prior to imagery, to teach basic biologic imagery of bone healing, the nurse explains

- reaction (cellular proliferation). Within the hematoma surrounding the fracture, cells and tissues proliferate and develop into a random structure (Figure 22–1A).
- regeneration (callus formation). At 10 to 14 days after the fracture, the cells within the hematoma become organized in a fibrous lattice. With sufficient organization, the callus becomes clinically stable. The callus obliterates the medullary canal and surrounds the two ends of bone by irregularly surrounding the fracture defect (Figure 22–1B).
- remodeling (new bone formation). Approximately 25 to 40 days after the fracture, calcium is laid down within bone that has spicules perpendicular to the cortical surface (Figure 22–1C). Osteonal bone gradually replaces and remodels fiber bone. The fracture has been bridged over by new bone (Figure 22–1D). Conversion and remodeling continue up to 3 years following an acute fracture.

Script: *In your relaxed state,* [name], *allow yourself to imagine a natural process that is occurring within your body. . . . New cells are gathering very fast at the site of your fracture* [cellular proliferation]. *This is an important process as it lays the foundation for your bone healing. With your next breath in . . . become aware of the fact . . . that right now your body is allowing those new cells to multiply rapidly* [positive sugges-

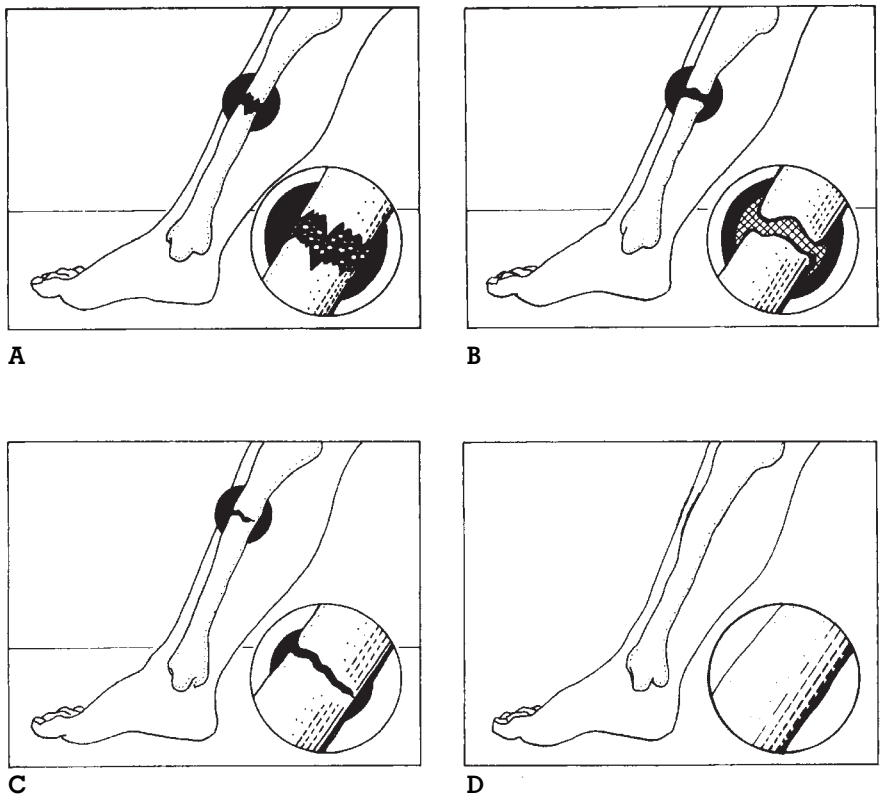


Figure 22–1 **A**, Reaction: hematoma and cellular proliferation. **B**, Regeneration. **C**, Remodeling: calcium ossification. **D**, Healed bone. *Source:* Reprinted with permission from J. Achterberg, B. Dossey, and L. Kolkmeier, *Rituals of Healing,* © 1994, Bantam Books.

tion]. *Your blood cells . . . at the site of your fracture are arranging themselves in a special healing pattern. You can relax . . . even more . . . if you want to . . . as you continue with this very natural healing process.*

In a few days, . . . your wise body will begin to create a strong lattice network of new bone [regeneration]. *This will allow your bone to become stable, bridging the new bone that is forming. As you focus in a relaxed way, . . . you help in your healing, . . . for relaxation increases this natural process. Imagine your relaxation to be like a gentle breeze of wind that flows over and throughout your body.*

In a few more weeks, your new bone will be formed. . . . Natural deposits of calcium from your body will be taken into the place of healing [remodeling]. *Allow an image to come to your mind now of beautiful, healed bone. In about 6 weeks, you will have a*

beautiful bridge where the calcium has formed new bone. . . . Can you imagine a healing light within you right now? Allow this healing light to radiate throughout your body, bringing its loving energy to every cell in your body. . . . Stay with this experience for as long as you want, and then whenever you feel ready, slowly bring your awareness back to the room. . . .[71]

Burn Graft Healing Imagery. In 20 to 30 minutes, the nurse can teach patients about the normal burn graft healing process with correct biologic images (Figure 22–2A).

- Day 1: The adhesion of surfaces and the bridging of the space between the graft bed and the graft begin (Figure 22–2B).
- Day 2: The vessels from the patient grow into the graft (Figure 22–2C).
- Day 3: The vessels establish vascular continuity (Figure 22–2D).

Script: *In your relaxed state now, . . . let's begin a journey into your body. . . . Begin to identify the capacity that you have to work with the healing process with your new graft. In your mind, go to the area where you have been burned. I am going to describe the healing process . . . that is taking place with your new graft. In your mind, go to the area of your body where you have received your new graft. If you begin to feel any tension, . . . just take a deep breath, and know that you can let yourself relax and release any tension at this time. . . . Notice how you can deepen your state of relaxation . . . releasing the tension as you breathe out* [positive suggestion]. . . . *Imagine relaxation is like a still mountain lake. Experience the gentle wind forming ripples on the surface of the lake. . . . As the ripples widen, . . . realize they are ripples of relaxation flowing through your body and mind* [metaphor]. *Before your graft, the area where you were burned was gently cleansed. . . . In this clean area, the graft was gently placed and covered with a thick layer of dressings.*

In your mind, begin to imagine the healing process. On Day 1, imagine that your own skin secretes a kind of glue. This glue is very important, because it will allow your new graft to stick and hold in a healthy way. Just take several relaxing breaths now . . . in . . . and out, . . . feeling the pause between each of those breaths. As you go deeply into relaxation, feel yourself . . . participating in natural healing processes, . . . your skin secreting a glue, and your new graft sticking to it and becoming part of your body . . . part of your healing. During this first day, you will also remember to move gently and work with the nurses as they help you with your comfort . . . your healing . . . your recovery. . . .

Now begin to move to Day 2. On this day, after receiving your graft, your body continues the healing process. Your body is sending nutrients to the graft, small blood vessels are sprouting out . . . like little hands moving out, sending nutrients to every cell in this area, nourishing and caring

A

B

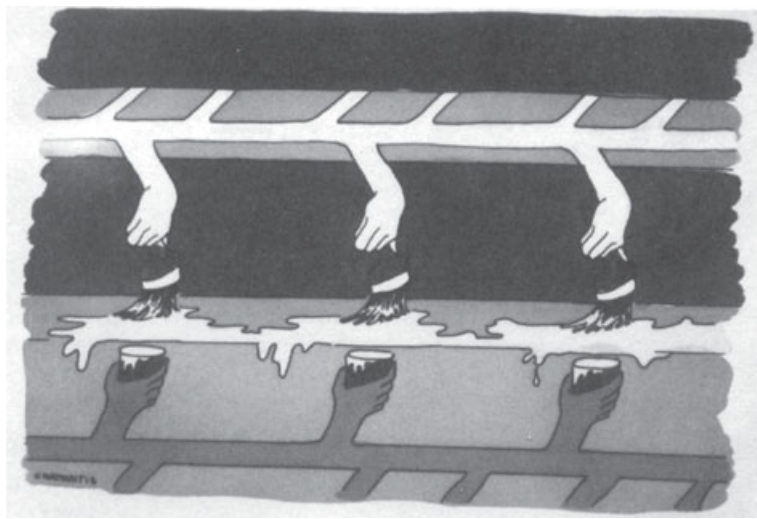
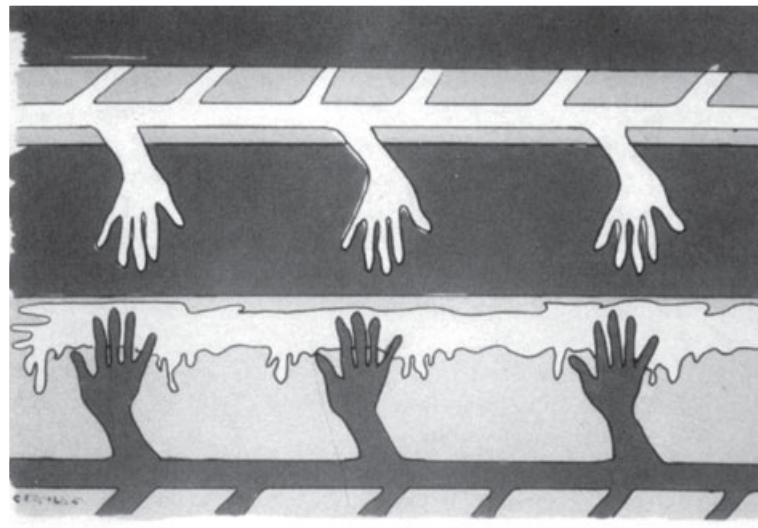


Figure 22–2 **A**, A child who has been severely burned is provided process images just prior to his surgery. **B**, Skin grafts, using the boy's own healthy skin, will be placed over the burned areas. He is shown these pictures and told that, on the first day, something like glue will come out of his body to stick on the graft. *Source:* Reprinted with permission from J. Achterberg, B. Dossey, and L. Kolkmeier, *Rituals of Healing,* © 1994, Bantam Books.

---

for you. Remember to stay as still as possible and let the nurses help you move. [Adapt this phrase as needed if working with a small child.] *This is important, . . . for it also helps those tiny blood vessels grow in a very healthy manner. During this time, you will continue to increase your relaxation to that particular area where your grafts will take hold. And as you exhale, let go of any tension and tightness.*

C



D

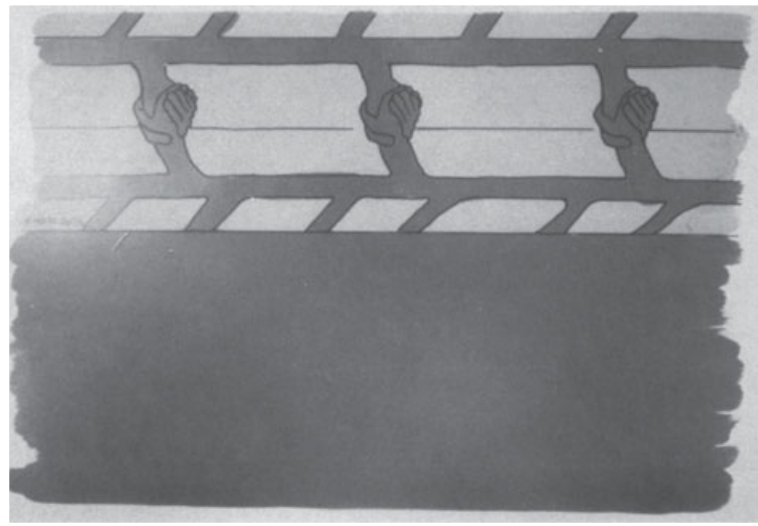


Figure 22–2 continued. **C**, On the second day, blood vessels (like hands) will reach out toward each other. **D**, Finally, if all goes well, on the third day, his skin graft will be complete. *Source:* Reprinted with permission from J. Achterberg, B. Dossey, and L. Kolkmeier, *Rituals of Healing,* © 1994, Bantam Books.

Now move to Day 3 of your recovery process. By Day 3, the blood vessels from your own body . . . and the blood vessels from your graft actually grow together. Imagine . . . blood vessels joining hands, uniting . . . [metaphor]. *As you feel this*

experience of your blood vessels joining hands, just imagine now this graft is part of your body . . . just like all the other cells of your body. Imagine this is happening now, . . . the graft is now a part of you. . . .

Again, let us go over these three important areas that will occur after your graft. On Day 1, your skin secretes a glue, and the glue sticks to your own skin. On Day 2, blood vessels from your own skin and the blood vessels from the graft begin to grow together. By Day 3, those blood vessels have joined together, and this graft is now a part of your body. [If the graft is from the patient, the nurse may continue.] *Spend some time now focusing on that area where the graft came from your body. The natural healing ability is also occurring there, with the new skin now being formed.* [Repeat information in the script on wound healing, but substitute the words "new skin" for "graft."][72]

Wound Healing Imagery. To teach the normal wound healing process with correct biologic images,[73] the nurse explains

- reaction. Fluid leaks into tissue at the time of the injury, causing swelling and inflammation; white blood cells migrate to the wound. Inflammation continues from injury to 72 hours (Figure 22–3A).
- regeneration. Granulation and deposit of fibrous collagen protein tissue continue for as long as 3 weeks following the injury (Figure 22–3B).
- remodeling. Healing of a wound takes from 3 weeks for minor wounds to 2 years for severe wounds (Figure 22–3C).

A wound healing imagery intervention may last 20 to 30 minutes.

Script: *Focus on calmness and rhythmic breathing . . . and become aware of your ritual . . . for cleansing your wound. Let it be done slowly . . . without hurry. To avoid holding your breath, . . . take several rhythmic breaths prior to cleansing your wound. When you are ready to begin the cleansing of your wound, . . . take a breath in . . . and, on the exhale, place the hydrogen peroxide or other solutions on the wound and surrounding area or along suture lines. Next, on the area that has been cleansed and patted dry, place the ointment in the same area to help speed the healing process. Now is the time to place a clean dressing on the wound.*

Allow yourself to imagine a natural process that is occurring within your body. . . . New cells are being made in the open skin area . . . to allow a stable place for repair and new growth. Now your blood flow is surging to this area. . . . Special white blood cells, your macrophages, are recognizing any foreign material and carrying it away. Remember . . . be with the special healing process of your wound. . . . If your wound is superficial, it heals from the edges toward the center. . . . A deep wound will heal from the inside to the outside.

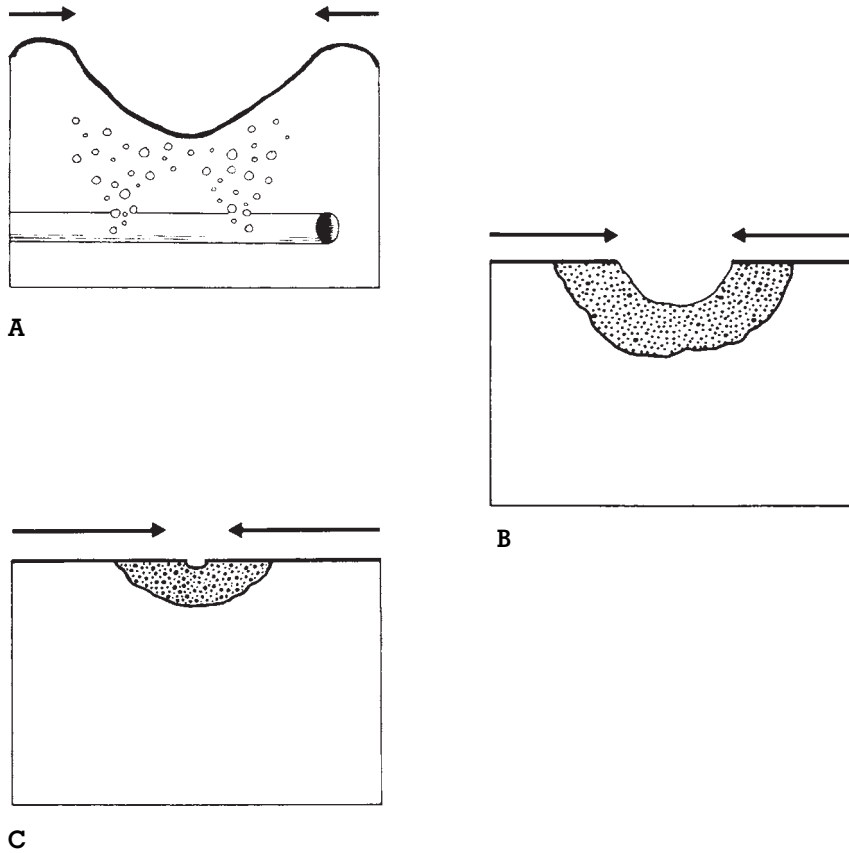


Figure 22–3 **A**, Reaction: inflammation and stabilization of wound (injury to 72 hours). **B**, Regeneration: granulation and deposit of fibrous collagen protein tissue (up to 3 weeks). **C**, Remodeling: healed wound (3 weeks to 2 years). *Source:* Reprinted with permission from J. Achterberg, B. Dossey, and L. Kolkmeier, *Rituals of Healing*, © 1994, Bantam Books.

A beautiful area is now forming. . . . you might imagine it like looking down into a lovely shallow bowl. Within this area . . . your body now places soft, healthy, delicate fibrous protein tissue . . . like a network of beautiful lights . . . the beginning of a strong scar that starts below the surface of the skin.

Become more aware . . . of the fact . . . that your own special cells, the fibroblasts, are producing this collagen protein. Many small buds of new tissue continue to be laid down and grow stronger and fuller, creating healthy new skin and scar tissue. The opening shrinks and becomes smaller as healing occurs.

Let an image or feeling of the new healed skin surface emerge. . . . Your skin has

healed from the inside to the outside. See, hear, and feel your healed, smooth, new skin that is strong and healthy.

Immune System Odyssey Imagery. Patients can be taught correct biologic images of the normal process of the immune system.[74] (For more details, see Chapter 4 on mind modulation of the immune system.) The nurse may explain the following:

- **Neutrophils.** The most numerous cells, billions of neutrophils swim in the bloodstream; when they sense unhealthy tissue, they pass through the blood vessel, move to the unhealthy tissue or cells, surround it, shoot caustic chemicals, and destroy the unhealthy tissue or cells (Figure 22–4).
- **Macrophages.** Moving throughout the body, ever ready to eat, macrophages travel in hoards; each one swells up, consuming the enemy (e.g., bacteria, viruses, yeast, cancer cells).
- **T-cells.** Born in the bone marrow, millions of T-cells go from infancy to adolescence each minute. They go to the thymus gland, where they get a special imprint; some are designated killer cells, while others become helpers or suppressors. All these specialized cells keep a watchful vigil in the lymph nodes and tissue until needed.
- **B-cells.** For years, B-cells wait and mature in the bone marrow until needed. They can change like caterpillars to butterflies, becoming plasma cells that manufacture magic bullets; the protein called antibodies. Operating like a guided missile, they can shoot the target, paralyze the enemy, shoot caustic chemicals, and explode the bad cells and tissue. B-cells can clone themselves and create whatever number it takes to do the battle.

In 20 to 30 minutes, the nurse can guide the client through an intervention, modifying the script as needed.

Script: *You are about to embark on the most incredible journey imaginable, a journey through your own immune system, touching your body's healing forces with your mind; you will sense, feel, envision a miracle. A miracle of defense and protection, a miracle of the billions of honorable, persistent warriors within that have but one mission: to guard you from disease and injury and invasion.*

To fully appreciate this odyssey, which is as complex as it is magnificent, it is important to clear and focus your mind, to relax your body. The bridge between your mind and body is easily crossed when distractions are released, when a sense of peace and calm spreads warmly from the top of your head to your toes. As you let go of stress, your immune system is activated. Relax, now, as you participate in and observe your own healing process.

As your mind becomes clearer and clearer, feel it becoming more and more alert. Somewhere deep inside of you, a brilliant light begins to glow. Sense this happening. . . . The light grows brighter and brighter and more intense. . . . This is your bodymind communication center. Breathe into

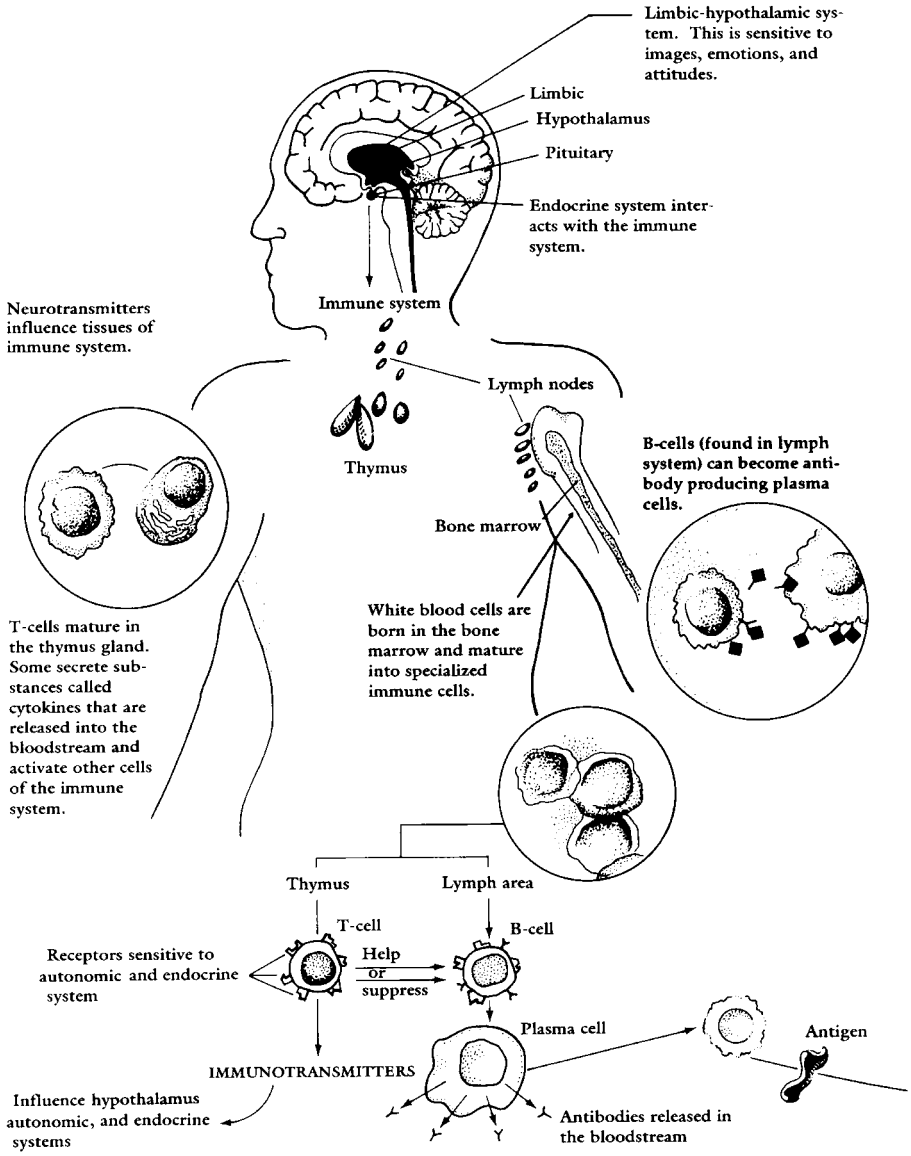
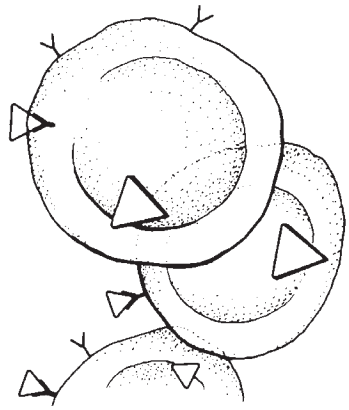


Figure 22–4 Immune system components. *Source:* Reprinted with permission from J. Achterberg, B. Dossey, and L. Kolkmeier, *Rituals of Healing*, © 1994, Bantam Books.

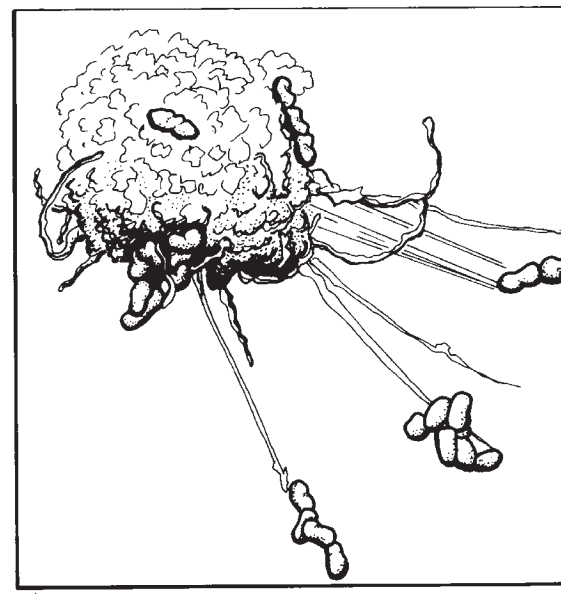
---

it. . . . Energize it with your breath. The light is powerful and penetrating, and the beam begins to grow from it. The beam shines into your body into any area you wish. It is your searchlight, your bridge into the glorious mysteries about to unfold. Practice shining it into your body. Sometimes this is easier to do than other times. Just allow it to happen.

The immune journey begins inside your bones. So take this



Neuropeptides produced in the brain lock onto specific receptors of immune cells.



Phagocytes, such as neutrophils and the macrophage pictured here literally eat bacteria, viruses, cancer cells, and other foreign particles or destroyed tissue and contain chemicals that break down and destroy the invaders.

The immune system produces memory cells when exposed to an antigen, and the immune system then remembers that encounter and becomes more efficient against it the next time it gets invaded by microorganisms that produce antigens.

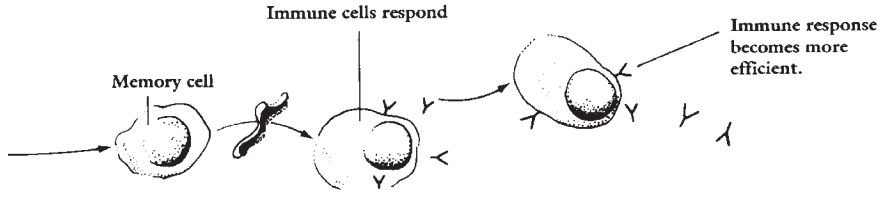


Figure 22–4 continued

---

most intelligent beam of light and shine it into a long bone . . . a leg bone perhaps. Penetrate deeply into the marrow. This is the birthing center for all your blood cells. Just imagine if you can, . . . feel if you can, . . . billions . . . of young cells being born . . . many kinds, each with a task to nurture and protect you. As we go through this exercise, we will focus on a few types of cells that are vital to defending you. They have

names: neutrophils, macrophages, T-cells, B-cells, natural killer cells. One by one, we'll shine the light on them, watching them work to guard and protect and remove cells that no longer serve you.

The most numerous cells are called neutrophils. They eat and engulf the invaders in a most ingenious way. Imagine them maturing, moving into your bloodstream, floating, ever alert for a call to work in your defense. As a call warns them of an invader, they become exceedingly alert. No longer swimming freely, millions, billions of them sense the danger and move methodically, directly, preparing for attack. The blood vessels become sticky, attracting the neutrophils to their surface. The small opening in the blood vessel walls dilates in the vicinity of the attack. Imagine the neutrophils being attracted to the walls. They move quickly along the vessel walls until they know with absolute certainty that the invader is near. Now, they extend a small foot, a pseudopod, into the walls, and changing shape, they slither through, entering your tissues. Moving forward now, as they approach the invader, they send another small foot out, surrounding the enemy, shooting caustic chemicals into it, wearing it thin. The enemy is halted, destroyed, may even explode into harmless bits. Imagine this happening, constantly, protecting you from the dangers of living in a hostile world. Billions and billions of neutrophils are born every day.

Now, shining the beam of light back into the bone marrow, imagine the macrophages, or the giant eaters . . . fewer of them, but long-lived with many talents. As they mature, watch them move into tissues and organs and blood. They line the walls of the lungs and liver . . . waiting, surveying, watching, ever ready to move. Bacteria, viruses, yeast cells, even cancer cells trigger the alarm. As the warning of an invader sounds, the macrophages swell up, becoming large and powerful. They may even mesh together with the other macrophages, moving rapidly in a powerful, connecting flank. They reach out for the enemy; lasso it with their armlike extensions, and bring the invader into their bodies, injecting it with potent enzymes. With lightning speed, they consume an enemy. What they can't destroy, they encircle and preserve, protecting you from its dangerous acts. The macrophages are also your scavengers. They can and will digest anything and everything in your body that you no longer have use for. Imagine this happening for a moment.

The macrophages and neutrophils are nonspecific, nondiscriminating in their attack and clean-up activities. Other cells, the lymphocytes, or the T-cells and the B-cells, have an assigned function, a target

that they spend their entire lives stalking. It might be a special virus, or bacteria, or cancer cell, or other foreign tissue. Let's look at these cells in action.

Shining the beam, again, into the bone marrow, observe the T-cells being born. Millions . . . more than you could possibly count . . . move from infancy to adolescence each minute. The T-cells will each be given a special task as they are processed in the thymus gland. Shine your imagery light into the middle of your chest, here is the thymus gland. Feel it pulsating with energy. Watch, now, as the adolescent T-cells flow in rapidly, each touched with a spark of wisdom, each challenged with a mission. Some will be killers, assassins with a single target. Others will be helpers for your B-cells. Still others will be suppressors, signaling that the battle is over, protecting your body from excessive immune activity. Imagine these, the killers, the helpers, the suppressors, maturing quickly and with glorious specificity in your thymus. When each has been imprinted, they leave the thymus to go about their tasks. The T-cells keep a wakeful vigil in your lymph nodes, your spleen, other lymph tissue. Think of this for a time. . . .

Back in the bone marrow once again, the B-cells are highlighted by the beam. They mature and move into the lymph tissues and blood, waiting for the encounter. Each has a specific enemy to protect you from, and they can wait patiently for years, patrolling, waiting, and watching. When the encounter finally takes place, the B-cells change, like cocoons into butterflies, becoming a plasma cell. The plasma cells manufacture magic bullets, which are proteins called antibodies. Each antibody is like a guided missile. . . . It moves directly for its target and hooks on to it, like a key in a lock. The enemy is paralyzed and its surface damaged. Other chemicals are liberated in the blood by this action, and they burn holes in the wall of the enemy, causing an explosion. The B-cells also clone themselves, creating whatever number is needed to do pure and perfect battle in your defense.

One last time, peering into the birthing center of the immune system, the light shines onto natural killer cells. The natural killers are wondrous defenses against cancer. Like viruses and bacteria, cancer cells are not especially unusual in the human body. The body simply recognizes them as invaders and sends out the forces of defense. Only in the most unusual circumstances (e.g., when cancer cells wear a disguise) does the immune system fail to find them. Watch now, as the natural killer cells are born and move into the bloodstream. Take the light and shine it on one cell, and watch its action.

Ever alert, it senses a cancer cell in the vicinity. Moving at lightning speed, it collides with the cancer cell. Its mere touch paralyzes the cell. Fingers of the natural killer cell reach into the cancer cell, oozing in its power and might. Then a small cannonlike structure within the natural killer cell tilts, aims, and fires deadly chemicals into the cancer cell. Already paralyzed, the cancer cell develops blisters, peels like an orange. Its cellular matter dissolves, leaving only harmless skeletal remains. The natural killer cell, alive and well, continues its alert patrol of your body.

Before you end this exercise, go over the immune process once more, sensing all the immune cells working in a superbly coordinated team of defense. In the bone marrow, billions of cells are being born each minute, in exactly the number and combinations that you need to stay healthy. As the white blood cells mature, each develops a remarkable intelligence. Each has a dedicated task. Witness these cells moving out of the bone marrow, into blood tissue, watching and waiting for the opportunity to protect and cleanse you. Feel the presence of these magnificent guardians, and sense their power. These dedicated warriors, this system of defense has a universe of its own. That universe is you. By relaxing, as you have just done, and concentrating on this process, you have actively participated in keeping yourself healthy.[75]

Imagery and Drawing. In the imagery process, drawing is an effective way to open up communication with the self and others. It externalizes previously internal mental images and emotions. The emphasis in this intervention is not on how well the client can draw, but on the client's ability to get in touch with feelings and healing potential through drawing. When clients are overwhelmed with emotions, drawing images of the feelings can be therapeutic. Drawing is also helpful with children who are not verbally sophisticated. Tremendous insight can be gained in this process with both adults and children who are going through painful procedures or are experiencing certain concerns, fears, or problems in daily life.

Drawing after being guided through an imagery exercise can bring further insights. The creativity that is evoked is different from the logical mode of explaining the experiences in words. Drawing works very well when a client is crying and is unable to talk easily, but wants to express what he or she is experiencing. When using drawing as an intervention, the nurse can suggest the following general ideas:

- Express yourself with a few images. There is no one best way to draw. Drawings can be either realistic or symbolic. The most important thing is that you express yourself in a nonlogical way. This can bring new awareness and understanding into your life.
- If you find that you are too focused on the result of the drawing exercise, use your nondominant hand. With your

eyes closed, allow yourself to get into the expressive quality of drawing.
- Do not judge your drawing. Allow your body, mind, and spirit to connect as you begin simply to be with the paper and crayons in the present moment.
- Notice the energy flow from you. Let your body energy resonate with your imagery/spirit energy. Let the energies slowly begin to resonate together. Do not try to control the process, because this inner quality comes from being immersed in the imagery and drawing experience.
- On the blank piece of paper, allow an image to begin to form that represents your feelings and thoughts in this moment. Choose colors that speak to you. If you wish to change the color that you started working with, feel free to do so.
- After you have drawn, you might want to write some details of your images. Often, what you felt or heard during the imagery drawing may surface into conscious awareness and provide new insights about your important images.

When working with drawing for a client's specific disease/symptoms, it is helpful for the nurse to educate the client about the body processes that are being affected. It is therapeutic for the client to have an understanding of, and an image for, the healthful state, the disease/symptoms and its medication, treatments, and associated procedures, and his or her personal belief systems. Asking the client to draw the disease/symptoms in the way that has self-meaning often reveals a client's constricted view of healing possibilities or misunderstanding of the disease/symptoms, either of which may impair recovery. The drawing process helps the client recognize that the disease need not control his or her life. Insight from drawing helps the client reframe experiences of illness, let go of the inner judgments and struggles, and mobilize his or her creativity for achieving desired outcomes.

The challenge for nurses is to develop innovative teaching worksheets, booklets, and verbal descriptions of bodymind healing; to integrate imagery as part of each nursing interaction and intervention; and to develop assessment tools.[76] The nurse and client should identify the following elements for the best outcome:

- Disease or disability: the vividness of the client's view of the disease, illness, or disability and, if the process is ongoing, the strength of the disease/illness to decrease health or the client's focus on the reverse—the vividness and the strength of the client's ability to stabilize the disease/illness or stop the process.
- Internal healing resources: the vividness of the client's perception of his or her healing ability and the effectiveness of this ability/action to combat the disease.
- External healing resources: the vividness of the treatment description and the effectiveness of the positive mechanism of action.

Case Study

Setting:	Coronary care unit (CCU), followed by outpatient cardiac rehabilitation program
Patient:	J.D., a 48-year-old male, with acute myocardial infarction complicated by congestive heart failure and pericarditis secondary to the infarction
Patterns/ Challenges/ Needs:	1. Decreased cardiac output related to mechanical factors (congestive heart failure)

2. Altered comfort related to inflammation (pericarditis)
3. Anxiety related to acute illness and fear of death

The nurse asked J.D. several questions in order to explore with him his psychospiritual state. Following the interaction, the nurse felt that further exploration of the meaning and negative images that he conveyed was essential to his recovery. She asked him if he wanted to pursue some new ideas that might help him access his inner healing resources and strengths. He said that he would.

Nurse: In your recovery now with your heart healing, how do you experience your healing?

J.D.: There is this sac around my heart, and every time I take a deep breath, my breath is cut off by the pain [*pericarditis*]. My heart is like a broken vase. I don't think it is healing.

Nurse: I can understand why you are discouraged. However, some important things that are present right now show that you are better than when you first came to the CCU. Your persistent chest pain is gone, and your heartbeats are now regular. If you focus on what is going right, you can help your heart and lift your spirits. Let me help you learn how to think of some positive things.

J.D.: I don't know if I can.

Nurse: I would like to show you how to breathe more comfortably. Place your right hand on your upper chest, and your left hand on your belly. I want to show you how to do relaxed abdominal breathing. With your next breath in, through your nose, let the breath fill your belly with air. And as you exhale through your mouth, let your stomach fall back to your spine. As you focus on this way of breathing, notice how still your chest is.

J.D.: (*After three complete breaths*) This is the easiest breathing I've done today.

Nurse: As you focused on breathing with your belly, you let go of fearing the discomfort with your breathing. Can you tell me more about the image you have of your heart as a broken vase?

J.D.: I saw this crack down the front of my heart right after the doctor told me about my big artery that is blocked, that runs down the front of my heart, that caused my heart attack.

Nurse: (*Taking a small plastic bag full of crayons out of her pocket and picking up a piece of paper*) Is it possible for you to choose a few crayons and draw your broken heart using those images you just talked about?

J.D.: I can't draw.

Nurse: This exercise has nothing to do with drawing, but something usually happens when you draw an image of your words.

J.D.: Do you mean the image of a broken vase? (*When halfway through with the drawing*) I know this sounds crazy, but my father had a heart attack when he was 55. I was visiting my parents. Dad hadn't been feeling well, even complained of his stomach hurting that morning. He was in the living room, and as he fell, he knocked over a large Chinese porcelain vase that broke in two pieces. I can remember so clearly running to his side. I can see that vase now, cracked in a jagged edge

down the front. He made it to the hospital, but died 2 days later. You know, I think that might be where that image of a broken heart came from [Figure 22–5A].

Nurse: Your story contains a lot of meaning. Remembering this event can be very helpful to you in your healing. What are some of the things that you are most worried about just now?

J.D.: (*Tears in his eyes*) Dying young. I have this funny feeling in my stomach just now. I don't want to die. I'm too young. I have so much to contribute to life. I've been driving myself to excess as far as work. I need to learn to relax and manage my stress, even drop some weight, start exercising, and change my life.

Nurse: J., each day you are getting stronger. You might even consider that this time of rest after your heart attack can be a time for you to reflect on what are the most important things in life for you. Whenever you feel discouraged, let images come to you of a beautiful vase that has a healed crack in it. This is exactly what your heart is doing right now. Even as we are talking, the area that has been damaged is healing. As it heals, there will be a solid scar that will be very strong, just in the same way that a vase can be mended and become strong again. New blood supplies also come into the surrounding area of your heart to help it heal. Positive images can help you heal, because you send a different message from your mind to your body when you are relaxed and thinking about becoming strong and well. You help your body, mind, and spirit function at their highest level. Let yourself once again draw an image of your heart as a healed vase, and notice any difference in your feelings when you do this.

With a smile, he picked up several crayons and began to draw a healing image to encourage hope and healing (Figure 22–5B).

When J.D. entered the outpatient cardiac rehabilitation program following his acute myocardial infarction, he was motivated to lower his cholesterol, lose weight, learn stress management skills, and express his emotions. Two weeks into the program, J.D. did not appear to be his usual extroverted self. The cardiac rehabilitation nurse engaged him in conversation, and before long, he had tears in his eyes. He stated that he was very discouraged about having heart disease. He said, "It just has a grip on me." The nurse took him into her office, and they continued the dialogue. After listening to his story, she asked J.D. if he would like to explore his feelings further. He very shyly nodded yes.

In order to facilitate the healing process, she thought it might be helpful to have J.D. get in touch with his images and their locations in his body. She began by saying, "If it seems right to you, close your eyes and begin to focus on your breathing just now." She guided him in a general exercise of head-to-toe relaxation, accompanied by an audiocassette music selection of sounds in nature. As his breathing patterns became more relaxed and deeper, indicating relaxation, she began to guide him in exploring "the grip" in his imagination.

Nurse: Focus on where you experience the grip. Give it a size, . . . a shape, . . . a sound, . . . a texture, . . . a width, . . . and a depth.

J.D.: It's in my chest, but not like chest pain. It's dull, deep, and blocks my

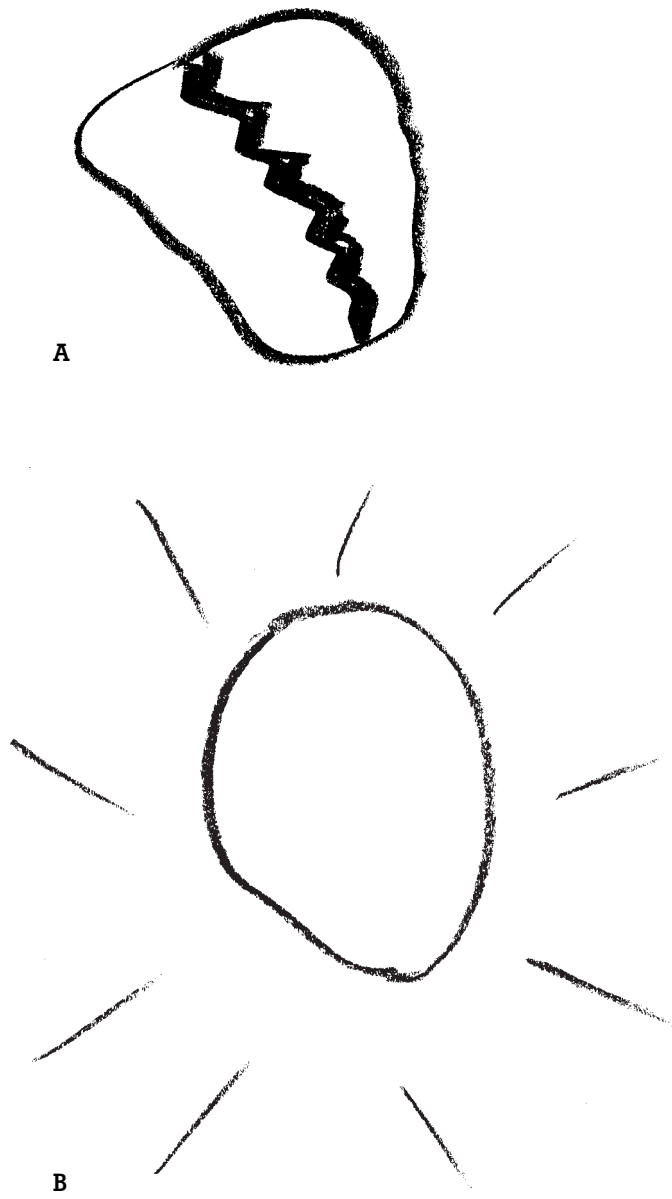


Figure 22–5 **A**, J.D.'s drawing of his broken heart. **B**, J.D.'s drawing of his healed heart.

---

knowing what I need to think or feel about living. I can't believe that I'm using these words. Well, it's bigger than I thought. It's very rough, like heavy jute rope tied in a knot across my chest. It has a sound like a rope that keeps a sailboat tied to a boat dock. I'm now rocking back and forth. I don't know why this is happening.

Nurse: Stay with the feeling, and let it fill you as much as it can. If you need to change the experience, all you have to do is take several deep breaths.

J.D.: It's filling me up. Where are these sounds, feelings, and sensations coming from?

Nurse: From your wise, inner self, your inner healing resources. Just let yourself stay with the experience. Continue to use as many of your senses as you can to describe and feel these experiences.

J.D.: Nothing is happening. I've gone blank.

Nurse: Focus again on your breath in . . . and feel the breath as you let it go . . . . Can you allow an image of your heart to come to you under that tight grip?

J.D.: It is so small I can hardly see it. It's all wrapped up.

Nurse: In your imagination, can you introduce yourself to your heart as if you were introducing yourself to a person for the first time? Ask your heart if it has a name?

J.D.: It said hello, but it was with a gesture of hello, no words.

Nurse: That is fine. Just say, "Nice to meet you," and see what the response might be.

J.D.: My heart seems like an old soul, very wise. This feels very comfortable.

Nurse: Ask your heart a question for which you would like an answer. Stay with this and listen for what comes.

J.D.: (*After long pause*) It said practice patience, that I was on the right track, that my heart disease has a message, don't know what it is.

Nurse: Just stay with your calmness and inner quiet. Notice how the grip changed for you. There are many more answers to come for you. This is your wise self that has much to offer you. Whenever you want, you can get back to this special kind of knowing. All you have to do is take the time. When you set aside time to be quiet with your rich images, you will get more information. You might also find special music to assist you in this process. . . . Your skills with this way of knowing will increase each time you use this process . . . now that whatever is right for you in this moment is unfolding, just as it should. In a few moments, I will invite you back into a wakeful state. On five, be ready to come back into the room, wide awake and relaxed. One . . . two . . . three . . . four . . . eyelids lighter, taking a deep breath . . . and five, back into the room, awake and alert, ready to go about your day.

J.D.: Where did all that come from? I've never done that before.

Nurse: These are your inner healing resources that you possess to help you recognize quality and purpose in living each day. In our future sessions, we will teach and share more of these skills.

Evaluation

With the client, the nurse determines whether the client outcomes for imagery were successful (Table 22–3). To evaluate the session further, the nurse may again explore the subjective effects of the experience with the client (see Exhibit 22–1).

Imagery is a tool for connecting with the unlimited capabilities of the bodymind. It is a nonverbal modality and a rich resource for information about all life processes. Using imagery, a nurse can help a client make changes in perceptions, behaviors, and attitudes that can promote healing.[77] The client experiences more self-awareness, self-acceptance, self-love,

and self-worth. Nurses and clients come to know themselves in a new way as they create and communicate in the symbolic language of the imagination.

DIRECTIONS FOR FUTURE RESEARCH

1. Determine whether a client's specific images increase the client's psychophysiologic healing.
2. Develop valid and reliable tools that measure imagery.
3. Compare the stress level, attitudes, and work spirit of nurses who routinely use imagery as a nursing intervention to those of nurses who do not use imagery.
4. Evaluate the relationship of imagery scripts, physiologic responses, and healing in different clinical settings.
5. Determine if subjects can learn through manipulation of both imagery scripts and their verbal reports to eliminate or modify negative psychophysiologic responses.
6. Examine cultural diversity through specific types of imagery and symbols.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- How do I feel about my imagination?
- When I work with imagery, what inner resources can assist me in my life processes?
- How am I able to remove the barriers to my imagery process?
- In what way do I recognize the nonrational part of myself?
- Can I allow my clients to interpret their own imagery to facilitate their own healing?

Exhibit 22–1 Evaluating the Client's Subjective Experience with Imagery

1. Was this a new kind of imagery experience for you? Can you describe it?
2. Did you have a visual experience? Of people, places, or objects? Can you describe them?
3. Did you see colors while being guided? Did the colors change as the guided imagery continued?
4. Were you aware of your surroundings? Were you able to let the imagery flow?
5. Did you like the imagery?
6. Did the imagery produce any feelings or emotions?
7. Did you notice any textures, smells, movements, or tastes while experiencing the imagery?
8. Was the experience pleasant?
9. Did you feel relaxed and refreshed after the experience?
10. Would you like to try this again?
11. What would make this a better experience for you?
12. What is your next step (or your plan) to integrate this on a daily basis?

NOTES

1. J. Giedt, Guided Imagery: A Psychoneuroimmunological Intervention in Holistic Nursing Practice, *Journal of Holistic Nursing* 15, no. 2 (1997):112–127.
2. J. Nickel, Placebo Therapy of Benign Prostatic Hyperplasia: A 25 Month Study, Canadian PROSPECT Study Group, *British Journal of Urology* 81, no. 3 (1998):383–387.
3. F. Benedetti et al., The Specific Effects of Prior Opioid Exposure on Placebo Analgesia and Placebo Respiratory Depression, *Pain* 75, no. 2–3 (1998):313–319.
4. P. Staats et al., Suggestion/Placebo Effects on Pain: Negative As Well As Positive, *Journal of Pain Symptom Management* 15, no. 4 (1998):235–243.
5. I. Hashish et al., Reduction of Postoperative Pain and Swelling by Ultrasound: A Placebo Effect, *Pain* 83 (1988):303–311.
6. R. Hahn, The Nocebo Phenomenon: Concept, Evidence, and Implications for Public Health, *Preventive Medicine* 26, no. 5 (1997):607–611.
7. M. Wall and S. Wheeler, Benefits of the Placebo Effect in the Therapeutic Relationship, *Complementary Therapies in Nursing and Midwifery* 2, no. 6 (1996):160–163.
8. J. Achterberg, *Imagery in Healing* (Boston: Shambhala, 1985).
9. A.A. Sheikh et al., Healing Images: Historical Perspective, in *Healing Images: The Role of Imagination in Health*, ed. A.A. Sheikh (Amityville, New York: Baywood Publishing Company, Inc., 2003), 3–26.
10. R. Schaub, Alternative Health and Spiritual Practices, *Alternative Health Practitioner* 1, no. 1 (1995):35–38.
11. J. Singer, *Imagery and Daydream Methods in Psychotherapy and Behavior Modification* (New York: Academic Press, 1974).
12. D. Foulkes and S. Fleisher, Mental Activity in Relaxed Wakefulness, *Journal of Abnormal Psychology* 84, no. 1 (1975):66–75.
13. J. Singer and J. Antrobus, Daydreaming, Imaginal Processes and Personality: A Normative Study, in *The Function and Nature of Imagery*, ed. P. Sheehan (New York: Academic Press, 1972).
14. J. Singer, *The Inner World of Daydreaming* (New York: Harper Colophon, 1975).
15. A. Kokoszka et al., Preliminary Evidence for Diurnal Fluctuations in Visual Imagery, *International Journal of Neuroscience* 101, no. 1–4 (2000):1–7.
16. W. Penfield, *The Mystery of the Mind* (Princeton, NJ: Princeton University Press, 1975), 34.
17. H. Graham, *Mental Imagery in Health Care* (London: Chapman & Hall, 1995), 2–4, 18.
18. Graham, *Mental Imagery in Health Care*.
19. E. Jacobson, Electrical Measurements of Neuromuscular States during Mental Activities: Imagination of Movement Involving Skeletal Muscle, *American Journal of Physiology* 91 (1929):597–608.
20. L. Yaguez et al., A Mental Route to Motor Learning: Improving Trajectorial Kinematics through Imagery Training, *Behavior and Brain Research* 90, no. 1 (1998):95–106.
21. W. James, *Principles of Psychology* Vol. 2 (New York: Henry Holt, 1890).
22. R. Suinn, Imagery and Sports, in *Imagery: Current Theory, Research, and Application*, ed. A. Sheikh (New York: John Wiley and Sons, 1983), 507–534.
23. D. Smith, Imagery in Sport: A Historical and Current Overview, in *Mental Imagery*, ed. R. Kunzendorf (New York: Plenum Press, 1991), 215–224.
24. R. Weinberg et al., Effects of Visuo-Motor Behavior Rehearsal, Relaxation, and Imagery on Karate Performance, *Journal of Sports Psychology* 3 (1981):228–238.
25. M. Quintyn and E. Cross, Factors Affecting the Ability To Initiate Movement in Parkinson's Disease, *Physical and Occupational Therapy in Geriatrics* 4 (1986):51–60.
26. Weiss et al., Mental Practice of Motor Skills Used in Poststroke Rehabilitation Has Own Effects on Central Nervous Activation, *International Journal of Neuroscience* 78, no. 3–4 (1994):157–66.
27. C. Simonton et al., Psychological Intervention in the Treatment of Cancer, *Psychosomatics* 21 (1980):226–227.
28. J. Achterberg and G.F. Lawlis, *Imagery and Disease* (Champaign, IL: Institute for Personality and Ability Testing, 1978).
29. Achterberg, *Imagery in Healing*.
30. H. Hall, Imagery, PNI and the Psychology of Healing, in *The Psychobiology of Mental*

Imagery, eds. R. Kunzendorf and A. Sheikh (Amityville, NY: Baywood Publishing Company, Inc., 1990).

31. H. Hall, Voluntary Immunomodulation, *The Challenge* 12, no. 4 (1990):18–20.
32. J. Schneider et al., Guided Imagery and Immune System Function in Normal Subjects: A Summary of Research Findings, in *Mental Imagery*, ed. R. Kunzendorf (New York: Plenum Press, 1991), 179–191.
33. J. Schneider et al., Psychological Factors Influencing Immune System Function in Normal Subjects: A Summary of Research Findings and Implications for the Use of Guided Imagery (Paper presented at the Tenth Annual Conference of the American Association for the Study of Mental Imagery, 1988). New Haven, CT.
34. M. Rider et al., The Effect of Music, Imagery and Relaxation on Adrenal Corticosteroids and the Re-Entrainment of Circadian Rhythms, *Journal of Music Therapy* 22 (1985):46–58.
35. R. Sloman, Relaxation for Anxiety and Depression Control in Community Patients with Advanced Cancer, *Cancer Nursing* 25, no. 6 (2002):432–435.
36. K. Syrjala et al., Relaxation and Imagery and Cognitive-Behavioral Training Reduce Pain during Cancer Treatment: A Controlled Clinical Trail, *Pain* 63, no. 2 (1995):189–198.
37. K. Kolcaba and C. Fox, The Effects of Guided Imagery on Comfort of Women with Early Breast Cancer Undergoing Radiation Therapy, *Oncology Nursing Forum* 26, no. 1 (1999):67–72.
38. M. Quirk et al., Evaluation of Three Psychological Interventions to Reduce Anxiety during MRI Imaging, *Radiology* 173 (1989):759–762.
39. M.B. Thompson and N.M. Coppens, The Effects of Guided Imagery on Anxiety Levels and Movement of Clients Undergoing Magnetic Resonance Imaging, *Holistic Nursing Practice* 8, no. 2 (1994):59–69.
40. D. Tusek et al., Guided Imagery As a Coping Strategy for Perioperative Patients, *American Operating Room Nurse Journal* 66, no. 4 (1997):644–649.
41. E.A. Fors et al., The Effect of Guided Imagery and Amitriptyline on Daily Fibromyalgia Pain: A Prospective, Randomized, Controlled Trial, *Journal of Psychiatric Research* 36, no. 3 (2002):179–187.
42. L.K. Mannix et al., Effect of Guided Imagery on Quality of Life for Patients with Chronic Tension-Type Headache, *Headache* 39, no. 5 (1999):326–334.
43. F. Luskin et al., A Review of Mind-Body Therapies in the Treatment of Cardiovascular Disease, Part 1: Implications for the Elderly, *Alternative Therapies in Health and Medicine* 4, no. 3 (1998):46–61.
44. L.S. Halpin et al., Guided Imagery in Cardiac Surgery, *Outcome Management* 6, no. 3 (2002):132–137.
45. M. Richardson et al., Coping, Life Attitudes, and Immune Responses to Imagery and Group Support after Breast Cancer Treatment, *Alternative Therapies in Health and Medicine* 3, no. 5 (1997):62–70.
46. Giedt, Guided Imagery.
47. C. Holden-Lund, Effects of Relaxation with Guided Imagery on Surgical Stress and Wound Healing, *Research in Nursing and Health* 11 (1988):235–244.
48. B. Rees, Effect of Relaxation with Guided Imagery on Anxiety, Depression, and Self-Esteem in Primiparas, *Journal of Holistic Nursing* 13, no. 3 (1995):255–267.
49. K. Kwekkeboom et al., Imaging Ability and Effective Use of Guided Imagery, *Research in Nursing and Health* 21, no. 3 (1998):189–198.
50. A. Aleman et al., Visual Imagery Without Visual Experience: Evidence from Congenitally Totally Blind People, *Neuroreport* 8, no. 12 (2001):2601–2604.
51. B. Stetson, Holistic Health Stress Management Program: Nursing Student and Client Health Outcomes, *Journal of Holistic Nursing* 15, no. 2 (1997):143–157.
52. Achterberg, *Imagery in Healing*, 115–116.
53. W. Braud, Transpersonal Images: Implications for Health, in *Healing Images: The Role of Imagination In Health*, ed. A.A. Sheikh (Amityville, New York: Baywood Publishing Company, Inc., 2003):448–470.
54. A. Ahsen, *Psycheye* (New York: Brandon House, 1977).
55. R. Assagioli, *Psychosynthesis: A Manual of Principles and Techniques* (New York: Hobbs, Dorman, 1965).
56. R. Assagioli, *Act of Will* (New York: Viking, 1973).
57. B.G. Schaub and R. Schaub, *Dante's Path: A Practical Approach to Achieving Inner Wisdom* (New York: Gotham Books, 2003).
58. Assagioli, *Act of Will*, 51–52.
59. L. Song et al., Heart-Focused Attention and Heart–Brain Synchronization: Energetic and Physiological Mechanisms, *Alternative Therapies in Health and Medicine* 4, no. 5 (1998):44–62.

60. B. Schaub and R. Schaub, *Healing Addictions* (Albany, NY: Delmar, 1997).
61. B.G. Schaub and R. Schaub, Spirituality and Clinical Practice, *Alternative Health Practitioner* 5, no. 2 (1999):145–50.
62. A.A. Sheikh and K.S. Sheikh, Death Imagery: Confronting Death Brings Us to the Threshold of Life, in *Imagination in Health*, ed. Sheikh (Amityville, New York: Baywood Publishing Co., 2003), 471–488.
63. Schaub and Schaub, *Dante's Path*.
64. N. Christman et al., Concrete Objective Information, in *Nursing Interventions: Essential Nursing Treatments*, 2nd ed., eds. G. Bulechek and J. McCloskey (Philadelphia: W.B. Saunders, 1992), 140–149.
65. B. Schaub et al., Clinical Imagery: Holistic Nursing Perspectives, in *Mental Imagery*, ed. R.G. Kunzendorf (New York: Plenum Press, 1991), 207–213.
66. B.G. Schaub, Imagery in Health Care: Connecting With Life Energy, *Alternative Health Practitioner* 1, no. 2 (1995):113–115.
67. J. Achterberg et al., *Rituals of Healing* (New York: Bantam Books, 1994).
68. Achterberg, *Imagery in Healing*.
69. Achterberg and Lawlis, *Imagery and Disease*.
70. Achterberg et al., *Rituals of Healing*.
71. Ibid., 131–132.
72. B. Dossey et al., Psychophysiologic Self-Regulation, in *Critical Care Nursing: Body-Mind-Spirit*, 3rd ed., eds. B. Dossey et al. (Philadelphia: J.B. Lippincott, 1992), 37–38.
73. Achterberg et al., *Rituals of Healing*, 124–128.
74. Ibid., 317–328.
75. Achterberg and Lawlis, *Imagery and Disease*.
76. Achterberg et al., *Rituals of Healing*.
77. K. Brown-Saltzman, Replenishing the Spirit by Meditative Prayer and Guided Imagery, *Seminars in Oncology Nursing* 13, no. 4 (1997):255–259.

RESOURCES

The Brigham Center for Conscious Living—Getting Well
Mind-Body Programs for Patients, Professional Training, Audiotapes, and other resources
Orlando, FL 32802
Telephone: 1-800-426-8662
E-mail: gtngwell@magicnet.net
www.gettingwellorlando.org

Life-Sciences Institute of Mind-Body Health, Inc.
4635 SW Wanamaker Drive
Topeka, KS 66610
Telephone: 785-478-4105
Fax: 785-478-4184
E-mail: lifesci@cjnetworks.com
www.cjnetworks.com/~lifesci/addictive_disorders

New York Psychosynthesis Institute
Certification Program in Clinical Imagery and Clinical Meditation
2 Murray Court
Huntington, NY 11743
Telephone: 631-673-0293
Fax: 631-423-2684
E-mail: rschaub@ix.netcom.com
www.newyorkpsychosynthesis.com

Belleruth Naparstek
Imagery tapes and publications
www.healthjourneys.com

The Medicine of Compassion: Core Skills for Delivering the Human Side of Health Care (2004)
45-minute video with 48-page Leader Guide.
Featuring real doctors and nurses at work with real patients—not role plays or reenactments—this video shows how compassion can be extended to patients, in timely, practical ways as a natural part of every day's work.

Communicating with Compassion: How to Communicate in Ways that Ease the Pain and Lift the Spirit (1997)
40-minute video with 100-page Leader Guide.
Volunteers, in real situations, show a step-by-step method for communicating compassion to people who are ill or injured, isolated, or in distress.

Adventures in Caring Foundation
P.O. Box 2859
Santa Barbara, CA 93139
Telephone: 805-687-5803
Fax: 805-563-7678
Website: www.AdventuresInCaring.org

Composing the Harmony

Grown-ups love figures. When you tell them that you have made a new friend, they never ask you any questions about essential matters. They never say to you, "What does his voice sound like? What game does he love best? Does he collect butterflies?"

Instead they demand: "How old is he? How many brothers has he? How much does he weigh? How much money does his father make?" Only from figures do they think they have learned anything about him.[1]

And we must learn that to know a man is not to know his name but to know his melody.[2]

Moisture from the drops of music nurtures and supplies vital nutrients to our physical and emotional well-being. We become healthy. We flourish as a species. We prosper. We grow. We laugh. We cry. We dance. We sing. We love. We live. We become one.[3]

Music therapy is personal power made manifest. It's a map to the place where strength and well-being and love lie buried deep inside us all. It is a force to create change from within, to find the healer in all of us.[4]

The ancients knew it; our bodies know it. The emerging physician, the new doctor of balance, fullness, and resonance, rests on a new understanding of the physics of harmonics and the powers in sound. The overture is sounding for the twenty-first century. The ancient healers are calling forth our deeper senses. Orpheus, Apollo, Tubal-cain, Aesculapius, David, St. Gregory, St. Francis, Saraswati, and St. Cecilia are sounding their calls. How soon will we be able to use the beauty of musical sound to compose ourselves into perfect octaves of harmony in mind, body, and spirit?[5]

NOTES

1. A. De Saint Exupery, *The Little Prince* (New York: Harcourt, Brace, & World, 1971), 16.
2. Unknown Oriental Philosopher.
3. B.J. Crowe, Music—The Ultimate Physician, in *Music: Physician for Times To Come*, ed. D. Campbell (Wheaton, IL: Quest Books, 1991), 118.
4. Ibid.
5. D. Campbell, Introduction: The Curative Potential of Sound, in *Music: Physician for Times to Come*, ed. D. Campbell (Wheaton, IL: Quest Books, 1991), 8.

Chapter 23

Music Therapy: Hearing the Melody of the Soul

Cathie E. Guzzetta

NURSE HEALER OBJECTIVES

Theoretical

- Evaluate the principles of sound.
- Analyze the psychophysiologic theories that explain why music therapy is effective as a bodymind modality.

Clinical

- List the factors to be considered in choosing music selections that are relaxing for clients.
- Develop a music library for use with clients.
- Develop several different music therapy techniques and use them in clinical practice.
- Explore with clients their internal responses when listening to music in a relaxed state.

Personal

- Participate in "experimental listening."
- Record your responses to various types of music in a music notebook.
- Participate in a "music bath."
- Participate in a toning and groaning exercise before listening to music.
- Practice focused and conscious hearing each day to recognize subtle differences in sound.

DEFINITIONS

Cymatics: the study of patterns of shape evoked by sound.

Frequency: the number of vibrations or cycles per unit of time.

Music Therapy: the behavioral science concerned with the systematic application of music to produce relaxation and desired changes in emotions, behavior, and physiology.

Oscillation: the fluctuation or variation between minimum and maximum values.

Resonance: the vibration of a structure at a frequency that is natural to it and most easily sustained by it.

Sonic: of or having to do with sound.

Sound: that which is produced when some object is vibrating in a random or periodic repeated motion.

Sympathetic Resonance: the reinforced vibration of an object exposed to the vibration at about the same frequency as another object.

THEORY AND RESEARCH

Music, which is a vital part of all societies and cultures, has been linked to medicine throughout history. According to Greek mythology, Orpheus was given a lyre by the god Apollo and was instructed in its use by the muses; hence, the word *music*. Apollo was the god of music and his son,

Aesculapius, was the god of healing and medicine. The Greeks believed music had the power to help heal the body and soul. Music has been used in spiritual ceremonies and in celebrations. Armies march to battle with music, and mothers lull their infants to sleep with song. Music is played during rites of initiation, during funeral ceremonies, and on harvest and feast days. There is something about the power of music that has been used throughout time. It comes as no surprise, then, that music is currently being applied as a complementary therapy in health care.

Sound, Frequency, and Intensity

It is necessary to appreciate the principles and theories of sound to understand fully its tremendous capacity to achieve therapeutic psychophysiologic outcomes. Sound is produced when an object vibrates in a random or periodic repeated motion. Sound can be heard by the human ear when its frequency or pitch ranges from 16 to 20,000 cycles per second. Within this vibratory range, we can hear 1,378 different tones.[1] We also hear and perceive sound by skin and bone conduction. Our senses of sight, smell, touch, and taste allow us to perceive an even wider range of vibrations than those sensed by hearing. Thus, we are sensitive to sounds in ways that most people do not even consider.

The interrelationship between wave forms and matter can be understood by rendering vibrations into physical forms. When scattered liquids, powders, metal filings, or sand are placed on a disk with a vibrating crystal, repeatable patterns form on the disk. As the pitch is changed, the harmonic pattern formed on the disk also changes. Thus, matter assumes certain shapes or patterns based on the vibrations or frequency of the sound to which it is exposed. The study of patterns of shapes evoked by sound is called *cymatics*.[2] The patterns of snowflakes and faces of flowers may take on their shape because they are responding to certain sounds in nature.[3] Likewise, it could be possible that crystals, plants, and even human beings are, in some way, music that has taken on visible form.

The human body also vibrates. The ejection of blood from the left ventricle during systole distends the aorta with blood. The pressure produced by aortic distension causes a pressure wave to travel down the aorta to the arterial branches. The pressure wave travels faster than the flow of blood and creates a palpable pulse called the pressure pulse wave.[4] Waves are a series of advancing impulses started by a vibration or impulse. The pressure pulse wave is composed of a series of waves that have differing frequencies (i.e., number of vibrations per unit of time) and amplitude. In the arterial branches, there is one fundamental frequency and a number of harmonics that usually have a smaller amplitude than the fundamental frequency. The arterial vessels resonate at certain frequencies (fundamental frequency), thereby intensifying some waves while other waves are damped and disappear. This phenomenon is called *resonance*.

The human body vibrates, from its large structures, such as the aorta and arterial system, down to the genetically preprogrammed vibrations coded into our molecules. Our atoms and molecules, cells, glands, and organs all have a characteristic vibrational frequency that absorbs and emits sound. Thus, the human body is a system of vibrating atomic particles acting as a vibratory transformer that gives off and takes in sound.

Because the human body absorbs sound, the concept of resonance has implications for everyone. Sympathetic resonance, or sympathetic vibration, refers to the reinforced vibration of an object exposed to the vibration at about the same frequency as another object.[5] For example, if two tuning forks are designed to vibrate

at approximately the same pitch, striking one of the tuning forks produces a sound that spontaneously causes the second tuning fork to vibrate and produce the same sound—even though the second fork was not physically struck. Actually, the sound wave from the first fork does physically strike the second fork, causing the second to resonate responsively to the tune of the first. This sympathetic resonance occurs because the vibratory characteristics of the two forks allow energy transfer from one to the other. When two objects have similar vibratory characteristics that allow them to resonate at the same frequency, they form a resonant system.

The atomic structure of our molecular system is also a resonant system. Nuclei vibrate, and the electrons in their orbit vibrate in resonance with their nucleus. Moreover, as long as the atom, cell, or organ contains an appropriate vibrational pattern, it can be "played" by outside stimuli in harmony with its vibrational makeup.[6] The phenomenon of entrainment happens when two or more vibrating objects come into step, or in phase, with each other to create a sympathetic resonant system. Thus, environmental sounds, such as those emitted from a dishwasher, television, or computer, or those hospital sounds associated with structural (e.g., open, closely located patient rooms), mechanical (e.g., beepers, monitors, alarms, and equipment), and personnel noise may be capable of stimulating or producing sympathetic vibrations in the molecules and cells of the body.[7] Music can act as a natural pacemaker, speeding up or slowing down heart rates, brain waves, and respirations to achieve a gradual entrainment with the music and a change in the individual's psychophysiologic state.[8]

When it is in a relaxed state, the human body vibrates at an inaudible fundamental frequency of approximately 8 cycles per second. During relaxed meditation, the frequency of brain waves produced also is about 8 cycles per second. Furthermore, the earth vibrates at this same fundamental frequency of 8 cycles per second. This phenomenon, called Schumann's resonance, is a function of electromagnetic radiation and the earth's circumference. Thus, there is a sympathetic resonance between the electrically charged layers of the earth's atmosphere and the human body, and, therefore, "being in harmony with oneself and the universe" may be more than a poetic concept.[9]

The intensity or loudness of a sound is measured in decibels (dB). The gentle rustling of leaves can be measured at 10 dB, a whisper at 30 dB, and a quiet home or work environment at 40 to 50 dB. Loud sounds such as jackhammers and motorcycles can register at 100 dB, car horns and loud music at 115 dB, while a rocket launch can register at 180 dB. Pain begins at 125 dB.[10] The Environmental Protection Agency recommends that the noise level of hospitals be less than 45 dB during the day and less than 35 dB at night.[11] The average noise level of most hospitals, however, has been found to be in the range of 50 to 75 dB during the day, with little reduction at night.[12]

Purposes of Music Therapy

Defined as a behavioral science that is concerned with the use of specific kinds of music to effect changes in behavior, emotions, and physiology,[13] music therapy can reduce psychophysiologic stress, pain, anxiety, and isolation. It also is useful in helping clients achieve a state of deep relaxation, develop self-awareness and creativity, improve learning, clarify personal values, and cope with a variety of psychophysiologic dysfunctions.[14,15] Music therapy complements traditional therapy, providing clients with integrated body-mind experiences and encouraging them

to become active participants in their own health care.

Appropriate music is an important vehicle in achieving the relaxation response; it removes a person's inner restlessness and quiets endless thinking. It can be used as a healing ritual to stop the mind from running away and to achieve inner quietness. The healing capabilities of music are intimately bound to the personal experience of inner relaxation.

Psychophysiologic Responses to Music Therapy

Our entire body responds to sound, whether we consciously hear the sound or not. Even though our minds can tune out the sounds of airplane or automobile traffic, our bodies cannot. Many sounds assault our body because they are not in harmony with our fundamental vibratory pattern. On the other hand, musical vibrations that are in tune with our vibratory pattern may have a profound healing effect on the entire human body and mind, affecting changes in emotions and in organs, enzymes, hormones, cells, and atoms. Theoretically, musical vibrations may help restore regulatory function to a body out of tune (i.e., during times of stress and illness), and help maintain and enhance regulatory function to a body in tune. The therapeutic appeal of music may lie in its vibrational language and its ability to align the body-mind-spirit with its own fundamental frequency.

Music alters a person's psychophysiology. The goal of music therapy and the type of music played (i.e., soothing or stimulating) determine the direction of the psychophysiologic changes. Music evokes psychophysiologic responses through the influence of musical pitch and rhythm on the limbic system (the seat of emotions, feelings, and sensations), and by stimulating the neurohormonal system and the release of endorphins (meaning endogenous morphine), which act on specific receptors in the brain to alter emotions, mood, and physiology (see Chapter 6).[16] Thus, the immediate influence of music therapy is on the mind state, which, in turn, influences the body state, producing a psychophysiologic response and a balance of body-mind-spirit. Research has demonstrated that music can affect physiologic outcome measures such as heart rate,[17,18] heart rate variability,[19] blood pressure,[20] respiratory rate,[21] galvanic skin response,[22,23] vasoconstriction,[24] muscle tension,[25] and immune function.[26] More recent studies evaluating the effects of relaxing music have directly measured changes in stress-related hormones such as cortisol, epinephrine, and norepinephrine, as well as melatonin and serotonin. Changes in these neurohormones can provide specific biochemical markers to help understand the underlying emotional, psychologic, and physiologic responses of individuals to music therapy.[27,28]

Shifting States of Consciousness

When appropriately used, music can serve as a vehicle for reaching nonordinary levels of human consciousness. Music makes it possible to alter ordinary states of consciousness to achieve the mind's fullest potential. With music therapy, individuals are able to shift their perception of time from virtual time, which is perceived in a left brain mode and is characterized by hours, minutes, and seconds, to experiential time, which is perceived through the memory.[29]

Experiential time exists because people experience both a state of tension and a state of resolution.[30] The memory perceives tensions and resolutions in a linear sequence that is called a disturbance or an event. An emotion or a sound, for example, is a disturbance that can produce tension (i.e., psychophysiologic effects), which is followed by a return to equilibrium or resolution. The rate of these linear sequences or events influences the perception of time. Slow-moving music lengthens the perception of time because

one's memory has more time to experience the events (tensions and resolutions) and the spaces between the events. Thus, clock time becomes distorted, and clients can actually lose track of time for extended periods, enabling them to reduce anxiety, fear, and pain.

Music can assist the individual in moving through the six states of consciousness: (1) normal waking state, (2) expanded sensory threshold, (3) daydreaming, (4) trance, (5) meditative states, and (6) rapture.[31] During relaxation, music is perceived first in a normal wakeful state. Continued relaxation reduces sensory thresholds and expanded awareness states predominate. The individual can then continue to move through the daydreaming, trance, and meditative states and progress to rapture, depending on the level of involvement with the music and the depth of the relaxation.

Hemispheric Functioning

Right brain functioning is concerned with the intuitive, creative, and imaging way of processing information. The right hemisphere is employed differently than the left in the musical process. The right "metaphoric" hemisphere is responsible for the major aspects of musical perception and music behavior (i.e., the recognition of pitch, a Gestalt sense of melody, rhythm, style, and musical memory).

The commonalities between the components of speech and music are a basis for the perceptual processes of the brain's right hemisphere that influence language functions and behavior. The left hemisphere is predominantly involved with analytic thinking, especially in verbal and mathematical functions.[32] Music may activate the flow of stored memory material across the corpus callosum so that the right and left hemispheres work in harmony rather than conflict.

As one's musical knowledge grows, the brain's response to music shifts from a holistic to a more sequential and linear experience. Music students and musicians tend to analyze the music to which they listen, classify the instruments, and critique the compositional techniques. Instead of integrating right and left brain functioning while listening to music in a relaxed state, such individuals tend to remain in, or change to, the left brain mode. With practice, however, they can let go of these conditioned responses to integrate the functioning of both hemispheres.[33]

Because music is nonverbal in nature, it appeals to the right hemisphere, whereas the traditional verbalization that the nurse uses in therapy with a client has its primary effect on the logical left brain. Music therapy, therefore, establishes a means of communication between the right and left brain.[34] The more connections that can be made in the brain, the more integrated the experience is within memory[35] (Figure 23–1).

Music, even more than the spoken word, "lends itself as a therapy because it meets with little or no intellectual resistance and does not need to appeal to logic to initiate its action . . . is more subtle and primitive, and therefore its appeal is wider and greater."[36] In a relaxed state, individuals can let go of preconceived ideas about listening to music and its patterns, instruments, and rhythm and shift their thinking to the right side of the brain to alter their states of consciousness.[37]

It has been suggested that listening to complex music (e.g., Mozart's Sonata for Two Pianos in D Major) can produce the "Mozart effect," which "warms up the brain" much like physical exercise, to organize and facilitate the firing patterns of neurons in the cerebral cortex. As a result, right brain functioning related to temporal–spatial reasoning may improve.[38] It is believed that the Mozart effect is responsible for enhancing concentration, intuition, intelligence, and healing.

Emotions, Imagery, and the Senses

Music elicits a variety of different experiences in individuals. Clients reaching an altered state of consciousness during

Figure 23–1. Melodic Memories. Courtesy of Philip C. Guzzetta III.

relaxation and music therapy may visualize settings, peaceful scenes, or images, or they may experience various sensations or moods. Music passages can evoke scenes from fantasy to real life. Not only can melodic patterns evoke such positive emotions as love, joy, and deep peace, but they can also reduce negative emotions such as hostility and sadness.[39]

During relaxation and music therapy, individuals can be guided in experiencing synesthesia, or a mingling of senses.[40] Musical tones can evoke color and movement, or tastes can evoke shapes (e.g., a musical note can taste like chocolate ice cream or take on a specific color; a flute may sound round or pointed, or taste like a banana).[41]

Music and color can be expressed in terms of vibrations. When color is translated into musical vibrations, the harmonies of color are 40 octaves higher than the ear can hear. A piano spans approximately 7 octaves. If the piano keyboard could be extended another 50 octaves higher, the keys played at these higher octaves would produce color rather than audible sound.[42]

The musical selection "Chakra Suite" (see Steven Halpern in the Resources at the end of the chapter) is designed to focus on seven main energy centers known to

exist in the body. In Eastern culture, these centers are called chakras. Each energy level is then associated with a specific musical tone and a specific color.[43]

Music Therapy Applications

Music has been used to foster a variety of desired outcomes. For example, music enhances creativity by developing new ways of association. Creativity is determined by how one approaches and considers things. It incorporates the unexpected, the unknown, and the peculiar. It can be enhanced by relaxation, wherein the busy mind settles into a more quiet and receptive state. Through visualization, the mind can envision new ideas and ways of thinking. Listening to appropriate music can also stimulate the brain to produce alpha and theta waves, which are known to stimulate creativity.[44]

Music and movement and/or tonal exercises help clients become aware of their bodies and the energies released in them. Such techniques are employed to achieve bodymind balance and release blocked energies. Therapists have used musical instruments in another form of music therapy, particularly with disabled individuals: Clients play various instruments during the therapy to develop the qualities of perseverance, perceptiveness, concentration, and initiative, as well as to promote perceptual–motor coordination and group interaction.[45]

Music has been used to improve learning. High psychophysiologic stress levels inhibit or block learning. When music and relaxation are combined, students learn better. Their learning can become more fun, and they become more fully involved in the experience. Music also has been used as a catalyst during the process of accelerated learning and fetal learning.[46]

Audiocassettes are now available that correct and reprogram unhealthy, unconscious thought patterns. Music enhances such tapes, as their aim is to put the listener in a relaxed and balanced state. During relaxation, the reprogramming message reaches the deeper unconscious mind where the new thought pattern will ultimately reside. Such self-help tapes frequently include desired affirmations or suggestions, combined with meditative music or white noise.[47]

Similarly, music has been used to facilitate reframing of past memories and experiences. In achieving an altered state of consciousness, the unconscious mind can remember details of past experiences that the conscious mind may have forgotten. When the conscious mind remembers such experiences, the client can be helped to reframe or reorganize the memories to produce a more healthy and positive experience.[48]

To enhance learning and facilitate self-help, music can be combined with subliminal suggestions. The subliminal technique involves the delivery of verbal messages to the individual at a volume so low, or through a change in speed or frequency so fast, that the conscious mind cannot perceive them. The conscious mind responds to the music while the unconscious mind absorbs and responds to the verbal suggestion.[49]

Music has been used to evoke imagery for a number of therapeutic ends (see Chapter 22). Clients who have difficulty with the imagery process may find relaxing background music helpful. Appropriately selected music can activate right hemisphere functioning and release a flow of images.[50]

Bonny has developed an innovative approach called guided imagery and music (GIM).[51] By means of the conscious use of imagery that is evoked by relaxation and music,[52] GIM is a method of self-exploration, self-understanding, growth, healing, and transformation. In this

approach, the client listens to classical music in a relaxed state, allowing the imagination to come to conscious awareness, and then shares these experiences with a guide. The guide helps integrate the experience into the client's life.

Music thanatology, a contemplative practice with clinical applications, is a field of music therapy that focuses on the physical and spiritual care of the dying using prescriptive music. The primary focus of the music is to help alleviate physiologic pain and interior suffering and to assist the person complete the transition between life and death. It helps patients let go of the physical body during the last hours before death by enhancing peace, acceptance, and a calm anticipation of death. Specially trained therapists, using the media of harp and voice, implement music thanatology.[53,54]

Music Therapy in Clinical Settings

Music can act as a catalyst to facilitate mental suggestion and enhance a client's own self-healing capacities. Thus, music has potential usefulness in the treatment of many health problems. For example, it can reduce stress and anxiety in

- healthy adults[55]
- hospital employees[56]
- mechanically ventilated patients[57–60]
- patients with cardiovascular disease[61–64]
- adults and children with cancer[65]
- surgical patients awaiting breast biopsy,[66] those in the perioperative care setting,[67,68] and those undergoing transurethral resection of the prostate[69] or cataract surgery[70]
- newborn infants in the nursery[71]
- low-birthweight infants in the neonatal intensive care unit[72,73]
- pediatric patients undergoing needle sticks[74]
- patients undergoing gastrointestinal endoscopic procedures[75]

Likewise, music has been used to reduce pain in burn patients undergoing debridement;[76,77] hospice patients;[78] patients recovering in the post-anesthesia care unit;[79] patients undergoing coronary artery bypass grafts,[80] abdominal surgery,[81] and gynecologic surgery;[82] bone marrow transplant patients;[83] patients with rheumatoid arthritis;[84] and adult and pediatric patients with cancer.[85] Music also can help to reduce the nausea and vomiting associated with chemotherapy.[86]

In addition, music has been used to reduce symptoms or improve recovery for

- patients with brain damage following head trauma[87]
- patients who are elderly or demented, or who have Alzheimer's disease[88–91]
- patients undergoing general anesthesia[92] and colonoscopy[93,94]
- pediatric patients in intensive care units[95]
- patients with asthma,[96] eating disorders,[97] acquired immunodeficiency syndrome (AIDS),[98] hypertension, migraine headaches, gastrointestinal ulcers, or Raynaud's disease[99]

Selection of Appropriate Music

It is an important—and challenging—task to select appropriate music for use in music therapy, as the selections can influence the outcomes. Most music, however, is not composed for the purposes of relaxation and healing. Individuals often associate events in their lives, both pleasing and displeasing, with certain kinds of music. This conditioned learning response influences their music preferences and perceptions. Likewise, the acceptability and perceptions of calming music differ among cultures and age groups.[100] Thus, the particular individual must choose the music that is appropriate for them.[101]

Table 23–1 Categories of Music

Category	*Composer Sources*
Classical Music	Beethoven, Mozart, Haydn, Bach, Dvorak
Baroque Music	Bach, Handel, Vivaldi, Purcell, Pachelbel
Romantic Music	Strauss, Wagner, Schubert, Schumann, Tchaikovsky, Chopin, Liszt, Brahms
Impressionist Music	Debussy, Faure, Ravel, Elgar
Big Band Music	Goodman, Ellington, Dorsey, Lombardo, Miller
Jazz	Davis, Neville, Coltrane, Najee, Koz, James
Blues	John Lee Hooker, Taylor, Cray, Lavette
Country Western	Cash, Nelson
Nontraditional, New Age Music	Halpern, Eno

A variety of soothing selections should be available for working with clients, because it is difficult to predict a client's music preference and response to a particular selection. Musical selections that are relaxing and meditative to one client can be disruptive and annoying to another. Moreover, music that some individuals identify as relaxing may not be physiologically relaxing at all. Researchers and music experts tend to agree that rock and grunge music, characterized by fast tempos, heavy drums, and repeating bass lines, do not evoke psychophysiologic relaxation[102,103]—even if the individual thinks they do. Classical, spiritual, or popular music may not be relaxing or soothing though, either.

Musical selections without words are preferable, as clients may concentrate on the words, their messages, and their meaning rather than allowing themselves to concentrate and flow with the music.[104] Some music has been designed to shift brain waves to more relaxed patterns. During ordinary consciousness and daily activities, beta brain waves predominate at a range of 14 to 20 cycles per second. Alpha waves, which occur at 8 to 13 cycles per second, characterize states of heightened awareness and calm. During periods of sleep, creativity, and meditation, theta waves occur at 4 to 7 cycles per second. Delta waves ranging from 0.5 to 3 cycles per second occur during unconsciousness, deep sleep, and deep meditation.[105] It is believed that music such as baroque, or any slow-moving selections that have a maximum pulse of 60 beats per minute, can be used to shift consciousness from the beta to the alpha range to improve alertness and reduce tension.[106]

Different types of music can have different effects on individuals. The categories of music outlined in Table 23–1 present a wide variety of selections that can be made available for clients. Each category of music incorporates an extensive array of styles and effects, ranging from fast-moving and active to slow-moving and relaxing selections.[107] The various categories and specific selections should be evaluated for their relaxing or active qualities before using them in music therapy sessions.

Several individuals and companies have developed relaxing musical selections for use in the clinical setting (see the Resources at the end of the chapter). These tapes are designed for patient use in hospitals before, during, and after surgery; during childbirth; and for all healing and

recovery stages, to reduce stress and enhance healing and well-being.[108–110]

Mazer and Smith have developed the Sondrex System®, which delivers soothing music through a high-quality compact disc (CD) player, and provides a microphone for caregivers to communicate directly with the patient while the music is playing.[111] This system has been recommended for use in the perioperative and obstetrics/gynecology settings, endoscopy and cardiac catheterization laboratories, emergency medicine departments, and physician offices (see the Resources at the end of the chapter).

Individual Musical Preference

Individuals need to evaluate their responses to various types of music. Although different musical selections can produce various effects, the fullest effect occurs when the listener is appropriately prepared to experience the sounds. The therapeutic effect of music is lessened when the listener is angry, distracted, critical, analytic, or resistant. With a relaxed and receptive bodymind, however, music has the potential to enter the body and play *through* it rather than *around* it. Thus, some form of relaxation exercise is recommended before the music experience.

Depending on the individual's physiology, mind state, and mood, music can produce different feelings at different times. An important rule to follow when listening to music is the iso-principle,[112] which states that matching the individual's mood to the appropriate music helps achieve an altered state of consciousness. When the mind and feelings are vibrating at a certain frequency, the music should be in resonance with that frequency.

Individuals can create their own tapes to match their moods and musical preference. If their mood is tense or angry and a relaxed outcome is desired, they may start out with a short selection (3 minutes or less) of music that resonates with the mood and then add selections that progress to a relaxed state.

Before creating a personal tape, an individual should spend some time experimenting with music—trying a variety of musical selections and learning what happens when listening to specific selections under a variety of circumstances. The kind of music that one uses to relax after a stressful day at work, for example, may be very different from the selection that one chooses while undergoing a painful dental procedure. "Experimental listening" involves listening to various types of music at different times of the day and week.[113] For example, an individual may spend 20 minutes listening to each type of music and then systematically evaluate his or her response to the selection, according to the following procedure:

1. Set aside 20 minutes of relaxation time.
2. Find a comfortable position.
3. Find a quiet place where there will be no interruptions.
4. Check your pulse rate.
5. Observe your breathing pattern (e.g., fast, slow, normal).
6. Assess your muscular tension (e.g., pain, muscle tightness, shoulder stiffness, jaw and neck tension, or loose, limp, sleepy?).
7. Evaluate your mood state (e.g., angry, happy, sad).
8. Listen to the music for 20 minutes. Let your body respond to the music as it wishes: loosen muscles, lie down, dance, clap, hum.
9. Following the session, assess your heart rate and breathing pattern again.
10. Assess your muscular tension (e.g., more relaxed? more stimulated? tighter? tenser? calmer?).
11. Evaluate your mood state.
12. Record the name of the music selection and your before-and-after responses in a music notebook for

use when developing your own therapeutic tapes.

13. On a separate page in your notebook, recall and write down the many ways that music has empowered your life psychologically, physically, and spiritually. Include your most dramatic, intimate, and emotional memories associated with music. You will begin to realize the importance of sound in your life and recognize its healing potential.
14. Based on your response, create your own relaxation music tape of 20 to 30 minutes in length. The more regularly you use the tape, the more effective it will become.

Listening to music can be a holistic experience. As more individuals come to realize that music can be a principal source of healing and stress reduction, they will take great care to select their music. Music therapy may be incorporated into daily living activities, such as taking a "music bath" after a morning shower as a means of preparing the bodymind for the events of the day.[114]

HOLISTIC CARING PROCESS

Assessment

In preparing to use music therapy interventions, the nurse assesses the following parameters:

- the client's music history and the types of music that the client prefers (e.g., classical, popular, country, folk, hymns, jazz, rock, blues, other)
- the client's ability to identify types of music that make him or her happy, excited, sad, or relaxed
- the client's ability to identify types of music that are distasteful and make him or her tense
- the client's awareness of the importance of music in his or her life: Is music played at home? In the car? At work? For relaxation? For excitement? For enjoyment? During times of stress? As a means of coping with stress?
- the client's frequency of music listening (per day or per week)
- the client's preference for music listening, such as radio, cassette, CD player, or through audio streaming via the worldwide web
- the client's previous participation in relaxation/imagery techniques combined with music: How long? How regularly?
- the client's use of some type of music for relaxation purposes; if so, ask the client to describe the bodymind responses evoked by music
- the client's insight into the use of music to produce psychophysiologic alterations
- the client's mood (iso-principle) that will determine the type of music to choose and the goals of the session

(Assessment parameters outlined in Chapter 21, Relaxation, and Chapter 22, Imagery, also should be included, because relaxation, imagery, and music cannot be separated.)

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with music therapy interventions that are related to the 13 domains of Taxonomy II (see Chapter 14):

- Social isolation
- Loneliness
- Spiritual distress
- Ineffective individual coping
- Impaired adjustment
- Noncompliance
- Sleep pattern disturbance
- Sleep deprivation
- Fatigue
- Adult failure to thrive
- Disorganized infant behavior

- Body image disturbance
- Self-esteem disturbance
- Hopelessness
- Powerlessness
- Confusion
- Altered thought processes
- Impaired memory
- Pain
- Nausea
- Chronic sorrow
- Risk for violence
- Post-trauma syndrome
- Anxiety
- Death anxiety
- Fear

Outcomes

Exhibit 23–1 guides the nurse in client outcomes, nursing prescriptions, and evaluation for the use of music therapy as a nursing intervention.

Exhibit 23–1 Nursing Interventions: Music Therapy

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client will select music of choice and will participate in music therapy sessions to achieve a relaxed response and facilitate healing.	Provide the client with various musical taped selections to facilitate selecting music of choice. Guide the client in music therapy sessions and help the client to establish the routine of listening to music once or twice a day.	The client chose music for listening and reported enjoying the music. The client participated in music therapy sessions twice a day to facilitate healing.
The client will demonstrate positive physiologic outcomes in response to the music therapy session, such as: • decreased respiratory rate • decreased heart rate • decreased blood pressure • decreased muscle tension • decreased fatigue	Assess the client's physiologic outcomes in response to music therapy before and immediately after the session. Evaluate the client's: • respiratory rate • heart rate • blood pressure • muscle tension • level of fatigue	The client demonstrated: • decreased respiratory rate • decreased heart rate • decreased blood pressure • decreased muscle tension • decreased fatigue
The client will demonstrate positive psychologic outcomes in response to the music therapy session such as: • positive emotions and relaxed feeling • decreased restlessness and agitation • decreased anxiety/depression • increased motivation • increased positive imagery • decreased isolation	Assess the client's psychologic outcomes in response to music therapy before and immediately after the session. Evaluate the client's: • emotions and level of relaxation • level of restlessness and agitation • level of anxiety/depression • level of motivation • type of imagery experienced • level of social isolation	The client demonstrated or verbalized: • positive emotions and more relaxed feeling • reduced restless and agitated behaviors • decreased levels of anxiety (or depression) • increased motivation to accomplish life's daily tasks • increased positive imagery • decreased feelings of social isolation

Therapeutic Care Plan and Implementation

Before the Session

- If in the clinical area, inform others of the need for minimal noise (may also post sign on patient door requesting no interruptions for 30 minutes).
- Establish the goals for the session with the client.
- Discuss how music therapy quiets the bodymind and facilitates relaxation and self-healing.
- Discuss the length of the session, usually 20 to 30 minutes.
- Ask the client to empty his or her bladder, if necessary.
- Ask the client to remove eyeglasses.
- Prepare the environment for optimal relaxation:
  - Close the drapes.
  - Dim the lights.
  - Turn off any potential environmental noises (e.g., monitor, alarms, beepers, phones).
- Ask the client to sit or lie in a comfortable position. It is sometimes helpful to place a small pillow under the knees to relieve lower back strain. Have a light blanket available for warmth, if needed.
- Spend a few moments centering yourself to be fully present with the client.

At the Beginning of the Session

Script: *The purpose of the session is to relax in a wakeful state and have a quiet experience listening to music. First, I will guide you in a few exercises to relax. Then I will guide you in how to listen to music (of your choice). Then try to let the music relax your body-mind-spirit even more as you listen to the music for 20 minutes. Now close your eyes if you wish. Find a comfortable position with your hands at the side of your chest or on your body—whatever is most comfortable. At any time, you may change positions, scratch, or swallow. There may be noises around, but these will not be important if you concentrate on my voice.*

Guide the client in a general relaxation or imagery script (see Chapters 21 and 22).

During the Session

Script: *Now, as you continue to relax, I will turn on the music. Listen to the music. Tell yourself that you would like to go wherever the music takes you. Allow yourself to follow the music. Let the music suggest to you what to think and what to feel. Do not try to analyze the music or the melody. If you find distracting thoughts occurring, simply let go of them and come back to concentrating on the music. Allow the music to relax you even more than you are now. The music will play for 20 minutes, and I will leave the room. I will quietly come back into the room before the music is over. Now continue to relax your body-mind-spirit; let the music help you.*

At the End of the Session

Script: *Now that the music is over, I will guide you in counting back from 5 to 1. You will come back into the room easily and quietly. You will feel very relaxed, calm, and peaceful. You will remember the pathway that led you to this new experience, and you will be able to find it quickly whenever you wish to return.*

Exhibit 23–2 Evaluating the Client's Subjective Experience with Music Therapy

1. Was this a new kind of music listening experience for you? Can you describe it?
2. Did you have any visual experiences? Of people, places, or objects? Can you describe them?
3. Did you see any colors while listening? Did the colors change as the music changed?
4. Did you notice any textures, smells, movements, or tastes while experiencing the music?
5. Were you less aware of your surroundings? Were you able to flow with the music?
6. Did you like the music?
7. Did the music produce any feelings or emotions?
8. Was the experience pleasant?
9. Did you feel relaxed and refreshed after the experience?
10. Would you like to try this again?
11. What would be helpful to make this a better experience for you?

Close the session as follows:

- While the client is in a self-reflective state, lead him or her in further guided imagery exercises, or journal entries, if desired.
- Use the client outcomes (see Exhibit 23–1) that were established before the session and the client's subjective experience (Exhibit 23–2) to evaluate the session.
- Schedule a follow-up session.

Specific Interventions

Development of Audiocassette/ Videocassette Library

Nurses can develop an audiocassette/CD/videocassette library on each clinical unit or in each practice area. Relaxation, imagery, and music therapy audiocassettes, CDs, and videocassettes are recommended for use in all clinical settings from the birthing to the dying process. Audiocassettes, CDs, and videocassettes can be developed and collected that are of specific benefit to the particular client/patient population with which the nurse is working. Following are suggestions for building a successful audiocassette/CD/videocassette library:

1. Equipment
   - Have several tape/CD players with comfortable headsets per unit.
   - Place all equipment in a safe and convenient location.
   - Establish a method of headset disinfection to be done after each patient finishes with the equipment.
   - Have a variety of music tapes/CDs available. Commercial tapes are relatively inexpensive and readily available. A complete tape library will include music, relaxation, imagery, and stress management tapes/CDs, as well as specific tapes for smoking cessation; pre-, intra-, and postoperative surgery; weight reduction; pain management; insomnia; self-esteem; subliminal learning; and so on. Consider different types of music, such as easy listening, light and heavy classical, popular, jazz, operatic, folk, country, hymns, choral, and nontraditional selections (see Table 23–1).
   - Ask staff members to donate one favorite relaxation tape/CD to the library.
   - Write to different companies (see the Resources at the end of the chapter) and request a catalogue of their selections.
   - Encourage nurses to develop tapes for specific client/patient problems that can help with procedures, tests, and treatments. The tapes may or may not have soothing background music.
   - Have brochures and catalogues of recording companies available upon request from the patient.

- Encourage use of different tapes/CDs for further relaxation, imagery, and stress management training.

2. Procedures
   - If tapes/CDs are checked out on an outpatient basis, have the client make a deposit to cover the replacement cost of the tape/CD in case it is not returned.
   - Label all equipment and materials with owner's name, telephone number, and return address.
   - Establish who will have authority to check out the tapes and equipment. If in the hospital, a volunteer could assist in checking out the equipment for the patient after the nurse has assessed the patient's needs and selected the appropriate tape/CD.
   - Prepare a sign-out log that records the patient's name, room, date, and check-out time for inpatients or address and telephone number for outpatients.
   - Instruct the patient in the use of the equipment and tapes, if necessary.
   - Allow 20 to 30 minutes of listening without interruption twice a day. Place a sign on the patient's door stating, "Relaxation Session in Progress—Please Do Not Disturb."
   - Following the listening session, evaluate the patient's response to the music and answer any questions.
   - Chart the type of music selected and the patient's specific response to the therapy. For example, were the desired outcomes achieved (e.g., lowered respiratory rate, decreased heart rate and blood pressure, decreased muscle tension and anxiety)? Identify the client's subjective evaluation of the experience (e.g., found the experience relaxing, helped with sleep, assisted in coping with pain, assisted with painful procedure).
   - Return the equipment and tapes/CD to the library and record the check-in information in the log.

Music Therapy Scripts

Training for Skillful Listening. Music therapy sessions of 15 minutes may help clients improve the art of listening and train them consciously to hear sounds clearly.

Script: *Concentrate on the sounds around you. Let your ears hear every possible sound. Explore the subtle sounds: breathing, distant cars, wind blowing, hum of the lights. . . . Limit your sensations. Keep your eyes closed. Heighten and isolate your perception of sound. Listen to the parts of sound. Listen to a sound. Imagine that the sound makes a line. Bend the line that the sound makes. Does it go up? Does it go down? Does it curve or have humps? The word—bend—itself has a bend. Notice the height of the bend. Imagine the top and bottom of the bend. . . .*

Imagine the grain of the sound. Is it rough or smooth? Rough like sandpaper or smooth like silk, or something in between? What is the volume? High or low? What is the intensity? Loud or soft? What color do you associate with the sound? What emotions do you notice as you listen to this sound?

Now use your voice to imitate sound. Imitate the sound of a jet flying high through the air. . . . Now imitate the sound of a helicopter flying through the air. . . . Imitate the sound of a soft wind. . . . Imitate the sound of an autumn leaf

falling. The point of this exercise is not to become an expert jet imitator, but to realize that there is more to the art of listening and hearing than we think. When you practice focused and conscious hearing, you will recognize subtle differences in sound. You will expand your skills in the art of listening.

Expanding the Senses. Listening to music for 10 to 20 minutes can help clients to expand awareness, open up the senses, and participate in a mingling of the senses. The nurse (1) explains the purpose of the session to the client, (2) conducts a general relaxation session with the client, (3) turns on the music, and (4) begins slowly, pacing the words with the client's increased relaxation.

Script: *Let the music take you to a soothing, peaceful place that is filled with various textures, sights, colors, and sounds. . . . Take a moment to find this place. . . . You feel comfortable and relaxed in this peaceful place. Slowly begin to explore the surface and texture of your surroundings. Permit the music to help you experience softness, smoothness, and gentleness. . . .*

As you continue to explore, discover the colors associated with the shape, texture, and feelings of things. Let the music suggest the sound of the colors and textures.

Touch the things in your environment. Let your fingers, tongue, and cheeks experience the textures. Take time to enjoy each feeling. Do not feel rushed as you explore. . . .

As you touch each thing in your surroundings, take time to investigate its source. Where did it come from? Why does it feel as it does? And why is it here?

With each surface, explore its color, its sound. The deeper you travel into the essence of your surroundings, the richer the experience will be. . . .

Continue this experience for another 10 to 20 minutes. Gradually come back into the room awake, alert, and ready to continue the day.

Toning and Groaning. By participating in this exercise for 10 to 20 minutes, clients can prepare for meditation, release intensive emotions, or induce an altered state of consciousness.

Script: *Lie comfortably on your back. Begin with an audible groan such as "oh-h-h" or "ah-h-h." Let the groan be as deep as possible without forcing it. Let it give you a feeling of release, of emptying out any tension. Feel your skin and bones vibrate with the sound.*

Many people spontaneously groan when they have taken off a tight belt or tight shoes. Your groaning should be a comparable release of and freedom from constraint. Let it be loud and natural without forcing the sound. . . . You might even feel a bit silly about groaning. You might giggle or laugh. That's okay. Just let it out. . . .

Stretch your arms and legs now. Then let your body relax and groan again. Notice the sound becoming effortless,

relaxing, and deeper. . . . Be sure to let the groan come from deep down in your feet. Notice the vibrations starting up your body. As you continue to groan, feel a weight being lifted from you. Heaviness is being lifted while a sense of lightness sets in. . . . Groaning is a healing process. Allow it to happen. Enjoy the feeling of release. . . .

You will notice a tendency for your voice to rise as your tensions are allowed to leave. Let your voice do what it wants as you continue to groan. It will find its natural place. When your body reaches its tone, it will be satisfied, and you will sigh a deep, satisfying sigh.

At this point you are toning. You have found your tone. You are sounding your tone. You are resonating with your body. This is your own music.

The nurse ends the session or prepares for imagery scripts, meditation, or music listening.

Taking a Music Bath. Listening to music for 20 minutes can help clients to prepare for a balanced day, prevent stress, and reduce stress. The nurse first explains the purpose of the session to the client. It also is important to conduct a general relaxation session with the client before proceeding with the script. After turning on the music, the nurse begins slowly, pacing the words with the client's increased relaxation.

Script: *As the music begins, you will begin a music bath. Allow the sound to wash over you, letting the music touch every surface of your body. Permit the sound to rinse off any tension, unpleasant emotions, and any sound pollution to prepare for the day. . . .*

Allow yourself to be immersed in the musical sounds as if you were in a warm, relaxing tub of water or standing under the warm water in a shower. Imagine the water filled with soothing, relaxing sounds. The sounds are cleansing your body and calming your emotions. . . .

As you allow your entire body to become immersed in the sounds, notice how the music resonates in different parts of your body. As you become more relaxed, notice how much more you are enjoying the music. . . .

As the music rinses away your tension, permit yourself to feel refreshed. The music bath has reached every part of your body. You have renewed and refreshed energy. . . .

Allow any remaining tension to be washed away, permitting you to feel balanced, calm, and refreshed.

Continue listening to the music for 20 minutes. As the music ends, gradually come back into a wakeful, relaxed, and refreshed state.

Merging the Bodymind with Music. A quiet listening experience that mingles the senses and induces relaxation may last 20 minutes. Nontraditional music, with nonmetered beat and periods of silence between sounds is suggested. (See Steven Halpern for nontraditional selections, as listed in the Resources at the end of this chapter.) After conducting a general relaxation session with the client, the nurse turns

on the music and begins, pacing the words with the client's increased relaxation.

Script: *Visualize your ears. Explore your ears. Feel your ears expanding and becoming larger. Permit your ears to become channels in the sides of your head that open and lengthen throughout your body and into your feet. Allow these channels to hear all parts of your body.*

Think of the sounds you are hearing as something more than a pleasant hearing sensation. The sounds are nourishment and energy for your body—your mind—your spirit. . . . Let the sound of the music move in you, around you, above you, below you. The sound is everywhere, and you can hear it throughout your body. . . .

See sound, taste it, feel it, smell it, hear it. Turn the sound into light and color and see it. Concentrate your attention on the sounds and the silence between the sounds. . . .

Open your ears. You have beautiful, big ears—channels throughout your body. Let the sounds pass through these channels to experience the event totally. Merge with the music. There will no longer be music and a listener, rather a state of total experiencing of the sound. Total concentration of the sound . . . moment-by-moment and on the silence between. . . . You can go beyond. . . . You will experience the soundless sound, the state where sound becomes silence, silence becomes sound, and they merge together.

Continue the experience for another 10 to 20 minutes. Gradually come back into the room awake, alert, and ready to continue the day.

Case Study

Setting:	Coronary care unit (CCU)
Patient:	W.R., a 62-year-old man who was admitted at 3:00 A.M. with the presumptive diagnosis of acute myocardial infarction
Patterns/ Challenges/ Needs:	1. Chest pain related to acute myocardial infarction 2. Anxiety related to cardiovascular stressors and hospitalization

Prior to admission, W.R. had experienced severe, substernal chest pain that radiated to the left shoulder, arm, and hand. It was associated with nausea, vomiting, and shortness of breath. The chief of military police at a local military base, he stated that he worked 10 to 12 hours every day and was a hard-driving individual. He had been in excellent health before this episode and denied any previous hospitalization.

Following admission to the CCU, W.R. had no current chest pain, and his vital signs and cardiac rhythm were stable. However, he was assessed to be highly anxious, with clenched fists and jaw, obvious muscle tension, startled reactions to minor noise, and flight of ideas with constant talking. When asked by the nurse if he wanted to participate in a relaxation exercise that would help him cope better with his admission to the CCU and his illness, W.R. was reluctant, but agreed because he said he did not have much else to do.

After providing a music history, the patient selected a soothing classical music tape from the CCU's audiocassette

library. The patient was supplied with a tape recorder and a comfortable headset. The music was checked for the appropriate volume and turned off, and the headset was placed beside the patient's pillow. A small finger thermistor was taped to the patient's left index finger, and his apical heart rate and peripheral temperature were recorded. The nurse guided the patient with a head-to-toe relaxation script and continued with the Merging the Bodymind with Music script. The headset was then placed on the patient, and he continued the relaxation exercise while listening to music for 20 minutes.

Following the first session, W.R. said that he was sure he was not doing it "right" and that he did not wish to try it again. The nurse said that she understood. She also explained that there is no "right" way to experience relaxation and that everyone experiences it a little differently. She added that relaxation is a skill to be learned, like riding a bike, and that the more people practice the technique, the better and richer is their response. She encouraged W.R. to try one more session, and he agreed. The nurse observed that there had been no change in W.R.'s finger temperature or heart rate following this first session.

Following the second session, W.R. was noticeably quiet. When the nurse inquired how he perceived the session, W.R. said, "It was OK—see you tomorrow." Following the third session, the nurse identified an 8-degree increase in finger temperature and a 10-beat/minute decline in heart rate from presession readings. W.R. had a small grin on his face and stated, "I can't believe what just happened to me. This stuff really works. I felt really relaxed. You know, I have a tough job. I work 10 hours a day. For me, relaxing means having a beer after work or going on a vacation one week a year. I have been walking around for 62 years with a stiff neck, and I never knew it. No one ever told me how to really relax. After this [session], I know now that, when I thought I was relaxing, I really wasn't. I have never felt like this in 62 years."

W.R. was transferred from the CCU to the telemetry unit that afternoon. He stated that he planned to continue his music therapy sessions twice a day during the remainder of his hospitalization and after his return home. He was given catalogues on relaxation music tapes and informed that such tapes also could be purchased from the hospital's gift shop.

Evaluation

With the client, the nurse determines whether the client outcomes of music therapy (see Exhibit 23–1) were achieved successfully. To evaluate the session further, the nurse may again explore the subjective effects of the experience with the client (Exhibit 23–2).

It is important to ask clients to share their experiences, as the sharing helps evaluate the experience and clarify any misconceptions. Some people may report that their experiences were totally different from any previous experience and that they discovered previously unknown mind spaces. Others may not perceive any beneficial effects of the therapy after the first or second session. They may worry if they cannot image, see colors, or feel relaxed.[115] These clients need reassurance that there is no right response and that not everyone experiences the same type of sensations, feelings, sights, or sounds in the same way. They also need encouragement to continue to practice the technique a few more times before drawing any conclusions regarding its effectiveness. The desired outcomes of music therapy in reducing stress are relaxation and a psychophysiologic quieting of the body-mind-spirit. Clients should understand that relaxation is an acquired skill, and that the effectiveness of such therapy

is usually a function of practice. The more they practice relaxation skills, the better they become in producing changes in their psychophysiology.

Some people may feel that they need "two or three more" sessions with the nurse before they have acquired the skills to practice the technique themselves. In reality, no guide can teach the client relaxation skills. Any changes happen because of the individual's motivation, involvement, and skill—not because a guide is present. As soon as clients realize that they can make similar suggestions to themselves to induce relaxation, they are ready to continue the technique alone. Some people may wish to make an audiocassette of the guide's voice during the session or record their own script. The audiocassette then serves as the guide.

DIRECTIONS FOR FUTURE RESEARCH

1. Pretest and posttest various types of "relaxing" music to validate that clients perceive such music as relaxing.
2. Create a sound-and-color healing room within a hospital setting, and evaluate its effects on patient recovery.
3. Evaluate several music scripts to determine whether one script is more effective than another in achieving specified outcomes.
4. Compare the effectiveness of music therapy with that of other relaxation techniques in various client groups to determine which technique is the most effective for which type of clients.
5. Develop valid and reliable evaluation tools that assess a client's subjective response to music therapy.
6. Evaluate the effects of a music audiocassette library on hospitalized patients' length of stay, recovery, and complications.
7. Compare the attitudes, stress levels, feelings of empowerment, and retention rates of nurses who routinely use music as a nursing intervention with those nurses who do not.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or will begin a process of answering the following questions:

- How do I feel about music as a healing ritual?
- When I listen to music, how do I allow myself to let go into the music?
- Am I able to use music with my clients to facilitate the healing process?

NOTES

1. R. Leviton, Healing Vibrations, *Yoga Journal* (1994, January–February):59–60.
2. H. Jenny, *The Structure and Dynamics of Waves and Vibrations* (Basel, Switzerland: Basilius Press, 1967).
3. S. Halpern and L. Savary, *Sound Health: Music and Sounds That Make Us Whole* (New York: Harper & Row, 1985), 33.
4. C.E. Guzzetta, Physiology of the Heart and Circulation, in *Cardiovascular Nursing: Body-mind Tapestry*, eds. C.E. Guzzetta and B.M. Dossey (St. Louis: C.V. Mosby, 1984), 104–153.
5. Halpern and Savary, *Sound Health*, 33–37.
6. Ibid., 37.
7. D. Campbell, *The Mozart Effect* (New York: Avon Books, 1997).
8. Ibid., 125.
9. Halpern and Savary, *Sound Health*, 39.
10. Campbell, *The Mozart Effect*, 32.
11. U.S. Environmental Protection Agency. Information on Levels of Environmental Noise Requisite to Protect Public Health and Welfare with an Adequate Margin of Safety (Washing-

ton, DC: U.S. Government Printing Office, 1974, #550/9-74-004).

12. D.O. McCarthy et al., Shades of Florence Nightingale: Potential Impact of Noise Stress on Wound Healing, *Holistic Nursing Practice* 5 (1991):39–48.
13. C. Schulbert, *The Music Therapy Sourcebook* (New York: Human Sciences Press, 1981), 13.
14. P.M. Hamel, *Through Music to the Self* (Boulder, CO: Shambhala Press, 1979), 166.
15. H. Bonny and L. Savary, *Music and Your Mind* (New York: Harper & Row, 1973), 15.
16. C.B. Pert, *Molecules of Emotion* (New York: Charles Scribner's Sons, 1997).
17. C.E. Guzzetta, Effects of Relaxation and Music Therapy on Patients in a Coronary Care Unit with Presumptive Acute Myocardial Infarction, *Heart and Lung* 18 (1989):609–616.
18. C. Webster, Relaxation, Music and Cardiology: The Physiological and Psychological Consequences of Their Interrelation, *Australian Occupational Therapy Journal* 20 (1973):9–20.
19. R. McCraty et al., Music Enhances the Effect of Positive Emotional States on Salivary IgA, *Stress Medicine* 12 (1996):167–175.
20. Webster, Relaxation, Music and Cardiology.
21. Ibid.
22. P.O. Peretti and K. Swenson, Effects of Music on Anxiety As Determined by Physiological Skin Responses, *Journal of Research Music Education* 22 (1974):278–283.
23. G.H. Zimny and E.W. Weidenfeller, Effects of Music upon GSR of Children, *Child Development* 33 (1962):891–896.
24. V.E. Kibler and M. Rider, Effects of Progressive Muscle Relaxation and Music on Stress as Measured by Finger Temperature Response, *Journal of Clinical Psychology* 39, no. 2 (1983):213–215.
25. J.P. Scartelli, The Effect of EMG Biofeedback and Sedative Music, EMG Biofeedback Only and Sedative Music Only on Frontalis Muscle Relaxation Ability, *Journal of Music Therapy* 21, no. 2 (1984):67–78.
26. M. Rider, Imagery, Improvisation, and Immunity, *Psychotherapy* 17 (1990):211–216.
27. A.M. Kumar, F. Tims, D.G. Cruess, M.J. Mintzer, G. Ironson, D. Loewenstein, R. Cattan, J.B. Fernandez, C. Eisdorfer, and M. Kumar, Music Therapy Increases Serum Melatonin Levels in Patients with Alzheimer's Disease, *Alternative Therapies in Health & Medicine* 5, no. 6 (1999):49–57.
28. C.H. McKinney, F. Tims, A.M. Kumar, and M. Kumar, The Effects of Selected Classical Music and Spontaneous Imagery on Plasma B-endorphins, *Journal of Behavioral Medicine* 20, no. 1 (1997):85–99.
29. R. McClellan, Music and Altered States of Consciousness, *Dromenon* 2 (1979):3–5.
30. McClellan, Music and Altered States of Consciousness.
31. S. Krippner, *The Highest State of Consciousness* (New York: Doubleday, 1972), 1–5.
32. D.G. Campbell, *Introduction to the Musical Brain* (St. Louis: MMB Music, 1984), 14–65.
33. Bonny and Savary, *Music and Your Mind*, 90.
34. R. Beebe, Synesthesia with Music, *Dromenon* 2 (1979):7.
35. Campbell, *Introduction to the Musical Brain*, 14.
36. I. Altshuler, A Psychiatrist's Experience with Music As a Therapeutic Agent, in *Music as Medicine*, eds. D. Schullian and M. Schoen (New York: Henry Schuman, 1948), 267.
37. McClellan, Music and Altered States of Consciousness, 4.
38. Campbell, *Introduction to the Musical Brain,* 15–16.
39. R. McCraty et al., The Effects of Different Types of Music on Mood, Tension, and Mental Clarity, *Alternative Therapies in Health and Medicine* 4, no. 1 (1998):75–84.
40. J. Page, Roses Are Red, E-flat Is, Too, *Hippocrates* (1987, September–October):63–66.
41. J. Houston, *The Possible Human* (Los Angeles: Jeremy P. Tarcher, 1982), 47–48.
42. Halpern and Savary, *Sound Health*, 183.
43. Ibid., 185.
44. Campbell, *Introduction to the Musical Brain*, 62–63.
45. Schulbert, *The Music Therapy Sourcebook*, 104.
46. D.K. Janes, C.J. Spencer, and B.W. Stepsis, Fetal Learning: A Prospective Randomized Controlled Study, *Ultrasound in Obstetrics & Gynecology* 20, no. 5 (2002):431–38.
47. Halpern and Savary, *Sound Health*, 136.
48. Bonny and Savary, *Music and Your Mind*, 31.
49. Halpern and Savary, *Sound Health*, 137.
50. Ibid., 96–97.
51. H. Bonny, Guided Imagery and Music Brochure (Port Townsend, WA: Institute for Music and Imagery, 1986).
52. K. Bruscia, Visits from the Other Side: Healing Persons with AIDS through Guided Imagery

and Music, in *Music and Miracles*, ed. D. Campbell (Wheaton, IL: Quest Books, 1992), 195–207.

53. T. Schroeder-Sheker, Music for the Dying: A Personal Account of the New Field of Music Thanatology—History, Theories, and Clinical Narratives, *Journal of Holistic Nursing* 12, no. 1 (1994):83–99.
54. U.B. Horrigan, Therese Schroeder-Sheker: Music Thanatology and Spiritual Care for the Dying, *Alternative Therapies in Health & Medicine* 7, no. 1 (2001):69–77.
55. C.H. McKinney et al., Effects of Guided Imagery and Music (GIM) Therapy on Mood and Cortisol in Healthy Adults, *Health Psychology* 16, no. 4 (1997):390–400.
56. O. Quintino et al., Job Stress Reduction Therapies, *Alternative Therapies in Health and Medicine* 3, no. 4 (1997):54–56.
57. L. Chlan, Psychophysiologic Responses of Mechanically Ventilated Patients to Music: A Pilot Study, *American Journal of Critical Care* 4, no. 3 (1995):233–238.
58. L. Chlan, Effectiveness of a Music Therapy Intervention on Relaxation and Anxiety for Patients Receiving Ventilatory Assistance, *Heart and Lung* 27, no. 3 (1998):169–176.
59. H.L. Wong, V. Lopez-Nahas, and A. Molassiotis, Effects of Music Therapy on Anxiety in Ventilator-dependent Patients, *Heart & Lung: Journal of Acute & Critical Care* 30, no. 5 (2001):376–387.
60. L. Chlan, M.F. Tracy, B. Nelson, and J. Walker, Feasibility of a Music Intervention Protocol for Patients Receiving Mechanical Ventilatory Support, *Alternative Therapies in Health & Medicine* 7, no. 6 (2001):80–83.
61. J.F. Byers and K.A. Smyth, Effect of Music Intervention on Noise Annoyance, Heart Rate, and Blood Pressure in Cardiac Surgery Patients, *American Journal of Critical Care* 6, no. 3 (1997):183–191.
62. S. Barnason et al., The Effects of Music Interventions on Anxiety in the Patient after Coronary Artery Bypass Grafting, *Heart and Lung* 24, no. 2 (1995):124–132.
63. M.E. Cadigan, N.A. Caruso, S.M. Haldeman, M.E. McNamara, D.A. Noyes, M.A. Spadafora, and D.L. Carroll, The Effects of Music on Cardiac Patients on Bed Rest, *Progress in Cardiovascular Nursing* 16, no. 1 (2001):5–13.
64. J. Hamel, The Effects of Music Intervention on Anxiety in the Patient Waiting for Cardiac Catheterization, *Intensive & Critical Care Nursing* 17, no. 5 (2001):279–285.
65. M.E. Barrera, M.H. Rykov, and S.L. Doyle, The Effects of Interactive Music Therapy on Hospitalized Children with Cancer: A Pilot Study, *Psycho-Oncology* 11, no. 5 (2002):379–388.
66. M. Haun, R.O. Mainous, and S.W. Looney, Effect of Music on Anxiety of Women Awaiting Breast Biopsy, *Behavioral Medicine* 27, no. 3 (2001):127–132.
67. M.F. Cunningham et al., Introducing a Music Program in the Perioperative Area, *AORN Journal* 66, no. 4 (1997):674–682.
68. B. Miluk-Kolasa, J. Klodecka-Rozka, and R. Stupnicki, The Effect of Music Listening on Perioperative Anxiety Levels in Adult Surgical Patients, *Polish Psychological Bulletin* 33, no. 2 (2002):55–60. (Blackhorse Publishing, Poland.)
69. P.M. Yung, S. Chui-Kam, P. French, and T.M. Chan, A Controlled Trial of Music and Preoperative Anxiety in Chinese Men Undergoing Transurethral Resection of the Prostate, *Journal of Advanced Nursing* 39, no. 4 (2002):352–359.
70. L. Bellan, A. Gooi, and S. Rehsia, The Misericordia Health Centre Cataract Comfort Study, *Canadian Journal of Ophthalmology* 37, no. 3 (2002):155–160.
71. J. Kaminski and W. Hall, The Effect of Soothing Music on Neonatal Behavioral States in the Hospital Newborn Nursery, *Neonatal Network* 15, no. 1 (1996):45–54.
72. J.M. Standley and R.S. Moore, Therapeutic Effects of Music and Mother's Voice on Premature Infants, *Pediatric Nursing* 21, no. 6 (1995):509–512.
73. J.M.Standley, A Meta-analysis of the Efficacy of Music Therapy for Premature Infants, *Journal of Pediatric Nursing* 17, no. 2 (2002):107–113.
74. A.B. Malone, The Effects of Live Music on the Distress of Pediatric Patients Receiving Intravenous Start, Venipunctures, Injections, and Heel Sticks, *Journal of Music Therapy* 33, no. 3 (1996):231.
75. P. Bampton and B. Draper, The Effects of Relaxation Music on Patient Tolerance of Gastrointestinal Endoscopic Procedures, *Journal of Clinical Gastroenterology* 25, no. 1 (1997):243–245.
76. J. Edwards, You Are Singing Beautifully: Music Therapy and the Debridement Bath, *Arts in Psychotherapy* 22, no. 1 (1995):53–55.
77. R.B. Fratianne, J.D. Prensner, M.J. Huston, D.M. Super, C.J. Yowler, and J.M. Standley, The Effect of Music-based Imagery and Musical Alternate Engagement on the Burn Debridement Process, *Journal of Burn Care & Rehabilitation* 22, no. 1 (2001):47–53.
78. R.E. Krout, The Effects of Single-Session Music Therapy Interventions on the Observed and Self-reported Levels of Pain Control, Physical

Comfort, and Relaxation of Hospice Patients, *American Journal of Hospice & Palliative Care* 18, no. 6 (2001):383–390.

79. K.E. Shertzer and J.F. Keck, Music and the PACU Environment, *Journal of Perianesthesia Nursing* 16, no. 2 (2001):90–102.
80. L. Zimmerman et al., The Effects of Music Interventions on Postoperative Pain and Sleep in Coronary Artery Bypass Graft (CABG) Patients, *Scholarly Inquiry for Nursing Practice* 10, no. 2 (1996):153–170.
81. L.K. Taylor et al., The Effect of Music in the Postanesthesia Care Unit on Pain Levels in Women Who Have Had Abdominal Hysterectomies, *Journal of Perianesthesia Nursing* 13, no. 2 (1998):88–94.
82. M. Good, G.C. Anderson, M. Stanton-Hicks, J.A. Grass, and M. Makii, Relaxation and Music Reduce Pain After Gynecologic Surgery, *Pain Management Nursing* 3, no. 2 (2002):61–70.
83. S. Boldt, The Effects of Music Therapy on Motivation, Psychological Well-Being, Physical Comfort, and Exercise Endurance of Bone Marrow Transplant Patients, *Journal of Music Therapy* 33, no. 3 (1996):164–188.
84. J.A. Schoor, Music and Pattern Change in Chronic Pain, *Advances in Nursing Science* 15, no. 4 (1993):27–36.
85. G. Kerkvliet, Music Therapy May Help Control Cancer Pain, *Journal of the National Cancer Institute* 82 (1990):350–352.
86. J. Frank, The Effects of Music Therapy and Guided Visual Imagery on Chemotherapy Induced Nausea and Vomiting, *Oncology Nursing Forum* 12 (1985):47–52.
87. C.M. Lucia, Toward Developing a Model of Music Therapy Intervention in the Rehabilitation of Head Trauma Patients, *Music Therapy Perspectives* 4 (1987):34–39.
88. M.A. Steckler, The Effects of Music on Healing, *Journal of Long Term Home Health Care* 17, no. 1 (1998):42–48.
89. M. Brotons et al., Music and Dementias: A Review of Literature, *Journal of Music Therapy* 34, no. 4 (1997):204–245.
90. M. Brotons and P. Pickett-Cooper, The Effects of Music Therapy on Agitation Behaviors of Alzheimer's Disease Patients, *Journal of Music Therapy* 33, no. 1 (1996):2–18.
91. R. Remington, Calming Music and Hand Massage with Agitated Elderly, *Nursing Research* 51, no.5 (2002):317–323.
92. L. Keegan, Holistic Nursing, *Journal of Post Anesthesia Nursing* 4 (1989):17–21.
93. D. Smolen, R. Topp, and L. Singer, The Effect of Self-Selected Music during Colonoscopy on Anxiety, Heart Rate, and Blood Pressure, *Applied Nursing Research* 15, no. 3 (2002):126–136.
94. U. Schiemann, M. Gross, R. Reuter, and H. Kellner, Improved Procedure of Colonoscopy under Accompanying Music Therapy, *European Journal of Medical Research* 7, no. 3 (2002):131–134.
95. B. Dun, A Different Beat: Music Therapy in Children's Cardiac Care, *Music Therapy Perspectives* 13, no. 1 (1995):35–39.
96. P.M. Lehrer et al., Relaxation and Music Therapies for Asthma among Patients Prestabilized on Asthma Medication, *Journal of Behavioral Medicine* 17, no. 1 (1994):1–24.
97. R.W. Justice, Music Therapy Interventions for People with Eating Disorders in an Inpatient Setting, *Music Therapy Perspectives* 12, no. 2 (1994):104–110.
98. Bruscia, Visits from the Other Side.
99. Campbell, *The Mozart Effect*.
100. McCraty et al., The Effects of Different Types of Music.
101. K. Allen and J. Blascovich, Effects of Music on Cardiovascular Reactivity among Surgeons, *Journal of the American Medical Association* 272 (1994):882–884.
102. McCraty et al., The Effects of Different Types of Music.
103. M.A. Wooten, The Effects of Heavy Metal Music on Affects Shifts of Adolescents in an Inpatient Psychiatric Setting, *Music Therapy Perspectives* 10, no. 2 (1992):93–98.
104. Tyson, Meeting the Needs of Dementia.
105. Campbell, *The Mozart Effect*, 65.
106. Ibid., 66.
107. Ibid., 78–80.
108. D. Aldridge, An Overview of Music Therapy Research, *Complementary Therapies in Medicine* 2 (1994):204–216.
109. Halpern and Savary, *Sound Health*, 203.
110. H. Bonny, Sound Spaces: Music Rx Is Proven in the ICU, *ICM West Newsletter* 2, no. 4 (1982):1–2.
111. S. Mazer and D. Smith, *Sound Choices: Using Music To Design Your Environments* (Carlsbad, CA: Hay House, 1999).
112. Bonny and Savary, *Music and Your Mind*, 43.
113. B. Wein, Body and Soul Music, *American Health* (1987, April):67–74.
114. Halpern and Savary, *Sound Health*, 150.
115. Campbell, *The Mozart Effect*, 258–259.

RESOURCES

Relaxation, Music, and Imagery Tapes

Healing HealthCare Systems
(Susan Mazer and Dallas Smith)
The C.A.R.E. Channel®, 24-hour music and nature programming for patient-television.
The Sondrex System®, a sound-inducing relaxation system for surgical patients.
http://www.healinghealth.com

Mind/Body Health Sciences
http://www.joanborysenko.com

MMB Music
http://www.mmbmusic.com

Mozart Effect Resource Center
http://www.mozarteffect.com

Music Design
http://musicdesign.com

Natural Wellness, Institute for Integrative Healthcare Studies
http://www.natural-wellness.com

New Era Media
425 Alabama Street
San Francisco, CA 94110
Telephone: 415-863-3555

Sounds True
http://soundstrue.com

Spring Hill Music
http://www.springhillmusic.com

Steve Halpern Inner Peace Music
(Music for caregivers, music for sound healing)
http://www.stevenhalpern.com

ADDITIONAL RESOURCES

American Music Therapy Association
http://www.musictherapy.org

The Bonny Foundation
Guided imagery and music (GIM)
http://www.bonnyfoundation.org

CAIRSS for Music (Computer-Assisted Information Retrieval Service System)
http://imr.utsa.edu/CAIRSS.html

Health Journeys: Guided Imagery
http://www.healthjourneys.com

MuSICA (Music and Science Information Computer Archive)
http://www.musica.uci.edu

Using Our Healing Hands

Imagine being transported into a dimension that bathes your entire being in a delicious sensation, one that stimulates and/or relaxes your physical sensory receptors and taps into mental and spiritual domains. Many people report this kind of opening, something that feels akin to floating on a cloud, when they experience hands-on healing for the first time. Subsequent sessions build upon and augment the initial effect.

Stroking and enfolding, kneading manipulation, light touch, pressure point, and working within an energy field are just some of the phrases that come to mind when thinking about the modality of touch. Within a single generation, the phenomenon of touch as a nursing intervention has evolved from the basic bedside back rub into an expansive variety of full-body hands-on techniques.

Many practitioners and recipients of the various touch modalities believe that the end result is more beneficial than simply the obvious physical effect. Numerous hands-on therapies are designed to awaken the recipient's psyche and heighten their spiritual awareness, while producing both overt and covert physical changes. The environment, the centeredness of the practitioner, the specific modality selected, and the receptivity of the client all contribute to an experience that has the power to embrace both psyche and soma and result in a positive alteration of body, mind, and spirit.

Nurses refer to the hands-on aspects of nursing as touch therapy, therapeutic touch, healing touch, therapeutic massage, or bodywork, as well as various other labels. Despite the different names, the intent is always the same: to care for another through some mode of physical touch or energy field manipulation. Although the techniques vary among practitioners, the objectives of the various therapies are similar: to relax; soothe; stimulate; relieve physical, mental, emotional, and/or spiritual discomfort; or aid in the transition of the client to a heightened plateau of being. Those who use touch as a therapeutic modality do so from a calm, centered place and believe that focused intention facilitates the transference of healing energy. However, just as not all nurses relate well to the technical nature of an intensive care unit or operating room, not all nurses have the ability or desire to use the medium of touch. Generally, both practitioners and recipients know after a few encounters if this approach works for them. When it does, the nurse who develops hands-on therapeutic skills can become a practitioner of a whole new array of powerful healing modalities.

Chapter 24

Touch: Connecting with the Healing Power

Lynn Keegan and Karilee Halo Shames

NURSE HEALER OBJECTIVES

Theoretical

- Learn the definitions of the various types of touch techniques.
- Compare and contrast the various touch therapies.
- Observe subjective and objective changes in the client after the touch therapy session.
- Compare and contrast your responses to touch therapy with the published descriptions of other nurses.

Clinical

- Develop your abilities to center and become calm before you use touch therapies in your practice.
- Learn to calm, soften, and steady your voice as you use it as an adjunct to touch therapy.
- Experiment with soothing music or guided imagery (spoken or from audiotapes) as an adjunct to the touch session.
- Create opportunities to practice touch therapies in your clinical area.
- Notice whether there are any changes in your emotions during or after you use touch therapy.
- Notice whether there is any change in your sense of time when you use touch. Does time slow down or speed up?

Personal

- Become aware of how you use touch in your everyday life.
- Examine the significance of touch in your personal and professional relationships.

DEFINITIONS

Acupressure: the application of finger and/or thumb pressure to specific sites along the body's energy meridians for the purpose of relieving tension, reestablishing the flow of energy along the meridian lines, and restoring balance to the human energy system.

Body Therapy and/or Touch Therapy: the broad range of techniques that a practitioner uses in which the hands are on or near the body to assist the recipient toward optimal function.

Caring Touch: touch performed with a genuine interest in the other person, as well as an expression of empathy and concern.

Centering: a sense of self-relatedness that can be thought of as a place of inner being, a place of quietude within oneself where one can feel truly integrated, unified, and focused.

Energy Center: specific center of consciousness in the human energy system that allows for the inflow of energy from the Universal Energy Field, as well as

for outflow from the individual's energy field. There are seven major energy centers in relation to the spine, and many minor centers at bone articulations in the palms of the hands and the soles of the feet. Also called *chakra*.

Energy Meridian: an energy circuit or line of force. Eastern theories describe meridian lines flowing vertically through the body, culminating at points on the feet, hands, and ears.

Foot Reflexology: the application of pressure to points on the feet held to correspond to other parts of the body.

Grounding: the process of connecting to the earth and the earth's energy field, to calm the mind and focus one's inner flow of energy as a means to enhance healing endeavors.

Human Energy System: the entire interactive, dynamic system of human subtle energies, consisting of the energy centers, the multidimensional field, the meridians, and acupuncture points.

Intention: the motivation or reason for touching; the direction of one's inner awareness and focus for healing; the state of being fully present in the moment.

Procedural Touch: touch performed to diagnose, monitor, or treat an illness; touch that focuses on the end result of curing the illness or preventing further complications.

Shiatzu: the systematic use of the thumb and/or heel of the hand for deep pressure work along the energy meridian lines.

Therapeutic Massage: the use of the hands to apply pressure and motion to the recipient's skin and underlying muscle to promote physical and psychologic relaxation, improve circulation, relieve sore muscles, and accomplish other therapeutic effects.

Therapeutic Touch: a specific technique of centering intention used while the practitioner moves the hands through a recipient's energy field for the purpose of assessing and treating energy field imbalance.

THEORY AND RESEARCH

Touch in Ancient Times

Healing through touch is as old as civilization itself. Practiced extensively in all ancient cultures, this oldest form of treatment was to "rub it if it hurts." The ancient Egyptians used bandages, poultices, touch, and manipulation. Inside the Pyramids, illustrations thousands of years old show representations of one person holding hands near another, with waves of energy depicted moving from the hands of the healer to the body nearby. The oldest written documentation of the use of body touch to enhance healing comes from Asia. The *Huang Ti Nei Ching* is a classic work of internal medicine that was written 5,000 years ago. The *Nei Ching*, a 3,000- to 4,000-year-old Chinese book of health and medicine, records a system of touch based on acupuncture points and energy circuits. The ancient Indian Vedas also described healing massage, as did the Polynesian Lomi practice and the traditions of Native Americans.

During the height of classical Greek civilization, Hippocrates wrote of the therapeutic effects of massage and manipulation; he also gave instructions for carrying out these practices. He wrote during the time of the great Aesculapian healing centers, at which many whole-body therapies included touch. Touch therapies were also employed at the healing centers to assist individuals who wished to make the transition to a higher level of function.

Massage was used as a mode of preparation for dream work, which was a significant part of therapy in the healing rites. The Roman historian Plutarch wrote that Julius Caesar was treated for epilepsy by being pinched over his entire body every day.

Both shamans and traditional practitioners used touch widely until the rise of the Puritan culture during the 1600s and the shift from primitive healing practices to modern scientific medicine. Puritan culture equated touch with sex, which was associated with original sin. During the late nineteenth and early twentieth centuries, health care moved away from anything associated with superstition and primitive healing, and was directed toward scientific medicine. All unnecessary touch was discouraged because of the association of touch with primitive healing, and because of the prevailing strong Puritan ethic. Consequently, touch as a therapeutic intervention remained undeveloped in U.S. health care until research into its benefits began in the 1950s.

Cultural Variations

The fact that many cultures, both ancient and modern, have developed some form of touch therapy indicates that rubbing, pressing, massaging, and holding are natural manifestations of the desire to heal and care for one another. However, attitudes toward touch vary among cultures. One society may view touch as necessary, whereas another may view it as forbidden. The nurse must be aware of personal and cultural views and reactions to touch.

Philosophic and cultural differences have influenced the development of touch in various areas of the world. The Eastern world view is founded on energy, whereas the Western world view is based on reductionism of matter. This basic cultural difference has led to the evolution of widely differing approaches to touch. The Eastern world view holds that qi (or chi), also described as energy or vital force, is the center of body function. A meridian is an energy circuit or line of force that runs vertically through the body. Magnetic or bioelectrical patterns flow through the microcosm of the body in the same way that magnetic patterns flow through the planet and the universe. Meridian lines and zones are influenced by pressure placed on points along those lines. Expert practitioners in acupuncture or Shiatzu purport to direct healing energy to the recipient via an energy flow that moves through the body and out through their hands.[1,2] In contrast, the Western world view holds that it is the physical effect of cellular changes occurring during touch that influences healing. For example, massage stimulates the cells to aid in waste discharge, promotes the dilation of the vascular system, and encourages lymphatic drainage. Swedish and therapeutic massage techniques were developed to produce these physical changes.

A blending of Eastern and Western techniques has resulted in an explosion of new and widely practiced modalities. The modern-day renaissance in body therapies is probably a healthy response to the fast-paced technologic revolution that has swept Western culture, bringing back a sense of balance and caring.

Modern Concepts of Touch

Research is finally beginning to document what healers have always intuitively known. Some of the first studies documenting the significance of touch involved infant monkeys and surrogate mothers.[3] In the 1950s, Harlow caged one group of infant monkeys with a monkey-shaped wire form that served as a surrogate mother, and a second group with a soft cloth mother surrogate. When frightened, the monkeys housed with the wire form reacted by running and cowering in a corner. The other group reacted to the same stimuli by running and clinging to the soft cloth surrogate for protection. These infant monkeys even preferred clinging to an

unheated cloth surrogate mother to sitting on a warm heating pad. Although the cloth surrogate was unresponsive, the offspring raised with it developed basically normal behavior. This and other classic studies conclusively documented the significance of touch in normal animal growth and development.

Studies of human development soon followed. One study of abandoned infants and infants whose mothers were in prison found that infants whom the nurses held and cuddled thrived, whereas those who were left alone became ill and died.[4] These studies led to the development of the concept of touch deprivation.

These early studies in the 1950s and 1960s awakened scientific interest in the phenomenon of healing touch. Bernard Grad, a biochemist at McGill University, was one of the first to investigate healing by the laying on of hands. He conducted a series of double-blind experiments with the renowned healer Oskar Estebany.[5] In these studies, wounded mice and damaged barley seeds were separated into control and experimental groups. After Estebany used therapeutic touch to manipulate the energy fields of the mice and seeds in the experimental groups, these groups demonstrated a significantly accelerated healing rate in comparison to the control groups. In a subsequent study, an enzymologist worked with Grad using the enzyme trypsin in double-blind studies.[6] After the trypsin was exposed to Estebany's treatments, its activity was significantly increased.

Within the past decade there has been a renaissance in the use of touch as a therapeutic practice. Many new books have been written and there is a proliferation of studies to document the effectiveness of this practice.[7–10]

Nursing Studies

Although touch therapy is as old as civilization, documentation of how, why, and where it works is relatively new in the nursing literature.

Care of Adults

In an investigation of the effect of massage therapy on chronic nonmigraine headache, chronic tension headache sufferers received structured massage therapy treatment directed toward neck and shoulder muscles. Headache frequency, duration, and intensity were recorded and compared with baseline measures. Compared with baseline values, headache frequency was significantly reduced within the first week of the massage protocol. The reduction of headache frequency continued for the remainder of the study (P =.009). The duration of headaches tended to decrease during the massage treatment period (P =.058). Headache intensity was unaffected by massage (P =.19). The conclusion is that the muscle-specific massage therapy technique used in this study has the potential to be a functional, nonpharmacological intervention for reducing the incidence of chronic tension headache.[11] Another study demonstrated that touch slowed the heart rate, decreased diastolic blood pressure, and reduced anxiety.[12]

Patients with cancer often use massage therapy as an adjunctive treatment. Oncology nurses can be advocates for patients seeking massage therapy by educating them to be informed consumers of massage therapy. They can stress that patients with cancer use massage therapists who have graduated from accredited programs, meet state licensure requirements, and have specialized training in the massage of patients with cancer. Oncology nurses often are the link between the physician

ordering or approving this therapy and the licensed massage therapist (LMT) delivering the therapy. LMTs need information about a patient's cancer diagnosis, comorbidities, type of treatment, and response to treatment to safely provide massage therapy. Nurses play an important role in conveying this and other relevant information to LMTs, including any special considerations, such as the presence of neutropenia or thrombocytopenia. Safe and effective massage therapy to patients with cancer is only achieved when the patient, health care providers, and the LMT collaborate effectively.[13]

A quasiexperimental study was done to accertain the effect of massage on the perception of pain, subjective sleep quality, symptom distress, and anxiety in patients hospitalized for treatment of cancer. The sample consisted of 41 chemotherapy or radiation therapy patients on the oncology unit at a large urban medical center in the United States. Twenty participants received therapeutic massage and 21 received the control therapy, nurse interaction. The outcome variables were measured on admission and at the end of one week via the following instruments: a Numerical Rating Scale for pain intensity and Likert-type scale for distress from pain, The Verran Snyder-Halpern Sleep Scale, McCorkle and Young's Symptom Distress Scale, and the Speilberger State Anxiety Inventory. ANOVA and *t* tests were used to analyze between and within group differences in mean scores and main effects on outcome variables. Mean scores for pain, sleep quality, symptom distress, and anxiety improved from baseline for the subjects who received therapeutic massage; only anxiety improved from baseline for participants in the comparison group. Statistically significant interactions were found for pain, symptom distress, and sleep. Sleep improved only slightly for the participants receiving massage, but deteriorated significantly for those in the control group. The findings support the potential for massage as a nursing therapeutic for cancer patients receiving chemotherapy or radiation therapy.[14]

Low-back pain is one of the most common and costly musculoskeletal problems in modern society. Proponents of massage therapy claim it can minimize pain and disability, and speed return to normal function. To assess the effects of massage therapy for nonspecific low-back pain, the Cochrane team searched Medline, Embase, Cochrane Controlled Trials Register, HealthSTAR, CINAHL, and Dissertation abstracts from the Cochrane's database abstracts beginning in May 2001, with no language restrictions. References in the included studies and in reviews of the literature were screened. Contact with content experts and massage associations was also made. The studies had to be randomized or quasi-randomized trials investigating the use of any type of massage (using the hands or a mechanical device) as a treatment for nonspecific low-back pain. Two reviewers blinded to authors, journals, and institutions selected the studies, assessed the methodological quality using the criteria recommended by the Cochrane Back Review Group, and extracted the data using standardized forms. The studies were analyzed in a qualitative way due to heterogeneity of population, massage technique, comparison groups, timing, and type of outcome measured.[15]

Nine publications reporting on eight randomized trials were included. Three had low and five had high methodological quality scores. One study was published in German; the rest were in English. Massage was compared to an inert treatment (sham laser) in one study that showed that massage was superior, especially if given

in combination with exercises and education. In the other seven studies, massage was compared to different active treatments. They showed that massage was inferior to manipulation and TENS; massage was equal to corsets and exercises; and massage was superior to relaxation therapy, acupuncture, and self-care education. The beneficial effects of massage in patients with chronic low-back pain lasted for at least one year after the end of the treatment. One study comparing two different techniques of massage concluded in favor of acupuncture massage over classic (Swedish) massage. The reviewers' conclusions were that massage might be beneficial for patients with subacute and chronic non-specific low-back pain, especially when combined with exercises and education. The evidence suggest that acupuncture massage is more effective than classic massage, but more studies are needed to confirm these conclusions and to assess the impact of massage on return-to-work, and to measure longer-term effects to determine cost-effectiveness of massage as an intervention for low-back pain.[16]

In a randomized trial comparing massage therapy with relaxation therapy for fibromyalgia, only massage therapy offered long-term benefits. Massage therapy was expected to increase restorative sleep, decrease substance *P* levels, and reduce pain. In 24 adult fibromyalgia patients randomized to massage or relaxation therapy consisting of 30-minute treatments twice weekly for 5 weeks, both groups showed decreased anxiety and decreased depressed mood immediately after the first and last therapy sessions. During the course of the study, only the massage therapy group reported increased number of sleep hours and decreased frequency of sleep movements. Substance *P* levels decreased, as did physician's ratings of pain, disease, and number of tender points.[17]

Care of Children

Several studies were conducted to assess the benefit of massage therapy in pediatric patients with various medical conditions. Generally, the massage therapy resulted in lower anxiety (epinephrine) and stress hormone (cortisol) levels.[18] One group of children with mild to moderate juvenile rheumatoid arthritis received massage for pain control. Parents of the children with rheumatoid arthritis received 30 minutes of training and a practice video. The children were massaged by their parents for 15 minutes a day for 30 days. Pain incidence and severity diminished on self-reports, parent reports, and physician pain assessments.[19]

Using parents and grandparents to administer massage is cost-effective and can contribute to the child's sense of comfort. Massage can benefit the parents as well by reducing their own anxiety. The parents of children with chronic pain or other conditions may feel helpless watching their child wander through myriad interventions. Massage therapy is a procedure in which the parents can contribute directly to their child's well-being. Massage therapy is "low tech." The training involved can be substantial, although not always necessary.[20]

A study was done to review and critique the research on the effect of massage therapy and therapeutic touch in children, and to describe clinical implications and make suggestions for future study. Studies were obtained through online computer searches of CINAHL, Medline, PsychInfo, and SocioFile. Fourteen massage therapy studies were selected because they met the following three criteria: they investigated massage therapy in children; were published in refereed nursing, allied health, or

infant and child development journals between 1969 and 1999; and were quantitative in nature. Studies were divided according to developmental age for analysis: neonates, preschool, and older children. Five Therapeutic Touch studies—three quantitative and two qualitative—were selected because they were the only empirical reports about the effect of therapeutic touch in children to date. In addition to critiques, the Therapeutic Touch studies were examined for the following ten characteristics: study purpose/hypotheses, background/literature review, sample selection method, study design/random assignment, independent variable/length of treatment/control and confounders, dependent variables/measurements, outcomes, study limitations, and implications for future research. It was discovered that more research exists to support the use of massage therapy than therapeutic touch in children. A set of common findings across two decades of study suggests that massage therapy may be useful in the care of infants and children. Because massage therapy and Therapeutic Touch seem to elicit similar parasympathetic effects, therapeutic touch may be useful. There is insufficient evidence, however, to recommend its use in children without confirming qualifications.[21]

Infant Massage

Infant massage is the newest touch modality gaining recognition. Some nurses have been hesitant to begin massage therapy for fear of overstimulating the infant, and because there has been insufficient research to prove its safety. Recent research, however, has shown that the significant benefits of infant massage therapy outweigh the minimal risks. When infant massage therapy is properly applied to preterm infants, they respond with increased weight gain, improved developmental scores, and earlier discharge from the hospital. Parents of the preterm infant also benefit because infant massage enhances bonding with their child and increases confidence in their parenting skills.[22]

Infant massage by the mother has become popular in many cultures, especially in India, and is growing in popularity in the West. Mothers with postnatal depression often have problems interacting with their infants. A small controlled study has shown that attending a massage class can help such mothers better relate to their babies. The mechanisms by which this is achieved are not clear, but may include learning to understand their babies' cues and the resulting release of oxytocin.[23]

Many infants in Neonatal Intensive Care Units are subject both to a highly stressful environment such as continuous, high-intensity noise and bright light, and to a lack of the tactile stimulation that they would otherwise experience in the womb or in general mothering care. As massage seems to both decrease stress and provide tactile stimulation, it has been recommended as an intervention to promote growth and development of preterm and low-birth-weight infants.

A study was done to determine whether preterm and/or low-birth-weight infants exposed to massage experience improved weight gain and achieved earlier discharge compared to infants receiving standard care, and to determine whether massage has any other beneficial or harmful effects on this population. Databases were searched using the term 'massage,' 'touch,' or 'tactile stimulation' with 'infant - newborn', 'infant - premature,' and 'infant - low birth weight'. The main databases searched were those of the Cochrane Collaboration Field in Complementary Medicine and the Neonatal Collaborative Review Group. Randomized trials in which infants with gestational

age at birth of less than 37 weeks or weight at birth of less than 2500g received systematic tactile stimulation by human hands. At least one outcome assessing weight gain, length of stay, behavior, or development must be reported. Data extracted from each trial were baseline characteristics of sample, weight gain, length of stay, and behavioural and developmental outcomes. Physiological and biochemical outcomes were not recorded. Data were extracted independently by three reviewers. Statistical analysis was conducted using the standard Cochrane Collaboration methods. The results were that massage interventions improved daily weight gain by 5g (95% CI 3.5, 6.7g). There is no evidence that gentle, still touch is of benefit (increase in daily weight gain: −0.2g; 95% CI −2.4, 1.9g). Massage interventions also appeared to reduce length of stay by 4.6 days (95% CI 2.6, 6.6g) though there are methodological concerns about the blinding of this outcome. There was also some evidence that massage interventions have a slight, positive effect on postnatal complications and weight at 4–6 months. However, serious concerns about the methodological quality of the included studies, particularly with respect to selective reporting of outcomes, weaken credibility in these findings. Evidence that massage for preterm infants is of benefit for developmental outcomes is weak and does not warrant wider use of preterm infant massage. Where massage is currently provided by nurses, consideration should be given as to whether this is a cost-effective use of time. Future research should assess the effects of massage interventions on clinical outcome measures, such as medical complications or length of stay, and on process-of-care outcomes, such as caregiver or parental satisfaction.[24]

Touching Styles

Data collected through in-depth interviews with eight experienced intensive care nurses revealed two substantive processes—the touching process itself and the acquisition of a touching style—neither of which had been previously reported in the literature. Estabrooks and Morse note that the touching process is more than skin-to-skin contact; it involves entering the patient's space, connecting, talking, following nonverbal cues, and eventually touching. Nurses learn about touch from their culture, family, street learning, personal experience, and nursing school.[25]

Bodymind Communication

Touch is perhaps one of the most frequently used, yet least acknowledged, of the five recognized senses. It is the first sense to develop in the human embryo, and the one most vital to survival. Touch can vary from subtle fleeting brush strokes to violent physical attacks. Touch evokes the full range of emotions from hatred to the most intimate love relationship. Figuratively, touch is used in literature, and even daily conversation, to describe emotions. For example, "That speech really touched me," or, "This workshop will allow you to touch one another heart to heart." These figurative expressions signify the deep importance and value of touch. As the largest and most ancient sense organ of the body, the skin enables us to experience and learn about the environment.[26] Through the skin, we perceive the external world. The skin—particularly the skin of the face—not only communicates knowledge to the brain about the external world, but also conveys to others information about the state of an individual's body-mind-spirit.

A piece of skin the size of a quarter contains more than 3 million cells, 12 feet of nerves, 100 sweat glands, 50 nerve endings, and 3 feet of blood vessels. There are estimated to be approximately 50 receptors per 100 square centimeters—a total of 900,000 sensory receptors.[27] Viewed from this perspective, the skin is a giant communication system that, through the sense

of touch, brings messages from the external environment to the attention of the internal environment—the bodymind.

Because health care increasingly is being delivered in very complicated technologic settings, nurses are concerned with ensuring that the human spiritual and social needs of patients not be overlooked. This is particularly valuable when working with the geriatric population, a group often touch deprived. Yet nurses must take into account social contexts and cultural differences before engaging in energetic efforts to provide touch therapy. A nurse should never assume that a client will find touch comforting, but should always ask before touching. If the suggestion evokes no response or a pained expression, the nurse may try a tentative touch and observe the client's response carefully. To be truly effective, touch must be given authentically by a warm, genuine, caring individual to another who is willing to receive it. It cannot and should not be packaged and dispensed. Phony touching may be more upsetting than none at all.

Like any other nursing intervention, hugging and touching demand careful assessment. Nurses need to recognize their own feelings, as well as to consider the client's age, sex, and ethnic background. A few key questions (e.g., "Would a back massage help you relax?" "Would it help if I held your hand?") can help the client clarify his or her own beliefs and values regarding different types, locations, and intensities of touch.

There are many variations in and names for the touch therapies available for use as nursing interventions. Some are basic human contacts, such as hand holding and hugging. Others are more complex. Some clients will react strongly to touch, especially if they have been exposed to inappropriate or uncomfortable touch at other times. The touch therapies described below are used by holistic practitioners who often advocate and teach healthy lifestyle behavior patterns to their clients to augment well-being during the course of the touch therapy treatments. The addition of guided imagery and/or music before and during treatment may heighten the relaxation response elicited during touch therapies. The setting—be it acute care, long-term care, home care, rehabilitation center, or wellness center—will also affect the focus and length of the treatment.

TOUCH INTERVENTIONS AND TECHNIQUES

A variety of techniques are included under the heading of body therapies. Except for Therapeutic Touch, all body therapies involve actual physical contact. The contact usually consists of the practitioner's touching, pushing, kneading, or rubbing the recipient's skin and underlying fascia tissue. Each of the therapies has its own body of knowledge, history, and technique.

Touch can be used therapeutically in nursing in a great variety of ways. Some methods require special licensure or certification, while others can be incorporated after minimal introduction via videotape or classroom presentation. All begin with the nurse's receiving permission to touch, followed by the nurse's efforts to center and set intentionality for the client's healing. Touch therapies can be classified into several categories: somatic and musculoskeletal therapies; Eastern, meridian-based, point therapies; energy-based therapies; emotional bodywork; manipulative therapies; and other holistic touch therapies. Many programs have been developed to teach these therapies.

Somatic and Musculoskeletal Therapies

The category of somatic and musculoskeletal therapies encompasses the generic work known as therapeutic massage. As a nursing intervention, therapeutic massage has a twofold purpose. First,

clients who are on bed rest or immobilized in a wheelchair require the circulatory stimulation that massage brings. Second, massage is a means of relaxation.

During this century, nurses have performed therapeutic massage primarily on the backs of their clients. Back care is not new; for decades, it has been incorporated into the standard bathing and evening care routine of most hospitals. Because of time constraints and traditional neglect of the body therapies in institutions, these patients receive only a portion of the complete range of touch therapies.

Learning full-body massage greatly augments and expands the nurse's basic massage techniques. Most practitioners learn these techniques in continuing education classes, but books on massage are also available that illustrate the techniques.

Because no two clients, either within or outside the institutional setting, have the same needs, the nurse must become skilled at adapting the therapy to the setting and the time available. Massage techniques that can be performed quickly—for example, massage for the hands, feet, or neck and shoulders—may have beneficial results in short time periods.

Other types of therapeutic massage include Swedish massage, Esalen massage, neuromuscular therapy, myofascial release, lymphatic massage/drainage therapy, and Aston-patterning. To use these specific techniques, the nurse must take special courses, which often grant a certificate of completion. Massage licensure laws vary from state to state; some states require that even registered nurses take an additional course to become certified prior to practicing massage therapy.

Eastern, Meridian-Based, and Point Therapies

The category of Eastern, meridian-based, and point therapies includes acupressure, AMMA therapy, Jin Shin Jyutsu, Shiatzu, myotherapy, reflexology, and touch for health. Because the Eastern medical approach is very different from that in our Western training and education, the nurse must study these methods in a program that teaches about meridians, pressure points, reflex points, and Eastern healing philosophy. AMMA therapy is a program in Eastern bodywork endorsed by the American Holistic Nurses' Association; it teaches nurses Eastern medical principles for assessing imbalances in the energy system, combined with a Western approach to organ dysfunction.

Energy-Based Therapies

New programs and modalities are being created regularly in the rapidly growing field of energy-based interventions. Some of the better-known and well-studied methods used by nurses include Therapeutic Touch, Reiki, polarity therapy, the techniques of Barbara Brennan, and the lightbody work of the Foundation for Unity Consciousness.

Therapeutic Touch

A healing modality that involves touching with the conscious intent to help or heal, Therapeutic Touch decreases anxiety, relieves pain, and facilitates the healing process. Krieger, Quinn, and others continue to document the importance of Therapeutic Touch and encourage its investigation using controlled studies.[28–31]

The process of Therapeutic Touch has four phases:

1. Centering oneself physically and psychologically; that is, finding within oneself an inner reference of stability.
2. Exercising the natural sensitivity of the hand to assess the energy field of the client for clues to differentiate the quality of energy flow.

3. Mobilizing areas in the client's energy field that appear to be nonflowing (i.e., sluggish, congested, or static).
4. Directing one's excess body energies to assist the client to repattern his or her own energies.

Several factors ensure the safe and successful practice of Therapeutic Touch: intentional motivation, personal recognition, and acceptance by the practitioner of the reason that he or she has chosen to act in the role of healer. Therapeutic Touch is taught at beginning, intermediate, and advanced levels in continuing education programs, graduate nursing education programs, and intensive summer workshops. Of all the touch therapies, Therapeutic Touch is the one that nursing regards most highly, for it arises through the natural potential of the process by which the nurse inspires healing in clients through touch. In recent years, literally hundreds of studies, articles, and books have explored Therapeutic Touch and related energy-based therapies from a great variety of nursing and health perspectives.

Most of the energy-based touch therapies have certain common tenets, although the methods for applying them may vary. Nurses are becoming increasingly involved in the use of energy-based modalities for inspiring balance and body-mind connection.

Energy Field Disturbance

In the 1995–1996 *Nursing Diagnoses: Definitions and Classification*, by the North American Nursing Diagnosis Association, the definition of "energy field disturbance" made its entry into the world of professional nursing. Energy field disturbance is defined as "a disruption of the flow of energy surrounding a person's being which results in a disharmony of the body, mind, and/or spirit. Defining characteristics include: temperature changes (warmth/coolness); visual changes (image/color); disruption of the field (vacant/hold/spike/bulge); movement (wave/spike/tingling/dense/flowing); sounds (tonewords)."[32]

Nursing Intervention Classifications

In addition to including a new nursing diagnosis related to energy healing, the *Nursing Interventions Classification*, which lists Therapeutic Touch, specifies simple massage as a nursing intervention, and consideration is being given to the addition of simple touch and therapeutic massage as well.[33]

Acupressure and Shiatzu

The Eastern energy system of meridian lines and points is the foundation of acupressure and Shiatzu. The application of finger and/or thumb pressure to energy points along the meridians releases congestion and allows energy to flow.

There are 657 designated points on the human body that can be stimulated or treated in acupuncture, acupressure, or Shiatzu.[34] These points run along 12 pathways, or meridians, that connect the points on each half of the body. In addition to the 12 pairs of body meridians, there are two coordinating meridians that bisect the body. Acupressure is concerned primarily with the 12-organ meridian system.

The word *shiatzu* comes from the Japanese words *shi* (finger) and *atzu* (pressure).[35] The technique is a product of 4,000 years of Eastern medicine and philosophy. Although widely known and practiced in Japan, Shiatzu was virtually unknown in the West until acupuncture began receiving widespread public attention. Shiatzu is based on the same points that are used in acupuncture. Instead of inserting needles, however, the practitioner applies pressure on these points with the thumbs, fingers, and heel of the hand. Another difference between acupuncture and Shiatzu

is that the main function of Shiatzu is to maintain health and well-being rather than to treat imbalance, as often occurs in acupuncture.

Reflexology

In the early 1900s, William FitzGerald noted that application of pressure to certain points on the hands caused anesthesia in other parts of the body. Another physician, Edwin Bowers, learned of FitzGerald's work and joined him in the exploration and development of this zone therapy. The technique became more specific as it evolved into reflexology, which encompasses many more pressure points.

Reflexology is based on the theory that ten equal longitudinal zones run the length of the body from the top of the head to the tips of the toes. This number corresponds to the number of fingers and toes. Each big toe matches to a line that runs up the medial aspect of the body through the center of the face and culminates at the top of the head. The reflex points pass all the way through the body within the same zones. Congestion or tension in any part of a zone affects the entire zone running laterally throughout the body. More than 72,000 nerves in the body terminate in the feet. A problem or disease in the body often manifests itself through formation of deposits of calcium and acids on the corresponding part of the foot.[36–38]

The purpose of this therapy is twofold. First, relaxation itself is an important goal. Good health is dependent on one's ability to return to homeostasis after injury, disease, or stress. From this perspective, reflexology is effective in helping the bodymind restore and maintain its natural state of health because foot manipulation triggers deep relaxation. The second goal of this therapy is to release congestion or tension along the longitudinal and lateral zones by pressure manipulation at the precise endpoints of the zones. This pressure stimulates the reflexes in the feet to cause a corresponding release. All skeletal, muscular, vascular, nervous, and organ systems are believed to be affected. Manuals with specific diagrams are used to instruct the therapist.

At this time, no documented scientific research exists to validate the effectiveness of reflexology, although it relaxes muscles and causes a simultaneous bodymind connection that results in the relaxation response. This relaxation affects the autonomic response, which is tied into the endocrine, immune, and neuropeptide systems.

Emotional Bodywork

The category of emotional bodywork includes numerous techniques developed by individuals operating in the various fields that combine psychotherapy and bodywork. Some of the specific techniques include Lomi, network chiropractic, Hellerwork, rolfing, structural integration, and psychoenergetic balancing. Some of these methods derive from ancient traditions, others from established health fields such as chiropractic. *Psychoenergetic balancing* is a phrase coined by the nurses who recently authored a book on energy healing and emotional release, *Energetic Approaches to Emotional Healing*.[39]

Manipulative Therapies

Manipulative therapies often involve more invasive bodywork and demand a complete program of education often considered separate from nursing. Some nurses study these techniques to augment their nursing endeavors. Manipulative therapies include chiropractic and osteopathy (which involve manipulation of bones, ligaments, and soft tissue areas, including

work on the head and dura). A similar, related field of study is physical therapy.

Other Holistic Therapies and Programs Related to Touch

The number of bodywork and somatic therapies and touch-related programs is too extensive to cover completely here. A sampling is included below to awaken nurses to the magnitude and scope of what is available.

- Alexander technique: a method using gentle hands-on guidance and verbal instruction to teach simple ways of moving for improved balance, posture, coordination.
- AMMA therapy: techniques for working with the physical body, bioenergy, and emotions to restore optimal balance.
- Barbara Brennan School of Healing Science program: a multidimensional healing program based on the teachings of Barbara Brennan; includes chelation work through the layers of the human energy field.
- Chiropractic: an alternative form of medical care involving manipulations to create spinal alignment; requires extensive training.
- Crucible Program: a multidimensional healing program based on the teachings of the Reverend Rosalyn Bruyere.
- Foundation for Unity Consciousness: a program headed by Mary Bell, RN, presents an eclectic 2-year program based on nursing and spiritual principles.
- Feldenkrais method: developed by Moshe Feldenkrais, this technique involves gentle manipulations to heighten awareness of the body; teaches movement reeducation.
- Healing touch: a multilevel energy healing program combining techniques from a variety of sources; endorsed by the American Holistic Nurses' Association.
- Jin Shin Jyutsu: "the art of compassionate spirit," a gentle acupressure-type self-healing approach.
- Lomi: a technique that aids the learning of postural alignment to enhance the flow of energies, directing attention to muscle tensions.
- National Association for Nurse Massage Therapists: for nurses specifically trained in massage therapy.
- Osteopathy: an alternative form of medical care that emphasizes soft tissue work, skeletal manipulation, and pulses.
- Reiki: a therapy that works with "universal life energy" and uses techniques to direct healing to specific sites.
- Robert Jaffe Advanced Energy Healing: a method that emphasizes "heart-centered awareness" and uses clairvoyant perception and other techniques to transform energy patterns thought to contribute to disease.
- Rolfing®: a technique developed by Ida Rolf that helps clients to establish structural relationships deep within the body; manipulates muscles for balance and symmetry.
- Touch for Health: a method that uses kinesiology (muscle testing) and points to strengthen.
- Trager work: an approach that involves rhythmic rocking to aid relaxation and optimize energy flow.

Professionals must examine their own feelings about the meaning of touch before using it as a therapeutic tool. The art of touch, as well as when to touch and when not to touch, can be learned. Nursing students can and should be taught the importance of touch as therapy. They need exposure and experience to overcome their cultural conditioning against touching adults, especially unfamiliar ones, to

increase their ease in initiating this intervention. They also need guidance in developing a sensitivity to those who desire or may decline touch.

HOLISTIC CARING PROCESS

Assessment

In preparing to use touch interventions, the nurse assesses the following parameters:

- the client's perception of his or her bodymind situation.
- the client's potential pathophysiologic problems that may require referral to a physician for evaluation.
- the client's history of psychiatric disorders. The nurse must modify the approach with clients who have present or past psychiatric disorders. Touch itself may present a problem, and the deeply relaxed, semihypnotic state that a balanced person finds enjoyable may actually frighten or alarm an unbalanced individual.
- the client's cultural beliefs and values about touch.
- the client's past experience with body therapies. The knowledge level of clients varies widely. The approach will differ markedly depending on the client's previous experience. Assisting a client in transferring prior learning, such as from childbirth preparation classes to a new situation, is a valuable nursing intervention.

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with the interventions for touch that are related to the 13 domains of Taxonomy II of the Unitary Person framework (see Chapter 14):

- Altered circulation
- Impairment in skin integrity
- Social isolation
- Altered spiritual state
- Impaired physical mobility
- Altered meaningfulness
- Altered comfort
- Anxiety
- Grieving
- Fear

Outcomes

Exhibit 24–1 guides the nurse in client outcomes, nursing prescriptions, and evaluation for the use of touch as a nursing intervention.

Therapeutic Care Plan and Interventions

Before the Session

- Wash your hands.
- Wear loose-fitting, comfortable clothing. If you're wearing street clothes, cover them with a laboratory coat.
- Have the client empty the bladder for comfort.
- Prepare the hospital bed, therapy table, or surface on which you will be working. If you will be using a therapy table, drape it with a cotton blanket and place a sheet over the top. Lay out a large towel for the client to use as a cover when he or she lies on the table. Adjust the height of the table or bed for optimal use of your body mechanics.
- Have small pillows or towel rolls available for supporting the head, back, or lower legs.
- Control the room environment so that the room is warm, dimly lit, and quiet. If you are in a client's hospital room, draw

Exhibit 24–1 Nursing Interventions: Touch

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client is relaxed following a touch therapy session.	Encourage the client to receive touch therapy in order to evoke the relaxation response.	The client willingly accepted touch therapy.
	During the touch therapy session, help the client • decrease anxiety and fear • decrease pulse and respiratory rate • recognize a feeling of body-mind relaxation • develop a sense of general well-being • increase effectiveness in individual coping skills • increase a sense of belonging and lessened loneliness • feel less alone and express that feeling	The client • exhibited decreased anxiety and fear • demonstrated a decrease in pulse and respiratory rate • reported muscle relaxation • exhibited satisfied facial expression and expressed inner calmness • reported greater satisfaction in individual coping patterns
The client has improved circulation.	Provide the client with information about how touch therapies improve circulation and tissue perfusion	Clients with white skin had a reddened color in the area where the nurse had used effleurage and pétrissage massage strokes. Skin in the massaged area is warmer than before the therapy.
The client receives touch therapy to maintain and enhance health.	Encourage the client to ask for touch therapy. Suggest that the client seek out the nurse. Recommend that the client accept touch when offered by the nurse.	The client asked for touch therapy.

the curtain and turn off the television set. A radio or audiocassette player may be left on for soothing music.

- Use relaxation and breathing techniques, imagery, or music to elicit the relaxation response.
- After you have talked with the client, spend a few moments to quiet and center yourself, focus on your healing intention, and then begin.

At the Beginning of the Session

- Explain to the client the steps in the touch process to be used. The first session always takes the most time because of the necessary explanations

and adjustments. The remaining sessions may last from 15 to 60 minutes.
- As you progress through the intervention, explain what you are about to do before you actually begin. Encourage the client to address concerns or discomfort at any time.
- Position the head comfortably. If the client has long hair, pull it up and away from the neckline.
- If you are working on the client's entire body, have the client disrobe completely and cover up with a towel from the chest to the thighs. The client lies on a padded therapy table or hospital bed that is covered with a cotton blanket and sheet. The sides of the sheet and blanket are then wrapped over the client so that he or she feels protected and warm. (This procedure is used for physical touch therapies and is not needed for Therapeutic Touch or other energy-based interventions, which may be done with the client fully clothed. However, remember that when the client experiences the relaxation response, the body may undergo cooling.)
- Uncover only the body area that is being massaged or pressed as the therapy proceeds.
- In most cases, begin with the client lying on the back. When therapy on the medial aspect and limbs of the body is complete, lift the wraps and reapply them after the client turns over.
- Encourage the client to take slow, deep, releasing breaths. When he or she lets go of tension through breath, affirm in a soft tone, "Ah, feel the body as it relaxes."
- During the turning process, slide the towel around the client's body to ensure that the client will not be exposed. As the client lies prone, continue the therapy on the dorsal aspect of the body.

During the Session

- Be attuned to the client's responses to therapy. This will help the client build trust and achieve optimal relaxation.
- In initial sessions, continue to explain what the client can expect to happen so that he or she feels comfortable with the continued direction of the touch sessions. After trust has been established and the relaxation response is learned, the client will relax more quickly and move to deeper levels in subsequent sessions.
- In subsequent sessions, proceed the same as in the initial session. Explanations may be shorter, however.
- Remember to use your voice in a soft, soothing manner that enables the client to relax.
- Reassess the client's responses as you proceed.

At the End of the Session

- When you have finished the touch therapy session, verbally let the client know that it is time to return gradually to the here and now, to begin to move around slowly, and to awaken fully.
- Anticipate that the client will take a few minutes to reorient to time and place after being in a deep state of relaxation.
- Allow a period of silence for the client to appreciate fully the wisdom of his or her relaxed bodymind.
- Stay in the room while the client rouses and sits up. Give necessary assistance to ensure a safe transfer to an ambulatory position.
- Allow time to receive the client's verbal feedback about the meaning of the session if the client feels the need to talk. If this does not occur sponta-

neously, ask for feedback. The insight gained provides guidelines for further sessions or specific ideas that the client can follow up in daily life.

- When the touch therapy is used for relaxation or sleep induction for hospitalized patients, close the session by softly pulling the bedcovers up over the patient's back and quietly turning off the light as the patient moves into sleep. Let the client know in advance that you will leave quietly at the end.
- Use the client outcomes that were established before the session (see Exhibit 24–1) and the client's subjective experience (Exhibit 24–2) to evaluate the session.
- Schedule a follow-up session.

Exhibit 24–2 Evaluation of the Client's Subjective Experience of Touch Therapies

1. Was this a new kind of experience for you? Can you describe it?
2. Did this feel like a comforting, stimulating, or both tactile sensation?
3. Was it pleasurable on all planes—physical, mental, emotional, and spiritual—or more focused in one area than another?
4. Were you aware of your surroundings during the experience, or did you sink into a sense of timelessness?
5. Did emotions surface during the experience? If so, what were they? Can you focus on them now?
6. Did you experience any imagery during the touch session?
7. Did you feel comfortable with the therapist? Is there anything that you want to do to increase your comfort level with the touch therapist?
8. Did you feel relaxed and refreshed after the experience?
9. Would you like to try this again?
10. What would be helpful to make this a better experience for you?
11. Can you develop a plan or strategy to integrate more of the touch therapies into your life on a regular basis?

Specific Interventions: Touch

General Touch (Basic)

Each of the therapies discussed in the text has basic, intermediate, and advanced levels. The complexity of each type depends on the amount of time spent studying the multiple variations of the therapy and whether the therapy is used in conjunction with another therapy, such as music and imagery. A nurse who begins at the basic level and likes the given approach will probably study or take continuing education courses to learn the intermediate and advanced levels.

Therapeutic Massage (Basic to Advanced)

Although they may be called by different names (massage, Swedish massage, massage therapy), the techniques of therapeutic massage are all essentially the same. They involve the use of effleurage, pétrissage, and tapotement: the classic nursing back-rub strokes. These strokes are designed to enhance the circulation of both blood and lymph. Therapeutic massage increases the dispersion of nutrients to promote the removal of metabolic wastes by increasing both lymphatic and blood flow.

Therapeutic Touch (Advanced)

Therapeutic Touch is generally taught by experienced practitioners in continuing education seminars. The courses include discussion of some or all of the following elements: centering; assessment; hand scanning; intuition; energy field reading, mapping, and recording; pattern comparison; verbal communication of information; stress levels; relaxation levels; meditation experience.

In a Therapeutic Touch session, the practitioner may ask the client to visualize clearly the part of the body that is to

be influenced in order to enhance contact with the energy field of that body part. The practitioner's goal is to ascertain the degree of blockage in the energy field of the muscles or viscera. For practitioners to come in contact with these energies, they must develop an awareness of events that normally occur below the level of consciousness. The imagery and visualization process is one way of tuning into this unconscious process. Therapists can synergistically use one modality (imagery) to affect another (touch).[40]

Figure 24–1 illustrates a 5-year-old child's use of imagery and drawing to describe her self-perception before and after the use of Therapeutic Touch to treat an asthmatic episode. The child said that when she has an asthma attack she "feels bald-headed and sad." In Figure 24–1A, the disconnected arm is moving up to wipe away her tears. The figure lacks sturdy legs to support it. At the completion of the 15-minute Therapeutic Touch session, the child felt well and happy and was free of respiratory distress. In Figure 24–1B, the child increased the figure size, strengthened the lines, and added long hair that symbolizes strength to the child.

The therapeutic touch process should be halted when there are no longer any differences in body symmetry relative to density or temperature variation. Four commonly observed responses are (1) flushed skin, (2) deep sighs, (3) physical relaxation, and (4) verbalized relaxation. A caution in Therapeutic Touch is to limit the amount of time spent and/or energy spent in working with the very young, the old, and the infirm. When the client's energy field is full, the energy pushes the nurse away.

Figure 24–1 Self-Perception of a 5-Year-Old Girl with Asthma before **(A)** and after **(B)** Therapeutic Touch Session.

Healing Touch (Advanced)

An energy-based therapeutic approach, healing touch combines philosophy with a way of caring and considers healing a sacred art. It uses a collection of noninvasive, energy-based treatment modalities with the purpose of restoring wholeness through harmony and balance. The healing is done through the centered heart, thus establishing a spiritual process.[41] Specific uses of healing touch are

- acceleration of wound healing

- relief of pain and increased relaxation
- reduction of anxiety and stress
- energizing of the field
- prevention of illness
- enhancement of spiritual development
- aid in prevention for and follow up of complications after medical treatments and procedures
- support for the dying process[42]

Acupressure and Shiatzu (Basic to Advanced)

A broad range and depth of techniques are used in acupressure and Shiatzu. Most practitioners receive continuing education in this area; some spend years perfecting these techniques.

Reflexology (Basic to Advanced)

The primary purpose of reflexology is to evoke bodymind relaxation. Some practitioners believe that the areas shown in Figure 24–2 represent the nerve or meridian endings for the specific vital body parts. When a therapist works on these specific areas, a corresponding energy release or relaxation occurs in the internal body system.

Nurses who have not studied reflexology can still use general massage on the

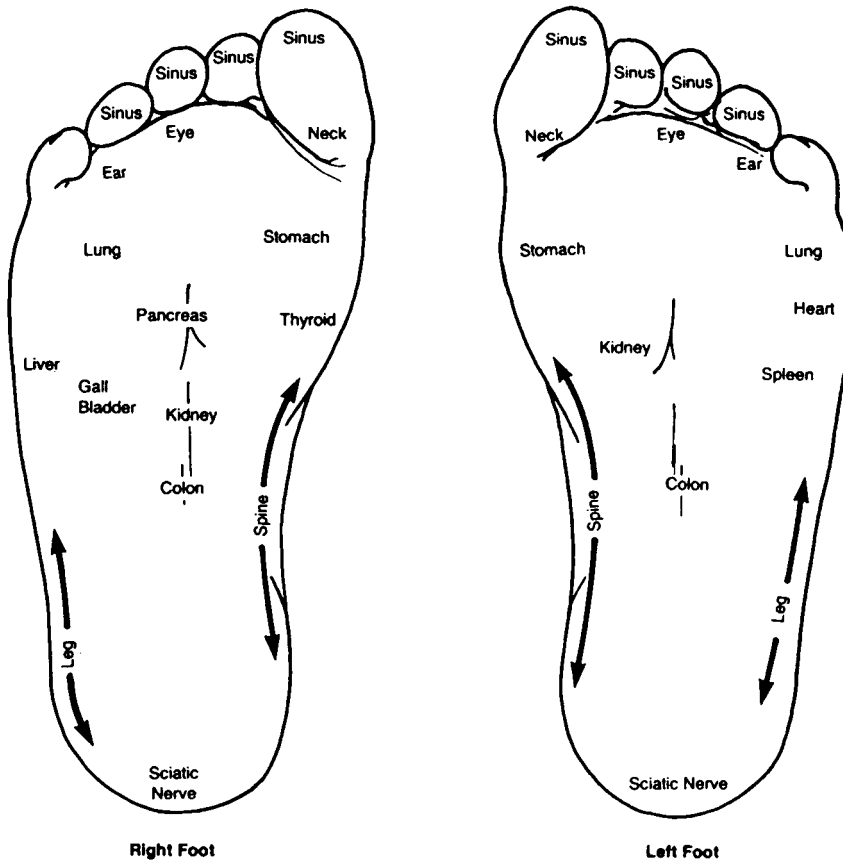


Figure 24–2 Foot Reflexology Chart.

client's feet to elicit relaxation. The primary caution in this practice, as well as in other body therapies, is to stop massage in any area that provokes pain. Additional touch therapies not discussed in this chapter are noted in Table 24–1.

Case Studies

Case Study No. 1

Setting:	Oncology unit of a general hospital
Patient:	E.S., a 58-year-old single male
Patterns/ Challenges/ Needs:	1. Anxiety 2. Altered comfort 3. Social isolation (All related to terminal cancer)

E.S. knew that he was in the terminal stage of cancer, yet he was ambulatory and in basically good humor. E.S. had grown up in the city in which he now found himself hospitalized. He had never married and had no remaining living family.

A nurse who was knowledgeable about touch therapy and felt comfortable using this modality worked evenings on the unit where E.S. was assigned. After assessing his condition, she felt that E.S. needed touch to increase comfort and to allay apprehension. Because the unit was continually short-staffed and little time was available for lengthy one-on-one interventions with clients, this intervention had to become a priority in E.S.'s care. Evening back care was entered on his care plan and, despite sometimes hectic assignments, was never omitted when this particular nurse was on duty.

Back care became so important to E.S. that he eagerly greeted the nurse when she came on shift and was ready when she arrived at the appointed time. The touch he received from this nurse was the high point of his hospital stay. During the sessions, he relaxed so deeply that his breathing rate became slowed; he stated that his perception of pain decreased and that he felt the pleasure of closeness to another caring human being. When the nurse was about to take a few days off after working for ten consecutive days, E.S. was profoundly saddened that he might have to go without this daily anticipated ritual. The nurse assured him that she had left specific orders for his back care for the oncoming nurse for the next evening. The next evening, however, the regular nurse called in sick, a float nurse was assigned to the unit, and E.S. received no special attention. He died unexpectedly in his sleep during the night.

At this point, we lack the sophisticated tools needed to measure the relationship between such deaths and the omission of certain nursing interventions. Consequently, we cannot make any direct correlations. We can only begin to ask research questions and gather anecdotal data about whether the omission of a nursing intervention such as back care can so grieve a terminally ill client that the resulting physiologic changes can lead to death.

Case Study No. 2

Setting:	Wellness center
Client:	J.S., a 36-year-old married woman
Patterns/ Challenges/ Needs:	1. Anxiety related to personal and family stress 2. Altered self-image related to obesity

A psychologist referred J.S. to a nurse in a wellness center for weight management. In addition to enrolling in the weekly counseling program, this client elected to follow each counseling session with a therapeutic massage. She also continued to work with the psychologist for resolution of personality disorder problems. Both the psychologist and the nurse saw J.S. regularly for more than a year until her move away from the area terminated the relationship.

Table 24–1 Additional Touch Therapies

Therapy	*Originator*	*Primary Purpose and Function*
Applied kinesiology	George Goodheart	Focuses on the relationship of muscle strength and energy flow. The theory is that, if muscles are strong, then circulation and other vital functions are also strong.
Chiropractic	D.D. Palmer	Based on alignment of spinal vertebrae. This therapy involves manipulations to restore natural alignment.
Feldenkrais method	Moshe Feldenkrais	Gives the client gentle manipulations to heighten awareness of the body. As awareness increases, clients can make more informed choices about how to move the body in daily situations.
Jin shin Jyutsu	Master Jiro Murai of Japan in early 1900s	A milder form of acupressure that involves pressure along eight extra energy meridians.
Kofutu touch healing	Frank Homan	Developed in the early 1970s when a series of symbols for use in touch came to the originator during meditation. It is called "Kofutu" for the symbols and "touch" healing because the auras of the healer and recipient must touch. This therapy uses higher consciousness energy symbols to promote self-development and spiritual healing.
Lomi	R.K. Hall, R.K. Heckler	Directs attention to current muscle tension to aid learning of postural alignment to enhance free flow of the body's physical and emotional energies.
Polarity therapy	Randolph Stone	Repatterns energy flow in the individual by rebalancing positive and negative charges. The practitioner places finger or whole hand on parts of the client's body of opposite charge to facilitate energy balancing where it is needed. Through these contacts, with the help of pressure and rocking movements, energy can reorganize and reorder itself.
MariEL	Ethel Lombardi	A 1980s variation of Reiki.
Neuromuscular release		Involves movement of the limbs toward and away from the body by the practitioner to assist the client in learning to let go for the purpose of enhanced circulation and emotional release.
Reiki	2,500-year-old Buddhist practice lost and rediscovered in late 1800s	Term means universal life energy. A touch technique in which the practitioner places hands in one of 12 positions on the recipient's body to direct healing energy to those sites.
Rolfing®	Ida P. Rolf	Helps the client establish deep structural relationships within the body that manifest themselves via a symmetry and balanced function when the body is in an upright position. Technique involves deep muscle manipulation.
Trager work	Milton Trager	Involves rhythmically rocking the limbs and often the whole body to aid relaxation of the muscles and promote optimal flow of blood, lymph, nerve impulses, and energy.

The counseling sessions with the nurse focused on J.S.'s eating disorders, nutritional education, and ways to institute lifestyle changes that would alter the pattern of overweight. These sessions were sometimes emotional but for the most part were straightforward and did not evoke emotional, spiritual, or attitudinal change. In contrast, the elective therapeutic massage elicited a response that allowed J.S. to make connections with a deeper level of herself and finally understand the true nature of her physical problems. While using touch, the nurse also played relaxation music and/or guided J.S. in imagery. In addition, the nurse performed foot reflexology and concluded the sessions with Therapeutic Touch.

When work with J.S. first began, the client complained of a feeling of a knot in her stomach that had not abated for 15 years. The only time her stomach felt better was after eating. After a few sessions of therapeutic massage, J.S. stated that this stomach pain was relieved during the time that she received the touch therapies.

As J.S. became more trusting of the nurse, she gradually began divulging more of her feelings while in the deeply relaxed state that she experienced during the session. She revealed that she was physically distant from her husband and her 14-year-old daughter. After receiving the massage for approximately six weeks, she learned to relax immediately upon reclining on the table—which dissolved her stomach knot. After eight weeks of massage, the pain stayed away for two to three days after a session, and weight loss became possible. By the fourth month, she began to hug and touch her daughter at home to dissolve the discomfort she had with their relationship.

The power of touch became so important to her that, by the eighth month, she brought her daughter to the nurse so that her daughter could experience massage firsthand. The daughter did not have the emotional response or release felt by the mother, for she had not experienced the years of holding tension and withdrawal. The daughter was happy to see how massage was done, however, as she and her mother planned to exchange massage sessions at home between visits to the nurse. Touch had initiated a healing bond between mother and daughter.

Evaluation

With the client, the nurse determines whether the client outcomes for touch therapies (see Exhibit 24–1) were successfully achieved. To evaluate the session further, the nurse may again explore the subjective effects of the experience with the client using the evaluation questions in Exhibit 24–2.

DIRECTIONS FOR FUTURE RESEARCH

1. Investigate the effects of therapeutic massage on relaxation, pain relief, sleep induction, stress management, relief of sensory deprivation and apprehension, and other parameters.
2. Examine the effects of reflexology on pain relief, relaxation, and/or specific physiologic parameters.
3. Develop valid and reliable tools to measure the effects of touch.
4. Formulate studies to examine the relationship among guided imagery, music, smell, color, taste, and touch.
5. Determine whether clients can be taught relaxation techniques by using images of the sensations and emotions evoked during the touch therapy session.

6. Conduct qualitative studies that investigate the meanings of nonprocedural touch throughout the life cycle.
7. Investigate whether periodic touch therapy sessions can increase work performance or productivity.
8. Examine the relationship between the touch therapies and healing.
9. Ask how the results of Therapeutic Touch on a child at rest compare to the results of Therapeutic Touch on a child under stress.
10. Examine how the age of the child influences the outcome of Therapeutic Touch.
11. Investigate how touch can be taught effectively in nursing schools and what methods are best suited to accomplish this.
12. Ask how the nurse's cultural learning, acquired prior to entering nursing school, affects subsequent learning in school.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin the process of answering the following questions:

- How do I feel about using touch as an intervention?
- What do I experience with touch therapy when I touch a client from a place of centeredness?
- When I touch with intention, what is my inner experience?
- When I use touch, what happens to my sense of time?
- How does my touch as a nurse affect the recipient?
- Whom do I know who can be my mentor to help me increase skills with touch?
- What other modalities can be used concurrently to heighten the effectiveness of touch?

NOTES

1. S. Cheesman, R. Christian, and J. Cresswell, Exploring the Value of Shiatsu in Palliative Care Day Services, *International Journal of Palliative Nursing* 7, no. 6 (2001 May):234–39.
2. Y. Irwin and J. Wagenvoord, *Shiatzu* (Lidiun, 1995).
3. H. Harlow, Love in Infant Monkeys, *Scientific American* 200 (1958):68–74.
4. R. Spitz, *The First Year of Life* (New York: International Universities Press, 1965).
5. B. Grad, Some Biological Effects of the Laying on of Hands: A Review of Experiments with Animals and Plants, *Journal of the American Society for Psychical Research* 59 (1965):95–127.
6. M.J. Smith, Enzymes Are Activated by the Laying on of Hands, *Human Dimensions* (February 1973):46–48.
7. M.J. Walker and J.D. Walker, *Healing Massage: A Simple Approach* (Albany, NY: Thomson Delmar Learning, 2003).
8. D. Hover-Kramer, *Healing Touch: A Guidebook for Practitioners*, 2nd ed. (Albany, NY: Thomson Delmar Learning, 2001).
9. D.F. Bruce and D. Krieger, *Miracle Touch: A Complete Guide to Hands-on Therapies that have the Amazing Ability to Heal* (Three Rivers Press, 2003).
10. D. Krieger, *Accepting your Power to Heal: The Personal Practice of Therapeutic Touch* (Santa Fe, NM: Bear and Co., 1993).
11. C. Quinn, C. Chandler, and A. Moraska, Massage Therapy and Frequency of Chronic Tension Headaches, *American Journal of Public Health* 92, no. 10 (2002 Oct):1657–1661.
12. S.J. Weiss, Effects of Differential Touch on Nervous System Arousal of Patients Recovering from Cardiac Disease, *Heart and Lung* 19, no. 5 (1990):474–480.
13. R.A. Gecsedi, Massage Therapy for Patients with Cancer, *Clinical Journal of Oncology Nursing* 6, no. 1 (2002 Jan–Feb):52–54.

14. M.C. Smith, J. Kemp, L. Hemphill, and C.P. Vojir, Outcomes of Therapeutic Massage for Hospitalized Cancer Patients, *Journal of Nursing Scholarship* 34, no. 3 (2002):257–262.
15. A.D. Furlan, L. Brosseau, M. Imamura, and E. Irvin, Massage for Low Back Pain, (Cochrane Review), in: *The Cochrane Library*, Issue 2 (2003), Oxford: Update Software, updated: 04/01/2003.
16. Ibid.
17. T. Field, Massage Better Than Relaxation Therapy for Fibromyalgia, *Journal of Clinical Rheumatolology* 8, no. 2 (2002):72–76.
18. T. Field, Massage Therapy for Infants and Children, *Journal of Developmental Behavioral Pediatrics* 16 (1995):105–111.
19. T. Field et al., Juvenile Rheumatoid Arthritis: Benefits from Massage Therapy, *Journal of Pediatric Psychololgy* 22 (1997):607–617.
20. T. Field, Massage Therapy for Infants and Children, *Journal of Developmental Behavioral Pediatrics* 16 (1995):105–111.
21. M. Ireland and M. Olson, Massage Therapy and Therapeutic Touch in Children: State of the Science, *Alternative Therapies in Health and Medicine* 6, no. 5 (2000 Sep):54–63.
22. J.M. Beachy, Premature Infant Massage in the NICU, *Neonatal Network* 22, no. 3 (2003 May–Jun):39–45.
23. V. Glover, K. Onozawa, and A. Hodgkinson, Benefits of Infant Massage for Mothers with Postnatal Depression, *Seminars in Neonatology* 7, no. 6 (2002 Dec):495–500.
24. A. Vickers, A. Ohlsson, J.B. Lacy, and A. Horsley, Massage for Promoting Growth and Development of Preterm and/or Low Birthweight Infants, (Cochrane reviews), in: *The Cochrane Library*, Issue 2 (2003), Oxford: Update Software, posted: 04/01/2003.
25. C.A. Estabrooks and J.M. Morse, Toward a Theory of Touch: The Touching Process and Acquiring a Touching Style, *Journal of Advanced Nursing* 17 (1992):448–456.
26. A. Montagu and F. Matson, *The Human Connection* (New York: McGraw-Hill Book Co., 1979), 89.
27. Ibid., 90.
28. J.F. Quinn, M. Smith, C. Ritenbaugh, K. Swanson, and M.J. Watson, Research Guidelines for Assessing the Impact of the Healing Relationship in Clinical Nursing, *Alternative Therapies in Health and Medicine* 9, no. 3 suppl (2003 May–Jun):A65–A79.
29. J.F. Quinn and A.J. Strelkauskas, Psychoimmunologic Effects of Therapeutic Touch on Practitioners and Recently Bereaved Recipients: A Pilot Study, *Advances in Nursing Science* 15, no. 4 (1993 Jun):13–26.
30. D. Krieger, Nursing As (Un)usual? *American Journal of Nursing* 99, no. 4 (1999 Apr):9.
31. Hover-Kramer, *Healing Touch.*
32. North American Nursing Diagnosis Association, *Nursing Diagnoses: Definitions and Classification 1995–1996* (Philadelphia, PA: NANDA) 37.
33. J.C. McCloskey and G.M. Bulechek, *Nursing Interventions Classification* [NIC], 2nd ed. (St. Louis, MO: Mosby-Year Book, 1996).
34. Irwin and Wagenvoord, *Shiatzu,* 15–19.
35. Ibid.
36. P. Wills, *The Reflexology Manual: An Easy-To-Use Illustrated Guide to the Healing Zones of the Hands and Feet* (Rochester, VT: Healing Arts Press, 1995).
37. B. Kunz, K. Kunz, and B. Kevin, *Reflexology: Healing at Your Fingertips* (New York, NY: Dk Pub Merchandise, 2003).
38. D. Buyers, *Better Health With Foot Reflexology,* 10th ed (St. Petersburg, FL: Ingham Publishing, Inc., 2001).
39. D. Hover-Kramer and K.H. Shames, *Energetic Approaches to Emotional Healing* (Albany, NY: Delmar Publishers, 1997).
40. K. Shames, *Creative Imagery in Nursing* (Albany, NY: Delmar Publishers, 1996).
41. J. Mentgen and M.J. Trapp Bulbrook, *Healing Touch: Level 1 Notebook* (Carrboro, NC: North Carolina Center for Healing Touch, 1994), 7.
42. Ibid., 1.

Accepting Ourselves and Others

Wholeness and healing can exist only when we have meaningful relationships. The extent to which we are willing to accept ourselves determines the quality of those relationships. If we are unable to accept ourselves we are unable to accept others. Without self-acceptance, relationships with an intimate other, family, or community may be confined to the fulfillment of social role obligations and expectations. When we remember that each moment with another is an opportunity to heal and be healed and to share love and forgiveness, we may learn to heal and be healed in a relationship.[1]

Habits, beliefs, assumptions, expectations, judgments, and misconceptions can be major obstacles in relationships. They create conflicts and barriers that block effective communication and sharing of perceptions. The following ten reflective questions are suggested to increase an awareness of patterns in relationships so that the process of healing can occur:[2]

1. *Do the important relationships in your life satisfy you? What do you bring to your relationships? What are the predominant qualities that you experience in your relationships? Do you feel competitive, manipulative, victimized, or rejected? Do you experience joy, vitality, synergy, love, and shared purpose?*
2. *What are the patterns of your relationships? Do you consistently feel misunderstood or mistreated? Do you think you give more than you receive? Do you experience the universal Self as the source and context of relationships?*
3. *What beliefs and assumptions do you hold about relationships? After taking an inventory of beliefs, do you recognize any restricted patterns? Did you become aware of any areas that you are unwilling to address?*
4. *What do you identify with as your true self? Is it your physical, mental, emotional, or spiritual potential, or a combination of all four? Are you authentic in your relationships? Do you find that when you are honest with yourself, your relationships are more satisfying?*
5. *What is the purpose of your important relationships?*
6. *What relationships in your life have had the most meaning?*
7. *If you were about to die, would you have any regrets concerning the qualities of relationships in your life? Is there anything that you would have changed?*
8. *If you could change your relationships unilaterally, what qualities would you want to cultivate in your relationships?*
9. *Which of your relationships are in need*

of healing right now? What are you willing to do to bring about that healing?

10. *Are you willing to forgive? What part of yourself do you have trouble forgiving?*

Relationships help us understand at a profound level our interconnectedness with people, nature, and the universe. When we are in healthy relationships, we exhibit mutual love, sharing, and the ability to forgive ourselves and others. Throughout our lives we search for answers to questions about living and dying. Our relationships can provide us with many aspects of these answers, for they help us recognize blind spots within ourselves. A relationship is healing if it nurtures expression of feeling, needs, and desires, and if it helps remove barriers to love.

NOTES

1. J. Achterberg et al., *Rituals of Healing* (New York: Bantam Books, 1994).
2. F. Vaughan, *The Inward Arc* (Boston: Shambhala Publications, 1986).

Chapter 25

Relationships

Dorothea Hover-Kramer

> Self-responsibility leads the nurse to greater awareness of the interconnectedness of all individuals and their relationships to the human and global community, and permits nurses to use this awareness to facilitate healing.
>
> American Holistic Nurses' Association[1]

NURSE HEALER OBJECTIVES

Theoretical

- Define three domains in which nurses are required to develop effective relationships.
- List eight characteristics of effective communication patterns that build and strengthen relationships.
- Identify ways that the humanistic psychologies of Jung and Maslow expand holistic thinking.
- Describe transactional psychology's concept of the three major ego states, distinguishing complementary and uncomplementary interaction patterns.
- Identify four archetypes of human relationships that address physical, emotional, mental, and spiritual domains.

Clinical

- Identify core elements that lead to establishing and maintaining effective relationships.
- Describe and use effective relationship styles that incorporate the four archetypes in a holistic model.
- Analyze human transactions to bring about effective nursing interventions and assist in conflict resolution.
- Implement and evaluate effective negotiating styles that address issues while maintaining a sense of relatedness.

Personal

- Increase your personal use of the eight effective personal relationship characteristics.
- Establish personal time to reflect on relationships in the three different external domains of your practice.
- Develop strategies to incorporate effective assertiveness styles into negotiation and conflict resolution.
- Strengthen intentionality and inner resolve to deal with complex relationship issues through inner focusing and mindfulness practices.

DEFINITIONS

Archetype: name given by Jung for specific patterns of human collective awareness that symbolically represent human potentials, such as the Healer, the Warrior, the Mother, or the Wise Person.[2]

Complementary Transaction: an interaction in which the ego states match (e.g., Adult-to-Adult communication). Complementary transactions support and strengthen relationships.

Defense Patterns: protective mechanisms that justify individual action while detracting from relationship building.

Ego State: an identifiable, understandable part of ourselves that is within our conscious awareness. Berne identified at least five ego states that can be brought into awareness for personal change or conflict resolution.[3]

Emotional Intelligence: awareness and attention to personal emotional needs that allow us to be in a position of equality with others, rather than seeking power and control or becoming overly passive.

Forgiveness: a willingness to acknowledge one's own mistakes and shortcomings and to allow others room to acknowledge their shortcomings as well.

Game: in psychological terms, a dysfunctional pattern of relationship interaction that is recurring and ends in an emotional payoff or sense of entrapment.[4]

Intimacy: a relationship of deep trust and ability to share oneself fully. Such a relationship may be inappropriate in coworker and policy-setting environments.

Relationship: a healthy sense of connection in which two or more persons agree to share successes, hurts, failures, learning, in a nonjudgmental fashion to enhance each other's life potentials. In the context of professional settings, healthy relatedness encompasses advocacy, influence, and effective assertiveness.

Uncomplementary Transaction: an interaction in which ego states do not match (e.g., critical Parent-to-Adaptive Child communication) that may lead to the formation of a psychological game; an interaction that reduces relationship formation.

THEORY AND RESEARCH

In recognizing the interconnectedness of individuals in relation to the human and global community, holistic nurses look with care at all aspects of their external, outgoing relationships. Effective awareness requires nurses to look at their daily interactions within three different aspects of professional nursing practice:

1. Interactions with their clients, those *for* whom they accept responsibility
2. Interactions with their co-workers, those *with* whom they work
3. Interactions with persons in authority or leadership, those *to* whom they are accountable. Attention to this aspect may involve interactions with supervisors, administrators, health care policy makers, physicians, the public in general, media, and political figures.

First and foremost, nurses accept responsibility for bringing caring and sensitivity into their relationships with their patients or clients. Because of diminished self-care capacity in physical or emotional domains, clients seek the support, advocacy, and useful interventions that nursing has to offer. In increasingly dehumanized clinical settings, nurses can demonstrate human caring via their creative and insightful relationships. Their active patient advocacy and health education help to build healing environments on a day-to-day basis.

If effective relating to clients were enough, nursing professionals would have an easy task, as most nurses have deep caring and respect for those in their care.

It is also necessary, however, to address intricate interactions with co-workers who possess a wide variety of backgrounds, skills, and educational levels. Thus, nurses may have ongoing transactions with colleagues ranging from a sophisticated medical specialist who focuses solely on a single domain, to a nursing aide who may have little training in interpersonal skills or orientation to person-centered values. Bringing these various interactions into harmony with holistic ethics, theory, and philosophy is a challenging task. It also offers a grand opportunity for building teamwork through effective relationship interventions.

Finally, and perhaps most demanding, are the issues of nursing's accountability in relation to various public sectors. These encompass not only the needs of the clients' families and community of friends, but also the very real requirements and pressures of insurance and/or managed care regulators, public policy setters, and facility administrators. Because many of these individuals constitute an anonymous "they" who may influence a nurse's basic feelings and behavior, it is essential to identify and to deal as directly as possible with these issues. The holistic nursing perspective requires nurses to review their relationship to the entire human community, with all its strengths and pitfalls, to create true healing environments.

The qualities of their relationships essentially determine the experiences of nurses' professional lives. Effective relationship skills extend beyond the personal arenas of listening and counseling to include a practical, psychologically sound, theoretical basis for managing conflict, making and keeping agreements, maintaining integrity in confrontations, and holding fast to the essence of holistic nursing philosophy.

With positive and supportive relationships, even the most difficult work situation can become a source of learning and opportunity. If relationships are conflicted or undermining, even a relatively easy work task becomes arduous; a peril to one's self-esteem and self-efficacy.

Relationships also may be viewed as interactive human energy fields. The interaction of two or more human energy fields always is enhanced when at least one person is centered and focused. It is as if the interaction moves to the vibrational frequency of the more mature person. If both persons are in a deficit, energetically speaking, outcomes of an interaction may be quite unsatisfactory and even damaging to the relationship. In psychotherapeutic language, effective relatedness is built on the experience of rapport, the bonding and trust that is required to reach to deeper than social levels of sharing.[5]

Personal Characteristics That Build, Maintain, and Enhance Relationships

Relationship implies connection. We are all interconnected in complex ways—from the subtle interaction of subatomic particles with each other, to the huge impact of political powers that rule and determine the lives of millions of people. Certain defense patterns undermine or detract from building a sense of connection with others, such as, for example, denial, displacement, rationalization, repression, and regression to more primitive behaviors.[6]

One of the major personal defense mechanisms that everyone knows and has used is denial, which means simply refusing to acknowledge what one does not wish to see. Displacement is the mechanism used to shift blame onto another person or situation rather than taking personal responsibility for one's part in the problem. Its cousin is projection, the process of ascribing internal conflicts to another person in an effort to diminish personal anxiety or responsibility. Rationalization is the mental justification of

feelings and thoughts that are inappropriate to a situation, such as justifying a questionable action by saying "Everybody else does it." Individuals also may repress an uncomfortable experience, selectively forgetting, or dissociating, from unpleasant memories. They may even regress, reverting to a more primitive style of behavior, such as cursing, yelling, slamming things, or even hitting. Clearly, none of these mechanisms allow for connection with others, nor do they create an environment that would lead to problem solving. Envisioning and developing effective outcomes requires a firm and consistent relationship base.

The following eight major personal characteristics are ones that the author has found most helpful in moving toward more effective relationship styles:

1. *Willingness to look at personal defenses* and "blind spots;" identifying and letting go of defense patterns.
2. *Holding an accurate sense of self-worth*, confidence, and self-esteem; neither with an over-inflated sense of self nor putting oneself down unnecessarily.
3. *Flexibility*; looking at things from different perspectives, "walking in another's shoes" and thinking "outside the box."
4. *Willingness to take personal responsibility* for feelings or actions, emotional intelligence; using "I" statements rather than blaming or using indirect "you" language.
5. *Intentionality and boundary setting* that allow a clear sense of purpose, goal orientation, and direction.
6. *Motivation to be understood, and perseverance* to find common ground; seeking and integrating feedback.
7. *Empathy and mutual respect for others* without appeasing, complying, or attempting to be overly pleasant.
8. *Willingness to re-visit, re-think, and/or re-define* previous decisions, accepting the possibility of being wrong and thereby allowing others the space to acknowledge their mistakes as well.

These qualities can be seen in skillful negotiators and effective communicators. They become the cornerstone of a positive psychology that can move us to our potentials and a sense of fulfillment.[7] They bring integrity and balance to the three identified areas of relatedness and professional concerns in nursing.

Well-Known Theorists

Carl Gustav Jung

In the early twentieth century, the great Swiss psychologist Carl Gustav Jung expanded the concept of personal consciousness. While Freud's theories focused largely on the nature of the individual, Jung came to believe that vast realms of the personal subconscious mind displayed the pervasive interconnectedness between all human beings.[8] His extensive cross-cultural research showed that humans are aligned with each other through a shared human history and experience, even to the point of having similar dreams and myths despite greatly varying cultural contexts. Long before quantum physics proved the interrelatedness of subatomic particles with each other, Jung posited the idea of a collective unconscious; the intuitive, creative interconnectedness that humans have with each other. This connection through a collective human awareness is the dynamic underpinning of successful, soul-satisfying relationships.

Jung used the term *archetypes* to describe symbolic representations of human potentials that emerge from the collective consciousness of humanity. Archetypes are broad personality typolo-

gies that have been in evidence throughout human history. Among these many patterns are the Healer, the Visionary, the Teacher, the Warrior, the Mother, and the Wise Person.

Abraham Maslow

In the middle of the twentieth century, the American psychologist Abraham Maslow moved the study of psychology from its predominant focus on pathology to an increased understanding of healthy human functioning and relationship patterns. This shift opened the way, in the latter part of the twentieth century, for medical practice to become more oriented to the study of human wellness and health maintenance practices. Thus, Maslow prepared the path for the modern holistic emphasis with its blossoming of consumer health awareness and interest in healing partnerships.

Maslow became the founding influence behind modern educational and industrial psychologies by exploring the realm of interpersonal relationships. He identified every individual's hierarchy of needs as follows:

- safety and security
- sense of belonging
- status
- meaning and significance
- self-actualization
- emergence of transpersonal spirituality[9]

Each level of need builds on the previous one and supports the next. As a more basic need is met, the individual can seek out the next level of understanding. For example, it would be inappropriate (and very frustrating) to discuss creative ideas for patient care in an organization that does not meet safety and security needs, as evidenced by tentative job assignments or irregular pay periods. Under such conditions, confusion and ill will that are destructive to individuals' well-being and their relationships will result. Successful negotiation requires addressing the needs of the lower level of the hierarchy before considering upper-level goals.

From his psychological perspective, Maslow identified health as an ever-expanding human potential for self-actualization. His ideas brought about the birth of the "human potential movement" with the founding of the Association of Humanistic Psychology and the Association of Transpersonal Psychology in the 1970s. His work is evidenced in the modern emphasis on the importance of all human relationships, the need for adequate self-care, and the importance of personal responsibility to bring about global change and healing.

Eric Berne

In the early 1970s the psychiatrist Eric Berne popularized transactional analysis, which is a practical approach to understanding human interactions. He viewed human relationships as based on a series of understandable transactions between two or more persons, who each have five powerful ego states.[10] So appealing were his ideas that much of Berne's language has passed into our everyday vernacular.

To summarize briefly, the consciously held and acknowledged ego states are the *Parent*, *Adult*, and *Child*, with two aspects each in the Parent and Child, giving a total of five different areas of personal awareness:

1. The *Nurturing Parent* is the accepting, caring, and supportive aspect of this dimension.
2. The *Critical Parent* encompasses the judging, discriminating, or discounting aspects of parental awareness.
3. The *Adult* ego state characterizes the thinking, decision-making capacity of the person. Nursing process ideally

comes from the adult, who simultaneously receives input from the other states of awareness.
4. The *Natural Child* is the lively, creative, and playful part of the personality.
5. The *Adaptive Child* is the feeling component of the personality that is less functional, and holds such emotions as compliance, shame, withdrawal, frustration, or fear.

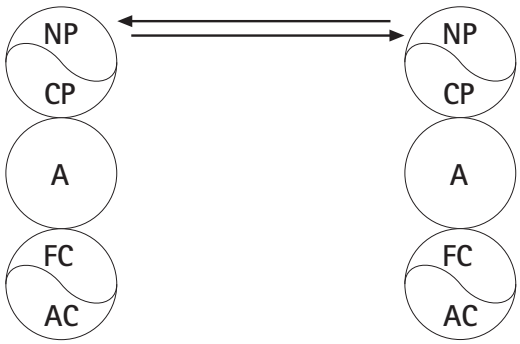
According to Berne, human relatedness is based on transactions between two or more persons who each utilize these five states. As we become more aware of the underlying source of our communications, we have the power to make effective changes in our relationship styles.

There are two types of transactions: complementary and uncomplementary. Complementary transactions are those in which the ego states match each other (Figure 25–1). Parent-to-Parent communication includes sharing of values or opinions, as demonstrated in a mutual discussion of "how things ought to be." Adult-to-Adult complementary transactions are based on mutual exploration of ways of getting things done, decision making, and resultant agreements. Child-to-Child communication is about feelings, either playfulness and joking, or the sharing of more adaptive emotions regarding a situation, such as frustration or helplessness. Complementary interactions build positive empathy in relationships.

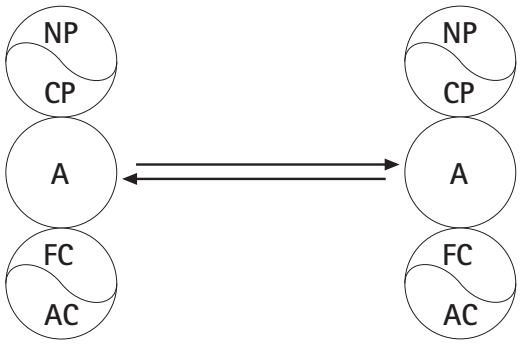
Uncomplementary transactions are those in which the ego states cross in some way (Figure 25–2). In such interactions, agreement is lacking, the outcome is unexpected, or a less than desirable pattern emerges. Berne coined the words *psychological games* to identify dysfunctional patterns which occur frequently and end with an emotional payoff or a sense of being "had."[11] Uncomplementary interactions and emotional games detract from wholesome relatedness and bring about a wide range of reactions, from mild discomfort to overt hostility.

Here is an example of a long-term game-like transaction that may be similar to patterns seen in many organizations: An insurance regulator (Parent) tells home health care nurses via the supervisor (another Parent) that they must limit patient visits to 15 minutes and chart on their own time. The nurses comply quietly because they fear the disapproval of the supervisor or the loss of employment (Adaptive Child). Later, there is grumbling and stress among the workers (more Child). Someone dares to question the whole process (Adult) by which this decision was made and is roundly chastised for questioning authority (Critical Parent). The nurses become frustrated, experience "burnout," and start to consider other careers (Adaptive Child behaviors) rather than renegotiating for other options (Adult capacities) that could bring about more favorable outcomes.

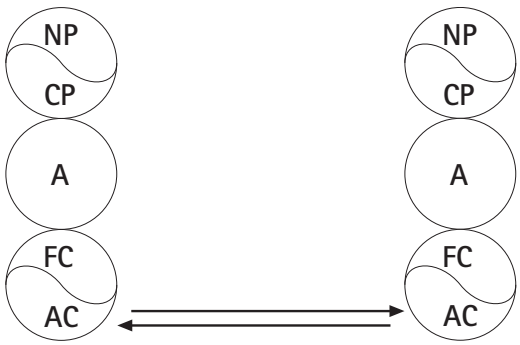
Another precept from Berne, so simple and profound it is now assumed in our understanding of interactions, is the idea of mutual respect, captured in his epithet "I'm OK; you're OK." In essence, healthy self-esteem and a sense of caring toward another is the only relationship style that can succeed. The belief that "I'm not OK; you're OK" results in many of the self-effacing, co-dependent patterns seen among nurses.[12] This belief may be used to justify passivity or a sense of innate helplessness. The opposite, also a faulty relationship pattern, is "I'm OK; you're not OK." This belief results in devaluing others, becoming aggressive, or communicating a sense of superiority and hostility. The most destructive pattern in this framework is the belief that "I'm not OK; you're not OK." The essential hopelessness of this position fosters the irrational and unpredictable behaviors seen in passive–aggressive individuals. Caregivers



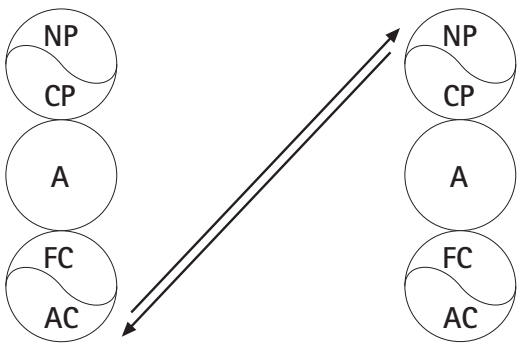
Nurturing Parent (NP) to NP
"I greatly value your opinion about this new policy."
"Thank you. Your understanding is important to me as well. Holistic philosophy asks us to see opportunities for learning in new things."



Adult to Adult
"This new policy has some puzzling aspects."
"I want to understand your concerns. Would you make a list of your questions?"

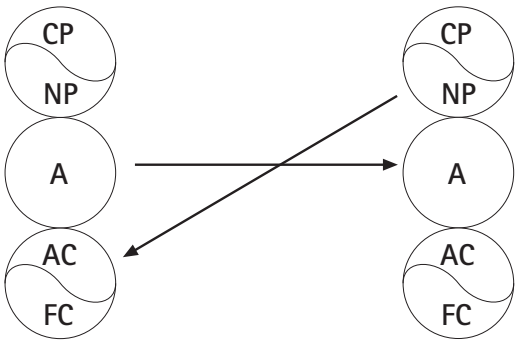


Adaptive Child (AC) to AC
"I'm so frustrated. Here's another new policy for us to conform to."
"Count me in. Someone in the office just cooks up this stuff. Our nursing department is weird."



Adaptive Child to Nurturing Parent
"This new policy is confusing and frustrating."
"I appreciate your point of view; I've been there."

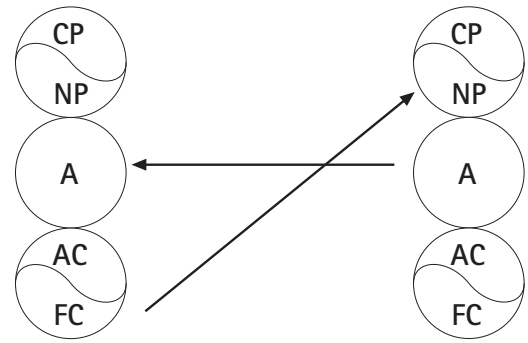
Figure 25–1 Complementary Transactions That Support Relationship Building



Example 1: Adult Communication with Critical Parent (CP) Response

(A) "Where are the keys to the filing cabinet?"

(CP) "You're so disorganized! Did you ever wonder why your memory is so poor?" (Communicator's AC is hurt or irritated)



Example 2: Free Child (FC) Communication with Adult Response

(FC) "This new job is fascinating; let me tell you about my visit with the D. family."

(A) "I just don't have time right now for this." (Communicator may accept response from A or feel offended in the AC)

Figure 25–2 Uncomplementary or Crossed Transactions That Detract from Relationships

who are passive–aggressive may not express themselves, even when seriously asked to do so, but may later criticize everyone and everything as if stabbing others in the back. No sense of collaboration or hopefulness can grow in relationships with such individuals. Steady assertiveness, coming from a sense of mutuality and agreement, fosters the trust and bonding needed for creativity.

Transactional analysis has been used in hospitals and other clinical settings to enhance staff functioning.[13,14] As students of the process learn the tools of accessing different ego states and identifying the nature of transactions, a sense of personal empowerment and self-confidence unfolds. Furthermore, transactions become more positive, supporting stronger relationship bonds for dynamic resolution of problems.

Angeles Arrien

Anthropologist and transpersonal psychologist Angeles Arrien has advanced the concept of four guiding principles, or Jungian archetypes, that manifest in all cultures.[15] These archetypes provide a helpful framework for viewing the physical, emotional, mental, and spiritual dimensions of interactive relationships. The four archetypes—Warrior, Healer, Teacher, and Visionary—also can be effectively used by nurses in bringing a holistic perspective to relationships.

The Warrior archetype corresponds to the physical aspect of relationship building. Characteristic of the Warrior is the

ability to stand firm and be well grounded. The Warrior uses resources and knowledge effectively. Reminiscent of swordsmanship in the past, the Warrior has the ability to use the sharp tools of knowledge, citing facts and statistics, having information, and sharing it appropriately. The Warrior also works with courage to modify behavior in self and others, and translates ideas into action with vitality.

The Healer archetype is more familiar to the nursing profession, as it honors the feeling dimension of relatedness. As a guiding principle, the Healer addresses others with love and compassion. The Healer is highly motivated to bring about emotional ease for others to become whole. In addition, the Healer brings a caring quality to all interactions, valuing self and others with unconditional positive regard.

The Teacher is the metaphorical representation of the mental aspect of relationships. This perspective brings wisdom and knowledge to others, and assists learners in developing insight and new perception. The Teacher delights in sharing wisdom and is always willing to learn. Many holistic nurses are presently manifesting as the Teacher in their practices and communities.

The Visionary is the archetype that demonstrates the spiritual component of relatedness. As a fair and nonjudgmental witness, the Visionary holds the image of higher truth as best as it presently can be understood. The Visionary uses qualities of clarity and perception to discern conflicts and assist in resolution. Furthermore, the holder of this ideal is intentional and focused. The Visionary acknowledges intuitive knowing, bringing others to the goal of achieving the highest good possible.

Nurses in general have effective interpersonal skills with clients, although relationships with peers and persons in power may be more confounded. Establishing and maintaining effective relationships with administrative personnel, third-party payers, medical organizations, and communities require conscious skill development. Because every interaction either builds or detracts from a relationship, nurses must enhance their interactive potentials to communicate effectively with these groups, and they must be willing to counter their detractors with effective assertiveness. The language of negotiation and conflict management must become an integral part of our relationship style, along with our well-recognized capacity for caring and compassion.[16,17]

HOLISTIC CARING PROCESS

Assessment

In preparing to use relationship interventions, the nurse can assess the following parameters:

- the ego state most in evidence in the other person's transactions
- the ego state that the nurse is using
- the events that happen repeatedly that may be patterns of a game
- the nurse's feelings (e.g., What is the Child part saying?)
- the nurse's values (e.g., What is the Parent input?)
- the nurse's options (e.g., what is the Adult input?)
- respect for self and the other person
- use of effective assertiveness rather than exerting control or being passive
- opportunities for mutuality in this exchange

The inherent qualities of Arrien's four archetypes lead to a more comprehensive, holistic assessment of relationships. The Warrior archetype addresses the physical dimension of relatedness in practical terms to determine the appropriate goal and to define the common ground for interaction. Awareness of the Healer archetype supports the emotional dimension; the caregiver may examine the overall feeling and tone of the interaction in order to

bring qualities such as nondefensiveness and positive regard into it. The Teacher archetype allows the nurse to assess specific learning needs of a given situation. The spiritual aspect of relatedness is addressed through the Visionary, who holds a sense of fairness and trust in outcomes for the highest good. In assessment, this archetype is manifest in determining the positive intent of each person and establishing the dimensions of human interconnectedness.

Patterns/Challenges/Needs

The following patterns/challenges/needs compatible with the interventions for relationships are associated with the 13 domains of Taxonomy II of the Unitary Person framework (see Chapter 14):

- Withdrawal
- Denial
- Repression
- Rationalization
- Regression
- Changes in parenting and family structure
- Human sexual dysfunction
- Lack of social coherence
- Spiritual disconnectedness and distress
- Altered family process
- Ineffective coping
- Self-care deficits
- Self-care dysfunction
- Anxiety
- Grief
- Fear
- Response to trauma

Outcomes

Exhibit 25–1 guides the nurse in client outcomes, nursing prescriptions, and evaluations for effective relationship interventions.

In addition to effective outcomes with clients, it is important to examine possible outcomes in the other areas of nursing interaction. Thus, an expansion of outcomes includes the following:

- The nurse will recognize family and relationship patterns.
- The nurse will use complementary transactions whenever possible and increase awareness of uncomplementary transactions to avoid psychological games.
- The nurse will demonstrate skill in communicating from the Adult ego state whenever possible, with awareness of the personal use of Parent and Child ego states.
- The nurse will use the Child ego state through humor and awareness of feelings when appropriate.
- The nurse will identify healthy boundaries in each interaction, assertively confronting any put-downs or defense patterns.
- The nurse will recognize opportunity for effective negotiations and conflict management, using the characteristics of effective communicators.
- The nurse will work from the dimension of mutual respect, valuing both self and others without discounting either.
- The nurse will plan for identifiable outcomes in transactions, drawing on the four archetypes as needed, and evaluate outcomes on an ongoing basis.
- The nurse will increase skills in addressing practical, emotional, mental, and spiritual aspects of relationships through the use of the four archetypes.
- The nurse will increasingly see opportunities for new relational patterns in challenging situations.

Therapeutic Care Plan and Implementation

The holistic nurse's careful planning and preparation enhance the effectiveness of relational interactions. The following are

Exhibit 25–1 Nursing Interventions: Relationships

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client will recognize personal and relationship patterns and how they support or detract from quality of life.	Assist the client in identifying • the importance of relationships • the patterns that increase comfort and effective communication • family relationship patterns and areas that could be improved • sources of emotional stress in his or her relationships • the human needs that are fulfilled by quality relationships • the impact of relationships on health and illness	The client verbalized the dynamics within the family relationship patterns. The client stated the importance of his or her relationships to quality of life. The client identified areas in which relationships could be improved. The client recognized factors that create stressors in relationships. The client stated understanding of the interconnection between relationships and health or illness.
The client will recognize and identify complementary and uncomplementary transactions in relationships.	Demonstrate examples of complementary and uncomplementary transactions, and help the client to identify such transactions in family and caregiver relationships.	The client identified a complementary transaction and an uncomplementary transaction.
The client will increase awareness of Parent, Adult, and Child ego states.	Demonstrate examples of the differences in the three ego states.	The client identified his or her personal use of Parent, Adult, and Child ego states.
The client will identify personal response patterns to others' ego states.	Assist the client in identifying personal response patterns to others' ego states, and help the client to improve the effective expression of inner feelings. Describe the four archetypes and their applications in communicating physical, emotional, mental, and spiritual perspectives.	The client recognized another person's use of an ego state and his or her personal response.
The client will incorporate new strategies to improve the quality of interpersonal relationships.	Provide the client with techniques to improve relationships, such as making "I" statements ("This is how I feel, . . . My feeling is . . ."), noting ego states in a transaction, and activating the four archetypes.	The client showed interest in the four archetype patterns and willingness to try out new communications from each perspective.
The client will increase awareness of the physical, emotional, mental, and spiritual aspects of relationship interactions.	Teach the client to express awareness of physical needs and take reponsibility for practical aspects of his or her care, such as need for more information and understanding of optimal outcomes.	The client demonstrated the ability to express personal feelings using "I" statements.
The client will recognize opportunities for effective negotiations with willingness to reconsider ineffective aspects.	Assist client to identify arenas where he or she can negotiate, make choices, or reconsider previous decisions; to see the open-ended nature of present relationships, especially with caregivers and family; to view the present disease as an opportunity for learning and change.	The client negotiated effectively after considering options. The client reconsidered relationship interactions that were ineffective. The client expressed interest in the open-ended nature of learning from his or her illness and treatment.

guidelines for planning and implementing effective relational patterns.

Before the Session

- Take a moment to set your intent and focus, allowing yourself to breathe fully, to sense your center, and to align with your sense of purpose.
  - —Take several deep breaths and relax the body.
  - —Rehearse a new pattern, such as giving accurate facts, in your mind.
  - —Imagine the successful outcome.
  - —Acknowledge your positive intent.
  - —Be willing to learn from each experience.

During the Session

- Notice the ego states that are in evidence, specifically the feelings that are triggered within yourself.
- Be aware of ways that finding common ground enhances rapport.
- Consider options that can achieve the goal of the communication.
- Make "I" statements when speaking about your personal point of view or experience.
- Set limits, by determining time frames, topics to be discussed, the context, and the environment.
- Be willing to change direction, or reconsider a point, to come to feasible compromises.
- Above all, keep the intent of the communication positive and maintain a relationship of mutual respect, even though specific content areas may be questioned and differing viewpoints are expressed.

At the End of the Session

- Use the client outcomes (see Exhibit 25–1) to assess ways you assisted the client in moving toward goals of understanding relationship patterns.
- Consider alternatives and make concrete plans for future action.
- Evaluate your own relational skills, your use of different ego states, your use of the archetypes.
- Honor your learning process in accepting mistakes or in thinking about what you might have done differently.
- Consider methods to make trying new behaviors safe and enjoyable, such as sharing your process with a friend or mentor.

Specific Interventions

Counseling. A client who exhibits normative behavior may seek counseling that focuses on coping behaviors.[18] For example, counseling may involve assistance with smoking cessation or weight reduction. Psychotherapy provides more in-depth interventions, such as working with clients in the struggles and challenges of life roles, individual/family priorities, intimacy, or changing relationship patterns in a marriage. Psychotherapy is definitely indicated when a client exhibits severe personality disorders or pathologic behaviors, although a client need not demonstrate pathology to be referred by the nurse for more in-depth work.

By demonstrating acceptance of the client's intrinsic worth and dignity, the nurse conveys empathy to the client and facilitates the client's disclosure of personal information. Genuineness and congruency convey the nurse's honesty and personal caring to the client.

Counseling techniques can be incorporated into all areas of nursing, although some of the advanced techniques lend themselves better to individual counseling. Even so, the nurse who is aware of the techniques can integrate various levels of the techniques in the acute care setting.

Storytelling. Stories reveal the importance that we assign to our experiences in life and our perceptions of the world.[19] Sto-

rytelling technique becomes advanced when parables and metaphors are used.

All stories may be a means of building descriptions of experiences that can be affectively shared and enable the perception of similar patterns to other situations. Because we can take our stories from one situation to the next, we establish different contexts and structures for those stories. This creates the potential for opening new dialogue with the self, which also can contain new purpose and meaning. An additional way to enhance storytelling is to incorporate relaxation, imagery, music, life review, and self-reflective interventions.

Nurses are always listening to clients' stories. If they listen with focused attention, they hear stories about stories. These stories are the therapy; they are the basis for the healing event. Therapy should be seen as conversation, rather than always classifying it in medical terms. The following guidelines enhance the use of stories.

- Listen for the themes that bridge one story to the next; listen for the threads of information that also weave through one story to the next.
- Train yourself to determine if a client is telling only one side of a story.
- Get the client to talk about what the two sides of any story may be, because clients frequently perceive only one side of a story. Viewing the other side gives new meaning and context, however, and enables one to create double descriptions of stories. For example, it is very easy to identify things and events that are wrong in one's life, but it is more valuable to find the strengths in the current situation and the underlying meaning or message of the present situation.
- Become aware of the importance of the stories that you construct from the client's stories. While listening to a client's stories, the nurse also is constructing a story that guides the therapy. When the nurse tells these stories to the client, the exchange of stories allows the client to see or hear new patterns and relationships. With this feedback, the client gains new information and can construct a new way of viewing life. All stories are a means of building double descriptions that facilitate change.

Development of Spiritual Understanding. Individuals must recognize that they are the spiritual experts about their lives, that the journey of wholeness and healing requires spiritual understanding, and that this understanding is a developing process.[20,21] Burkhardt and Nagai-Jacobson suggest that, if spirituality is a given and is the essence of one's being, it is useful for individuals to acknowledge their innate qualities.[22] When a person gives these qualities names and tends to them, the qualities are more likely to become healing tools. Ways to increase clients' awareness of opening to their healing potentials include the following:

- Connecting: connecting with self, others, higher power, universe; allows individuals to experience being grounded.
- Disconnecting: opening to new creative techniques, such as relaxation, imagery, dance, and laughter.
- Empowering: challenging one's mind to learn things other than the day-to-day work; exploring personal wisdom; taking a class in a new interest; consulting friends, family, or a therapist when necessary.
- Purifying: washing away, not only with water; sitting quietly by a roaring fire or out in nature in the sunshine; "playing in the dirt" without transforming the garden; taking a long bath or shower.
- Journeying: traveling in one's imagination; reading a good book; walking

or taking a leisurely drive; writing in a journal.
- Transforming: using raw materials to restore order and create something new; painting, weaving, needlepoint, or other craft; gardening or creative cooking; cleaning a closet, drawers, or desk.

Facing Fears. Individuals often have difficulty making changes within relationships or in other life situations because of fear. While there are many different levels of fears—fear of inevitable changes such as those caused by aging or illness, fear of the unknown, fear that we cannot cope with change, fear that we will be alone or abandoned—they have one thing in common: they usually exemplify a concern about something that is not actually occurring in the present moment. Focusing fully on the present is a vitalizing form of relaxation and allows us to manage anticipated distress from a different vantage point.[23]

A valuable strategy for holistic nurses is to engage the client in a full experience of a pleasant, present moment, as in the many meditative practices described in this book. Then, the nurse can ask the client to list all the possible fears that he or she holds, including those that are probably way beyond our control, such as fear "that the world will end." This listing begins to unburden the person and allows him or her to become more objective about the areas where changes can realistically be made and to identify the areas that are quite literally beyond personal control. Turning the latter over to powers beyond our personal selves—the transpersonal view of a Higher Power—can become a valuable spiritual practice.[24] In fact, a positive worldview is at the heart of spirituality, encompassing a faith in that which is beyond our finite knowing and control. As we relinquish the need to control, and give up "catastrophizing" about the future, we have more energy for enjoying the present moment and appreciating the little things that are helpful. Perhaps, we can help our patients to notice the beauty of a bird's song, a ray of sunshine, a flower, a warm greeting, a kindness, a simple smile. As holistic practitioners, we are purveyors of hope.

Improved Communication. Communication patterns have a direct impact on mind modulation of the autonomic, immune, endocrine, and neuropeptide systems. Because our relationships evoke every conceivable emotion and communication pattern, they have a significant impact on our physiologic state.

Nurses can help clients improve communication patterns by teaching an awareness of the physical and emotional responses that occur with each communication. With an increased awareness of the direct link between body and emotions, the client can learn to recognize and increase healthy dialogue. As a result, there will be more sharing and owning of emotions, and relationships will be healthier.

Communication involves state-dependent learning and the imagery process, so there are an enormous number of variables in communication interventions. Because they facilitate the incorporation of relaxation skills and awareness of bodymind responses with all dialogue, these interventions are helpful for all nurses and clients. Advanced communication interventions incorporate in-depth psychophysiologic therapy and biofeedback training.

Case Studies

Each of the following case studies suggests a variety of situations in which relational options can effect useful outcomes. These case studies demonstrate how evaluation of relationships is an ongoing, moment-by-moment process with long-term results. Review at the end of a working day is also

helpful to note which interactions were effective and which ones were not.

Case Study No. 1: Use of Different Archetypes

Setting:	Outpatient cardiac rehabilitation unit
Client:	46-year-old white businessman who is used to having his own way and being in charge
Patterns/ Challenges/ Needs:	1. Altered comfort level related to physical distress 2. Altered relationship patterns caused by loss of usual social status 3. Ineffective individual coping related to anxiety and stress

Nurse K. was a sweet and gentle person who demonstrated the empathic Healer archetype most frequently. She became tongue-tied and flustered when Mr. B., one of her patients in the outpatient cardiac rehabilitation program, suddenly and emphatically refused to comply with his treatment schedule. At first, she attempted to side with his emotional state. She reflected back to him, "You seem upset. Perhaps you could tell me what you are feeling." He retorted, "You have no idea how I feel. I hate this illness and this unit. Don't even try that psychologic stuff on me!" All of Nurse K.'s usual interventions caused Mr. B. to become even more defensive and irate.

At first, Nurse K. felt confused and helpless. She centered herself with a few quiet moments away from the treatment area and considered her options. She decided that exploring other archetypes would give her the following alternatives:

1. As a practical Warrior, Nurse K. could bring her knowledge and information into the situation. She could ask with courage and integrity, "What is causing this change? Please tell me what's happening with you. My experience and the statistical research tell me that your medical condition can improve if we implement the cardiac treatment plan developed in this unit on a daily basis." She realized that she could also ask Mr. B. to tell his story, and with her connecting and listening skills she could increase mutual understanding.
2. As a manifestation of the Teacher, Nurse K. could educate her client with wisdom to bring more insight. For example, she could say, "Our outpatient schedules are designed to accomplish the best results in the shortest amount of time. There are some areas of choice and some areas that cannot be redesigned. I need to know your goals for being here. The best outcome would be to negotiate a compromise that honors your goals and allows you to learn all you can about your illness."
3. As a Visionary who brings intuition and fair witness to difficult settings, Nurse K. would have the option of allowing time to establish a centered healing presence with Mr. B. She might say, "We seem to be at an impasse here. Let's take a moment to take some deep breaths, going back to the positive intent we both have—yours, to be well; mine, to assist you as best as I can."

Bringing awareness of the archetypes into conflict situations allows the nurse to be more flexible and to consider the relationship from a holistic, integrative perspective. The physical, mental, emotional, and spiritual dimensions of human consciousness enrich interaction and may facilitate problem resolution from the Adult ego states. Even if this does not occur, both parties can acknowledge positive intent while they work through differences of opinion.

Nurse K. re-approached Mr. B. after internally exploring her archetype options and simply asked him, "What can we do

today that would honor your desire for healing? We both recognize that it is an ongoing daily commitment, and I'm willing to assist you when you feel ready."

Feeling safe with her nondefensive response, Mr. B. decided to give himself time to "bottom out," to express his feelings about his illness fully; to tell his story. The empathic nurse assisted him by providing him with clay for directly expressing his frustration and with paper for journaling his inner experience. He admitted later, "I was just an awful kid needing to vent and you heard me. Thanks."

He continued the 6-week treatment program and returned to work. He stated to all that would listen that the day of venting was the beginning of a new lifestyle change that would affect his family life, his professional relationships, his health, and his heart.

Case Study No. 2: Use of Different Ego States

Setting:	Medical surgical unit at time of shift change
Clients:	Nurses in relation to each other
Patterns/ Challenges/ Needs:	1. Anxiety related to job performance 2. Ineffective individual coping 3. Spiritual distress related to professional ideals in conflict with reality situation

The incoming day shift nurse barked at the tired night nurse, "You probably forgot to do X again. It's always the same with you night people" (Critical Parent). The night nurse bit her tongue, feeling cowed, helpless, and angry (Adaptive Child).

Alternatives for dealing with such a transaction may be as follows:

1. Activate the Adult. The night nurse may respond, "You're right, this is a frequent problem. What could we do about it? Let's sit down and explore options."
2. Admit feelings and acknowledge the Child. The night nurse may respond, "I feel bad when you say that. We both have strong feelings here for various reasons" and then (moving to Adult) "Let's vent to get feelings out in the open, and invite someone neutral to help us sort this out."
3. Bring in the Nurturing Parent. The night nurse and day shift nurse may assist each other by affirming their strengths. For example, they may say to each other, "I sense how much you care about your patients. I share with you your concern and support you in finding solutions."

As nurses consider the holistic perspective, they must recognize that their relationships with each other are as vital to professionalism and ethics as their relationship with clients. The quality of interactions in today's hectic clinical settings can help to create a healing environment in which caregivers can grow and thrive, empowering and supporting each other. Without mutual respect and consideration, the work environment can be destructive to the participants as well as to the clients who will surely sense unresolved tension and pressures.

Case Study No. 3: Negotiation with Co-Workers

Setting:	Hospital staff wishing to incorporate holistic ideas
Clients:	Interested co-workers with varying goals
Patterns/ Challenges/ Needs:	1. Ineffective individual coping related to job stress and anxiety 2. Ineffective valuing related to uncharted nature of the discussions and moving into new domains

The nurses in Hospital D wished to establish an alternative health care clinic. Many of the staff wanted to participate, although only a few could be hired for the project. Those who were truly interested decided to hold a meeting and identify the strengths and resources within the group. Some of those present were interested primarily in their own advancement, while others wanted to collaborate in order to reach the goal of establishing a complementary health care program.

As the group developed over time, those with the knowledge base and practical skills, the empathy toward others, the goals of teaching and learning, and clear intent—in other words, those manifesting the four archetypes—became more vocal. Natural leaders emerged from those who could most clearly maintain good relationships while discussing complex issues.

Of course, things did not go smoothly in terms of human relationships. One of the self-oriented people asserted, "I'm not getting what I want." Several of the collaborative-style workers countered with empathy, facts, and their vision. In essence, they said, "I understand your frustration. We're all in this together, and the nature of negotiation requires each of us to release some of our individual desires so that we can find what is best for most of the group and accomplish our goal. Would you insist on your own way if it were to hurt others or limit our project?" This response allowed for inner reflection on the common goals of the project, which were quite different from the individual's needs for recognition or status. She started learning from the leaders of the group. Later, she decided that she had other goals and would rather open an independent center than work with a group.

Effective communication requires maintaining mutual respect and recognizing the positive intent behind each person's actions, while addressing very real differences of opinion. A rule of thumb for effective negotiations is to be "hard on the issues and soft on the people" while working to reach an agreement that results in the best outcomes for the most people. This kind of confrontational, yet caring, communication is new to nursing. In truth, there are values higher than individual contentment. Nurses must develop a wide variety of skills to build and maintain relationships in order to bring about the policy changes that will be required in the twenty-first century.

Case Study No. 4: Conflict Management with a Health Maintenance Organization

Setting:	Home health care organization that is part of a health maintenance organization (HMO)
Clients:	Nurses employed by the HMO
Patterns/ Challenges/ Needs:	1. Anxiety related to job insecurity 2. Ineffective individual coping due to stress and anxiety 3. Spiritual distress related to professional ideals in conflict with mercenary values of a for-profit corporation 4. Altered comfort related to lack of clarity and lack of enforceable agreements

The management of a large HMO told the staff nurses that costs must be decreased and asked the nurses to choose between reducing the number of staff or accepting lower salaries (i.e., a 10 percent wage cut). The nurses voted for the salary reduction, but three months later, half of them were laid off anyway. Feeling abandoned and discounted, they cried, "Foul!"

Unfortunately, such dilemmas are all too common in these days of budget cuts and medical cost overruns. As a professional group, nurses may jump too quickly

for short-term advantages (Adaptive Child) rather than looking at the bigger picture (Parent values) and ensuring effective, legally binding negotiations (Adult).

In this situation, the basic steps of negotiation to define management's relationship with nurses did not take place. If, for example, a tenacious, assertive spokesperson had been able to demonstrate the cost-effectiveness of nurses' services to the organization, agreement about finances might have included a provision for job security for at least six months. Then, any nurses laid off as quickly as three months later would have had legal recourse. Better yet, there should have been a provision for legal monitoring of the pay cut agreement at the outset, bringing in the practical, down-to-earth Warrior archetype.

In another home health care organization, a group of nurses in a somewhat similar situation worked through their union representative to bring their negotiation points to discussion. At first the management team was hostile, but because it had signed the union contract, it had to negotiate. After many meetings, which were open to all who could attend, an agreement involving pay cuts was struck for a period of one year. It was not ideal, but at least it gave the nurses the job security that allowed them to move forward and establish good relationships with their clients. As the year progressed, new referrals increased because of the positive nurse–client interactions, and community faith in the agency grew. The next year, management gave small pay raises to the nurses and praised the union for their positive participation in the agency's efforts. It became a win-win situation.

Evaluation

With clients or co-workers, the nurse determines whether outcomes for relationship interventions were successfully achieved (see Exhibit 25–1). To evaluate the session or interactions further, the nurse may explore the subjective effects of the experience (Exhibit 25–2). Healthy relationships increase well-being and wholeness. As clients and nurses become more aware of the value of open, effective relationship patterns, they can mutually move in the direction of increased health and healing in the relational context.

Exhibit 25–2 Evaluating the Nurse's Subjective Experience with Relationship Interventions

1. Can you continue to identify and be aware of the relationship that is troublesome to you?
2. Is it possible for you to be clear about your wants and expectations in this relationship?
3. Have you tried out new patterns, such as making a conscious choice of a different ego state? What was the result?
4. Have you considered the transactions in this relationship to make them more complementary?
5. Is it possible for you to communicate your strengths in this relationship? What are the strengths and intent of the other person that could also be acknowledged?
6. Can you imagine how the Healer in you could approach this relationship? How about the Teacher? The Visionary? The practical, grounded Warrior?
7. What would a healed relationship with this person be? How would you feel?
8. Can you identify the steps you could take to move in this direction?
9. What interventions would be most helpful in moving toward healing this relationship?
10. Do you have any questions about any of the new strategies that you have learned for healing this relationship?
11. What is your next step?

As pressures of population numbers, limited resources, managed care, and devaluation of the individual impact the health care field, nurses are called on at even deeper levels to keep the spirit of caring alive.[25,26] The very presence of our unwieldly health care system could be

destructive to the art and science of nursing that is so well expressed in the holistic perspective.

New trends also are bringing the role of the nurse into new light. For example, an increasing number of nurses are establishing themselves as nurse practitioners, which alters their relationship with physicians to be much more equal. In this new level of interaction, nurses are learning to combine their judgment, intuition, and healthy relationships with themselves as never before.[27] These nurses advise physicians in handling direct patient care and have learned to back up their intuitive knowing with hard facts, to work within the rules and protocols of the agency, to use effective strategies for voicing their concerns, to present clients in a way that can be heard by the physicians, and to master the art of persistence. Their role requires taking care of their patients as well as maintaining a healthy sense of self-confidence and pride.

It is true that "hindsight is always better than foresight." Similarly, it has been said that all good counseling brings today's solutions to yesterday's problems. It is always easier to see things in review than when we are in the midst of a crisis. We come to recognize that there are no ideal solutions, no perfect relationships. Life, in terms of the important interconnections, is a series of encounters from which individuals gain experience and gradually progress toward more insight. Everyone is in the learning curve for establishing and maintaining relationships. It also is wise to remember that hindsight is far better than no sight at all. As long as there is willingness to learn, there is hope for relationships, even the most thorny and conflicted.

Human connectedness is an open-ended process of assessing problems, trying out new options, and evaluating outcomes. Martha Rogers, one of nursing's meta-theorists, held that nurses are continually evolving to higher levels of complexity as "our patterns are continually changing, innovative and creative."[28] Even in space travel, she asserted, nurses' skills in relationship building would be an essential requirement for establishing healing environments.

CONCLUSION

Inner work with the expressive arts is helpful in understanding personal feelings and clarifying relationship patterns. Ultimately, moving into right relationships with ourselves, each other, and our environment is the healing force for our lives. The poem that follows celebrates the use of the breath to refocus in the day-to-day complexities of nursing practice. It is offered here to be used as a reminder that realigning of thought and action can flow from your integrative, focused intention.

With Every Breath

With every breath
there's a chance to forget
to become lost in the brambles
the entangled pathways of thoughts,
activities, overdoing,
losing purpose
trailing nowhere. . .
With every breath
there's a chance to remember
to bring back the mind
to its true nature
simplicity, strength
loving-kindness
forgiveness, peace
to find the direct path
that leads home.

—Dorothea Hover-Kramer, © 2003

DIRECTIONS FOR FUTURE RESEARCH

1. Develop valid and reliable tools that help nurses to identify barriers to effective relationships.

2. Evaluate the efficacy of relationships tools, such as Transactional Analysis, for analyzing functional and dysfunctional relationship patterns.
3. Develop and evaluate active programs for relationship building in clinical work settings.
4. Demonstrate and evaluate effective relationship interventions through role playing and workshops.
5. Document and evaluate in the nursing literature effective group problem-solving processes in dealing with current issues, such as policy changes and complementary modalities.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- How do I feel at the end of the workday?
  - —Can I acknowledge the Child within?
  - —What gives me pleasure?
  - —What bothers me?
  - —Which defenses do I use?
  - —What do I wish I had done differently?
- Were there any unpleasant interactions?
  - —Who was the Critical Parent, the Adaptive Child, the Adult?
  - —What other options could have been considered?
  - —How would I respond to the situation from each of my five ego states?
- Are there repeated patterns in my relationships that indicate "games" or "payoffs"?
  - —What belief (such as "I'm not OK," and/or "You're not OK") or action on my part maintains this pattern?
  - —How could I change the pattern?
- Will I be able to practice new responses with a friend or co-worker?
  - —What will I do differently?
  - —Will I have support from trusted friends?
  - —Will I honor and acknowledge myself as a growing, learning being, aligned with inner light and truth?

NOTES

1. American Holistic Nurses' Association, *Standards of Holistic Nursing Practice* (Flagstaff, AZ: AHNA, 1998), 1.
2. C.G. Jung, *Man and His Symbols* (New York: Doubleday & Co., 1964), 67–69.
3. E. Berne, *Principles of Group Treatment* (New York: Oxford University Press, 1964), 281.
4. E. Berne, *Games People Play* (New York: Grove Press, 1964).
5. D. Hover-Kramer and K. Shames, *Energetic Approaches to Emotional Healing* (Albany, NY: Delmar Publishers, 1997), 25–47.
6. E. Wachtel and P. Wachtel, *Family Dynamics in Individual Psychotherapy: A Guide to Clinical Strategies* (New York: Guilford Press, 1986), 43–64.
7. M. Seligman, *Authentic Happiness* (New York: Free Press, 2002).
8. Jung, *Man and His Symbols*.
9. A. Maslow, *The Farther Reaches of Human Nature* (New York: Penguin Books, 1971).
10. E. Berne, *Transactional Analysis in Psychotherapy* (New York: Grove Press, 1961).
11. Berne, *Games People Play*.
12. C. Snow and D. Willard, *I'm Dying To Take Care of You* (Redmond, VA: Professional Counselor Books, 1989).
13. D. Jongeward, *T.A. for Hospitals* (Boston: Addison-Wesley, 1976).
14. D. Hover-Kramer, The Evaluation of Learning of a Course in Transactional Analysis for Hospital Personnel (Unpublished doctoral dissertation, Nova University, 1978).
15. A. Arrien, *The Four-Fold Way* (San Francisco: HarperCollins, 1993).

16. R. Fisher and W. Ury, *Getting to Yes* (New York: Penguin Books, 1981).
17. G.I. Nierenberg, *The Art of Negotiating* (New York: Simon & Schuster, 1981).
18. L. Banks, Counseling, in *Nursing Interventions: Essential Nursing Treatments*, 2nd ed., eds. J. Bulechek and J. McCloskey (Philadelphia: W.B. Saunders, 1992), 279–291.
19. M. Sandelowski, We Are the Stories That We Tell, *Journal of Holistic Nursing* 12, no. 1 (1994):23–33.
20. M. McKivergin and M.J. Daubenmire, The Healing Process of Presence, *Journal of Holistic Nursing* 12, no. 1 (1994):65–81.
21. M. Burkhardt and M.G. Nagai-Jacobson, Reawakening Spirit in Clinical Practice, *Journal of Holistic Nursing* 12, no. 2 (1994):9–21.
22. M. Burkhardt and M.G. Nagai-Jacobson, Spirituality: The Cornerstone of Holistic Nursing Practice, *Holistic Nursing Practice* 3, no. 3 (1989):18–26.
23. D. Hover-Kramer, *Creative Energies: Integrative Psychotherapy for Self-Expression and Healing*, (New York: W.W. Norton, 2002).
24. G.D. Sherwood, The Power of Nurse/Client Encounters: Interpreting Spiritual Themes, *Journal of Holistic Nursing* 18, no. 2 (2000):159–175.
25. J. Young-Mason, The Caring Ethic, *Clinical Nurse Specialist* 15, no.3 (2001):103–104.
26. L.H. Aiken, S.P. Clarke, and D.M. Sloane, Hospital Restructuring: Does It Adversely Affect Caregiving Outcomes? *Journal of Nursing Administration* 30, no.10 (2000):457–465.
27. M.M. Kosowski and V.W. Roberto, When Protocols Are Not Enough, *Journal of Holistic Nursing* 21, no.1 (2003):52–72.
28. M. Rogers, *Portraits for Excellence*, video (Oakland, CA: Studio III, Helene Fuld Trust fund, 1987).

SUGGESTED READING

Benne, K., Babad, E. *The social self* (Beverly Hills, CA: Sage Publishing, 1983).

Corey, G. *Theory and practice of counseling and psychotherapy* (Pacific Grove, CA: Brooks Cole, 1991).

Deluca, P. *The solo partner: repairing your relationships on your own* (Point Roberts, WA: Hartley & Marks, 1996).

Gilbert, R.M. *Extraordinary relationships: a new way of thinking about human interactions* (New York: Anchor, 2001).

Gorsevski, E.W. *Peaceful persuasion: The geopolitics of nonviolent rhetoric* (New York: SUNY, 2003).

Gottman, J. *Seven principles for making your marriage work* (New York: Simon & Schuster, 1999).

Hawkins, D.R. *Power vs. force: The hidden determinants of human behavior* (Carlsbad, CA: Hay House, 2002).

Heilveil, I. *When families feud: Understanding and resolving family conflicts* (Berkeley, CA: Berkeley Publishing Group, 1998).

Kippner, D.A. Dynamics of role satisfaction, *Journal of Group Psychology* 44, Spring 1991:2.

Lee, L. *Listen up: How to improve relationships, reduce stress, and be more productive* (New York: Bantam, 2000).

McCollon, M. The group dynamics instructor as boundary manager, *Journal of Management Education* 16, May 1992:2.

Miller, M.J. Training issues in group work, *Journal for Specialization in Group Work* 18, May 1993:2.

Mills, R., Spittle, E. *The wisdom within* (Auburn, WA: Lone Pine Publishing, 2001).

Needleman, J. *A little book on love* (New York: Doubleday, 1996).

Neuman, M.A. *Health as expanding consciousness* (New York: National League for Nursing, 1994).

Peplau, H.E. *Interpersonal relations in nursing* (New York: Springer, 1988).

Pierrakos, E. *The pathwork of self-transformation* (New York: Bantam Books, 1990).

Roark, A.S., Sharah, H.S. Factors related to group cohesiveness, *Small Group Behavior* 28, February 1989:1.

Semmelroth, C. *The anger habit* (New York: I Universe, 2000).

Semmelroth, C. *The anger habit workbook: Practical steps for anger management* (New York: I Universe, 2002).

Seligman, M.E.P. *Authentic happiness* (New York: Free Press, 2002).

Schaefer, K.M. Caring behaviors in advanced practice nursing students, *Journal of Holistic Nursing* 21, no.1 (2003):36–51.

Todd, M.K. *The managed care contracting handbook: Planning and negotiating the managed care relationship* (New York: McGraw-Hill,1996).

Weeks, G.R., Hof, L. (eds.) *The marital relationship therapy case book: Theory and application of the intersystem model* (New York: Brunner-Mazel, 1994).

Wheatley, M.J. *A simpler way* (New York: Barrett-Koehler Publishing, 1996).

Witkin, G. *Stress relief for disasters great and small* (New York: Newmarket Press, 2002).

Wright, S.G., Sayre-Adams, J. *Sacred space: Right relationship and spirituality in healthcare* (New York: Churchill Livingstone, 2000).

Releasing Attachment

Nothing prepares us completely for our own death, or for the death of a loved one. Although we know that we will eventually die, most people have become so accustomed to their bodies that they fear death or view it as a tragedy. Modern culture emphasizes extending life at all costs, often despite pain and suffering. When we choose to prolong life, however, we may deny death. One's soul may literally die in agony before the physical body dies.

Nouwen tells the story of a trapeze artist who admonished a fan to watch the catcher of the trapeze artist, not the one who jumps from a trapeze to the catcher. "The catcher is the real star. . . . The secret is that the flyer does nothing and the catcher does everything. . . . A flyer must fly, and a catcher must catch, and the flyer must trust, with outstretched arms, that his catcher will be there for him."[1] For Nouwen, the dying person is a flyer who chooses to let go of the bar and trusts that the catcher will pull him safely into the next world. Nouwen suggested that this is what is meant by the words of Luke 23:46, "Father into your hands I commend my Spirit." Dying well—moving to a new existence—requires choice, trust, and the willingness to let go.

Despite the notion that life is a series of episodic events from birth to death, it has been shown that time is very different from the classic Newtonian model that real time flows in a linear sequence and is divisible into past, present, and future (the predominant Western view). We are dependent on an external reality when we think of these events in a linear fashion, but the only way that we can experience birth, health, illness, and death is by our senses, by our own internal experience. Thus, our meaning in life determines our sense of time.[2] Thoughts of death often evoke words such as desperate, panic, final, always, ending, or forever. These words create a constricted sense of time and inflict fear and urgency on our experiences. Because our experience of time is bound to our senses, we can learn to expand time, not constrict it with fear and worries.

We also can gain insight from the Eastern world view, which approaches life and death as complementary dimensions of the same unified experience. To experience one is simultaneously to experience the other. Conscious preparation for the moment of death begins with the little daily deaths that serve to prepare us for the death at the end of our physical lives.[3] These little deaths include changes, losses, and disappointments at work or with family and friends; goals not accomplished; or temporary illnesses (e.g., allergies, ulcers, infection). These little deaths also can occur as realizations that we should release old behaviors and relationships that no longer serve us in order to allow room for new behaviors, relationships, and possibilities.

True healing and dying in peace come from releasing our attachment to the physical body, and to the conflicting emotional and spiritual issues that hold one in bondage to this body and this world.[4] Recognizing our integration in the Divine universe, we must learn to open our body-mind-spirit to healing. The paradox is that, although this healing awareness may seem to be rare, it is a very ordinary and natural event available to each of us at all times. As we practice living in peace, we enter a healing state in which our questions about the complementary nature of living and dying are answered. The insight comes from our own inner wisdom and strength.

Many fears surrounding death have to do with our ego, the separate individual I-ness; our identifying with personal mental images of objects, desires, wants, and needs.[5] The will to live is very strong, and it is hard to give up our individual personalities and bodies. The ego keeps us separate from the grander scheme of totality of beingness, connectedness, and wholeness. We can, however, learn to listen to an inner voice, and experience thoughts, feelings, and images without attachment. Going to the core of our inner wisdom dissolves the ego attachment as we move toward the death moment and know that death is near.

NOTES

1. H. Nouwen, *Our Greatest Gift: A Meditation on Dying and Caring* (San Francisco: Harper, 1995), 67.
2. L. Dossey, *Recovering the Soul* (New York: Bantam Books, 1989).
3. A. Sheikh and K. Sheikh, *Death Imagery* (Milwaukee, WI: American Imagery Institute, 1991).
4. S. Levine, *A Gradual Awakening* (New York: Anchor Press, 1979).
5. K. Wilbur, *Grace and Grit* (Boston: Shambhala Publications, 1991).

Chapter 26

Dying in Peace

Melodie Olson and Barbara Montgomery Dossey

NURSE HEALER OBJECTIVES

Theoretical

- Use theories of grief, self-transcendence, myths, and beliefs to guide the process of helping the dying to experience their deaths peacefully and meaningfully.
- Discuss with colleagues difficult issues surrounding the care of dying people.
- Interview patients who have experienced nearing death awareness.

Clinical

- Explore personal myths and beliefs about death with colleagues.
- Use co-meditation to help a dying patient experience peace.
- Use the life review process to help a person experience a sense of integration.

Personal

- Plan your ideal death.
- Record several imagery scripts and experience "letting go" with these exercises.

DEFINITIONS

Death: a moment in time.

Dying: a stage of life that fits into a broader philosophy, giving both death and life meaning.

Grief: a response to loss, characterized as dynamic, pervasive, individual, yet normative.

Loss: the absence (or anticipated absence) of someone or something of real or symbolic meaning.

Mourning: the expression of sadness or sorrow resulting from a loss.

Myth: story lines created by individuals and cultures about meaning and journeying in life.

Nearing Death Awareness: the dying person's knowledge of death and his or her attempts to describe this experience to health care providers, family, and friends.

Peri-Death: the last hours of life; the actual death and the care of the body after death.[1]

Self-Transcendence: the ability to move beyond conceptual self-boundaries of time and space.[2]

THEORY AND RESEARCH

To die peacefully—to die with the knowledge that life has had meaning and that

one is connected through time and space to others, to God, and to the Universe—is to die well. Helping people to die well requires knowledge and skill, as well as a willingness to be intensely involved in the most intimate phases of another's life. Physical, spiritual, psychological, and social distress must be addressed with concern and compassion. The nurse, in being present "in the moment" with the patient and family, inevitably confronts her or his own mortality. Care for the caregiver (professional and family) is a requirement, a part of the care of the dying. The patient and the family are the unit of care.

Studies are beginning to address appropriate ways of easing the burden for those who are caring for the terminally ill.[3,4] Developing theories to guide end-of-life care are based on standards of care, like "the standard of a peaceful end of life" proposed by Ruland and Moore.[5] Theories related to grief and loss, self-transcendence, myths and beliefs, and nearing death awareness are particularly useful in formulating effective plans of care for the dying.

Grief and Loss

Grief theory weaves concepts of loss, bereavement, and mourning into a fabric of ideas that help decide action on the part of caregivers, family members, and patients. Several theorists have identified stages of grief, or patterns of grief, as a part of the framework that guides appropriate care. However, grief is not only normative, but also dynamic, pervasive, and individual. Each individual moves through bereavement at a different pace and copes in a different manner, depending on inner resources, support, and relationships. Society may think that the period of mourning has been long enough (a normative statement), but the individual may need more (or less) time before beginning to take charge of a changed life.

Grief is a necessary process for both the dying person and his or her significant others. The more bonded and intimate two people have been, the more intense the grief. Feinstein and Mayo stated that appropriate grief work has three characteristics.[6] First, it furthers the healthy grieving process by encouraging ventilation, planning, and insight. Second, it does not exploit others; the mourner has a healing team to provide comfort, but does not act as a parasite who feeds on another's energy. Transactions are caring and clear. The mourner continues to recognize the importance of personal inner work. Third, appropriate grief work cannot be rushed. It takes time to accept that death has occurred and to work through feelings. The person who successfully addresses grief and goes through the process may experience a sort of transformation from profound sadness to a comfort with memories, and even joy.[7] Ersek[8] discusses the issue of hope and the fact that it is present in grieving people, especially those expecting to die or their loved ones. Hope increases as death approaches, but the nature of hope changes.

Stepnick and Perry linked the stages of spiritual development first identified by Peck with the phases of grief originally identified by Kubler-Ross.[9,10] Nursing care during each of the phases takes into account the spiritual maturity of the griever, whether it is the dying person or those who love that person. A person who is in the early stages of spiritual maturity, whether a child or an adult, needs much external help, information, communication, and developing trust. This person may not achieve acceptance (and transcendence) without moving to a higher level of spiritual development. Persons who have a more formal spiritual practice

may use rituals, rites, symbols, and activities that incorporate them for comfort; thus, they may find comfort in planning their own funeral. Skeptics may build on the comfort found in the formal structures, but often add intellectual processes, such as bargaining with medical science (e.g., becoming part of experimental studies), reading books on death and dying, considering their contributions in this life; yet they acknowledge a fear of the final moments . . . a fear of pain and loss. Those in the last spiritual stage (labeled "mystic" by Peck) believe in a common bond uniting humanity, the world, and the universe. They are attracted to the mystery of faith. Therefore, the dying person in this stage may worry more about others, become angry about the effect the disease or the dying has on loved ones, choose humanitarian goals, become introspective and prayerful, and contact family and friends to say good-bye. Nursing care requires a careful assessment of a dying person's spiritual resources to assist with peaceful death.

The nurse's own developing spiritual maturity can be a useful support, as when one accompanies an acquaintance for a while along a road. The nurse maintains an attitude of being open, listening, and assessing the client's path even when his or her own journey changes directions. Successfully dealing with grief allows the dying client to achieve peace and allows the family and significant others to move on with a changed life, cherishing memories while creating new ones.

Self-Transcendence

Many people have studied self-transcendence—the sense of a temporal integration of self, the feeling that past and future enhance the present. In studying survivors of concentration camps, Frankl discovered that those who survived seemed to transcend (beyond self) either toward other people or toward meaning.[11] Transcendence can occur through creativity, the family, or works of art; through receptivity toward others; or through acceptance of a situation that cannot be changed. People who can be identified as self-transcendent at the end of life tend to have less depression, less self-neglect, and less hopelessness.[12] They have a greater sense of well-being and a greater ability to cope with grief.[13] The self-transcendent person lives in the present and usually sees death as a normal part of life. Encouraging people to seek meaning and connections either in the present or through all time helps people move toward self-transcendence to achieve peace.

Measures to support one's movement toward self-transcendence build on the need to look inward for connectedness and a sense of timelessness. Life review—the systematic review of one's life to see that it was meaningful, to remember those who are loved, and to know one's own place in history—is one example of a useful process.[14] Life review is the story of this life, of living in this space on this earth in this time. Studies show that systematic life review helps reduce depression and anxiety and promotes a feeling that this was *my* life, no one else would have done it this way, and I have a unique place in this universe.[15]

Myths and Beliefs

Myths are our story lines, values, beliefs, and images; they are our personal manual about the meaning and the journey of the human spirit.[16] Myths help us seek the unfolding mystery in life. In seeking life's meaning and purpose, personal myths help us manifest hope, learn to accept daily struggles and challenges, and deal with

ambiguity and uncertainty. Myths help us to recognize strengths, choices, goals, and faith. They also help us to assess our perception of our world, recognize our capacity to pursue personal interests, and demonstrate love of self and self-forgiveness. Myths provide a sense of connection and of oneness with all of life and nature.

Throughout life, we create many myths. Some serve us well, while others hinder our healing journey. From their work on rituals for living and dying, Feinstein and Mayo suggested a five-stage program to create empowering mythologies that evoke courage in dealing with death and, thus, promote a peaceful death.[17] Each of the five stages has a specific purpose and corresponds with one of the phases in the natural development of personal myths. The first stage deals with recognizing our deepest fears about death. The second stage helps us search for counterforces to our fear of death. The third stage attempts to resolve the natural conflict between the prevailing myth identified in the first stage and the emerging countermyth identified in the second stage by integrating the best of each side into a renewed mythology. In the fourth stage, the deeper solutions to inner conflicts are further articulated, expanded, and anchored in our being. The task in the fifth stage is to weave our renewed mythology into daily life by involving three personal rituals: (1) attending to that which will survive us, (2) creating ceremony for the final hour and beyond, and (3) establishing peaceful moments with what we do between now and the final hour.

More than twenty years ago, the Senior Actualization and Growth Exploration (SAGE) study began to question society's beliefs about older people and their potential.[18] The researchers taught seniors deep relaxation, biofeedback, breathing exercises, meditation, yoga, and ways to expand creativity through movement, music, art, education, and group discussion. This project not only helped the participants reshape their declining years to an understanding of healthy aging and lifestyles that promote the goal of healthy aging, but also gave them new, practical ways to cope with personal problems and a more confident self-image. With healthier lifestyles, most people can add a vital 30 or more years to their lifespan. There is also more time to practice a new way of living so that dying in peace is a clear choice for each person.

Nearing Death Awareness

During their many years of hospice nursing, Callanan and Kelly have identified several recurring themes in the stories of dying patients and their families.[19] Messages about death awareness from dying persons fall into two categories: (1) attempts to describe what they are experiencing while dying, and (2) requests for something that they need for a peaceful death. This awareness is not to be confused with near death experiences that happen as a result of cardiac arrest, drowning, or trauma, in which a person feels the self suddenly leave this life but quickly return. In a state of nearing death awareness, a person's dying is slower, often because of a progressive illness such as acquired immunodeficiency syndrome (AIDS), cancer, or heart or lung disease. The person remains inside the body, but at the same time becomes aware of a dimension that lies beyond, a drifting between this world and another—perhaps a space of transcendence—yet not one that touches "an Ultimate." The slower dying process allows the dying person to have more time to assess his or her life and to determine what remains to be finished before death. Some dying patients try to describe being in two places at once, or somewhere in between. It is a time for a caregiver to respond to their wishes and needs, and to listen to what dying is like

for them. It is at this time that discussions about the patient's wishes about cardiopulmonary resuscitation should be heard if they haven't been discussed prior to this time.[20] This can be a period of challenge for many caregivers. This is also a final gift to prepare each of us for what may happen in our dying. Those individuals who are tired of living but do not believe that it is time to die describe the dying process differently from those who are truly ready to depart. The statements of those who are truly ready are different in the clarity with which the words are spoken, the look from their eyes, or their touch. Their statements, looks, or touches are like no others that have been made before or during the dying process.

HOLISTIC CARING PROCESS

Assessment

In preparing to use interventions for promoting peaceful dying, the nurse assesses both the dying person and the family or significant others in the following areas:

- the different emotions that surface during the process:
  - **guilt:** blame of self and others over management of the dying person; distress over inability to decrease pain.
  - **anger:** toward God, disease, family/significant others, doctors, or survivors; over inability to fix things physically, emotionally, and spiritually.
  - **ability to laugh:** the shortest distance between two people; relationship between comedy and tragedy (joy and sadness pathways cannot operate simultaneously).
  - **love:** an essential element in living and in dying; a state of self-giving and presence of beingness of a person, where openness and willingness exist for self or another; the network that brings and weaves families/significant others together to work through the dying process and move into total acceptance of death.
  - **fear:** often evocation of separateness and aloneness, but can become a path leading deeper into the present moment; useful in that it reveals areas of resistance; return to unconditional love and a sense of equanimity after release of fear.
  - **forgiveness:** an essential element for inner peace; an exercise in compassion that is both a process and an attitude.
  - **faith:** the larger vision of existence, which is different for each person; helps to harness energy to evoke healing resources and power.
  - **hope:** support of patient or family/significant others during death's darkness; an inner moment that perceives lightness when in the midst of darkness and has the potential for leading to deeper love; hope for decreased pain and increased physical and spiritual comfort, for a miracle, for peace of mind, for a remission, for peaceful death transition, and for acceptance of a shorter life than expected or the death of a loved one.
- the patient's interactions with others and the effect of the patient's emotions on these interactions.
- the need for education about what will happen and what can be done to help, both for the family and the patient.
- comfort needs, assessed according to the patient's culture and wishes for:[21]
  - pain control and symptom management
  - hydration
  - nutrition
  - respiratory assistance
  - movement
  - touch

- signs of psychiatric illness, under- or overmedication that may interfere with a patient's ability to cope with dying:
  - —hallucinations
  - —delusions
  - —depression
  - —denial that interferes with the ability to move toward comfort and peace
  - —excessive anxiety
  - —confusion, agitation, or memory loss, especially in the aged

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with the interventions for dying in peace that are related to the 13 domains of Taxonomy II of the Unitary Person framework (see Chapter 14):

- Altered circulation
- Altered oxygenation
- Altered body systems
- Altered communication
- Effective communication (see section on Nearing Death Awareness)
- Spiritual distress
- Spiritual well-being (see section on Nearing Death Awareness)
- Ineffective individual/family coping
- Self-care deficit
- Body image disturbance
- Powerlessness
- Hopelessness
- Pain
- Anxiety
- Death anxiety
- Grieving
- Fear

Outcomes

Exhibit 26–1 guides the nurse in identifying patient outcomes, nursing prescriptions, and evaluation for assisting patients and their families/significant others during the dying process.

Therapeutic Care Plan and Implementation

The following guidelines are appropriate both for the dying person and the caregivers, whether family, friends, or nurse. They are helpful in all settings. The guidelines apply from the first awareness of a coming interaction with a patient and family who are moving through the dying process, through dying, and afterward.

Before the Interaction

- Spend a few moments centering yourself to recognize and honor your presence there.
- Begin the session with intention to facilitate healing and peaceful dying.

At the Beginning of the Interaction

- Encourage the patient and the family/significant others as the caregiver(s):
  - —set realistic goals.
  - —identify different behaviors that have surfaced in their interactions with each other during this period.
  - —gather a healing team and honor the patient's personal needs and feelings to avoid more suffering.
  - —accept current circumstances, and release things that are beyond their control. Accept the fact that release may not be possible at this time, but they can work toward it.
  - —take frequent breaks, at least 20 minutes daily, to evoke quality quiet time with relaxation, imagery, music, meditation, prayer, journal keeping, or dreamwork to assist in the letting-go process.
  - —exercise, take long hot baths or showers, eat nutritious foods, eliminate excess caffeine or junk food, and ask other people for relief.
- Encourage the patient and caregivers to tell themselves over and over what a good job they are doing and that it

Exhibit 26–1 Nursing Interventions: Dying in Peace

Patient Outcomes	*Nursing Prescriptions*	*Evaluation*
The patient will demonstrate an understanding of reasons for ongoing assessment and management of anxiety, including • quiet environment • explanations of all personnel, procedures, and equipment • touch and reassurance by nurse • relaxation skills	Continue to reassess states of anxiety and provide ways to decrease anxiety. • Provide quiet environment. • Explain all interventions. • Offer reassurance. • Teach relaxation and imagery skills.	The patient demonstrated an understanding of the reasons for assessment and management of anxiety.
The patient will verbalize feelings of anxiety and will talk spontaneously about fears. (If the patient is intubated, the patient and the nurse use specific communication codes.)	Provide quality time for the patient to share worries and fears. Use common symbols for communication if the patient is intubated.	The patient verbalized anxiety and fears.
The patient will use effective coping mechanisms during course of illness.	Focus on the patient's strengths.	The patient used effective coping mechanisms during the course of illness. (List specific examples.)
The family will communicate stressors associated with the patient's illness to staff.	Allow time for the family to express worries and fears.	The family/significant others communicated stressors to staff.
The patient will verbalize fears of death.	Be present with the patient and allow time for the patient to talk about fears of dying.	The patient talked of death.
The family/significant others will verbalize fears that the patient may die and what this means to them.	If death seems imminent, be with the patient and family to assist them through the death.	The patient's family/significant others acknowledged the impending death and shared feelings about death.
The family/significant others will receive support from nurses and clergy.	Provide spiritual support for the patient through presence, life review, prayer, talking, and handholding. Allow the family to be with the patient. Call clergy for assistance, if requested.	The family/significant others received spiritual support and talked to nurses and clergy.
The patient, family, and significant others will express fears and other feelings associated with dying and death.	Assist the patient and family to focus on what has been accomplished in life. Provide as much privacy as possible.	The patient and the patient's family focused on life accomplishments.
The patient will experience closure on matters of daily living.	Provide the opportunity to complete "unfinished business." Fulfill the patient's requests to see a member of the family, a lawyer, a member of the clergy, or a physician.	The patient and the family completed unfinished business.
The patient will be comfortable and participative until death occurs.	Evaluate the procedures and treatments that can be discontinued to make the patient more comfortable. Make provisions for someone to remain with the patient all the time if so desired by the patient.	Procedures and treatments were used for comfort only.

is the best job that they can do. Repeating it helps in releasing guilt, anger, and frustration.

During the Dying Process

- Recognize the one who is dying as the person who is usually the best teacher about what is right. The place of death is not as important as the care, trust, compassion, acceptance, and love that is provided and shared in the peri-death interactions.
- Determine the care needed. The family and significant others should consider the following questions and issues:
  - Will the dying person receive better care in a hospital, in a hospice, or at home?
  - What kind of medical treatment, technology, and equipment is needed?
  - What information is needed to make decisions about care choices (e.g., providing hydration, withholding nutrition)?
  - Can a hospice nurse or health care professional assist with treatments and medication?
  - Is a parish nurse or congregational nurse available for liaison with the congregation involved?
  - What expenses will be involved? What expenses will be covered by insurance? Is the patient eligible for state or federal disability payments, veteran's or Social Security benefits, or Medicaid or Medicare?
  - Who will assume the patient's care 24 hours a day? Who will provide respite care? Are there children at home who also need continuous care? Can the care of the dying person and the young children both be managed?
  - Will organs be donated?
- Explore the advantages and disadvantages of dying at home (or alternative sites). Advantages for staying in the home include the freedom of the patient and the family to do anything they wish because they can change or alter routines and schedules at will. In addition, staying in the home makes the continuous support of family, friends, and even pets available; allows meals to be prepared fresh and served with attention to details; eliminates the stress of traveling to and from the hospital or hospice; provides the unique beauty of familiar surroundings; makes quality time available to focus on inner work for the moment of death; and permits the patient and family to experience feelings and emotions in a different way because their closeness is subject to fewer interruptions. Finally, the patient and family can make most of the decisions regarding care, medication, and treatments and can ask advice from professionals when needed. Disadvantages to staying at home may include inadequate support for coping with care needs or competing needs for care by small children, older adults, and other sick or disabled family members. Sometimes inpatient hospice units help blend some of the advantages of care in the home with the additional support an individual may need that significant others cannot provide.
- Integrate therapies.
  - Does the dying person believe that medical and nonmedical modalities are complementary?
  - How motivated is he or she to try nonmedical resources (e.g., acupuncture, aromatherapy, touch therapies, music)?
  - What nonmedical resources are available?
  - Does the dying person really want to try different modalities, or is he

or she receiving so much advice about therapies that the response is passive rather than active?
  - —Is the dying person choosing to try therapies to please caregivers? A patient should feel free to choose not to include complementary therapies if they are not wanted.
- Incorporate the senses in rituals.
  - —***Touching.*** Lovingly, freely, and joyfully convey through your hands what your heart is feeling. Touching is a powerful way to break the illusion of separateness, loneliness, and fear; it may evoke laughter, calmness, or tears. Create times to give and get hugs. Hold a hand now and then.
  - —***Smelling.*** Use lotions and colognes with mild fragrances, remembering that illness will probably change the types of fragrances that can be tolerated. Use caution, as some odors cause nausea and unpleasant feelings. Try light, natural scents such as rosemary or vanilla, perhaps as a plant growing in the patient's room or a candle in the bathroom.
  - —***Tasting.*** Remember that taste varies with degrees of illness, but stays with us until the end of life. Tasting and eating have social and symbolic meanings to the patient and his or her family. Explain what will happen if the patient stops eating within the progression of terminal illness, noting that it may be normal and may not cause undue suffering. Provide tastes and foods that the patient desires.[22]
  - —***Seeing.*** Arrange in a pleasing manner healing objects and different touchstones that have special meaning and symbolize people, places, and events in the patient's life. A room that receives soft, subdued rays from the sun can bring balance to surroundings. Sitting out on the patio in good weather allows one to feel the sun as well as see the sunlight. Light colors usually are more soothing than dark colors.
  - —***Hearing.*** Remember that the sense of hearing is often sharp to the end of life, so special words at death can be heard. Be present in silence also, sitting or holding one another. Music can be nice, but should be used only at the patient's request.
- Try sitting quietly while practicing relaxation, meditation, or prayer. Gentle sounds from wind chimes or environmental recordings of ocean waves, wind, rain, birds, and music (e.g., harp, flute, stringed instruments) can offer a sense of peace. Music thanatology, referred to as sung prayer, uses the human voice when chanting or singing to bring balance to the dying, dissolving fears and lessening the burden, sorrows, and wounds.[23] Use words ending in *ing*, such as releasing, letting, floating, and softening, or words ending in *ness*, such as openness, beingness, awareness, and vastness, to help the patient to relax.
- Recognize the patient's going in and out of awareness. The moment of death itself has no pain, but is a reflex last breath. It opens up very special exchanges of intention, intimacy, and bonding where the patient may share the dying spaces. The patient's eyes can take on a staring, or glazing, appearance; a spaciness so different that the patient appears to be going to another realm of knowing, or to be focusing on something that the caregiver cannot see. The dying person can return with a smile and possibly share that he or she was in a space of peace.
- Learn about the changes that occur in the body during dying. Knowing what

body changes to expect as death approaches helps the family anticipate personal healing rituals and removes the fear, shock, and mystery from the moment of death.
- Understand and accept the body's shutting down. The conscious dying person knows that it is time to leave the physical body and can choose to shut down physical life. The caregiver and family journey with the dying person as far as possible and then tell the person it is all right to leave; this can evoke the purest, most special moments for all involved. For those patients who wish to experience every morsel of life, even if that morsel is physical agony, respect the choice. For them, it may be inappropriate to suggest that they may let go of this life. Tell them that you love them and will stay with them as long as they need you (or a significant other).

At the Moment of Death

- Prepare rituals for the moment of death. The dying person usually has serenity and inner calm, particularly if healing rituals have been carried out prior to death. Before the dying person's eyes close, tight brow muscles may become relaxed; the peace in the face or within the room is often palpable. Trust your inner wisdom for how to touch, hold, talk, and be with the dying one in ways that deepen hope and faith for a peaceful crossing into death and beyond.
- Surround yourself and the dying person with the peace and the light of love, taking the energy of love and light in with each breath; imagine and experience literally going inside the breath, flowing inside the breath with co-meditation (see the Specific Interventions section that follows) into the death of each moment.
- Continue to communicate with family caregivers and those there to support the dying patient. Talk to the dying loved one as restlessness or agitation moves to unresponsiveness; give gentle love squeezes, touches, and hugs; play favorite music; read poems, or say mantras and prayers. Shut the half-closed eyes, stroke and hug the physical body, and adjust the loved one's head on the pillow for the last time. Give permission for this special person to be free, to soar, to meet God and others who have died before, if this is appropriate. Say all you need to say, and share your own kind of blessings for the smooth transition.
- If appropriate, when the person has taken a last breath, carry out additional rituals that may be helpful to those present. Holding hands around the bed, saying a blessing or prayer, or anointing with healing oil, for example, may be planned ahead of time for this moment.
- Schedule a follow-up session/visit with family/significant others, if appropriate. If grief support groups are available, a referral may be helpful.
- Take care of yourself. Adequate rest, relaxation, exercise, and nutrition are always important; the person who cares for dying people needs to "go apart for a little while." Center, meditate, celebrate, or plan your own self-renewal time. There are retreat centers and sanctuaries for those who wish to use them. Simply sharing your experience with others, either verbally or in writing (e.g., journaling, writing poetry or narratives), is helpful. Be glad for the opportunity to share such a sacred moment with others, and use those special times for your own growth.

Specific Interventions

Planning an Ideal Death. To help patients and families experience peace in the dying process, it is important to engage them in

planning. To be of maximum assistance to someone else on the journey toward his or her own death, it is helpful for the nurse to explore this journey as well. The following reflective questions provide enormous insight about death myths, beliefs, problem solving, loving, and forgiving:

- What would an ideal death be like?
- When are you going to die?
- Where are you going to die?
- Who do you want to be with you, or do you want to be alone?
- What legal matters, relationships, or other personal business must be finished?
- What have been and what are the most precious events in your life?
- Who are the important people in your life?
- Have you told them why they are important?
- Are there family or friends who need to be told special things that you have never shared?
- Do you need to forgive or be forgiven?
- Have you written your obituary or your epitaph?
- Have you completed advanced directives, in writing, and shared them with those involved?
- Who do you want to care for your pets?
- What are your assets?
- What treasures do you wish to leave to specific family members or friends?
- What person/s have you appointed to be in charge of your medical decisions? Do they know what you want done?
- Have you planned rituals for your burial, or a funeral, memorial service, or cremation? Are they recorded and available to those who will perform them—family, religious institution, funeral home?
- If you are to be buried, what kind of coffin or container do you want your body to be buried in?
- Who will perform your burial ceremony?
- What kind of a ceremony do you want?
- Do you prefer a wake or another form of ceremony?
- What prayers, passages, poems, or music do you want to have used?
- Who will direct the ceremony? Or do you want a death day celebration for people to celebrate your life during or in place of a funeral, and to be celebrated in subsequent years?

Part of confronting death is deciding how to use medical care and technology. As part of their right to die, individuals can decide whether they want medical treatment; what kind of treatment; and under what circumstances to start, continue, or stop treatment. The American Medical Association has created a document called the medical directive,[24] a three-page form on which an individual can record his or her wishes for four different life situations: (1) mental incompetence, (2) terminal illness, (3) irreversible coma, or (4) persistent vegetative state. It also has a place for the appointment of someone to make medical decisions for the individual, should that become necessary, and a place for information about the individual's wishes regarding organ donation. Most hospital and hospice organizations have similar documents available.

Because states vary in the legislative details of such documents, it is necessary to call the office of the state attorney general or consult an attorney. Furthermore, because these wishes often reflect philosophic, personal, religious, and spiritual desires, individuals should discuss these matters with the family members and/or friends who will function on their behalf should the individual become incompetent. It is important for those who will be asked to make decisions to understand fully the nature of the request. Withholding of nutrition and fluids often is thought to be a cruel decision and a cause of suffering, yet history suggests that artificially feeding and hydrating a person who is clearly dying is an anomaly and reflects

society's denial of death. Some research has indicated that patients who stop taking food and fluids slowly sink into unconsciousness and coma over a period of five to eight days and die several days later.[25] Any discomfort that they experience, such as dry mouth, can be addressed with routine care. Those who make these kinds of decisions need to be fully informed, both about the patient's desires and about the effects of their wishes. Those who cannot do what the patient asks of them should have the choice of withdrawing from the decision-making role.

Learning Forgiveness. Forgiveness is important because it helps us get on with life. Many people are "stuck" in feeling guilt or assigning blame. Self-guilt leads to depression, and blaming others leads to anger. Both of these conditions steal energy and focus, reduce coping ability, and rob a person of precious time that could be used in establishing a positive relationship and attending to end-of-life goals. Borysenko described the steps for forgiving self and others as a parallel six-step process.[26] The six steps for forgiving ourselves are (1) taking responsibility for what we have done; (2) confessing the nature of the wrongs to ourselves, another human being, or God; (3) looking for the good points in ourselves; (4) being willing to make amends where possible, as long as we can do this without harm to ourselves or other people; (5) looking to God for help; and (6) inquiring about what we have learned. Likewise, the six steps for forgiving others are (1) recognizing that we are responsible for what we are holding on to; (2) confessing our story to ourselves, another person, and God; (3) looking for the good points in ourselves and the other person; (4) considering whether any specific action needs to be taken; (5) looking to God for help; and (6) reflecting on what we have done. Other writers echo these views.[27,28] These steps take time to complete. As the awareness of forgiving self and others is developed, we recognize unconditional love. Because it helps us connect more with our source of joy instead of focusing on loss, sadness, or pain, unconditional love helps release us from fear.

Becoming Peaceful: Relaxation and Imagery Scripts. To learn how to let go of attachments—of what is right and wrong, and of what is good and bad—requires commitment and practice. Nurses encourage patients to hear their inner voice of judging and to release the judging; to just listen and be ready for the next moment of listening, and to be in the present moment. Centering, meditation, and contemplative prayer are helpful in learning to listen to the inner soul. The skill of opening and releasing ordinary fears allows a person to emerge with awareness in the healing moment and to be more present when assisting another during death.

Patients who are dying and their caregivers can set aside 20 minutes or more several times a day to practice opening to the moment. It can be helpful to create a special relaxation and imagery tape as part of a personal ritual to practice releasing and letting go. The breathing, relaxation, imagery, and music scripts that follow are important experiential exercises to help self and others learn the letting-go experience of calming the mind and creating a sense of spaciousness within the body (see Chapters 21, 22, and 23). Recording one or several of these scripts, after a 5- to 10-minute relaxation exercise, allows the dying patient and his or her caregivers to use them repeatedly, even when professionals are not present. It is important to be sensitive about which scripts are likely to be useful for particular individuals. For example, a person who has suffered for many years from a respiratory disorder such as emphysema may not do well with a script focused primarily

on breathing. The following scripts are adapted from the work of Stephen Levine, and Anees and Katrina Sheikh.[29–31]

Script: *Introduction. (Name), as your mind becomes clearer and clearer, feel it becoming more and more alert. Somewhere deep inside of you, a brilliant light begins to glow. Sense this happening. The light grows brighter and more intense. Breathe into it. Energize it with your breath. The light is powerful and penetrating, and a beam begins to grow out from it. The beam shines from the core of your spirit.*

Script: *Letting Go. Notice the rhythm of the breath . . . becoming more aware of all the sensations that arise from the breath. Watching . . . noticing . . . feeling . . . as the breath begins to breathe you. As you become more aware of the breath, let your conscious awareness release the notion of breathing . . . becoming more and more aware as the breath arises in each moment. As interfering thoughts arise, let them float on . . . dissolving into awareness . . . quieting the constant chatter of the ego. . . .*

Script: *Opening the Heart. Relax into the moment of the awareness of the breath. . . . Let the rhythm of the breath just breathe you. Allow a fearful image to emerge in thought . . . noticing where it is in the body . . . letting the feelings of fear be in the body. In a way that seems right for you . . . let the fear move to the center of your chest . . . to the center of your heart. There is space within your heart to let the fear be . . . noticing the sensations of fear as they rest in the spaciousness of your heart center . . . opening and softening . . . opening and releasing denial . . . letting the fears become what they need to be . . . opening and accepting. Within the center of your heart . . . your love and compassion are present to let the fear(s) be present.*

Script: *Forgiving Self and Others. Relax into the moment of the awareness of the breath. . . . Let the breath just begin to breathe you. Allow yourself to let an image emerge of a person . . . alive or dead . . . who brings forth feelings of resentment. As that image is forming, . . . notice the spaciousness of your heart . . . and the openness of your heart center. Send the image of the person who causes you to feel resentment into your heart center. From the spaciousness of the center of your heart . . . hold the image of this person as you repeat, "I forgive you for anything you may have done in the past . . . in thoughts, words, or actions that may have caused you or me pain. I forgive you."*

As you do this, . . . notice any change in the feelings of resentment . . . opening and softening to the moment. If any feelings such as pain . . . tightness . . . or any other body sensation arise . . . just let them be . . . watching . . . noticing . . . all

changes . . . opening into the moment. Just continue to focus on the image of this person . . . speaking from your heart . . . releasing resentment . . . pain . . . forgiving yourself . . . forgiving others.

Script: *Releasing Grief and Pain. With one or both thumbs or the palms of your hands, locate the point just at the base of your sternum, and press into this area; feel the point of maximum pressure for you. Notice any sensations of tension, pain, or aches that result from sadness, grief, and loss. Continue to hold the thoughts, feelings of yourself, the loved one you have lost, or any other person or issues that cause you loss. If it seems right, as often as needed, return yourself to the power of the awareness of your own breath as it breathes you.*

Relax into the moment of the awareness of the breath. . . . Let the breath just begin to breathe you. Within your heart just now may be grief and pain . . . the feelings of loss . . . the heaviness of sadness. With your thumb(s) or palm(s) of your hand(s), . . . press into the area below your sternum. . . . Become aware of any sensations of pressure, pain, or any aches. Continue to hold the pressure. As you notice the pressure in this area, . . . breathe slowly into the sensations as they arise . . . emerging through the many levels of protection. Let yourself open into the pain . . . being with the feelings that come . . . not holding back . . . not pushing away . . . opening . . . softening. Observing and experiencing . . . allowing the pain . . . the fear . . . the sadness . . . the loss . . . just to be *. . . not evaluating. Continuing to hold the pressure . . . releasing control . . . become aware of the fear . . . all fears that come as you feel the fear of losing your loved one . . . all loved ones. And become aware of your fear of your own death . . . any pain, fear . . . anger . . . sadness.*

Let all your feelings now penetrate to the center of your heart . . . opening to the moment . . . receiving the love . . . the caring . . . the warmth . . . coming from the center of your heart. And now . . . let yourself release the physical pressure . . . continuing to receive the love and caring from your heart center.

While consciously living, it is possible to experience conscious dying. It is helpful to use a relaxation or imagery technique to become grounded before the exercise. After the exercise, this same technique can facilitate the return to full alertness and readiness to proceed with daily activities. These scripts are intended to be a rehearsal, not an actual shutting down and leaving of the physical body.

Learning to confront our own death helps us to be more present to assist others in facing their death. It reaffirms that we really need to do nothing but be present with another and speak with our hearts in dying time. The nurse may begin with an extended head-to-toe general relaxation or other breathing exercise (see the previous scripts). Because the experience of dying can be described as melting or dissolving away at the moment of death, the words dissolving and melting

are used in the script. To continue this script, the four elements of the body described by the ancients—earth, water, fire, and air—are used to represent decomposition as the body dissolves.

Script: *Conscious Dying. Relax into the moment of the awareness of the breath. Let the breath just continue to breathe you. As you focus on the breath, . . . begin to notice how the breath lets you move from heavy sensations in the body to the lighter . . . subtle body of awareness . . . all awareness on the breath . . . the breath in . . . and the breath out. . . . Let yourself be in the heavy body . . . and now all awareness on being in the light body. . . . The breath is all that there is . . . just breathing . . . let each thought dissolve into the breath . . . melting into the breath . . . awareness of the light body . . . and now letting the breath go . . . this is the final breath . . . let the breath in . . . and the breath out . . . dissolving . . . opening to death . . . and let yourself die.*

Script: *Earth. The body . . . solid . . . heavy . . . mass . . . compact . . . all changing as death comes . . . the vital body losing its form . . . weakening and dissolving . . . becoming thinner like the elements of earth . . . changing . . . dissolving . . . all parts dissolving . . . organs . . . extremities . . . muscles . . . all senses dissolving . . . fading away . . . melting away. . . .*

Script: *Water. All feelings becoming one . . . dissolving . . . all sensations dissolving . . . body fluids that flow through you . . . drying up . . . all body organs closing down . . . dissolving. . . .*

Script: *Fire. The fire of life within you . . . going out . . . all body warmth and heat leaving . . . all organs ceasing to function . . . your body becoming cooler and cooler . . . your sense of boundary is dissolving . . . all senses dissolving . . . breath is dissolving. . . .*

Script: *Air. Your body is without function. . . . The air is the element of consciousness . . . dissolving . . . all sensation . . . all feeling . . . all senses have gone . . . body boundaries are no more . . . light . . . melting . . . dissolving . . . no separate body . . . no separate mind . . . all separateness dissolving . . . all in the vastness of oneness. . . .*

Take a few slow, energizing breaths and, as you come back to this awareness, know that whatever is right for you at this point in time is unfolding just as it should and that you have done your best, regardless of the outcome.

Adapted from Levine's work, the following script is useful for someone who is preparing for the death moment or for a family member or friend whose loved one has just died.[32] It can be expanded as needed. The four elements part of the imagery script also can be used to assist one whose death is imminent.

Script: *Moving into the Light. Fill yourself with an awareness of brilliance of clear light . . . a pure light within you and surrounding you . . . go forward . . .*

releasing anything that keeps you separate . . . pushing away nothing . . . spaciousness . . . releasing . . . dissolving . . . all body . . . dissolving into consciousness itself. . . . Let go of all distractions. . . . Listen and be with the transition . . . what is called death has arrived. . . . You are not alone . . . many have gone before you . . . let yourself go . . . into the clear light.

The dying person may move in and out of sleep or comatose states after this script or the conscious dying script. The nurse or family member sits with the person as long as necessary to bring closure to this time. If the person lingers a while longer, the nurse or family member may close with the following phrases.

Script: *Closure. Take a few slow, energizing breaths and, as you come back to this awareness, know that whatever is right for you at this point in time is unfolding just as it should, and that you have done your best, regardless of the outcome.*

The Pain Process. In 90 to 99 percent of cases, pain can be managed. Pain medication response patterns should be evaluated at least every 72 hours, as well as after each administration. When giving the medication, the nurse reminds the patient that the pain medication is in the body and working. Nurses should understand and use the most current pain management strategies and treatments. These include new medications, methods of administration, physical treatments (e.g., massage, ice, movement), combinations of treatments, documentation, and evaluation techniques. The administration of medication should precede activity (e.g., positioning).

Although the physical body can experience pain, the mind's fear of the pain often is more intense. Acute pain has qualities of suddenness and surprise that can evoke anxiety and fear. The best thing to do with this suddenness is to encourage the dying person to breathe rhythmically and soften into the pain to decrease the resistance to the experience. Relaxation, imagery, or acupressure can be combined with pain medication. Even the worst of pain can be shifted in many ways. For example, shifting the pain experience by calling it sensations rather than pain often reduces discomfort. It also helps to encourage the person to make decisions over that which he or she has control, such as decisions about medications, treatments, and daily routines.

When guiding the person in pain, the nurse can suggest allowing pain images and the different felt experiences to emerge. Each person enters pain in a way that opens in the moment, and each person will know how far to go in exploring the pain. Common expressions an individual might have about the pain (e.g., "pain attacks," "it has a grip on me and takes my breath away," "it has a loud and deafening pulsation," "it is violent and unrelenting") create negative images that may interfere with the emergence of healing images. These negative images might become positive if the person focuses on the grip of pain being released, a deep belly breath coming forth evenly and effortlessly, or the pulsating sound becoming like the falling of gentle raindrops or falling snowflakes. Different relaxation and imagery exercises help the person practice letting go of the perception of the physical body. This letting go helps ease both physical pain, like difficult procedures, and emotional pain, like conflicts, and allows the person to experience death with peace and dignity.

With continued gentle exploration of opening and releasing into the pain, the person may begin to experience the pain

as floating and diminishing. This is also a way of expanding one's sense of time. Another suggestion is to have the patient step aside in the mind and watch the pain to see how it might be changed to release some of the pressure, resistance, and holding on to the pain. Such guidance and presence over time will help the person to stay with a focused attention, opening, softening, and expanding into the pain.

Blending Breaths and Co-Meditation. The simple release of the breath and the *ah-h-h-h* sound is an ancient ritual for dying into peace. The practice of sharing the breath with another is called co-meditation or cross-breathing.[33] Co-meditation is based on the principle that respiration evokes a particular state of mind and serves as a direct link to the nervous system. There is a direct correlation between breathing and thinking. At first, the *ah-h-h-h* sounds may be like an echoing of words, but staying with the sounds allows the release of tension, fears, and pain.

Following are the steps for co-meditation:

- Position yourself comfortably close to the patient. A session may last 20 to 30 minutes or longer. Obtain whatever is necessary to make you and the person comfortable, such as pillows or a light blanket.
- Suggest to the person that watching the breath is an ancient method of calming the body and the mind. Let the person first begin noticing the rise and fall of his or her abdomen with each breath in and each breath out.
- Sitting at the person's midsection, focus on the rise and fall of the abdomen with each inhalation and each exhalation. Focus your attention on the person's lower chest area, and observe closely for the natural flow of the exhalation from the person. With this focused attention, you can begin breathing in unison with the person. At the beginning of the exhalation, begin softly and out loud to make the sound *ah-h-h-h*, matching the respiration of the person.
- Occasionally, say simple, powerful phrases, such as "peaceful heart" or "releasing into the breath." The fewer words spoken, however, the more powerful the breath work. If the person should fall asleep, you may wish to sit with the person for a while or sit until he or she awakes.

Mantras and Prayers. A mantra is the repetition of a word or sound, either aloud or silently. The word can be given by another or discovered. It has meaning to the individual. Repetition moves one toward peace.

A prayer may be special phrases or repeated words, or it may be a unique and spontaneous communication with God. There is considerable evidence for the effectiveness of at least two forms of prayer: the directed and the nondirected.[34,35,36] In direct prayer, the individual has a specific goal or outcome in mind. In nondirected form, the individual takes an open-ended, nonspecific, non–goal-oriented approach. In one form of contemplative prayer, Lectio Divina, one listens for the word of the Divine following a meditative focus on a few words of scripture.[37] In centering prayer, individuals seek "an original place, deep inside themselves, where they live in rich harmony with other people and with God . . . the place of wisdom, of not-wanting and yet having."[38] Every faith group has prayers of the faithful that provide comfort and joy in the last moments.

Saying mantras and prayers can decrease the number of lonely hours at home, as well as in the hospital, although this is not the main reason for the practice. They serve as an affirmation of a deeper faith. In asking the dying person about wishes for prayers or repeated phrases, we should encourage him or her to select phrases that are short, easy to

remember, and rhythmic. The personal selection of focus words enhances the faith factor. It can be helpful to pray for the highest good for the dying one or ourselves rather than for what we want. If we are praying for another, we need to hold the person for whom we are praying in our conscious thought, not ourselves. If we are totally focused on the patient, we cause ourselves less grief, frustration, and fear, recognizing that we are not responsible for outcomes. The nurse and the patient should agree on what to pray for before the prayer begins, and the nurse must be sensitive to the individual's formal system of belief.

Reminiscing and Life Review. A process basic to human existence is reminiscing and recounting past events, either alone or with friends. We spend much of our time talking, thinking, or writing about plans, goals, resources, successes, disappointments, and failures. This is especially true when facing death. Life review is a more formal process that involves reviewing present and past experiences. A life review experiencing form (Exhibit 26–2) is

Exhibit 26–2 Haight's Life Review and Experiencing Form

Childhood:

1. What is the very first thing you can remember in your life? Go as far back as you can.
2. What other things can you remember about when you were very young?
3. What was life like for you as a child?
4. What were your parents like? What were their weaknesses, strengths?
5. Did you have any brothers or sisters? Tell me what each was like.
6. Did someone close to you die when you were growing up?
7. Did someone important to you go away?
8. Do you ever remember being very sick?
9. Do you remember having an accident?
10. Do you remember being in a very dangerous situation?
11. Was there anything that was important to you that was lost or destroyed?
12. Was church a large part of your life?
13. Did you enjoy being a boy/girl?

Adolescence:

1. When you think about yourself and your life as a teenager, what is the first thing you can remember about that time?
2. What other things stand out in your memory about being a teenager?
3. Who were the important people for you? Tell me about them. Parents, brothers, sisters, friends, teachers, those you were especially close to, those you admired, those you wanted to be like.
4. Did you attend church and youth groups?
5. Did you go to school? What was the meaning for you?
6. Did you work during these years?
7. Tell me of any hardships you experienced at this time.
8. Do you remember feeling that there wasn't enough food or necessities of life as a child or adolescent?
9. Do you remember feeling left alone, abandoned, not having enough love or care as a child or adolescent?
10. What were the pleasant things about your adolescence?
11. What was the most unpleasant thing about your adolescence?
12. All things considered, would you say you were happy or unhappy as a teenager?
13. Do you remember your first attraction to another person?
14. How did you feel about sexual activities and your own sexual identity?

continues

Exhibit 26–2 continued

Family and Home:

1. How did your parents get along?
2. How did other people in your home get along?
3. What was the atmosphere in your home?
4. Were you punished as a child? For what? Who did the punishing? Who was "boss"?
5. When you wanted something from your parents, how did you go about getting it?
6. What kind of person did your parents like the most? The least?
7. Who were you closest to in your family?
8. Who in your family were you most like? In what way?

Adulthood:

1. What place did religion play in your life?
2. Now I'd like to talk to you about your life as an adult, starting when you were in your twenties and up to today. Tell me of the most important events that happened in your adulthood.
3. What was life like for you in your twenties and thirties?
4. What kind of person were you? What did you enjoy?
5. Tell me about your work. Did you enjoy your work? Did you earn an adequate living? Did you work hard during those years? Were you appreciated?
6. Did you form significant relationships with other people?
7. Did you marry?
   (yes) What kind of person was your spouse?
   (no) Why not?
8. Do you think marriages get better or worse over time? Were you married more than once?
9. On the whole, would you say you had a happy or unhappy marriage?
10. Was sexual intimacy important to you?
11. What were some of the main difficulties you encountered during your adult years?
    a. Did someone close to you die? Go away?
    b. Were you ever sick? Have an accident?
    c. Did you move often? Change jobs?
    d. Did you ever feel alone? Abandoned?
    e. Did you ever feel need?

Summary:

1. On the whole, what kind of life do you think you've had?
2. If everything were to be the same would you like to live your life over again?
3. If you were going to live your life over again, what would you change? Leave unchanged?
4. We've been talking about your life for quite some time now. Let's discuss your overall feelings and ideas about your life. What would you say the main satisfactions in your life have been? Try for three. Why were they satisfying?
5. Everyone has had disappointments. What have been the main disappointments in your life?
6. What was the hardest thing you had to face in your life? Please describe it.
7. What was the happiest period of your life? What about it made it the happiest period? Why is your life less happy now?
8. What was the unhappiest period of your life? Why is your life more happy now?
9. What was the proudest moment in your life?
10. If you could stay the same age all your life, what age would you choose? Why?
11. How do you think you've made out in life? Better or worse than what you hoped for?
12. Let's talk a little about you as you are now. What are the best things about the age you are now?
13. What are the worse things about being the age you are now?
14. What are the most important things to you in your life today?
15. What do you hope will happen to you as you grow older?
16. What do you fear will happen to you as you grow older?
17. Have you enjoyed participating in this review of your life?

NOTE: Derived from new questions and two unpublished dissertations:

Gorney, J. (1968). *Experiencing and Age: Patterns of Reminiscence Among the Elderly*. (Unpublished Doctoral Dissertation, University of Chicago).

Falk, J. (1969). *The Organization of Remembered Life Experience of Older People: Its Relation to Anticipated Stress, to Subsequent Adaptation and to Age.* (Unpublished Doctoral Dissertation, University of Chicago).

Source: © 1982 Barbara K. Haight, RNC, Dr.PH.

useful in ordering questions related to each stage of life from earliest memories to old age. To conduct a life review, it is best to plan six to eight sessions. Each session requires approximately 45 minutes. During each session, the patient tells the story of a particular phase of life. Open-ended questions are preferable, and it may be helpful to record the session. The first session is primarily an introduction. The last session is the most important, as it is a summary or discussion of the meanings of the story. The patient may feel emotions of all kinds during any session, reflecting the emotions that he or she felt during the stage of life being discussed. It is the acknowledgment of emotional content, in part, that facilitates integration. In the summary, or perhaps earlier, an individual usually begins to feel a sense of integration with the past and present, a kind of wholeness to life. Unfinished business becomes finished. This is helpful in achieving peace.[39,40] Levine used a meditative approach to the life review, reviewing the life story to honor and heal the past.[39]

Death Bed Ritual (Basic). At the moment of death and immediately after, it can be helpful to implement a planned ritual. If anointing has not already been done, it can be done at this time. Family, special friends, care staff, and clergy may choose to hold hands, surround the bed of the deceased, and share a moment of silence, a prayer, a song, or hugs. They may choose to touch the body, prepare the body according to rituals within the faith community involved, and say good-bye. It is important to allow as much time as needed.

Leavetaking Rituals (Basic). A nurse who works with survivors must remember that their grief period is unique for them. Furthermore, grief has no timetable. Healing grief requires a commitment to imagine a fulfilling life without a loved one. Action steps toward continued self-discovery after the death of a loved one may include dreamwork, meditation, movement, drawing, journal keeping, crying, sighing, drumming, chanting, singing, and music, as well as the following rituals.[41]

- ***Celebrating Holidays.*** Special holidays, birthdays, anniversaries, and other important dates can be a time for creating rituals to ease the pain of loss and acknowledge feelings. For example, a widow fixed a place at the Christmas dinner table for her deceased husband. She and her six children gave him a farewell toast and shared special memories of him before they ate. A young couple who had a stillborn child asked several of the nurses and the attending physician to a memorial service in the hospital chapel before the baby was taken to the funeral home. After her mother died, a woman chose to have her healing team of eight friends with her at a memorial service by the sea. The family of a teenaged girl who died in an automobile accident had a gathering for her class and gave each person an opportunity to say special things about the girl. Her favorite music was played while dancing and singing began in her honor.
- ***Rearranging and Giving Away.*** If a loved one has died at home, the family member who shared the bedroom must decide what is best to do. Some wish to rearrange the room and remove hospital beds and other equipment quickly after death. Giving away a loved one's possessions, such as special mementos of jewelry, clothes, shoes, makeup, shaving equipment, and other personal possessions, is healing. Others might need a shrine or memorial for a period of time that includes some of the loved one's possessions.
- ***Letting Grief Be Present.*** There are periods after the death of a loved one when a person appears brave, in con-

trol, or strong to others. Grief will come, though. It is important to share with the grieving person that there is no special way to grieve. When pain, fear, and anger dissipate, the body-mind-spirit knows the best way to grieve. Grieving allows love to heal the loss one feels for self and for the person who has died.

- ***Sustaining Faith and Hope.*** There are many ways to sustain faith and awareness toward life, meaning, and purpose while grieving. For example, survivors sometimes have a sense of talking to deceased loved ones, being enveloped in their love, and feeling their presence. People have described experiences such as having a faith in oneness, feeling an energy, vaguely sensing the presence of the deceased person, hearing the voice of the deceased giving guidance, or working on the same problem at different energy levels. One woman said, "My [deceased] husband told me how to finish this business deal." Another woman created a healing ritual after the death of her husband. When the weather permitted, she would get in her truck in the evening and drive to her husband's favorite hill on their big Texas ranch. As she looked out over the prairie and gazed into the Milky Way, she would choose a bright star and carry on a dialogue with the star, experiencing a sense of unity with her deceased husband somewhere in infinity. This provided her with calmness, wisdom, and clarity of thought.
- ***Releasing Anger and Tears.*** The release of anger, sadness, and tears is a cleansing process of the human spirit that makes a person more open to experience living in the moment. Holding in grief increases suffering, fear, and separation.
- ***Healing Memories.*** It is not necessary to stop thinking about the person who has died. Often, a grieving person who feels that the grief process is over finds that a memory, a song, or a meal suddenly evokes a sense of loss so deep that it seems as though it will never heal. The person needs to stay with the pain, sadness, guilt, anger, fear, or loneliness. Love and joy will begin to fill the heart again. The wisdom is to let pain in and to stay open to it, to let the pain penetrate every cell in your body, to trust pain, to know that what emerges from the pain is a new level of healing awareness.
- ***Getting Unstuck.*** Grieving can bring on suffering; therefore, it may be helpful for survivors to ask for assistance from friends, family, or a health care professional to help them move past the blocks. Some people think, "It's been six months since my mother died [or a year since my husband, son, or wife died], why am I still depressed and why do I still cry so frequently?"

Case Studies

Case Study No. 1

Setting:	Critical care unit where visiting schedule was one visitor every two hours.
Patient:	S.R., a 30-year-old mother of three children
Patterns/ Challenges/ Needs:	1. Decreased cardiac output related to end-stage heart failure 2. Grieving related to imminent death 3. Spiritual strength related to dynamic belief systems and family/friend support

S.R. said to the nurse, "I feel death over my right shoulder. Call my husband. I need him to come and bring my children, my parents, and my three friends. Tell them to come as soon as possible." The nurse also felt an inner sense of the presence of death and began calling S.R.'s family.

Four hours before her death, all her family was present. Her friends sang her favorite songs as one played a guitar.

Case Study No. 2

Setting:	Writing thoughts about healthy grief in a letter, four years after son's death
Client:	V.D.J., a 45-year-old professional and mother
Patterns/ Challenges/ Needs:	Spiritual strength related to ability to deliberate the meaning of life, death, grief, and suffering

There is a holy purpose in grief and nothing should stand in its path. Grief begins with so few words. Sounds take shape traveling from a great distance. Within, a reserve is sensed. Something sacred that holds a luminous darkness which stills the mind even as the heart shudders with waves of deep sorrow. The natural quality of grief is ancient and bone bare. It tolerates nothing false. Grief is unrestrained; conscious effort is not required.

A mother who has lost a child learns what true freedom is. It is being cut free from the knot of habit, customs, rules. It is not being bound by considerations or even fear, for the worst has happened. Your child is dead, and you live. A mother's lament begins.

Your heartbeat creates a tone for your body to hear. It drums and moves you slowly forward with your family even as you weep and prepare to say your last goodbye. Now is not the time to be a bystander. It is crucial that you support and include your other children and family in the vigil, the wake, the funeral and burial or cremation ceremonies. They, too, are in shock and disbelief. And it doesn't end there.

Let nothing be left undone, unsaid, unwritten or unsung in this farewell. This is not the place to lose courage or even your humor, for you will need both to sustain the intense suffering you have yet to bear. Nature provides the exact dosage for dealing with the constant strikes of pain experienced. Usually there is no real need for outside medication. Your body in its perfect wisdom gauges your requirements and numbs you accordingly. You will feel cold, but your mind/body will not allow more pain than you can tolerate. To disrupt the natural safeguards may only postpone the initial pain in your mourning process.

During the vigil and the wake your only thought is to do everything you can do to console your children and other family members. You realize they have the same concern for you. Plan the funeral ceremonies together. In the process, some small consolation may be experienced. The Path of Grief leads inward when you watch and listen. Didn't you bring this spirit child into the world, flesh of your flesh? This last goodbye may enable you to complete the circle; keeping a vigil through the night allows you to be closer to your child.

The vigil with your child provides a place to begin to say goodbye, the goodbye you were both denied, by sudden, unexpected death. You hear yourself talking and reassuring your son. You must now help your child to take the first steps into the Great Mystery, by talking aloud and guiding, much as you did when he was very young. Empty your mind and your heart, and give him all your love and spiritual strength for his journey.

The week following the funeral I moved everything from my bedroom

except basic essentials. I felt driven to sleep on a mat and to make a low altar which I filled with family photographs, mementos, and childhood treasures belonging to Sean and my children, family poetry, drawings, vigil candles, prayer fans, fresh flowers and ceremonial sage.

Prayers became conversations and chants and death songs for the son who had no time to create them for himself. Forty-nine days of talking-prayer asking the angelic beings to guide my son on his journey. Each member of the immediate family scattered Sean's ashes in places special to him. A spirit bundle was placed and kept before the altar for him. Always the moving between worlds; letting go of the loneliness through weeping, sound and moving prayer to returning to repose, listening, and sitting. A year goes by.

You find it difficult to speak. Your breathing habits are changing. You become aware of differences in your breath. You sense your heart breathing, your brain breathing. You notice that when you breathe out, you see thought. Some days you don't remember breathing at all.

You keep a journal as an on-going discussion with your child, seeking solace. You somehow deal with daily life, guilt, illness, helplessness, and the grief of your other children.

Four more years go by; four years of dreams, voices and mourning. I begin to understand the innate usefulness of creative work and humor as an antidote to loneliness and pain. My children need me and continually pull me onto the more solid ground where they stand. Dream walks, drumming, chanting, and round dancing lead me to my tribal traditions. My children personify the creative weaving of compassion, intelligence and courage and remind me of how precious each individual life is and the miracle of being together with Sean and with each other in this life and in this time and in this place.

My son Sean has taught me that the true object of death is life. I have learned that a dream can be shaped by the dreamer; that in the act of sacrifice, the sacred is manifested through surrender of all that is.[42]

Case Study No. 3

Setting:	Bedroom at home of daughter (M.L.) who recently brought her ill mother (L.Y.) home to care for her
Patient:	L.Y., a 90-year-old mother of two middle-aged adults and grandmother of two, who has been ill for four months. She had lived alone for the last 40 years
Patterns/ Challenges/ Needs:	1. Moderate pain related to diagnosis of cancer 2. Decreased cardiac output (including altered oxygenation) related to multisystem organ shutdown 3. Family grieving related to imminent death 4. Spiritual well-being and effective individual coping related to patient desire to care for her grieving family

M.L. checked with her mother to see that she was not in pain or distress prior to going out of the house on a short errand. L.Y. told her daughter to go, adding that she was quite comfortable and would be fine. M.L. noticed her mother's skin was mottled and cool, but her breathing was unlabored and she seemed peaceful. Her husband remained in the home. When M.L. returned, she found that her mother had stopped breathing. The bedclothes were unruffled, and her mother's face was peaceful. Her husband had heard nothing

to indicate when the passing occurred. M.L. called the hospice nurse, the nun who was her neighbor and belonged to the same church, and other family members, and they carried out the ritual that they had planned for this moment. They held hands around the bed, prayed together in the ways of their tradition, and played a hymn that had been taped. After this, they informed the doctor, called the funeral director, and took care of legal obligations. A woman who had lived alone for 40 years had chosen to die alone, but cared for, to the end. The family grieving needs were also addressed.

Evaluation

With the patient (family/significant others), the nurse evaluates whether the patient outcomes for planning and implementing a peaceful death (see Exhibit 26–1) were successfully achieved. To evaluate the interventions further, the nurse may explore the subjective effects of the experience with the patient (family/significant others), using questions such as those in Exhibit 26–3.

Like peaceful living and dying, the care of a dying person and the family/significant others is an art. Preparing for death can be a series of conscious, spirit-filled, and light-filled moments that lead to the ultimate peaceful moment of death. It is different for each person. True healing and dying in peace come from integrating the creative process and the art of healing into our daily lives. The paradox is that, although this healing awareness may appear at first to be rare, it is a very ordinary and natural event that is available to each of us at all times. As each of us seeks to understand and integrate our spirit-filled lives as meaningful and connected with others throughout the ages, we learn about life and death. The more we integrate solitude, inward-focused practice, and conscious awareness into daily life, the more peaceful dying and the moment of death will be.

Exhibit 26–3 Evaluating the Patient's (Family's/Significant Other's) Subjective Experience with Dying Interventions

1. Can you continue to be aware of ways to recognize your anxiety, fear, and grief at this time?
2. Which of your strengths can best serve you as you move through this difficult time?
3. What are the things that you will do to take care of yourself at this time?
4. Do you have any questions that I can help you with just now?
5. Will you call on others to help you?
6. Whom can you ask for help?
7. Were the imagery exercises helpful for you? Do you pray?
8. Are there images, feelings, or emotions that surfaced during the imagery exercises that I can help you with?
9. Can I help you with anything just now?
10. Are there rituals that you can begin to create to help you deal with your grief?

Note: These subjective experiences may be used in helping a patient/family/significant others during the dying process or with the family/significant others during the grieving process.

DIRECTIONS FOR FUTURE RESEARCH

1. Evaluate the attitudes and stress levels of nurses who work with death; compare the stress levels in nurses who routinely use self-regulation nursing interventions with the levels in nurses who do not use self-regulation interventions.
2. Determine the effects of using scripts to let go on the patient's physiologic responses, nearing death awareness, and peaceful dying.

3. Evaluate the use of life review in assisting patients with a sense of integration of life.
4. Determine the special needs of nurses who are working with, or have worked with, a friend or relative who is dying, and who may have had special experiences while dying, such as near death experiences.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- Do I feel a greater sense of healing intention when I include relaxation, imagery, or music in my daily life?
- What are the effects on me when I guide others in healing modalities to facilitate peace in dying?
- How do I know that I am actively listening?
- What new death mythologies and skills can assist me in releasing attachment to my physical body, my possessions, and the people in my life?

NOTES

1. M.L. Matzo, Peri-death Nursing Care, in *Palliative Nursing: Quality Care at the End of Life*, eds. M.L. Matzo and D.W. Sherman, (New York: Springer Publishing Co., 2001).
2. P. Reed, Self-Transcendence and Mental Health in Oldest-Old Adults, *Nursing Research* 40, no. 1 (1991):5–11.
3. R. McCorkle et al., The Effects of Home Nursing Care for Patients during Terminal Illness on the Bereaved's Psychological Distress, *Nursing Research* 47, no. 1 (1998):2–10.
4. B. Davies, Supporting Families in Palliative Care, in *Textbook of Palliative Care Nursing*, eds. B.F. Ferrell and N. Coyle, (New York: Oxford University Press, 2001).
5. C.M. Ruland, Theory Construction Based on Standards of Care: A Proposed Theory of the Peaceful End of Life, *Nursing Outlook* 46, no. 4 (1998):169–175.
6. D. Feinstein and P.E. Mayo, *Rituals for Living and Dying* (San Francisco: HarperSanFrancisco, 1990).
7. G.G. Fersz et al., Transformation through Grieving: Art and the Bereaved, *Holistic Nursing Practice* 13, no. 1 (1998):68–75.
8. M. Ersek, The Meaning of Hope in the Dying, in *Textbook of Palliative Care Nursing*, eds. B.F. Ferrell and N. Coyle, (New York: Oxford University Press, 2001).
9. A. Stepnick and T. Perry, Preventing Spiritual Distress in the Dying Client, *Journal of Psychosocial Nursing and Mental Health Services* 30, no. 1 (1992):17–24.
10. E. Kubler-Ross, *On Death and Dying* (New York: Macmillan, 1969).
11. V. Frankl, *Man's Search for Meaning*, 3rd ed. (New York: Simon & Schuster, 1963).
12. Reed, Self-Transcendence and Mental Health in Oldest-Old Adults.
13. D. Coward, Self-Transcendence and Emotional Well-Being in Women with Advanced Breast Cancer, *Oncology Nursing Forum* 18, no. 5 (1991):857–863.
14. B. Haight, Psychological Illness in Aging, in *Perspectives on Gerontological Nursing*, ed. E.M. Baines (Newbury Park, CA: Sage Publications, 1991), 292–322.
15. Haight, Psychological Illness in Aging.
16. L. Dossey, *Meaning and Medicine* (New York: Bantam Books, 1991).
17. Feinstein and Mayo, *Rituals for Living and Dying*.
18. G. Luce, *Your Second Life: The SAGE Experience* (New York: Delacorte Press, 1979).
19. M. Callanan and P. Kelly, *Final Gifts: Understanding the Special Awareness, Needs, and*

Communication of the Dying (New York: Bantam Books, 1993).

20. ELNEC (End-of-Life Consortium), *Graduate Curriculum: Faculty Guide* (City of Hope & American Association of Colleges of Nursing, 2003).
21. J.M. Hoefler, *Managing Death: The First Guide for Patients, Family Members, and Care Providers on Forgoing Treatment at the End of Life* (Boulder, CO: Westview Press, 1997).
22. E.E. Bral, Caring for Adults with Chronic Cancer Pain, *American Journal of Nursing* 98, no. 4 (1998):26–32.
23. M. Good, B.L. Picot, S.G. Salem, C. Chin, S.F. Picot, and D. Lane, Cultural Differences in Music Chosen for Pain Relief, *Journal of Holistic Nursing,* 18 (2003):3.
24. L.L. Emanuel and E.J. Emanuel, The Medical Directive: A New Comprehensive Advance Care Document, *Journal of the American Medical Association* 261 (1989):3288–3293.
25. Hoefler, *Managing Death*.
26. J. Borysenko, *Guilt is the Teacher, Love is the Lesson* (New York: Warner Books, 1990).
27. S. Dowrick, *Forgiveness and Other Acts of Love* (Ringwood, Victoria, Australia: Viking Books, 1997).
28. J. Kornfield, *The Art of Forgiveness, Lovingkindness and Peace* (London: Random House, 2002).
29. S. Levine, *A Gradual Awakening* (New York: Anchor Press, 1979).
30. S. Levine, *Healing into Life and Death* (New York: Doubleday, 1989).
31. A. Sheikh and K. Sheikh, *Death Imagery* (Milwaukee, WI: American Imagery Institute, 1991).
32. S. Levine, *Who Dies?* (New York: Anchor Press, 1982).
33. R. Boerstler, *Letting Go* (Watertown, MA: Associates in Thanatology, 1982).
34. L. Dossey, *Healing Words: The Power of Prayer and the Practice of Medicine* (San Francisco: HarperSanFrancisco, 1993).
35. L. Dossey, *Recovering the Soul* (New York: Bantam Books, 1989).
36. H. Koenig, M.E. McCullough, and D.B. Larson, *Handbook of Religion and Health* (New York: Oxford University Press, 2001).
37. M. Casey, *Sacred Reading: The Ancient Art of Lectio Divina* (Liguori, MO: Liguori Publications, 1995).
38. G. Black and B.K. Haight, Integrality as a Holistic Framework for the Life-Review Process, *Holistic Nursing Practice* 7, no. 1 (1992):7–15.
39. M. Olson, *Healing the Dying* (Albany, NY: Delmar Publishers, 1997).
40. S. Levine, *A Year To Live: How To Live This Year As If It Were Your Last* (New York: Bell Tower, 1997), 75.
41. J. Achterberg et al., *Rituals of Healing* (New York: Bantam Books, 1994).
42. V. Durling Jones, personal communication, 1991.

RESOURCES

Compassionate Care of the Dying Training Program

Upaya Zen Center, Santa Fe, New Mexico

This eight-day intensive training program is for health care professionals, the clergy, and individuals who wish to engage in compassionate care of the dying. It emphasizes mindfulness and the awareness of death as the ground for the experience of dying, and, ultimately, of living and caring for life. The training covers many important areas that includes the following: contemplative, spiritual, and psychological issues related to dying and death; community-building around dying persons; cross-cultural and family concerns around religion and ethnicity; spiritual care of the dying; exploration of pain and suffering; and, self-care of the caregiver. The following manual and standards is used in this training:

J. Halifax and B.M. Dossey. *Compassionate Care of the Dying: Manual and Standards for Practice* (Santa Fe, NM: Upaya Zen Center, 2004).

For information on the training, manual and standards, and related activities, contact:

Upaya Zen Center, 1404 Cerro Gordo, Santa Fe, New Mexico 87501

Phone 505.986.8518; Fax 505.986.8528

E-mail: upaya@upaya.org

Web page: www. upaya.org and www. peacemaker-community.org

Nourishing Wisdom

Our hurried meals often reflect our hurried lives. Explore for a few minutes how we can experience food as nourishing wisdom. David referred to this awareness as principles of ordered eating.[1]

When we eat with conscious awareness, the true meaning of the nourishing wisdom of food deepens. It is an awareness of the food (e.g., its color, texture, aroma), the process of eating (e.g., chewing, swallowing, feeling food in our stomach), and all aspects of the atmosphere and environment (e.g., temperature of the room, the colors and shapes within the room, the table setting).

If we are sharing a meal with others, we are aware of the company and enjoyment of these people. We recognize that the presence of others can be nourishing to us, as well as to them. If we are eating alone, this awareness may provide an intimate experience of being alone, calm, relaxed, and present with each morsel of food. If we smile while we eat, we may experience more joyfulness in the moment of eating. As we reflect on the way that food feels within us and how it satisfies us, we deepen the experience of the art and ritual of eating.

We acknowledge our connection with the food by recognizing the origin of the food (e.g., the earth, animals, plants, trees) and being thankful for the sun, rain, water, and soil; for the farmers who cultivate the growing, flowering, and harvesting of the food; and for the packaging and delivery of the foods to the store or marketplace. Our awareness of being connected to the food source also can help us to eat in moderation and to eat balanced, healthy foods. This wisdom encourages us to choose from a variety of foods grown locally and to receive the benefit and nourishment of seasonal foods. Then, as we prepare the food, adding our own personalized touch with herbs and spices, we experience the joy of composing a meal of different foods, tastes, and textures that we believe to be right for us—not what another imposes on us as a correct combination of foods.

Nourishing wisdom of food also helps us to increase our awareness of the synergy of the food by combining food with exercise, rest and sleep cycles, relaxed breathing, and other healing rhythms.

The more we are aware of body-mind-spirit connections while choosing, preparing, and eating foods, the greater our potential for inner satisfaction and personal unfolding in relationship to food.

NOTE

1. M. David, *Nourishing Wisdom: A New Understanding of Eating* (New York: Bell Tower, 1991), 170–173.

Chapter 27

Weight Management Counseling

Sue Popkess-Vawter

NURSE HEALER OBJECTIVES

Theoretical

- Discuss the strengths and weakness of biological, behavioral, psychological, and cognitive theories of weight management.
- Describe and explain the theoretical framework for cognitive restructuring based on reversal theory.

Clinical

- Describe three differences between unidimensional and multidimensional interventions for long-term weight management.
- Discuss and adapt the basic principles of the holistic self-care model for long-term weight management to clients in your nursing practice.
- List one positive self-talk statement to replace the three negative self-talk statements most frequently used by your clients; identify in which of the eight metamotivational states these statements originated.

Personal

- Discuss how you base your eating habits on the food pyramid and the American Diabetic Association diet using the EAT for Hunger strategy.
- Describe your personal aerobic and strength exercise program using the Exercise for LIFE strategy.
- Describe how you nourish your self-esteem through spiritual connections each day.

DEFINITIONS

Body Mass Index (BMI): weight [kg]/height squared [m^2] with healthy weight ≤ 24.9.

Obesity: body mass index ≥ 30.

Overeating: eating when not hungry or eating more than is required to satisfy hunger.

Overfat: percentage of body fat greater than recommended for a client's gender and age (e.g., 28 percent for women and 20 percent for men).

Overweight: body mass index ranging from 25 to 29.9.

Self-Talk: mental verbalizations that elicit emotional responses.

Weight Cycling/Yo–Yo Dieting: repeated weight loss greater than 10 pounds followed by weight gain three or more times over the past 2 years.

Weight Management: holistic, long-term lifestyle adjustments in clients' bio-psycho-social-spiritual dimensions to promote a high level of individual wellness; caring for and assisting clients to reach sufficient self-acceptance, self-love, and self-responsibility to adjust

their lifestyles to support eating for hunger, exercising regularly, and esteem for self and others.

THEORY AND RESEARCH

The Weight Gain Epidemic in the United States

Almost two-thirds of adult Americans and 15% of their children are overweight or obese today.[1] In 1995, costs related to obesity were $99 billion and escalated to $117 billion in 2000.[2] During the Great Depression and through World War II, however, those in the United States focused on peace and financial security. Times were literally lean because of financial and nutritional shortages. As the economic struggles in the United States began to resolve and its citizens gained greater wealth, they also gained weight. Advances in automation rapidly mechanized a once active society, making it faster paced but paradoxically slowing it down physically. Four key factors can explain the stimulus–response nature of being overweight in the United States: (1) a fast-paced eating style consisting of fatty "fast foods" and "super sizing," (2) excessive calorie intake, (3) reduced physical activity, and (4) heightened responsiveness to food as a stimulant.[3] People learned to overeat in celebration of their new-found freedom and prosperity, and they used eating as a coping mechanism. From an operant conditioning perspective, food acted as the powerful positive reinforcer that stopped the unpleasant feeling of hunger (the negative reinforcer).[4] Eating to feel better, in the presence or absence of hunger and a wide variety of pleasant and unpleasant feelings, soon became a habit in U.S. culture as foods (usually those high in fat) became more affordable and convenient.

Around 1950, dieting to lose weight came into style to achieve the fashion model and movie star thinness flashing before Americans' eyes in the burgeoning media. Soon feelings of deprivation and preoccupation with food and dieting yielded a rise in eating disorders and weight cycling.[5] Long-term habits of overeating without hunger and little or no physical exercise in a fast-paced society can explain the growing weight problem among U.S. citizens. In the 1950s and 1960s only 14% of women and 7% of men (21% total) were dieting to lose weight, while recently 40% of women and 24% of men (64% total) were dieting.[6] To date, most weight loss interventions in the United States have not helped to reduce weight over the long term, and perhaps have even contributed to the overweight problem. Comorbid conditions associated with overweight and obesity include heart disease and hypertension, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, and cancers (endometrial, breast, prostate, colon); the most dramatic overweight comorbidity is type 2 diabetes. Currently, 15.6 million Americans are diabetic, with about 95% being type 2.[7]

Approaches to Weight Management

Most weight management approaches are based on at least one of four categories of theories—biological, behavioral, psychological, and cognitive.

Biological Theories

Interventions based on biological theories are aimed at correcting excess weight and fat by reducing the number of available calories, so excessive fat will not be deposited and fat stores will be used. Four biological theories explain excess weight gain from genetic and energy balance perspectives.

According to two genetic theories, individuals have a genetic predisposition to an excessive accumulation of fat, either by

hypertrophy (enlarged size) or hyperplasia (excessive numbers) of fat cells. Average-sized adults have approximately 30 billion fat cells, or adipocytes, that store fat synthesized from the diet.[8] One theory focuses on the size of the fat cell as a regulatory mechanism for food consumption; that is, when existing adipocytes have expanded to their size limitation, a signal causes the individual to stop eating.[9] Individuals who have excessive numbers of fat cells could continue eating longer than those who have fewer fat cells, thus maintaining their original size.

Another genetic theory focuses on the number of fat cells resulting from fat cell proliferation, which usually happens during infancy and puberty. According to this theory, individuals are destined to continue their degree of fatness according to the number of fat cells present in childhood and adolescence. The adipocyte hypertrophy theory supports adult-onset obesity, while the adipocyte hyperplasia theory supports child-onset obesity.[10] Neither genetic theory leaves much room for therapeutic interventions.

Set point theory, another popular theory, gained attention in the 1980s and 1990s. Nesbitt, who introduced this theory in 1972,[11] claimed that individuals have but one body weight at which their energy expenditure is normal. Despite changes in the rate of energy expenditure, be they higher or lower, individuals eventually will gain or lose weight to return their weight to its set point.[12] Thyroid hormone (given in past years to increase metabolism) may facilitate weight loss, but at the cost of normal thyroid function. In some cases, its administration has resulted in permanent damage to the thyroid. Other metabolic stimulants used for weight loss, such as amphetamines and nicotine, involve similar risks. Regular, vigorous exercise is one healthy way to lower the set point. According to the theory, no matter which measure is used to lower the set point, weight returns to its previous level once the measure is withdrawn.

Energy balance theory has been widely used as the basis of weight loss interventions.[13] The chronic positive energy balance version of the theory perhaps is most accepted, to the extent that most believe it to be a law of physiology. Some describe this theory in the opposite view and from a therapeutic perspective as the negative energy balance theory. Simply put, the theory holds that an excessive number of calories ingested, but not required, for metabolic needs results in an excessive body weight. Conversely, fewer calories in the presence of demanding exercise and work create a deficit that allows weight loss to occur. No matter what the source of energy (e.g., carbohydrate, protein, fat), excessive calories are converted to be stored as fat. Excessive body weight, then, usually is from excessive intramuscular and subcutaneous fat stores.

Behavioral Theories

The primary focus of behavioral theories in weight management is that behaviors such as overeating are learned responses. Interventions such as behavior modification techniques (based on Skinner's stimulus response theory) are aimed at controlling stimuli that result in actions that perpetuate overeating.[14] Some believe stimulus control strategies can permanently change external motivations related to eating. Thus, stimulus control strategies are designed to control eating by restricting calories, choices, locations, and timing, while avoiding environmental or external stimuli that may lead to eating outside those limitations.

Many calorie-restricted diets and food supplements are a type of stimulus control strategy that concentrates on controlling antecedent stimuli (controlling what, when, where, and how much to eat). At one end of the nutritional continuum are extreme, unhealthy diets (e.g., a grapefruit

diet or a high-protein diet); at the other end are balanced healthy diets from the food pyramid. Even healthy diets can be difficult to comply with over the long term when they are aimed at controlling hunger. No matter how healthy they may be, stimulus-controlled diets focus on avoiding or eliminating hunger. When the body's natural, physiologic, internal signals of hunger are erased, individuals are forced to focus on external cues to tell them when they need to eat.

The holistic self-care model for long-term weight management is based on the premise that stimulus control addresses only half of the reasons for weight gain—the external reasons. The other half of the reasons for weight gain are internal. To make long-term lifestyle changes that promote fat loss, it is necessary to emphasize healthy eating for hunger rather than the elimination of hunger.

Clients should be assisted in calculating the number of calories that they require to meet their basic metabolic and exercise metabolic needs, based on American Dietetic Association guidelines (daily calories ≥ 1,200). Health-promoting behavioral techniques help clients learn how to distribute calories among the food pyramid groups and record daily intake according to time, place, kinds, amounts, pyramid groups, social situation, and hunger level.

Weight management strategies that concentrate on modifying behavior by differentiating stimuli before, during, and after eating (i.e., identifying stimuli other than hunger that trigger eating, monitoring amounts and conditions during eating, and rewarding appropriate actions) are a healthy start toward lasting weight management. Two health-promoting programs based primarily on behavioral strategies are Weight Watchers and Brownell's LEARN program—*L*ifestyle, *E*xercise, *A*ttitudes, *R*elationships, and *N*utrition.[15] Environmental modifications can enhance the effectiveness of dietary restrictions that lead to weight loss.[16] Modifying environmental stimuli before eating include limiting the places where we eat, the amounts and types of available foods, shopping, and food preparation. Techniques for modifying environmental stimuli during eating include using small dishes, eating slowly, chewing multiple times before swallowing, and putting down eating utensils between bites. Modifying behavior after eating includes keeping a food diary, weighing-in daily, and reinforcing positive actions (losing weight and exercising).

Most behavioral programs require individuals to monitor and record their compliance with prescribed dietary restrictions. They are assisted with setting up a meaningful reward system, such as money, special gifts, and entertainment. Individuals usually are weighed weekly, as weight loss becomes the external indicator of progress. Generally, there is less emphasis on internal indicators of progress, such as changes in thinking and feelings, than on external indicators, such as weight, body shape, and body size. Behavioral therapy is effective on a short-term basis, but is less effective for helping obese individuals address disturbed thinking, emotions, and body image related to overeating and poor self-esteem.[17]

Psychological Theories

Weight management interventions based on psychological theories usually are directed toward decreasing stress-induced eating and helping to find ways to control eating in the presence of stressful situations. Similarly, negative body image, poor self-esteem, depression, and issues of social discrimination become the focus of psychotherapy, while dietary and exercise prescriptions usually receive less emphasis during therapy. Binge eating disorder, bulimia, and compulsive overeating are treated as relationship disorders that have similar etiologies but are manifested dif-

ferently. Usually in psychotherapy, individuals with eating disorders are encouraged to focus on related issues of abandonment and verbal, sexual, and physical abuse rather than the eating problem per se, unless physical well-being is threatened.[18] Depression and obesity are growing concerns as related problems and both are on the rise in America.[19]

Cognitive Theories

Beck explained how unrealistic and negative thinking trigger unpleasant emotional responses that can lead to overeating and not getting regular exercise.[20] Interventions based on cognitive theory are aimed at providing rapid symptomatic improvement and understanding of mood changes, coping strategies for self-management when upset, and guidance for personal growth. Individuals are assisted in assessing their basic values and attitudes that lead to negative feelings, as well as in reevaluating and challenging basic assumptions about their self-worth. Problem solving and coping techniques help clients to deal effectively with major, realistic problems (e.g., low self-esteem, guilt) and minor vague irritations (e.g., frustration, apathy) that seem to have no obvious external cause.

The first principle of cognitive theory is that all moods are created by thinking. Beliefs, perceptions, and mental attitudes make up cognitions; that is, how people interpret their world and what they are saying to themselves at a specific moment in time. Thinking brings about feelings and emotional responses. The second principle of cognitive theory is that negative emotional responses are pervasive and tend to color other perceptions of the world in a negative way. Although people's negative perceptions are very real to them, their perceptions often are illogical. The final principle is that the negative thoughts that elicit emotional turmoil usually contain gross distortions; most of the time, suffering results from distorted thinking rather than from the actual perceived cause.

Beck offered cognitive restructuring techniques to help identify and eliminate cognitive distortions that elicit irrational emotional responses. Beck's approach to cognitive restructuring uses three steps:

1. Identify automatic thoughts that are self-critical.
2. Identify any cognitive distortions and unrealistic beliefs underlying the thoughts.
3. Provide rational responses that defend the self.

The aim of cognitive restructuring is to substitute objective rational thoughts for illogical, harsh self-criticisms that predominate in response to negative events.

Failure of Traditional Weight Management Interventions

Failure rates for most weight reduction programs have been estimated to be as high as 90 to 95 percent.[21,22] Many interventions that have been shown to fail to promote long-term weight management (1) are restrictive in calories, choices, and times to eat; (2) are unidimensional, using only one major means to achieve weight loss, and do not include regular exercise; (3) do not permit individuals to tailor weight management to their preferences, lifestyles, and humanness; and (4) do not focus on internal motivations for overeating and for not exercising regularly.

Restrictions on Calories, Choices, and Times

Interventions that restrict calories, choices, and times to eat offer a temporary and artificial modification that is unrealistic for the long term. In the 1960s, 7% of men and 14% of women were on reducing diets (21% total), while 24% of men and 40% of women were on diets in the 1990s.[23]

Despite dieting attempts, the prevalence of being overweight increased from 25 to 33 percent between 1980 and 1991.[24] Although Americans were trying to eat less fat, they were getting fatter.[25] In a 1994 Agriculture Department survey of 5500 U.S. citizens, one in three adults was overweight.[26] In an effort to follow recommendations to reduce fat intake, they reported eating more grains, but in doing so increased their intake of snacks by 200 percent and their intake of ready-to-eat cereals by 60 percent. It seems that their responses to dietary restrictions and deprivation have ultimately resulted in overeating, which may have led to weight gain. When calories and choices are restricted, human beings often revert to old patterns that led to being overweight in the first place. The national guidelines on weight management focused on less restrictive means of reducing caloric intake while providing for human fallibility, which is the necessary ingredient for long-term weight management.[27,28]

Unidimensional Treatments

Interventions that use only one major means to achieve weight loss fail to address the many reasons why people gained weight. In 1992, Brownell and Wadden stressed that the time has come to abandon the societal mentality that a single weight reduction approach will be successful for all people desiring to lose weight.[29] The most successful long-term interventions to date are those that have combined a control of healthy food intake and aerobic exercise.[30,31] In the 1980s, weight management literature often focused on the very low calorie diets (VLCDs) offered alone, in combination with stimulus control, or in combination with exercise, or on all three interventions at once.[32] Once again, while most of these diets led to weight loss, the regain of weight was remarkable across all programs. It seems likely that the long-term failure of these programs can be traced to the food restrictions discussed earlier. Most diets, especially VLCDs, are unnatural and time-limited. Exercise that has been teamed with dieting is often discontinued when the diet is discontinued, possibly because the program was not tailored to individuals' preferences, lifestyles, and humanness.

Similarly, many medical interventions that can yield weight loss in the short term fail in the long term. Such interventions include surgical reduction of the gastrointestinal tract, stomach expansion devices to simulate feeling full, and drugs to suppress the appetite—all aimed at reducing amounts of ingested foods. The Food and Drug Administration recommended withdrawal of dexfenfluramine hydrochloride and fenfluramine hydrochloride due to associated reports of valvular heart disease and pulmonary hypertension. Sibutramine hydrochloride (satiety-enhancing agent) and orlistat (inhibits intestinal lipase) are currently approved for long-term use.[33] Often there is dramatic weight regain when the medication is withdrawn and clients have not incorporated lifestyle changes, such as concurrent regular exercise.[34] Perhaps equally disconcerting about taking pharmacologic agents are detrimental side effects.[35]

Regular exercise as part of weight management is no longer controversial. Researchers have found supportive evidence that exercise plays a vital role in weight loss. Research findings suggested that exercise can prevent a reduction in the resting metabolic rate, either by elevating it following the exercise or by maintaining or increasing fat-free mass (lean body mass).[36]

Insulin resistance syndrome, or metabolic syndrome, formerly called Syndrome X, is a condition of insulin resistance associated with a cluster of abnormalities associated with type 2 diabetes and its

comorbities.[37] Most individuals who display metabolic syndrome are hypertensive, overweight, glucose intolerant, and have lipid abnormalities, which all put them at higher cardiovascular disease risk. Insulin-dependent diabetes mellitus, or adult-onset diabetes, is now called type 2 diabetes and accounts for almost 95% of all diagnosed cases of diabetes.[38] As the degree of being overweight increases, so does the risk for developing type 2 diabetes, especially when visceral adiposity increases, as evidenced by greater waist circumference or an "apple shape." Waist measurements ≥ 35 inches for women and ≥ 40 inches for men may indicate a higher disease risk than people with smaller waist measurements. Increased central obesity among Americans may be related to greater intake of high-glycemic index foods, in addition to recognized overindulgence of fatty, fast foods.[39] High sugar and starch content in low-fiber, refined foods may be directly related to the growing incidence of insulin resistance.

The "good news" about this disheartening evidence is that modest weight loss of 5% to 10% of initial body weight can improve glucose tolerance and reduce blood pressure, lipids, and mortality.[40] Health care providers are urged to assess those at risk for insulin resistance and related health risks and offer long-term lifestyle interventions to reverse this growing epidemic.

Magical thinking encourages individuals to seek "quick fix" programs with little or no exercise. Some individuals, especially women, hold to the magical thinking that they can rapidly achieve slimmer images and will have lasting results without extended and consistent use of nutritional and exercise strategies. In the author's experience, women who do *not* think magically about weight loss are usually older (35 to 45 years), have tried many weight loss methods, failed frequently, and learned from their experiences that quick-fix weight loss methods only lead to more failures. Realistic thinkers can articulate what they want in life and are more willing to expend effort to achieve "a healthier, more energetic body, mind, and lifestyle."

Foster and associates found that obese women who were more dissatisfied with their weight had greater feelings of failure and initially made greater efforts to lose weight.[41] These dissatisfied subjects, however, also felt less success when they reached their goal weight. They expressed less self-acceptance, were less likely to have long-term success, and often regained weight.

Inability to Tailor Weight Management Program to the Individual

Interventions that do not permit individuals to tailor weight management to their preferences, lifestyles, and humanness do not last. Weight loss interventions fail when program directives are too stringent for individuals to gain a sense of ownership and to accept the weight management strategies as a way of life. Instead, individuals view weight management as something that will happen magically if they can endure program directives long enough. Usually, they do not view "the program" as a long-term lifestyle change and, therefore, do not address their individual preferences (e.g., dislike for certain foods and types of exercise), way of life (e.g., working nights, family versus single), and "being human" along the way (e.g., not feeling guilty or dropping out when they deviate from the plan).

The American Dietetic Association has stated that, to achieve long-term weight management, adults must make a lifelong commitment to healthy lifestyle changes.[42] Both daily physical activity and eating should be *sustainable* and *enjoyable*—terms that imply personal tailoring of healthy, yet livable lifetime habits. Without individualization, a lifelong program

is not possible, because life is ever-changing and adaptation is the norm.

Inability to Focus on Internal Motivation for Overeating and Lack of Exercise

Interventions that are not focused on internal motivations for overeating and for lack of regular exercise generally do not uncover the underlying reasons for overweight—reminiscent of the old saying, "Don't look where you fell, but where you slipped." Weight management programs often do not help overweight individuals uncover motivations for weight regain or reasons for staying overweight.[43] Perhaps the reason that stimulus control techniques have had limited success is because they seek to control the diet and environment, but do not take into account that eating may be a coping mechanism to manage unpleasant feelings.[44] Researchers have emphasized that weight management should include biological, psychological, and social interventions to normalize eating and separate physical from emotional hunger.[45]

Toxic stress is the uncontrollable, chronic type of stress that causes sustained high levels of serum cortisol, the powerful stress hormone necessary for fueling stressful events.[46] Sustained high cortisol levels can lead to fatigue, impaired immune response, lower mental sharpness, and stimulated appetite, which all can contribute to metabolic syndrome. Attempts to lower stress usually include relaxation exercises and physical exercise. Techniques to prevent a toxic stress response involve seeking a different, healthier perception of troublesome stressors through healthy self-esteem. Healthy self-esteem can be cultivated through daily spiritual nurturance and spiritual coping, which conceptually can lower levels of the stress response and, thus, can lower cortisol. Healing from the "inside out" may be the only lasting intervention to address America's over-stressed, overweight epidemic. Support books such as *The Language of Letting Go*[47] and *10 Secrets for Success and Inner Peace*[48] can help clients reach the inner healing necessary to make lifelong lifestyle changes.

New Weight Management Interventions

When overweight individuals first recognize that they often cope with stressors by eating and then learn to manage stressors in healthier ways, controlling intake and environmental influences gradually can lose their importance for long-term weight management. Existing programs that use behavioral approaches, cognitive restructuring, or combinations thereof may not address the effects of negative beliefs about self and irrational perceptions of the world. Self-talk and cognitive restructuring used in most interventions focus on thinking about food, relationships with others around food, and restructured thinking about hunger and satiation. For example, in his popular LEARN Program for Weight Control, Brownell presented a cognitive approach concerning unattainable goals that individuals trying to lose weight tend to set for themselves for eating, exercise, and weight loss: "When the goals are not met, the negative emotional response can send . . . progress into a tailspin."[49] Setting realistic goals is important for a long-term weight loss program; however, the holistic self-care model takes a different approach by first helping individuals set realistic goals for assessing overeating situations and discovering what feelings may have triggered them (instead of goals focused on eating, exercise, and number of pounds lost). Holistic goal setting, with equal consideration for eating, exercise, and esteem, needs to be determined by clients themselves, but guided by nurse healers.[50] Cognitive

restructuring based on reversal theory extends the current use of this technique to include self-talk about self-esteem and others *in addition* to food and weight-related topics.

Based on reversal theory states as a frame of reference, cognitive restructuring centers on the negative self-statement (probably unrelated to being overweight) that triggered overeating and/or prevented regular exercise. Using cognitive restructuring based on reversal theory worksheets (see Exhibit 27–1), clients are assisted to pinpoint negative self-talk stemming from overeating situations, but they also are assisted to move to a higher level than many weight management programs to identify illogical, unrealistic, and negative self-talk about themselves and their relationships. Traditional stimulus control strategies offer assistance to lose weight by controlling diet and environmental factors. Cognitive restructuring strategies discussed in weight management literature offer assistance only at the first level beyond stimulus control strategies by adding inquiry about self-talk related to being overweight, eating, and dieting. When cognitive restructuring is used in a limited or random way of relating only to weight-related concerns, it may serve as just another stimulus-control strategy.

Reversal theory states provide needed structure for ensuring that the underlying issues related to overeating and lack of exercise can be discovered and managed directly. Cognitive restructuring based on reversal theory offers a higher level of assistance to address negative and faulty thinking about self and relationships that may lead to overeating and skipping exercise. The National Task Force on the Prevention and Treatment of Obesity urged researchers to help overweight individuals make lifelong changes in behavioral patterns, diet, and physical activity that eventually bring about a moderate, permanent weight loss.[51] The holistic self-care model is a multidimensional approach designed to counter each reason that traditional weight management programs fail.

First, reversal theory will be explained and then the combined theoretical framework for cognitive theory based on reversal theory (used as the basis of the holistic self-care model) will be reviewed. Specific cognitive strategies based on reversal theory will be presented.

Reversal Theory

Apter's theory of psychological reversals, commonly referred to as reversal theory, provides a framework to explain factors related to overeating and lack of exercise in overweight individuals.[52] According to this phenomenological theory of arousal, motivation, and action, Apter posits that personality is inherently inconsistent and that individuals reverse between opposing, paired states called metamotivational states because they are not, in themselves, concerned with motivation, but rather with the way in which motivation is experienced. Psychologically healthy individuals experience their motivations and actions in different ways, depending on metamotivational states. Four pairs of opposing states have been identified: telic/paratelic, conformist/negativistic, mastery/sympathy, and alloic/autic (Exhibit 27–2). At a given point in time, individuals are in combinations of the different states, consisting of one state of each of the four pairs, but never in both states of a pair at the same time.

When in the telic state, individuals are serious-minded and goal-oriented; when in the paratelic state, they are playful and spontaneous (see Exhibit 27–2). When in the conformist state, people prefer to go along with rules and regulations; when in the negativistic state, they prefer to break rules and want to be rebellious or noncompliant. When in the mastery state, individuals feel that being tough and being in

Exhibit 27–1 Reveral Theory Sample Self-Talk

About Self and Others

What is my fat self saying to me? What is my thin self saying to me?

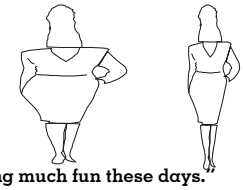
TELIC
(Serious-minded, goal- & future-oriented)
(anxious or calm?)

"I keep on task."

"I never seem to get my work done."

PARATELIC
(Playful, emphasizing good feelings, present-oriented)
(bored or excited?)

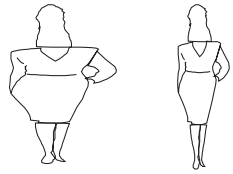
"I'm active & play often."



"I'm not having much fun these days."

CONFORMIST
(Following rules, agreeable, concerned about what others think) (uncomfortable or comfortable?)

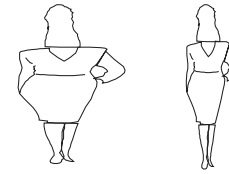
"I know when to play people games."



"I never seem to be able to do the right thing."

NEGATIVISTIC
(Sticking up for what I think, angry, doing my own thing)
(trapped or free?)

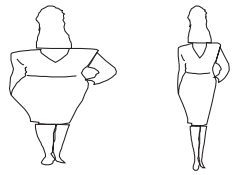
"I can tactfully say what I think."



"I can't say what I really think."

MASTERY
(Do my best, be strong, be tough, compete)
(out of control or in control?)

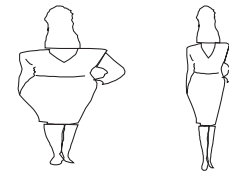
"I know when to give it my all."



"I'm out of control."

SYMPATHY
(Want harmony, feel deserved reward, feel tender)
(deprived or cared for?)

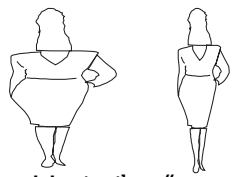
"I'm having a good social life."



"I have no social life."

ALLOIC
(Think of others first before myself)
(Feel ashamed or satisfied?)

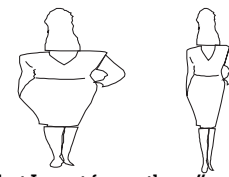
"I like to give to others."



"I withdraw from giving to others."

AUTIC
(Think of self first before others)
(Feel bad about self or good about self?)

"I'm not afraid to put myself first occasionally."



"I never get what I want from others."

Source: Copyright © 1996, Sue Popkess-Vawter.

Exhibit 27–2 Reversal Theory Metamotivational States Pairs and Characteristics

EIGHT WAYS OF BEING HUMAN
(Characteristics of Apter's Reversal Theory Metamotivational States Pairs)

TELIC
Serious-minded
Goal-oriented
Plan ahead
Try to accomplish something
Future-oriented
*anxiety **calmness

PARATELIC
Playful
Spontaneous
Emphasize good feelings
Have fun for fun's sake
Present-oriented
*boredom **excitement

CONFORMIST
Don't make waves or disagree with others
Follow the rules
Feel embarrassed/guilty if I break a rule
Compliant
Agreeable
Stay in line
Do what others do
Worry about what others think
*unprotected **protected

NEGATIVISTIC
Stick up for what I think when I disagree with others
Bend/break the rules
Feel angry
Stubborn
Rebellious/defiant
Want to be difficult
*trapped **free

MASTERY
Do your best
Give it your all
Be strong & don't show feelings of weakness
Be tough, stay strong
Compete
Be in control
*soft **hardy

SYMPATHY
Let my feelings tell me what to do
Deserve a break
OK to show & tell feelings of weakness
Be tender, OK to not be strong
Don't compete
Be nurturing
*insensitive **sensitive

ALLOIC
Think of others first
Put self last
Others are most important
*shame **modesty
*guilt **virtue

AUTIC
Think of self first
Put others after self
I am most important
*humiliation **pride
*resentment **gratitude

*unpleasant feelings/responses (tension stress) associated with specific metamotivational states
**pleasant feelings/responses associated with specific metamotivational states
Source: From Popkess-Vawter, S. (1997). Chapter 27 Weight Management. In B.M. Dossey (ed.), *American Holistic Nurses' Association Core Curriculum for Holistic Nursing* (pp. 211–219). Gaithersburg, MD: Aspen.

control are important; when in the sympathy state, they feel that being tender and noncompetitive are important. In the alloic state, people derive pleasure from thinking of others before themselves in an altruistic way; in the autic state, they derive pleasure from thinking of themselves before others. Healthy individuals reverse between states easily and often throughout the day.

Researchers explored reversal theory in smoking cessation studies as an explanation of behaviors in smoking relapse and abstinence.[53] Subjects who were more likely to relapse were in the paratelic, negativistic, and sympathy states, while

those who were more likely to abstain were in the telic, conformist, and mastery states. Similarly, reversal theory may explain how dieting and resisting overeating are consistent with telic, conformist, and mastery states. Paratelic, negativistic, and sympathy states may be one explanation for the apparent self-sabotage of overweight individuals who can cope with stressors some of the time without overeating, but not at other times.

Unpleasant Feelings and Tension Stress. Each metamotivational state has pleasant and unpleasant feelings and responses associated with it (indicated by asterisks in Exhibit 27–2). Pleasant responses, depending on the metamotivational state, include feeling calm, excited, free, and proud. Unpleasant responses include feeling anxious, bored, angry, trapped, ashamed, humiliated, guilty, and resentful, which represent tension stress. According to reversal theory, tension stress is the discrepancy between desired and actual feelings. Individuals can take actions to reduce the level of tension stress within the same metamotivational state or may experience a spontaneous reversal to the opposing state within the metamotivational pair.

> K.Z., 29 years old, reported how she repeatedly used overeating as an attempt to reduce tension stress within the same reversal theory state.[54] "While I'm eating, I'm oblivious to everything else. I'm not thinking about what is hurting me . . . . It's just like an escape . . . to be able to eat is just an escape from everything. . . . The only time I can turn myself off is when I'm eating." K.Z. spontaneously described a happening referred to in the literature as the escape phenomenon and in clinical practice as "numbing out." She obtained relief from unpleasant feelings (tension stress) by "numbing out" during eating, even though she knew she would not feel good later.
>
> On the particular occasion that K.Z. related overeating, she had an unpleasant telephone exchange with her mother. She was saying to herself in her mind, "It's always my fault! I'm always the bad guy!" She related that these negative self-talk words represent many old interpersonal conflicts experienced with her mother and family members.

Repeated negative thoughts can evoke negative feelings that, in turn, can evoke negative behavior such as coping by eating favorite foods to feel better. Another client told about a similar unpleasant incident on the telephone with her sister. "Even though I had eaten breakfast and was not hungry, while still on the phone I knew I was going to go get donuts to feel better."

Cognitive Therapy Based on Reversal Theory. Beck described cognitive therapy as helping clients restructure self-statements to be more realistic and positive, which in turn will elicit positive responses.[55] Cognitive theories by themselves cannot explain why people can cope with stressors some of the time (do not overeat to cope) and not at other times (overeat to cope). Reversal theory, a relatively new theory, offers an added dimension to cognitive restructuring by providing the necessary organizing structure to do two things: (1) locate tension stress in the most salient state where negative self-talk originates, and (2) tailor interventions to decrease tension stress. Reversal theory was found in previous studies to explain overeating and lack of exercise in overweight women, and served as the basis for cognitive strategies discussed later.[56–58]

Brownell and others emphasized that overweight individuals need help accept-

ing themselves rather than being in relentless pursuit of an unrealistic ideal.[59] When weight management program designers try to address the humanness involved in weight management, it is easy either to oversimplify or to oversaturate the cognitive–behavioral content. Perhaps program designers are simply inexperienced in including cognitive content specifically directed at underlying thinking and feelings that lead to overeating or not exercising. There is growing objective evidence, however, that this critical psycho-social-spiritual portion in the holistic self-care model can contribute to long-term weight management.[60]

The theoretical framework guiding intervention strategies is based on cognitive and reversal theories. Exhibit 27–3 depicts the theoretical framework and the three cognitive restructuring strategies (EAT for Hunger, Exercise for LIFE, and STOP Emotional Eating). Cognitive restructuring based on reversal theory provides a vehicle focused on self and relationships with others in general *and* on hunger, eating, and exercise in particular.

Cognitive Restructuring As a Weight Management Technique

Although cognitive restructuring is not a new technique used in weight management, the applications cited in the literature do not address directly how negative beliefs about self and irrational perceptions of the world can produce the negative self-talk that triggers overeating behavior. Instead, cognitive techniques seem to be targeted at feeling better about food, weight, and weight-related relationships. Self-talk *unrelated* to food, weight, and weight-related relationships can reveal repeating, powerful, and caustic messages that lead to overeating and skipped exercise, however.

Cognitive restructuring based on reversal theory is a set of strategies to identify and replace unrealistic, negative self-talk with realistic, positive self-talk. The eight metamotivational states of reversal theory provide the needed structure for tracking three types of salient self-talk statements: (1) self-talk about self and others in general, (2) self-talk about hunger and eating, and (3) self-talk about exercising in particular (Exhibit 27–1). Beliefs about the self, including self-esteem and body image, may be sufficiently negative and unrealistic to evoke negative thoughts and feelings. Overweight clients can learn to recognize negative self-talk, accept their irrationality, and develop new cognitive skills to manage negative motivations. Cognitive restructuring based on reversal theory seems to bring the first level of understanding and healing for overweight individuals. The next level involves the long-term process of self-discovery, values clarification, and self-talk replacement in order to equip clients with internal skills and strategies for dealing directly with emotional upsets.

Subjects in a previous study responded to unpleasant feelings by overeating in everyday situations, including feeling anxious on the job and before examinations, feeling angry after disagreements with family or friends, and feeling bored and tired after getting off work.[61] Most overeating occasions were *unrelated* to being overweight. It follows that long-term weight management may logically focus more of the time on managing responses to everyday emotional upsets (cognitive restructuring based on reversal theory) rather than on manipulating the environment to remove temptations to eat (stimulus control). For example, in the case of K.Z. discussed earlier, a nurse would assist her (alone or in a group) to reflect on a reported overeating situation and would guide her through the EAT and STOP strategies (see Exhibit 27–3).

The nutritional strategy is called "EAT for Hunger": *E*at for body or mind hunger?, *A*sk appetite and enjoy each bite, and *T*ell

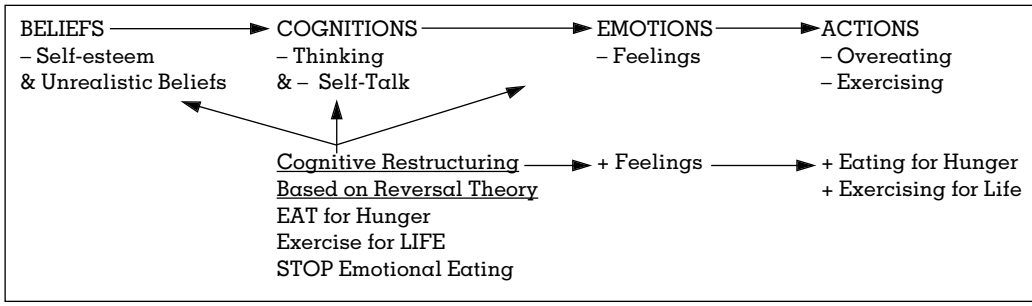
Exhibit 27–3 Daily Calendar

HOLISTIC SELF-CARE *Thought for the Day:* I equally accept my eight ways of being human.

Today's date ___-___-___ positive self-talk _____

Today's planned exercise _____

This week's goals _____



E at for body or mind hunger ? Paratelic? starving 1 2 3 4 5 feel nothing 6 7 8 9 10 stuffed
A sk appetite & enjoy each bite. Paratelic?
T ell self when hunger is gone. Telic goal?
If mind hunger, go to STOP strategy

(Circle) Low tension stress 1 2 3 4 5 6 7 8 9 10 high tension stress
[Go to RT relaxation-affirmation and Self-talk sheets]

S top RT relaxation-affirmation
T ell RT state, feelings & self-talk
O ptions for positive self-talk
P lan to deal with feelings without eating
exercise self-talk strategy journal call friend other _____

Did I do my planned exercise today? Yes!! ___ No ___ (Why?)

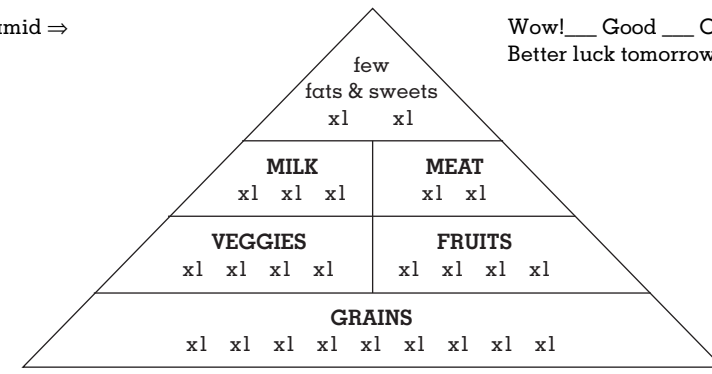
Did I overeat today? No!! ___ Yes ___ How many times? _____

What is the *underlying trigger* leading me to overeating, no exercise, and feeling bad about myself?_____

"X" off servings as you eat from the Pyramid ⇒

How was my nutrition today?

Wow!___ Good ___ OK ___
Better luck tomorrow ___



Source: Copyright © 1996, Sue Popkess-Vawter.

self when hunger is gone. The first step is cognitive, represented by *E* because it asks individuals whether they are experiencing actual physiologic hunger or emotional hunger. The nurse would guide K.Z. in determining whether she was actually *physically* hungry or *emotionally* hungry. If actually hungry, clients rate their hunger on a scale of 1 to 10, where 1 represents feeling starved, 5 represents feeling nothing, and 10 represents feeling excessively full. In the second step, *A*, the nurse asks clients what food their bodies are hungry for while encouraging them to make healthy choices and yet not deprive themselves of formerly forbidden foods. They concentrate on enjoying the personal pleasures of tastes, textures, and consistencies of the food as they slowly enjoy every bite. (Paratelic and autic are salient states.) In the last step, *T*, the nurse again asks K.Z. and the group members to think about rating hunger on a continuum from 1 to 10 while eating and to stop when hunger was gone, usually at about a 5 on the scale. Eating smaller amounts is the aim of the last step to assist them to satisfy the body's needs without excess.

Again using K.Z.'s example, if she identified that she was "emotionally hungry," the nurse would assist her with the psycho-social-spiritual strategy, "STOP Emotional Eating." Negative self-talk involving self and others can trigger desires to eat, often at times when the individuals are not hungry, adding excess calories. Overweight clients may not be aware of the many daily emotional triggers that habitually lead to overeating. Thoughts, memories, and self-talk can lead them to emotional triggers of overeating.

The purpose of the "STOP Emotional Eating" strategy is to help clients separate emotions from the eating response and learn new, constructive strategies for managing triggers of overeating. K.Z. and the group would learn to *S*top for relaxation–affirmation, *T*ell feelings and self-talk, explore *O*ptions for positive self-talk, and *P*lan to deal with feelings without eating. The first step is the reversal theory relaxation–affirmations exercise, a 10-minute activity that begins a head-to-toe relaxation response (Exhibit 27–4).

After relaxing, clients move to affirmations intended to remind them of their eight ways of being human (i.e., the eight reversal theory states). Emotions stemming from one salient reversal theory state can be traced to discover the faulty self-talk that triggered the desire to eat. "Feeling the Feelings," a cognitive technique consisting of four ordered skills, can facilitate the *T*ell feelings and self-talk step. With this technique, the nurse helps clients release tension from unpleasant feelings (lower tension stress) and accept negativistic and sympathy state responses by

1. Recognizing and experiencing feelings, such as feeling tired, bored, lonely, anxious, tense, angry, and depressed. Often, clients think that feeling negative emotions is undesirable, rather than viewing feelings as natural human responses to illogical thinking patterns.
2. Accepting their feelings as part of being human.
3. Thinking about ways that past conditioning may have caused them to think about issues in irrational or unrealistic ways, which in turn leads them to respond to feelings by overeating.
4. Learning new skills to manage feelings, such as the "Fighting Fair" technique used to manage anger, disappointment, and resentment.

The self-talk worksheets are given to clients to help pinpoint emotional triggers of overeating and excuses not to exercise regularly (see Exhibit 27–1). By using the worksheets, they can learn to "hear" negative self-statements and then replace them with Options for positive self-talk. The

Exhibit 27–4 Reversal Theory Relaxation–Affirmations Exercise

TEN-MINUTE *EIGHT WAYS OF BEING HUMAN
Relaxation–Affirmations Exercise

Relaxation

Now, seated comfortably, I close my eyes and take three deep, cleansing breaths letting go of all unpleasant feelings. I gently tighten and relax muscles from my head to my toes (face & neck, hands, arms & shoulders, abdominal & back, legs & feet). Remaining relaxed, I choose to go to my most favorite place in the whole world on a one-minute vacation. I experience fully all of the sights, sounds, smells, and feelings of this place.

2'

2'45" (after 1 minute). . . . Now, with my eyes still closed, I choose to listen to my Eight Ways of Being Human affirmations. As I listen, I can feel myself becoming more and more balanced and becoming my real self.

Affirmations

I know when to **1-work** and when to **2-play**. I choose to do both and I accept both parts of me.

I know when to **3-follow the rules** and when to **4-break the rules**. I choose to do both and I accept both parts of me.

I know when to be **5-tough** and when to be **6-tender**. I choose to do both and I accept both parts of me.

I know when to **7-give to others** and when to **8-give to myself**. I choose to do both and I accept both parts of me.

4'30" I will make good choices for myself. I am letting go of all unpleasant feelings and choose to trust that I will make good choices for myself.
I am still very relaxed with my eyes closed. For the next few minutes, I will picture in my mind a figure "8" representing my Eight Ways of Being Human. I will focus only on that figure "8". If thoughts come into my awareness, I will simply go with them rather than resist them, getting back to my figure "8" as soon as I can.

5' I'm now tracing that figure "8" in my mind.

6' (after 1 minute). . . . Very relaxed, still tracing the figure "8."

9' (after 3 minutes). . . . Now, very slowly, I'm coming back to this time and place.

(after 30 seconds). . . . Still very relaxed, I now open my eyes and keep this relaxed and balanced feeling as I go and make good choices.

*Numbers 1 to 8 in the affirmations indicate the eight ways of being human. Times in the left margin may be used to record a personal audiotape for daily use.

Source: Copyright © 1996, Sue Popkess-Vawter.

sample worksheets contain eight sets of abstract drawings of an overweight woman and a normal weight woman, one set for each of the reversal theory states. Beside each drawing, respectively, is a line where clients are assisted to identify and write the self-talk statements in response to two questions, "What is your fat self saying to you?" and "What is your thin self saying to you?" The worksheets in Exhibit 27–1 are samples of self-talk frequently used by individuals who gain and

lose weight in a cyclic pattern. Clients can complete worksheets monthly to identify their current self-talk and compare worksheets with those in past months. Clients thus can identify progress and problem areas for support and suggestions.

Nurses teach their clients the four ordered skills in the Fighting Fair technique to help them manage most negative emotions. First, the technique assists clients in determining objectively what they thought about the situation that triggered negative emotions. Second, they tell what they did not like about what happened; third, how it made them feel. The fourth step is to ask clients what they need from themselves and/or other person(s) to negotiate a win–win situation in which they and others can get at least part of what they need. This technique is intended to help clients *P*lan to deal with feelings without overeating.

Holistic Self-Care Model

Designed to assist overweight clients with individualized nutritional, exercise, and psycho-social-spiritual strategies for a long-term pursuit of healthier and happier lifestyles, the holistic self-care model has an individualized focus. Health care professionals help overweight clients become sensitive to their bodies, motivations, self-talk, feelings, and actions. Holistic self-care emphasizes concurrent work in nutritional, exercise, and psycho-social-spiritual dimensions to reduce the percentage of body fat and increase physical fitness.

Externally focused, "quick fix" methods have limited effects and may compound the overweight problem through, for example, a reduction in metabolic rate and serious drug side effects. In contrast, the holistic self-care model takes an internal perspective to seek insight about negative self-talk that obstructs long-term guidance from the body's natural hunger and satiety signals, as well as the positive benefits and sensations of regular exercise. The challenge that faces health care professionals is to design multidimensional interventions aimed at correcting what researchers know causes individuals to drop out of weight programs—namely, feelings of restrictions and deprivations, no time for exercise, and hassles of daily living that habitually send overweight clients to seek relief from stressors by eating.

The holistic self-care model provides a unique plan of weekly face-to-face counseling appointments and continuing support and guidance for individualizing and adjusting lifelong strategies. It is based on the following principles for long-term weight management:

- There is continual feedback among the three dimensions of eating, physical exercise, and self-talk, as in the integration among mind, body, and spirit.
- Both nurses and clients who gain and lose weight in a cycle must give equal consideration to the mind, body, and spirit trinity as they develop permanent life changes.
- Clients are in charge of redesigning lifestyle patterns in these three areas, consistent with self-care tenets.
- Permanent life changes take a very long time. Old habits can be changed through small steady efforts that lead to greater success, as opposed to drastic changes that lead to feelings of deprivation, burnout, relapse, and eventual failure.

The holistic self-care model emphasizes integrated care and empowerment of clients in mind, body, and spirit. Nurses sometimes find performing interventions for the mind and body more familiar and comfortable, but supporting and intervening for spirituality concerns may be the most important contribution that they can

make to promote health. Spirituality can hold all the other parts of individuals together. Religious beliefs are those beliefs in a power greater than that which humans possess—a higher authority and guiding spirit. Existential beliefs include values, meanings, and sense of purpose.

Nurses who address clients' spirituality as part of caregiving can help strengthen clients' sense of meaning, dignity, worth, and identity; healing becomes possible for low self-esteem, feelings of isolation, anger, powerlessness, and hopelessness. Human practices of honesty, love, caring, wisdom, imagination, and compassion can create a flowing, dynamic balance that allows and creates healing. The cognitive restructuring based on reversal theory is the part of the holistic self-care model that addresses clients' spirituality; it is the glue that can hold together bio-psycho-social-spiritual beings to become greater than the sum of their parts and to make long-lasting lifestyle changes.

HOLISTIC CARING PROCESS

Assessment

In preparing to use weight management interventions, the nurse assesses the following parameters:

- **body composition**—baseline and at least every 6 months
  - — body mass index
- **resting heart rate and blood pressure**
- **blood profile**—baseline and at least every 6 months
  - — lipid profile
  - — blood glucose level
  - — thyroid level
  - — hemoglobin and hematocrit
- **physical fitness**
  - — if possible, exercise testing using submaximal bicycle ergometer or maximal treadmill
  - — strength testing using repetition maximum for chest press and leg press (or comparable exercises)
  - — weekly exercise calendar (see Exhibit 27–5)
- **psychological profile**
  - — life review and dieting history—from clients' stories of their lives and the evolution of their weight problem; identification of lifestyle patterns
  - — BULIT (Bulimia Test) scale to screen for bulimia[62]
  - — body image according to a 10-point visual analog scale (1 being the best)
  - — tension stress scale[63]
  - — personal daily calendar (see Exhibit 27–3)

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with weight management interventions that are related to the 13 domains of Taxonomy II of the Unitary Person framework (see Chapter 14):

- Altered nutrition (more than body requirements)
- Spiritual distress
- Ineffective individual coping
- Decreased physical mobility
- Disturbance in body image
- Disturbance in self-esteem
- Hopelessness
- Knowledge deficit
- Anxiety

Specific patterns/challenges/needs related to the holistic self-care model and reversal theory include the following:

- Overeating related to increased tension stress.

Exhibit 27–5 Weekly Calendar

I, [*Name*], will do the following for the week of _____

My Realistic Goals for This Week:

Last week's major triggers that keep me overeating, not getting exercise, and feeling bad about myself:

1.

2.

Monday through Sunday Exercise Schedule:

Day of the Week	Aerobic Exercise	Resistance Exercise
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Source: Copyright © 1996, Sue Popkess-Vawter.

- Decreased aerobic/resistance exercise related to a poor body image and a feeling of being unworthy to take time for self to exercise.
- Infrequent episodes of play which are related to early modeling and values that consider work to be more important than play.
- Lack of skills to express anger/disagreement related to belief that it is unacceptable behavior.
- Lack of skills to express feelings related to early suppression of feelings as a self-protective mechanism.
- Inability to put self first related to early teaching that others have greater value and worth.

Outcomes

Prochaska and DiClemente developed the transtheoretical therapy model to expand the applicability of change theory.[64] Their stages of change have been applied to a wide variety of health care problems, including weight management. They proposed that individuals may move through five stages of motivational readiness

when confronted with lifestyle changes: (1) precontemplation, (2) contemplation, (3) preparation, (4) action, and (5) maintenance. Nurses should tailor their assessments, interventions, prescriptions, and evaluations to the individual's stage to attain long-term weight management (Exhibit 27–6).

Most clients will begin sessions at either the precontemplation or the contemplation stage. It is possible for an individual to be in different stages of the nutritional, exercise, and psycho-social-spiritual dimensions of the program. For example, in the case of K.Z., she may be starting to exercise two to three times per week (preparation stage), but refuses to even discuss nutritional interventions (precontemplation stage). She apparently has no insight into her negative self-talk

Exhibit 27–6 Nursing Interventions: Long-Term Weight Management According to Prochaska and DiClemente's Stages of Change

Client Outcomes According to Stage of Change	*Nursing Prescriptions*	*Evaluation*
Precontemplation (no intention of changing in the next 6 months): The client will verbalize reasons for not wanting to reduce weight and fat, and perform regular exercise.	Measure client's body mass index, body fat, resting heart rate and blood pressure, cholesterol, lipids, and blood glucose. Administer life review and dieting history, BULIT (bulimia test) scale to screen for bulimia, and body image 10-point visual analog scale.	The client received a clinic weight management brochure with written report of her or his physical and psychologic findings. The client verbalized understanding of the report, implied risks, and invitation to learn more about the clinic weight program.
Contemplation (considering changing in the next 6 months, but not active yet): The client will report fewer overeating episodes and less tension stress during daily eating.	Assist the client to apply the EAT for hunger cognitive restructuring nutritional strategy based on reversal theory. Administer Tension Stress Scale.	The client verbalized the three steps of the EAT for Hunger strategy and one difficulty with the strategy to work on in the next 6 months. The client was pleased with freedom of eating for hunger.
Preparation (making some changes, but not at goal): The client will report exercising more frequently, resulting in greater muscle strength, less fatigue, and more energy.	Assist the client to apply the Exercise for LIFE strategy based on reversal theory.	The client described aerobic and strength exercises that she or he is willing to do and one difficulty with the strategy to work on in the next 6 months. The client reported lower tension stress.
Action (6 months of active behavior change): The client will have lower levels of total cholesterol and low-density lipoproteins, a higher level of high-density lipoproteins, and blood glucose levels within normal limits.	Assist the client to apply the STOP Emotional Eating cognitive restructuring psycho-social-spiritual strategy based on reversal theory.	The client verbalized the four steps of the STOP Emotional Eating strategy and one difficulty with the strategy to work on in the next 6 months. The client is pleased with exercise progress.
Maintenance (sustained change past 6 months): The client will have a lower percentage of body fat, lower weight, lower resting heart rate, and lower blood pressure.	Assist the client to apply the acceptance of obstacles cognitive restructuring psycho-social-spiritual strategy.	The client verbalized the acceptance strategy and one difficulty with the strategy on which to concentrate efforts in the next 6 months. The client is pleased with lipid levels, weight, and blood pressure.

and, therefore, has no intention of changing (also precontemplation state).

Therapeutic Care Plan and Implementation

Before the Session

- Spend a few moments centering yourself to recognize your presence and to begin the session with the intention to facilitate healing.
- Create an environment in which the client will be encouraged to share his or her story.

At the Beginning of the Session

- Show a listing of the stages of change to the client and have him or her explain any differences between his or her stage at the last session and now. Accordingly, proceed with the holistic self-care model as shown in Exhibit 27–6.

At the End of the Session

- Ask the client to review what he or she gained from the session and answer any questions. Give the client a copy of any relevant support materials, and ask him or her to explain how to use them. Ask him or her to complete a copy of the weekly calendar (Exhibit 27–5) and verbalize what he or she has written and the times allotted for the behaviors.

Specific Interventions

Specific interventions used in the holistic self-care model are listed and interpreted according to the five stages of change as described in Exhibit 27–6.[65]

Precontemplation

When clients are not ready to make lifestyle changes, a nurse cannot "motivate" or manipulate them to do so. The nurse can inform them about his or her assessment of their situation, risks involved, and options available to them. Raising their consciousness without demands can do more to move them to the next level of readiness than giving them "pep talks" and trying to force them to see other perspectives. Thus, the nurse should teach the client the basic principles of the holistic self-care model for long-term weight management:

- There is no need to diet, count calories, and weigh daily/weekly. The percentage of body fat is a more accurate way to determine if clients weigh too much, because weight can be normal but consist of a high percentage of body fat and vice versa.
- Both physical and psychological reasons that clients are not losing excess pounds must be addressed to be successful for the rest of their lives.
- Most people with weight problems have lost weight successfully at some point in their lives, but regained the weight. Often, they are very knowledgeable about food and exercise, and they may even be somewhat in touch with the psychological reasons that they "go off" of their weight reduction programs.
- When young, many people learned to eat to feel better when they experienced unpleasant feelings; their active lifestyles kept them from having an overweight problem until adult years. Greater responsibilities in adult life forced them to be more sedentary, allowing fat to accumulate and reducing lean body mass.
- Increasing pressures, stressors, and short-term bouts of weight gain (e.g., because of pregnancy, loss of a job) put extra pounds on individuals' bodies.
- Eating must be separated and disconnected from emotions and reconnected with naturally occurring

hunger. Emotions, then, must be recognized, felt, and acted upon in healthy ways.
- The holistic self-care model for long-term weight management is the combination of stopping overeating, getting challenging exercise four to six times every week, and reprogramming negative, self-destructive self-talk to be realistic and personally valued self-talk.

Contemplation

Clients in the contemplation stage still believe that the reasons for not changing their behaviors (e.g., I am too tired, too hungry, too busy, don't have enough money) overbalance the reasons that they should. When past dieters view a future of dietary restrictions, their negative feelings toward past failures tip the balance of the scales in the negative direction.

EAT for Hunger Strategy. Under the EAT for Hunger strategy, clients learn to eat according to their internal control (hunger) with as many food choices as desired; regulation of eating is according to internal satiation of their hunger.

The purpose of this nutritional strategy is to bring physiologic hunger and the pleasure of eating into balance. Clients should weigh only monthly or wait until the nurse weighs them at an appointment to increase the accuracy of true weight fluctuations and avoid unnecessary emotional responses to false readings of temporary water weight loss and gain. They can be given the audiotape *Diets Still Don't Work* about how to stop overeating.[66] Group exercises, such as participating in a taste-testing exercise or eating a meal together, can reinforce new principles. Topics discussed in group or individual sessions can include why people overeat, why they lose weight, how thin people think and eat, why diets do not work, and why people choose fat over thin. Essential content in this nutritional strategy includes the food pyramid; the fat, fiber, sugar, cholesterol, and sodium content of foods; and the need for healthy choices.

Before beginning the strategy, the nurse should administer the BULIT and the tension stress scale to determine the client's risk for overeating and tension stress level before overeating, respectively. Scores on these measures serve as evaluation outcomes over time. The nurse should also encourage clients to think about the meaning that hunger has for them. In most cases, feeling hungry is associated with negative feelings of deprivation, past restrictions, and physical discomforts. They can learn to manage negative feelings associated with hunger and begin to think of hunger as a positive signal that tells them to eat.

Ways to Stop Overeating. Schwartz studied naturally thin people and discovered universal eating patterns.[67] Fat people have a different eating style, mainly that of eating certain predetermined foods and usually feeling deprived when these foods are forbidden. The sense of deprivation can lead to binge eating of the forbidden foods.

The three steps to stop overeating are written as positive self-talk (affirmations):

1. I eat only when I'm hungry, after rating my hunger on a scale of 1 to 10.
   a. Ravenously starved = 1
   b. Uncomfortably stuffed = 10
   c. Feeling nothing = 5
   d. Eating to satisfy hunger = between 4 and 6
2. I eat exactly what I want. My body has the natural ability to know what it wants and needs. When I crave "unhealthy, junk, and forbidden" foods, I ask myself if it is truly a physi-

cal craving; if so and I am hungry, I can eat it. If the food does not taste good, I don't eat it. I eat slowly, enjoying every bite. Eating slowly helps me fully experience the pleasure of eating the food. Eating slowly allows time for my brain to get the messages of satisfaction and feeling nothing (usually about 20 minutes). Conscious, enjoyable eating satisfies cravings so they will not return for a while.

3. I stop eating when my hunger is gone and I feel nothing (a rating of 5 on the 1 to 10 hunger scale). When I eat to a rating of 5, it is like drinking water until my thirst is gone. If hunger is still present, I take and enjoy three more bites slowly and then stop.

Minimum daily requirements may be met over two or three days rather than every day. When clients take in all of their calories to meet minimal daily requirements from foods that they "should" eat, extra calories eaten to satisfy natural cravings will be beyond their needs and result in stored fat. The American Diabetic Association Diabetic Diet consists of taking in six small feedings at regular intervals throughout waking hours.[68] The purpose is to keep blood sugar at a relatively stable level, preventing dramatic peaks and valleys. Similarly, the EAT for Hunger pattern does not allow dramatic swings between hunger and fullness. Current emphasis on portion control can be accomplished using the EAT for Hunger strategy. Increasing water intake to the recommended 8 to 10 cups per day also is essential for effective metabolic processes.

Old overeating habits come from self-talk that clients may need to become aware of and discuss. Later, new positive self-talk replacements can be learned to overcome these overeating habits:

- I always eat a "good breakfast"—even when I'm not hungry.
- I had better eat now, because I may not have time later.
- I always finish off my meals with a little something sweet.
- I always clean my plate (for the starving children).
- I cannot stand to throw away perfectly good food.
- I eat it whether it tastes good or not.
- I can't eat the foods I want until I eat the healthy foods I should eat first.

Preparation

In the preparation stage, clients begin to make lifestyle changes, but they perform the new behaviors sporadically and have not yet incorporated them as a permanent part of their lifestyles. The nurse can play an important supportive role at this time as the clients gradually override their individual reasons not to incorporate new behaviors into their lifestyles. After each success, they will gain confidence in their new behaviors and find ways to adapt daily habits to accommodate them. The nurse should not push clients at this stage, but rather should be available when they have questions and need suggestions. The Exercise for LIFE strategy is introduced at this stage because individuals often need to be at a higher level of change to put forth the effort and time demanded by regular exercise habits.

Exercise for LIFE Strategy. The purpose of the Exercise for LIFE strategy is to introduce regular, challenging exercise as a means to express self-value and love. The LIFE stands for Love self In Fitness and Exercise. When clients learn to accept exercise as part of their life, they learn to truly love themselves and their bodies. Valuing self enough to schedule and maintain regular exercise is an act of self-love. When they exercise for others (e.g.,

physician, spouse, friend, child), efforts are usually short-lived and can end in resentment. When they hold to a regular and challenging exercise plan, while at the same time allowing themselves to miss a few days without panic or guilt, they have learned to Exercise for LIFE.

Clients can be given the book *Fight Fat After Forty*.[69] Sessions may be divided equally to discuss the book's topics: reasons that women are fatter than men, use of aerobic and strength exercises to reduce fat, design of a personal aerobic and strength exercise program, incorporation of exercise into one's lifestyle. A health care professional should assess risks involved in performing aerobic and strength training before the client begins training. Once the client's safety is ensured, it is time to prescribe beginning, intermediate, and advanced levels of combined aerobic and strength training protocols based on physical exercise pre-testing results. When possible, the assistance of a colleague educated in exercise physiology or physical therapy is helpful for exercise testing. If colleagues cannot assist clients directly, they can assist the nurse in developing a step test that is easily administered in most settings.

In 1990, the American College of Sports Medicine recommended exercising two to three days per week at an intensity equal to 65 to 85 percent of age-predicted heart rate maximum (H R max).[70] Clients may use any mode of aerobic exercise to sustain heart rate within their working heart range for duration according to their fitness levels. To maintain fat-free mass and increase muscular strength and endurance, the American College of Sports Medicine recommends strength training (weight lifting) with one to three sets of 8 to 12 repetitions using moderate-intensity resistance at least two days per week. Clients should receive instruction about exercising all muscle groups using no equipment, minimal equipment, and strength training gym equipment. Muscle group and related exercises include leg press, bench press, leg curl, lateral pull shoulder press, calf raises, arm curls, triceps press, rowing, back extension, pectorals, and abdominals. Clients usually can begin training for the first month with one set of 12 repetitions at a resistance they can perform with ease (to minimize muscle damage and soreness).

By the second month, clients will perform according to beginning, intermediate, and advanced levels. The usual goal by the end of the first year is to participate in aerobic and strength exercises two to three times per week each, for a total of four to six exercise days per week (consistent with American College of Sports Medicine recommendations). If clients need regular, anticipated support, they may find it helpful to join a gym.

Ways to Get Regular, Challenging Exercise. To get ready for a regular and challenging exercise program, clients should seek physician approval and should ensure that their risks are minimal. They should wear loose-fitting, environmentally proper clothes and supportive shoes matched for the type of exercise (e.g., walking, jogging, cross-training). Clients should be knowledgeable about and plan for physical and environmental safety. The nurse should educate and help clients design exercise to fit their lifestyles.

- Clients can learn that having a healthy percentage of body fat (22 to 28%) is necessary for metabolic rate to be driven by fat-free or lean body mass. Excess fat is metabolically less active than muscle and results in a slow metabolism, making it more difficult to lose weight.
- Clients can learn about differences between aerobic and anaerobic exercise. Aerobic exercises (e.g., walking, slow jogging, swimming, biking) use

more oxygen, use large muscle groups, and are at lower intensities and of longer duration. Anaerobic exercises (e.g., running, swimming, stair-climbing, biking, weight lifting at a very fast/vigorous pace) use more glucose stores, usually use isolated muscle groups, and are at higher intensities and of shorter duration.

- An exercise schedule should address frequency, duration, and intensity. Frequency of aerobic exercises is three and four times per week; frequency of strength training/weight lifting exercises is two and three times per week. Duration of an aerobic workout is from 20 to 60 minutes; duration of a strength workout is from 30 to 60 minutes. Intensity of an aerobic workout is from 70 to 80 percent of the maximum heart rate. A quick method to calculate working heart range (the range within which rate should be kept to gain aerobic benefit) is:

  (220 − Age) × 70 percent (lower end) and × 80 percent (upper end)

  Example: 220 − 40 = 180
  180 × .80 = 144
  180 × .70 = 126

  Working heart range = 126 − 144

  Intensity of a strength workout is from one to two sets of 12 to 15 repetitions of lifting weights.

  Sample workout plans may be prescribed in four levels:

  1. Level 1: Exercise 3 days, 1 strength day, and 2 aerobic days
  2. Level 2: Exercise 4 days, 2 strength days, and 2 aerobic days
  3. Level 3: Exercise 5 days, 2 strength days, and 3 aerobic days
  4. Level 4: Exercise 6 days, 3 strength days, and 3 aerobic days

- An exercise workout should start with stretching the arms and legs in a static stretch without bouncing. Then comes the warm-up, lasting three to five minutes to increase the heart rate slowly. After the exercise is the cool-down phase, which is slow-paced, continuing aerobic exercise, again followed by stretching the arms and legs in a static stretch without bouncing.
- A slight soreness 12 to 24 hours after exercise shows that the muscles have been sufficiently challenged to require energy-expending repair to build muscle and indicates an increased excess post-exercise oxygen consumption (EPOC). Often called afterburn, EPOC helps clients lose excess fat even at rest, particularly with resistance exercise. For maximum benefit, the client should not do the same workout repeatedly, since the body adapts and will not be challenged.
- Scheduling exercise weekly ahead of time will help develop a new habit. Writing workout days and times in the personal calendar can build the commitment to exercise. Great variability in workouts from day to day will prevent boredom and maximize use of different muscle groups. Workouts with friends and family add interest and challenge.

Action

At six months, clients usually have their eating and exercise habits well under control and have experienced pride and satisfaction in their lifestyle changes. They still can resume former habits if boredom, illness/injury, life crises, and burnout occur, however. Thus, it is especially important at this stage to introduce the cognitive portion of the intervention to help prevent relapse. They can truly understand that their new eating and exercise habits are for a lifetime. By learning to listen to their self-talk, they can decrease negative self-talk and increase positive self-talk to support long-term, holistic self-care weight

management. The STOP emotional eating strategy based on reversal theory can help clients pinpoint and change their most threatening and sabotaging self-talk.

STOP Emotional Eating Strategy. The purpose of the STOP Emotional Eating strategy is to separate emotions from eating responses and direct actions for managing underlying stress without eating to cope. Clients can be given copies of books such as *Self-Esteem*,[71] *The Language of Letting Go*,[72] and *Fight Fat After Forty*.[73]

Clients can complete homework using self-talk worksheets for identifying and reframing negative self-talk into positive self-talk replacements (see Exhibit 27–1). Discussion topics include how beliefs, thinking, feelings, and actions are related. Individual and group discussions can include real-life examples of each type of irrational thinking:

- All-or-nothing thinking—perceiving absolute, black and white categories.
- Overgeneralization—seeing negative situation as never-ending.
- Mental filter—dwelling on negatives, ignoring positives.
- Mind reading and fortune telling—interpreting others/events as negative without the facts.
- Magnification or minimization of importance—blowing situation out of proportion or shrinking it unrealistically.
- "Shoulding" and blaming—saying should, shouldn't, have to and take/don't take too much/not enough responsibility.
- Labeling—naming self instead of behavior (instead of I *made* a mistake, I *am* a mistake).

To counter each type of irrational thinking, clients can review and practice the challenges to irrational thinking:

- Where is the *evidence* that this thought is true/not true?
- Would an informal *survey* of those I trust show that this thought is realistic?
- Would I talk to and treat my *best friend* the way I talk to and treat myself?
- Can I consider *shades of gray* instead of black and white thinking?
- How can "should thinking" be restated with "preferably" and "sometimes"?

Ways to Change Negative Self-Talk Triggers. Helping clients use reversal theory to balance their eight ways of being human begins with an examination of the frequent emotions found to trigger overeating and lack of exercise. At this point, the effort focuses on desensitizing, practicing, and accepting being in the negativistic state. Then the four steps for fighting fair are phrased as positive self-talk (affirmations):

1. I tell objectively the facts about what happened. ("I saw you with Lucy after you told me you didn't have time to get together this evening.")
2. I tell what I didn't like about his or her behavior. ("I didn't like seeing you with another of your friends after you told me you didn't have time for us to get together.")
3. I tell how I feel about it. ("I felt pushed aside for you to be with Lucy instead of me; I felt unimportant; I felt lonely.")
4. I tell what I realistically want him or her to do. ("I would like to spend time with you every week, and I would like you to make some time for me if that's what you want also.")

By knowing the positive and negative feelings associated with each state, clients can pinpoint states in which they repeatedly experience increased tension

stress and turn to overeating to deal with the unpleasant feelings. After posing questions for the eight states to help clients understand their personal meanings and beliefs, the nurse can suggest healthy self-talk replacements.

1. ***In the telic state***, feeling pleasant is experienced as flow and productivity, while feeling unpleasant is experienced as anxiety. In the paratelic state, feeling pleasant is experienced as flow and fun, while feeling unpleasant is experienced as boredom. Questions to raise consciousness and pinpoint areas of growth include:
   - What do I believe about work and play? About being serious and fun-loving?
   - To me (work/serious-minded)(play/fun-loving) is _____.
   - Being serious/playful is different for women compared to men in these ways: _____.
   - I believe (work/seriousness) (play/light-heartedness) is important because _____.

   New, healthy self-statements about work and play include:
   - It is good for me to work and be serious-minded because _____.
   - It is good for me to play and be fun-loving because _____.
2. ***In the conformist state***, feeling pleasant is experienced as feeling protected, while feeling unpleasant is experienced as feeling unprotected (fear people won't like/love me if I don't act/perform/dress/etc. . . . perfectly). In the negativistic state, feeling pleasant is experienced as feeling free, while feeling unpleasant is experienced as feeling trapped (fear that if I express my anger or don't act as I should, people won't like/love me). Questions to raise consciousness and pinpoint areas of growth include:
   - Do I feel I have unconditional love, positive regard, and am I taken seriously?
   - Do I fear abandonment? I can really be ME, and you won't leave me?
   - Have I learned to meet others' narcissistic needs to provide what they never got from their parents out of fear of not being loved, disapproval, or abandonment?

   New, healthy self-statements about being conformist and negativistic include:
   - Sometimes I will choose to do things less than 100 percent.
   - Sometimes I will choose to ask others to do my task.
   - It's OK to be angry if I fight fair.
3. ***In the mastery state***, feeling pleasant is experienced as feeling hardy and strong, while unpleasant feelings are experienced as feeling soft and wimpy (fear of not being liked/respected if I appear weak, less than perfect). In the sympathy state, feeling pleasant is experienced as feeling sensitive and cared for, while feeling unpleasant is experienced as feeling insensitive and ashamed (fear if I don't act as I should, people won't like/love me). Questions to raise consciousness and pinpoint areas of growth include:
   - When I truly feel like giving myself a break and being tender with myself, does it feel good, or do I feel guilty?
   - Why can't I feel my real feelings? And when I do feel, why do I eat to feel better?

   New, healthy self-statements about work and play include:
   - I choose to feel my true feelings even when they hurt.

- I have the knowledge and skills to express my feelings effectively.

4. ***In the alloic state***, feeling pleasant is experienced as feeling modest, useful, and loyal, while feeling unpleasant is experienced as shame and guilt (fear of not being liked/loved/respected if I put myself first). In the autic state, feeling pleasant is experienced as feeling satisfied with self, grateful, and cared for while feeling unpleasant is experienced as feeling humiliated, resentful, hurt, and deprived (fear if I don't act as others expect me to act and do what they want, they won't like/love/stay with me). Questions to raise consciousness and pinpoint areas of growth include:
   - Why can't I give to myself first?
   - Are these my beliefs versus those of my parents, teachers, religious leaders?
   - Why do I feel undeserving of being first?
   - Do I have to earn the right to consider myself before others?

   New, healthy self-statements about work and play include:

   - I choose to put myself first; right now I need my full attention.
   - I choose to give to/spend time with this person.
   - I choose to omit feeling guilty from my vocabulary and my life.

Maintenance

Beyond six months of clients' practicing and refining lifestyle changes, the nurse can be very instrumental in helping them maintain their lifestyle changes by continuing supportive actions such as being available to answer questions, providing resources, and assisting with modifications in eating and exercise routines. By allowing clients to stay "in touch" and approaching them when the nurse has innovative ideas, the nurse may spark their new and continued interest in their programs.

The nurse may help clients to examine their patterns when they overeat and do not exercise to discover ways to reinforce and strengthen areas of deficit. For example, the nurse may suggest that a client examine the last months of daily exercise sheets for the following:

1. What are the total number of days I reported?
2. What is my average number of exercise days per week?
3. What is my major trigger for not exercising?

The client may also examine overeating over the last months of daily sheets for the following:

1. What is my average number of overeating days per week?
2. What is my major trigger for overeating?
3. On the days I overate, did I exercise or not?
4. On the days I exercised, did I overeat or not?
5. On the days I did not exercise and overate, what reversal theory state was I in and how high was my tension stress?
6. What way of being human do I need to work on?

The final key to lasting change is *acceptance*. When clients fully accept sadness, anger, and the bad, irritating things in life, rather than try to change perfectly, manipulate, succumb to, and overpower these things, a peace can settle into their spirits. Acceptance opens new possibilities that can help move them ahead to grow beyond obstacles. The nurse may point out that constantly "fighting it" (like trying to break the door down) actually can keep them in one place stuck in the past. As a key in a locked door, acceptance can move them to places they have never been or even fathomed.

The nurse guides and directs clients to write in a journal the most problematic obstacle in simple, succinct statements. Obstacles are the triggers that repeatedly set-off negative self-talk that keep clients overeating, not exercising, and feeling bad about themselves. Four steps to the acceptance of the obstacles are written as positive self-talk (affirmations):

1. I say aloud the statements about what I am accepting one time with my eyes open.
2. I say aloud the statements about what I am accepting one time with my eyes closed.
3. I pray/meditate for complete acceptance and am silent with my eyes still closed, listening to and accepting whatever comes to mind.
4. I repeat this exercise daily until it feels comfortable and unnecessary to continue on a daily basis.

Case Study

A.W., a single 34-year-old high school English teacher, experienced all the stages of change over a period of approximately one year. At each stage, the client was asked to rate her readiness in response to a listing and descriptions of the stages of change.

A.W. in the Precontemplation Stage

Setting: Afternoon appointment in a health clinic for Pap smear and breast examination

Patterns/ Challenges/ Needs:

1. Altered nutrition, more than body requirements (167 pounds, 5 feet, 2 inches tall, 31 body mass index, 35 percent body fat)
2. Body image disturbance (8 on a 10-point scale, 1 being best)
3. Hopelessness related to 17 years of past failures at weight management

After her regular wellness check, Pap smear, and breast examination, A.W. told her story in a brief life review and weight management history. She had a 17-year history of weight cycling that began when she was in high school. She had always been active in sports and aerobic exercise. In high school, she had a muscular build and average weight. When she entered college, she was less active because she studied more to keep her grades above average. She always felt a lot of pressure from her parents to make all A's and become a college professor like her father.

In high school and college, A.W. developed a habit of munching on chips and candy while studying. She continued the habit as she prepared lectures and graded papers as a high school teacher. As she gradually gained weight and became more self-conscious about her physical appearance, she did not pursue relationships with men. She remained healthy except for occasional sinus headaches. Because she dieted and exercised throughout the 17 years of weight cycling, she was very pessimistic about her ability to lose and maintain a healthy weight. She became tearful when she told of her repeated failures and said that she was much too busy to exercise regularly.

A.W. was in relatively good physical health other than being mildly obese and inactive. She was to return to the clinic for blood work to be drawn within the next two weeks. She was rated "at risk" for binge eating on the BULIT scale, and she ranked her body image as an 8 on a 10-point scale (1 being best). She rated herself as being in the precontemplation stage; she was given a brochure that contained a section in which the nurse wrote a report of the physical findings to date, the health risks involved, and a summary of the holistic self-care model weight management program offered at the clinic. The nurse

answered questions and encouraged A.W. to call her for more information about the program whenever she was ready.

A.W. in the Contemplation Stage

Setting: Return appointment of A.W. one month later in a health clinic for blood work (blood glucose and lipid levels)

Patterns/ Challenges/ Needs:
1. Altered nutrition, body requirements
2. Body image disturbance
3. Hopelessness

A.W.'s blood glucose level was within normal range, but her total cholesterol level and cholesterol/high-density lipoprotein ratio were slightly elevated. She said that she had been thinking about the program and wondered if individuals could choose to attend individual or group sessions. She asked for clarification about the fact that the brochure specified no type of diet—only eating according to hunger. When the nurse asked if A.W. was considering making some changes in eating and exercise, A.W. said that she was intrigued about a "no-diet" diet. The nurse noted A.W.'s interest in attending a group session and gave her the month's schedule of meetings about the EAT for Hunger strategy in the clinic's weight management program.

A.W. in the Preparation Stage

Setting: Last evening group meeting about the EAT for Hunger strategy in the clinic's weight management program (one month later after four group meetings)

Patterns/ Challenges/ Needs:
1. Altered nutrition, more than body requirements
2. Body image disturbance
3. Hopelessness
4. Decreased mobility related to no regular exercise program
5. Increased tension stress before overeating episodes —"at risk" scores on the tension stress scale

A.W. related that she enjoyed the group meetings about EAT for Hunger and felt great relief not dieting. She said that she realized how much she had been eating when she was not hungry, especially when she felt pressured to complete her teaching responsibilities. She expressed more hope that she could cut down on overeating by using the new EAT for Hunger strategy. Her major difficulty with the strategy was stopping at a "5" when her hunger was gone (preparation stage). A.W. also said that she was planning to attend next month's sessions on the Exercise for LIFE strategy, although she had not changed her activity level to date (contemplation stage for exercise).

A.W. in the Action Stage

Setting: Last evening group meeting about the Exercise for LIFE strategy in the clinic's weight management program (one month later)

Patterns/ Challenges/ Needs:
1. Altered nutrition, more than body requirements—loss of 6 pounds
2. Body image disturbance—rated 7 on a 10-point scale (1 is best)
3. Hopelessness—more hopeful to make long-term lifestyle changes in new program with group support
4. Decreased mobility related to no regular exercise program—attending group meetings regularly and beginning a 3- to 4-day per week workout program

5. Increased tension stress before overeating episodes —overeating less often, but tension stress still high with overeating

A.W. began walking with a friend twice every week and came early to walk with two group members before meetings once a week. She bought videotapes of combined aerobics and strength exercises and did a 30-minute workout before leaving for work once a week. She lost 3 more pounds at the end of the third month of participating in the program and lost inches in her body proportions almost equal to one dress size.

A.W. began the third month of the program learning how to STOP emotional eating. She described the pressures in her high school teaching job that kept her eating when anxious. Others in the group explained how troubled relationships with husbands, friends, and family members often precipitated overeating. A.W. could not relate to their stories, because she almost never had disagreements with her father, mother, and women friends. Gradually, through the use of the self-talk worksheets, she discovered sources of anxiety, boredom, and anger of which she was unaware. Perhaps her most startling discovery was her new awareness of feeling angry with her father's high expectations and her resultant perfectionism. She did not feel comfortable expressing her feelings in the group; she felt guilty and thought she was being a dishonorable daughter.

A.W. announced to her group three weeks later that she was so confident in her progress that she was going to continue working on her own and not return to the group. She said that she needed the extra time for her increasing work demands. She expressed sadness about leaving the group, but was excited to live her new lifestyle on her own.

A.W. did not return to the group until three months later after she came to the nurse for a bout with the flu and a sinus infection. She said that it was more difficult to continue the EAT, LIFE, and STOP strategies on her own without the group support. She had regained 4 pounds, but continued to exercise two times most weeks. She thought of returning to the group several times, but said that she thought the discussions were too personal at times. When the nurse asked for specifics, she learned about the anger that A.W. felt toward her father and the consequent guilt she experienced.

A.W. and the nurse agreed to have two or three private, individual sessions to learn more about A.W.'s angry feelings and how they relate to overeating and not getting regular exercise. A.W. was able to understand her perfectionistic behaviors and need for others' approval. After two weekly individual sessions, she said that she wanted to return to the group to continue work in the program.

A.W. in the Maintenance Stage

Setting: Last evening group meeting about the Acceptance of Obstacles in the clinic's weight management program (about 11 months after first meeting A.W. attended)

Patterns/ Challenges/ Needs:

1. Altered nutrition, more than body requirements—from 167 to 148 pounds, from 31 to 27 body mass index, from 35 to 32 percent body fat
2. Body image disturbance—from an 8 to a 6 on a 10-point scale (1 being best)
3. Hopelessness—diagnosis resolved after individual counseling and continued group work
4. Decreased mobility related to no regular exercise program—improving; need more strength exercises

added to workout to maximize metabolic rate
5. Increased tension stress before overeating episodes —lowered "at risk" scores (i.e., within normal range on the tension stress scale)

A.W. returned to group meetings at least monthly, but found individual help from a psychologist recommended by the nurse to work on issues of self-esteem, perfectionism, and approval needs. A.W.'s EAT for Hunger and Exercise for LIFE habits were becoming integrated into her lifestyle. She found that writing in her journal was a helpful way to work on her own issues when not in the group or in counseling. Her major focus was on acceptance and love of herself. Although the experience was painful at times, A.W. said that she was thankful to have greater insight into her past overeating and no-exercise habits.

Evaluation

With clients, the nurse determines whether their outcomes for weight management were achieved (see Exhibit 27–6). To evaluate clients' progress on goals, the nurse examines with them their weekly and daily calendar sheets. Together, the nurse and a client may explore the subjective effects of their experiences in the program by answering the questions found in Exhibit 27–7.

Exhibit 27–7 Evaluating the Client's Subjective Experience with Weight Management Interventions

1. How am I feeling about myself and my progress right now?
2. Do I have any questions about my eating and exercise programs?
3. What new insights have I gained about my self-talk?
4. What is my next step, and do I need help to take that step?
5. Are my goals realistic for me right now?
6. What pain and joy can I expect in reaching my goals?
7. Am I seeking my Higher Power to accept the things that I cannot change, and am I thinking positively about changing the things I can change?

DIRECTIONS FOR FUTURE RESEARCH

1. Contrast and evaluate discrepancies between nurses' and clients' perceptions of client readiness according to the transtheoretical stages of change for eating, exercise, and psycho-social-spiritual work.
2. Analyze clients' progress toward outcome variables listed in Exhibit 27–6, and describe differences among individuals within and between different stages of change.
3. Analyze clients' progress toward outcome variables listed in Exhibit 27–6 according to whether they received primarily individual, group, or a combination of individual and group counseling sessions.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- How did I accommodate my eating within the food pyramid and the American Diabetic Association diet using the EAT for Hunger strategy?
- How did my personal aerobic and strength exercise program incorporate the Exercise for LIFE strategy?
- How did I deal directly with unpleasant feelings, instead of eating to cope, using the STOP overeating strategy?

NOTES

1. National Center for Health Statistics, Centers for Disease Control, *Prevalence of Overweight and Obesity Among Adults* (Hyattsville, MD: National Center for Health Statistics, Centers for Disease Control, 1999).
2. A. Wolf et al., Current Estimates of the Economic Cost of Obesity in the United States, *Obesity Research* 6 (1999):97–106.
3. M. Perri et al., *Improving the Long-Term Management of Obesity* (New York: John Wiley & Sons, 1992), 39.
4. C.B. Ferster et al., The Control of Eating, *Journal of Mathetics* 1 (1962):87–109.
5. G.M. Timmerman et al., Dieting, Perceived Deprivation, and Preoccupation With Food, *Western Journal of Nursing Research* 25 (2003):405–418.
6. M.A. Friedman et al., Differential Relation of Psychological Functioning with the History and Experience of Weight Cycling, *Journal of Consulting and Clinical Psychology* 66 (1998):646–650.
7. National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health, *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report* (United States Department of Health and Human Services, Public Health Service, 1998).
8. R.L. Leibel et al., Biochemistry and Development of Adipose Tissue in Man, in *Health and Obesity*, eds. H.L. Conrt et al. (New York: Raven Press, 1983), 21–48.
9. I.M. Faust et al., Diet-Induced Adipocyte Number Increase in Adult Rats, *American Journal of Physiology* 235 (1978):E279–E286.
10. Perri et al., *Improving the Long-Term Management of Obesity*.
11. D.W. Reiff and K.K. Reiff, *Eating Disorders* (Gaithersburg, MD: Aspen Publishers, 1992).
12. R. Keesey, A Set-Point Theory of Obesity, in *Handbook of Eating Disorders*, eds. K. Brownell and J.P. Foreyt (New York: Basic Books, 1986), 103–123.
13. J.S. Garrow, *Energy Balance and Obesity in Man* (New York: Elsevier, 1978).
14. Perri et al., *Improving the Long-Term Management of Obesity*, 39.
15. K.D. Brownell, *The LEARN Program for Weight Control* (Dallas, TX: American Health Publishing Company, 1997).
16. R.W. Jeffery et al., Strengthening Behavioral Interventions for Weight Loss: A Randomized Trial of Food Provision and Monetary Incentives, *Journal of Consulting and Clinical Psychology* 61 (1993):1038–1045.
17. J.P. Foreyt et al., The Role of the Behavioral Counselor in Obesity Treatment, *Journal of the American Dietetic Association* 98 (1998):S27–S30.
18. R.E. Vath, Psychiatric Factors, in *Eating Disorders*, eds. D.W. Reiff and K.K. Reiff (Gaithersburg, MD: Aspen Publishers, 1992), 457–462.
19. K.M. Carpenter, Relationships Between Obesity and DSM-IV Major Depressive Disorder, Suicide Ideation, and Suicide Attempts, *American Journal of Public Health* 90 (2000):251–257.
20. A.T. Beck, *Cognitive Therapy and the Emotional Disorders* (New York: International Universities Press, 1976).
21. K.D. Brownell et al., The Dieting Maelstrom: Is It Possible and Advisable To Lose Weight?, *American Psychologist* 49 (1994):781–791.
22. M.L. Klem et al., A Descriptive Study of Individuals Successful at Long-term Maintenance of Substantial Weight Loss, *American Journal of Clinical Nutrition* 66 (1997):239–246.
23. Friedman et al., Differential Relation of Psychological Functioning with the History and Experience of Weight Cycling, 66.
24. R.J. Kuczmarski et al., Increasing Prevalence of Overweight Among U.S. Adults: The National Health and Nutrition Examination Surveys, 1960–1991, *Journal of the American Medical Association* 272 (1994):205–211.
25. R. Green, Americans Eat Less Fat But Are Getting Fatter, *The Kansas City Star* (17 January 1996):A1, A6.
26. Ibid.
27. American Dietetic Association, Position on Weight Management, *Journal of the American Diabetic Association* 97 (1997):71–74.
28. National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health, *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report*.

29. K.D. Brownell and T.A. Wadden, Etiology and Treatment of Obesity: Understanding a Serious, Prevalent, and Refractory Disorder, *Journal of Consulting and Clinical Psychology* 60 (1992):505–517.
30. Foreyt et al., The Role of the Behavioral Counselor in Obesity Treatment, 98.
31. Perri et al., *Improving the Long-Term Management of Obesity*, 103.
32. T.A. Wadden, Treatment of Obesity by Moderate and Severe Calorie Restriction, *Annals of Internal Medicine* 119 (1993):688–693.
33. B.J. Jones et al., The Medical Benefit of 5-HT, *Research, Pharmacology, Biochemistry, and Behavior* 71 (2002):555–568.
34. C.K. Haddock et al., Pharmacotherapy for Obesity: A Quantitative Analysis of Four Decades of Published Randomized Clinical Trials, *Clinical Pharmacology and Therapeutics* 51 (1992):619–633.
35. U. McCann et al., Dexfenfluramine and Serotonin Neurotoxicity: Further Preclinical Evidence That Caution is Indicated, *Journal of Pharmacology and Experimental Therapeutics* 269 (1994):792–798.
36. E. Poehlman et al., The Impact of Exercise and Diet Restriction on Daily Energy Expenditure, *Sports Medicine* 11 (1991):78–101.
37. National Heart, Lung, and Blood Institute (NHLBI), National Diabetes Information Clearinghouse, *http://www.niddk.nih.gov/health/diabetes/pubs/insulinres/index.htm#2*.
38. National Task Force on the Prevention and Treatment of Obesity, Overweight, Obesity, and Health Risk, *Archives of Internal Medicine* 160 (2000):898–904.
39. S.B. Roberts et al., High-Glycemic Index Foods, Hunger, and Obesity: Is There a Connection?, *Nutrition Reviews* 58 (2000):163–169.
40. R.R. Wing et al., Effect of Modest Weight Loss on Changes in Cardiovascular Risk Factors: Are There Differences Between Men and Women or Between Weight Loss and Maintenance, *International Journal of Obesity-Related Metabolic Disorders* 19 (1995):67–73.
41. G.D. Foster et al., What is a Reasonable Weight Loss? Patients' Expectations and Evaluations of Obesity Treatment Outcomes, *Journal of Consulting and Clinical Psychology* 65 (1997):79–85.
42. American Dietetic Association, Position on Weight Management, 74.
43. C.M. Grilo et al., The Metabolic and Psychological Importance of Exercise in Weight Control, in *Obesity: Theory and Therapy*, eds. A.J. Stunkard and T.A. Wadden (New York: Raven Press, 1993).
44. Brownell et al., The Dieting Maelstrom: Is It Possible and Advisable To Lose Weight?, 791.
45. J.I. Robison and K. Carrier, Reinventing Health Promotion: Moving from Biomedical, Risk-Factor Control to Holistic Health and Healing, *Wellness Management* 15 (1999):8–10.
46. P. Peeke, *Fight Fat After Forty* (New York: Penguin Books, 2000).
47. M. Beattie, *The Language of Letting Go: Daily Medications for Codependents* (New York: Harper Collins, 1990).
48. W. Dyer, *10 Secrets for Success and Inner Peace* (Carlsbad, CA: Hay House, 2001).
49. Brownell, *The LEARN Program for Weight Control*, 94.
50. J. Turner et al., Nurse Practitioner and Client Partnerships in Long-Term Holistic Weight Management, *American Journal of Nurse Practitioners* 6 (2002):9–18.
51. M.J. Devlin et al., Obesity: What Mental Health Professionals Need to Know, *American Journal of Psychiatry* 157 (2000):854–866.
52. M. Apter, *Reversal Theory: Motivation, Emotion, and Personality* (London: Routledge, 1989), 18–32.
53. K.A. O'Connell et al., Reversal Theory's Mastery and Sympathy States in Smoking Cessation, *Image* 27 (1995):311–316.
54. S.A. Popkess-Vawter et al., Reversal Theory, Overeating, and Weight Cycling, *Western Journal of Nursing Research* 20 (1998):67–83.
55. Beck, *Cognitive Therapy and the Emotional Disorders*.
56. S.A. Popkess-Vawter et al., Unpleasant Emotional Triggers to Overeating and Related Intervention Strategies for Overweight and Obese Women Weight Cyclers, *Journal of Applied Nursing Research* 11 (1998):69–76.
57. S.A. Popkess-Vawter et al., Development and Testing of the Tension Stress Scale, *Journal of Nursing Measurement* 8 (2002):2.
58. Popkess-Vawter et al., Reversal Theory, Overeating, and Weight Cycling, 67.
59. Brownell et al., The Dieting Maelstrom: Is It Possible and Advisable To Lose Weight?, 791.
60. S.A. Popkess-Vawter et al., Use of the BULIT Bulimia Screening Questionnaire To Assess Risk and Progress in Weight Management for Overweight Women Who Weight Cycle, *Addictive Behaviors* 24 (1999):497–507.

61. Popkess-Vawter et al., Unpleasant Emotional Triggers to Overeating and Related Intervention Strategies, 76.
62. Popkess-Vawter et al., Use of the BULIT Bulimia Screening Questionnaire, 4.
63. Popkess-Vawter et al., Development and Testing of the Tension Stress Scale, 3.
64. J.O. Prochaska and C.C. DiClemente, In Search of How People Change, *American Psychologist* 47 (1992):1102.
65. B.H. Marcus and L.H. Forsyth, The Challenge of Behavior Change, *Medicine and Health* 80 (1997):300–302.
66. B. Schwartz, *Diets Still Don't Work* (Houston, TX: Breakthru Publishing, 1990), 58–62.
67. Ibid.
68. The American Diabetes Association and the American Dietetic Association, *Exchange Lists for Meal Planning* (Chicago: ADA Press, 1995).
69. Peeke, *Fight Fat After Forty*.
70. American College of Sports Medicine, *ACSM Position Stand: The Recommended Quantity and Quality of Exercise for Developing and Maintaining Cardiorespiratory and Muscle Fitness in Healthy Adults* (Houston, TX: Breakthru Publishing, 1990), 265–274.
71. M. McKay and P. Fanning, *Self-Esteem* (Oakland, CA: New Harbinger Publications, 2000).
72. Beattie, *The Language of Letting Go: Daily Medications for Codependents*.
73. Dyer, *10 Secrets for Success and Inner Peace*.

SUGGESTED RESOURCES

For additional information, see the following websites:

American College of Sports Medicine
http://www.acsm.org/health%2Bfitness/index.htm

American Dietetic Association
http://www.eatright.org/Public

Centers for Disease Control and Prevention
www.cdc.gov/washington/overview/obesity.htm

National Center for Health Statistics
www.cdc.gov/nchs/products/pubs/pubd/hestats/obese/obse99.htm

National Heart, Lung, and Blood Institute, National Institutes of Health
http://www.nhlbi.nih.gov/nhlbi/cardio/obes/prof/guidelns/sum_evid.htm
http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm
http://www.nhlbi.nih.gov/about/oei/index.htm

National Institute of Diabetes & Digestive & Kidney Diseases
http://www.niddk.nih.gov/health/nutrit/nutrit.htm

U.S. Department of Agriculture—Food Pyramid
http://www.nal.usda.gov:8001/py/pmap.htm

Acknowledging Fear

What is fear, and where does it come from? Fear can surface as we contemplate changes in lifestyle patterns. For example, a person who wishes to stop smoking fears not being able to stop, gaining weight, experiencing nicotine withdrawal, and offending other people by asking them not to smoke, among other things. Fear comes only in relation to something else. If this is so, how can we gain freedom from fear? This is the healing journey—learning more about fear in relationship with all things.

Fear somehow can attach itself to the spirit and lodge somewhere within the physical body. Fear makes us feel separate and alone, but it can become a path that will lead deeper into the present moment. It does not have to be a barrier to the moment. Although fear always creates more fear, its every occurrence can become a moment to learn more about another level of life's journey. Fear is useful in that it alerts us to areas in which we have some resistance. Releasing the fear returns us to our unconditional core of love so that we release the "shoulds." Approaching an event with the notion that we "should" behave in a certain way further distances us from our core of being present in the moment. The basic human fears—fear of failure, fear of rejection, fear of the unknown, fear of isolation, fear of dying, and fear of loss of self-control—are closely related and may overlap. Any kind of fear is related to our level of self-esteem. When our self-esteem is low, our fears even increase. The negative self-talk intensifies the lack of self-confidence and takes us further from the resolution of the fear. It is helpful to identify our stressors and determine the fears that they evoke. We need to reflect on the following questions:

- *How do I usually deal with my fears? Am I the type of person who hopes that the circumstances surrounding these fears will go away?*
- *Does one of these basic human fears tend to dominate my list of stressors? If so, why do I suppose that is the case?*
- *What strategies can I use to deal with some of these major fears?*

Chapter 28

Smoking Cessation: Freedom from Risk

Christine Anne Wynd and Barbara Montgomery Dossey

NURSE HEALER OBJECTIVES

Theoretical

- Analyze the bodymind responses to nicotine.
- Examine theoretical strategies for successful smoking cessation.

Clinical

- Interview a client who smokes and listen to the reasons that the client gives for smoking. Ask if the client has ever tried to quit smoking or will attempt smoking cessation again.
- Give the Smoking Profile Questionnaires to clients. Discuss the scores with clients to gain insight into what the meaning of smoking is to them, and explore ways to teach smoking cessation.
- Design interventions that correspond to the stages and processes of change as appropriate to the client.

Personal

- Examine the effect of passive smoking on you.
- If you are a smoker, identify habit breakers to become a successful nonsmoker.

DEFINITIONS

Focused Smoking: a smoking reduction technique done under supervision.

Habit Breakers: new action behaviors that replace old smoke signals.

Nicotine Fading: gradual reduction of the nicotine level in the body to avoid withdrawal symptoms.

THEORY AND RESEARCH

The Prevalence of Smoking and Its Health Consequences

Smoking is a major health hazard as well as the chief preventable cause of death in the United States. It is responsible for an estimated 430,000 deaths annually, or approximately one of every five deaths.[1] Tobacco kills more people than acquired immunodeficiency syndrome (AIDS), car accidents, alcohol, homicides, illegal drugs, suicides, and fires combined.[2,3] Cigarette smoking contributes to four of the five leading causes of death per year in the United States, including lung cancer (124,813 deaths), ischemic heart disease (81,976 deaths), chronic airway obstructive disease (64,735 deaths), and stroke (24,000 deaths).[1] The United States spends more than $75.5 billion each year for smoking-related health care costs.[1] In the international scene, it is estimated that by the

year 2020, tobacco will kill more people than any single health problem, including the human immunodeficiency virus (HIV) epidemic.[2]

Smokers constitute 23.3% of the U.S. population. Twenty-six percent of males and 21.0% of females smoke cigarettes, and 24.1% of white adults and 23.2% of African-Americans use tobacco.[4] Rates of smoking prevalence continue to be high among certain population groups, especially American Indians/Alaska Natives (36.0%), blue-collar workers, and military personnel (approximately 30.0%).[4,5] Five years ago a most frightening trend was noted with the nation's youth: High school students had a significant increase in smoking prevalence. Fortunately, that trend is turning and improvements are being seen, possibly due to 70% increases in retail prices on cigarettes, increased efforts in the schools to prevent tobacco use, and aggressive media campaigns focusing on the extremely adverse effects of smoking and tobacco use. Prevalence of current smoking in high school students is 28.5%, which is down from a rate of 36.4% in 1997.[6]

Environmental tobacco smoke (ETS) is a combination of smoke from the burning end of a cigarette, cigar, or pipe and the smoke exhaled from a smoker's lungs.[7] It contains more than 4,000 highly toxic chemicals, such as formaldehyde, nitrogen oxide, acrolein, Group A carcinogens (asbestos), cadmium, nickel, and carbon monoxide. In addition, ETS contains a radioactive substance from tobacco leaves that are subjected to high phosphate fertilizers.[8]

Children and adults exposed to ETS have a greater risk for respiratory illness, including lung cancer; higher rates of respiratory tract infections; exacerbation of asthma; otitis media; and sudden infant death syndrome.[7–9] Aligne and Stoddard found that the exposure of children to parental smoking costs the United States $4.6 billion in annual direct medical expenditures.[10] Increased exposure to ETS nearly doubles a woman's risk of heart attack.[11] Measures of cotinine, a metabolite of nicotine in the bloodstream, demonstrate that 37% of adult nonsmokers, and 43% of U.S. children, aged 2 months through 11 years, are exposed to ETS in their homes or workplaces.[12]

In the United States, approximately 70% of children live in homes where at least one adult smokes. Because mothers usually spend more time in the home and more time with their children than do fathers, maternal smoking has been linked with childhood respiratory problems. Data available on 4,331 children, from infants to five year olds, show that young children whose mothers smoke more than ten cigarettes per day are twice as likely to develop asthma as are children of nonsmokers.[13] These same youngsters are 2.5 times more likely to develop asthma in their first year of life and 4.5 times more likely to need medicine to control asthma attacks. Maternal smoking remains an indicator of childhood asthma even after variables such as gender, race, presence of both biologic parents in the household, and number of rooms in the house were taken into account.[14]

Physiologic Responses to Smoking

Smoking and tobacco contribute directly to death. Yet, deaths from smoking do not receive the same amount of attention from the news media as do airplane crashes, violence, and disease epidemics, situations resulting in far fewer deaths. Smoking causes more deaths, but these deaths take a very long time to occur.

Over time, smoking strips the lungs of their normal defenses and completely paralyzes the natural cleansing processes. The early morning cough associated with smoking results from attempts by the bronchial cilia to clear the thick yellow or

yellow-green mucus that accumulates in the air passage to an abnormal amount because toxic cigarette smoke interferes with the cilias' normal function. This cleansing action triggers the cough reflex. As exposure continues, the bronchi begin to thicken, which predisposes the person to bacterial and viral infections, asthma, emphysema, and cancer.[15–17]

The smoker's heart rate speeds up an extra 10 to 25 beats per minute, with a predisposition to dysrhythmias. The blood pressure increases by 10 to 15 percent, thus exposing the person to risks of myocardial infarction, stroke, and vascular disease.[18]

Within seconds after the smoke is inhaled, irritating gases (e.g., formaldehyde, hydrogen sulfide, ammonia) begin to affect the eyes, nose, and throat. With each inhaled breath of smoke, carbon monoxide enters the bloodstream, and its concentration eventually rises to a level 4 to 15 times as high as that of a nonsmoker. The carbon monoxide passes immediately to the bloodstream, binding to the oxygen receptor sites and, thus, depleting the cells of oxygen. Hemoglobin, which normally carries oxygen throughout the body, becomes bound to the carbon monoxide and is converted to carboxyhemoglobin, which is unable to deliver oxygen to the cells. In addition, smoking increases platelet aggregation, allowing the blood to clot more easily.[19,20]

The constriction of tiny blood vessels decreases the delivery of oxygen to the skin and contributes to "smoker's face," where deep lines appear around the mouth, eyes, and center of the brow. There is an established link between nicotine and erection problems in male smokers, and smoking is believed to be the leading cause of impotence in the United States today. Smoking also adversely affects fertility by decreasing sperm count and sperm motility. Female smokers are three times more likely than nonsmoking females to be infertile, and female heavy smokers have a 43 percent decline in fertility.[21]

Nicotine is the drug inhaled from cigarettes that quickly reaches the smoker's brain. As the average smoker takes an estimated 10 puffs per cigarette, a pack-a-day smoker gets about 200 puffs per day. Each nicotine "hit" goes directly to the lungs, and the nicotine-rich blood travels to the brain in approximately 7 seconds. This time is twice as fast as that of an intravenous injection of heroin, which must pass through the body's systemic circulatory system before reaching the brain.[22,23]

As nicotine enters the brain, it acts as a "mood thermostat." It does not necessarily alter mood, but it maintains a steady and pleasant mood of psychologic neutrality. Nicotine stimulates people when they are drowsy and calms them when they are tense; it affects cognitive processes of concentration and emotional states. Unlike other powerful "street drugs," nicotine does not interfere with the capacity to work and create, and it may actually enhance individuals' capabilities.[24]

The action of nicotine causes the brain to release norepinephrine and dopamine.[25,26] The brain then adapts to accept these chemicals by increasing the number of nicotine receptors and becomes physically dependent on nicotine. Thus, the general level of arousal is adjusted up or down by introducing nicotine levels that allow the smoker to feel stimulated or relaxed.[27] The effects of nicotine are reached in a matter of seconds; the smoker experiences drug-induced contentedness, all in a legally sanctioned manner.

Norepinephrine controls arousal and alertness. Beta-endorphin, referred to as the brain's natural analgesic, can decrease pain and anxiety. Dopamine is part of the brain's pleasure center and is also able to decrease pain and anxiety. Smoking's "attention thermostat" effect is mediated through the brain's limbic system, where

the major neurotransmitters are adrenaline and dopamine, both of which are influenced by nicotine. It appears that nicotine helps the smoker concentrate by promoting selective attention to important tasks, which increases learning and memory. Continued smoking also prevents the unpleasant side effects of nicotine withdrawal, such as irritability, irrational mood changes, low energy levels, inability to feel stimulated, and increased sensitivity to light, touch, and sound.[28]

The overall effect of smoking is a shift in brain chemistry that creates the mood needed for the situation at hand; that is, increased relaxation, alertness, or pleasure and decreased pain or anxiety. Even though this is true, concerned smokers can create and sustain new behaviors to achieve the same positive effects without the health risk to themselves or to passive smokers. Success in smoking cessation requires a plan of action. Moreover, smoking cessation is a process, not something that occurs in a week or so.

Strategies for Smoking Cessation

Measuring Successful Cessation

Because smoking cessation is not an easy task, success is often measured in small increments. Quit rates vary with the different approaches to cessation. Over the years, researchers have evaluated a variety of public and private multicomponent cessation programs, physician-directed counseling, and community-based programs. Measures of success also vary, and smoking cessation may be defined as point prevalence (a measure taken at one point in time) at the end of a cessation program or long-term abstinence lasting for one year or more.[29]

Self-Quitters, Physician Counseling, and Nurse Follow-Up Advice

Fiore and colleagues demonstrated that more than 90% of successful quitters kicked the habit on their own.[30] Quit rates were twice as high for those who quit on their own as for those who participated in a cessation program. Smokers who quit "cold turkey" were more likely to remain abstinent than were those who gradually decreased their daily consumption of cigarettes, switched to cigarettes with lower tar or nicotine, or used special filters or holders. Smokers who received nonsmoking advice from their physicians were nearly twice as likely to quit smoking. Heavy smokers (25 cigarettes a day) and more addicted smokers were much more likely to participate in an organized cessation program than were people who smoked less.

Physicians and nurses have considerable opportunity to reach all demographic subgroups of the population.[31–33] Seventy percent of smokers see a physician at least once per year. Although the impact of physician advice varies, 70% of smokers say that they would quit if urged to do so by a physician.[34] For smoking intervention to become a routine part of medical practice, however, medical education must integrate smoking cessation strategies into the curriculum.[35,36] Since 1990, the National Cancer Institute has worked to train practicing physicians nationwide in techniques to prevent tobacco use and to facilitate smoking cessation.[37] Its goal is to train 100,000 practicing physicians in these techniques. Nursing education must also emphasize these techniques, as follow-up can be most effective if done by a physician–nurse team.

Pharmacologic Therapies in Support of Cessation

Physicians can offer smokers nicotine replacement therapy (NRT) in the forms of gum, transdermal patch (nicotine gum and the patch can also be purchased over-the-counter by smokers themselves), intranasal spray, or inhalation; however, NRT must be used in tandem with a smoking cessation program that addresses behavior/lifestyle change. Although NRT is a

means for achieving short-term smoking cessation for nicotine-addicted individuals, it does not substitute for learning new and healthier behaviors.[38,39] With NRT, the smoker focuses on breaking the emotional ties with the cigarette. Nicotine replacement therapy does not release the client from the bad effects of nicotine, which continue to be present in the gum or patch. Thus, NRT must be discontinued as soon as possible. Because of nicotine's dangerous side effects, NRT must be used with extreme caution in cardiac patients.

Although NRT is expensive, it can be helpful. In one study, nicotine patch therapy showed clinical significance when combined with physician interventions, nurse counseling follow-up, and relapse interventions.[40] Smokers with lower baseline nicotine and cotinine levels had better cessation rates. These results provide indirect evidence that a fixed dose of transdermal nicotine may be less satisfactory for those smokers with higher baseline levels.

It is now widely known that cigarette smoking is closely associated with a history of depression that often predicts failure with initial cessation attempts.[41] Smoking cessation may also trigger the onset of depression as a serious nicotine withdrawal symptom in otherwise healthy individuals.[42] To counteract potential symptoms of depression and to maintain mental balance during cessation, several assistive pharmaceutical therapies are being explored. Nortriptyline, a tricyclic antidepressant, and buproprion (Zyban), an atypical antidepressant, are used to improve abstinence in smokers independent of a history of depression. Inhaled through smoking or ingested through "spit" tobacco, nicotine binds to receptors in the brain and causes the release of dopamine and norepinephrine. Nortriptyline has adrenergic activity for producing dopamine,[43] and buproprion blocks the uptake of norepinephrine and inhibits the neuronal reuptake of dopamine. These drugs mimic the neurochemical effects of nicotine on noradrenergic and dopaminergic systems in the brain, thus alleviating negative affect and depression.[44,45]

Behavior and Lifestyle Change for Long-Term Cessation and Abstinence

Over one million U.S. citizens quit smoking every year. In the year 2000, greater than 41% of the individuals who smoked during the preceding year reported that they tried to quit during that same period. If the one million ex-smokers are representative of the 17 million who attempt cessation, it seems that less than 10% who try to quit are successful each year.[46] The major reason that people find it so difficult to quit smoking is that they do not take the time to learn new behaviors for sustained change.[47]

There is often no effective means for measuring individual readiness to change smoking behavior. Within the dynamics of smoking cessation, there are many issues of resistance to change and recidivism. Smoking cessation is not a dichotomous product of smoking, then nonsmoking, but a process of progress and regression, ups and downs, successes and failures.[48,49] The transtheoretical model of change provides a theoretical basis for explaining when and how people change behaviors.[50–70] It is useful for comprehending self-initiated as well as professionally facilitated change. The model supports the notion that change occurs in a cyclic rather than linear fashion, often causing certain sequences and phases to be repeated before a change goal is reached. There are also varying rates of change. Some individuals move through the change sequence rapidly, while others never move beyond a particular stage.[71]

Prochaska and colleagues began investigating and developing the transtheoretical model of change by integrating diverse theories of change from the psychotherapy literature.[72,73] They examined

the cognitive, affective, and behavioral processes as individuals moved through different levels of change. Specifically, the researchers studied attrition and relapse, which were more the rule than the exception. "Inadequate motivation, resistance to therapy, defensiveness, and inability to relate are client variables frequently invoked to account for the imperfect outcomes of the change enterprise."[74]

Two major constructs organize the framework of the transtheoretical model—the stages and the processes of change. Other important concepts are self-efficacy, pros and cons of decisional balance, and temptations for relapse.[75] Five stages of change provide a temporal structure for monitoring the change process. Applied to smoking cessation, the five stages of change are:

1. Precontemplation: no intention of quitting within the next 6 months.
2. Contemplation: seriously considering quitting within the next 6 months.
3. Preparation: seriously planning to quit within the next 30 days and has made at least one quit attempt in past year.
4. Action: former smoker continuously quit for less than 6 months.
5. Maintenance: former smoker continuously quit for greater than 6 months.[76]

The stages are important for measuring progress toward quitting and helping to predict relapse.[77]

Precontemplators have no intention of changing their behaviors in the near future. They cannot really see that they have a problem. Contemplators are aware that a problem exists and are thinking seriously about changing their behaviors, but they have not yet made a commitment to take action. Individuals in the preparation stage combine intention with preliminary actions to change behaviors in the near future. They may have made a past attempt to change that was unsuccessful. Smokers in the preparation stage may begin with small changes, such as smoking fewer cigarettes in a day, delaying the first cigarette of the morning, and changing some of their smoking habits (e.g., forgoing the "pleasant" cigarette with coffee after a meal). People who move into the action stage actually shift from thinking about the problem to doing something about the problem. They dedicate a considerable amount of commitment, time, and energy to the change. Finally, individuals who make a change and stick with it move into the maintenance stage and work to prevent relapse. They begin to stabilize the behavior change and make it a way of life.[78–83]

The processes of change are activities and events used to change problem behaviors successfully. These processes help to explain and predict change at each stage. Many interventions for promoting change are tailored to the five experiential and five behavioral processes of change (Table 28–1).[84] The experiential processes of consciousness raising, dramatic relief, and environmental reevaluation are most successfully used during movement from precontemplation to contemplation. Behavioral processes are more appropriately used during the later stages of change from preparation to action and maintenance.

The transtheoretical model of change is well-founded in empirical research and provides sound principles for evidenced-based practice.[85] In one study, cardiac patients who smoked were recruited into an intensive action and maintenance-oriented smoking cessation program. Ninety-four percent of the smokers who began the program at the preparation or action stages were successful nonsmokers at a 6-month follow-up. Sixty-six percent of the smokers in a control group receiving traditional care, but assessed

Table 28–1 Processes of Change

Type	*Process*	*Definition*	*Possible Interventions*
Experiential	Consciousness raising	Increasing information about self and problem	Observations, confrontations, interpretations, education
	Dramatic relief	Experiencing and expressing feelings about one's problems and solutions	Psychodrama, grieving losses, role playing; negative imagery
	Environmental reevaluation	Assessing how one's problem affects the physical environment	Empathy training, documentaries
	Self-reevaluation	Assessing how one feels and thinks about oneself with respect to a problem	Values clarification, positive imagery, corrective emotional experience
	Social liberation	Increasing alternatives for non-problem behaviors available in society	Advocacy for rights of repressed, empowerment, policy interventions
Behavioral	Reinforcement management	Rewarding one's self or being rewarded by others for making changes	Contingency contracts, overt and covert reinforcement, self-reward
	Helping relationships	Being open and trusting about problems with someone who cares	Therapeutic alliance, social support, self-help groups
	Counterconditioning	Substituting alternatives for problem behaviors	Relaxation imagery, desensitization, assertion, positive self-statements
	Stimulus control	Avoiding or countering stimuli that elicit problem behaviors	Restructure of one's environment (e.g., removing alcohol, cigarettes, fattening foods), avoidance of high-risk cues, fading techniques
	Self-liberation	Choosing and making a commitment to act or to believe in ability to change	Decision-making therapy, New Year's resolutions, commitment-enhancing techniques, positive imagery

as being in the preparation and action stages of change, were also successful nonsmokers at 6 months. Independent of membership in the treatment or control groups, 22% of those in the precontemplation stage, 43% of those in the contemplation stage, and 76% of individuals in the preparation/ action stages were not smoking 6 months after completing the program. These results firmly demonstrate that internal commitment and readiness for change are necessary before any smoking cessation intervention becomes effective. The pretreatment stage is directly associated with outcomes.[86] In other studies, demographics, such as age and gender, socioeconomic status, smoking histories, goals and expectations, and other fairly stable variables, had little influence on smoking cessation outcomes, but stage differences predicted quit attempts and cessation success at 1- and 6-month follow-up checks.[87,88]

Fava and colleagues studied a highly representative sample of 4,144 smokers from the community at large and found that the early stages of change (precontemplation, contemplation, and preparation) were strongly related to processes of change, therefore validating the transtheoretical model of change.[89] Finally, additional research is demonstrating that health care professionals support the use of the transtheoretical model of change because it allows specific processes and interventions to be tailored to the individual client (as determined by stage). This prevents wasted efforts and provides maximum use of resources for greatest success.[90,91]

The Good News! Prevention As the Best Protection from Smoking

Prevention of tobacco use must focus on today's youth, and so far improvements are being noted in terms of the prevalence of high school students who smoke. In 1991, the high school student smoking prevalence was 27.5%, and by 1997 it had grown to 36.4%; however, since that time cigarette smoking rates decreased significantly and the current rate for teen smoking in the U.S. has dropped to 28.5%.[92] These data support the findings of other studies that indicate youth smoking reached its peak and is now in decline.[93,94] The reports cite factors that may have been successful in discouraging teen smoking through more aggressive school health policies, effective role models on television and in magazines, and through public advertising. Additionally, a 70% increase in cigarette prices, which occurred during 1997 to 2001, may have contributed to the decrease in youth smoking prevalence.[95–97] Astute surveillance cannot be relaxed as yet, however. Professional vigilance is required for many years to come in order to prevent and treat smoking as the scourge of health, both nationally and globally.

HOLISTIC CARING PROCESS

Assessment

In preparing to use smoking cessation interventions, the nurse assesses the following parameters:

- the client's level of addiction to cigarettes
- the client's attitudes and beliefs about successful and sustained smoking cessation
- the client's motivation to learn interventions to become a permanent nonsmoker
- the client's stage of change in terms of smoking cessation
- the client's eating patterns and exercise program
- the client's existing stress management strategies
- the client's support and encouragement from family and friends

Patterns/Challenges/Needs

The following are patterns/challenges/needs compatible with smoking cessation interventions that are related to the 13 domains of Taxonomy II of the Unitary Person framework (see Chapter 14):

- Altered circulation
- Altered oxygenation
- Spiritual distress
- Spiritual well-being
- Ineffective individual coping
- Effective individual coping
- Self-care deficit
- Disturbance in body image
- Disturbance in self-esteem
- Hopelessness

- Knowledge deficit
- Anxiety
- Fear

Outcomes

Exhibit 28–1 guides the nurse in client outcomes, nursing prescriptions, and evaluation for successful smoking cessation.

Therapeutic Care Plan and Implementation

Before the Session

- Spend a few moments centering yourself to recognize your presence and to begin the session with the intention to facilitate healing.
- Gather teaching sheets to be used during the session.
- Create a quiet place to begin guiding the client in smoking cessation strategies.

At the Beginning of the Session

- Go over the results of the smoking profile, and explore the meaning of these patterns with the client. Elicit insight into changing behaviors.
- Instruct the client in the importance of keeping a smoking diary.
- Establish pre-quitting strategies. Suggest that the client be patient and identify and combine the methods that can work best.
- Encourage the client to take a few days before the quit date to rid the body of toxins and to clean the house,

Exhibit 28–1 Nursing Interventions: Smoking Cessation

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client will demonstrate attitudes, beliefs, and behaviors that indicate the desire to be a nonsmoker.	Determine the client's desire to be a nonsmoker.	The client demonstrated attitudes, beliefs, behaviors, and the desire to be a nonsmoker.
	Assist the client in setting realistic plans for being a nonsmoker by:	The client set a realistic plan and became a nonsmoker over 1 week as follows:
	• establishing a quit date	• focused on quit date goal
	• drawing up a nicotine withdrawal schedule	• went "cold turkey"
	• cleansing self and environment of nicotine	• cleansed body/environment of nicotine
	• developing habit-breaker strategies	• adhered to habit-breaker strategies
	• keeping a smoking diary	• kept a smoking, exercise, food diary
	• practicing relaxation and imagery	• practiced relaxation/imagery daily
	• integrating behavior changes	• integrated behavior changes daily
	• deciding on rewards for attaining goals	• rewarded self for attaining goals

office, and car of any evidence of cigarettes or odors.
- Have the client establish the quit date and sign a contract that specifies the quit date.
- Encourage the client to call on family and friends on the first smoke-free days, particularly when confidence is low. Remind them that their support is very important.

During the Session

- Reinforce the quit date and have the client imagine being smoke-free in five days.
- Teach basic relaxation and imagery skills to shape bodymind changes for internal and external smoke-free images. These new images also create a new felt sense and are a major source of the client's success. Rhythmic breathing and muscle relaxation are most helpful in teaching body-centered awareness and effective coping. Relaxation and imagery help the client to recognize and block smoking triggers. Combine this practice with a "stop smoking" video once or twice a day.
- Teach the client to create specific imagery patterns (see Chapter 22).

  1. Active images—cleansing the body of nicotine and other toxins; finding a safe place that establishes a feeling of security and comfort; envisioning a protective bubble that receives what is needed from others and blocks out negative images, such as smoking triggers.
  2. Process images—people, events, and situations that make the client smoke. Have the client rehearse being in a situation where smoking normally occurs, but now using a new behavior, such as reaching for a glass of water.
  3. End-state images—being smoke-free; accessing one's inner healer.

- Have the client create strategies to break smoking triggers and become smoke-free—waking up and having a glass of water, reading the morning paper in a different room, taking a break and drinking water or juice, talking on the telephone, and practicing relaxation and rhythmic breathing.
- Encourage the client to be patient in making this major lifestyle change and to remember that smoking is about self-protective control. The old, unhealthy control must be replaced with a new, healthy control. Identify internal and external experiences as new health behaviors are being shaped. Some are easy to change; others take longer.
- Ask the client to become aware of new opportunities for being with family, friends, and self while being smoke-free.

At the End of the Session

- Suggest that the client create a personal reward after five smoke-free days.
- Evaluate with the client the goals of behavior changes—reduction of smoking urges and development of new habit patterns.
- Encourage the client to make a list of anticipated high-risk situations and decide in advance steps to prevent a relapse. The most frequent high-risk situations are social situations, emotional upsets, home or work frustration, interpersonal conflict, and relaxation after a meal.
- Reinforce the fact that the client can avoid relapse. Having learned to recognize high-risk situations for relapse, the client can be ready to act quickly in using strategies to resist

smoking temptations. Successful coping strategies must honor internal responses (bodymind feelings and thoughts) and action-oriented responses (action steps).
- Suggest that the client become a support person for someone else who is trying to become smoke-free to decrease chances of relapse.
- Use the client outcomes (see Exhibit 28–1) that were established before the session to evaluate the session.
- Schedule a follow-up session.

Specific Interventions

Recording Habits. Smoking is such a pervasive, automatic habit that it is essential to keep a smoking diary of when, where, how often, and what moods are associated with smoking. The client records the feelings associated with smoking and begins to think about new habits to replace these urges. Keeping such a record for several weeks before the quit date allows the client to identify patterns, and knowing the smoking triggers leads to permanent changes. To strengthen the new awareness, the client may record thoughts, feelings, urges, and observations about smoking. With each cigarette that is smoked, for example, the client should consider the following questions:

1. What internal cues made me think that I needed a cigarette (e.g., breathing patterns, mouth watering, tense muscles, fidgety hands)?
2. What external cues made me think that I needed a cigarette (e.g., talking on the phone, watching television, finishing eating, sitting down with friends)?
3. Now that I've smoked that cigarette, did I enjoy it?

Preparation for Quit Date. The desire to be a nonsmoker should build. Becoming smoke-free requires preparation. The client should take the time to identify personal reasons for quitting, such as to reduce the risk of heart, lung, or circulatory disease; to increase endurance and productivity; to improve sense of smell and taste; to increase self-esteem; to be in control; or to decrease the risk to family health from passive smoking. Once certain that it is time to quit, the client's goal is to be a nonsmoker in five days. The nurse may encourage the client to identify family members, friends, or a specific person who may want to join the effort as a quit-smoking partner. The client should tell significant people the quit date.

Preparation for Nicotine Withdrawal. There is no one best way to quit smoking. Some people are successful at just quitting "cold turkey" and going through the nicotine withdrawal, with the worst part usually lasting five days or less. Others require a gradual decrease of nicotine with the use of NRT. The client must decide which way is best for him or her.

If the client does not wish to use NRT, nicotine fading is a way to reduce the nicotine level in the body gradually and avoid withdrawal symptoms (e.g., irritability, lack of energy, increased cough). Each week for three weeks, the client buys a different brand of cigarette, each containing progressively less nicotine. By the end of the three weeks, the level of nicotine in the body has been substantially reduced. While using nicotine fading, it is important to record smoking habits accurately; the nicotine amount, time smoked, place smoked, alone or with others, and mood or feeling. The client should continue to smoke the same number of cigarettes and maintain the same manner of inhaling, because changes here defeat the purpose of this technique.

Another way to quit smoking is called focused smoking, or rapid smoking.

Clients should try this technique only under supervision, particularly those with heart disease or diabetes. Because this technique is not a pleasant experience, many researchers believe that it should be a last resort. The client needs cigarettes, matches, ashtray, candle and candle holder, wastepaper basket, paper to record responses, and pen or pencil. During a session, the smoker goes to his or her place and arranges the supplies. The wastepaper basket is placed to one side to be available in case vomiting occurs. The smoker lights a candle, then lights a cigarette from the candle flame, and takes a puff every six seconds. Immediately upon finishing one cigarette, the client lights the next cigarette. This is continued until the client is nauseated, three cigarettes have been smoked, and more smoking is impossible due to unpleasant body responses. The process is recorded and then repeated.

The client should record unpleasant body responses, such as hot lips, hot mouth, hot tongue, burning throat, burning lungs, dizzy feeling, pounding heart, tingling hands and legs, flushed face, watering eyes, nausea, or headache. The responses should be rated on a scale of 1 (not at all unpleasant) to 10 (extremely unpleasant).

Acupuncture programs that include the use of citrate compound are another means of reducing the body's nicotine level and are a rapid way to quit smoking. But, for sustained success, it is necessary to plan and learn new behavior strategies to bring about new health behaviors to replace smoking habits. This kind of program involves a single acupuncture session and the oral administration of a citrate compound, which causes the urine to become alkaline and retards the urinary excretion of nicotine. This process prevents a sudden fall of nicotine blood level, which reduces the craving for nicotine and the withdrawal symptoms.

Smoke-Free Body and Environment. During the first few nonsmoking days, the client rids the body of toxic waste left from the cigarettes by bathing, brushing teeth, drinking water, exercise, relaxation, imagery, rest, and good nutrition. A fresh nonsmoking living environment can be accomplished by placing clean filters in heating and cooling units and cleaning carpets, drapes, clothes, office, and car. Signs may be placed on the office door: "Thank you for not smoking." The more energy that the client puts into these activities, the more likely that the client will quit on the target date and become a permanent nonsmoker. The client should become aware of how quickly the senses of smell and taste increase and how disgusting the smell and taste of cigarettes become.

Identification of Habit Breakers. Becoming smoke-free is directly related to minor changes in daily routines, referred to as habit breakers. Many ex-smokers report that the first five days of being smoke-free are the hardest. Minor or major changes in daily activities can be less stressful if accompanied by a healing state of awareness. If the client should slip and fall back into old routines, these relapses can become learning situations. The client can identify negative self-talk or a stressful situation in which a new habit breaker may not have been used soon enough. The following events are the times when smoking is most likely:

Before starting the day:	• Getting out of bed • Taking a bath or shower • Eating breakfast • Reading the newspaper • Starting work or driving to work
Mornings:	• Telephone calls • Office or housework • Meetings • Morning breaks

- Before, during, and after lunch

Afternoons:
- Telephone calls
- Office or housework
- Meetings
- Afternoon breaks
- Completing and organizing your work for the next day
- Driving home or resting in late afternoon

Evenings:
- Before, during, and after dinner
- Relaxing, watching television, or out with family or friends
- Preparing for bed

It is helpful to create habit breakers for each of these events. Success with habit breakers requires commitment to identifying them, writing them down, and finding ways to personalize this list. For example, the client can take this list, divide a piece of paper into two columns, and write down new habit breakers.

Routine	***Habit Breaker***
Turning to radio news on awakening	Play relaxing music
Five cups of coffee at breakfast	Hot tea instead of coffee
Frequent lighting of cigarettes	Keep hard candy nearby
Get energy from morning smoke	Eat an apple; drink water

Integration of Exercise. To the person becoming smoke-free, an exercise program serves as a stress manager (as an alternative to smoking), helps with weight management, and increases energy levels. If the client does not have an exercise program, the nurse offers assistance and helps the client decide what lifestyle patterns to approach first. It usually takes about three months for an exercise program to become a regular part of life, so the client may look for an exercise partner who is as serious about exercising or being a nonsmoker.

Weight Gain Can Be Avoided. Weight gain occurs because the nonsmoker eats too much, lacks aerobic exercise, and consumes too much alcohol. If weight management is a challenge, it is helpful to set a target date for establishing and following an exercise program three months or longer before the quit date. (Refer to Chapter 27 for specific strategies to maintain healthy weight.) Then, as the client commits to quitting smoking, one component of an effective stress management program has already begun.

Assertion of Bill of Rights. Clients may find it helpful to recite their Bill of Rights. They can be creative and add to this list.

I have a right to

- be smoke-free in any situation.
- review my list of reasons to stop smoking frequently, particularly before any social gathering.
- ask others not to smoke in my home, office, or car.
- sit in nonsmoking sections.
- remind myself that cigarettes actually taste bad and leave toxic substances in my body.
- throw away all objects associated with smoking.
- keep sugarless gum and hard candy close at hand.
- practice my relaxation, imagery, and coping skills anywhere and at any time.
- keep liquids close by at work and at home.
- support legislation to protect nonsmokers from the dangers of passive smoking in public places.

Integration of Rewards. The client should plan a reward at least every five to seven days for having a smoke-free lifestyle. These rewards should continue as long as

the client needs to be aware of new lifestyle habits. The client is considered smoke-free when his or her habits are indeed nonsmoking behaviors. Continued use of the listed habit breakers always helps a client anticipate when smoke signals can surface and, thus, quickly take actions to prevent relapse.

Reinforcement of Positive Self-Talk. Feelings, moods, behaviors, and motivation affect physiologic changes. As the client learns to recognize the self-talk that sabotages his or her positive outlook, it is possible for the client to remain in control and not give in to the urge to smoke. Negative rationalization must be recognized, because it can gradually lead to doubt about the ability to change. The client may change "I've become more nervous since I quit smoking" to "I am noticing a change in my moods since quitting and am replacing it with relaxation and imagery practice. This makes me feel much better than the short burst of nicotine energy." Similarly, negative thoughts must be identified and replaced with positive thoughts. For example, "I'll never get over this urge to smoke; I'll never be successful at breaking the habit" may be reframed as "Of course, I can get over this urge. I am learning new coping strategies, and I can really imagine myself smoke-free."

Smoking Cessation: Imagery Scripts. To enhance the client's success at becoming smoke-free, the nurse can create a relaxation and imagery tape or provide the following script/s to the client to make his or her own tape. The following scripts help the client form correct biologic images of being smoke-free. They can be modified or expanded, depending on present habits and which new skills the client wishes to develop in order to break the nicotine habit. A relaxation exercise from Chapter 21 may be recorded for 5 to 10 minutes; then the script for smoking cessation is recorded for 15 minutes. The nurse should encourage the client to listen to the tape for 20 minutes several times a day.

Script: *Introduction.* (Name), *as your mind becomes clearer and clearer, feel it becoming more and more alert. Somewhere deep inside of you, a brilliant light begins to glow. Sense this happening. . . . The light grows brighter and more intense. . . . This is your body-mind communication center. Breathe into it. . . . Energize it with your breath. The light is powerful and penetrating, and a beam begins to grow from it. The beam shines into your body now as you prepare to focus on being smoke-free. . . .*

In your relaxed state, . . . affirm to yourself at your deep level of inner strength and knowing . . . that you can stop smoking. Say it over and over as you begin to see the words and feelings in every cell in your body. Feel your relaxed state deepen. You can get to this space anytime you wish. . . . All you have to do is give yourself the suggestion and stay with the suggestion as you move into your relaxed state. This is a skill that you will use repeatedly as you move into being smoke-free.

Script: *Quit Date. Congratulate yourself for setting your quit date. You are aware of all your resources to quit. With your mind's eye now . . . see your calendar and experience yourself reading your quit date. With full intention to quit, mark your quit date on the cal-*

endar. Enlist the help of your family or a friend as you set your quit date.

Script: *Cleansing Your Body and Environment. It is now time to rid your body of toxins left from the cigarettes. Begin to cleanse your body. . . . Feel the toxins flowing out of your body as you increase the liquids you drink. Practice your deep breathing exercises, remembering to exhale completely . . . enjoying this new awareness of how healthy your lungs will become with the cleansing and clearing of toxins. Experience your breath, skin, hair . . . fresh as a spring breeze. See yourself making your surroundings smoke-free day by day. Notice the pleasant changes in your new, nonsmoking environment. . . . First, begin to notice how you are becoming more sensitive to smells. . . . Enjoy the freshness of your clothes, home, office, and car being free of smoke.*

As you keep your records, become aware of your progress. Reward yourself regularly. Imagine you have had five smoke-free days. The worst of any withdrawal is over. What is your first reward going to be? Give yourself a big reward!

As you continue to deepen your relaxation, repeat to yourself the words "I am calm." Let your body experience these words in your own unique way. Register this feeling throughout your body. Begin to increase your awareness of feeling good about being alive, to be conscious of beginning new habits . . . free of smoking.

Script: *Smoking Triggers. Starting now, reflect on your wonderful decision to release the habit of smoking . . . a habit that could cause illness and take away your energy and vitality. Get in touch with your smoking triggers. Is it a certain time of day, a person, a place, or social gathering? As you bring them into awareness, . . . rehearse in your mind the healthy behaviors you will use to replace the urges. . . . Is it drinking a glass of water . . . chewing sugar-free gum, going for a walk, listening to music, chewing on a toothpick, or taking a hot shower or bath? And as you think about smoking urges . . . those foolish habits . . . you can hear your powerful inner voice repeating clear affirmations, . . . "I have stopped smoking . . . I am free of smoking . . . I feel strong and healthy . . . I can taste, and I can smell fragrances. My cough has gone."*

Hear your own voice saying, "I no longer crave a habit negatively affecting my health. This habit is diminishing steadily, and I can envision being completely free of this addiction. My mind is functioning in such a manner that I no longer crave tobacco . . . a habit that has affected my lungs and heart. I no longer place unnecessary strain on these organs so vital to life."

When you feel the urge to smoke, hear yourself saying,

"Stop! I don't need to smoke any more. I am free." These words will become more powerful the more you say them. Remember this message is always with you . . . and you are no longer a smoker. That is behind you.

Script: *Nutritious Eating and Exercise. "As I stop smoking, I will not be excessively hungry or eat excessively. Because of the power of my unconscious mind, I am free of my addiction. I am conscious of increasing my exercise to three or four times a week for 20 minutes or longer. I am increasing my fluid intake and chewing sugar-free gum. I am sleeping soundly at night. I am free of smoking. . . . I am free." You can reach this inner wisdom any time that you wish. . . . All you have to do is take the time.*

Script: *Closure. Take a few slow, energizing breaths and, as you come back to full awareness of the room, know that whatever is right for you at this point in time is unfolding just as it should and that you have done your best, regardless of the outcome.*

Case Study

Setting:	Nurse-based wellness clinic smoking cessation program
Client:	J.N., a 48-year-old interior designer, telling her story to the new clients after she has been smoke-free for five years
Patterns/ Challenges/ Needs:	Health maintenance related to engagement in strategies to remain smoke-free

"You can call it midlife crisis or whatever; I just happened to wake up and tell myself that I'm worth a better state of health and mind. How did I do it—lots of determination and reprogramming my mind with successful images. I never dreamed that I could be so successful at quitting smoking. I'd tried to quit on many occasions, but the reason I never was able to sustain change is that I had tried to quit before I really was ready to do so.

"I'd been smoking for 27 years, and I just got tired of my chronic cough and feeling tired. Other things began to happen also. My family and friends began to ask for nonsmoking sections in restaurants and gave me three months before they declared the house a nonsmoking house. They also placed a disgusting, ugly series of pictures of me smoking with a title on it saying, 'We Love You—Quit Smoking!' The first time I looked at the pictures, I burst into tears and heard their message loud and clear. I got in touch with why I began smoking in the first place as a teenager—I thought I looked important and glamorous. Those pictures certainly didn't convey that image.

"The last straw that really got my attention was when a friend and I were driving along with our windows down on a nice spring day. My friend said to me, 'Who do you think is smoking?' We could see no person smoking, but my friend could smell it. It turned out that our lane of traffic started moving before the one next to us. Sure enough, there was a smoker three cars in front of us in the left lane to us. I was driving, and, as we passed the car, smoke came in our window. I couldn't smell it even though I could see the smoke coming in the window. My friend was able to smell it long after we passed the smoker. I was astounded that I couldn't smell it.

"I really planned a ritual for my quit date for ending smoking—which has changed my life in many ways. I have now been smoke-free for five years. Let me begin by saying that, in the previous 15

years, I had tried to quit smoking seven times; each time I was successful for one month at the longest, so I knew that it was possible. As I look back on it now, the reason that I didn't have any sustained change was that I didn't shape any new behaviors or thoughts.

"Let me share with you my rituals. I planned a 5-day period to be by myself to focus on shaping new behaviors. The reason I chose to stay at home was the importance of preparation and concentration of new thoughts and behaviors prior to my quit date.

"Prior to that special week, I began my 'detox' process. I decided to buy a new bright blue toothbrush, which I placed in a beautiful small wicker basket. I also placed this on the opposite side of where I usually kept my toothbrush. It just seemed important to change all of my bathing habits. When brushing my teeth gently, frequently followed by a mouthwash, I was aware of repeating words to myself about cleansing and purifying. I used these same thoughts when I bathed. I would stand in the shower and concentrate on the water washing the toxins from my skin. For the internal removal of toxins, I increased my fluid intake of water and herb teas to six to eight glasses a day. Exercise also became part of my ritual. I would get up each day and start my morning with a 30-minute walk. On the walk, I used the time to see myself smoke-free. When I came in from my walks, I would watch a 20-minute video of beautiful images and healing statements about successfully breaking the smoke habit and being free.

"Well, my home environment reeked of smoke and staleness. My drapes and fabric chairs and couches had not been cleaned in 16 years; my carpets, in eight. I allowed myself the luxury of having them professionally cleaned. Not only did the house smell fresh, but all the colors were very fresh and seemed new. Air conditioning filters were changed. I cleaned clothes that were well overdue. I aired the house.

"The biggest task was to gather all the cigarette packages throughout the house. They were in every room, and I had about three full cartons when I finally gathered them all up. This was really scary for me, because when I saw them all together, the thought that came to me was, 'I'm really addicted. There is no way I can break this habit.' Out of nowhere, this very loud, powerful voice blurted out, 'Yes, you can, and you have already begun.' I have never heard such volume from my own voice. It was as if it was a voice other than my own. Prior to that, I also removed all of the ashtrays and bought a beautiful door sign which read, THANK YOU FOR NOT SMOKING. When I placed it above the door bell, I felt this inner sensation of glee and energy. It was very affirming to me, and, from that moment on, there was no stopping my success. I really believed for the first time that I was going to be successful, and I felt an inner strength that I had never experienced before. I also received so much encouragement from my husband and two children when they came home that evening. I cleaned my car as well as I had the house. Now it was time to sign my contract with the family.

"During this period of one week of cleaning my body, house, and car, I recorded my internal and external cues of why I smoked. It was when I was hungry, talking on the phone, when I was putting on my makeup in the morning, and after meals. During this time, I let myself smoke no more than three cigarettes a day—outside standing up. I concentrated on what a disgusting habit smoking was. As I focused on these messages to myself, I not only slowed down the smoking, I also didn't enjoy the cigarettes and found that it was really not as pleasant as in the past. I had tried this before, but my thoughts were also on how much I was going to miss the smoking

and pleasure of the buzz from smoking. I was so aware of not really enjoying it as much as I used to.

"I well remember my quit date five years ago. It is so clear; it is as if I planned it just yesterday. The reason it seems so recent is that my preparation and commitment to stopping smoking has spilled over into other areas in my life. Do I miss smoking? Frankly, I'll say yes. I have those urges on occasions. However, as I've integrated relaxation, imagery, and positive affirmations in my life, my commitment to being smoke-free is stronger. I honor that inner voice that says, 'Light Up.' For me, what works best is to hear the message, honor that I heard it, but to replace smoking with something that is always with me—the power of relaxed breathing. I also use a saying a friend taught me, which is Avoid H.A.L.T.—Avoid becoming too hungry, too angry, too lonely, or too tired. Time, commitment, and believing in my success is part of every day for me. Quitting smoking is one of the hardest things I've ever done. I can't remember planning so well for any event in my life. I believed I could do it, and that is exactly what continued to happen."

Exhibit 28–2 Evaluating the Client's Subjective Experience with Smoking Cessation Interventions

1. Did you gain any new insight today about your smoking patterns?
2. Do you have any questions about preparing for a quit date?
3. Do you have any questions about recording your habits?
4. Can you identify two new habit breakers right now to be smoke-free?
5. Are you aware of your bodymind signals of wanting to smoke?
6. What relaxation exercises are most helpful to you in replacing smoking habits?
7. What will be your exercise program?
8. Do you have any questions about the active, process imagery and the end-state imagery exercises that you experienced today?
9. Did you like the imagery exercises?
10. Did you gain any new insight about your self-talk of being smoke-free?
11. What are three affirmations to help you just now create an image change of being smoke-free?
12. What is your next step?

Evaluation

With the client, the nurse determines whether the client outcomes for smoking cessation (see Exhibit 28–1) were achieved. To evaluate the session further, the nurse may again explore the subjective effects of the experience with the client (Exhibit 28–2).

In becoming an ex-smoker, a client must understand that it is a gradual, step-by-step process that requires learning new skills. Smoking cessation involves (1) recognizing smoking habits, (2) establishing habit breakers, (3) preparing for detoxification of body and environment, (4) following a good nutrition and exercise program, and (5) modifying behavior. The integration of these five areas helps clients achieve new awareness about being smoke-free with new lifestyle patterns and improved relationships with people at work and at home.

DIRECTIONS FOR FUTURE RESEARCH

1. Determine the nursing interventions that most effectively minimize stress as clients begin a smoking cessation program.
2. Evaluate combinations of smoking cessation content and teaching methods to determine which are most effective in assisting a client in sustained smoking cessation.

3. Determine the nursing interventions that are most effective in helping a client cope with fears regarding relapse.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- What rituals can I create or assist others in creating to detoxify and cleanse the body and environment of all traces of nicotine?
- What are my internal cues of reacting to smoke?
- What are my external cues of reacting to smoke?
- What are specific process, end-state, and general healing images for teaching myself or others about releasing attachments to smoking and moving forward in being smoke-free?

NOTES

1. Centers for Disease Control and Prevention, Annual Smoking-Attributable Mortality: Years of Potential Life Lost, and Economic Costs—United States, 1995–1999, *Morbidity and Mortality Weekly Report* 51 (2002):300–305.
2. J.M. McGinnis, Does Proof Matter? Why Strong Evidence Sometimes Yields Weak Action, *American Journal of Health Promotion* 15 (2001):391–396.
3. D.R. Shopland, Tobacco Use and Its Contribution to Early Cancer Mortality with a Special Emphasis on Cigarette Smoking, *Environmental Health Perspective* 103 (1995):131–142.
4. Centers for Disease Control and Prevention, Cigarette Smoking Among Adults—United States, 2000, *Morbidity and Mortality Weekly Report* 51 (2002):642–645.
5. R.M. Bray et al., *1998 Department of Defense Survey of Health Related Behaviors Among Military Personnel* (RTI/7034/006-FR, Research Triangle Park, NC, 1999).
6. Centers for Disease Control and Prevention, Trends in Cigarette Smoking Among High School Students—United States, 1991–2001, *Morbidity and Mortality Weekly Report* 51 (2002):409–412.
7. American Nurses Association, *Position Statement: Environmental Tobacco Smoke* (Washington, DC: ANA, 1997).
8. A.M. Lukachko and Y. Ponirovskaya, *Environmental Tobacco Smoke: Health Risk or Health Hype?* (New York, NY, 1999).
9. California Environmental Protection Agency, *Health Effects of Exposure to Environmental Tobacco Smoke* (Sacramento, CA, 1997).
10. C.A. Aligne and J.J. Stoddard, Tobacco and Children: An Economic Evaluation of the Medical Effects of Parental Smoking, *Archives of Pediatrics and Adolescence* 151 (1997):648–653.
11. I. Kawachi et al., A Prospective Study of Passive Smoking and Coronary Heart Disease, *Circulation* 95 (1997):2374–2379.
12. K. Streenland et al., Environmental Tobacco Smoke and Coronary Heart Disease in the American Cancer Society CPS-II Cohort, *Circulation* 94 (1996):622–628.
13. B.A. Berman et al., Household Smoking Behavior and ETS Exposure Among Children with Asthma in Low-Income, Minority Households, *Addictive Behaviors* 28 (2003):111–128.
14. J.P. Winickoff et al., A Smoking Cessation Intervention for Parents of Children Who are Hospitalized for Respiratory Illness: The Stop Tobacco Outreach Program, *Pediatrics* 111 (2003):140–145.
15. K.D. Clark, N. Wardrobe-Wong, and P.D. Snashall, Endogenous Cortisol and Lung Damage in a Predominantly Smoking Population, *American Journal of Respiratory Critical Care Medicine* 159 (1999):755–759.
16. K. Kubo et al., Expiratory and Inspiratory Chest Computed Tomography and Pulmonary Function Tests in Cigarette Smokers, *European Respiratory Journal* 13 (1999):252–256.

17. D. Morrison et al., Epithelial Permeability, Inflammation, and Oxidant Stress in the Air Spaces of Smokers, *American Journal of Respiratory Critical Care Medicine* 159 (1999):473–479.
18. S. Houterman, W.M.M. Verschuren, and D. Kromhout, Smoking, Blood Pressure, and Serum Cholesterol Effects on 20-Year Mortality, *Epidemiology* 14 (2003):24–29.
19. G. Howard et al., Cigarette Smoking and Progression of Atherosclerosis: The Atherosclerosis Risk in Communities (ARIC) Study, *Journal of the American Medical Association* 279 (1998):119–124.
20. M.L. Terry, H.D. Berkowitz, and M.D. Kerstein, Tobacco: Its Impact on Vascular Disease, *Surgical Clinics of North America* 78 (1998):409–429.
21. K. Fagerstrom, The Epidemiology of Smoking: Health Consequences and Benefits of Cessation, *Drugs* 62 (2002):1–9.
22. Ibid.
23. C. Leccese, Tailored Approach Works Best for Smoking Cessation, *ADVANCE for Nurse Practitioners* (1998, April):67–69.
24. Fagerstrom, The Epidemiology of Smoking: Health Consequences and Benefits of Cessation.
25. J. Addington, Group Treatment for Smoking Cessation Among Persons with Schizophrenia, *Psychiatric Services* 49, no. 7 (1998):925–928.
26. S.M. Hall et al., Nortriptyline and Cognitive–Behavioral Therapy in the Treatment of Cigarette Smoking, *Archives of General Psychiatry* 55 (1998):683–690.
27. Leccese, Tailored Approach Works Best for Smoking Cessation.
28. Ibid.
29. U.S. Department of Health and Human Services, *Treating Tobacco Use and Dependence* (Washington, DC: Public Health Service, 2000).
30. Ibid.
31. M.G. Goldstein et al., A Population-Based Survey of Patients' Perceptions of Health Care Provider–Delivered Smoking Cessation Interventions, *Archives of Internal Medicine* 157 (1997):1313–1319.
32. C. Senore et al., Predictors of Smoking Cessation Following Physician Counseling, *Preventive Medicine* 27, no. 3 (1998):412–421.
33. M.E. Wewars et al., Smoking Cessation Interventions in Nursing Practice, *Nursing Clinics of North America* 33, no. 1 (1998):61–74.
34. U.S. Department of Health and Human Services, *Treating Tobacco Use and Dependence*.
35. R.L. Richmond and C.P. Mendelsohn, Physicians' Views of Programs Incorporating Stages of Change to Reduce Smoking and Excessive Alcohol Consumption, *American Journal of Health Promotion* 12, no. 4 (1998):254–257.
36. R. Richmond et al., Family Physicians' Utilization of a Brief Smoking Cessation Program Following Reinforcement Contact after Training: A Randomized Trial, *Preventive Medicine* 27, no. 1 (1998):77–83.
37. U.S. Department of Health and Human Services, *Treating Tobacco Use and Dependence*.
38. J. Stapleton, Commentary: Progress on NRT for Smokers, *British Medical Journal* 318 (1999):289.
39. C. Silagy et al., Nicotine Replacement Therapy for Smoking Cessation, *Cochrane Database of Systematic Reviews* 4 (2002), (*http://www. cochrane.org/cochrane/revabstr/ab000146.htm*.
40. J.A. Simon et al., Intensive Smoking Cessation Counseling Versus Minimal Counseling Among Hospitalized Smokers Treated with Transdermal Nicotine Replacement: A Randomized Trial, *The American Journal of Medicine* 114 (2003):555–562.
41. A.H. Glassman, Psychiatry and Cigarettes, *Archives of General Psychiatry* 55 (1998):692–693.
42. L.S. Covey, Major Depression Following Smoking Cessation, *American Journal of Psychiatry* 154 (1997):263–265.
43. Hall et al., Nortriptyline and Cognitive–Behavioral Therapy in the Treatment of Cigarette Smoking.
44. Addington, Group Treatment for Smoking Cessation among Persons with Schizophrenia.
45. J. Earles et al., Clinical Effectiveness of Sustained-Release Bupropion and Behavior Therapy for Tobacco Dependence in a Clinical Setting, *Military Medicine* 167 (2002):923–925.
46. Centers for Disease Control and Prevention, Cigarette Smoking Among Adults—United States, 2000.
47. C.C. DiClemente et al., The Process of Smoking Cessation: An Analysis of Precontemplation, Contemplation, and Preparation Stages of Change, *Journal of Consulting and Clinical Psychology* 59 (1991):295–304.
48. DiClemente et al., The Process of Smoking Cessation.

49. T. Baird, A.Banter, and J. MacKenzie, Transtheoretical Model Useful for Patient Education, *Family Medicine* 35 (2003):6–7.
50. C.C. DiClemente, Motivational Interviews and the Stages of Change, in *Motivational Interviewing: Preparing People for Change*, eds. W.R. Miller and S. Rollnick (New York: Guilford Press, 1991), 191–202.
51. J.L. Fava et al., Applying the Transtheoretical Model to a Representative Sample of Smokers, *Addictive Behaviors* 20, no. 2 (1995):189–203.
52. J.L. Kristeller et al., Processes of Change in Smoking Cessation: A Cross-Validation Study in Cardiac Patients, *Journal of Substance Abuse* 4 (1992):263–276.
53. J.O. Prochaska, *Systems of Psychotherapy: A Transtheoretical Analysis* (Homewood, IL: Dorsey Press, 1979).
54. J.O. Prochaska and C.C. DiClemente, *The Transtheoretical Approach: Crossing Traditional Boundaries of Change* (Homewood, IL: Dorsey Press, 1984).
55. J.O. Prochaska et al., Predicting Change in Smoking Status for Self-Changers, *Addictive Behaviors* 10 (1985):395–406.
56. J.O. Prochaska and C.C. DiClemente, Common Processes of Change in Smoking, Weight Control, and Psychological Distress, in *Coping and Substance Abuse*, eds. S. Shiffman and T. Wills (San Diego, CA: Academic Press, 1985), 345–363.
57. J.O. Prochaska and C.C. DiClemente, Toward a Comprehensive Model of Change, in *Treating Addictive Behaviors: Processes of Change*, eds. W.R. Miller and N. Heather (New York: Plenum Press, 1986), 4–27.
58. J.O. Prochaska et al., Measuring Processes of Change: Applications to the Cessation of Smoking, *Journal of Consulting and Clinical Psychology* 56, no. 4 (1988):520–528.
59. J.O. Prochaska, Prescribing to the Stages and Levels of Change, *Psychotherapy* 28 (1991):463–468.
60. J.O. Prochaska, What Causes People To Change from Unhealthy to Health Enhancing Behaviors? *Cancer Prevention* 2 (1991):30–34.
61. J.O. Prochaska et al., In Search of How People Change: Applications to Addictive Behaviors, *American Psychologist* 47, no. 9 (1992):1102.
62. J.O. Prochaska and C.C. DiClemente, Stages of Change in the Modification of Problem Behaviors, in *Progress in Behavior Modification*, eds. R.M. Eisler, M. Hersen, and P.M. Miller (Sycamore, IL: Sycamore Press, 1992), 184–214.
63. J.O. Prochaska et al., Stages of Change and Decisional Balance for Twelve Problem Behaviors, *Health Psychology* 13 (1994):39–46.
64. J.O. Prochaska et al., Standardized, Individualized, Interactive and Personalized Self-Help Programs for Smoking Cessation, *Health Psychology* 12 (1993):399–405.
65. J.O. Prochaska and W.F. Velicer, Introduction, *American Journal of Health Promotion* 12, no. 1 (1997):6–7.
66. W.F. Velicer and C. C. DiClemente, Understanding and Intervening with the Total Population of Smokers, *Tobacco Control* 2 (1993):95–96.
67. W.F. Velicer et al., Minimal Interventions Appropriate for an Entire Population of Smokers, in *Interventions for Smokers: An International Perspective*, ed. R. Richmond (Baltimore: Williams & Wilkins, 1994), 69–92.
68. E.S. Froelicher and Y. Kozuki, Theoretical Applications of Smoking Cessation Interventions to Individuals with Medical Conditions: Women's Initiative for Nonsmokign (WINS)–Part III, *International Journal of Nursing Studies* 39 (2002):1–15.
69. D.T. Kennedy and R.E. Small, Development and Implementation of a Smoking Cessation Clinic in Community Pharmacy Practice, *Journal of the American Pharmaceutical Association* 42 (2002):83–92.
70. K. Reeve, K. Calabro, and J. Adams-McNeill, Tobacco Cessation Intervention in a Nurse Practitioner Managed Clinic, *Journal of the American Academy of Nurse Practitioners* 12 (2000):163–169.
71. A.B. Herrick et al., Stages of Change, Decisional Balance, and Self-Efficacy Across Four Health Behaviors in a Worksite Environment, *American Journal of Health Promotion* 12, no. 1 (1997):49–56.
72. Prochaska, *Systems of Psychotherapy: A Transtheoretical Analysis*.
73. J.O. Prochaska and C.C. DiClemente, Stages and Processes of Self-Change in Smoking: Toward an Integrative Model of Change, *Journal of Consulting and Clinical Psychology* 5, no. 3 (1983):390–395.
74. Prochaska et al., In Search of How People Change.
75. Prochaska and Velicer, Introduction.
76. Fava et al., Applying the Transtheoretical Model to a Representative Sample of Smokers.
77. E.A. O'Connor et al., Gender and Smoking Cessation: A Factor Structure Comparison of

Processes of Change, *Journal of Consulting and Clinical Psychology* 64, no. 1 (1996):130–138.

78. DiClemente et al., The Process of Smoking Cessation.
79. Prochaska et al., In Search of How People Change.
80. Prochaska and DiClemente, Stages of Change in the Modification of Problem Behaviors.
81. Prochaska et al., Stages of Change and Decisional Balance for Twelve Problem Behaviors.
82. Prochaska et al., Standardized, Individualized, Interactive and Personalized Self-Help Programs for Smoking Cessation.
83. Prochaska and Velicer, Introduction.
84. Prochaska et al., Predicting Change in Smoking Status for Self-Changers.
85. M. O'Donnell, Editor's Notes, *American Journal of Health Promotion* 12, no. 1 (1997):4.
86. J. Ockene et al., *The Coronary Artery Smoking Intervention Study* (Worcester, MA: National Heart Lung Blood Institute, 1988).
87. DiClemente et al., The Process of Smoking Cessation.
88. Prochaska and DiClemente, Stages of Change in the Modification of Problem Behaviors.
89. Fava et al., Applying the Transtheoretical Model to a Representative Sample of Smokers.
90. Richmond and Mendelsohn, Physicians' Views of Programs.
91. R.G. Boyle et al., Stages of Change for Physical Activity, Diet, and Smoking among HMO Members and Chronic Conditions, *American Journal of Health Promotion* 12, no. 3 (1998):170–175.
92. Centers for Disease Control and Prevention, Trends in Cigarette Smoking Among High School Students—United States, 1991–2001.
93. L.D. Johnston, P.M. O'Malley, and J.G. Bachman, *Monitoring the Future National Results on Adolescent Drug Use: Overview of Key Findings 2001* (Bethesda, MD: National Institute on Drug Abuse, 2002, NIH publication no. 02-5105).
94. Substance Abuse and Mental Health Services Administration, *Summary of Findings from the 2000 National Household Survey on Drug Abuse* (Rockville, MD: U.S. Department of Health and Human Services, 2001, DHHS publication no. [SMA] 01-3549).
95. L.J. Kolbe, L. Kann, and N.D. Brener, Overview and Summary Findings: School Health Policies and Programs Study 2000, *Journal of School Health* 71 (2001):253–259.
96. M.C. Farrelly et al., Getting to the Truth: Evaluating National Tobacco Countermarketing Campaigns, *American Journal of Public Health* 92 (2002):901–907.
97. Federal Trade Commission, *Cigarette Report for 1999* (Washington, DC: Federal Trade Commission, 2001).

Changing One's World View

A world view is the set of beliefs that each of us holds about the way the world operates, the reasons that things happen as they do, and the rules that each of us follows. We seldom give a thought to our world view, but it is a powerful, guiding force in our lives. We cannot escape the effects of our world view. It begins to operate the very moment we begin each day. The moment we walk into work or into a social gathering, we put our world view into action. Do we have control over our life, or do things happen by accident? Is there some purpose or meaning behind the events with which we are dealing (e.g., stress level, interactions when dealing with clients and families)? Do people with addictions have any control over their illness, or is it only a function of the physiologic processes occurring in the body? Does choice exist in health and illness, or is the body entirely "on automatic pilot"? Our world view gives us answers to difficult questions like these. The more conscious we become of the assumptions that we make in our world view, about "how things work," the more effective we will become in our interactions with self and others.

How can we become more conscious about our world view and our choices in life? To be present for ourselves or others, we must honor our personal needs or we will be physical and emotional wrecks. What are the current circumstances in our lives? We must accept them, releasing efforts to control things over which we have no control. We must honor ourselves each day with relaxation, imagery, music, meditation, or prayer. We can create an exercise program; take long, hot baths or showers; eat nutritional foods; eliminate excess caffeine or junk food; and ask other people for help if needed. We need to tell ourselves over and over that we are doing a good job.

Caring for ourselves each day requires simple things. When waking up in the morning and before getting out of bed, we should say to ourselves, "The part of me that is most in need of healing right now is . . ." and, "The things that I can do to bring about my healing are . . ." The answers are usually simple, such as "I need to take a morning break and a lunch break, have a massage, or ask a friend to meet me for a chat." We can repeat this as often as necessary during the day. This increases our awareness of basic assumptions and life choices. By honoring ourselves we allow fear, depression, loneliness, suffering, feelings of discouragement, crisis, or tragic moments to be released, so that being with ourselves or others is quality time. Recognizing one's world view and learning how to care for oneself are at the core of helping a person with addictions move toward healing and spiritual transformation.

Chapter 29

Addiction and Recovery Counseling

Bonney Gulino Schaub and Barbara Montgomery Dossey

NURSE HEALER OBJECTIVES

Theoretical

- Discuss factors leading to addiction.
- Identify patterns of thinking and behavior associated with addictions.
- Identify the reasons that spiritual development is important in long-term recovery.

Clinical

- Develop skills in assessing clients' relationships to drugs and alcohol and to addictive patterns of behavior.
- Learn to recognize the patterns of denial that perpetuate and protect addictive behaviors.
- Become knowledgeable about the long-term issues in recovery and in relapse prevention.
- Identify support systems within the community for the person in recovery, such as support groups, psychotherapists knowledgeable about issues in recovery, meditation, prayer groups, and other resources for spiritual development.

Personal

- Take the Problem Drinker Self-Assessment and determine if drinking is a problem in your life.
- Assess your responses to stress from the perspective of addictive patterns of behavior (e.g., alcohol or drug use, smoking, excessive sugar consumption), and learn more effective stress management strategies.
- Recognize your own feelings of vulnerability and your characteristic responses to these feelings.
- Assess your environment, and determine whether there are any people with addictions in your personal or work life; notice if you have any patterns of denial and enabling in relating to them.

DEFINITIONS

Addiction: a physiological or psychological dependence on a substance (e.g., alcohol, cocaine) or behavior (e.g., gambling, sex, eating).

Denial: a major dynamic in the process of addiction in which the person willfully refuses to accept the reality of his or her behavior and its effect on self and others.

Detoxification: the physical process of withdrawing from use of drugs or alcohol.

Dry Drunk: referring to alcoholism (dry = not drinking) where a person has stopped drinking but has not extended this change to developing mentally, emotionally, and spiritually.

New Consciousness: a concept used in Alcoholics Anonymous that refers to a movement away from addictive thinking and toward an understanding of one's life purpose or spiritual purpose.

Recovery: the mental, emotional, physical, and spiritual actions that support conscious living and freedom from addictive behaviors.

Relapse: a return to addictive behavior, even if on only one occasion.

Spiritual Awakening: an expansion of awareness that results in a realization that the isolated individual is, in fact, participating in a universe of divine intention and order.

THEORY AND RESEARCH

About 90% of adults in the United States consume alcohol. For the majority of these people, the "social drinkers," alcohol seems to be a relatively safe relaxant. On the other hand, it is estimated that between 10% and 20% of men and between 3% and 10% of women become alcohol dependent. There has been a steady increase in the incidence of alcoholism in women over the past 30 years. On any day, more than 700,000 Americans are being treated for alcoholism.[1] It is estimated that about 1.9 million young people between the ages of 12 and 20 are heavy drinkers and 4.4 million are binge drinkers. There are many theories about the amount that someone can drink and remain healthy, but it is clear that anyone who begins drinking heavily in adolescence is at higher risk for developing alcoholism.[2]

Alcoholism leads to approximately 200,000 premature deaths a year, disrupting the lives of some 40 million family members.[3] In 1998, the costs of alcoholism were estimated as follows: $134.2 billion in lost productivity, including $87.6 in losses from alcohol-related illness; $36.5 from premature death; $10.1 in costs resulting from crime; and $15.7 from property loss and administrative costs of alcohol-related traffic accidents.[4]

Because of the prevalence of alcoholism and other addictions, nurses in every practice setting inevitably will be working with individuals who are addicted, who are in recovery, or whose lives are affected by the addiction of a friend or family member.

Addiction Defined

Alcoholics Anonymous (AA), in its basic book (referred to by people in AA as the "Big Book"), describes alcoholism as a "mental obsession and a physical compulsion."[5] This description of a pattern of thinking and behaving applies to many things besides alcohol, most obviously the use of other substances such as cocaine, heroin, methamphetamine, and marijuana. This pattern also is visible in a broad range of behaviors that are recognizable as addictive processes. The elements of obsession and compulsion are evident in the actions of people with unhealthy relationships to food, exercise, work, gambling, Internet use, television viewing, shopping, sexual behaviors (including compulsive use of pornography), and other activities. Coleman-Kennedy and Pendley state that as many as 20 million people in the United States are affected by sexual addiction which often co-exists with addiction to substances, and they recommend including screening for this during substance abuse assessments.[6]

Certain elements distinguish the process of addiction from the healthy or recreational use of any of these substances or behaviors. The key difference is in the individual's relationship to the substance or behavior. In the addictive process, the element of choice is absent. A woman no longer chooses to relax with a glass of wine at a dinner party—she goes to the party because it will be an opportunity to drink a great deal. A man no longer enjoys watching a sporting event—he only

watches it because he has a bet on it. A young college student takes up running to lose weight and feels compelled to go for a run despite her knee injury, because she will be depressed and obsessing about her weight without a run of at least five miles a day. In other words, the mental obsession has overruled any ability to reflect on behavior and has bypassed any self-awareness that could lead to alternative behaviors. These addictive behaviors often coexist with various forms of substance abuse. The addictive use of any of these activities serves the same purpose as alcohol or drugs: The person is seeking relief and distraction from painful, unsafe, and vulnerable feelings.

Cycle of Addiction

All addictions have a basic cycle. Understanding this cycle makes it possible to understand the specific kinds of help that a person with an addiction needs to facilitate the healing process. In the early stage of addiction, people use a substance or substances as a means of changing unsafe or vulnerable feelings. Some commonly heard descriptions of these feelings are "I feel like I don't have any skin," "Everything gets to me," and "Everything is just too much." Typically, there are physical signs of anxiety such as lightheadedness, palpitations, painful levels of self-consciousness and social discomfort, and generally heightened degrees of agitation or irritability.

Vulnerability is a normal human emotion that everyone has experienced, but the person vulnerable to addiction feels it more intensely and more frequently. Characteristics such as a low frustration tolerance, a low pain threshold, and a need for instant gratification go along with this vulnerability. These characteristics present challenges for nurses when caring for addicted clients.

Most people who have become addicted to a substance have a vivid memory of their first experience of relief from feelings of discomfort as a result of using the substance. This first encounter typically occurs in early adolescence, a time of normal emotional turmoil and struggle for social identity and acceptance. Getting high may have alleviated social anxiety or the pain of family conflicts. The incidence of substance abuse is high among young people in conflict about their sexual identity because they are often lacking in support and positive role models in their life. Sharing drugs or alcohol becomes a way of being accepted into a peer group for these young people, as well as others that do not feel they "fit in." Thus, the stage is set for dependence and progression to addiction. The process of building emotional and social skills, which is a major developmental task of adolescence, stops because an instant solution has been found. Picking up where they have left off in this process of emotional and social skill building is one of the major challenges for people in recovery.

In the early stage of addiction, the person has some awareness of seeking relief from discomfort. It may simply be an awareness of feeling stressed, anxious, or self-conscious.

Early Stage of Addictive Cycle

1. unsafe feelings
2. mental focus on the feelings
3. a desire to get rid of the feelings
4. using chemicals to get rid of the feelings
5. nervous system disturbance because of the chemicals
6. unsafe feelings[7]

In the middle stage of addiction, the unsafe feeling is not experienced as a thought. It is experienced only as danger or discomfort. The person knows that immediate relief comes with use of the substance.

Middle Stage of Addictive Cycle

1. unsafe feeling
2. using chemicals to get rid of the feelings
3. nervous system disturbance because of the chemicals
4. unsafe feelings[8]

People in the depths of addiction rarely talk about feeling high. The need is more frequently described as a desire to feel "normal." The impulse is to escape a feeling that is intolerable. At the late stage of addiction, physical instability replaces the emotional vulnerability. The addiction has come full circle. What was initially used as an answer to unsafe feelings has become the source of unsafe feelings. Mental instability and confusion, mental terrors and paranoia, and hallucinations or feelings of unreality are all possible results of the neurological damage from the substances.

Late Stage of Addictive Cycle

1. nervous system disturbance
2. using chemicals
3. nervous system disturbance[9]

Models of Addiction

There have been many models put forth to explain why a person develops an addiction. Any nurse who has worked with addicted patients can recognize recurring themes such as familial and environmental patterns of addiction or early childhood trauma and loss. Clearly, addiction defies simple explanations. Each of the different models offers a piece of a complex puzzle.

Medical Model

In the medical model, the emphasis is on the physiologic effect of the substance itself. The body's tolerance for the drug leads to the need for greater and greater amounts in order to achieve the desired effect, which results in addiction. The absence of the drug leads to cravings and then to a withdrawal/abstinence syndrome characterized by symptoms such as fever, nausea, seizures, chills, hallucinations, or delerium tremors. In this model, the progression toward addiction is a property of the drug's effect. Those in the media often demonstrate this attitude toward addiction when they describe a celebrity who has attended a 30-day alcohol or drug rehabilitation program as "free" of drugs. In fact, 30 days is the beginning of treatment.

Genetic Disease Model

Research in this area has focused primarily on alcoholism. Much research points to strong patterns of alcoholism within families. People with close relatives who are alcoholic are at a three to four times greater risk for alcoholism. The closer the genetic tie and the higher the number of affected relatives, the greater the risk. Adoption studies show a three times greater incidence of alcoholism in children of alcoholics, even if they have been raised in a nonalcoholic family.[10] This risk factor also is seen with drug addictions across a wide range of substances, including cannabis, cocaine, and opioids.[11,12] The genetic disease model suggests that genetically-based differences in biochemistry alter the processing and metabolism of alcohol and other substances, making the affected individuals more susceptible to addiction. Other researchers have suggested that personality traits, such as those related to antisocial behavior, are heritable elements that contribute to susceptibility to addiction.[13]

Dysfunctional Family System Model

The frequent appearance of addictions within the families of addicts may indicate that substance abuse can be a learned behavior. In effect, the child learns through daily close observation of

the adults in the environment that conflicts and stressors are to be dealt with by drugs and alcohol. Children usually do not have a conscious awareness of this message. They may not have a full understanding of the role that addiction played in their home life until they reach adulthood and begin their own recovery. It is important to acknowledge that many other people who have grown up in such an environment are aware of the damage done, and make a conscious choice to abstain from alcohol or other substances.

Self-Medication Model

According to the self-medication model, the addict has an underlying psychiatric disorder and is, in effect, self-prescribing to alleviate symptoms. For example, it is estimated that at least half of all patients diagnosed with schizophrenia concurrently abuse substances.[14] Addicts characteristically have tried a variety of substances and have found that they have a strong preference for a particular category of drug and drug effect. For example, a strong relationship has been documented between exposure to traumatic events and alcohol abuse.[15] It is not unusual for addicts to say their preferred substance makes them feel "normal."

Psychosexual Psychoanalytic Model

Emerging from Freud's conceptualization of psychosexual stages of development,[16] addiction appears to be a fixation at the oral stage of development. In the psychosexual psychoanalytic model, an infant or child whose basic needs are unmet becomes focused on seeking gratification of those unmet needs. Emotional development becomes fixated at the age of this early trauma.

Oral gratification is the most basic need of the infant, as seen in the way an infant receives nourishment and pleasure through sucking. In adulthood, people continue to seek comfort and pleasure from gratification of oral needs through behaviors such as eating, smoking, talking, touching their mouth, and various chewing behaviors. While healthy human activity includes some seeking of oral gratification, the addict is fixated at this developmental phase. The compelling need for comfort derived from oral gratification then becomes focused on the consuming of substances.

Ego Psychology Model

Also emerging from Freudian theory,[17] ego psychology suggests that, when an infant's or child's environment does not provide an adequate degree of nurturance and acknowledgment, the child grows into adulthood with an impaired sense of self. This results in feelings of emptiness and hypersensitivity that lead to a self-absorbed and narcissistic relationship with the world. The addict's behaviors are then seen as self-soothing attempts to relieve the basic feelings of emptiness.

Cultural Model

Our culture may be a major contributing factor in addiction, because it teaches us to seek materialistic answers outside ourselves in order to experience well-being. People in the United States confront a relentless message of consumerism and quick fixes. This then leads to a society of impulse-disordered consumers who seek instant gratification and believe that there is a pill for every ill.

Character Defect Model of AA

Alcoholics and other addicts are seen as different in character and morals from nonaddicts in the character defect model of AA. Although the idea of a "moral" defect is not used extensively in addiction treatment settings, it is a concept that pervades the AA literature. A person in recovery may explain "my character defect" as

the reason for his or her difficulty in making behavioral and attitudinal changes.

Trance Model

Derived from learning theory and the principles of hypnosis, the trance model proposes that the memory of the intense pleasure experienced in response to a substance is never forgotten. The experience is recorded by the pleasure-seeking, pain-avoiding part of the brain and remains, in effect, as a deeply planted, posthypnotic suggestion that repeatedly seeks expression. The addict essentially falls in love with the feelings that the addictive behaviors produce.[18] The AA literature speaks to this idea in stating, "The urge to repeat the experience of becoming 'high' is so strong that we will forsake . . . our responsibilities and values . . . our families, our jobs, our personal welfare, our respect and integrity . . . to satisfy the urge."[19]

Transpersonal Intoxication Model

According to the transpersonal intoxication model, the desire to break free of a limited, time-bound, socially defined sense of self and the desire to expand consciousness are the driving forces in addiction. Many people have experimented with lysergic acid diethylamide (LSD), marijuana, psilocybin mushrooms, peyote cactus, and other psychedelic substances, and experienced expanded states of awareness that have resulted in spiritual and creative breakthroughs. The challenge then is to integrate these insights into daily life.

There is a significant degree of substance abuse and addiction among artists, writers, performers, and musicians. This model suggests that their desire to break free of mental and emotional limitations is at the heart of their substance use. One part of the artistic process is about finding a way to express the most intimate, subtle, and spiritual aspects of human experience. Artists often mention a fear of loss of this creative capacity—of becoming "ordinary"—as they enter recovery. They have given the creative power to the substance rather than trusting that it resides within themselves. The ability to practice their creative endeavor while sober then becomes a major milestone in the recovery process.

Transpersonal–Existential Model

In the transpersonal–existential model, the human condition is such that humans are inherently anxious because they have knowledge of their mortality. Everyone finds ways to bypass or deny this awareness of reality. Becker, in a book authored when he was dying of cancer, wrote that a person "has to protect himself against the world, and he can do this only as any other animal would: by . . . shutting off experience, developing an obliviousness both to the terrors of the world and to his own anxieties. Otherwise he would be crippled for action . . . some people have more trouble with their lies than others. The world is too much with them. . . ."[20] This heightened awareness and sensitivity to the human condition then leads to addiction as a solution to the existential pain.

VULNERABILITY MODEL OF RECOVERY FROM ADDICTION

As a holistic nursing model of the recovery process, the vulnerability model of recovery honors the biologic, emotional, social, familial, neurochemical, and spiritual aspects of addiction. It focuses on the lived experience of the addict, which is that of essential vulnerability. The model points to specific ways that the holistic nurse can facilitate the healing journey of full bio-psycho-social-spiritual recovery. The basic points are presented in Exhibit 29–1.

The vulnerability model points directly to emotional education of children as a key intervention in preventing substance abuse. Children need to learn, in a safe and nonjudgmental setting, about the normalcy of difficult and vulnerable feelings.

Exhibit 29–1 The Vulnerability Model of Recovery

- Addiction is a repetitive, maladaptive, avoidant, substitutive process of getting rid of vulnerability.
- This addictive process is triggered by an experience of vulnerability that is believed to be intolerable.
- Vulnerability is anxiety ultimately rooted in the human condition of being conscious, separate, and mortal. As such, this vulnerability is a normal emotion, an elemental aspect of our actual human situation.
- People who have a greater degree of vulnerability (explanations for which range from genetic to biochemical to characterlogical to familial to cultural to spiritual) have a greater degree of need to get rid of it.
- Getting rid of vulnerability is accomplished by trying to feel powerful or by trying to feel numb. Trying to feel powerful is an act of willfulness. Trying to feel numb is an act of will-lessness. Drugs are selected to help produce these results. Trying to feel powerful or numb are both choices. Made repeatedly, they become addictive, producing predictable but brief episodes of relief from vulnerability.
- People in recovery from addiction begin to heal their feelings by recognizing and respecting their vulnerability.
- Continued recovery is based on developing new, non-avoidant responses to vulnerability.
- This vulnerability, however, cannot be effectively responded to on a long-term basis by the separate, ego level, temporary sense of self, since it is that sense of self which is at the very root of the vulnerability.
- Advanced recovery therefore requires the development of an expanded sense of self that is communal and spiritual in awareness. Such spiritual development is a normal aspect of adult development, despite the fact that it is ignored by most western psychology.
- Communal awareness is provided by Alcoholics Anonymous and other 12-Step programs through fellowship and service to others in recovery. Spiritual awareness requires development that has been studied by the world's wisdom traditions and, more recently, by transpersonal psychology.
- Many people in recovery do not experience spiritual awareness because this aspect of human nature has been neglected and poorly understood in modern culture. Pioneering transpersonal psychiatrist, Roberto Assagioli, referred to this issue as "repression of the sublime."
- Transpersonal approaches offer insights and practices that can: a) lift repression of the sublime; b) energize spiritual awareness and increase inner peace; and c) work at the deepest root of the addictive process.

Source: Reproduced by permission. *Healing Addictions* by Schaub and Schaub. Delmar Publishers, Albany, NY. Copyright 1997.

Learning to identify and then articulate feelings relating to peer approval, self-esteem and self-acceptance, performance anxiety, family conflict, trauma, and loss are important tools for healthy living. Self-care skills and stress management skills should be part of children's basic education if they are to be protected from the unhappiness of addiction.

Nurses often have contact with children during one of the most traumatic times they can experience, the serious illness or death of a family member or close friend. Often, the adults involved try to "protect" a child from their own pain and stress by withholding information or offering simplistic or euphemistic explanations. The profound vulnerability that children experience at such a time can be the root of future susceptibility to substance abuse.

Recognition of Addiction

Given the prevalence of alcoholism and other addictions, it can be assumed that nurses in every clinical area are working with people whose lives are affected by this problem—even when the issue is never directly addressed. Therefore, it is essential that all nurses become skilled in

assessing the possibility of addiction and recognizing risk factors and behaviors suggestive of problems with substance abuse. Nurses must first examine any preconceived notions that they may have about what an addict or alcoholic looks like. Addiction is a problem that occurs in every profession, in every educational and socioeconomic group, in every ethnic group, and in every age group from early adolescence through senescence.

There is a great opportunity for early intervention in trauma centers, which have largely ignored alcohol abuse. Nearly half do not screen patients for alcohol abuse, and those that do only rarely refer patients found to be alcoholics to treatment programs. Researchers at Seattle's Harborview Medical Center tested 2,378 trauma patients for intoxication on admission (blood alcohol count higher than 100 mg/dL) and chronic alcohol abuse (abnormal levels of the liver enzyme gamma-glutamyltransferase) and followed these patients for an average of 28 months after discharge. Even after other factors had been accounted for, patients who were drunk at the time of the trauma or chronic abusers were 50 to 60% more likely than others to return. This research suggests that trauma can be used to motivate the patient and his or her family to confront alcohol or drug problems.[21]

In another study, 4,663 adult emergency department patients were screened over a six-month period, using a standardized alcoholism questionnaire. Of the 22% of the people screened who were judged to be drinking excessively, only 41% were offered help for their drinking problem. Of these, 88% declined the help.[22]

The most challenging, and potentially frustrating, aspect of working with people at the stage of active addiction is their pervasive denial of the problem, even when confronted with blatant evidence of his or her addiction. Alcoholics Anonymous uses the phrase "self-will run riot" in describing this behavior. It is the key obstacle to entering into the healing process of recovery. (See Exhibit 29–2 for definitions of denial.)

The addicts' loyalty to their substance is profound. It surpasses loyalty to family and friends and is the cause of the addicts'

Exhibit 29–2 Definitions of Denial

- Continuous negative behavior in the face of obvious negative physical, emotional, and social consequences

  "My girlfriend is constantly bugging me and threatening to break up with me because of my drinking. She's really got hang-ups about drinking because her father is an alcoholic."
- Prideful insistence the person has control of behaviors that are out-of-control

  "I didn't get into that car accident because of the coke. I actually am a better driver when I've done a few lines. It keeps me alert and my reflexes are better."
- A maladaptive strategy for achieving security

  "I don't really have a problem with alcohol, I just need a few drinks when I get home from work because I work the evening shift. My job is very stressful and it's hard to relax enough to fall asleep."
- The energy used to maintain a destructive lie

  "I only use drugs because my girlfriend does. I can stop whenever I want."
- A narrowing of awareness to shut out anything that makes the person vulnerable

  "When I get high I just don't give a damn. All this crap just fades away."
- An unwillingness to experience the feelings the truth provokes

  "My boss was a total hypocrite. He was always on my case. All the guys have a few beers at lunch time. He fired me because he never liked me."

Source: Reproduced by permission. *Healing Addictions* by Schaub and Schaub. Delmar Publishers, Albany, NY. Copyright 1997.

manipulations. The nurse should not personalize these manipulations. Attempts to be of help often meet outright rejection or failure. The root of the addicts' behaviors is an intense fear of living without the mood-altering effects of the alcohol and/or drugs. The behaviors are attempts to control the world and avoid painful feelings. The first step of recovery is relinquishing this control effort and admitting to self and others that the addictive process is not working, that it is actually making everything worse, that he or she does not know what to do, and that he or she must learn a new way to be in the world. This new way means a change in attitude to recognize that people who want to help stop the addictive behaviors are acting from a place of caring.

Detoxification

The simplest, most straightforward aspect of the recovery process is detoxification. When medical management of the detoxification is necessary, brief inpatient or outpatient treatment is available in many hospitals and addiction treatment centers. Acupuncture has been successfully used in detoxifying people from alcohol, heroin, nicotine, and other drugs. Its use was pioneered in New York City in the 1970s by Dr. Michael O. Smith. In recent years, it has gained wider acceptance and has been found to be a powerfully effective, natural treatment that is simple, safe, and inexpensive. It can be used in either inpatient or outpatient settings.[23,24]

Alcoholics Anonymous

With its 12-step self-help treatment approach, AA offers one of the most important, effective, and widely accepted interventions in addiction treatment. The 12 Steps of Alcoholics Anonymous put forth a systematic progression of actions to take that, when followed, will assist the person in recovery to find a new way to be in the world (Exhibit 29–3). In studies of female participants in AA, Rush[25] has demonstrated the empowering effect of regularly attending meetings. The value of ongoing peer support as well as support for spiritual development were cited as significant factors in the effectiveness of this program.

An important element in AA is the practice of providing service to other members of the program by becoming a "sponsor." Members who have achieved a strong recovery are encouraged to be available to newer participants to help them in their sobriety. They may attend meetings with them, be available by phone on a regular basis, and generally serve as a role model and guide to effective use of the program. In another study conducted by Rush,[26] she looked at the impact of sponsorship on the experience of female AA members. The women who had sponsors scored significantly higher in measures of total social support and personal support. The availability of the sponsor was a major factor in this.

Enabling

A person in the addictive process has fears about change, and the people closest to him or her have fears as well. It is in the nature of the addictive process that the people living and working closest to the person with the addiction have made accommodations to compensate for and cover up the addicted person's behaviors. The nurse who takes on the role of working with a person in recovery will find it necessary to help the people closest to the person to change their behavior, too. They need to look at their own patterns of enabling the addicted person's behavior and be willing to keep the focus on their own process of growth and change.

Al-Anon is a self-help program for the friends and family members of alcoholics and other substance abusers. Family

Exhibit 29–3 The Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people whenever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to others, and to practice these principles in all our affairs.

Source: The Twelve Steps of Alcoholics Anonymous have been reprinted with permission of Alcoholic Anonymous World Services, Inc. (A.A.W.S.). Permission to reprint the Twelve Steps does not mean that AA is in any way affiliated with this publication, or that it has read and/or endorses the contents thereof. AA is a program of recovery from alcoholism *only*—inclusion of the steps in this publication, or use in any other non-AA context, does not imply otherwise.

members, particularly spouses and partners, who have undoubtedly expended much energy in trying to help the addicted person, learn in Al-Anon how to accept their powerlessness to control others. The emphasis is on reorienting priorities and supporting the group members in focusing energy on making positive life changes for themselves.

Early Recovery

Detoxification, the initial step in early recovery, is just the beginning of a moment-by-moment, hour-by-hour, day-by-day process of making new choices. The nurse can help the person in recovery to make healthy choices by intensive questioning about old patterns of substance abuse and other behaviors. This information can then be used in planning for new ways of responding. Because behaviors associated with addiction are totally integrated into the person's life, he or she needs help in recognizing them and accepting the fact that they are no longer possible. Some important questions for the nurse to ask are:

- *Where did the addictive behavior take place?* Some people stay isolated in their home or car when using drugs, while others prefer social settings such as bars, clubs, or work environment.
- *What special rituals were a part of the addictive behavior?* People typically have a routine associated with their substance use. A marijuana abuser may purchase her favorite foods before using the drug, for example.
- *What places served as cues for the addictive behavior?* For the alcoholic, particular liquor stores or bars may have strong memories and pulls. A particular street sign or exit on the expressway may trigger the desire to go to the neighborhood where drugs were bought and shared.

- *What people in the environment were associated with addictive behavior?* The person in recovery may come to realize that everyone he or she knows is associated with the drug use. People in recovery often cannot name a single person they can count on to be drug-free. The sense of loss of family and friends associated with this realization can be profound.

Nutritional Factors

Alcohol has high caloric content, but is useless as a source of nutrients. Malnutrition is common in those who are alcoholic because drinkers often fail to consume adequate amounts of food. In addition, alcohol interferes with the absorption of vitamins and minerals. Alcoholics typically are deficient in B vitamins, especially thiamine, pyridoxine, and vitamins B_{12} and folate. There is also some evidence that the B vitamin deficiency itself may increase alcohol cravings.[27]

Some studies have indicated that alcoholics who followed healthful dietary plans that included both nutritional and vitamin supplementation, along with nutrition education, were more successful at maintaining sobriety.[28] The effectiveness of this approach may be attributable not only to the actual physiologic impact of improved nutrition, but also to the individual's commitment to making significant lifestyle changes. As stated earlier, recovery is a process of repeatedly choosing healthy, life-affirming actions.

For the recovering alcoholic or other addict, working with a holistic nurse to develop a nutritious eating plan may be an important first step on the path to health. As with any treatment plan, the key to its success will depend on compliance. Having a variety of approaches helps to develop personalized care and increase the likelihood of acceptance.

Body Work and Energy Work

In the early phase of recovery, shortly after cessation of use and resolution of any primary withdrawal symptoms, the person in recovery may experience difficulty sleeping, general agitation, and irritability. Acupuncture has been found to be very effective in the reduction of withdrawal symptoms and in the overall rebalancing of the physical system. Other types of body work such as reiki, therapeutic touch, massage, and reflexology can be of help in calming the body. Modalities offering direct physical touch or energy work are of value in the very early stages of recovery. Techniques requiring concentration, such as meditation and imagery for self-care, may be too difficult in the early phase of recovery; relaxation exercises that focus on very simple breath awareness and counting may be all the person can handle. Avoiding caffeine, drinking plenty of water and soothing herbal teas, exercising, and taking warm baths or showers are all helpful during this period when the body is literally releasing and cleansing itself of a build-up of toxins.

Relapse

A person can achieve abstinence and still not make life changes at the level of emotions and spirit. A person can, in fact, stop drinking and continue to be hostile, rageful, blaming, and irresponsible. These people are controlling their behavior through force of will. Alcoholics Anonymous calls these people "dry drunks." The person functioning in recovery in this way is at greater risk for relapse.

Relapse is an ongoing issue in every stage of recovery. Many people stop without treatment, or with very brief intervention, but others relapse repeatedly.[29] In AA, there is a saying: "The further you are from your last drink, the closer you are to

your next." Some addiction specialists have begun differentiating between someone who very briefly returns to drinking and then returns to abstinence, versus someone who resumes heavy drinking. The brief episode is referred to as a "lapse" rather than a full relapse.[30] This distinction may be in response to the "all-or-nothing," black-and-white thinking that can sabotage the process of recovery.

It is estimated that up to 75% of people in recovery relapse within the first year. It is significant to note that the figure is estimated to be even higher, up to 90%, for women with a history of sexual abuse and trauma.[31] This information points back to the vulnerability model. If sexual abuse and trauma exacerbate the person's unbearable feelings of vulnerability that lead to the addiction, then abstaining from the substances that served as the emotional anesthesia results in a return of these feelings. It becomes important to connect the painful feelings to the trauma rather than to attribute them all to the absence of the substance. This opens the door to the need for a second recovery process—the treatment and recovery from trauma. This issue is not addressed in Alcoholics Anonymous, or in basic addictions treatment. It is addressed in the literature and treatments that focus on Inner Child work.

Alcoholics Anonymous has a helpful acronym that is referred to in identifying the times that a person in recovery may be most vulnerable to drinking: H.A.L.T. This is shorthand for *H*ungry, *A*ngry, *L*onely, *T*ired. The advice is, if the person in recovery notices the impulse to drink, he or she should stop and take time to determine if any of these factors are creating this feeling. The advice is also to avoid, whenever possible, letting these situations develop. This simple advice is a very helpful tool to offer a person in recovery.

Gorski and Miller outlined the signs that lead back toward addiction.[32] Nurses can use this list to evaluate a relapse trend in the person's recovery process. Paraphrased from Gorski and Miller, the signs leading to relapse include:

- active denial in many areas of life
- efforts to convince others of the need for sobriety, referred to in AA as taking someone else's inventory
- defensiveness
- compulsive behaviors
- impulsive behaviors
- tendencies toward isolation and bitterness
- failure to see the big picture
- idle daydreaming with wishful and magical answers to complex problems
- helplessness and hopelessness
- an immature wish to be happy always
- frequent episodes of confusion
- tendency to judge other people
- quick anger
- irregular eating habits
- listlessness
- irregular sleeping habits
- progressive loss of daily structure
- irregular attendance at treatment meetings
- development of an "I don't care" attitude
- open rejection of help
- self-pity
- opinion that social drinking is manageable
- conscious lying
- complete loss of self-confidence

These are warning signs, not inevitable signs of relapse, and constructive responses are possible. These thoughts and feelings will be with the person in recovery, to one degree or another, on a recurring basis throughout his or her life. Each time the person lives through the experience and finds that it passes, and

each time the person tolerates the feeling effectively and responds to it in a healthy manner, recovery and satisfaction in living deepen.

Deepening of the Recovery Process

Choosing to take new actions in response to vulnerability is the key to recovery. If the element of choice is absent in the obsession and compulsion of addiction, then reclaiming the ability to make life-affirming choices—reclaiming free will—is the essence of recovery. The use of will can be considered the use of one's life energy. If someone is "willing" to do something, he or she is choosing to give energy to the task at hand. If he or she is "unwilling" to do something, he or she is withholding life energy. There are three different ways to use energy: willfully, will-lessly, and willingly. "Willingness and willfulness become possibilities every time we truly engage life. There is only one other option—to avoid engagement entirely [will-lessness]."[33]

Behaviors that reflect willfulness are seen energetically in the use of force, exertion, strain, contraction, constriction, violence, manipulation, controlling actions, and drivenness. It is the fight aspect of the fight-or-flight response to perceived danger. Will-lessness—the withdrawal of energy—is seen in behaviors reflecting withdrawal, escape, giving up, immobilization, collapse, and numbness. Will-lessness is the flight response to fear and vulnerability.

Every person tends to favor one of these patterns of behavior. Typically, a person who is predominantly willful eventually becomes exhausted and collapses into will-less behaviors. A person following a very restrictive and rigid weight loss diet, for example, ultimately binges. In contrast, a person who has fallen into a pattern of total will-lessness (e.g., has gone on an extended alcohol binge) suddenly becomes scared, vows to stop drinking, and goes on a "health kick." This grasp of control cannot be sustained because it is not grounded in any deeper changes. Consequently, the person swings back to the will-less behavior.

The array of behaviors that can be identified as willful and will-less are shown in Figures 29–1 and 29–2. These models are useful in teaching a person in recovery about patterns of behavior. People readily recognize and identify with these descriptions, and they generally appreciate the nonjudgmental presentation. As can be seen in these charts, the behaviors can be observed in every aspect of a person's life—in the physical, mental, emotional, and spiritual realms.

Willfulness and will-lessness are extreme uses of energy. They each represent an energetic state of imbalance. The goal in recovery from addictions is to lead a life of balance, harmony, and increasing serenity. Willingness is the active state of living life from the place of dynamic balance, as opposed to the extremes. It can be likened to the ideal of many of the world's wisdom traditions. It is spoken of in the Buddhist path of the middle way, in the Taoist concept of balance of yin and yang energies, in the Greek ideal of the golden mean, and in the common sense of moderation in all things. The qualities of life lived from this ideal are depicted in Figure 29–3.

Spiritual Development and Transformation

Spiritual development is an innate evolutionary capacity of all people. As indicated in Chapter 7, spirituality is not a concept, but a process of learning about love, caring, empathy, and meaning in life. This process leads a person to connect with his

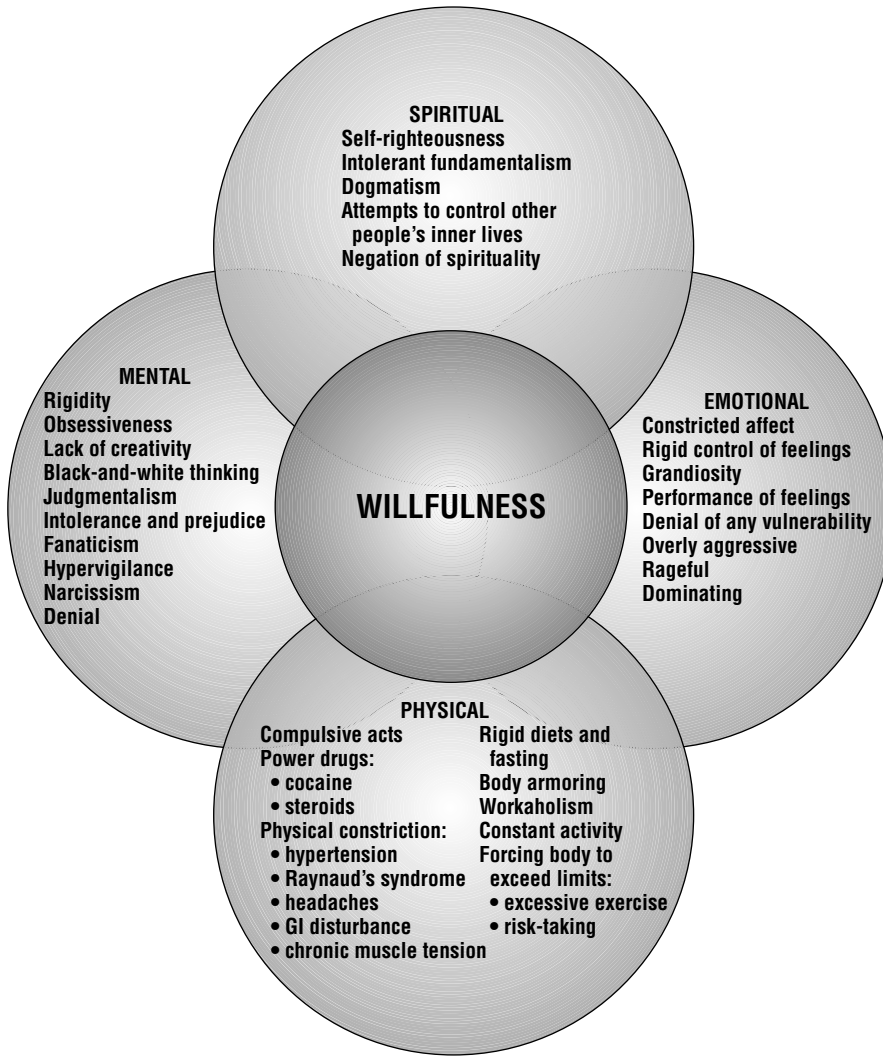


Figure 29–1 The Spectrum of Willfulness. *Source:* Reproduced by permission. *Healing Addictions* by Schaub and Schaub. Delmar Publishers, Albany, NY. Copyright 1997.

or her psyche, soul, or spirit and to have a lived experience of inner peace and harmony that allows access to inner wisdom.

Participants in AA and other 12-step programs are encouraged to seek spiritual growth and connection with their Higher Power. Green and associates explored the process of spiritual awakening experienced by a number of people in recovery.[34] They described the life-changing transformations that these people experienced as a result of their intense spiritual journey and their embracing of a power higher than themselves. This spiritual awakening appeared to be a significant factor in their sustained abstinence.

In a qualitative phenomenological study conducted by Bowden,[35] eight recov-

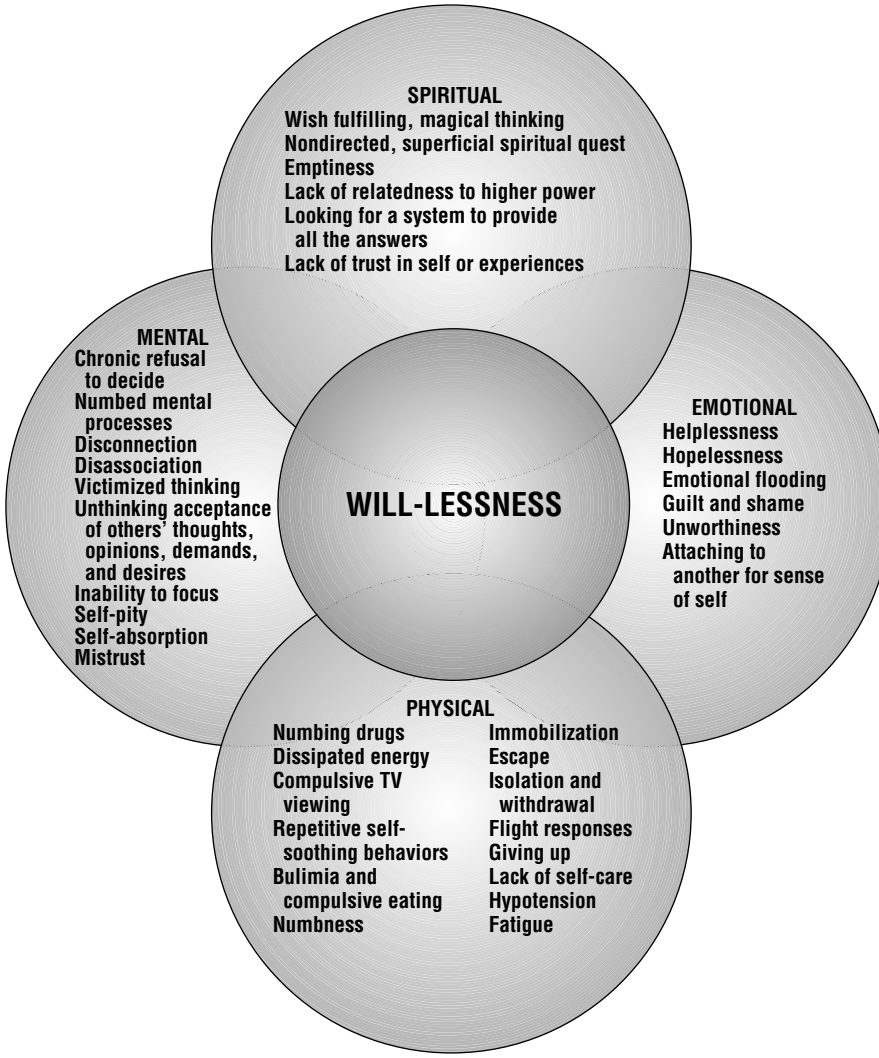


Figure 29–2 The Spectrum of Will-lessness. *Source:* Reproduced by permission. *Healing Addictions* by Schaub and Schaub. Delmar Publishers, Albany, NY. Copyright 1997.

ering alcoholics described the importance of integrating spiritual practices into their daily lives. In addition to developing self-acceptance, those who were doing well in recovery were also participating in an ongoing search for connections with the transpersonal realm. This information confirms that it is important to encourage the person in recovery to explore his or her spiritual nature (see Exhibit 29–1).

Bodymind Responses

In a study of 1,862 persons, Benson and Wallace found that those who used prescription and illicit drugs began reducing

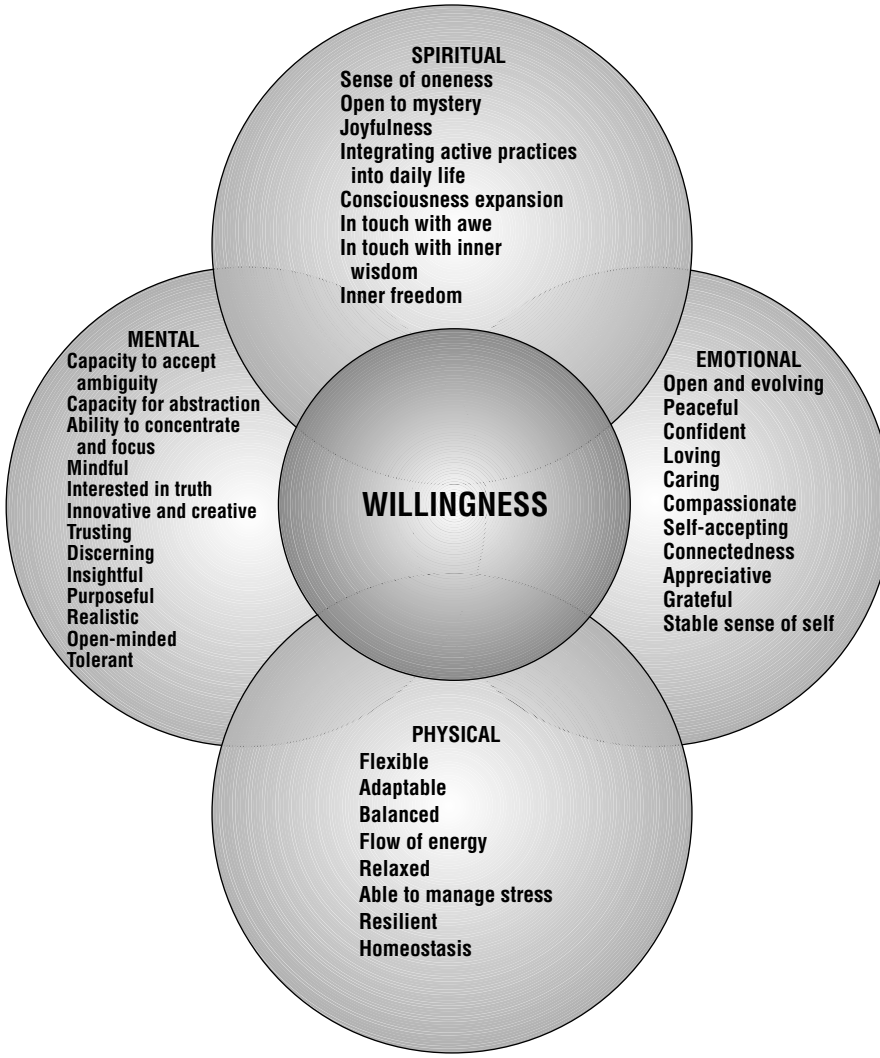


Figure 29–3 The Spectrum of Willingness. *Source:* Reproduced by permission. *Healing Addictions* by Schaub and Schaub. Delmar Publishers, Albany, NY. Copyright 1997.

their intake of drugs as they learned to enter a deep state of relaxation. After 21 months of regular meditation, most had stopped using drugs completely. The investigators looked closely at alcohol use in these same subjects. They classified drinkers as light users (three times a month or less), medium users (once to six times a week), and heavy users (once a day or more). After 21 months of meditation, heavy use of illicit drugs had dropped from 2.7 to 0.6%, medium use dropped from 15.8 to 3.7%, and light use dropped from 41.4 to 25.8%. The percentage of nonusers of alcohol rose from 40.1 to 69.9%. Most participants in this study, 61.1%, reported that meditation was "extremely important" in helping to

reduce their alcohol consumption. The more these people meditated, the less they drank.[36]

In another study, 20 male drug users between the ages of 21 and 38 began a meditation program. Over several months, the men reported that they were no longer taking drugs because drug-induced feelings became extremely distasteful when compared to those experienced during the practice of meditation.[37]

At the University of Washington in Seattle, Marlett and Marques found that college students who were heavy drinkers were able to reduce their alcohol use by 50 to 60% when they exercised and meditated regularly.[38] Exercise and meditation are effective because they offer an alternative method of reducing daily stress, confusion, discomfort, and fear.

Brain wave biofeedback also has been used successfully with people in recovery. It is a process in which electroencephalographic feedback helps participants go into deep states of relaxation. This heightened awareness also assists clients in recognizing their feelings of tension and then learning that deep relaxation can replace the chemically-induced relief from addictive substances.[39,40]

HOLISTIC CARING PROCESS

Assessment

In preparing to use strategies to assist clients in overcoming alcoholism, the nurse assesses

- the client's characteristics that may suggest alcoholism
  - —restlessness, impulsiveness, anxiety
  - —selfishness, self-centeredness, lack of consideration
  - —stubbornness, irritability, anger, rage, ill humor
  - —physical cruelty, brawling, child/spouse abuse
  - —depression, isolation, self-destructiveness
  - —aggressive sexuality, often accompanied by infidelity, which may give way to sexual disinterest or impotence
  - —arrogance that may lead to aggression, coldness, or withdrawal
  - —low self-esteem, shame, guilt, remorse, loneliness
  - —reduced mental and physical function; eventual blackouts
  - —susceptibility to other disease
  - —lying, deceit, broken promises
  - —denial that there is a drinking problem
  - —projection of blame onto people, places, and things
- the client's current drinking patterns (Exhibit 29–4 provides a self-scoring test that can be taken by a client or by a family member or friend concerned about the client's drinking.)
- the client's attitudes, beliefs, and motivation to learn interventions to become nonaddicted
- the client's available family and friends
- the client's eating and exercise patterns
- the client's existing stress management strategies
- the client's willingness to join a support group

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with interventions for addictions that are related to the 13 domains of Taxonomy II of the Unitary Person framework (see Chapter 14):

- Altered nutrition (more/less than body requirements)
- High risk for trauma
- Impaired verbal communication
- Altered social interaction
- Altered family processes

Exhibit 29–4 Are You a Problem Drinker?

1. Have you ever tried to stop drinking for a week (or longer), only to fall short of your goal?
2. Do you resent the advice of others who try to get you to stop drinking?
3. Have you ever tried to control your drinking by switching from one alcoholic beverage to another?
4. Have you taken a morning drink during the past year?
5. Do you envy people who can drink without getting into trouble?
6. Has your drinking problem become progressively more serious during the past year?
7. Has your drinking created problems at home?
8. At social affairs where drinking is limited, do you try to obtain "extra" drinks?
9. Despite evidence to the contrary, have you continued to assert that you can stop drinking "on your own" whenever you wish?
10. During the past year, have you missed time from work as a result of your drinking?
11. Have you ever "blacked out" (had a loss of memory) during your drinking?
12. Have you ever felt you could do more with your life if you did not drink?

Did you answer YES four or more times? If so, chances are you have a serious drinking problem or may have one in the future.

Source: The preceding twelve questions have been adapted from questions appearing in the pamphlet, "Is A.A. For You?", with permission of Alcoholics Anonymous World Services, Inc. Permission to use this material does not mean that Alcoholics Anonymous has reviewed and/or endorses this publication. AA is a program of recovery from alcoholism only—use of AA material in any non-AA context does not imply otherwise.

- Altered sexuality patterns
- Spiritual distress
- Ineffective individual/family coping
- Noncompliance
- Health-seeking behaviors
- Decreased physical mobility
- Sleep pattern disturbance
- Disturbance in self-esteem
- Disturbance in personal identity
- Hopelessness
- Powerlessness
- Knowledge deficit
- Altered thought processes
- Anxiety
- Potential for violence
- Fear

Outcomes

Exhibit 29–5 guides the nurse in client outcomes, nursing prescriptions, and evaluation for overcoming addictions.

Therapeutic Care Plan and Implementation

Before the Session

- Spend a few moments centering yourself, connecting with your inner wisdom and intention to facilitate healing.
- Create a quiet place to begin guiding the client in strategies to overcome addiction(s).

At the Beginning of the Session

- Review the results of the self-assessment.
- Reinforce the concept that overcoming addictions is a process requiring commitment, new behavioral skills, and support from family and friends.
- Ask the client to tell his or her personal story.
- Assist the client in identifying the steps necessary for overcoming addictions. If necessary, assist the client in going through detoxification.

During the Session

- Teach the client general relaxation and imagery exercises with a focus on awareness of body sensations and their connection to feelings.
- Teach the client how to create specific imagery patterns (see Chapter

Exhibit 29–5 Nursing Interventions: Overcoming Addictions

Client Outcomes	*Nursing Prescriptions*	*Evaluations*
The client will demonstrate attitudes, beliefs, and behaviors that result in overcoming addictions.	Determine the client's intention to overcome addiction by: • seeking support from healthy family and friends • attending AA meetings • seeking support of a sponsor • detoxifying self and environment of alcohol/drugs • practicing relaxation and imagery • integrating behavioral changes • selecting ways to reward self for attaining goals	The client demonstrated attitudes, beliefs, and actions that reflect an intention to overcome addiction. The client set realistic plans for overcoming addiction as evidenced by: • accepted support of healthy family or friends • attended AA daily • contacted AA sponsor regularly • detoxified self and environment of drugs and alcohol • practiced relaxation/imagery daily • integrated behavioral changes on a daily basis • rewarded self for attaining set goals

22) and to practice and integrate the following:

1. *active images*—cleansing the body of impurities, such as by a gentle waterfall; creating a safe place where the client can feel secure and comfortable; using a protective shield to let the client receive what is needed from others and to block out negative images, such as drink or drug signals, places, or events.
2. *end-state images*—of feeling healthy, of living with a sense of accomplishment and satisfaction, of having healthy supportive relationships.
3. *healing images*—connecting with inner healer, inner wisdom, and with spiritual resources.
4. *process images*—imagining successfully overcoming drink or drug signals and making healthy alternative choices.

- Teach the client to reframe current situations and problems. For example, instead of the client saying, "I can't admit publicly that I'm an alcoholic," help the client rehearse being at a 12-step meeting and saying, "Thank you for letting me share my story with you. I have been an alcoholic for 10 years, and I am ready to quit."
- Teach the client to use H.A.L.T., checking to notice if being *H*ungry, *A*ngry, *L*onely, or *T*ired is a contributing factor when experiencing drink or drug signals. Encourage the client to avoid these conditions whenever possible.
- Encourage the development of creative skills as a means of working with strong emotions and experiences. Some of these areas are actively working with dreams, journal

keeping, letter writing (see Chapter 17); using artistic expressions by drawing, painting, sculpting with clay; playing evocative music to enhance images or to dance with the emotions (see Chapter 23).
- Have the client identify his or her habit breakers (see Chapter 28).
- Have the client learn forgiveness (see Chapter 7).

At the End of the Session

- Encourage the client to explore the value of a 12-step program as an adjunct to treatment.
- Emphasize the value of selecting someone in the program as a sponsor, so that a support person is available to be contacted on a daily basis.
- Reinforce the idea that the client can outwit relapse by learning how to recognize high-risk situations. Reinforce the value of using H.A.L.T. when experiencing signals for substance use. Is *H*unger, *A*nger, *L*oneliness, or *T*iredness contributing to these feelings? Encourage the client to make a list of particular high-risk situations and decide in advance quick action steps to prevent relapse.
- Reinforce the importance of integrating healthful habits into daily life. Encourage the client to select one or two practices to which he or she is willing to make a commitment to include in daily life. Imagery, breathing exercises, meditation, yoga, jogging or other physical activities, and dietary changes are all of value.
- Use the client outcomes (see Exhibit 29–5) that were established before the session to evaluate the session.
- Schedule a follow-up session.

Specific Interventions

Support from Family and Friends. The best gift that a family can give an addicted member is to affirm that the person is loved unconditionally, but that the addicted behavior can no longer be tolerated. *Each family is unique.* The family must decide the best approach to help that member and the whole family with recovery. It is helpful for the spouse to get professional help, as many husbands and wives are blamed—or blame themselves—for a spouse's addiction. Professional counseling for the family is advisable even if the addicted person chooses to join a support group.

If the addicted person's behavior is unmanageable, a team of people will be necessary to intervene to get the addicted person admitted into a residential treatment program. An "intervention" is a process in which the significant people in an addict's life join together to confront the individual with the truth of his or her behavior and insist on the need for treatment. Specific information on treatment options is an important component of the intervention. The intervention also must include specific actions that the family is going to take if the person with the addiction fails to cooperate with treatment.

Support Groups and Professional Help. The client needs to continually assess personal and work life stressors. Because group support is vital to success, the client should become actively involved in a local support group for those with his or her specific addiction. Group support programs based on the 12-step programs—for example, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), OverEaters Anonymous (OA), and CoDependency Anonymous (CODA)—are helpful. These groups are listed under the specific types of addiction in the telephone directory. Alcoholics Anonymous is the best known support program, with a success rate that studies show is on a par with, or better than, expensive inpatient programs. The client also should seek out a professional who is knowledgeable about addictions.

Few individuals successfully achieve freedom from addiction on their own. Addictive behaviors have been established and repeated over many years. Even if a client stays free of alcohol and drugs or stops the binge–purge cycle of bulimia or other addictions without help, the data show that the odds of relapse are high if the person has not learned any new attitudes or health behaviors. Those who stop an addictive behavior often replace it with a new addiction, develop physical symptoms or illness, or begin other destructive behaviors that lead to further dysfunctional patterns. For this reason, it is very important for people in recovery to seek out counseling that can address the tasks of emotional and transpersonal education. Alcoholics Anonymous views recovery as a lifelong issue. The addicted person must be "working the program," according to AA terminology, which means that the individual must explore inner psychological work. Any resistance to "working the program" is seen as a danger signal in the abstainer's recovery process.

Learning to Tell a Personal Story. Support groups provide clients with an opportunity to tell their unique stories in an environment that is open and accepting. This helps the participant to get past the feelings of shame and self-hatred that are uncovered as the person begins to view past behaviors, and abuse of self and others, with sober eyes. Taking full responsibility for past actions is a part of the "fearless moral inventory" that people in 12-step programs are advised to take. One of the most painful and challenging parts of this process is learning to forgive oneself and those who may have caused the addicted person harm.

Listening to other individuals' stories, as well as being listened to while telling a personal story, allows the client more opportunities to restore self-esteem, meaning, and purpose in life, and to develop a deeper insight into what is life-affirming or self-destructive. The action of bearing witness to others' stories, without offering advice or judgment, allows an inner awareness to develop. This awareness helps in reaching and trusting inner sources of guidance and hope. This process of self-observation can lead to the ability to alter and challenge the self-defeating inner dialogues that cause suffering and threaten recovery.

Resistance to Spirituality. There is much cynicism and discouragement in addictions treatment because professionals in rehabilitation and treatment centers often witness the "revolving door syndrome." Yet, unlike so many other conditions that nurses work with, an addiction is completely reversible. There is a real possibility for a person to transform his or her life dramatically and to begin living a healthy and sane life.

Because of their compatibility with 12-step programs and AA philosophy, spiritually-oriented therapies and psychotherapy are important components of care. Addictions treatment is one of the few areas in health care where spiritual development and exploration are not only openly addressed, but are recognized as an integral aspect of care. As nurses and other health care professionals interested in addictions counseling explore their own spirituality, they can serve as role models for grounding spirituality in real, human terms.[41] Furthermore, it is genuinely difficult for spiritually repressed nurses or psychotherapists to assist clients who are working through AA's 12-step program.[42]

No single nurse or therapist can provide enough support and reinforcement for the recovery process. Thus, the nurse must be aware of a client's degree of participation in AA and any resistance to the spiritual aspect of the AA meetings. A person who feels alienated by the spiritual components of AA is unlikely to participate in meetings. Some individuals hear the word "God" or "Higher Power" in meetings and begin to

reject AA's "God talk." If this is the case, the nurse can find out if there is a way the person can translate the concepts into personally acceptable ideas to facilitate a broader approach to spirituality. For some people, the idea of a Higher Power can be translated into Mother Nature, or the healing energy and intention of the people in their AA group. Clients may benefit from developing a more open view of spirituality by seeking out books on different spiritual philosophies or exploring spiritual practices such as yoga, t'ai chi, or meditation that offer people ways to experience expanded awareness (see Chapter 7).

Relaxation and Imagery. As previously noted, addicted individuals are not in touch with their bodies or feelings. Basic relaxation and imagery training can help them to experience themselves with new awareness. The daily practice of relaxation and of imagery exercises not only reverse stress and depression, but also increase clients' recognition of inner knowledge. People who have been addicted have lost trust in themselves because of all the poor choices that they have made while in their addiction. In addition, there is a deep shame when thinking of all the people they have hurt or disappointed. There is a harsh, condemning, inner voice with which these clients must contend.

Clients must become aware of their physical responses to stress (e.g., heart palpitations, muscle tightness, headaches, or stomach aches). The abuse of alcohol, drugs, food, or other substances or behaviors numbs awareness of body responses, short-circuiting body–mind communication. Clients must learn to practice stress management skills daily rather than waiting until a vulnerable moment occurs. For example, the nurse can teach diaphragmatic breathing as a very basic skill. Shallow, chest–shoulder breathing is a common stress response, one that often becomes chronic. Simply breathing diaphragmatically can bring about significant physiological and psychological responses. Changing to this breath pattern efficiently slows the heart rate, increases oxygenation of the blood, strengthens weak intestinal and abdominal muscles, and can bring about a sense of well-being and inner calm.[43]

Teaching a client the concept of "constant instant practice" is a way of linking a new behavior to an activity that is done repeatedly during the course of the day. For example, if the person spends a great deal of time on the telephone, he or she can let the telephone be the reminder to take a few deep, cleansing breaths. If the telephone is ringing, the person can let it ring a few extra times and take a deep breath before answering. This practice can be linked with any activity that occurs frequently during the client's day.

The mind responds best when it is given positive images about new ideas and new behavior patterns. A nurse may start by guiding clients in rhythmic breathing exercises. When the clients are in a quieted state, they can be guided to imagine being clean and sober and walking down a street where they went to use drugs or alcohol with friends, now experiencing this place from a sober perspective. The image of experiencing their world from a new perspective can then be practiced and reinforced, resulting in the breakdown of addictive responses and the strengthening of positive coping strategies.

Healing Addictions: Imagery Script. To assist in the client's recovery process, the nurse can take time to create special relaxation and imagery tapes that the client can listen to several times a day. The following three imagery scripts focus on substance abuse, but they can be modified for other addictions. A relaxation exercise from Chapter 21 may be recorded for 5 to 10 minutes; then one or several of

the scripts for overcoming addictions may be recorded for 15 minutes or longer.

It is best to use these scripts as suggestions. The most effective imagery tapes take advantage of the nurse's creativity, intuitions, and clinical insights—in combination with words and images the client has used—to create an imagery script that is designed for a particular person (see Chapter 22).

Script: ***Introduction.*** (Name), *as your mind becomes clearer and clearer, feel it becoming more and more alert. Somewhere deep inside of you, a brilliant light begins to glow. Sense this happening. The light grows brighter and more intense. This is the bodymind communication center. Breathe into it. Energize it with your breath. The light is powerful and penetrating, and a beam begins to grow out of it. The beam shines from the core of your spirit.*

Script: ***Affirming Strengths.*** *In your relaxed state . . . affirm to yourself at your deep level of inner strength and knowing . . . that you can stop drinking* [or taking drugs]. *Say it over and over as you begin to imagine the words and feelings in every cell in your body. Feel your relaxed state deepen. You can get to this space anytime that you wish. . . . All you have to do is give yourself the suggestion and stay with the suggestion as you move into your relaxed state. This is a skill that you will use repeatedly as you move into your new healthy life patterns.*

You have gone through detox . . . you are sober. Notice what you are feeling. Increase your awareness of deepening your relaxation. You have come a long way and are on your path toward healing.

The client provides affirmations and repeats them several times. For example, "I am at peace," "I am totally relaxed," "I feel safe and calm," "I can drink water or other kinds of liquids that will satisfy my oral needs," "I am secure in my inner knowledge that I have the strength for recovering."

Script: ***Overcoming Drink/Drug Signals.*** *Get in touch with your drink* [or drug] *signals. Is it a building, a time of day, a certain person, a social gathering? As you bring them into awareness, rehearse in your mind changing one of those signals. For example, if a certain bar is your signal, . . . imagine you are walking down the street and you approach that favorite bar. But see yourself doing something different . . . as you pass by, you take a deep relaxed breath . . . and on the exhale . . . you have walked by the front door of the bar. Consciously affirm to yourself the choice that you have made. You feel confident, excited, pleased with your new patterns.*

Imagine that you are with people who are drinking at a party. You have water or another nonalcoholic beverage in your hand. You are enjoying your friends, but in a new way. Experience how well you can talk and share some stories without alcohol

[or drugs]. *If any tension arises, . . . once again, access your skills of relaxation and images of confidence . . . in control of your life and free of addiction. Notice these new, sensation-rich images of awareness and responsibility.*

Script: ***AA Meeting Rehearsal.*** *Imagine yourself attending an AA meeting. You have opened your body and mind to receive many positive messages and support from others about being sober. Imagine now that you have entered the meeting room and are pleased with yourself for being there. Look around the room. Is there any one person that you might like to meet? If yes, see yourself going over to meet this person, and hear your voice as you introduce yourself. If there is no one you wish to meet, that is OK. See yourself finding a place to sit, and continue to focus on your relaxed breathing. With your relaxation you are able to be more present during the meeting . . . to be open to hear other people share their stories.*

Imagine that you are ready to share part of your story. Remember, there are many ways to share your story . . . sharing with a friend . . . a counselor . . . or your AA sponsor. Listen to your inner wisdom . . . you will know what is right for you. Can you imagine sharing something special about your journey? What would it be? How would you like to feel? The meeting is now over. Is there anyone that you wish to greet? If so, see yourself doing so.

Script: ***Closure.*** *Take a few slow, energizing breaths and, as you come back to full awareness of the room, . . . know that whatever is right for you at this point in time is unfolding just as it should . . . that you are willing to enter on this healing journey . . . and that you have done your best.*

Case Study

Setting:	AA meeting
Client:	S.W., a successful, married professional with two children. At the time he told us his story, he had been free of alcohol and amphetamines for three months and had begun his path toward recovery.
Pattern/ Challenges/ Needs:	Health maintenance related to engagement in strategies to remain free of addiction

"My healing began when I finally admitted to myself, my family, and my friends that I was addicted to alcohol and drugs. I began to explore and own my dark side. I've created some wonderful healing rituals, which include getting the nerve up to attend my first AA meeting—which gave me the opportunity to hear other people tell their story. I've been regularly attending AA meetings and have a sponsor who I've called several times when I felt myself slipping. I realized I didn't know how to do anything to relax except drink. If I needed energy, I didn't know any way to get it but to take speed. So I've learned relaxation and imagery skills, started an exercise program, and am taking time for myself.

"Here I was at 45 feeling lost and wondering if this was all life had to offer. How could I feel lost? I had so much. My career was going well. I had good kids, a loving and supportive wife, good looks, and I was involved in several civic projects. Everyone was always telling me how wonderful I was and stressing my contributions to the community. But I was searching for more to fulfill my life. I had been a secret drinker and had taken speed off and on since college in order to do all that I needed to accomplish. Everybody saw me as perfect, but I could feel my world falling apart. I got scared.

"For the past five years or so my wife had said that she thought I was drinking too much—which had recently become a source of tension between us. I told my wife to take the kids and go on a holiday while I worked at home alone. As soon as they left, I got drunk. When I fractured my ankle from a fall in my own house the first day they were gone, I really began to look at my life. I had a month of deep depression. During that time, my inner voice was screaming at me about all the abuse I was into. It was as if I was having a conversation with a part of myself that I had never heard. The message was so clear I could not turn it off.

"I'm not like many addicts who lose family, money, jobs, and friends. During a month of struggling to perform and continuing to hear my inner dialogue, one day my depression lifted enough for me to find a local AA meeting and hear myself say, 'I've had it; I need help.' I finally admitted in public that I was addicted to alcohol and drugs and used them to be successful. I began educating myself about addictions. I asked for help. What I recognized was that previously I sought ways to connect with sources outside of myself to make me feel good. The real healing came when I learned to connect with the core of my spirit, which awakened my inner resources for feelings of wholeness."

Exhibit 29–6 Evaluating the Client's Subjective Experience with Overcoming Addictions

1. What new awarenesses have you had today?
2. Do you understand how to keep a journal of your habits?
3. Can you identify two habit breaker strategies that you are planning to utilize?
4. Are you aware of your bodymind's signals of wanting a drink?
5. Which relaxation exercises are you finding most beneficial?
6. Do you have any questions on how best to practice your imagery and meditation?
7. What physical activities are you including in your daily routine?
8. Have you been monitoring the pattern of your craving by using H.A.L.T.?
9. What affirmations are you working with to reinforce your intentions to be conscious and sober?
10. What have you observed about your patterns of response to vulnerability? Do you tend toward willfulness or will-lessness?
11. What have you discovered is your preferred way of connecting with your spiritual nature?
12. What is your next step?

Evaluation

With the client, the nurse determines whether the client outcomes for overcoming addictions (see Exhibit 29–5) were achieved. To evaluate the session further, the nurse may explore the subjective effects of the experience with the client (Exhibit 29–6).

DIRECTIONS FOR FUTURE RESEARCH

1. Determine the effectiveness of imagery and breathing techniques in assisting clients in managing cravings.
2. Determine the effectiveness of cognitive strategies (e.g., teaching about willfullness and will-lessness, using H.A.L.T.) in helping clients to manage feelings of vulnerability.

3. Study the role of spiritual perspective and practice in long-term recovery.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- What addictive patterns do I recognize in my own life?
- What patterns of response to vulnerability do I observe in myself?
- What practices and changes am I willing to bring into my life to encourage my own healing?
- Who are the people in my life who would support me in making healthy changes?
- Can I allow an image to emerge that represents my inner wisdom?
- Can I identify what interferes with my connection to my inner wisdom?
- How do I connect with my spiritual nature and how do I support this in my daily life?

NOTES

1. Well-Connected Reports (2003, July 8), *Alcoholism, Health and Age*, Available at: http://www.healthandage.com/Home/gm=6!gid6=5603.
2. Ibid.
3. K. Blum and J. Payne, *Alcohol and the Addictive Brain* (New York: Free Press/Maxwell Macmillan, 1991).
4. National Institute on Alcohol Abuse and Alcoholism Publications (2001, January), Economic Perspectives in Alcoholism Research, *Alcohol Alert*, Available at: http://www.niaaa.nih.gov/publications/aa51.htm.
5. Alcoholics Anonymous, *Alcoholics Anonymous* (New York: AA World Services, 1976).
6. C. Coleman-Kennedy and A. Pendley, Assessment and Diagnosis of Sexual Addiction, *Journal of the American Psychiatric Nurses Association* 8, no. 5 (2002):143–151.
7. B. Schaub and R. Schaub, *Healing Addictions* (Albany, NY: Delmar Publishers, 1997), 5.
8. Ibid., 8.
9. Ibid., 11.
10. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Washington, DC: APA, 1994).
11. K.R. Merikangas et al., Familial Transmission of Substance Use Disorders, *Archives of General Psychiatry* 55, no. 11 (1998):973–979.
12. L.J. Bierut et al., Familial Transmission of Substance Dependence: Alcohol, Marijuana, Cocaine, and Habitual Smoking, A Report from Collaborative Study on the Genetics of Alcoholism, *Archives of General Psychiatry* 55, no. 11 (1998):982–988.
13. National Institute on Alcohol Abuse and Alcoholism Publications (1992, July), The Genetics of Alcoholism, *Alcohol Alert*, Available at: http://www.niaaa.nih.gov/publications/aa18.htm.
14. K.H. Littrel and S.H. Littrell, Schizophrenia and Comorbid Substance Abuse, *Journal of the American Psychiatric Nurses Association* 5, no. 2 (1999):17–24.
15. S.H. Stewart, Alcohol Abuse in Individuals Exposed to Trauma: A Critical Review, *Psychology Bulletin* 120, no. 1 (1996):83–112.
16. Schaub and Schaub, *Healing Addictions*, 23.
17. Ibid., 24.
18. R.L. DuPont, Addiction: A New Paradigm, *Bulletin of the Menninger Clinic* 62, no. 2 (1998):231–242.
19. Hazelden Foundation, *The Twelve Steps of Alcoholics Anonymous* (New York: Harper/Hazelden, 1987), 2.
20. E. Becker, *The Denial of Death* (New York: Free Press, 1973), 178.
21. Blum and Payne, *Alcohol and the Addictive Brain*.
22. J. Peters et al., Problems Encountered with Opportunistic Screening for Alcohol-Related Problems in Patients Attending an Accident

and Emergency Department, *Addiction* 93, no. 4 (1998):589–594.

23. E. Nebelkopf, Drug Abuse Treatment, *Journal of Holistic Health* 6 (1981):95–102.
24. NIH Consensus Conference, Acupuncture, *Journal of the American Medical Association* 280, no. 17 (1998):1518–1524.
25. M.M. Rush, Power, Spirituality and Time From a Feminist Perspective: Correlates of Sobriety in a Study of Female Participants in Alcoholics Anonymous, *Journal of the American Psychiatric Nurses Association* 6, no.6 (2000):114–119.
26. M.M. Rush, Perceived Social Support: Dimensions of Social Interaction Among Sober Female Participants in Alcoholics Anonymous, *Journal of the American Psychiatric Nurses Association* 8, no. 4 (2002):114–119.
27. M.R. Werbach, *Nutritional Influences on Mental Illness* (Tarzana, CA: Third Line Press, 1991), 15.
28. Ibid., 22.
29. W.R. Miller, Why Do People Change Addictive Behavior? The 1996 H. David Archibald Lecture, *Addiction* 93, no. 2 (1998):163–172.
30. M.J. Meyers, The New Neurochemistry of Recovery, *Professional Counselor* 10, no. 4 (1995):29.
31. Schaub and Schaub, *Healing Addictions*.
32. T. Gorski and M. Miller, *Counseling for Relapse Prevention* (Independence, MO: Independence Press, 1982).
33. G. May, *Addiction and Grace* (San Francisco: Harper, 1991).
34. L.L. Green et al., Stories of Spiritual Awakening: The Nature of Spirituality in Recovery, *Journal of Substance Abuse Treatment* 15, no. 4 (1998):325–331.
35. J.W. Bowden, Recovery From Alcoholism: A Spiritual Journey, *Issues in Mental Health Nursing* 19, no. 4 (1998):337–352.
36. H. Benson and K. Wallace, Decreasing Drug Abuse with Transcendental Meditation, *Drug Abuse—Proceedings of the International Drug Abuse Conference* (Boston: 1972), 369–375.
37. Ibid.
38. G.A. Marlett and J.K. Marques, Meditation, Self-Control and Alcohol Use, in *Behavioral Self-Management: Strategies, Techniques, and Outcomes*, eds. R. Stuart and B. Stuart (New York: Brunner/Mazel, 1977), 117–153.
39. E. Saxby and E.G. Peniston, Alpha-Theta Brainwave Neurofeedback Training: An Effective Treatment for Male and Female Alcoholics with Depressive Symptoms, *Journal of Clinical Psychology* 51, no. 5 (1995):685–693.
40. S.L. Fahrion et al., Alterations in EEG Amplitude, Personality Factors, and Brain Electrical Mapping after Alpha-Theta Brainwave Training: A Controlled Case Study of an Alcoholic in Recovery, *Alcohol Clinical and Experimental Research* 16, no. 3 (1992):547–552.
41. B. Schaub and R. Schaub, Alcoholics Anonymous and Psychosynthesis, in *Readings in Psychosynthesis: Theory, Process, and Practice*, vol. 2, eds. J. Weiser and T. Yeomans (Toronto: Ontario Institute for Studies in Education, 1988), 55–59.
42. Ibid.
43. P. Parks, Psychophysiologic Self-Awareness Training: Integration of Scientific and Humanistic Principles, *Journal of Humanistic Psychology* 37, no. 2 (1997):67–113.

RESOURCES

Alcoholics Anonymous: World Services, Inc.
P.O. Box 459
Grand Central Station
New York, NY 10163
Telephone: 212-870-3400
www.alcoholics-anonymous.org

Online AA Recovery Resources
AA information: phone numbers, meetings, publications and conventions
www.recovery.Org/aa

Al-Anon and Alateen
Support and education for people whose lives have been affected by substance abuse of someone close to them
http.//www.al-anon.alateen.org/alateen.html
Online Al-Anon Outreach
www.ola-is.org

Family Group Headquarters
P.O. Box 862
Midtown Station
New York, NY 10018-0862
Telephone: 212-254-7230

Children of Alcoholics Foundation
164 West 74th Street
New York, NY 10023
Telephone: 212-595-5810 x7760
www.coaf.org

Adult Children of Alcoholics-World Service
Official site for the support group of people who grew up with an alcoholic parent.
www.adultchildren.org

National Clearinghouse for Alcohol and Drug Information (NCADI)
P.O. Box 2345
Rockville, MD 20847-2345
Telephone: 800-729-6686
http://ncadi.samhsa.gov/gov/about/aboutncadi.aspx

NCADI Center for Substance Abuse Prevention
http://healthfinder.gov/org/HROO27.htm

New York Psychosynthesis Institute
Training in psychospiritual development for people in advanced recovery
2 Murray Court
Huntington, NY 11743
Telephone: 631-673-0293

The Life Sciences Institute of Mind-Body Health
Neurofeedback Therapy for Addictions - Thermal Biofeedback and Alpha-Theta EEG Biofeedback
Telephone: 785-478-4105
www.cjnetworks.com/~lifesci/watch.htm

VISION OF HEALING

Recovering and Maintaining the Self

> The great majority of us are required to live a life of constant, systematic duplicity. Your health is bound to be affected if, day after day, you say the opposite of what you feel, if you grovel before what you dislike and rejoice at what brings you nothing but misfortune. Our nervous system isn't just a fiction, it's a part of our physical body, and our soul exists in space and is inside us, like the teeth in our mouth. It can't be forever violated with impunity.[1]

The client who has endured abuse or violence has had to live a life of distortion and lies. The choice to move beyond the duplicity and into the truth impacts the physical and emotional health of the individual as well as the family system. The journey toward healthy relationships may expose secrets whose effects ripple out into the client's present family as well as back through generations of abuse.

Working with survivors of abuse and violence is one of the most difficult nursing experiences, but it is also one of the most rewarding. Because of a reluctance to inquire, it is possible to work with a client for a long period of time without knowing that he or she has been—or may even still be involved in—a violent situation. At the other end of the continuum, a nurse may be called upon to provide immediate care for a rape victim in an emergency room. In addition to caring for the client, the nurse must be sure to stay grounded and clear about his or her own needs and issues.

Survivors of abuse may move in and out of the medical–psychologic care system over a period of several years as they process the effects of their abuse. The recovery of the self moves in cycles and layers. Both client and caregiver must be prepared for this circuitous journey to wholeness, taking each new stage as reassurance of progress.

NOTE

1. B. Pasternak, *Doctor Zhivago* (New York: Pantheon, 1958), 483.

Chapter 30

Incest and Child Sexual Abuse Counseling

E. Jane Martin

NURSE HEALER OBJECTIVES

Theoretical

- Trace the history of child sexual abuse from antiquity to the present, identifying the current incidence rates.
- Discuss the repressed memories/false memories controversy.
- Discuss the physical, emotional, and behavioral consequences of incest and child sexual abuse.

Clinical

- Initiate direct questions about abuse into your client interview format as part of your routine nursing history taking.
- As appropriate, incorporate teaching about normal physiology and child development in your counseling.
- Know the counselors, support groups, and other sources in your community for referral of survivors and perpetrators of abuse whom you counsel.
- Try the intervention techniques on yourself before recommending them to your clients.

Personal

- Do a genogram of your family, noting episodes of abuse or violence over three generations.
- Identify any personal experiences of abuse and, if indicated, seek resolution with a trained counselor.
- Carefully assess your readiness to function as a counselor when abuse/violence are the concerns, referring clients as appropriate.

DEFINITIONS

Child Sexual Abuse: Exploitive psychosexual activity that goes beyond the developmental level of the child, to which the child is unable to give informed consent, and that violates social taboos regarding roles and relationships.[1]

Dissociation: The experience of one's mind temporarily splitting off from one's body—a feeling of separation from the body.[2]

Flashback: A nonpsychotic episode in the present in which the person actually relives the abuse as it originally happened.

Grounding: Staying oriented in the present, rather than being engulfed by memory.

Incest: Any type of exploitive sexual experience between relatives (or surrogate relatives) before the person is eighteen years old.[3]

Trigger: Any sight, sound, smell, or other sensory experience that stimulates recall of a memory.

Violence: A component of all incest/child sexual abuse, regardless of the intent of the perpetrator.

THEORY AND RESEARCH

History of Incest and Child Sexual Abuse

A request to name one universal cultural belief is likely to elicit mention of the incest taboo. If asked whether this universal prohibition of incest were effective, many would no doubt answer "Yes." Most educational programs for health care professionals include information about the universal incest taboo and the result—a virtual absence of incest in nearly all societies. Levi-Strauss, a prominent anthropologist, said, "The prohibition of incest can be found at the dawn of culture . . . [it] is culture itself."[4] Few questioned this pronouncement. Any discussion appeared to be more focused on explaining why incest is a universal taboo rather than on identifying if, in fact, it is a taboo. Many reasons have been offered to explain why incest should not, or does not, occur. There are biological arguments (e.g., to prevent genetic defects arising from inbreeding), economic arguments (e.g., to broaden the family base of power and wealth), sociological arguments (e.g., to solidify society through a wide network of connections and relationships), and psychologic arguments (e.g., to prevent collapse of the family due to sexual rivalries).[5]

In spite of the universal taboo against it, incest, and the related activity of child sexual abuse, have existed since antiquity in every, or nearly every, known culture. In ancient Eastern cultures, the practice of pedophilia was common. In India, according to Mayo,[6] whose extensive investigations there led to the first child marriage laws, childhood begins with the child being regularly masturbated by the mother. Children slept in the family bed for several years and regularly observed sexual relations between the parents. By the time they were 4 or 5 years of age, children usually were taken to bed by others in the extended household. Child marriage was commonplace. Mayo noted that of the nine volumes of testimony published by the Age of Consent Committee in 1929, most defended child marriage, pointing out that children, especially girls, were so oversexed that by the time they were 7 years old marriage was their only salvation. Historical data from ancient China supports institutionalized practices of pederasty of young boys, child concubinage, castration of young boys so they could be eunuches, child marriage, boy and girl prostitution, and foot binding to break the bones of the foot and facilitate shaping it to become a penis substitute, a practice that continued well into the twentieth century.[7]

Incest and child sexual abuse have been commonplace in Western cultures since antiquity. In ancient Greece, the frequent practice of pederasty of young boys is well documented on pottery and in poetry from the period. Although these young boys, many of whom had been sold as sexual slaves, were described in loving words, the Greeks' cruelty to their children, including the practice of infanticide, is historically established.[8] Inspired by Greek culture, the Romans adopted many of their practices, including a loss of interest in boys when they began to sprout facial and body hair. For example, in the Epigrams of Martial, one finds the following verse:

> Before your mouth was fringed
> with hair:
> All pricks might find a haven
> there.[9]

Incest and child sexual abuse were rampant at the courts of the Roman emperors.

In ancient Egypt, practices were similar to those of the Greeks and Romans.

Although more enlightened, even the Hebrews saw sexual violation of a young boy under 9 years of age as deserving of only a whipping, because boys under 9 were not considered sexual beings. Violation of a boy over 9 years old, however, was punishable by stoning to death.[10]

As Christianity emerged as an influential force, people began to associate feelings of shame and guilt with all sexual behavior, reaching a peak in the Medieval Period. It appears that, although they did not eliminate incest and abuse, there were attempts to control the behaviors. The years of the Enlightenment and the Victorian era were characterized by public nonacceptance of incest and child abuse, and as a result the behaviors were carefully hidden. The major evidence of incest and child abuse emerged first in popular literature; as sensibilities became even more acute in the Victorian era, such topics appeared in pornographic literature, a vast industry in that period.

Freud's early writings showed his acceptance of the stories of abuse that he heard from his women clients with "hysterical illness," resulting in the publication of his conclusions in the *Ideology of Hysteria* in 1886. However, Freud's colleagues rejected this revolutionary theory of mental illness (i.e., that sexual experiences in childhood were the major cause of neurotic behavior in adults) and excluded him from membership in the Vienna Psychoanalytic Society. Freud radically revised his thinking and the Oedipal Complex, which he posited and published in *The Interpretation of Dreams* in early 1899, was the result. The stories of his clients' sexual abuse at the hands of their parents became wishful fantasies that the patients created of a sexual relationship with the parent. This new theory was acceptable to the Vienna Psychoanalytic Society, and Freud was soon an active member.[11]

As Freud's new theory gained wide acceptance, public knowledge that child abuse by parents in their homes was not uncommon was lost again, and only rediscovered in 1962 with the publication of "The Battered Child Syndrome" in *The Journal of the American Medical Association*.[12] Since 1962, child sexual abuse has been a subject of continued concern and interest, and the reported incidence rates have risen steadily. From an estimated 7,000 incidents in 1976, the number had risen to an estimated 113,000 by 1985. Careful studies with sufficiently large samples began to be reported in the 1980s, and the ratios climbed alarmingly to one in four for girls and one in seven for boys. Current research suggests that the rates are even higher. De Mause estimates that 60% of girls and 45% of boys have been victims of incest and/or child sexual abuse.[13]

During the 1990s, when so much national attention was paid to the apparent increase in, or at least awareness of, the alarming incidence of incest and child sexual abuse; with the striking increase in self-disclosure in the popular press and on radio and television talk shows; and with the greatly increased frequency of legal action on the part of the survivors, it was no surprise that a backlash response occurred.[14] Many date this response from 1991, when Marilyn Van Derbur (Miss America 1958) broke years of silence and publicly told the story of her years of abuse by her (then deceased) prominent, highly respected father to a prestigious audience in Denver. Van Derbur related that for many years she had no "daytime" memory of the events that had occurred at night in her home. The memories were repressed. The media coverage of her speech seemed to open the floodgates: hotlines and women's shelters were deluged with calls for help from other survivors, and many other public figures were moved to disclose their similar histories.[15]

Public response to these disclosures was mixed. Although many people were deeply touched, offering help and support, others expressed disbelief, anger, and even condemnation. Among the most troubled and angry were some of the accused parents. In 1992, they formed a support and advocacy organization called the False Memory Syndrome Foundation (FMSF). These parents questioned the whole concept of repressed memories, and while refusing to blame their children—who made the accusations—they vehemently blamed those who had taken on their cause, calling them "New Age healers, self-help movement promoters, political activists, radical feminists, social service providers, and mental health professionals."[16]

Whitfield describes the FMSF defense as simply the most recent in a long line of organized resistance against increasing public awareness of child sexual abuse. He systematically addressed the accusations of the FMSF—that repression had not been "scientifically proven" and did not exist, and that most delayed memories of abuse were false. Citing eight then-current (1987–1995) research studies that examined the memories of 1,091 abuse victims, Whitfield noted that from 16 to 78% of the survivors, depending on the study, had delayed memories of having been sexually abused.[17] One of the strongest studies from this group of eight investigations, in which the childhood sexual abuse of all 129 women in the study was documented through prior medical records, found that when interviewed 17 years later, 38% had forgotten the abuse and another 10% had forgotten it in the past but had recovered the memory in treatment, for a total of 48%.[18] Thus, the majority (52%) neither had repressed nor delayed recall.

In 1995, an entire issue of *The Journal of Psychohistory* was devoted to the experimental and clinical evidence that recovery of repressed memories not only was common but also that it formed a reliable, scientific basis for trusting the childhood memories of traumatic events that are the cause of most mental and social problems. In introducing the issue the editor, Lloyd deMause, made it clear that he was responding to the backlash atmosphere in the United States and Europe and intended the issue to serve "teachers, students, attorneys, psychotherapists, patients and scholars as a central source for refuting the current widely-repeated notion that no scientific evidence exists for the recovery of repressed memories."[19]

In 2000, a longitudinal study of 51 female adult survivors of incest reported on the role of amnesia following the trauma of child sexual abuse. Women who recovered memories of the trauma many "long silent years" after the abuse were followed through the triggering of memories, the remembering, and the healing. Amnesia was found to have played a major role in their survival and their recovery process.[20]

Emotional, Behavioral, and Physical Consequences of Incest and Child Sexual Abuse

Adult survivors of incest and child sexual abuse suffer a wide array of emotional disorders that manifest themselves in behavioral symptoms.[21] The most common diagnoses are depression, anxiety, eating disorders, personality disorders, dissociative disorders (multiple or splitting personality disorders), and post-traumatic stress disorder. The severity of the illness appears to correlate with the duration of the abuse, the type of abuse the person has experienced, the relationship of the perpetrator to the victim (the greatest severity of mental illness occurs when a trusted caretaker is part of the abuse), and the presence of violence.

Depression can occur either intermittently or constantly through adolescence

and into adulthood. Associated with the depression are low self-esteem, feelings of worthlessness and hopelessness, an inability to trust, passivity, lethargy, feelings of helplessness, inability to concentrate, inability to take control of one's life, confusion, and guilt. Impulsive behavior is common in depression and may include mood swings, rage, inappropriate spending, self-mutilation, accidents, and suicide gestures and attempts.

Dissociation also occurs frequently and may be manifested by nightmares or night terrors, with resultant sleep disorders, amnesia (especially for segments of childhood), feelings of depersonalization, fainting spells, panic attacks, hyperventilation, flashbacks, denial (of incest/abuse), and splitting or multiple personalities.

Relationships are frequently problematic; interpersonal skills often are impaired, and the survivor may seem to seek out those who revictimize him or her, and to run from those who offer positive regard and nurturance.

Equally noteworthy is the wide range of physical symptoms that survivors suffer, that often affect several organ systems and challenge precise medical diagnosis. Survivors rate their general health lower than do nonsexually abused persons, and survivors use health care more throughout their lives.[22,23]

Gastrointestinal symptoms are very common. They include nausea, gagging, vomiting, "nervous" stomach, stomach pain, ulcers, and irritable bowel syndrome. Other general physical symptoms include headaches, insomnia, seizures, back pain, and chronic tension. Multiple hospitalizations and multiple surgeries are also common.

Survivors often develop eating disorders, including anorexia nervosa, bulimia, and obesity. Some perceive food as the only area in which they feel in control. Others hope to alter body appearance (becoming very fat or painfully thin) in an attempt to appear unattractive and, thus, sexually unappealing. Substance abuse is a pattern frequently found, as survivors learned early that alcohol and drugs would temporarily numb the pain of their existence; it is a kind of chemical dissociation.

Sexual dysfunction of all kinds commonly result from incest and sexual abuse. Manifestations include a range of behaviors, from sexual promiscuity to the point of sexual addiction, all the way to sexual abstinence and phobic behaviors. In addition, survivors may experience pain and discomfort, particularly in the ano-genital and/or pelvic areas, whether they are sexually active or not. Intolerance, or even fear, of physical touch is another manifestation of sexual dysfunction, further adding to the difficulty with interpersonal relationships.

HOLISTIC CARING PROCESS

Assessment

In preparing to use abuse interventions, the nurse assesses a variety of parameters. Nurses must first

- be personally comfortable with discussions of incest and child sexual abuse and aware of their attitudes toward it
- be aware of their personal history regarding incest and child sexual abuse, and seek resolution of any unresolved issues or concerns
- increase their knowledge base about this serious problem

Nurses must then

- take responsibility for asking about incest and child sexual abuse as part of their routine nursing history-taking
- initiate a discussion rather than wait for the client to offer information
- use good communication techniques
- allow sufficient time for the client to tell his or her story

- provide psychological support during the interview

Nurses also should assess

- the client's history of dissociative behaviors, which may be manifested by flashbacks, sleep disorders, and splitting or multiple personality
- the client's present level of safety, as well as the current period of safety (i.e., how long since the last abuse?)[24]

If more information is needed, nurses may ask a client to describe his or her perception of the effects of the incest and sexual abuse on eight life domains:

- Social (e.g., Do you feel isolated, different from others, or unable to interact with others?)
- Psychologic/emotional (e.g., Are you unable to feel anything, or do you have too many feelings?)
- Physical (e.g., Do you have pain, headaches, or muscle tension, or do you feel sick when certain activities are mentioned?)
- Sexual (e.g., Do you engage in sexual behavior or avoid it? Do you have sexual fears?)
- Familial (e.g., Has your family life changed, for example, through divorce, estrangement, increased closeness?)
- Sense of self (e.g., Do you feel strong, powerless, worthwhile, ashamed?)
- Relation to men (e.g., Do you trust them, feel hostile to them, avoid them?)
- Relation to women (e.g., Do you trust them, feel hostile to them, avoid them?)[25]

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with the interventions for incest and child sexual abuse survivors that are related to the 13 domains of Taxonomy II of the Unitary Person framework (see Chapter 14):

- Social isolation
- Impaired social interaction
- Ineffective parenting
- Sexual dysfunction
- Altered spiritual state
- Altered participation in family
- Impaired adjustment
- Ineffective coping
- Altered self-concept
- Disturbance in body concept
- Disturbance in self-esteem
- Disturbance in self-identity
- Powerlessness
- Pain
- Grief
- Anxiety
- Fear
- Post-traumatic response
- Sleep disturbance
- Self-care deficit

Outcomes

Exhibit 30–1 guides the nurse in outcomes, nursing prescriptions, and evaluation of selected incest and child sexual abuse interventions. Outcomes should flow from the assessment data and problem list, and the client should participate in their development. There should be one or more measurable outcomes for each problem.

Therapeutic Care Plan and Implementation

Before the session

- If it is the first session, prepare to be open and receptive to the client.
- If it is not the first session, prepare by reviewing your records, reminding yourself of the "homework" asked of the client, and the goals for the present session.
- Be sure the environment is comfortable and therapeutic.

Exhibit 30–1 Nursing Interventions: Incest and Child Sexual Abuse

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client will attend a social activity three times a week.	Help the client identify feelings of being socially isolated and find ways to move out of social isolation through relating to others; assist the client to choose activities in which he or she can engage comfortably.	The client reports attending social activities of his or her choosing and is comfortable in those social situations.
The client will be comfortable with altered participation in the family of origin.	Help the client understand that altered relationships with the family of origin are a common outcome when incest/child sexual abuse has occurred. Support the client in defining the parameters of relating that are within his or her sphere of comfort.	The client is able to set limits and define the level of relating with the family of origin that supports comfort and healing. This is a recurrent dynamic and will require ongoing support from and teaching by the nurse.
The client will no longer feel powerless.	Help the client identify the goal of empowerment, and support the client in the belief that he or she has the right to make decisions about his or her life.	The client reports that he or she has the right to make decisions about his or her own life.
	Support and facilitate disclosure at the client's level of comfort.	The client discloses the past trauma.
	Provide psychologic support and teach, as appropriate, principles of normal physiology and child development.	The client reports feelings of support and now understands that the body responses felt during the incest/child sexual abuse are "normal physiologic responses" and not evidence of "bad" behavior.
	Explore new behaviors, and teach those of interest to the client.	The client reports attending assertiveness training at the local YMCA.

- Take time to center yourself and create a space within to be with the client.

At the Beginning of the Session

- After appropriate introductions or greetings, be still and listen to the client.
- Support the client nonverbally and nonintrusively as you listen to the client's story or report of the week's events.
- Keep your questioning to a minimum until the client has the time needed to speak.
- Assess the verbal and nonverbal behavior of the client to evaluate the present situation.

During the Session

- Using the assessment data, validate your impressions with the client.
- Identify both the strategies that have worked well and those that have not.
- Explore these strategies with the client to gain an understanding of the outcomes.
- Hear the client's suggestions for next steps or new directions.

- Work with the client to develop a plan, including goals and interventions to achieve the desired outcomes.

At the End of the Session

- Summarize the session, including the gains and roadblocks.
- Have the client validate or modify the summary.
- Assign "homework," gaining the client's agreement to carry it out.
- Provide a copy of the plan for the client as well as for the client's record.
- Schedule the next session.
- Document the care provided.

Specific Interventions

Nurses do not need to be experts in working with survivors to be helpful. Many helping techniques decrease the guilt and the shame associated with the long-kept "dirty" secret.

Empowerment

The nurse supports the client while empowering him or her, which enables the client to increase self-esteem and feel more in control of life events. The client goals and outcomes are a result of a joint planning effort, and the treatment plan builds on the client's strengths. With the nurse's support, the client comes to believe that he or she can and should make the decisions about his or her life.

Disclosure is the first step for the survivor, but the client must feel that he or she has the nurse's permission to "tell the story." Thus, the nurse facilitates the disclosure whenever and however the client chooses. The nurse should never express shock or horror at the details of the story. Furthermore, the nurse should be comfortable with the client's silence if it occurs during the disclosure, should follow the client's lead, and should help the client strategize when he or she is ready. The nurse should provide psychologic support if the client experiences flashbacks during the disclosure. The nurse can help the survivor realize that self-disclosure takes great courage and is a real strength. It may help the nurse to feel more comfortable facilitating patient disclosure if he or she realizes that through disclosure survivors are often empowered to resurrect their buried selfs, a part of the self that had kept them from living to their highest potential.[26]

The nurse should teach basic principles of normal physiology and child development. It may be necessary to help the client forgive himself or herself for any sexual pleasure experienced during the abuse. Reinforcing that the adult is always the responsible party is critical. It also is important to explain that current negative habits and traits such as hyperventilation, somatization, dissociation, denial, and substance abuse can be linked to the incest/abuse and may have been adaptive—and even creative—when the survivor developed them, but they are no longer helpful and may even be destructive. Finally, the nurse should assist the client in exploring new behaviors and teach those of interest to the survivor, such as assertiveness, anger control, journaling, imagery, and relaxation. It also may be helpful to point out the many books, journal articles, conferences, and self-help organizations that support recovery.[27]

Grounding Skills

Many clients have developed their own ways of staying in the present, and the nurse may observe grounding behaviors during the history taking. (For example, clients may consistently touch a piece of jewelry or hold a small object in their hand.) It is important for the nurse to verify that it is a grounding object, however, rather than assume that it is. Asking clients to share their most useful grounding techniques can be an effective icebreaker in a group situation.

The nurse should teach clients to assess and monitor their current level of awareness in order for them to stay grounded in the present. Grounding is especially helpful when clients experience flashbacks or dissociate. The first step is to teach survivors to identify and verbalize when they are having a flashback. During a flashback, the nurse should (1) ask the client to describe what he or she is experiencing in the present, (2) tell the client that he or she is safe and not actually in the situation that is being experienced, and (3) encourage the client to reorient him- or herself in the present (grounding). This approach enables the client to achieve a sense of control and to distinguish the present from the past. The client learns to recognize that the flashback is in the mind and that it is not an actual experience. It can be useful to teach clients the signs of dissociation, such as losing track of thoughts, stopping in the midst of talking, and staring into space. Additional grounding skills to help clients stay oriented in the present include maintaining eye contact or keeping their eyes moving by looking around the room or at other people in the room, stating aloud the day or the date, or saying the names of the people in the room. Repeating "I am safe" can help the client separate the memory from the present reality.

Because survivors often are revictimized, or their children become victims, grounding skills can help the survivor become empowered to prevent either situation. Therefore, grounding is useful not only in the therapeutic situation, but also in day-to-day activities.

Relaxation

Survivors of abuse often find that relaxation exercises reduce anxiety, promote grounding, and discourage dissociation. Although the nurse may find that survivors initially are reluctant to take part in relaxation exercises, the survivors should be encouraged to take part because the skills can be very helpful. Some survivors may not feel "worthy" to take time away from their recovery to relax, whereas others may equate relaxation with vulnerability and, in fact, may experience flashbacks when in a relaxed state. Sometimes survivors may need to relearn the skill of relaxation, which can help them achieve more restful sleep, clearer thought processes, and more pleasant physical sensations.

The nurse can teach clients progressive relaxation, which involves the controlled tensing and relaxation of specific muscle groups. This technique can allow the clients to feel more fully in control of their bodies, thus alleviating feelings of helplessness and vulnerability. If progressive relaxation is joined with systematic desensitization, the survivor can gain some comfort in regard to anxiety-inducing people or events. (See Chapter 21 for in-depth relaxation strategies).

Writing

Writing is an expressive technique and can enable the exploration of feelings inaccessible through conventional talk therapy. Clients can be encouraged to use various writing techniques such as journaling, writing a detailed autobiography, developing a detailed lifeline, and writing letters, even if they choose not to send them.

Keeping a journal—writing in it each day, recording thoughts, feelings, dreams, nightmares, flashbacks, and memories—can be very helpful to survivors, both while they are in treatment and later as a daily exercise throughout their lives. Journals can include poetry and stories, and can help clients regain forgotten memories, see improvements in behaviors, and recall strategies that were useful in difficult times. Clients may bring their journal to the treatment session for the nurse's review and suggestions. Because the content of the journal is so personal and sensitive, it

is wise to discuss with clients the importance of keeping the journal in a secure place in order to ensure their privacy.

Writing a detailed autobiography can help the survivor acknowledge details about the past and can work against reforgetting, which is a common occurrence. Even when repression is strong and memory sketchy, the survivor can be encouraged to write what he or she does remember. This can then serve as a general framework for added memories. It often is useful for survivors to ask relatives and friends for information about their childhood. This information may jog their memory or at least add to the store of information.[28]

A detailed lifeline can supplement an autobiography with its graphic portrayal of important family and life events. A lifeline can reveal a previously undetected pattern in the survivor's childhood, adolescence, and adulthood. If the timeline becomes a focus of discussion in the treatment, the nurse may ask the client to bring in family photographs to assist in telling the story and prompting memory recall. Such photographs can make childhood less remote and hazy, while making the reality of the family situation and the abuse more vivid.

To facilitate full, uncensored expression of thoughts and feelings, the nurse can encourage the survivor to write letters to either or both of the parents, other family members, or significant others. Initially the letter is not to be sent. It is written to a particular person, (e.g., the abuser or the nonprotective parent) without regard for style, tone, emotional censorship, or guilt. The survivor should freely express all thoughts and feelings. The letter can be brought into treatment to facilitate verbal expression of feelings. If at a later point the survivor decides to send the letter, it can be reworked until the form is satisfactory. The value of this technique lies in the survivor's uncensored full expression of his or her feelings toward the person addressed. One note of caution, however: If the survivor wants to send the letter in the hope that the letter will "make a difference" (i.e., the person addressed will finally understand the survivor's suffering and beg for forgiveness), it is better not to send the letter. Such an outcome rarely occurs.

Anger Expression and Management

Both the expression of anger and the management of anger are common challenges for the adult survivor of incest and/or child sexual abuse. It is essential for the nurse to teach survivors first to recognize their anger, and then to express and manage it in appropriate ways. Survivors have usually learned early that only the perpetrator is allowed to express anger in the home without punishment; as a result, they learn that anger equals power. Because all survivors have experienced anger and have been unable to express it openly, they usually have internalized it and expressed it only in disguised form, such as passive-aggressive behavior, manipulativeness, depression, anxiety, and somatic complaints (e.g., headaches, colitis, ulcers). It also can be expressed as self-blame, self-contempt, and self-defeating and self-abusive behaviors.

When the survivor begins to get in touch with his or her anger, it is the ideal time in treatment to explore appropriate anger management techniques. The survivor must learn that feelings of anger and rage are appropriate in view of what happened, but that indirect and aggressive expression of anger will not promote healing. It is helpful for the survivor to learn to "dose anger" (i.e., express it in small, manageable amounts). The use of a 30-second to 3-minute timer can guide expression of anger for a safe amount of time. Also,

recording a verbal expression of anger on an audiotape can be useful if the tape is played in the presence of a nurse or a supportive friend who can help validate and justify the anger. Physical exercise (e.g., running) or other techniques (e.g., throwing "softballs at a wall", hitting a punching bag with a plastic pipe, hitting sofa cushions or a bed with a tennis racket) can reduce anger. Workouts to reduce anger should be appropriate to the lifestyle and the comfort level of the survivor.

Imagery

Because imagery, which is a very private experience, usually has not been punished in the past, the survivor is less likely to censor it in the present. An effective guided imagery technique can help a survivor remember experiences from the past and connect with the lost emotions associated with the abuse.

The nurse assists the client to relax deeply and then asks the client to close his or her eyes and imagine the face of the abuser (or some other significant person in the client's past). The nurse may suggest that the face appear on a television screen to protect the client from overwhelming emotion. The client is then asked to describe the facial expression of the person on the screen, and describe his or her somatic response to it (e.g., "knots in my stomach"). Next the client is asked to interpret the image; to say what the face represents, and to identify the intensity of the somatic response. Then the client is asked what the face is saying and what the somatic response is. The nurse and the client together determine how far to go with this exercise. Finally, the client is given an opportunity to respond to the abuser by releasing lost emotions.

The nurse can vary this technique to help clients connect with long buried feelings of pain, anger, sadness, or pleasure. If the client has never felt, or cannot recall ever feeling safe or nurtured, for example, imagery can provide the means to present the possibility. Because acting "as if" produces the same biochemical response as the actual experience, the possibilities for healing are limitless.[29] (See Chapter 22 for more information on imagery).

Case Study

Setting:	Nursing Center (College of Nursing)
Client:	J.K., a 35-year-old man
Patterns/ Challenges/ Needs:	1. Disturbance in self-identity 2. Grief 3. Social isolation 4. Altered participation in family

J.K. called the Nursing Center in response to a radio announcement about group therapy for men who were adult survivors of incest and child sexual abuse that was being offered for the first time at the Center. He recently had moved to the community and was more isolated than usual. His partner of 14 years was employed (they had moved to town for his new position), but J.K. was currently unemployed and feeling at loose ends. He reported that making the call was very difficult; he almost hung up when I answered, but he thought he recognized my voice. He asked if I had ever lived in X (the city he had just moved from), and I replied that yes, I, too, had recently moved to the community. He asked if I was a season ticket holder at the local theater in X, and if I had ever called to change tickets for a performance. I said yes to both. He had worked at the theater ticket office, had liked my voice then, and recognized it now. He saw this as a good sign, a sign that he should follow through with the interview.

At the screening interview, J.K. was very apprehensive, ill at ease, anxious, and seemingly very sad. He described a history of sexual abuse by an older brother that began when he was 6 years old and continued for ten years until the brother left home to marry. He identified unresolved anger at his mother, questions about his self-identity, and sadness at the loss of his childhood as issues he would like to address in group sessions. He met the screening criteria, and although he reported that he was not generally comfortable in groups and did not relate well to men, he was determined to make the commitment.

J.K. joined a group in progress, along with three other new members, and found the group to be supportive and helpful in resolving the conflicts and concerns that he had carried alone for so many years. He participated fully and appropriately, taking his turn at telling his story (disclosing) to the group. He found disclosure—both his and that of the other men—to be a powerful healing experience. It helped him to realize that he was not alone, that his story was not so different from those of other men, and that he had not somehow brought the abuse on himself because of his behavior or because he was "bad" and deserved to be abused.

One of the activities of the group, writing a letter to the perpetrator, proved to be a pivotal experience for J.K. He stated that it took him the better part of 16 hours to write what turned out to be a one and a half page letter. In those 16 hours, he said, he relived his life; he identified the chain of events that had followed one after another from the first episode of abuse, and he realized the losses he had experienced—the choices he had never been allowed to make. He understood his life in a way he never had before, and he grieved for all that might have been and never would be. He put all this in the form of a story-letter and sent it to his brother, who is a writer. He told the group, "let him [the brother] use it [the story] if he wants." The important thing was that J.K. felt it "go from him," and his burden was lifted.

Evaluation

With the client, the nurse determines whether the client outcomes for incest and child sexual abuse (see Exhibit 30–1) were achieved. To evaluate the session further, the nurse may explore the subjective effects of the experience with the client (Exhibit 30–2). Because the accomplishment of these interventions can take place over a period of days or weeks, they must

Exhibit 30–2 Evaluating the Client's Subjective Experience of Sexual Abuse Interventions

1. Was this the first time you have ever disclosed the abuse?
2. Can you describe what you felt like before you began to disclose?
3. Did you experience physical or emotional sensations during the disclosure? Can you describe them?
4. Were you able to stay grounded during the disclosure? If not, do you know what triggered your dissociation?
5. Did you feel safe during the disclosure?
6. What did you feel immediately following the disclosure?
7. Would you be willing to disclose to another person at another time?
8. What could I have done to be more helpful to you during the disclosure?
9. Is there anything I can do right now to be helpful?
10. What is your next step or plan to integrate this disclosure experience?

Source: Data from E. Jane Martin and L. Gooding Kolkmeier, Sexual Abuse: Healing the Wounds, in *Holistic Nursing: A Handbook for Practice,* eds. B.M. Dossey et al., p. 423, © 1995, Aspen Publishers, Inc.

be reviewed and reevaluated periodically. Continuing support and encouragement for the client are necessary.

In the process of evaluation, the nurse evaluates outcomes based on the client's attainment of goals, assesses effectiveness of nursing and self-care measures in meeting outcomes, and revises the plan on an ongoing basis. It is essential for the nurse to document evaluation and outcomes in the client record.

Although counseling with incest/child sexual abuse survivors can be among the most challenging work a nurse will ever do, it is likely to be among the most—if not *the* most—rewarding. If the nurse has first prepared himself or herself through personal assessment and self-reflection and has taken the steps, if indicated, for personal resolution of any abuse issues, he or she should be ready to function effectively with these most deserving clients.

DIRECTIONS FOR FUTURE RESEARCH

1. Determine if one-to-one counseling or group counseling is most effective for adult survivors of incest and child sexual abuse in terms of length of treatment.
2. Determine the impact of disclosure or nondisclosure on treatment effectiveness.
3. Compare the effectiveness of a closed group model of treatment versus an open group model.
4. Explore the impact of therapist gender on all women groups, all men groups, and mixed groups.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin a process of answering the following questions:

- Are any patterns of abuse evident in my own family genogram?
- What issues are triggered in my own relationships as a result of my work with adult survivors of incest and child sexual abuse?
- Am I comfortable treating clients when sexual abuse and violence are the concerns?
- Do the interventions I use with clients work for me?

NOTES

1. L.G. Kolkmeier, Sexual Abuse: Healing the Wounds, in *Holistic Nursing: A Handbook for Practice*, 2nd ed., eds. B.M. Dossey et al. (Gaithersburg, MD: Aspen Publishers, 1995), 404.
2. C. Courtois, *Healing the Incest Wound: Adult Survivors in Therapy* (New York: W.W. Norton & Co., 1988), 154.
3. J.C. Urbanic, Intrafamilial Sexual Abuse, in *Nursing Care of Survivors of Family Violence*, eds. J. Campbell and J. Humphreys (St. Louis, Mosby, 1993), 133.
4. C. Levi-Strauss, *The Elementary Structures of Kinship* (London: Eyne and Spottiswoode, 1969), 41.
5. M. Lew, *Victims No Longer* (New York: Harper & Row, 1988), 19.
6. C. Mayo, *Mother India* (New York: Harcourt Brace and Co., 1927), 25–26, 68.
7. L. de Mause, The Universality of Incest, *The Journal of Psychohistory* 19, no. 2 (1991):123–164.
8. B. Kahr, The Sexual Molestation of Children: Historical Perspectives, *The Journal of Psychohistory* 19, no. 2 (1991):191–214.
9. Ibid.
10. Ibid.

11. J.M. Masson, *The Assault on Truth: Freud's' Suppression of the Seduction Theory* (New York: Farrar, Straus and Giroux, 1984).
12. C. Kempe et al., The Battered-Child Syndrome, *Journal of the American Medical Association* 18, no. 1 (1962):17–24.
13. de Mause, The Universality of Incest.
14. E.J. Martin, Incest/Child Sexual Abuse: Historical Perspectives, *Journal of Holistic Nursing* 13, no. 1 (1995):7–18.
15. L. Terr, Day Child/Night Child, *Family Therapy Networker* 18, no. 5 (1994):54–63.
16. M. Wylie, The Shadow of a Doubt, *Family Therapy Networker* 17, no. 5 (1993):18–29, 70, 73.
17. C. Whitfield, *Memory and Abuse: Remembering and Healing the Effects of Trauma* (Deerfield Beach, FL: Health Communications, 1995).
18. L.M. Williams, Recovered Memories of Abuse in Women with Documented Child Sexual Victimization Histories, *Journal of Traumatic Stress* 8, no. 4 (1995):649–673.
19. L. de Mause, Trusting Childhood Memories, *The Journal of Psychohistory* 23, no. 2 (1995):118–190.
20. C. Cameron, *Resolving Childhood Trauma: A Long-term Study of Abuse Survivors* (Thousand Oaks, CA: Sage Publications, Inc., 2000).
21. Courtois, *Healing the Incest Wound*, 98–99.
22. Ibid.
23. J. Lesserman et al., Sexual and Physical Abuse History and Gastroenterology Practice: How Types of Abuse Impact Health Status, *Psychosomatic Medicine* 58, no. 4 (1996):4–15.
24. Kolkmeier, Sexual Abuse, 407–408.
25. Courtois, *Healing the Incest Wound*, 368–369.
26. P. Kirk and G. Dickerson, The Role of Disclosure in Incest Survival: Resurrection of the Buried Self (Doctoral Dissertation, University of Colorado Health Sciences Center, 2000). *Dissertation Abstracts International*, 60, 8–B, 3850.
27. J. Campbell and J. Humphreys, *Nursing Care of Survivors of Family Violence*, 2nd ed. (St. Louis: Mosby, 1993), 152–153.
28. Courtois, *Healing the Incest Wound*, 195.
29. Kolkmeier, Sexual Abuse, 412-413.

Healing Through the Senses

Smell is very important throughout life. Smell allows a newborn baby to identify its mother, and pheremones or subliminal smells govern both our choice of friends and what we perceive to be attractive or unattractive places to work, play, and live. Until recently, smell was not taken seriously despite the fact that aromas have a profound effect on us physically, as well as psychologically. The first cranial nerve is the olfactory nerve—a direct link from the outside world to the inner world of the limbic system. The limbic system governs how we react to fear, stress, and pain.

Hippocrates wrote that aromatics could play an important role in health and suggested that this went beyond a nice smell working as a pick-me-up. He promoted the use of essential oils as protection against plague and infectious diseases. Certainly essential oils, as used in aromatherapy, could turn out to be lifesavers, as many are effective against Methicillin-resistant Staphylococcus aureus. However, in the modern world we have turned to synthetic aromas and have forgotten the power of natural smells. Unfortunately, synthetic aromas are now being linked to the increase in asthma and allergies. Perhaps it is time to return nature to the medicine cabinet, where she has always belonged. Essential oils can produce clinical effects as published studies on alopecia, insomnia, and infection have shown.

Nursing is about nurturing—about facilitating and speeding recovery. This includes helping the patient feel the best they can about their situation. Nurses are in a unique position to de-stress patients through the use of familiar smells, and can literally make a hospital more hospitable. Nurses also can alleviate symptoms such as nausea, insomnia, and chronic pain using inhaled essential oils. As all essential oils are antiseptics, they can play a key role in the control of infection—viral, bacterial, or fungal. The future of nursing care can be a sweet-smelling one.

Chapter 31

Aromatherapy

Jane Buckle

NURSE HEALER OBJECTIVES

Theoretical

- Describe the historical path of aromatherapy, from ancient times to the present renaissance.
- Describe the relevance of learned memory in the choice of essential oil.
- Compare the different methods of using essential oils.
- Discuss the safety issues of using essential oils.

Clinical

- Describe the use of aromatherapy for insomnia.
- Describe the use of aromatherapy for chronic pain.
- Describe the use of aromatherapy for infection.
- List three uses for essential oil of Lavandula angustifolia.
- List three uses for essential oil of Eucalyptus globulus.
- List three uses for essential oil of Mentha piperita.
- List three uses for essential oil of Melaleuca alternifolia.
- List three uses for essential oil of Boswellia carteri.

Personal

- Integrate aromatherapy into your daily life to enhance your well-being.
- Experience each of the five essential oils mentioned previously both inhaled and topically.

DEFINITIONS

Aromatherapy: the use of essential oils for therapeutic purposes.

Clinical Aromatherapy: the use of essential oils for specific, measurable outcomes.

Chemotype: a cloned variety of a plant that always has the same chemistry as the original plant.

Essential Oil: the distillate from an aromatic plant, or the oil expressed from the peel of a citrus fruit.

The 'm' Technique®: a form of structured touch that is suitable when massage is inappropriate, either because the receiver is too fragile or the giver is not trained in massage.

The Limbic System: the oldest part of the brain; it contains the amygdala, hippocampus, thalamus, and hypothalamus.

Learned Memory: the ability of the mind to condition the response to an aroma based on previous experience.

HISTORY

Aromatherapy is often misunderstood and maligned. Its name is a bit of a misnomer; most people think aromatherapy is just about smelling. It is not a new therapy, but part of one of the oldest: Aromatherapy is derived from herbal medicine which dates back 6,000 years. Many parts of the world have used aromatic plants, including India, China, North and South America, Greece, the Middle East, Australia, New Zealand, and Europe. According to the World Health Organization, today over 85% of the world population still relies on herbal medicine, and many of the herbs are aromatic.

The renaissance of modern aromatherapy began in France just prior to World War II, at about the same time the first antibiotics were being introduced. A medical doctor, Jean Valnet, a chemist, Maurice Gattefosse, and a surgical assistant, Marguerite Maury, were key figures in the rediscovery of this ancient art of healing. It is interesting to note that they did not use aromatherapy for its nice smell, nor did they use it for stress-reduction—two of the most popular ways aromatherapy is used today. Instead, they used aromatherapy *clinically*. They used essential oils as they would use any medicine—to help wounds heal, to fight infections, and to reduce skin problems, and for the most part they used essential oils topically.[1]

This more clinical approach to aromatherapy has survived in France and Germany, where aromatherapy is seen as an extension of orthodox medicine. German doctors and nurses are tested in the use of essential oils in order to become licensed. The clinical use of aromatherapy is easy to understand, as many of today's drugs originally came from plants: aspirin from the Willowbark, digoxin from the foxglove. Even the contraceptive pill originally came from a plant—the humble yam—and the yew tree produces cytotoxic drugs to fight cancer.

THEORY AND RESEARCH

Aromatherapy utilizes essential oils obtained by steam distillation from aromatic plants for the physical, psychological, and spiritual benefit of the patient. Essential oils are powerful tools that are up to one hundred times more concentrated than the herb itself. Many of them have familiar smells, such as lavender, rose, and rosemary. Essential oils are highly volatile droplets created by the plant to prevent (or treat) infection, to regulate growth, and to mend damaged tissue. These tiny reservoirs of plant medicine are stored by the plant in veins, glands, or sacs, and when they are broken by being crushed or rubbed, the essential oil and its aroma are released. Some plants store large amounts of essential oil, some store very little. This, along with the difficulty of 'harvesting' the essential oil, dictates the price. Over 100 kilograms of fresh rose petals are needed to produce 60 grams of essential oil, making rose one of the most expensive essential oils, and therefore one of the most frequently adulterated.

There are a few important things to know about essential oils before they can be used safely. These are the method of extraction, the botanical name (for clear identification), the method of application, safety, storage, and contraindications.

Extraction

The method of extraction is crucial. Only steam-distilled or expressed extracts legitimately can be called essential oils. These two methods produce a product with no additional solvent or impurity. However, many of the 'essential oils' on the market

are solvent-extracted using petro-chemicals. These leave residues that can give rise to allergic or sensitive reactions. A bottle of essential oil should state that the contents are pure essential oils: steam-distilled or expressed. (Only the peel from citrus plants such as mandarin, lime, or lemon produces an expressed oil.)

Identification by Botanical Name

It is very important to know the botanical name of a plant, as there can be many different species of the same plant and using just the common name can lead to confusion. For example, there are three species of lavender and many hybrids, each with different chemistry and very different therapeutic effects. There are four hundred different species of eucalyptus. Identification is simple if the full botanical name is given. This should include the genus, species, and where relevant, the chemotype. The genus of lavender is Lavandula, and so all lavender plants begin with Lavandula. The species is the second part of the name. The chemotype, if there is one, will come last. See Table 31–1 for a

Table 31–1 Essential Oils Mentioned in This Chapter

Common Name	*Botanical Name*
Aniseed	Pimpinella anisum
Basil	Ocimum basilicum
Chamomile, German	Matricaria recutita
Chamomile, Roman	Chamomelum nobile
Clary sage	Salvia sclarea
Coriander seed	Coriandrum sativum
Eucalyptus	Eucalyptus globulus
Fennel	Foeniculum vulgare dulce
Geranium	Pelargonium graveolens
Ginger	Zingiber officinale
Hyssop	Hyssopus officinalis
Lavender, true	Lavandula angustifolia
Lemongrass	Cymbopogon citratus
Neroli	Citrus aurantium var amara
Palmarosa	Cymbopogon martini
Parsley	Petroselinum sativum
Pennyroyal	Mentha pulegium
Peppermint	Mentha piperita
Rose	Rosa damascena
Rosewood	Aniba rosaeodora
Sage	Salvia officinalis
Sandalwood	Santalum album
Tarragon	Artemesia dracunculus
Wintergreen	Gaultheria procumbens
Ylang ylang	Cananga odorata

list of essential oils mentioned in this chapter, which gives both the botanical name and the common name.

Do not buy anything that is labeled 'lavender oil,' as there is no way of knowing which lavender is in the bottle. One lavender is soothing, calming, and exceptional for burns, but another lavender is a stimulant and expectorant (helps to cough-up mucus). This second lavender will not promote sleep or sooth burns.

Methods of Application

Essential oils can be absorbed by the body in one of three ways. For methods of using essential oils that are congruent with holistic nursing practice, see Exhibit 31–1.

Touch in Aromatherapy

Aromatherapy often is used with a gentle stroking sequence of movements called the 'm' technique®. This registered method of touch is suitable when massage is inappropriate either because the receiver is too fragile or the giver is not trained in massage.[2] The 'm' technique® is being taught in universities and medical facilities across the United States.[3] It is simple to learn, quick to do, and produces a profound parasympathetic response in only a few minutes. Gentle friction enhances absorption of essential oils through the skin into the bloodstream. (For more details on this method of structured touch see www.rjbuckle.com.)

Exhibit 31–1 Methods of Application

1. Inhalation: 1–5 drops undiluted.
2. Topical: In baths: 1–8 drops. Compresses: 1–8%. Massage: 1–10%. Wounds: 8–20%. Burns, bites and stings (first aid): 100%. Radiation burns: 3–10%.
3. Vaginal: Useful for yeast infection or cystitis. Use 1–5% diluted on tampon.
4. Ingestion: This is not accepted as part of holistic nursing care.

Olfaction

The fastest effect from aromatherapy is through olfaction. Essential oils are composed of many different chemical components. These different chemical components travel via the nose to the olfactory bulb. There is debate as to whether the components are recognized by shape or vibration, but through either method they trigger responses in the limbic system of the brain—the oldest part of our brain—where the aroma is processed. The limbic part of our brain contains the amygdala, where fear and anger is analyzed. Valium is thought to have a calming, sedative effect on the amygdala. Lavandula angustifolia (True lavender) has a similar effect.[4] The limbic system contains the thalamus where pain is analyzed. The limbic system also contains the hippocampus, which is involved in the formation and retrieval of explicit memories.[5] This is why an aroma can trigger memories which may have lain dormant for years. Smell is very important, beginning with the newborn baby's identification of its mother[6] and continuing into old age, where studies have shown that the depression of residential elderly was reduced with the aromas of familiar fruit and flowers.[7]

The effect of odors on the brain has been 'mapped' using computer-generated graphics. These Brain Electrical Activity Maps (BEAM) indicate how a subject, linked to an electroencephalogram (EEG), rated different odors presented to them.[8] From these maps it has been discovered that aromas can have a psychological effect even when the aroma is subliminal; i.e., below the level of human awareness. These maps also showed that, provided the olfactory nerve is intact, the components in the aroma still can have a measurable effect on the brain.

Topical Applications

Components within essential oils are absorbed into and through the skin via diffusion, in much the same way as medicines used in patch therapy. The two layers of the skin, the dermis and fat layer, together act as a reservoir before the components within the essential oils reach the bloodstream. There is some evidence that massage or hot water enhances the absorption of at least some of the essential oil components. Essential oils, because they are lipophyllic (dissolve in fat) can be stored in the fatty areas of the body, and can pass through the blood–brain barrier and into the brain itself.

Negative Reactions

Essential oils are common ingredients in the pharmaceutical, perfume, and food industries and as such are experienced by most of the population on a daily basis.[9] Pure essential oils rarely produce an allergic effect, unlike their synthetic cousins. Today, increasingly more essential oils are being replaced with synthetic copies.

Nursing Theory

Aromatherapy links into many of the most recognized nursing theories. Certainly it resonates with Watson's theory of caring[10] because aromatherapy allows nurses a method of showing their care at a deep level. It resonates with Barrett's theory of power[11] because it allows the patient to participate knowingly in change, and offers a model for change through empowerment. Nightingale put forward the first theory—putting the patient in the best condition for nature to act—and thus aromatherapy clearly fits here as it allows the patient to relax sufficiently for the healing process to occur from within.[12] Nightingale also suggested creating an environmental space conducive to healing—aromatherapy fits very well here as well, as essential oils create a safe environment in many levels. Erickson's work led to the Modeling theory,[13] which requires building trust, promoting positive orientation, promoting strength, and setting mutual health-directed goals—these requirements also fit exceptionally well with aromatherapy. Roger's theory suggests that human beings are more than just physical entities, and have specific energy fields. Aromas clearly impact both the psyche and the human energy field. One of the most recent theories of smell is that it works on a vibrational level. This would explain how the body recognizes hundreds of thousands of different smells when there are only a few thousand receptor sites.[14]

How Aromatherapy Works

The term 'aromatherapy' refers to the therapeutic use of essential oils. Essential oils are the volatile organic constituents of plants. Essential oils are thought to work at psychological, physiological, and cellular levels. This means that they can affect our body, our mind, and all the delicate links in between. The effects of aroma can be rapid, and sometimes just thinking about a smell can be as powerful as the actual smell itself. Take a moment to think of your favorite flower. Then think about a smell that makes you feel nauseated. The effects of an aroma can be relaxing or stimulating depending on the previous experience of the individual (called the learned memory), as well as the actual chemical makeup of the essential oil used.

Who Uses Aromatherapy?

Aromatherapy is commonly practiced by nurses in the United Kingdom, France, Germany, Switzerland, Sweden, Australia, New Zealand, and Japan. In France and

Exhibit 31–2 Warnings/Contraindications/ Precautions When Using Essential Oils

1. Avoid with patients with severe asthma, or multiple allergies.
2. Do not take by mouth (unless guided by a person trained in aromatic medicine)
3. Do not use essential oils near the eyes. If essential oils get into eyes, rinse out with milk or carrier oil (essential oils do not dissolve in water) then water.
4. Store away from fire or naked flame. Essential oils are volatile and flammable.
5. Store in cool place out of sunlight, in colored glass—amber or blue. Store expensive essential oils in refrigerator.
6. Many essential oils stain clothing. Beware!
7. Don't use phenol-rich essential oils undiluted on the skin (for example, red thyme).
8. Keep away from children and pets.
9. Only use essential oils from a reputable supplier who can supply the correct botanical name, place of origin, part of plant used, method of extraction, and batch number where possible. See Table 31–11 for suggested suppliers.
10. Always close the container immediately.
11. Use carefully during pregnancy.
12. Be aware of which essential oils are photosensitive; e.g. bergamot.

Germany, medical doctors and pharmacists also use aromatherapy as part of conventional medicine, often for the control of infection. Aromatherapy is the fastest growing therapy among nurses in the United States.[15]

Although essential oils are very safe to use, there are some guidelines that need to be followed. See Exhibit 31–2 for a list of relevant warnings, contraindications, and precautions. Potential drug interactions can be found in Exhibit 31–3.

Adverse Reactions

There is some evidence of remote cases of adverse skin reactions caused by sensitivity. The majority of cases were from extracts which contained topical preservatives, rather than pure essential oils. People with multiple allergies are more likely to be sensitive to aromas. Bergamot used in conjunction with sunshine or sun-beds can result in skin damage ranging from redness to full-thickness burns.[16] It is recommended that some essential oils should be avoided during pregnancy, although the risk is extremely small when the essential oils are used only topically or inhaled. These are sage, pennyroyal, camphor, parsley, tarragon, wintergreen, juniper, hyssop, and basil. However, Tisserand and Balacs state that there is "no evidence that essential oil are abortificient in the amounts used in aromatherapy." [17] The following are thought to be safe in pregnancy: cardamom, chamomile (Roman and German), clary sage, coriander seed, geranium, ginger, lavender, neroli, palmarosa, patchouli, petitgrain, rose, rosewood, and sandalwood.[18]

Exhibit 31–3 Drug Interaction When Using Essential Oils

1. Avoid with patients receiving homeopathy—strong aromas like peppermint and eucalyptus can negate homeopathic remedies.
2. People who are allergic to ragweed may be allergic to chamomile.
3. The effect of tranquilizers, anticonvulsants, and antihistamines may be slightly enhanced by sedative essential oils.

Administration

Essential oils can be used topically or inhaled. A typical topical application would use a 1–5% mixture. This is 1–5 drops of essential oils diluted in 5 ccs (a teaspoon) of cold-pressed vegetable oil such as sweet almond oil. Some wound infections may require higher concentrations—up to 20%. Some essential oils, such as lavender and teatree, can be applied undiluted topically for stings or bites. Oth-

ers, like clove and thyme, should never be used undiluted on the skin as their high phenol content would cause burning. For insomnia, nausea, or depression, inhale for 5–10 minutes as necessary. Use touch methods such as massage or the 'm' technique® where appropriate. Simple stress management can be incorporated into every day regime with the use of baths and foot soaks, vaporizers, and sprays. Oral intake of essential oils, while extremely effective for acute infection or gastrointestinal problems, is not recognized as part of holistic nursing care at this time.

Self-Help

Aromatherapy can be very useful when self-applied for stress-management, insomnia, or depression. It is extremely portable and easily can be used anywhere at anytime. A drop of peppermint can help clear your mind at the end of a busy day, or a drop of ylang ylang can help calm battered nerves. Because there are so many essential oils to choose from, it is simple to choose an essential oil that is pleasing as well as efficacious.

Credentialing

At the moment there is no recognized national certification for aromatherapy. The closest thing is the Aromatherapy Registration Board (ARB), a nonprofit entity which is responsible for setting a national exam (www. aromatherapycouncil.org). The exam is administered by the Professional Testing Corporation (PTC) of New York. Details of the exams are available from www. ptcny.com. The exam, which is open to anyone who has studied aromatherapy and meets the criteria, is available at various sites throughout the country. The main professional body is the National Association of Holistic Aromatherapy (NAHA). At present there are no requirements to become certified or accredited and aromatherapy training can range from one day to several years. However, as nurses are accountable, if they wish to use aromatherapy within their nursing care it is strongly recommended that they be able to show documented evidence of training, preferably with a clinical course that is nurse-taught and patient-centered. Angela Avis, the Chair of the Royal College of Nursing Complementary Therapies Forum, London, states that "nurses who had only had a couple of weekends of training are not in a position to encourage the use of essential oils and should not be integrating the use of oils into their practice."[19] See the AHNA website for endorsed aromatherapy courses for nurses (www.ahna.org).

Aromatherapy for Insomnia

Henry[20] et al. (1994) carried out a study of nine dementia patients at Newholme Hospital, Bakewell, England, where he monitored the effects on them of a nighttime diffusion of lavender. The trial ran for seven weeks and showed that lavender had a statistically significant sedative effect when inhaled. Eight of the nine patients in the study had improved sleep and improved alertness during the day. Hudson,[21] Hardy et al. (1995)[22] completed a similar study and showed that lavender was as effective as conventional medication for elderly patients. Interestingly, lavender straw (the stems that are not discarded before distillation) was itself found to reduce stress of pigs in transit in a study by Bradsaw et al. (1998).[23]

Weihbrecht (1999)[24] investigated the effect of inhaled Lavandula angustifolia on ten adults (three men and seven women) who had a history of chronic insomnia. Subjects took baseline measurement for the first fourteen days and recorded difficulty getting to sleep, naps taken during the day, difficulty returning to sleep, and feeling rested in the morning. A visual analog scale of 1–10 was used (1 = very difficult, 10 = no difficulty). Subjects were asked not to change what they

normally did and to continue sleep medication. For days 15–29 two drops of Lavandula angustifolia were placed on the pillow or smelled from a tissue at bedtime. Subjects mailed back a sleep questionnaire, and there was a telephone interview following completion of the study. One participant pulled out of the study as she did not like the smell of lavender. Eight of the remaining participants had improved sleep in one of the four areas measured, and reported less difficulty in falling asleep. The one person who did not (no. 8) reported that his difficulty was neither improved nor worsened by the use of lavender. Eight participants reported feeling more rested in the morning. The one person who did not (no. 4) had the flu during the experimental stage. The sleep aids normally used by the participants remained the same.

King (2001)[25] tested the effect of Chamomelum nobile (Roman chamomile) and Origanum majorana (sweet marjoram) on insomnia. Ten women between the ages of 36 and 59 who had sleep problems took part in the study. One client had an allergy to ragweed so a patch test was completed before the study commenced to make sure she was not allergic to chamomile. Each subject was given a bottle containing a mixture of Roman chamomile and sweet marjoram in a ratio of 1:2. For the first seven days, baselines were established. During the second week the subjects used the aromatherapy mixture, the third week was a washout week with no aromatherapy, and the fourth week was a repeat of the second week. During weeks 2 and 4 (the aromatherapy weeks), 2 drops of essential oils were put on a cotton ball and placed in the pillowcase of the subject at bedtime. Subjects recorded time to fall asleep, number of times waking, how long it took to fall back to sleep, span of time from bedtime to getting up, and if they felt rested in the morning. The data was entered on a spreadsheet so that the results could be compared.

Two subjects withdrew from the study, as neither of them had liked the aroma and both experienced headaches. These two subjects were not entered into the analysis.

The results indicated a small improvement in almost every category. Five women experienced an improvement in the time it took to go to sleep. (One subject took 240 minutes to fall asleep one night due to a death in the family. The outcomes of the study were not changed to accommodate that.) Six women showed a reduction in the number of times they woke up during the night. Only three women showed a reduction in the time taken to fall back to sleep. Five women felt more rested with the aromatherapy mixture.

Aromatherapy for Pain

One study using lavender (Lavandula angustifolia) cites a 50% reduction in the pain perception of patients in critical care.[26] Thirty-six patients were divided into three groups of 12: One group received massage plus lavender, one group received massage without lavender; the third group was a control group that rested 'curtained off but received no treatment.' Treatment consisted of a 20-minute foot massage twice a week for five weeks. The study was not randomized or blinded.

Questionnaires documenting pain, wakefulness, heart rate, and systolic blood pressure were completed by the investigators, which limited the validity of the study. Observations were taken before and immediately following the intervention and up to half an hour later. This was an interesting study, as 50% of the patients were artificially ventilated and therefore the effects of the essential oil could not be from inhalation. The most striking difference between the group receiving massage with lavender (Group A) and the group without lavender (Group

B) was in the effect upon heart rate. Ninety percent of Group A showed a reduction of between 11 and 15 beats per minute, whereas only 58% of Group B showed any reduction, and it was consistently less. Only 41% of the control group showed any reduction. The study gives no formal statistics or analysis.

Brownfield[27] studied the effects of aromatherapy and massage on nine patients with rheumatoid arthritis in a hospital using a quasiexperimental design. This was a randomized, controlled study using a visual analog as the measurement tool. Intervention was a ten-minute upper neck and shoulder massage, with or without Lavandula angustifolia (True lavender), carried out on two consecutive evenings. Inclusion criteria were:

1. Diagnosis of rheumatoid arthritis in accordance with the American Rheumatism Association.
2. Older than 18-years-old.
3. Disease duration of over two years.

The quantitative results did not reveal any reduction in pain levels following massage with or without lavender. However, the interviews showed that those patients receiving massage with lavender oil were able to reduce their intake of analgesia. The author concludes that the apparent contradictory findings could be because many patients with RA "have difficulty distinguishing pain from stiffness." Patients also reported that they slept better or were able to roll over in bed. A total of 83% (n = 5) expressed a desire for further aromatherapy treatment. This study is limited because (a) the researcher interviewed the subjects and may have biased them to 'approve' of the treatment, and (b) the patient population is very small. However, it does highlight that perception plays an important role in pain and that this perception can be affected by touch and smell.

In a study of 20 hospitalized children[28] (aged 3 months and older) with HIV, nurses used aromatherapy to give 'comfort and relieve physical pain.' The nurses chose a range of essential oils recognized for their analgesic and nervine properties. The essential oils chosen were Chamomelum nobile (Roman chamomile) and Lavandula angustifolia (True lavender). All of the children responded well to the essential oils. In many cases the essential oils decreased the need for analgesic drugs ranging from acetiminophylen to morphine. Some of the children said their pain had "been relieved completely." In addition, discomfort from intermittent muscle spasm (due to encephalopathy) was relieved. Chronic chest pain that had been unresponsive to regular analgesia was eased, and painful peripheral neuropathy was alleviated almost completely. This was a descriptive study and no statistical analysis was given.

Styles, whose specialty is aromatherapy in pediatric palliative care, suggests that massage and aromatherapy easily can be used alongside orthodox treatments. She writes that aromatherapy can "enrich the child's experience of hospitalization" and "offers a valuable means of comfort and communication for dying children." Essential oils used by Styles in her research and listed as suitable for children in pain can be found in Table 31–2.

Aromatherapy in Infection

Possibly because aromatherapy is perceived to be useful mainly for stress, the antimicrobial properties of essential oils have not been properly acknowledged. There is, however, considerable published research available on the in vitro antibacterial, antifungal, and antiviral effects of a great number of essential oils. A search on Pubmed or Medline using the botanical name of the individual aromatic plant coupled with essential oil will produce

Table 31–2 Topically Applied Essential Oils Used By Styles for Children in Pain

Botanical Name	*Common Name*
Lavandula angustifolia	True Lavender
Chamaemelum nobile	German chamomile
Citrus aurantium	Neroli
Citrus reticulata	Mandarin
Santalum album	Sandalwood
Cymbopogon martini	Palma rosa
Pelargonium graveolens	Geranium

between twenty and a hundred papers per essential oil. Several databases dedicated to medicinal plants are available such as Napralert (University of Chicago) and the Agricola Database—available via Silver Platter (www.silverplatter.com).

With the emergence of increasingly resistant pathogens and unknown viruses, it is more important than ever to know that essential oils may be effective when conventional antibiotics fail, and that essential oils appear to enhance rather than detract from the use of conventional antibiotics.

A randomized, controlled study using teatree was carried out on 30 adult inpatients who were either infected or colonized with MRSA.[29] The study was carried out at John Hunter Hospital, Newcastle, New South Wales, Australia. Participants were randomly assigned to receive either 2% mupirocin nasal ointment and triclosan body wash (routine care RC), or a 4% teatree nasal ointment and a 5% teatree oil body wash (intervention care IC). Treatment lasted for a minimum of three days. Screening for MRSA was from the nostrils, the perianal region, and any site previously positive for MRSA. Swabs were taken 48 and 96 hours after cessation of the topical treatment. Treatment was carried out for a minimum of three days, and a maximum of thirty-four days.

The most common site of isolation of MRSA was the skin, which accounted for 19 of the 30 patients (63%). The average age for the RC group was slightly older (74 years) compared to the IC group (58 years). Two of the RC group (13%) were cleared of MRSA, compared to 5 of the teatree group (33%). Eight of the RC group (53%) remained chronically infected or colonized at the end of the treatment, compared to three of the teatree group (20%). Teatree was shown to be more effective than mupirocin and triclosan although the difference was not statistically significant due to the small number of patients.

No adverse effects were reported from the mupirocin ointment or teatree body wash. One person complained of 'burning' from the teatree nasal ointment and one person complained of tightness from the triclosan body wash. No one complained of adverse effects from the teatree oil body wash.

A further study by Sherry and Warnke was presented at the American Academy of Orthopedic Surgeons in 2002.[30] The paper states that 90% of hospital-acquired infections in Australia are Methicillin-resistant staphylococcal (MRSA) infections. Twenty-five patients with MRSA infections were treated: sixteen involved bone, six a joint, and three, soft-tissue. Ten patients were diabetic. Following debridement, diluted essential oils were applied to the infected sites. In the case of bone, calcium (oestoset) beads were used soaked in essential oils. In twenty-two cases the infection was completely resolved either without antibiotics (19) or with antibiotics (3). The paper also states that in vitro studies on teatree and eucalyptus showed that both teatree and eucalyptus were effective against 90% of the five multiple resistant TB tested within one minute. The paper concludes that essential oils could be a possible mass treatment for TB.

In a small controlled study (n = 8) at Tri-County Hospital, Wadena, MN, diluted

essential oils were put directly into slow healing wounds to promote healing.[31] Two patients had wounds that were grade 2 pressure ulcers measuring 1 × 1.5 cm and 2.5 × 1.7 cm on their buttocks. Three patients had deep wounds on their lower extremities. The three control subjects were actually three of the experimental group who had conventional treatment applied to other wounds on their other limbs.

Subjects gave informed consent and received patch testing to eliminate sensitivity to the essential oils chosen. The study was carried out by a clinical aromatherapist (CCAP)[32] who was also a physiotherapist and an MD. A 6% solution of Lavandula angustifolia and German chamomile (Matricaria recutita) diluted in grapeseed oil was put directly into and around the wound. The mixture was applied twice a day and covered with a Telfa dressing. The wounds were measured and photographed. All wounds improved slowly but steadily after the first two weeks when there was increased exudate. One of the wounds was a grade 4 which extended down to the deep tendons. In the two months of treatment new tissue grew over the exposed tendons and the patient began to regain feeling in his foot.

An Australian study[33] reports on a three-year program of using essential oils in wound care of over 100 patients in nursing homes around Sydney. The mixture used in the wounds was lavender, German chamomile, myrrh, and teatree in an aloe vera gel. The mixture varied between 5–12% with 5% being deemed the lowest dilution to have any measurable effect on healing. Out of the 100 wounds observed, measured and treated with essential oils, there were no adverse effects. A slight stinging sensation that quickly passed was reported in a handful of patients. The wounds quickly became less inflamed and red, there was pain relief and the odor of the wound was greatly reduced. The wounds mainly involved skin tears and slow healing ulcers. Finally, a paper by Inouye et al.[34] suggests that just the gaseous contact with essential oils will be sufficient to kill many airborne pathogens including Hemophilus influenzae, Streptococcus pneumoniae, and Streptococcus pyogenes. The most effective essential oils tested were lemongrass (Cymbopogon citratus) and thyme (Thymus vulgaris).

Several exhibits follow that contain descriptions of the therapeutic value of five of the most useful and commonly available essential oils that are being used in holistic nursing care. See Exhibit 31–4 for applications for lavender. Applications for peppermint can be found in Exhibit 31–5. Applications for teatree can be found in Exhibit 31–6. Applications for eucalyptus can be found in Exhibit 31–7. Applications for frankincense can be found

Exhibit 31–4 Properties of Lavender (Lavandula angustifolia)

1. Skin regenerative[35] for burns, all skin problems: abscesses, acne, acne rosacea, bruises, mild eczema, insect bites, lice, psoriasis, ringworm.
2. Sedative/calming action, insomnia, nervous tension,[36,37] good for depression, PMS. Possibly as effective as Diazepam.[38]
3. Analgesic for earache, muscular pains, and rheumatism.
4. Antispasmodic: asthma, bronchitis, hay fever, whooping cough. For abdominal cramps, colic, dyspepsia, flatulence.
5. Antiseptic, antivenous, antiviral, antibiotic: Effective against MRSA,[39] typhoid, diptheria, tuberculosis.[40]
6. Fungistatic not fungicidal.[41]
7. Enhances sense of well-being.[42]
8. Enhances effect of pentobarbitol.[43]
9. Inhibits Pseudomonas aeruginosa by 75%.[44]
10. Effective against mites (Psoroptes cumiculi).[45]
11. Effective against MRSA.[46]

Exhibit 31–5 Properties of Peppermint (Mentha piperita)

1. Analgesic.[47–51]
2. Antinausea.[52,53] Enhances the effect of antiemetic drugs.
3. Antiviral.[54]
4. Effective against oral bacteria.[55]
5. Antilactogenic.[56]
6. Choleretic and reduces cholesterol.[57]
7. Cooling, antipyretic.
8. Antispasmodic.[58]
9. Antibacterial: Effective against Staph aureus, E.Coli, Klebsiella, Pseudomonas aeruginosa, Vabrio cholerae.[59] Effect similar to penicillin.[60]
10. Effective against MRSA & VREF.[61]
11. Decongestant.

Exhibit 31–6 Properties of Teatree (Melaleuca alternifolia)

1. Bacterial infections including abscesses, acne.[62,63]
2. Fungal infections including athlete's foot, tinea.[64]
3. Most skin infections, including impetigo, cold sores, herpes.[65]
4. Vaginal infections: thrush[66] /trichomoniasis[67] /anerobic infections.[68] Can be diluted and used as a vaginal douche for infections. Dilute in carrier oil on tampon. Put 2 drops of teatree in one teaspoonful of carrier oil. Roll tampon in mixture and insert into vagina. Repeat with fresh tampon every four hours and leave in overnight. Relief should occur within 48 hours. Vaginal thrush should not reoccur.
5. Insect bites, poison ivy. Use undiluted on poison ivy or in aloe vera gel. For wounds, use 5–20% strength dilution.
6. Teatree is effective against MRSA[69]
7. Respiratory infections, viral/bacterial, asthma, TB, whooping cough.
8. Mouth infections, pyorrhea, gingivitis. Use in mouthwash.
9. Use in a spritzer spray for room cleansing and to prevent cross-infection. Put 2–5 drops undiluted onto a handkerchief for those who have depressed immune system.

Exhibit 31–7 Properties of Blue Gum (Eucalyptus globulus)

1. Respiratory complaints, including TB.[70]
2. Antibacterial against all bacteria tested.[71–73] Action comparable to orthodox antibiotics.[74]
3. Enhances the activity of streptomycin, isoniazid, and sulfetrone Tuberculosis.[75]
4. Enhances dermal absorption of 5-fluorouracil 60 fold (5-FU).[76]
5. Reduces narcotic effect of barbiturates.[77]
6. Effects glutathione S-Transferase activity.[78]
7. Mild topical analgesic.[79]
8. Antiinflammatory.[80]
9. Antifungal[81] (including Cryptococcus neoformans).
10. Antiparasitic.[82]
11. Kills house mites.[83]
12. Mosquito repellent,[84,85] mosquito larvicide.[86]
13. Antiviral.[87]
14. Muscle relaxant.[88]
15. Antiseptic to sterilizing level.
16. Granulation inhibiting.[89]

in Exhibit 31–8. The kind of application will depend of if a psychological or physiological response is required. Remember to ask your patient if they like the aroma before you begin their aromatherapy treatment. Essential oil companies used by the author are listed in Table 31–3.

CONCLUSION

There is tremendous emphasis on 'doing' in the Western World, where we are judged (and tend to judge others) on what we 'do' rather than our ability 'to be.' But illness takes away a patient's ability 'to do' and forces him or her to address his or her 'being' on a much broader scale. This can be very frightening. However, it allows the nurse the opportunity to share with the patient a glimpse of a multidimensional world which until then has remained hidden. In the concept of inte-

Exhibit 31–8 Properties of Frankincense (Boswellia carteri)

1. Antiinflammatory.[90]
2. Good for chesty coughs, asthma.
3. Effective against Staph aureus, Bacillus subtilis, E. coli, Mycobacterium phlei.
4. Cicatrisant: good for old scars, ulcers, wounds.
5. Possible immunostimulant.
6. Possibly useful in skin cancer.
7. Helps induce meditative state, useful for calming the actively dying.
8. The 'key-opener'—opens the door to the subconscious—very good for helping teenagers open up, or to help release unmourned grief in anger situations.

grality, perhaps a little comfort in the form of aromatherapy might put some holistic CARE back into our health CARE system, and allow patients 'to be' as they journey back toward the land of 'the doing.' Not only will aromas help the journey, they may also help recovery on every level. Aromatherapy gives caring to the soul, the mind and the body—a true holistic therapy. And it smells good!

HOLISTIC CARING PROCESS

Assessment

In preparing to use essential oils clinically, the nurses assesses the following parameters:

- the client's like or dislike of particular aromas, as this will impact the choice of essential oils
- the client's like or dislike of touch, as this will impact what method is chosen
- the client's perception of the problem, as this will indicate the targeted outcome
- the client's level of stress, as this will directly affect the oils chosen
- the client's understanding of what aromatherapy is, as this will indicate if they are expecting cure or care
- the client's skin integrity, as certain essential oils are safest to poor skin integrity
- the client's age—very young or elderly client's will need low percentages of essential oils
- the client's medical history, as previous illness could be related to the current problem
- the client's current medical status, as this will indicate which essential oils are safest to use
- the client's sleep pattern, as this will indicate if this is one of the main areas for improvement
- the client's weight and height, as these will indicate the amount of essential oil required
- the client's blood pressure, as this will indicate if hypotensive or hypertensive essential oils could be used
- the client's medication, as certain medications could be affected by essential oils
- the client's respiratory pattern, as this will indicate if there is COPD or asthma, which will indicate the method required
- the client's reproductive status, as this will indicate if the patient is pregnant, reducing the choice of essential oils
- the client's allergy status, particularly to ragweed or herbal teas, as certain essential oils would then need to be disallowed
- the client's close proximity to others who may be affected by the aromas, as this will impact which essential oils are chosen

Patterns/Challenges/Needs

The following are the patterns/challenges/needs compatible with aromatherapy that are related to the 13 domains of

Table 31–3 Essential Oils Distributors Used By the Author

Elizabeth Van Buren Inc.
P.O. Box 7542
Santa Cruz, CA 95061
Phone: 800-710-7759
www.evb-aromatherapy.com

Essentially Oils Ltd.
8-10 Mount Farm, Junction Road
Churchill, Chipping Norton, OX7 6NP UK
www.essentiallyoils.com

Florial France
42 Chemin Des Aubepine
06130 Grasse, France
Phone: 513-576-9944
Email: danannscrossing@yahoo.com
www.florial.com
U.S. distributor: Lisa Roth

Fragrant Earth Ltd.
Orchard Court, Magdelene Street
Glastonbury, Somerset BA6 9EW UK
www.fragrant-earth.com
Director: Jan Kusmerik

Kneading Wellness
453 South Broad Street
Lititz, PA 17543
Phone: 717-626-8182

Nature's Gift Ltd.
40 Cheyenne Blvd
Madison, TN 37115
Phone: 615-612-4270
Email: marge@naturesgift.com
www.naturesgift.com
Director: Marge Clarke

Northwest Essence
P.O. Box 428
Gig Harbor, WA 98335
Phone: 253-858-0777
Email: northwestessence@earthlink.net
Director: Cheryl Young

Recommended Diffusers
Leyden House Ltd.
200 Brattleboro Road
Leyden, MA
www.leydenhouse.com
Director: Eileen Cristina

Therapeutic Essentials
5 Michelle Court
Edgewood, NM 87015
Phone: 505-281-9547
Email: Ther1Ess1@aol.com
Director: Wendy Lundgren

Taxonomy II of the Unitary Person framework (see Chapter 14):

- Altered circulation
- Risk of Infection
- Constipation
- Perceived constipation
- Risk for constipation
- Altered tissue perfusion (peripheral)
- Ineffective breathing pattern
- Dysfunctional ventilatory weaning Response
- Impaired tissue integrity
- Risk for impaired skin integrity
- Energy field disturbance
- Impaired verbal communication
- Social isolation
- Risk for loneliness
- Sexual dysfunction
- Caregiver role strain
- Ineffectual individual coping
- Defensive coping
- Ineffective family coping
- Family coping: potential for growth
- Decisional conflict
- Impaired physical mobility
- Impaired bed mobility
- Activity intolerance
- Fatigue
- Sleep pattern disturbance
- Delayed surgical recovery
- Adult failure to thrive
- Ineffective breastfeeding
- Bathing/hygiene self-care deficit
- Relocation stress syndrome
- Body image disturbance
- Chronic low self-esteem

- Sensory/perception/alterations: olfactory, tactile
- Hopelessness
- Powerlessness
- Chronic confusion
- Impaired memory
- Chronic pain
- Nausea
- Dysfunctional grieving
- Chronic sorrow
- Post-trauma response
- Anxiety
- Fear

Outcomes

Exhibit 31–9 guides the nurse in client outcomes, nursing prescriptions, and evaluations for the use of aromatherapy as a nursing intervention.

Setting Goals

It is important to establish mutually acceptable goals prior to beginning an aromatherapy and 'm' technique® session. These outcomes may be immediate or long-term, but should be relevant to aromatherapy and the role of holistic nursing care. Clients are more likely to be content with the outcomes if they are perceived to be achievable within a specified timeframe, and are deemed successful with recognizable tools such as visual analogs. It is recommended that such goals are judged by using a visual analog scale (0–10), where 0 is lack of the symptom (such as pain) and 10 is the worst imaginable symptom (such as pain). Informed consent (with written consent where possible) is required before using essential oils.

Therapeutic Care Plan and Implementation

Before the Session

- If in a clinical area, inform other people that aromatherapy will be used and assess if they are comfortable with the aromas that will be used.
- Request no interruptions for the period required. This could be 5 minutes for a hand 'm' technique® using essential oils, or 15 minutes for hand, face, and feet. Allow 15 minutes for inhalation.
- Discuss the length of the session, the required outcome, and the method to be used.
- Ask client to empty the bladder for comfort.
- Prepare the hospital bed or surface on which you will be working. Adjust the bed height for your convenience.
- Ensure the temperature of the room is appropriate.
- Ask the client to remove eyeglasses if using direct inhalation as a method.
- Prepare the environment for optimal relaxation if this is the purpose of the session.
- Place a clean towel under the hand or foot for 'm' technique®.
- Wash hands.
- Prepare mixture of essential oils in carrier oil if being applied topically to the skin.
- Prepare diffuser with mixture of undiluted essential oils if inhalation is being used.
- Prepare compress with either water or carrier oil for wound care.
- Prepare bath for emersion of limb or body.
- Prepare basin with very hot water for steam inhalation.
- Prepare basin with warm water and essential oils for body wash.

Exhibit 31–9 Nursing Interventions: Aromatherapy

Client Outcomes	*Nursing Prescriptions*	*Evaluation*
The client will select aromas from a selection offered by the nurse.	Provide the client with various aromas to chose from that are suitable for client's condition.	The client chose aromas from a selection offered by the nurse.
The client will demonstrate positive physiologic outcomes in response to the aromatherapy and the 'm' technique® sessions, such as: • decreased respiratory rate • decreased heart rate • decreased blood pressure • decreased muscle tension • decreased fatigue • decreased pain • improved physical mobility • improved bed mobility • improved activity tolerance • improved sleep pattern • improved surgical recovery • improved ability to thrive • improved breastfeeding • improved self-care • reduced nausea • reduced constipation • reduced risk of infection	Assess the client's physiologic outcomes in response to aroma therapy and the 'm' technique® before and immediately after each session. Evaluate the client's: • decreased respiratory rate • decreased heart rate • decreased blood pressure • decreased muscle tension • decreased fatigue • decreased pain • improved physical mobility • improved bed mobility • improved activity tolerance • improved sleep pattern • improved surgical recovery • improved ability to thrive • improved breastfeeding • improved self-care • reduced nausea • reduced constipation • reduced risk of infection	The client demonstrated: • decreased respiratory rate • decreased heart rate • decreased blood pressure • decreased muscle tension • decreased fatigue • decreased pain • improved physical mobility • improved bed mobility • improved activity tolerance • improved sleep pattern • improved surgical recovery • improved ability to thrive • improved breastfeeding • improved self-care • reduced nausea • reduced constipation • reduced risk of infection
The client will demonstrate positive psychologic outcomes in response to the aromatherapy and the 'm' technique® sessions such as: • improved body image • improved self-esteem • improved olfactory ability • improved tactile ability • reduced hopelessness • reduced powerlessness • reduced confusion • improved memory • more functional grieving • reduced sorrow • improved trauma response • reduced anxiety • reduced fear • more effective coping • less decisional conflict • better family coping	Assess the client's psychologic outcomes in response to aroma therapy and the 'm' technique® before and immediately after each session. Evaluate the client's: • improved body image • improved self-esteem • improved olfactory ability • improved tactile ability • reduced hopelessness • reduced powerlessness • reduced confusion • improved memory • more functional grieving • reduced sorrow • improved trauma response • reduced anxiety • reduced fear • more effective coping • less decisional conflict • better family coping	The client demonstrated: • improved body image • improved self-esteem • improved olfactory ability • improved tactile ability • reduced hopelessness • reduced powerlessness • reduced confusion • improved memory • more functional grieving • reduced sorrow • improved trauma response • reduced anxiety • reduced fear • more effective coping • less decisional conflict • better family coping

- Focus on your healing intention and then begin.

At the Beginning of the Session

- Tell the client what you are going to do before you do it.
- Tell the client which part of the body you are going to touch before you touch it.
- Make sure that the limb is supported.
- Ask the client to tell you what the pressure feels like to them (on a level of 0–10) if you are using the 'm' technique®.
- Warm your hands by rubbing them together.
- Apply a small amount of dilute essential oil in to one hand if using the 'm' technique®.
- Put required drops of essential oil in basin for steam inhalation.
- Put required number of drops of essential oil in diffuser.
- Begin slowly and rhythmically if using the 'm' technique®.
- Help position client above steaming bowl for inhalation and place towel over head and shoulders.
- Begin applying dilute essential oils to wound or burn.

During the Session

- Maintain constant pressure, rhythm, and speed if using manual therapy.
- Discourage conversation.
- Encourage client to focus on the treatment.
- If client is using inhalation method encourage them to breath deeply.
- Have tissues available for expectoration if steam inhalation is used.
- Have empty basin available if essential oil is being used for nausea.
- Stay with a confused, elderly, infirm, or very young patient if inhalation or bath is being used.
- Reassess the client as you move through the session.

At the End of the Session

- Remove any apparatus used for aromatherapy (basin, bath, diffuser).
- If the client has gone to sleep gently wake him/her after a few moments.
- Tell the client that you have finished the session.
- Dry skin if bath has been used.

Specific Interventions

- Have the client identify and verbalize any changes or experiences that occurred during the session.
- The nurse may reassess physical parameters such as blood pressure, pulse, and respiration.
- The nurse may suggest that the treatment is self-applied at regular intervals.
- The nurse may make up a series of treatments in a bottle for such self-application.
- The nurse may schedule a follow-up treatment.

Case Studies

Case Study No. 1

Setting:	Outpatient unit
Client:	G.D, a 54-year-old Caucasian woman with mild asthma
Medical Diagnosis:	Asthma
Patterns/ Challenges/ Needs:	1. Altered physical regulation (asthma) 2. Anxiety 3. Fear 4. Powerlessness 5. Ineffective coping related to anxiety around asthma attacks

G.D. is a 45-year-old woman who had been diagnosed with asthma several years previously. She has had frequent wheezing and coughing problems for the last ten years and fears each attack when she feels she "just cannot get enough air."

The attacks seem to be triggered by very cold weather, exercise, and stress. She has tried relaxation techniques but none have really worked. G.D. developed asthma as a child but during her teenage years her symptoms resolved, and only reappeared about 10 years ago. She has been wheezing on a daily basis for the last 9 months and currently the wheezing is controlled with Advair. Prior to commencing Advair, G.D. required emergency department treatment due to an asthma flare-up. At the time she was prescribed a course of oral corticosteroids, albuterol, and amoxicillin. This resolved the asthma completely and she was much better for a month. But after a month, she felt the albuterol did not really help so her physician switched her to Advair. This seems to be controlling the asthma; however, when she exercises, her chest tightens and she coughs. She particularly resents that the asthma prevents her from exercising, as she is trying to lose weight. She has allergies to mold and some animals, she does not smoke, and there are no pets in the house. Her father has eczema.

The nurse outlined the use of inhaling essential oils and their affect on opening up the respiratory tract. She invited the client to smell the aromas of Eucalyptus globulus, Eucalyptus smithii, Eucalyptus citriadora, Ravansara aromatica, Lavandula latifolia, and Boswellia carteri. The client liked Eucalyptus globulus and Boswellia carteri best. The nurse prepared a bowl of steaming hot water and added 2 drops of Eucalyptus globulus and 2 drops of Boswellia carteri and asked the client to lean forward and inhale the aroma. The client did so. The nurse reassured her that she (the nurse) would stay with her and asked if it would be acceptable to place a towel over her head and shoulders to make a steam tent. This steam tent could be removed at any time. The client agreed. The client was encouraged to breathe slowly in and out through her mouth as the water cooled and then in and out through her nose. The client was asked if she could feel the essential oils deep within her chest and the client said yes. The session was concluded after 8 minutes when the client felt that she had received enough.

The client stated that the effect of inhaling the essential oils and the steam was quite remarkable and appeared to open up her airway almost immediately. The steam was comforting to her chest, she felt the aromas were familiar and calming—and she felt it was a very reassuring treatment to receive although she had been dubious if aromatherapy would have any effect. The nurse offered the client a towel to wipe her face that was very wet from the steam.

The nurse told G.D. where she could obtain essential oils if she wished to continue treatment on her own and to come back in a week to reassess the situation. G.D. continued to use daily inhalations of Eucalyptus globulus and Boswellia carteri. She found that the effects of the essential oils and steam on her asthma lasted for about 3 hours, but that the calming effect lasted considerably longer. She felt the aromatherapy session was quite intense initially because of the steam and the heat. However, it was a very simple and inexpensive way to help herself, and she felt empowered and no longer helpless. She was particularly pleased that she did not need to go and see her physician and her supply of Advair lasted a long time, as she only needed to use it once a day and sometimes would do for several days without needing to use it at all. G.D. was shown how to apply the essential oils topically to her chest if she did not want to use steam. She found the topical method very useful although not as effective on the asthma as the steam inhalation.

Evaluation

The nurse determined with G.D. if the desired outcomes had been achieved. Both the nurse and G.D. felt that the inhaled essential oils had proved effective on all five outcomes:

1. *Altered physical regulation (asthma).* Went from a 7 to a 3.
2. *Anxiety.* Went from an 8 to a 2.
3. *Fear.* Went from a 7 to a 2.
4. *Powerlessness.* Went from an 8 to a 2.
5. *Ineffective coping related to anxiety around asthma attacks.* Went from a 7 to a 3.

Case Study No. 2

Setting:	Hospital inpatient
Client:	B.S., an 82-year-old Caucasian woman with unresolved chronic pain
Medical Diagnosis:	Severe spinal degeneration.
Patterns/ Challenges/ Needs:	1. Chronic pain 2. Anxiety 3. Fear 4. Powerlessness 5. Ineffective coping related to chronic pain

B.S. is an 82-year-old woman who had been experiencing severe back pain. X-rays revealed spondylolisthesis of L 4-5 secondary to severe degenerative changes, a central spinal stenosis of L1-4, and a mild compression fracture of L-2. B.S. had a caudal epidural block without relief. For the following ten days she had been on bedrest with bathroom privileges only. She was on 6-hourly medication for pain control, but the medication (morphine-derived) left her nauseated and confused. The pain remained at a 5–6 on a scale of 0–10. Prior to the aromatherapy session she was lying rigid in bed with her eyes closed, her respirations were shallow, and her skin was very pale. When she was called by name her eyes seemed glazed and her lips stuck to her teeth when she tried to reply. She said that she had been given pain medication about three hours previously but it 'hadn't helped much.' She had been unable to eat because she felt so nauseated. Her oxygen saturation was 94%, her heart rate was 89 beats per minute, and her breathing was shallow (24 breaths per minute).

The nurse asked B.S. if she had any likes or dislikes when it came to aromas. She said she liked flowery smells and disliked the smell of food at the present time. She was open to being touched and said she would prefer her hands and face to be touched rather than her feet and legs. The nurse chose specific essential oils to alter perception of pain (Rosa damascena and Lavandula angustifolia), relieve nausea (Zingiber officinalis), and give comfort and relaxation (Salvia sclarea and Chamomelum nobile). She made a 5% solution of the essential oils in jojoba oil.

The nurse centered herself before making her touch known, so B.S. would know the texture and temperature of her touch. Then the nurse carried out a five minute 'm' technique with 5% solution of Lavandula angustifolia, Zingeber officinalis, Chamomelum nobile, Salvia sclarea, and Rosa damascena (1 drop each essential oil in 5 ccs of grapeseed carrier oil) on each of her hands. She worked slowly and rhythmically keeping her pressure light. She checked with B.S. that the pressure was a 3 (on a scale of 0–10). B.S. nodded but did not say anything. The nurse wrapped each hand in a hand towel at completion. Then the nurse completed an 'm' technique® of B.S.'s face; this took an additional 5 minutes. B.S.'s face began to soften a little toward the end of the technique and her breathing became less shallow. She sighed several times. At the end of the treatment B.S. was nearly asleep. The nurse checked oxygen saturation (97%) and her heart rate

(74 beats per minute). Her respirations were down to 14 breaths a minute.

B.S. slept for two hours and later stated it was the first time she had been without pain since the accident. The nurse continued to return to give the aromatherapy treatment using the 'm' technique® to B.S. each day. Each time B.S. experienced profound pain relief that was unobtainable through medication. Immediately following the 'm' technique, her pain was rated as a 1. This effect lasted for three hours. The relaxing effect of the 'm' technique coupled with the analgesic effect of the essential oils seemed to enable B.S. to relax into her pain and thus achieve relief.

Evaluation

The nurse determined with B.S. if the desired outcomes had been achieved. Both the nurse and B.S. felt that the 15 minutes of 'm' technique® with dilute essential oils had proved effective on all five outcomes:

1. *Chronic pain*. Went from a 5 to a 1.
2. *Anxiety*. Went from a 7 to a 1.
3. *Fear*. Went from a 7 to a 2.
4. *Powerlessness*. Went from a 9 to a 2.
5. *Ineffective coping related chronic pain*. Went from a 7 to a 2.

DIRECTIONS FOR FUTURE RESEARCH

1. Evaluate the outcomes of inhaled essential oils on sinusitis.
2. Evaluate the outcomes of topically applied dilute essential oils on post-radiation burns.
3. Evaluate the outcomes of inhaled aromas on post-operative nausea.
4. Evaluate the effect of inhaled aromas on depression.
5. Evaluate the effect of topically applied dilute essential oils on infected wounds.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin the process of answering the following questions:

- What is important for me to know before I begin using essential oils?
- How do I know whether to apply an essential oil topically or inhale it?
- What is my experience of inhaling the five essential oils in this chapter?
- What is my experience of applying the five essential oils topically to my skin at 5%?
- What do I feel about using aromatherapy for infection?
- What do I feel about using aromatherapy as part of holistic nursing care?

NOTES

1. J. Buckle, *Clinical Aromatherapy: Essential Oils in Practice* (New York: Churchill Livingstone, 2003).
2. J. Buckle, The 'm' Technique®, *Massage & Bodywork* (2000):52–64.
3. J. Buckle, Aromatherapy in Nursing, *Journal of Perianesthesia Nursing* 14, no. 6 (1999):336–344.
4. R. Tisserand, Lavender Beats Benzodiazepines, *International Journal of Aromatherapy* 1, no. 2 (1988):1–2
5. J. Buckle, The Use of Aromatherapy As a Complementary Treatment for Chronic Pain, *Alternative Therapies in Health and Medicine* 5, no. 5 (1999):42–51.
6. A. Macfarlane, Olfaction in the Development of Social Preferences in the Human Neonate, *Parent-Infant Interaction*, Ciba Foundation Symposium 33 (1975):103–107.
7. S.S. Schillmann and J.M. Siebert, New Frontiers in Fragrance Use, *Cosmetics and Toiletries* 106, no. 6 (1991):39–45.
8. W. Klemm et al., Topographical EEG Maps of Human Responses to Odors, *Chemical Senses* 17, no. 3 (1992):347–361.

9. L. Halcon, Aromatherapy: Therapeutic Applications of Plant Essential Oils, *Minnesota Medicine*, November (2002):42–46. Available at: www. MMAonline.net
10. J. Watson, *Nursing: Human Science and Human Care* (New York: National League for Nursing Press, 1988), 54.
11. E. Barrett, The Theoretical Matrix for a Rogerian Nursing Practice, *Theoria: Journal of Nursing Theory* 9, no. 4 (2000):3–7. Copyright 2000 by the Swedish Society for Nursing Theories in Practice, Research, and Education.
12. B. Dossey, *Florence Nightingale* (Springhouse, PA: Springhouse Corporation, 2000).
13. M.E. Erickson, Modeling and Role-Modeling Theory in Nursing Practice, in *Nursing Theory: Utilization and Application*, 2nd ed., eds. M.R. Alligood and A.M. Tomey (St. Louis, MO: Mosby, 2002), 339–366.
14. C. Burr, *The Emperor of Scent* (New York: Random House, 2003).
15. J. Buckle, The Role of Aromatherapy in Nursing Care, *Nursing Clinics of North America* 36, no. 1 (2001):57–72.
16. R. Tisserand and T. Balacs, *Essential Oil Safety* (London: Churchill Livingstone, 1995).
17. Ibid.
18. D. Tiran, *Aromatherapy in Midwifery Practice* (London: Bailliere Tindall, 1996).
19. A. Avis, Aromatherapy in Practice, *Nursing Standard* 13, no. 24 (1999):14–15.
20. J. Henry et al., Lavender for Night Sedation with People with Dementia, *International Journal of Aromatherapy* 6, no. 2 (1994):28–30.
21. R. Hudson, Lavender Oil Aids Relaxation In Older Patients, *Nursing Times* 90, no. 30 (1994):12.
22. M. Hardy, M. Kirk-Smith, and D. Stretch, Replacement of Chronic Drug Treatment For Insomnia In Psychogeriatric Patients v. Ambient Odor, *Lancet* 345 (1995):701.
23. R. Bradsaw et al., Effects of Lavender Straw on Stress and Travel Sickness In Pigs, *Journal of Alternative Complementary Medicine* 4, no. 3 (1998):271–275.
24. L. Wiehbrecht, Insomnia and Lavender, unpublished dissertation, R.J. Buckle Associates, Hunter, NY (2001).
25. P. King, An Insomnia Study Using Origanum majorana and Chamomelum Nobile, unpublished dissertation, R.J. Buckle Associatess, Hunter, NY (2001).
26. A. Woolfson and D. Hewitt, Intensive Aromacare, *International Journal of Aromatherapy* 4, no. 2 (1992):12–14.
27. A. Brownfield, Aromatherapy in Arthritis—A Study, *Nursing Standard* 13, no. 5 (1998):34–37.
28. J. Styles, The Use of Aromatherapy in Hospitalized Children with HIV, *Complementary Therapies in Nursing* 3, no.1 (1997):16–20.
29. M. Caelli, J. Porteous, C. Carson, R. Heller, and T. Riley, Teatree Oil As an Alternative Agent Decolonization for Methicillin-Resistant Staphylococcus Aureus, *Journal of Hospital Infection* 46 (2000):236–237.
30. E. Sherry and P. Warnke, Alternative for MRSA and Tuberculosis (TB): Eucalyptus and Teatree Oils As New Topical Antibacterials, Feb. 13–17, Orthopedic Surgery Conference, Dallas, TX (2002).
31. D. Hartman and J. Coetzee, Two U.S. Practitioners' Experience of Using Essential Oils for Wound Care, *Journal of Wound Care* 11, no. 8 (2002):317–320.
32. Certified Clinical Aromatherapy Practitioner (CCAP), R.J. Buckle-Trained.
33. J. Kerr, The Use of Essential Oils in Healing Wounds, *International Journal of Aromatherapy* 12, no. 4 (2003):202–206.
34. S. Inouye, T. Takizawa, and H. Yamaguchi, Antibacterial Activity of Essential Oils and Their Major Constituents Against Respiratory Tract Pathogens By Gaseous Contact, *Journal of Antimicrobial Chemotherapy* 47 (2001):565– 573.
35. J. Valnet, *The Practice of Aromatherapy* (Rochester, VT: Healing Arts, 1990), 146.
36. R. Hudson, The Value of Lavender for Rest and Activity in the Elderly Patient, *Complementary Therapies in Medicine* 4, (1996):52–57.
37. H. Buchbauer et al., Aromatherapy: Evidence for Sedative Effects of the Essential Oil of Lavender After Inhalation, *Zeitschrift fur Naturforschung Teil* 46, nos. 11–12 (1991):1067– 1072.
38. Tisserand, Lavender Beats Benzodiazepines, 2.
39. R. Nelson, In Vitro Activities of Five Plant Essential Oils Against MRSA and Vancomycin-Resistant Enterococcus Faecium, *Journal of Antimicrobial Chemotherapy* 40 (1997):305–306.
40. Valnet, *The Practice of aromatherapy*, 148.
41. S. Perrucci et al., In Vitro Antifungal Activity of Essential Oils Against Some Isolates of Microsporum Canis and Microsperoum Gypseum, *Planta Medica* 60, no. 2 (1994):184–186.
42. J. Corner, N. Cawley, and S. Hildebrand, An Evaluation of the Use of Essential Oils on the Well-Being of Cancer Patients, *International Journal of Palliative Nursing* 1, no. 2 (1995):67–73.

43. J. Guillemain, A. Rousseau, and P. Delaveau, Neurodepressive Effects of the Essential Oil of Lavandula Angustifolia Mill, *Annales Pharmaceutiques Francais* Fr 47, no. 6 (1989):337– 343.
44. J. Larrondo, M. Agut, and M. Calvo-Torras, Antimicrobial Activity of Essences from Labiates, *Microbios* 82 (1995):171–172.
45. S. Perruci et al., The Activity of Compounds From Lavandula angustifolia Against Psoroptes cuniculi, *Phytotherapy Research* 19, no. 1 (1996):5–8.
46. R. Nelson, In Vitro Activities of Five Plant Essential Oils Against MRSA and Vancomycin-Resistant Enterococcus Faecium, 305–306.
47. M. Maury, *Les Huiles Essentielles Pour Votre Sante* (Roulien, France, 1990).
48. R. Mabey, *The Complete New Herbal* (London, UK: Elm Tree Books, 1988).
49. C. Briggs, Peppermint: Medicinal Herb & Flavoring Agent, *Canadian Pharmacy Journal* 126, no. 2 (1993):89–92.
50. H. Gobel, Effect of Peppermint on Headache, *Cephalagia* 14, (1994):228–234.
51. H. Gobel et al., Essential Plant Oils and Headache Mechanisms, *Phytomedicine* 2, no. 2 (1995):93–102.
52. H.L. Duthie, The Effect of Peppermint Oil on Colonic Motility in Man, *British Journal of Surgery* 68, (1981):820.
53. C.J. Sigmund and E.F. MacNally, The Action of a Carminative on the Lower Oesophageal Sphincter, *Gastroenterology* 56 (1969):13–18.
54. E. Kucera and E. Kerman, Antiviral Substances in Plants of the Mint Family, *Proceeds from the Society of Experimental Biological Medicine* 124 (1967):865, 874.
55. S. Shapiro, A. Meir, and B. Guggenheim, The Antimicrobial Activity of Essential Oils and Essential Oil Components Towards Oral Bacteria, *Oral Microbiology & Immunology* 9 (1994):202–208.
56. S. Price and L. Price, *Aromatherapy for Health Professionals* (London: Churchill Livingstone, 1995), 256.
57. L. Trabace et al., Choleretic Activity of Thapsia Chem I, II and III in Rats: A Comparison with Terpenoid Constituents and Peppermint Oil, *Phytotherapy Research* 8, no. 5 (1994):305–307.
58. I. Taddei, D. Giachetti, E. Taddei, and P. Mantovani, Spasmolytic Activity of Peppermint, Sage and Rosemary Essences and Their Major Constituents, *Fitoterapia* 59, no. 6 (1988):463–468.
59. S. Pattnaik, V.R. Subramanyam, and C. Kole, Antibacterial and Antifungal Activity of Ten Essential Oils In Vitro, *Microbios* 86 (1996):237–246.
60. S. Pattnaik, V.R. Sybramanyam, and C.C. Rath, Effect of Essential Oils on the Viability and Morphology of E. Coli, *Microbios* 84 (1995):195–199.
61. R. Nelson, In Vitro Activities of Five Plant Essential Oils Against MRSA and Vancomycin-Resistant Enterococcus Faecium, *Journal of Antimicrobial Chemotherapy* 40 (1997):305–306.
62. C. Carson and T. Riley, Susceptibility of Propionibacterium Acne to the Essential Oil of Melaleuca Alternifolia, *Letters of Applied Microbiology* 19, no. 1 (1994):24–25.
63. I. Bassett, D. Pannowitz, and R. Barnetson, A Comparative Study of Tea-Tree versus Bensoyl Peroxide in the Treatment of Acne, *Medical Journal of Australia* 153, no. 8 (1990):455– 458.
64. M. Tong, P. Altman, and R. Barnetson, Teatree Oil in the Treatment of Tinea Pedis, *Australasian Journal of Dermatology* 33, no. 30 (1992):145–149.
65. K. Hammer, C. Carson, and T. Riley, Susceptibility of Transient and Commensal Skin Flora to the Essential Oil of Melaleuca Alternifolia, *Australian Journal of Infection Control* 24, no. 3 (1996):186–189.
66. P. Belaiche, Treatment of Vaginal Infections of Candida Albicans With the Essential Oil of Melaleuca Alternifolia, *Phytotherapy* 15 (1985):13–15.
67. E.F. Pena, Melaleuca Alternifolia Oil: Its Use for Trichomonal Vaginitis and Other Vaginal Infections, *Obstetrics and Gynecology* 19, no. 6 (1962):793–795.
68. R. Blackwell, Teatree Oil and Anaerobic Vaginosis, *Lancet* 337, no. 8736 (1991):300.
69. C. Carson et al., Susceptibility of Methicillin-Resistant Staphylococcus Aureus to the Essential Oil of Melaleuca Alternifolia, *Journal of Antimicrobial Chemotherapy* 35, no. 3 (1995):421–424.
70. F. Kufferath and G.M. Mundualgo, The Activity of Some Preparations Containing Essential Oils in Tuberculosis, *Fitoterapia* 25, (1954):483–485.
71. E. Dellacassa et al., Antimicrobial Activity of Eucalyptus Essential Oil, *Fitoterapiea* 60, no. 6 (1989):544–546.
72. M. Hmamouch, A. Tantaoui-Elaraki, N. Es-Safi, and A. Agoumi, Illustration of Antibacterial

and Antifungal Properties of Eucalyptus Essential Oils, *Plantes Medicinales Phytotherapie* 24, no. 4 (1990):278–289.

73. S. Pattnaik, V.R. Subramanyam, and C. Kole, Antibacterial and Antifungal Activity of Ten Essential Oils In Vitro, *Microbios* 86, no. 349 (1996):237–245.
74. A. Benouda, M. Hassar, and B. Benjilali, The Antiseptic Properties of Essential Oils In Vitro, Tested Against Pathogenic Germs Found in Hospitals, *Fitoterapia* 59, no. 2 (1988):115–119.
75. F. Kufferath and G.M. Mundualgo, The Activity of Some Preparations Containing Essential Oils in Tuberculosis, 483–485.
76. D. Abdullah, Q.N. Ping, and G.J. Liu, Enhancing Effect of Essential Oils on the Penetration of 5-fluorouracil Through Rat Skin, *Yaozue Xuebao* 31, no. 3 (1996):214–221.
77. A. Jori, A. Bianchetti, and P.E. Prestini, Effect of Essential Oils on Drug Metabolism, *Biochemical Pharmacology* 18, no. 9 (1969):2081–2085.
78. L.K. Lam and B. Zheng, Effects of Essential Oils on Glutathione S-Transferase Activity in Mice, *Journal of Agricultural & Food Chemistry* 39, (1991):660–662.
79. W. Weyers and R. Brodbeck, Skin Absorption of Volatile Oils, *Pharmacokinetics Pharm* 18, no. 3 (1989):82–86.
80. N. Mascolo et al., Biological Screening of Italian Medicinal Plants for Anti-Inflammatory Activity, *Phytotherapy Research* 1, no. 1 (1987):28–31.
81. C. Viollon and P. Chaumont, Antifungal Properties of Essential Oils and Their Main Components Against Cryptococcus neoformans, *Mycopathologia* 128, no. 3 (1994):151–153.
82. V. De Blasi et al., Amoebacidal Effects of Essential Oils In Vitro, *Journal of Toxicology & Environmental Health* 10, no. 6 (1990):361–373.
83. L.F. McDonald et al., The Effectiveness of Benzyl Benzoate and Some Essential Plant Oils As Laundry Additives for Killing House Dust Mites, *Journal of Allergy & Clinical Immunology* 92, no. 5 (1993):771–772.
84. J.A. Klocke, M.V. Darlington, and M.F. Balandrin, 1,8-cineole (eucalyptol), A Mosquito Feeding and Ovipositional Repellent From Volatile Oil of Hemizonia Fitchii (Asteraceae), *Journal of Chemical Ecology* 13, no. 12 (1987):2131–2141.
85. J.K. Trigg and N. Hill, Laboratory Evaluation of a Eucalyptus-Based Repellent Against Four Biting Arthropods, *Phytotherapy Research* 10, no. 4 (1995):313–316.
86. S.A. Corbet, G.W. Danahar, W. King, C.L. Chalmers, and C.F. Tiley, Surfactant-Enhanced Essential Oils As Mosquito Larvicides, *Entomologia Expermentalis et Applicata* 75 (1995):229–236.
87. G. May and G. Willuhn, Antiviral Activity of Aqueous Extracts From Medicinal Plants in Tissue Cultures, *Arzneim-Forsch* 28, no. 1 (1978):1–7.
88. H. Gobel, G. Schmidt, and D. Soyka, Effect of Peppermint and Eucalyptus Oil Preparations on Neurophysiological and Experimental Algesimetric Headache Parameters, *Cephalalgia* 14 (1994):228–234.
89. T. Sawada, A Novel Granulation Inhibiting Agent From E Globulus, *Chemical Pharmacology Bulletin* 28, no. 8 (1980):2546–2548.
90. M. Duwieja et al., Anti-Inflammatory Activity of Resins From Some Species of the Plant Family Burseraceae, *Planta Medica* 50 (1993):12–16.

Nursing Voices of St. Charles Medical Center

"The nursing profession derives its rare beauty from the impression it leaves on those it touches. You cannot hold this tool or enter this profession without its imprint upon your life."

"It impacts the way I think. Each day I will be faced with the opportunity to learn more and to think more critically. . . .This new way of thinking has and will continue to be integrated into my life . . . not simply when I am on the clock."

"It changes the way I see. It provides me with the priceless opportunity of developing relationships with a variety of people. . . . It is this that will continue to give me a broader view of humanity. This is where the theory turns into reality and you walk into a patient's room and the stereotypes are broken, the fears are dissolved, and you see the person."

"It teaches me the power of love. Often I am asked how I do the gross smelly part of nursing. How the vomit and diarrhea doesn't revolt me. No, it isn't that I love those things. It is that I want to love people . . . much of the disgust for such things vanish when you see how distressed the person's suffering is."

Andrea Hedges
Student Nurse

"In my 30 years of hospital nursing—from critical care to women's health—I was always pulled back to the experiences I had with dying patients and their loved ones."

"Although sophisticated medical interventions can bring human beings back from the edge of death, they often do not support patients' values and/or expectations for quality of life, and this was extremely disconcerting to me. I could see that the 'naturalness of dying' had been obscured. Often the fear of death was greater than the fear of suffering. To help our patients and their loved ones find meaning during this phase of life and to make better care of the dying a routine part of our hospital's commitment became my personal mission."

"To empower the patients and families to tell their stories and say those final good-byes continues to teach me to embrace love as the meaning of life. This work helps me look inward to face my own mortality and the nuances of this final stage of growth. It has been the ultimate gift and grace of my nursing career."

Terrie Oberst, RN
Comfort Care Case Manager

"I love nursing because it gives me an opportunity to interact with patients in a sacred space where position, title, and economic status don't matter. Through injury or illness, a level playing field is created where we meet with our one commonality: our humanity. Nursing gives me the tools of science and caring to support my patients in expanding into the experience of healing and finding meaning in their healing process."

Rosemary Johnson, RN
Surgery Center Nurse

"Embracing the philosophy of healing health care enables me to honor the sacredness and nobility of providing care and service to my community—inclusive of caregivers, peers, patients, and families. The satisfaction derived from this renews and revitalizes my dedication to the nursing profession and my personal growth. Health care is truly a human service and as such holds a responsibility to establish an environment and to build relationships that meet the needs of the whole person—body, mind, and spirit. Healing health care is the articulation of the principles necessary to meet these needs, making it tangible, and a goal to which we aspire to."

Pam Steinke, RN
Patient Care Vice President

"Humor is a universal medicine for the spirit. I believe humor helps us to keep things in perspective, remember the wonders of life, and also increases our capacity to deal with whatever we are facing. Most of the people I know, whether caregiver or patient, are starving for something to smile about. Health care is serious business . . . but delight can be found if you remember to look for it."

Karen McGuire, RN
Team Leader

HOLISTIC INSIGHTS

Teddy Richardson, RN, HNC

As caregivers, our personal presence with patients is as important as our technical skill. To be present implies a quality and essence of being in the moment. It requires focus, active listening, healing intention, and understanding.

Intentional breathing is a powerful tool to achieve focus and therapeutic presence. Breathe deeply, in and out, using your diaphragm. As you breathe, your abdomen should rise and fall, not your shoulders.

When we look into our patients' eyes, touch their hands, hear what they have to say, and see their distress or ease, we demonstrate a physical presence.

When we are caring, empathetic, nonjudgmental, accepting, actively listening, counseling, communicating, and attending to our patients, we are demonstrating psychological presence.

When we are centered, in the moment, open, intuitive, and loving with a positive caring intention, this demonstrates therapeutic presence.

The intention of holistic-based nursing is to recognize, honor, and incorporate these principles for the benefit of both caregiver and client.[1]

Teddy Richardson, RN, writes monthly articles, Holistic Insights, *in the hospital newsletter* Center Page, *where she references materials from* Holistic Nursing: A Handbook for Practice, *3rd edition.*

GRANTING A COWBOY'S LAST WISH

Susan Long, RN

Beneath his rough exterior, Martin was a big softie; newly fragile and afraid of losing control over his body as leukemia, and treatments to fight it, took their toll.

Just days after his respiratory isolation, Martin's oxygen needs increased, his fever increased, and his blood counts dropped. While Martin could still be part of the decision, a Do Not Resuscitate Order was prepared.

Martin couldn't rest. He was anxious, in pain, and unable to eat. Music, massage, his favorite foods, and medication changes had no impact. He sat, day and night, in a recliner chair. As a nurse, I felt helpless. We all did. He was slipping away.

Martin's once large frame was frail. Standing was impossible, even with his two sons supporting him. Martin's wife, Lori, called their family to come. I prayed that night for Martin, and for peace for him and his family.

When I returned to work Sunday morning, Martin was ashen, anxious, and adamant he was going home. We couldn't relieve his pain and anxiety. I felt he was dying. We made

every effort to comply with Martin's request to go home. At each turn, though, options to transport him home to die closed.

Could he go outside? I wondered. Martin had lived much of his life outdoors. Maybe he could find peace beyond our walls.

I heard that the Critical Care Unit nurses took one of their patients outside to die. If we could get Martin outside, maybe he would be less anxious. His family wouldn't have to be masked. . . . It was warm. . . Perhaps we could use Lynn's Garden. . .*

I asked Lori. She brightened. Martin wanted to go. . . outside. His sons wanted it, too.

A whole team of us went to work to make it happen. Lynn's Garden would work. It was close to the chapel. We could ensure privacy by posting signs and pulling the curtains in the patient rooms overlooking the garden. The day was expected to be warm and shade was available.

We got food coupons for the family from the cafeteria. Pastoral Care would stay with the family as long as they wished. Respiratory Therapy would check on Martin periodically. We gave the family a phone from the department with a list of numbers in case they needed any of us. The family and we agreed that if Martin died in Lynn's Garden, it was OK. If they wanted to bring him back to his room, it was OK.

*My last memory of Martin is of he and his wife, head-to-head, in Lynn's Garden. Martin was reclining in the cardiac chair, restful. He wasn't aware of me. He looked at peace. That was 3:30 p.m. That evening a full moon rose, and I believe with it Martin's spirit soared to heaven. He was finally at peace, with family's love around him.***

*See Lynn's Garden, Figure 32–6, p. 870.

**The names in this story were changed to protect the family's privacy.

NOTES

1. T. Richardson, Holistic Insights, *Center Page* (July, 1999):4.
2. S. Long, Granting A Cowboy's Last Wish, *Center Page* (March, 1999):3.

Chapter 32

Relationship-Centered Care and Healing Initiative in a Community Hospital

Nancy Moore

NURSE HEALER OBJECTIVES

Theoretical

- Describe the Healing Health Care Philosophy.
- Identify nursing theorists that support the Healing Health Care Philosophy.
- Describe key elements of a healing environment and their application in a tertiary medical center.

Clinical

- Describe key elements of therapeutic presence.
- Identify noninvasive methods for anxiety and pain management.
- Identify nursing interventions in providing care to patients and their families in the dying process.
- Describe how arts in the hospital can help the healing process.
- Identify research studies that support the Healing Health Care Philosophy.

Personal

- Discuss how nurses (themselves) are instruments of healing.
- Explore the ethical responsibility for self-care.
- Explore the importance of caring relationships at all levels (provider-to-patient, provider-to-provider, provider-to-community).

DEFINITIONS

Healing Health Care: an applied philosophy that facilitates and promotes healing of the "whole person"—body, mind, and spirit. It responds to and serves the unique needs of individuals, groups, organizations, communities, and cultures. A healing health care project demonstrates the ethic of healing health care: healing ourselves, our relationships, and our communities.

The Association of Healing Health Care Projects: The mission of the Association of Healing Health Care Projects is to both inspire and support health care models that exemplify human caring and healing.

THEORY AND RESEARCH

The Healing Health Care Philosophy guides all of the activities of St. Charles Medical Center (SCMC). This philosophy was developed in the early 1990s to serve as a guide to enhance the hospital's healing mission during the chaos of a rapidly changing health care environment. It is based on the belief that the essence of healing is in our relationships, and that everything in the environment has an

effect on recovery and well-being, either enhancing or impairing the healing process. This philosophy incorporates the ethic of the national Association of Healing Health Care Projects—healing ourselves, our relationships, and our communities—and is rooted in the healing service of the founders of SCMC, the Sisters of St. Joseph of Tipton, Indiana. The Healing Health Care Philosophy is an applied philosophy that is supported and enriched by the following nursing theorists:[1]

- Jean Watson—Transpersonal Caring Nursing Science
- Martha Rogers—Science of Unitary Human Beings
- Margaret Newman—Model of Health as Expansion of Consciousness

The following are examples of research studies that support the Healing Health Care Philosophy.

Knaus, Draper, Wagner, and Zimmerman of George Washington University Medical Center (1986) research indicates that patients' lives may depend on the quality of the teamwork of care providers.[2] They studied the treatment and outcomes of 5,030 intensive care unit (ICU) patients from 13 hospitals using diagnosis, indication for treatment, and APACHE 11 scores. The APACHE 11 score predicts the chances of a patient's survival. In units with the "best" outcomes, 55% more patients lived than were predicted. In units with the "worst" outcomes, 58% more patients died than were predicted. After careful study of these findings, the researchers concluded that the significant difference between the "best" and "worst" units was related more to the interaction and coordination of the care providers than to the amount of specialized treatment, administrative structure, or teaching status of the hospital.

Lynch (1979) provides a review of studies supporting the effects of human interaction on health.[3] One study demonstrated that the simple act of holding a patient's hand can suppress heart irregularities.

Beecher (1955) analyzed data from fifteen studies involving 1,082 patients with conditions as varied as headache, anxiety, severe postoperative pain, and the common cold.[4] He found placebos had a significant effect in treating 35% of these conditions.

Heidt (1979) investigated the use of Therapeutic Touch to treat anxiety in 90 cardiovascular patients.[5] She found a significant decrease in anxiety in the group receiving Therapeutic Touch as compared with control groups receiving casual touch or no touch.

Ulrich (1991) compared two groups of postsurgical patients over a six-year period. One group had windows that faced a brick-walled courtyard; the other had a view of a park filled with trees, plants, and people.[6] Comparing the rate of recovery of these two groups showed that the patients with a view of plants and the outdoors had shorter stays and took fewer painkillers than did the other group.

Cross (1990) found that patients exposed to serene pictures, such as pastoral scenes, had lower blood pressures than those who had no pictures.[7]

Campbell of the Institute for Music, Health, and Education in Boulder, Colorado finds that having patients listen to slow classical music through headphones for 30 minutes before an operation can reduce the amount of anesthesia needed by as much as 30%.[8]

ABOUT ST. CHARLES

Why and How a Healing Philosophy Became Integrated Into the Hospital's Strategic Initiatives

St. Charles Medical Center (SCMC) in Bend is a 225-bed tertiary medical center serving central and eastern Oregon. It is

the only tertiary medical center within its 31,000-square-mile service area. It offers a broad scope of services, from open-heart surgery to rehabilitation, and averages a 3.5-day length of stay. It is a level 2 trauma center and has a level 3 neonatal intensive care unit (NICU). St. Charles recently formed Cascade Healthcare Community (CHC) which now includes, in addition to St. Charles Medical Center in Bend, St. Charles Medical Center in Redmond, two managed hospitals, and a number of physician partnerships. St. Charles is consistently cited as one of Oregon's 100 best places to work.[9] In 2000, St. Charles Medical Center was honored with the Norman Cousin's Award for relationship-centered care. The selection committee described St. Charles as "the best hospital in the country with regard to the sacredness of care."[10] In addition, Solucient, a leading source of health care intelligence, listed St. Charles as one of the nation's top 100 hospitals in areas of quality of care, financial performance, operational efficiency, and adaptation to the environment.[11] St. Charles also has been honored with the prestigious Oregon Quality Award, serving as an example of service and quality for all Oregon industries.

In 1990, St. Charles, like many hospitals, was in the process of restructuring services in an effort to prepare for a rapidly changing health care environment. The Healing Health Care Philosophy was developed to guide the hospital in intentionally preserving and enhancing its mission during the chaotic change. At first there were many people that felt the application of this philosophy was unnecessary fluff, but over time the reaction from both patients and staff affirmed its value. The CEO, Jim Lussier, realized that applying the philosophy was not only the *right* thing to do, as it enhanced the hospital's mission—"*to improve the health of those we serve in a spirit of love and compassion*"—but it was also the *smart* thing to do. It was the smart thing to do in that people choose SCMC due to the healing nature of its service. The Philosophy also helps recruitment and retention, as caregivers prefer to work in an environment that supports healing. When the environment is healing for patients, it is also healing for the people providing the care. The differentiation of service and care through the Healing Health Care Philosophy is now one of the hospital's key strategic initiatives. As a strategic initiative the Philosophy includes an operational plan, and although it continues to require a designated leader, its implementation—making it a reality—is everyone's responsibility. The main applications of the Philosophy are healing ourselves and our relationships, patient-focused and family-focused care, life skills, life–death transition, arts in the hospital, healing our community, and a principle-based care model.

Healing Ourselves and Our Relationships

Early in the Healing Health Care Philosophy implementation we believed that we needed to create something tangible, so that people could understand the philosophy. I recall a pivotal moment that dramatically informed our understanding of healing. I was working with the design task force, leading them toward a decision to create a wellness program. I recall a nurse holding up her hand and saying, "What about us?" In my wisdom at the time, I said, "Oh, we will get to us, but first we have to take care of the patients." Given all the turmoil and emotions of a major restructuring effort, it became clear that it would not matter what we did for the patients if the caregivers themselves were not cared for in the process. We could create a state-of-the art wellness center, change how we were organized to bring all of the disciplines involved in a patient's care to the bedside, but if the

caregivers were not themselves healed in the process it would be an empty shell. No one would want what we created.

It eventually became crystal clear that the essence of healing is in our relationships. We were, and are, a human service; who we are and how we work together is what our patients and their families receive. We use technology, but by and large it is an extension of ourselves. We also recognized at that time that many of us did not learn from our family of origin, or during our formal education, the skills and attitudes necessary for healthy relationships.[12] As a result, we developed personal growth and development workshops, *People-Centered Teams: Healing Our Workplace I*. These two-day workshops provide an opportunity for participants to reflect on what is most important to them, and identify belief systems and behaviors that can support them in getting more of what they want. Participants learn to create healthier relationships through improved personal awareness, listening, and differentiated communication. They explore how broadening their personal "comfort zone" can increase individual flexibility and internal resourcefulness. Participants also discover ways to more fully contribute their unique talents, skills, and experience to the work they do and the people they serve. Other topics include understanding the normal reaction to major change and how to support themselves and others during this type of transition, and learning how the victim triangle undermines personal and organizational growth and how to dismantle it. Participants also explore how their attitudes, assumptions, and intentions determine the outcomes they obtain, and they develop a personal vision statement to guide them into the future. These seminars are one of the most successful efforts the hospital has ever undertaken. Participants report that the skills help them not only in their practice and work, but also in their personal lives. All employees now attend the workshops as part of orientation, and the workshops are open to the community, as well as employees that wish to retake them. Healing Health Care coaches are available to assist staff with the integration of the newly learned skills, and all teams set expectations and use the skills they've acquired by developing written team agreements that are integral to each team's functioning.

In recognition of the increasingly stressful work environment, we also have added a second workshop, *Resiliency and Renewal*, in collaboration with Adaptive Learning Systems. This workshop is based on the work of Martin Seligman, PhD. Seligman and other researchers from the University of Pennsylvania have spent the last 30 years studying why some people succeed—no matter how formidable the roadblocks they encounter.[13] The researchers learned that it's the *way* these people react to and deal with adversity that lets them move beyond it to success. We cannot control all the adversity we face, but we can learn to control and change thoughts and emotions about adversity and setbacks. In this workshop, participants learn concepts and skills to help combat emotional fatigue and burnout, as well as how to become more optimistic.

Other resources to support healing ourselves and our relationships include a Caregiver Assistance Program (CAP) and critical incident stress debriefings. CAP offers on-site confidential counseling that is available to caregivers and their family members, as well as assessment and referral to appropriate resources. The critical incident stress debriefings are available through social services for teams or individuals experiencing unusual amounts of stress, such as caring for many critical patients for a prolonged period of time or helping in a severe accident.

Throughout all of our programs, we weave in the concept of excellence in clinical care. We emphasize that excellence is not about perfection; it is about ongoing learning, and changing based on that learning.

Patient-Focused and Family-Focused Care

Research indicates that the most effective way to promote healing is for patients to become actively involved in their care. It has been demonstrated that providing patients with information about what to expect after their surgery, and how they can participate in their recovery, results in reduced length of hospital stays and decreases the need for narcotics.[14] Patient-focused and family-focused care actively involves patients and family members or significant others as the patient desires in the care process and provides services based on their needs.

During a recent professional nursing practice enhancement initiative, we identified that one of the major sources of nurse burnout is that nurses often work on their assumptions of what the patient needs. This can lead to dissatisfied patients as well as burned-out nurses. Most nurses are conditioned to try to meet all of the needs they can identify for the patient whether the patient identifies them as needs or not. When nurses were students, they learned that if they missed a patient's need in developing the care plan it often meant a lower grade. Nurses transfer this learning to the work setting. Everyday nurses go home feeling frustrated and angry because they couldn't meet all of the needs they identified for their patients. There always is more work to do than time to do it. Prioritizing care based on the patent's needs as identified by the patient is one of the most important nursing skills. We now are using, as a consistent service standard, Sharon K. Dingman's *The Caring Model*™ to address this need. The Caring Model™ consists of five behaviors that are part of an organization-wide or nursing department change initiative.[15] Exhibit 32–1 lists The Caring Model™ behaviors.

Nurses themselves are the most important therapeutic intervention. We are people caring for people. We use technology, but it usually is as an extension of ourselves. During orientation, I ask new caregivers to reflect on their own experiences as a patient, and to identify what helped and what impaired the healing process. Nearly always the most commonly mentioned factor is the attitude and communication of the nurses. Where healing was enhanced, the nurse's attitude was described as caring, procedures were explained in advance, and education was integrated into care. This realization, and the need for enhanced anxiety and pain management, led to the development of *Pain/Anxiety Management: Integrating Healing Health Care Principles Core*

Exhibit 32–1 The Caring Model™

The Caring Model™

1. Introduce yourself to patients and explain your role in their care/service today.
2. Call the patient by his/her preferred name.
3. *Direct caregivers*, sit at the bedside for at least five minutes each shift to plan and review the patient's care and outcomes.

   Nondirect caregivers, sit if possible, to discuss procedures, processes, and services involved in attaining desired outcomes.
4. Use touch, handshake, or touch on the arm.
5. Use the mission, vision, and values statements in planning patient care.

The Caring Model™ is a registered trademark and service mark of Sharon K. Dingman used under license.

Source: Sharon K. Dingman, consultant with Creative HealthCare Management. Used by permission of Sharon K. Dingman.

Competencies.[16–29] Key among these core competencies is therapeutic presence which is outlined in Exhibit 32–2.

Additional pain/anxiety management competencies include several modalities that can be offered and taught to patients. The intention is to assist patients in accessing their own natural healing abilities. Exhibit 32–2 describes the performance criteria and validation methods for these competencies.

Patient-focused and family-focused care also requires attention in design. Healing design is design with intent to give as much control to the patient as possible (temperature, lighting, etc.) and creating a home-like environment with access to natural light and views of nature.[30] Prior to implementing the Healing Health Care Philosophy, one of the most common patient complaints was concerning the quality of the food. Deneen Porter, leader

Exhibit 32–2 Therapeutic Presence Core Competency

Therapeutic Presence Core Competency

The concept of therapeutic presence is based on the premise that how we are with others is as important as what we do for them. It is defined as the conscious intention to be present for another in a helping or healing way. Therapeutic presence is more an *intention* than it is a *technique*. Awareness of how we move into a person's personal space, the tone of our voice, and the way we make contact with our touch enhances therapeutic presence. The following are key elements in enhancing therapeutic presence.

You only get one first impression. The initial contact is critical in creating an atmosphere of trust.

Inform but don't overwhelm. Introduce yourself and your role. Explain your intentions, procedures, and medications. Be clear about your expectations. Provide information in the person's own terminology.

Be congruent. Make sure your verbal language matches your body language (body posture, level and angle of eye contact, tone of voice). Remember that your nonverbal language is speaking about 80% louder than your verbal language.

Make eye contact. Eye contact can convey acknowledgement, attentiveness, and concern. Also, be aware of the uniqueness in how people interpret eye contact based on cultural values.

Use attending actions. Attending actions such as, "uh-huh," "um," nodding, and smiling can demonstrate interest and encourage the person to express their needs.

Avoid listening blocks. Improve your listening skills by developing a commitment to listening quietly, suspending judgements, avoiding distractions, and allowing the person to finish before thinking of solutions or responding.

Set the environmental stage. *Stop, look,* and *feel* what is in the person's environment. Use the TV sparingly. Keep rooms organized and free of clutter, and control the number of visitors and the length of visits based on the desire of the person. Adjust the blinds to allow natural, nonglaring light. Monitor room temperature. Learn to use a variety of positioning methods. Help the person up and out of bed more frequently, but for shorter duration. Make sure their physical environment encourages their active participation and sense of control. For example, make sure they can reach their personal belongings and call light.

Use caring touch. Begin or end physical tasks or procedures with a mindful, caring touch. Offer massage of hands, feet, or back. A five-minute massage can increase blood flow to an area of the body by 60%, and the effects last up to three hours.

Be a role model. Help others by modeling correct breathing, quiet tone of voice, listening skills, nonthreatening body language, and rational problem solving. It will benefit the person as well as yourself.

Exhibit 32–3 RN/LPN Nursing Care Delivery Skills—Pain/Anxiety Management

RN/LPN Nursing Care Delivery Skills—Pain/Anxiety Management

Orientation Competence Assessment and Skills List

Performance Criteria	*Validation Method*
Demonstrates knowledge of physiology of pain and assessment of pain/anxiety interventions	Demonstration or role play; written quiz
Assesses patient for pain, anxiety, discomfort	Demonstration or role play
Demonstrates creation of therapeutic presence and therapeutic healing environment: • Introduces self to patient/family • Asks patient/family how they wish to be addressed	Demonstration or role play; written quiz
Demonstrates application of: • Intentional breathing • Progressive muscle relaxation • Imagining a pleasant place	Demonstration or role play
Administers appropriate pain medications as prescribed	Demonstration or written quiz
Describes options for potentiation of pain medication	Written quiz
Demonstrates use of comfort measures: • Back rub • Ice • Positioning • Music • Relaxation tapes • C.A.R.E. channel	Demonstration or discussion
Access pain/anxiety management resources: • Therapeutic Touch • Healing Touch • Psychology • Physiatrist • Social service • Pastoral care • Physical therapy • Occupational therapy	Demonstration, role play, or discussion; written quiz
Evaluates effectiveness of pain/anxiety interventions and revises plan as necessary	Demonstration, role play, or discussion; written quiz

manager for clinical support including food services, researched best practice both inside and outside of the health care industry including such sites as the Ritz Carlton. She applied her learning by hiring a chef and implementing room service twenty-four hours a day, seven days a week. Patients now select what they want to eat and when they want to eat from a bedside menu. Special diets are noted through a computerized system and patients are helped with their choices if they choose an excluded item. The meals are delivered within 15 minutes. We are now the national benchmark for patient satisfaction with the quality of food services.[31]

Also, to better support the patient's control of his or her environment, we remodeled our semiprivate rooms into private rooms in the areas where patients experience longer lengths of hospital stay, including sleeper sofas, a microwave, and a refrigerator. This allows family members to stay with their loved one, offering support, as well as learning about the care that will need to continue when their loved one returns home. When we needed to build a new critical care unit we included floor-length windows in every room, an atrium with trees and plants in the center of the unit, and skylights in the halls. Nurses report that the access to light and the natural diurnal cycle of the day has decreased patients' confusion and ICU psychosis. Our current facilities expansion, which will add 45 new rooms at the Bend site and totally renovate the Redmond site, will have larger, acuity-adaptable patient rooms, including zones for the nurse, patient, and family.

We also provide resources to support patients and families in becoming informed and active participants in their care. These resources include printed materials as well as VCRs in each room for viewing entertainment and educational videos (see Figure 32–1). Family and patient visiting rooms on each unit offer an audiovisual library and computers that provide computer-based information on medications and diseases as well as access to the Internet.

Figure 32–1 Nurse and family in patient's room. *Source:* Copyright © 2003, St. Charles Medical Center.

LIFE SKILLS

In 2002, what started as a simple handout for patients advising them of health risks and what they can do about them became the Center for Health and Learning (CHL, or Center). The CHL, funded primarily from community and caregiver donations, is now at the front door of St. Charles Medical Center. As noted in an editorial from the local newspaper, *The Bulletin*, "The new space . . . surely accomplished all that they had hoped it would, and in a beautiful fashion to boot. The commitment to education and prevention is visible. . . . The subtle message: Stop here, learn to take care of yourself properly and, one hopes, spare yourself a stay upstairs someday. . . . A hospital all too often is a terrifying place, both for patients and those who come to call on them. The small touches—the fountain, the color scheme, and the like—help take some of that anxiety away. They're worth the price."[32] The Center's services include support groups; a health resource center with a library,

books, and health-related items for purchase; computers and audiovisual learning methods; educational programs; massage therapy; health coaching; personal growth and development workshops; and lifestyle-change programs.

The Center's signature lifestyle-change programs (*New Directions,* a ten-week behavior change program; *Health Coach Services;* and a one-day *Life Choice Seminar*) incorporate a body-mind-spirit approach to making and sustaining lifestyle and behavior changes in support of optimal wellness. These programs are based on research defining the components necessary to support successful lifestyle change:[33,34]

- education
- nutrition
- mind/body medicine (stress management/relaxation response)
- exercise/body work
- psychosocial support
- spirituality/purpose

New Directions Program

New Directions is a ten-week program designed to assist patients with symptoms of chronic disease and stress. Using an integrated model of cognitive behavior change, and standard medical care, this body-mind-spirit program is now in its sixth year of supporting people in making life changes and experiencing greater health. Participants consistently report improvement in health outcomes and well-being. These outcomes are determined by health risk appraisal comparisons pre- and post-program, plus annually for four years. We have acquired insurance support by some, but not all, companies. Upon completion of a targeted pilot program with covered participants, an Oregon-based insurance company recently found that members who participated in this program had a decrease in health care utilization of up to 56% one year after completing the program.

Health Coach Services

Health Coach Services provide one-on-one support to individuals by a Health Coach Nurse in all aspects of their health care: reducing risk factors for heart disease, diabetes, and cancer; managing stress; preparing for surgery; and overall lifestyle changes. The Health Coach Nurses assist people in overcoming barriers to physical, emotional, and spiritual health through better managing stress and creating more balance in their lives. Each participant creates a health action plan. Health coach sessions also are used as an adjunct to primary prevention screening for heart disease by Electron Beam Tomography (EBT) studies. Patients who receive EBT reports indicating risk of heart disease are offered health coach services to assist them in developing a health action plan. The Health Coach Service receives a greater than 50% response to satisfaction and evaluation surveys. Clients report 98% overall satisfaction (see Exhibit 32–4). Most importantly, participants consistently report successful lifestyle changes.

In its efforts to improve the health of the community through multiple venues, the hospital also offers the *Taking Charge of Your Health TV Show* and online answers

Exhibit 32–4 Health Coach Survey Results

Component	*Percent of Reported Improvement*
Nutrition	72%
Exercise	72%
Stress management	40%
Reduction in medication use	22%
Spirituality	9%

to questions regarding health and self-care through CareWise®, which is accessed through the SCMC website, www.scmc.org (see Figure 32–2).

LIFE-DEATH TRANSITION

We live in a death denying society. How do we allow ourselves to come into the inevitable unknown with openheartedness and courage? How do we support others in their grieving time, to allow the full and personal expression of their aliveness: their denial, their anger, their sadness, their joy, and final acceptance? St. Charles is committed to the continual development of the skills and presence necessary to assist dying patients and their families. Oregon passed the nation's first physician-assisted suicide legislation. The SCMC Board of Directors viewed this act by the people of Oregon as a message that health care, in general, has failed in supporting people through the dying process. As a result, the Board directed the hospital staff to improve end-of-life care. Peggy Carey, RN, Cancer Services Leader Manager, took on the challenge with gusto. She formed a task force and performed a community assessment. The survey found that people want sovereignty over self, including control over decisions at end-of-life and choice in how and where they die. They also feared becoming a burden, and did not want to die in pain. They wanted care that supports their comfort. The task force evolved into two tracks: hospital-based, through St. Charles Comfort Care Services, and community-based, through the Deschutes County Coalition for Quality End-of-Life Care.

Figure 32–2 Center for Health and Learning caregiver assisting a child in accessing the CareWise® health resource program. *Source:* Copyright © 2003, St. Charles Medical Center.

St. Charles Comfort Care Services

The St. Charles Comfort Care Services goals are as follows:

- Raise the standard of care for dying inpatients.
- Create a palliative care team.
- Create a comfort care consult service.
- Create comfort care rooms as sacred space.
- Bring hospice/palliative care principles to dying inpatients.
- Promote positive transitions: ICU to patient unit and inpatient to home with hospice.
- Promote bereavement.
- Increase comfort level of all staff in dealing with death and dying.

Terrie Oberst, RN, Comfort Care Case Manager, was supported by the hospital in becoming a thanatology nurse specialist. Terrie works with a multidisciplinary team including a medical director, physicians, pharmacist, pastoral care, social services, nursing, volunteer musicians, and others as needed. Services are accessed through a physician's order, although the case manager is available to all staff to assist with determining if the consult service is appropriate. The team developed an education plan, policies and procedures, and

preprinted orders, and consistently works to support physicians and caregivers in caring for their patients in the dying process. Exhibit 32–5 shows the Comfort Care Patient Checklist.

Due to the commitment of the staff involved in the program and the exceptional quality of their services, the service grew quickly and is a great success. The service helped reduce costs, as physicians became more conscious of when heroic treatments are futile and that there are effective measures that can help patients in the dying process. The preprinted orders emphasize comfort measures and eliminate unnecessary testing and treatments. As a result, the average daily charges decreased by 67%. Most importantly, surveys showed improved satisfaction for families, nurses, and physicians. (See Figures 32–3 and 32–4.)

Exhibit 32–5 Comfort Care Patient Checklist

Comfort Care Patient Checklist

1. Order for Comfort Care written.
2. Comfort Care pre-printed orders filled out.
3. Physician's Order for Life Sustaining Treatment (POLST) completed in chart.
4. Case manager or relief notified.
5. Diet in Order Communications "NPO" message—Comfort Care patient will order as needed. For patient eating, order appropriate diet.
6. Review with patient and family the cafeteria hours. Encourage use of microwave and refrigerator.
7. Give information about chapel and prayer times. Page Pastoral Care when needed for patient or family. Note on worksheet which Chaplain has seen patient.
8. Take vital signs every shift *when patient awake*; may be just respiration rate and heart rate if BP too uncomfortable for patient. Do not call physician with reading. This is so we have an awareness of a downward trend.
9. Make sure adequate charting is done about interactions you have with the patient and family regarding emotional state, how they are feeling about the pending death, if there are family issues that need to be healed.
10. Encourage use of music and, if appropriate, Therapeutic Touch, relaxation therapies, aromatherapy, etc.
11. Are there phone calls or letters that the patient wants to make saying good-bye to anyone that can't be there?

Source: Terrie Oberst, RN, Comfort Care Case Manager. Used by permission of Terrie Oberst.

The Deschutes County Coalition for Quality End-of-Life Care

The second track for improving end-of-life care, the Deschutes County Coalition for Quality End-of-Life Care, focuses beyond the walls of the hospital to the community and all of the various settings where people die. This coalition includes a broad scope of stakeholders, including:

- the American Association for Retired Persons (AARP)
- physician clinics
- area hospitals
- home health agencies
- assisted living centers
- the Sacred Art of Living Center
- the Central Oregon Health Council
- hospices
- funeral homes
- long-term care providers
- the Retired Seniors Volunteer Program
- citizens

The coalition members' mission is to strengthen the community's capacity to care for persons at the end-of-life and to support healthy grieving. Their goals are as follows:

- Articulate and represent the community's vision on end-of-life care issues.
- Routinely assess community needs based on local values and current issues.
- Develop a coordinated system for citizens in need of end-of-life services.

Satisfaction of Improved End-of-Life Surveys

Percent of returned surveys with a rating of 4–5 "Good"

Families

Management of pain: 90%

Management of shortness of breath: 64%

Management of anxiety: 60%

Amount of time physicians spent with family members: 73%

Physician concern for questions/worries: 69%

Degree to which staff addressed your emotional/spiritual concerns: 87%

Nurses & Physicians

Has Comfort Care Services at SCMC helped make your bedside or clinical care easier? RN-88%/MD-100%

Has Comfort Care Services at SCMC improved end-of-life care for your hospital patients and their families? RN-88%/MD-100%

Has Comfort Care Services at SCMC helped you have discussions (conversations) about withdrawing aggressive medical interventions and supporting the dying process with your patients and their family members? RN-53%/MD-67%

Figure 32–3 Comfort Care Satisfaction Survey, 1999. *Source:* Terrie Oberst, RN, Comfort Care Case Manager. Used by permission of Terrie Oberst.

Figure 32–4 Patient and Comfort Care Team (Nurses, Physician, Pastoral Care, Social Service, and Harpist). *Source:* Copyright © 2003, St. Charles Medical Center.

- Recruit necessary resources.
- Report to the community.

The coalition started by doing a community assessment, then set priorities for its work. These priorities include care based on citizen values, providing appropriate pain and symptom management (treating pain as the fifth vital sign), as well as developing community protocols and measurement tools for monitoring care. Members also focus on promoting advanced-care planning, improving reimbursement of care, and emphasizing the important role of bereavement services. The coalition leverages its work through its liaison with community, state, and national agencies.

Healing Has Many Dimensions

My mentor, Leland R. Kaiser, PhD, once told me, "Nancy, a hospital is a sacred place. The hospital is where people most often come into life and it is also the place where they leave life. People are in the hospital during their most significant life experiences." As I heard these words, I experienced a wonderful sense of awe. The reality of the hospital as a sacred place and space made a significant

impact on how I view my work and its setting. Martha Rogers' concept that healing is pandimensional (has many dimensions) certainly supports this view.[35]

A major principle of our Healing Health Care Philosophy is that everything a person experiences can be used to enhance healing and the recovery process. This principle guides all of our architecture and design. Unfortunately, since the 1900s most hospitals have been designed as functional and efficient medical workshops rather than centers for integrating the power of the body, mind, and spirit to accelerate the healing process. Research has shown that design that ignores people's psychological and spiritual needs contributes to anxiety and stress.[36] Conversely, a warm, nurturing environment with access to natural light enhances recovery and healing, leading to a shorter length of stay in the hospital and a decrease in the need for pain medication.[37] It is important to integrate the need for functionality and efficiency with the need for a warm and nurturing environment. The impact of environment is significant for patients and their families as well as caregivers.

Nurse-architect Kerrie Cardon, RN, who is working with St. Charles Medical Center on its facility expansion, expressed the important role of healing intention in architecture during an interview for *NurseWeek* magazine. "Creating a total healing environment is a long-term design goal of many facilities, including St. Charles Medical Center in central Oregon, where patients can relax by a cozy lava fireplace, enjoy a piano concert in the lobby, and even fish for bass in a well-stocked pool. The emphasis isn't only on patient comfort; it's also on creating a warm, efficient environment for nurses that reduces stress and replenishes their spirit, according to Kerrie Cardon, RN (nurse-architect). . . . With every project, I envision myself in the spaces I'm designing, and really draw on my nursing experience to assure the needs of nurses are met."[38]

The SCMC facility was designed in the mid-1970s. The design supports nurses in being with their patients through a decentralized nursing concept, including nurse servers containing all of the needed supplies at each patient room, and a central communications system that literally did away with a central nursing station. All patient rooms have panoramic views of the high desert and the Cascade Mountain range, and careful attention was paid to detail to assure healing in the use of colors and design.

Each time there is an opportunity for expansion and remodeling, we have applied this principle to enhance the healing environment. For example, when we needed to expand our critical care unit we added full-length windows in each room, skylights in the halls, and included an atrium with trees in the center of the unit to allow for natural light and views of nature. The nurses report after moving into the new unit that patients experienced less confusion, as they now had access to natural light and the diurnal cycle.

When we needed to remodel the lobby we added large windows and a natural wood staircase. We also enhanced the chapel as a result of focus groups with people of all religions and belief systems. The chapel is circular with stained-glass windows, a variety of religious symbols, and includes elements of earth, water, fire, and air. (See Figure 32–5.)

Intentional architecture and design can act as symbolic representations of significant importance and meaning.[39] When a local physician died, the nurses and physicians wanted to contribute to a memorial. This memorial became *Lynn's Garden*, shown in Figure 32–6. It was funded entirely by donations and is located on a second floor patio adjacent to the chapel. It has a fountain and pool with a sculpture and plants. It is a popular site for patients and caregivers to go for reflection and peace in the beauty of nature.

Figure 32–5 Window and staircase of the main lobby with the exterior wall of the chapel in the background. *Source:* Copyright © 2003, St. Charles Medical Center.

One other example of creating a warm and nurturing environment is the addition of a fireplace to the waiting room for the surgery center expansion. The idea of adding a fireplace was almost value-engineered out of the plan in order to meet the project budget. Fortunately, after reviewing the cost the planners decided not to cut it, as it was not an expensive item given the scope of the project. All now agree that it makes a significant contribution to the room's healing potential. The space was kept small to create a more cabin-like, cozy feeling. Patients' family members and friends are also given beepers and encouraged to feel free to run short errands or visit the cafeteria. (See Figure 32–7.)

Another example of a healing environment—one that was an idea of a nurse and emerged as a significant impact on the environment—is the fish bowl of the emergency department (ED). The central medication room of the newly designed ED was enclosed in glass to allow for sound privacy and visual access. A nurse, building on the sense of the space feeling like a fish bowl, brought a stuffed fish toy to hang in the space. Soon others brought stuffed aquatic toys to hang and the space became a literal fish bowl. Nurses also began to receive stuffed aquatic toys from patients in gratitude for their care. This

Figure 32–6 Lynn's Garden. *Source:* Copyright © 2003, St. Charles Medical Center.

Figure 32–7 Surgery center waiting room. *Source:* Copyright © 2003, St. Charles Medical Center.

simple act created a different feeling in the stressful and at times chaotic ED. It became a focal point for humor and warmth. It humanized the environment. (See Figure 32–8.)

Creating a healing environment does not have to be expensive. Little things can make a big difference. Perhaps one of the most effective ways to enhance healing is through providing a safe, clean, quiet environment. These are things that require each person's awareness, and simple things like picking up a piece of trash that is on the floor can mean a lot in enhancing the healing environment.

ARTS IN THE HOSPITAL

Curing is of the body. Caring is of the soul. The arts speak to the soul. The environment is a mirror of the individual and of the culture. It echoes the values of the culture. Art enriches the environment and can connect people to purpose and meaning by representing the organization's unique mythology. Perhaps most importantly in the hospital setting, art can influence healing and recovery.[40] The St. Charles Arts in the Hospital program includes art, music, and humor.

Art

The significance of art in the hospital is highlighted in the hospital's newsmagazine, *Focus*.[41] "Brooke isn't having a very good day. Her blood pressure is running low and she is not feeling well. It isn't the first time her daily routine seems overwhelming since a recent car accident left her in a wheelchair.

'I've got something for you,' says Arts Coordinator Marline Alexander, beaming broadly at Brooke. She has a lump of bright yellow clay in her palm and a twinkle in her eye that affects Brooke almost instantly.

Just like a light going on, Brooke's blue-gray eyes brighten. Within five minutes, she's laughing as she rolls the clay beneath the heel of her hand, intent on making the colorful beads pictured in her book."

Marline Alexander has been serving the patients and staff of St. Charles Medical Center for many years, first as a volunteer and now as a part-time arts coordinator. Marline helps patients heal faster through

Figure 32–8 Emergency department medication room, affectionately called the *Fish Bowl*. *Source:* Copyright © 2003, St. Charles Medical Center.

their own artistic expression. She and her volunteers run three separate galleries, provide an Art Cart service for patients, sponsor art exhibits, and help the hospital select art. The hospital also sells art, and 30% of the proceeds directly benefit the arts program.

The three galleries, the Alexander Gallery in the Cancer Treatment Center, the Family Birthing Center Gallery, and the Second Floor Gallery, display work created by local artists and patients. The purpose of the galleries is to enhance the healing environment, and for patients and families to have something interesting to view.

The Art Cart travels around the hospital bringing crafts and projects to patients. These crafts and projects offer creative channels for expression, as well as promote relaxation and positive thought processes.

During a local newspaper interview, Marline expressed the power of caring: "To have a purpose in life, that's what I love to see." She concluded, "I think that this program has really helped heal me because I love to help others heal. As long as this program can enhance the healing process, it will succeed."[42]

St. Charles also uses art to express its mythology and historical roots. Sister Catherine, SCMC president emeritus, commissioned a sculptor to come to the hospital, experience its community, and create a sculpture representing the hospital's mythology. The sculptor met with caregivers, physicians, and community members, then left to manifest the spirit of this experience. The fruits of this endeavor resulted in the Yoke of Compassion, shown in Figure 32–9. The Yoke of Compassion, which graces the garden at the hospital's entrance, evokes a fundamental image of simple human caring. It has become the symbol of the healing role St. Charles plays for the people of central and eastern Oregon. It represents the sacredness of our care, in that you cannot at first tell which figure is holding the other figure. We are blessed in health care in that as we give we also receive the gift of helping others.

Figure 32–9 The Yoke of Compassion, by Father David Kocka. *Source:* Copyright © 2003, St. Charles Medical Center.

Music

Everything in the environment has an effect on healing; very little is just neutral. This is certainly true when it comes to the sound environment. Most people would agree that rest is a vital component of healing. Yet most would also agree that the hospital is the last place anyone would come to for rest. Prior to 1990, one of our most frequent patient complaints was inability to rest due to environmental noise. We worked with Healing Health-Care Systems™ to address this concern. We began with an experiential workshop, *Music: A Life-Altering Decision*, by Susan Mazer and Dallas Smith, developers and owners of the systems. This workshop develops an experiential knowledge of music as a tool in the design of healing

health care environments. Most importantly, the workshop heightens awareness of the sound environment and the power of intention in creating a healing environment. An intentional healing health care environment extends the therapeutic presence of the caregiver during and in the absence of their presence. It creates a caring sensory environment that envelops the patient.

Soon after the workshop, we implemented the Continuous Ambient Relaxation Environment (C.A.R.E.) channel. The C.A.R.E. channel is an audiovisual system designed specifically for health care facilitates. It is a TV channel programmed for the day–night cycle, providing a nurturing sound and visual environment while screening out most of the ambient environmental noise. The C.A.R.E. channel offers patients a tool to control their visual and auditory environment while offering nurses a therapeutic tool for alleviating patients' pain and anxiety.

We are now implementing a new audiovisual service, the *C.A.R.E. Channel with Guided Imagery*. St. Charles Medical Center worked with Healing HealthCare Systems™ to create an additional channel that includes hourly segments of guided imagery exercises. Rosemary Johnson, RN, a surgery center nurse, and Dallas Smith of Healing HealthCare Systems™, guide the listener through a healing journey with loving and healing intention.

Healing HealthCare Systems™ also provides St. Charles with custom music in lobbies and waiting areas. This music helps reduce the actual and perceived noise levels, protects confidentiality, and relieves the sense of isolation in long corridors and halls that can often feel generic.

Volunteers are a vital component of creating a healing environment. Community musicians and artists wanted to volunteer once they were aware that the hospital was open to the use of music and art in healing. These volunteers range from a barbershop quartet, to harpists, to employees who play the lobby's baby grand piano on their breaks. The hospital provides support through assisting with funding education and some travel expenses. The harpists personally sought funding from the community to purchase harps that now remain at the hospital. One of the harps is designed so that patients can hold it while learning to express their feelings through stroking the strings, as shown in Figure 32–10.

Humor

Just as stress can have negative effects, humor can have beneficial effects. Humor can increase communication, decrease

Figure 32–10 Volunteer harpist and patient. *Source:* Copyright © 2003, St. Charles Medical Center.

anger and conflict, change perceptions, create a sense of well-being, allow detachment, and facilitate learning.[43]

Patty Riley, an enterostomal therapist, first taught us the value of humor. Patty took the lead in developing our humor program. Early in the process she attended Clown College®. Patty returned with a clown personality and the full clown make-up and dress. She received a consultation to see a young boy who had recently had a colostomy. The little boy refused all efforts of care and teaching from his nurses. Patty went in with a new attitude and new methods for working with the "noncompliant patient." This time she sat down with the little boy and offered him a handful of balloons. Together they made all sorts of balloon animals and toys. After awhile she interrupted the laughter and asked him why he was in the hospital. He replied, "I have this thing," pointing to his colostomy. Patty asked, "What is it?" He replied, "I don't know." Patty asked if he would like to know and he replied, "Sure." They were off and running—the little boy quickly learned about the colostomy and its care and was soon released from the hospital. Patients also enjoy visits by volunteer professionally trained clowns.

Connecting humor is also a vital part of creating a healing environment in the work place. Every one of the hospital's teams identifies humor as one of the key success factors for achieving their vision. Nurses JoAnn Miller-Watts and Karen McGuire, shown in Figure 32–11, have emerged as particularly gifted in this arena. They routinely use humor to enhance education and support the healing environment of teams throughout the hospital. Sometimes St. Charles management and staff start taking themselves too seriously. Karen and JoAnn are quick to design a song or a skit that reflects back the hazards of our perfectionism and helps us laugh at ourselves. This wonderful service always serves as a release for tension and opens up new and more beneficial perspectives.

Figure 32–11 Karen McGuire and JoAnn Miller-Watts, Nurse Humorists. *Source:* Copyright © 2003, St. Charles Medical Center.

HEALING OUR COMMUNITY

"To improve the health of those we serve in a spirit of love and compassion."

St. Charles Medical Center Mission

In 1995, Jim Lussier, CEO, formed the Central Oregon Health Council (COHC) as a resource for accomplishing our mission. The council now has 35 member agencies, including such agencies as the Bend/Lapine School District, the Commission on Children and Families, the City of Bend, and the Central Oregon Council on Aging. The first few years were spent getting to know each other and the services offered by each agency. We found that we all shared in a similar mission of improving the health of our community. We began to see a metaphor emerge in that the health of our community is similar to a big mountain that each agency has been working on from their own perspective. Each of us was digging away on our area of the mountain of health in an effort to improve our community. Once we fully understood each agency's work we could see that sometimes,

unknowingly, we were being counterproductive, and that if we pooled our efforts we could be much more effective.

The Council developed a mission statement, community health values, and benchmarks for measurement. The Council focuses on five methods of creating a healthy community:

- Pubic education focusing on health
- Developing new public–private partnerships
- Resource development and alignment
- Monitoring progress of benchmarks and reporting to the community
- Influencing public policy

The Central Oregon Health Council mission is to promote the health and well-being of central Oregonians. We foster interagency collaboration, identify areas in need of support, and build on existing programs and strengths to create a healthier community.

One example of the Council's work is the formation of an unprecedented public–private partnership, the Central Oregon Partners for Healing Environments (Deschutes County, the Central Oregon Regional Housing Authority, and St. Charles Medical Center), to address the mental health needs of central and eastern Oregon. In order to meet this need, the partners contributed their experience and expertise to the development of the Healing Health Campus. The Healing Health Campus includes a Crisis Resolution Center (CRC), a 15-bed adult psychiatric residential treatment center designed to assess, stabilize, and treat adults who are experiencing a mental or emotional crisis, and Horizon House, a 14-unit transitional housing facility. Transitional housing fills a critical gap in the continuum of care for mentally ill patients, and often is the bridge between failure and success in returning clients to independent living.

Other examples of healing our community include the Sara Fisher Breast Health Project and the Stepping Stones Project. The Sara Fisher Breast Health Project, formed in 1991 in memory of Sara Fisher, is a community coalition of volunteers, physicians, and community sponsors led by Peggy Carey, Cancer Services Leader Manager. This project seeks to improve women's health through aggressive prevention, research, education, and outreach with an emphasis on early detection of breast cancer. Through a combination of community fundraising and grants, they have developed the following services:

- **Community Education and Outreach**, including programs to promote early detection, such as an annual low-cost mammogram program.
- **The Navigator Program**, a partnership with community volunteers and professional counselors providing peer support for women newly diagnosed with breast cancer.
- **Breast Cancer Research**, involving breast cancer studies to determine effectiveness of medications for prevention and treatment of breast cancer.
- **A Community Breast Cancer Case Manager**, who is an RN acting as patient advocate coordinating seamless care for women diagnosed with breast cancer.
- **Massage and Relaxation Series**, offering participants opportunities to explore complimentary therapies and education on health-related topics.
- **Emotional and Educational First Aid Kits**, developed by navigators and distributed by physicians to help newly diagnosed women progress to the decision-making phase of care.
- **Sara's Sisters Sponsorships**, to assure that newly diagnosed women continue to receive services.

Central Oregon is now a benchmark for early detection of breast cancer. Rates of detecting cancer at the in situ and local

stage is 76%, whereas the national average is reported at 49%.

Stepping Stones is a foundation-supported program including HealthyStart Prenatal Services, newborn hearing screening, and home visits for new mothers. HealthyStart provides prenatal care to low-income women. HealthyStart's goal is to prevent low birth weight babies. It is a unique partnership of local physicians, the county health department, St. Charles Medical Center, and the Foundation. It provides a broad range of services including prenatal care through delivery, parenting and alcohol/drug/tobacco education, and referral services. The program is a great success, as nearly every mother who delivers at St. Charles has received prenatal care: Annually, less than 5 mothers out of approximately 1,500 who deliver at St. Charles lack prenatal care. Hearing screening is a service that provides for early detection of hearing loss, so that every child has the hearing ability needed to develop language and social skills. Interested mothers can take advantage of home visits that bring check-ups, referrals, and nurse support into the home, at no cost, within a week of birth.

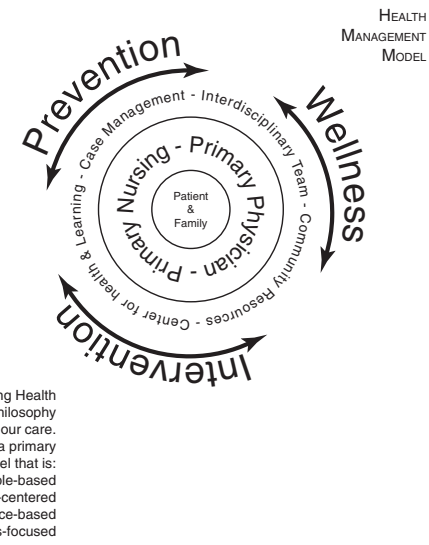


Figure 32–12 Health Management Model. *Source:* Copyright ©, 2002, St. Charles Medical Center.

PRINCIPLE-BASED CARE MODEL

The Healing Health Care Philosophy, along with the collective vision of both management and staff nurses, guided the recent revision of the system's care model, the health management model. The health management model, shown in Figure 32–12, is principle-based, relationship-centered, resource-based, and outcome-focused. The person accesses care through prevention, wellness, and/or intervention services. Prevention and wellness services are provided through the Center for Health and Learning. Intervention services (inpatient and outpatient) are provided through physicians and primary nursing.[44] The primary nurse is responsible for developing a therapeutic relationship and a plan of care throughout the patient's stay on his or her unit. The primary nurse works as part of a team with either a licensed practical nurse (LPN) or a certified nursing assistant (CNA), along with physicians, case managers, and other disciplines as needed. The plan of care is respected and followed by the entire health care team. When patients are discharged, they are connected to the appropriate services of the Center for Health and Learning, as well as other community resources as needed.

Key success factors in implementing the new care model were the creation of Unit Practice Committees (UPCs) and a set of clearly-defined principles that guide each unit in creating their unit-specific plan. The unit practice committees, which comprise staff nurses and other relevant disciplines, are responsible for designing, implementing, and continuously improving their unit's plan for patient care based on the Professional

Nursing Practice Principles. (See Exhibit 32–6.) UPCs now are a permanent part of our nursing structure and report on a quarterly basis to the nurse executive. These quarterly meetings provide a forum to share innovations, promote consistency between the units' practice plans, and inform the nurse executive in preparation for strategic planning.

One of the most exciting outcomes of the health management model is the difference it is making in nurse satisfaction. For example, in a recent newspaper interview, one of our nurses is quoted:

"After 23 years of caring for sick patients, nurse Susan Long has found new excitement in her profession . . . 'It made me more accountable to my patients, really looking at their needs as a whole person from the time we admit to the time we discharge.' Before, she said, nurses focused mainly on the tasks assigned by physicians. Now, nurses focus more on relationships with patients."[45]

We are convinced that strengthening the nurse–patient relationship is a critical success factor in preparing for a more challenging future. Resources for care are not infinite and will always be, to various extents, limited. Nurses are continuously making decisions regarding how best to use their resources. Ideally, these decisions are made within a therapeutic relationship with patients, and knowing what patients identify as their most important needs. Resource-based care—intentional decision making based on patient needs and time available—must include a therapeutic relationship with the patient.[46] To assist nurses in the development of resource-based decision making, we have added clinical nurse specialists, and are developing our system's capacity to support nurses in making care decisions while 'owning' their time. We believe that when nurses have a therapeutic relationship with their patients and truly own their time, they will set appropriate care priorities based on patient needs, as articulated by the patient, and available time and resources. Nurses thus can be empowered to say what will and will not be done. By doing so, they create a real-life scenario in which they truly can provide better care, and experience greater autonomy and satisfaction, even in the midst of difficult times.

CONCLUSION

Sustaining a culture of healing requires the intention and commitment of all of the members of the organization. It also requires a clearly defined process, and the discipline to manage and continuously improve the process. St. Charles defines this process as the Performance Excellence Process. The Performance Excellence Process, shown in Figure 32–13, starts with defining the hospital's mission and developing a vision that is the ideal state of accomplishing the mission. Our values, the quality policy, and the Healing Health Care Philosophy guide the process. The Board of Directors developed the *Nature of Care Policy*, that provides goals for the design and character of the system's care.[47]

In order to assure that the *Nature of Care Policy* goals are implemented, cluster (department) leadership is responsible for meeting cluster requirements. Cluster requirements include performing quality, customer, skill, and resource assessments, as well as identifying the cluster's scope of service. This responsibility begins with performing a quality assessment that includes how the cluster is performing in relation to organization-wide quality objectives, internal and external audit results, and regulatory requirements. Scope of service includes defining aspects of service, developing a cluster vision and creating success factors for achieving the vision, as well as managing key processes. Customer needs assessment is performed through surveys and focus groups. Skill

Exhibit 32–6 Professional Nursing Practice Principles.

PROFESSIONAL NURSING PRACTICE

PRINCIPLES

1. Healing Health Care Philosophy: "Healing Ourselves, Our Relationships, Our Communities"

Our intention is to create an environment which supports healing: healing for our patients, their families, and caregivers. We understand that a truly healing environment will exist only to the extent that our caregivers themselves have found healing. Healing for each of us is enhanced when we care for ourselves and our team members as well as the people we serve. We are a human service. Who we are and how we work together are what our patients and their families receive.

People are indivisible; they are more than the sum of their parts. We care for the wholeness (body, mind, spirit) of our patients and one another. We use technology appropriately and recognize that healing is enhanced in caring relationships. Everything in the environment has an effect on healing. Very little is simply neutral. It either enhances or impairs the healing process. This includes all sensory experience (sight, hearing, smell, and touch).

2. Responsibility for Therapeutic Relationship and Plan of Care

The primary nurse is responsible for establishing an individualized therapeutic relationship and a plan of care with a patient and family throughout the patient's length of stay on the unit or service. The relationship is known to the patient, family, and staff.

The plan is based on a holistic, individualized assessment of needs and resources.

The primary nurse facilitates patient control over health care decisions and advocates for the patient. Outcomes are patient-driven.

The plan of care is specific to the disease process (standardized) and customized to the patient's unique needs and involvement (individualized).

The primary nurse will partner with peer registered nurses and the patient's physician in implementing the nursing plan of care and will serve as a guide for all caregivers in the team, attending to continuity in relationships within the Healing Health Care Philosophy.

The primary nurse will collaborate with physicians, case managers, and the interdisciplinary team.

All caregivers are responsible for therapeutic presence in implementing the plan of care.

3. Work Allocation and Assignments

Assignments are patient-driven and provide for continuity and consistency. Caregivers (primary nurses, registered nurses, licensed practical nurses, technicians, and care associates) may choose to work consistently in care teams.

Assignments and delegation of activities of care are based on the nurse's assessment of patient needs and are congruent with the caregiver's knowledge and skill.

4. Communication

Communication and documentation are patient-focused, direct, and specific to the plan of care.

Focused attention is given to communication of a patient's individualized plan of care across the continuum, i.e., in "hand-offs" between shifts, service areas, departments, and caregivers.

Communication is direct between caregivers and collaborative with the interdisciplinary team.

5. Leadership

Leaders have interlocking accountability within the context of stewardship and the healing health care philosophy.

Leaders manage the caregivers who manage patient care.

Based on mutual respect, shared vision, and values, leaders are cognizant of the diversity of the workforce and promote the growth and development of staff.

Leaders promote recruitment and retention.

Leaders provide resources and support in navigating system issues.

Source: Copyright © 2002, St. Charles Medical Center and Creative HealthCare Management™.

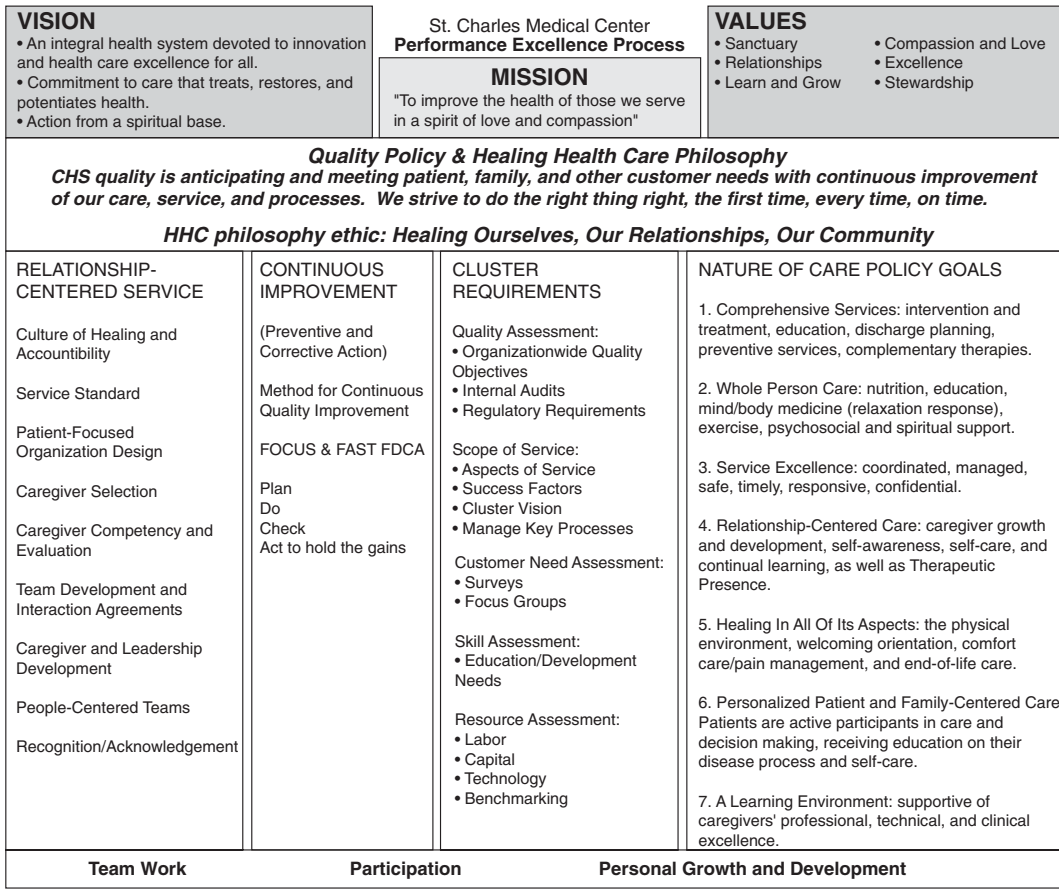


Figure 32–13 Performance Excellence Process. *Source:* Copyright © 1999, St. Charles Medical Center.

assessment includes assessing caregiver learning needs and developing an education plan. Resource assessment marries the cluster requirements with the budgeting process, including labor, capital, and technology needs. Leaders are expected to benchmark with other facilities both within and outside of health care to assure they are meeting or exceeding national as well as local standards.

Continuous improvement involves addressing opportunities for improvement related to the cluster requirements, as well as preventive and corrective actions. Preventive and corrective actions are identified through internal and external surveys and audits as well as addressing variances in quality indicator monitors.

Relationship-centered service is achieved through creating a culture of healing and accountability, implementing service standards, and designing the hospital around patient needs. It also requires a process for selecting caregivers that are compatible with the hospital's values and philosophy of care, as well as assuring caregiver competency. Relationship-centered service requires a commitment to the

ongoing development of caregivers and their teams. People-Centered Teams Workshops provide an experiential learning setting for the development of relationship-building skills. In addition, each team develops interaction agreements that describe their intention for their team, and agreements on how they will work together to achieve the work environment they desire.

As with any document, this process is just words on a page unless it rests on a solid foundation of each person's participation and teamwork, as well as the hospital's commitment to the ongoing investment in the caregiver's personal growth and development.[48]

In conclusion, at St. Charles it really does not matter what position you are in or role you play—you may be a CEO responsible for strategic planning, a nurse caring for a patient at the bedside, or a housekeeper cleaning the room—you are a *caregiver*. Whether we directly touch the patient or not, we are all to some extent caregivers. We are all there to serve patients. *Patient care is our core business.* What is important is that each caregiver brings a healing intention to his or her work. Creating a healing environment happens in large ways, such as designing a new hospital, and it happens in the everyday acts of people as they pick up a piece of trash on the floor, hold a hand, smile at a patient, or help a visitor find their way. We have learned that implementing relationship-centered care and the Healing Health Care Philosophy is really a life-long work. It starts with the intention to provide a healing environment, and requires a commitment to personal growth and continuous learning. It also requires everyone's participation, and is best sustained when it is a strategic initiative of the hospital supported by the Board of Directors and management.

DIRECTIONS FOR FUTURE RESEARCH

1. Further explore understandings of the role of relationships in health and healing.
2. Investigate how the arts can be used to help the healing process.
3. Research the effect of intention in healing.
4. Explore the many dimensions of healing and how they apply in your own environment.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or begin the process of answering the following questions:

- How does the environment affect my own healing?
- After reflecting on a recent time when I felt most helpful to a patient, what do I think contributed to this experience? Ask myself why at least five times.
- What can I do now in my work environment to better support healing?
- What does the ethic of the Healing Health Care Philosophy: healing ourselves, our relationships, and our communities, mean to me personally?

NOTES

1. S. Leddy and J. Pepper, *Conceptual Bases of Professional Nursing* (New York: J.B. Lippincott, 1989).
2. W. Knaus, E. Draper, D. Wagner, and J. Zimmerman, An Evaluation of Outcomes from Intensive Care in Major Medical Centers, *Annals of Internal Medicine* 104, no. 3 (1986):410–418.
3. J.J. Lynch, *The Broken Heart: Medical Consequences of Loneliness* (New York: Basic Books, 1979).
4. H. Beecher, The Powerful Placebo, *Journal of the American Medical Association* 159 (1955):1602–1606.
5. P. Heidt, An Investigation of the Effects of Therapeutic Touch on Anxiety Level of Hospitalized Patients (unpublished doctoral dissertation, New York University, 1979).
6. R. Ulrich, Effects of Interior Design on Wellness: Theory and Recent Scientific Research, *Journal of Health Care Interior Design* 3 (1991):97–109.
7. R. Cross, Picture Perception and Patient Stress: A Study of Anxiety Reduction and Post Operative Stability (unpublished paper, Department of Psychology, University of California–Davis, 1990).
8. D. Campbell, *The Mozart Effect* (New York: Avon Books, 1997).
9. Editors. The 100 Best, *Oregon Business* 25. no. 23 (2002):30.
10. D. Sluyter, *Relationship-Centered Care Newsletter* (Kalamazoo, MI: Fetzer Institute, 2000).
11. L. Tarsis, News Release, *Solucient* (Evanston, IL, 12/9, 2002).
12. C. P. Tresolini and the Pew-Fetzer Task Force, *Health Professions and Relationship-Centered Care* (San Francisco, CA: Pew Health Professions Commission, 1994).
13. M. Seligman, *Learned Optimism* (New York: Knopf, 1991).
14. E. Speedling and G. Rosenberg, Patient Well-Being: A Responsibility for Hospital Managers, *Health Care Management Review* 11, no. 3 (1986):9–19.
15. S. Dingman, M. Williams, D. Fosbinder, and M. Warnick, Implementing a Caring Model to Improve Patient Satisfaction, *Journal of Nursing Administration* 29, no. 12 (1999):30–37.
16. J. Achterberg, B. Dossey, and L. Kolkmeier, *Rituals of Healing: Using Imagery For Health and Wellness* (Bantam Books, 1994).
17. H. Benson and M. Klipper, *The Relaxation Response* (New York: Avon, 1976).
18. H. Benson and E. Stuart, *The Wellness Book: The Comprehensive Guide to Maintaining Health and Treating Stress-Related Illness* (New York: Simon and Schuster, 1992).
19. J. Borysenko, *Minding the Body, Mending the Mind* (Reading, MA: Addison-Wesley, 1987).
20. M. Caudill, *Managing Pain Before It Manages You* (New York: Guilford Press, 1995).
21. M. Davis, E. Eshelman, and M. McKay, *The Relaxation & Stress Reduction Workbook* (Oakland, CA: New Harbinger Publications, 1995).
22. B. Dossey, L. Keegan, and C. Guzzetta, *Holistic Nursing: A Handbook For Practice*, 3rd Edition (Gaithersburg, MD: Aspen Publishers, 2000).
23. S. Gawain, *Creative Visualization: Use the Power of Your Imagination to Create What You Want in Your Life* (Novato, CA: New World Library, 1995).
24. B. Hafen, K. Karren, K.J. Frandsen, and N. Smith, *Mind/Body Health: The Effects of Attitudes, Emotions, and Relationships* (Boston: Allyn and Bacon, 1996).
25. J. Kabat-Zinn, *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* (New York: Delacorte Press, 1990).
26. J. Kabat-Zinn, *Wherever You Go There You Are: Mindfulness Meditation in Everyday Life* (New York: Hyperion, 1994).
27. D. Sobel and R. Ornstein, *The Healthy Mind Healthy Body Handbook* (New York: Patient Education Media, Inc., 1996).
28. L. Gerteis, J. Daley, T. Delbanco, and S. Edgman-Levitan, eds., *Through the Patient's Eyes: The Picker/Commonwealth Program for Patient-Centered Care* (San Francisco: Jossey-Bass, 1993).
29. D. Krieger, *The Therapeutic Touch* (Engelwood, NJ: Prentice-Hall, Inc., 1979).
30. N. Moore and H. Komras, *Patient-Focused Healing: Integrating Caring and Curing in Health Care* (San Francisco: Jossey-Bass, 1994).

31. Press Ganey Associates, Press Ganey Satisfaction Measurement, St. Charles Medical Center, Bend, Oregon, 2000–2003 (South Bend, IN: 2000–2003).
32. J. Stephens, St. Charles Improvements Will Serve the Community, *The Bulletin* (11/14/02).
33. Benson and Stuart, *The Wellness Book: The Comprehensive Guide to Maintaining Health and Treating Stress-Related Illness*.
34. Dossey, Keegan, and Guzzetta, *Holistic Nursing: A Handbook For Practice*.
35. M. Madrid and E. Barrett, eds., *Rogers' Scientific Art of Nursing Practice* (New York: National League for Nursing Press, 1994).
36. Moore and Komras, *Patient-Focused Healing: Integrating Caring and Curing in Health Care*.
37. Ulrich, Effects of Interior Design on Wellness.
38. J. Leighty, Healing By Design, *NurseWeek* (April, 28, 2003).
39. R. Carpman, M. Grant, and D.A. Simmons, *Design That Cares: Planning Health Facilities for Patients and Visitors* (Chicago: American Hospital Publishing, 1986).
40. Cross, Picture Perception and Patient Stress.
41. T. Fenske, ed., The Healing Power of Art, *Focus* 8, no. 2 (2003):9.
42. S. Daucsavage, Arts in the Hospital: How Expressing Creativity is Helping Heal Patients, *Cascade Arts & Entertainment* 9, no. 6 (June 2003):14.
43. N. Cousins, *Anatomy of an Illness as Perceived by the Patient: Reflections on Healing and Regeneration* (New York: Bantam Books, 1979).
44. M. Manthey, *Primary Nursing*, 2nd Edition (Minneapolis, MN: Creative Healthcare Management, 2002).
45. Editorial, *The Bulletin* (November 3, 2002).
46. Manthey, *Primary Nursing*.
47. N. Moore, Relationship-Centered Service: St. Charles Medical Center and Perspective: How You Can Become Involved, in *Integrating Complementary Medicine Into Health Systems*, ed. N. Faass (Gaithersburg, MD: Aspen Publishers, 2001).
48. K. Malloch, D. Sluyter, and N. Moore, Relationship-Centered Care, *Journal of Nursing Administration* 30, nos. 7–8 (July/August 2000):379–385.

RESOURCES

St. Charles Medical Center

People-Centered Teams: Healing Our Workplace I Workshops
Resiliency and Renewal Workshops
Life Choice Seminar
New Directions
Health Coach
Center for Health and Learning
St. Charles Medical Center
2500 NE Neff Road
Bend, OR 97701
Phone: 541-385-6390
www.scmc.org/chm.htlm

Organizations (websites and email addresses)

The Fetzer Institute: *www.fetzer.org*
Healing HealthCare Systems: *www.healinghealth.com*; email: healhealth@aol.com
Kaiser and Associates: *www.kaiser.net*
The Association of Healing Health Care Projects: *www.healinghealthcareassoc.org*
The Arnold P. Gold Foundation: *www.humanism-in-medicine.org*
The Creative Connection: email: creativeconnection @oakweb.com
Society for The Arts in Healthcare: www. thesah.org
Symposium on Health Care Design: www.hcaredesign.com
Planetree: *www.planetree.org*
Creative HealthCare Management: *www.chcm. com*
IMPAQ: *www.impaqcorp.com*

Transformation of the Acute Health Care Environment

The movement of hospitals to "create a healing environment" seems like a surprising statement. Shouldn't a healing environment be the fundamental aspect of a hospital? The reality is that hospitals have not been "healing" because the focus has been on "curing" in the most cost-effective ways, utilizing the latest forms of technology. Cost-effectiveness and the unquestionable benefits of technology in the saving of lives are important aspects to the sustainability and viability of health for the organization and individuals. However, the void felt within hospitals, and certainly felt by those seeking care, is the absence of the "healing" aspect. This encompasses not only the physical environment (e.g., air quality, sound, structure), but also the emotional, psychological, social, and spiritual elements of those who lead and serve within the hospital. In essence, hospitals are now realizing that the essential element of success comes from a holistic approach to the business of health care.

The intent of this chapter is to provide a vision, a framework, tools, and guidance in the movement toward a healing environment within the hospital setting. It is only one story; there are probably many. As the story of this hospital unfolds in the following pages, it is essential to keep in mind that enmeshed in every step of the structure is a heart-centered, mindful intention to foster relationships that comprise respect, a sense of peace, and ultimately healing for both those served and those who are serving.

A Story of Healing

A rather seasoned nurse on a neurological unit was beginning to ask herself whether she would continue to do nursing as she realized she was spending more time with machines and documentation than she was spending with her patients. The lack of nursing staff only added to her discontent. On one particular day, not so different from others, she was running from room to room giving pain medications and manipulating IV machines. One of the patients she was assigned to had spine cancer and was experiencing multisystem shut down. He had numerous IVs. Throughout the morning this nurse found she was getting behind in her work and was at the point of tears when the gentleman with spine cancer put on his nurse call light. She went in and immediately attended to the machines. She turned to the patient and said "there is nothing wrong with your IVs." The man said, "I know I need you." The nurse sat down on the bed and began to cry. The patient put his arms around the nurse and said, "I just needed to know you cared." You see he was dying, and symbolically, so was she. At that caring moment the nurse realized she could never leave nursing and that she had a choice in how she cared for her patients.

"We are spiritual beings, composed of minds, bodies, and a spiritual side. To unleash the whole capability of the individual—mind, body and spirit gives enormous power to the organization. It truly empowers members of the organization to devote their entire beings to the ultimate purpose for which the organization exists, which is to serve others."

William George, Former Chairman,
Medtronic Corporation[1]

"In order to counter the negative organizational dynamics stimulated by stress and uncertainty, we must give full attention to the quality of our relationships. Nothing else works, no new tools or technical applications, no redesigned organizational chart. The solution is each other. If we can rely on one another, we can cope with almost anything."

Margaret Wheatley[2]

NOTES

1. W. George, Spirit in Business, *Quotes,* Available at: *http://www.spiritinbusiness.org,* Accessed June 10, 2003.
2. M.J. Wheatley, *When Change is Out of Control*, Available at: *http://www.margaretwheatley.com/articles/whenghanceisoutofcontrol.html,* 2002, 1–7.

Chapter 33

Exploring Integrative Medicine and the Healing Environment: The Story of a Large Urban Acute Care Hospital

Lori Knutson

NURSE HEALER OBJECTIVES

Theoretical

- Explain the concept of the healing environment.
- Discuss the integrative approach to health care.
- Analyze the components of a healing environment assessment.

Clinical

- Integrate Holistic Nursing in the acute care hospital setting.
- Explore ways to initiate practice changes that integrate holistic therapies.
- Determine the relationships required for successful culture change within the hospital environment.
- Model relationship-centered care in professional partnerships and in the care of the patient.

Personal

- Determine if your spiritual practice supports your ability to be a change agent in the hospital environment.
- Explore whether you are a role model in the practice of health and healing.
- Commit to the development of therapeutic partnerships as a way to stimulate the transformation of the environment of health care.

DEFINITIONS

Total Healing Environment: a health care environment that demonstrates aspects of healing in the physical space, relationships, therapeutic interventions, and leadership.

Integrative Medicine: a philosophy of health care practice that emphasizes the 'whole person' view of health and healing and, in practice, blends conventional, alternative, and complementary interventions to optimize curing and healing.

Quality Initiatives: processes that utilize specialties of clinical practice in therapeutic partnerships to create improved patient care.

Holistic Nurse Clinician: a certified Holistic Nurse who performs needs assessments of patients and the clinical environment and initiates appropriate healing interventions to enable positive changes in health.

INTRODUCTION

A "Total Healing Environment" within a large urban acute care hospital encompasses many elements. Successfully blending these elements may, in the broad

view, seem to be an overwhelming accomplishment, but the foundation for doing so lies in simple relationships. Whether we speak about the internal or external elements, or the physical or psychological elements, the foundation is based on the interconnectedness of relationships, with the primary focus on the balance of healing and curing, Abbott Northwestern Hospital in Minneapolis is moving from a culture of treatments and cures to a total healing environment. The dynamics of changing a culture are continuous and require an openness to honor both the successes and the perceived failures. One strategic initiative in stimulating the hospital's changing culture is the development of integrative medicine.

Currently, integrative medicine at Abbott Northwestern Hospital is a department that provides:

- **Professional services:** holistic nurse consultation, nutrition consultation, herbal consultation, healing coach, massage therapy, healing touch/therapeutic touch, acupuncture/acupressure, guided imagery, music therapy, reflexology, biofeedback, stress mastery, mindbody therapies.
- **Quality initiatives:** primary indicators that focus on pain and anxiety.
- **Education and training:** professional development in integrative care and personal self-care for the professional caregiver.

The goal is to see these initiatives as the norm in the hospital's environment, without the need for a specific department of integrative medicine. When the culture of Abbott Northwestern Hospital has evolved to this ideal and the values and beliefs of the organization's people are based fully on the healing and curing dynamics, the Total Healing Environment will be complete and fully alive.

TOTAL HEALING ENVIRONMENT MODEL: LARGE URBAN ACUTE CARE HOSPITAL

Abbott Northwestern Hospital is the largest not-for-profit hospital in the Minneapolis area. Each year, the hospital provides comprehensive health care for more than 200,000 patients and their families from the Twin Cities area and throughout the upper midwest. More than 5000 nonmedical employees, 1600 physicians, 2000 nurses, and 550 volunteers work as a team for the benefit of each patient served. Abbott Northwestern Hospital is a part of Allina Hospitals & Clinics, a family of hospitals, clinics, and care services in Minnesota and Western Wisconsin. Abbott Northwestern Hospital's services include:

- complete medical, surgical, and critical care for patients age 12 and older
- 24-hour emergency services
- multispecialty care and clinical expertise in behavioral health services, cardiovascular services, medical/surgical services, neuroscience, oncology, orthopedics, rehabilitation, spine care, and women's health
- outpatient care in more than 50 different specialty areas
- innovative and individual pain treatment
- overnight guest accommodations for patients' families and friends, and for outpatients
- education programs, support services, and public health screenings
- outreach programs to improve the health of the community

The concept for the Healing Environment at Abbott Northwestern Hospital, which was introduced in 2000, stemmed from the recognition of the needs of the patients, their families, and the staff. This recognition came from key nursing leaders, the CEO, the hospital's Board, and significant philanthropic

donors. This partnership gave energy to the driving force in determining the desired culture change and holistic approach to care delivery. It was key nursing leaders in collaboration with executive leadership that earmarked the framework for the Total Healing Environment.

There are four primary components to Abbott Northwestern Hospital's concept of a total healing environment:

External/Physical

The external/physical elements of the Total Healing Environment are related to the visible and concrete. These include the appearance and privacy of the patient rooms, as well as the appearance of the public spaces, the views from the windows, the quality of the air, and environmental sounds.

External/Psychological

The external/psychological elements refer to how staff relate to one another and to patients and their families; the customers' perspectives of the hospital reputation; the expertise of staff; the quality, variety, and efficiency of services; inclusion of the patient and family in all aspects of care; and access to information.

Internal/Physical

The internal/physical elements address the ability to treat and cure disease, manage physical pain, and optimize the body's health.

Internal/Psychological

The internal/psychological elements emphasize supporting positive mental and spiritual well-being, and promoting self-responsibility and acceptance, and are sensitive to individual beliefs and values related to health and healing.

This model provides the framework from which to assess, analyze, plan, implement, and evaluate the movement toward the Total Healing Environment; the framework does not have the ability to make it happen. The primary factor in creating the culture change is in the relationships fostered during the dynamic process. It is more about the *being* in the initiative than the initiative itself. A culture is not changed by giving people a list of tasks to accomplish and mandating that people perform a certain way. The underlying impetus must be in the intentionality for culture change. The energy behind the intention will grow as those who lead stay true to the mission. It is truly a virtuous process that grows and spreads, and in its purest form is self-organizing. With this understanding, an organization must start by assessing its current culture.

Healing Environment Assessment

Four assessments of the Abbott Northwestern Hospital environment were conducted to provide a general understanding of the knowledge and beliefs of the employees and customers served:

- A Healing Environment Survey directed at nursing staff.
- A chart audit of the nurses' intake tool, which included questions about herbal and dietary supplement use by patients as well as complementary and alternative medicine (CAM) use.
- Department team assessments.
- A Patient Admission Survey.

A fundamental component of an assessment needed to include staff members' beliefs, or worldviews, about a healing environment. "A worldview is that set of beliefs each of us holds about the way that the world operates, the reasons that things happen as they do, and the rules that they follow."[1] The knowledge gained by assessing the beliefs of nurses regarding a healing environment would have a

direct impact on the initiative of a change in the culture of the hospital. Exhibit 33–1 is a survey that was conducted with the nursing staff of Abbott Northwestern Hospital. The survey was administered at the beginning of an all-day workshop on professional development and personal self-care. During each workshop day a random number of nurses from each of the specialty areas of the hospital attended, with an average of 70 nurses per workshop.

Instructions were given as follows: "In Quadrant One and Quadrant Two, answer the questions with the perspective of any place of employment, not specific to Abbott Northwestern Hospital." This was emphasized to ensure that the answers reflected the nurses' beliefs and so were not specifically reflective of the nurses' Abbott Northwestern Hospital work experience.

The results of the survey (which are continuing with a goal of $n = 1700$) showed a significant indication that the nurses at Abbott Northwestern Hospital share the beliefs that a healing environment requires a physical space that promotes health, supporting the nurse's ability to provide care and for the healing of the patient, that relationship with colleagues and the nurse's relationship with the patient affect overall healing within the environment, and that the nurse's physical and emotional health directly impacts the patient's healing, and the environment.

The Integrative Medicine Chart Audit shown in Exhibit 33–2 was conducted using a small sample ($n = 181$) of charts.

The chart audit originally was conducted to provide a basic patient profile of what Abbott Northwestern Hospital patients incorporate in their health care regarding CAM. Although this information was obtained in its limited assessment, there were two unforeseen significant findings: First, although the intake tool cued nurses to ask questions related to CAM, with a specific question about herbal and dietary supplement use, the information was rarely entered. Nurses were asked why the information was not complete, and the common answer was their lack of knowledge regarding CAM, and thus the lack of confidence in which to respond to the patient if the patient were to ask questions related to CAM use and its affect on their current reason for hospitalization. Second, there was not a method in place to communicate the information that was collected by nurses to physicians or pharmacists. Physicians were not routinely asking whether patients were currently using herbals or dietary supplements on admission, and pharmacists, because they were not informed of patients' use, did not see a patient safety issue.

The third assessment was a comprehensive interdisciplinary department interview. Each department interview included senior management, unit managers, nursing staff, physicians, and representatives from support service departments that worked directly with the specific department interviewed. Questions were asked regarding their understanding of a healing environment and integrative medicine, whether there were current services in place that they believed were complementary and/or alternative, and the department needs and desires related to the healing environment and integrative medicine. Information collected revealed that there was a need and desire for education and training in the field of integrative medicine; that pockets of CAM were happening throughout the hospital, but in isolation and without needed support; and that there was overall support for the development of integrative medicine. Finally, the interviews revealed that employees wanted assistance with improving their own health and healing. They expressed that the health care environment was directly impacting their own health as providers, and they felt limited in their resources.

Exhibit 33–1 Healing Environment Survey

Quadrant One

Statement	*Strongly agree*	*Agree*	*Neither agree or disagree*	*Disagree*	*Strongly disagree*
The physical space that I work in affects the health of my patients.	40%	56%	3%	1%	
The physical space that I work in affects the health of my working relationships.	41%	57%	1%	1%	
The current physical space that I work in promotes healing.	2%	37%	21%	34%	6%

Quadrant Two

Statement	*Strongly agree*	*Agree*	*Neither agree or disagree*	*Disagree*	*Strongly disagree*
My relationships with my coworkers affects the health of my patients.	38%	57%	5%	2%	
My relationships with my patients affects their health.	55%	43%	2%		
My current working relationships support my role in the healing of patients.	25%	62%	5%	8%	

Quadrant Three

Statement	*Strongly agree*	*Agree*	*Neither agree or disagree*	*Disagree*	*Strongly disagree*
My physical health is important to the health of the working environment.	32%	60%	5%	1%	
I am physically healthy.	13%	67%	13%	6%	
Pain management for my patients needs to include options that support their emotional health.	61%	38%	1%		

Quadrant Four

Statement	*Strongly agree*	*Agree*	*Neither agree or disagree*	*Disagree*	*Strongly disagree*
The ways in which I handle stress affect the health of my patients.	50%	48%	1%	1%	
I am emotionally healthy.	9%	75%	13%	2%	
I feel I have meaning and purpose in my work.	46%	47%	5%	2%	

© 2003. Used with permission by Lori Knutson, RN, BSN, HNC, Abbot Northwestern Hospital, Director of Integrative Medicine, Minneapolis, Minnesota.

Exhibit 33–2 Integrative Medicine Chart Audit

Reported CAM Use

- Total patients reporting CAM use: 102 (56%)
- Women reporting supplements or CAM use: 75 (60%)
- Men reporting supplements or CAM use: 27 (50%)
- Physician reporting of patient's CAM use: 18 (10%)
- Pharmacy reporting of patient's CAM use: 15 (8%)

© 2003. Used with permission by Lori Knutson, RN, BSN, HNC, Abbot Northwestern Hospital, Director of Integrative Medicine, Minneapolis, Minnesota.

The final assessment conducted was a CAM survey done on patient admission. This was done as a follow-up to the chart audit to gain better insight into the use of CAM by the patients of Abbott Northwestern Hospital. (See Exhibit 33–3.)

Analysis of the Healing Environment Assessment

The data collected from the four assessments provided the framework for the strategic plan:

1. Incorporate the philosophy of Relationship-Centered Care, and the concepts of presence, intention, and practitioner self-care.
2. Education and training of staff regarding complementary and alternative health care practices that are evidence-based and that can be incorporated for a blended approach in optimizing the patients' health and healing.
3. Documentation tools that include an accurate patient profile depicting the use of CAM.
4. Communication systems that support the safety and desires of patients with respect to CAM.
5. Development of integrative medicine programs and services specific to the patient population of Abbott Northwestern Hospital.
6. Creation of programs and services that focus on a holistic approach to self-care for employees.

Initiating the Culture Change

Essential to renewing and enhancing the spirit within the hospital and providing the catalyst for change was the nurturing of relationships. To strengthen healing of relationships, three components of holistic philosophy were introduced to staff: 1) Relationship-Centered Care; 2) presence and intention; and 3) psychoneuroimmunology. The initial focus for education was with the nurses, who by virtue of their role and sheer number have the greatest impact in changing the organic aspects of the environment.

Relationship-Centered Care (see Chapter 1, Tables 1–4, 1–5, and 1–6) serves as a guideline for addressing the bio-psycho-social-spiritual dimensions of individuals in integrating caring, healing, and holism into health care.[2] The framework, which consists of patient–practitioner relationship, community–practitioner relationship, and practitioner–practitioner relationship, provided a concrete criteria which staff could begin to integrate into practice. The introduction of presence and intention with the nursing staff engaged them in revisiting their purpose; reminding them of their personal impact on the healing process of the patient; and provided them with skills in mindfulness. The science of psychoneuroimmunology was incorporated to provide a scientific basis to the power of thought and its impact on their personal self-care.

Exhibit 33–3 Integrative Medicine CAM Admission Survey

Use of Herbal Products

- 16% of patients had used at least one of the listed herbal products within the past 3 months.
  - —14% of males
  - —17% of females
- The most commonly used herbal products are:
  - —Garlic (8%)
  - —Echinacea (5%)
  - —Gingko Biloba (4%)
  - —Chamomile (4%)

Vitamins

- 59% of patients had used at least one vitamin supplement within the last three months.
  - —53% of males
  - —62% of females
- 39% of those patients had used only a daily multivitamin.
- The most popular vitamin supplements are:
  - —Vitamin C (25%)
  - —Vitamin B (14%)
  - —Vitamin E (22%)
  - —Vitamin D (14%)

Use of Supplements

- 37% of patients had used at least one of the listen supplements during the last 3 months.
  - —29% of males
  - —42% of females
- The most commonly used supplements included:
  - —Calcium (30%)
  - —Glucosamine (11%)
  - —Chondroitin (7%)

Complementary/Alternative Therapies

- 32% of patients had used at least one of the listed therapies within the past three months.
  - —26% of males
  - —35% of females
- The most commonly accessed therapies were:
  - —Chiropractic services (17%)
  - —Massage (14%)
  - —Acupuncture (5%)

© 2003. Used with permission by Lori Knutson, RN, BSN, HNC, Abbot Northwestern Hospital, Director of Integrative Medicine, Minneapolis, Minnesota.

The education of nursing staff regarding the aforementioned components was actualized in an eight-hour interactive workshop. The expectation of the workshop was to plant the seeds for change and begin nurturing the growth of the healing environment. The support from both hospital administration and nursing leadership was essential in allowing this endeavor to manifest. The process of bringing awareness and new knowledge regarding the aspects of a healing environment is continuous and must reach all employees within the organization.

Integrative Medicine

"Integrative medicine is a comprehensive, primary care system that emphasizes wellness and healing of the whole person (bio-psycho-socio-spiritual dimensions) as major goals, above and beyond suppression of a specific somatic disease."[3] Integrative Medicine is not CAM (Complementary and Alternative Medicine). Integrative medicine is patient-centered, healing-oriented care that emphasizes the patient–caregiver relationship. It focuses on the least invasive, least toxic, and least costly methods to promote health by blending the practices of CAM and conventional, Western medicine. Central to integrative medicine is the view of the whole person as a dynamic being interrelating with his or her environment, both internal and external, and that this interrelationship is the key to health and well-being. "Integrative medicine is not a radical movement but it can produce major change. Its point is to position medicine to continue to build upon its fundamental platform of science but to reposition itself to create a health system which broadly focuses on well-being of our patients as well as its practitioners."[4]

Distinctions of Integrative Medicine, Complementary Therapies, and Alternative Medicine

Alternative Medicine: Consists of traditional medical systems and treatments that are used instead of conventional medical care (e.g., Traditional Chinese Medicine, Ayurveda, Homeopathy).

Complementary Therapies: Treatments and therapies that are used in addition to conventional care (massage, reflexology, aromatherapy, herbal therapies, and dietary supplements).

Integrative Medicine: A comprehensive approach to care that treats the whole person, not simply the illness. Integrative medicine includes conventional, alternative, and complementary care that is evidenced-based and encourages safe, cost-effective, minimally invasive, individualized approaches to health, healing, and wellness.

Integrative Medicine Initiative at Abbott Northwestern Hospital

The design of the department included the roles and responsibilities of staff within the department, identification of programs and services for patients and employees, financial viability, quality measures to support enhanced patient care and outcomes, interdepartmental partnerships to establish dynamic working relationships, and a focus on the self-care of the health care professional.

The leadership of Abbott Northwestern Hospital's Integrative Medicine Department is based on servant leadership principles. "Servant-Leadership is a practical philosophy which supports people who choose to serve first, and then lead as a way of expanding service to individuals and institutions. Servant-leadership en-

courages collaboration, trust, foresight, listening, and ethical use of power and empowerment."[5]

Integrative Medicine Team

The Integrative Medicine Team is composed of six members:

Medical Director. Overall accountability, physician relationships, philanthropic initiatives, national trending, external partnerships.

Director of Programs and Services. Strategic plan and financial accountability, personnel and HR activities, performance improvement, stakeholder relationships, executive leadership for patient care communities, partner with nursing leadership.

Holistic Nurse Clinician. Provides integrative medicine patient consultations, participates in program development, staff education and training, facilitates and manages the continuum of care, partners in research and quality initiatives.

Healing Coach. Patient advocate; provides emotional support through the continuum of care, participates in the "Healing Plan of Care."

Education and Research Coordinator. Provides resources for IM education, plans and implements clinical research and quality initiatives.

IM Practitioners. Provide specific alternative and complementary services; practitioners employed have a primary specialty service (i.e., massage therapy) but are trained to provide other services (guided imagery, healing touch) as well.

Integrative Medicine Components

- Relationship-Centered Care
- Partnerships
- Whole person view
- Focus is on healing
- Emphasis on self-responsibility
- Prevention
- Blending of conventional and nonconventional health care practices

Integrative Medicine (IM) Program Principles

There was a need to create a framework in the development of integrative medicine programs and services that would provide guidance to IM staff as they created programs. The framework stated that:

- A program is developed with solid objectives.
- A program must be developed based upon solid scientific or experiential evidence.
- Education and research compiled by content experts will guide program development from the beginning.
- Anticipated outcomes are designated and appropriate outcome measures developed.
- The program is fiscally responsible.
- Productivity and accountability are expected.
- Qualified practitioners and personnel are involved.

Functions of Integrative Medicine at Abbott Northwestern Hospital

1. **Education of staff, patients, and the community.** Exhibit 33–4 provides the framework in the approach used for hospital-wide integrative health education. The example of educational

Exhibit 33–4 Integrative Medicine Educational Offerings

Theory/Research	*Modalities*	*Self-Care*
Holistic health care model	Acupuncture and acupressure	Self-care assessment
Psychoneuroimmunology	Massage therapy	Holistic approach to stress management
Relationship-centered care	Reflexology	Nutrition: The body's response to whole food.
Dynamics of energy healing	Touch therapies: Healing touch and therapeutic touch	Spirituality: Purpose and meaning the foundation to health
Strategic integrative medical care	Guided imagery	Body dynamics: Movement and exercise
Traditional health practices	Music therapy	Creating a self-care plan

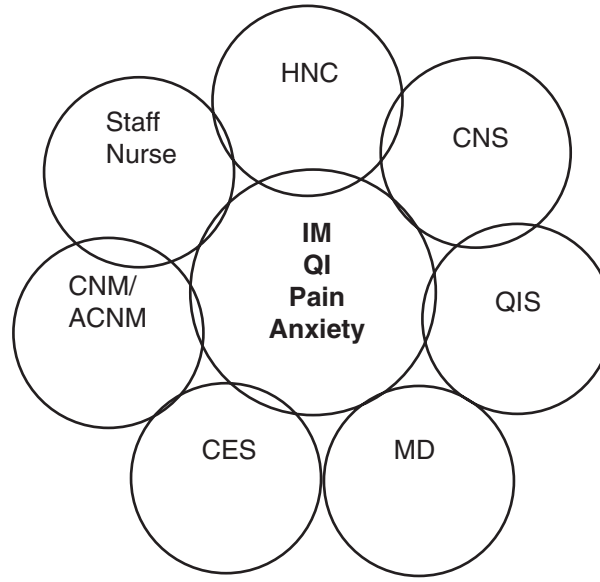
© 2003. Used with permission by Lori Knutson, RN, BSN, HNC, Abbot Northwestern Hospital, Director of Integrative Medicine, Minneapolis, Minnesota.

topics is formatted according to the audience (nurses, physicians, support services) and their specific identified need.

2. **Provide programs and services that enhance the innate healing of patients and staff.** New programs and services developed to integrate into the hospital environment include those provided by specialists and those provided by nurses as Independent Integrative Nursing Interventions (IINI). Specialty services include massage therapy, acupuncture/acupressure, reflexology, healing touch/therapeutic touch, mindbody therapies, healing coach, consultative services of nutrition, herbal therapies, and Holistic Nurse.

In accordance with hospital protocol, documentation tools have been developed to quantify services, communicate to other disciplines, and support outcome data measurements. Documentation tools, which were approved by the hospital medical records department and physician leadership as permanent medical records, include an Integrative Medicine Initial Assessment and a Healing Touch Treatment form. Integrative Medicine practitioners are also required to document in the Interdisciplinary Plan of Care and Progress Notes indicating assessment, identified reason for treatment, treatment, and follow-up. Chart audits are conducted both to assess interventions as well as for peer review of Integrative Medicine practitioners.

The Holistic Nurse Clinician role warrants further description. Requirements for this position are certification as a Holistic Nurse through the American Holistic Nurses' Certification Corporation,[6] training in a healing modality, a minimum of five years conventional acute care nursing



HNC - Holistic Nurse Clinician
CNS - Clinical Nurse Specialist
QIS - Quality Improvement Specialist
MD - Medical Doctor
CES - Clinical Education Specialist
CNM - Clinical Nurse Manager
ACNM - Assistant Clinical Nurse Manager
IM - Integrative Medicine
QI - Quality Improvement

Figure 33–1 Integrative Medicine Approach to Quality Improvement. *Source:* © 2003. Used with permission by Lori Knutson, RN, BSN, HNC, Abbot Northwestern Hospital, Director of Integrative Medicine, Minneapolis, Minnesota.

practice, and a dedication to personal self-care. The responsibilities of a Holistic Nurse Clinician include:

- Inpatient holistic health assessments
- Patient, staff, and community education
- Provider of healing therapies for inpatients
- Quality initiatives and program development

The Independent Integrative Nursing Interventions (IINI) currently in development and implementation are Guided Imagery and a Therapeutic Music Listening Program. Staff nurses identified the need for

options they could employ in the reduction of pain and anxiety for their patients. Quality initiatives were established through an interdepartmental partnership. The therapeutic relationship established in the design and implementation of the quality initiatives is a component in the dynamics of the Total Healing Environment. It required clinical experts collaborating through a healing process, raising their consciousness of the importance of relationships as a vehicle in the healing interventions for patients. Figure 33–1 provides a picture of this partnership.

Quality Improvement Practitioner Roles:

- **Holistic Nurse Clinician (HNC):** Integrative Medicine content specialist.
- **Clinical Nurse Specialist (CNS):** Liaison to bridge IM with clinical specialty.
- **Quality Improvement Specialist (QIS):** Process and tool design.
- **Clinical Nurse Manager/Assistant Clinical Nurse Manager (CNM/ACNM):** Financial support, time allocation, staff nurse support.
- **Clinical Education Specialist (CES):** Educational support.
- **Staff Nurse:** Actualization of therapeutic intervention.
- **Medical Doctor:** Medical guidelines and physician–peer communication.

The integration of guided imagery and a therapeutic music listening program into a patient's plan of care requires that the nurse assess the needs of the patient, determine the appropriate imagery and/or music, and utilize the documentation form developed to determine effectiveness of the intervention (Exhibit 33–5). Preliminary results of the integration of these two IINI indicate an increase in the patient's perception of quality of care, a decrease in patient pain and anxiety, and an improved sense in the provision of care by nurses.

Conclusions

We are in unprecedented times in the delivery of health care by hospitals. Patients, practitioners, and hospital leadership are recognizing the need to engage in an integrative approach to health and healing. This approach requires that hospitals invest in people as their bottom line in an effort to optimize the hospital experience for the patient. A healing environment begins by acknowledging that the current hospital environment emphasizes curing and is devoid of healing both for the patient and the employee. An effort is required to determine the individual needs of the hospital, the patient population, and the staff. Interdepartmental partnerships that are based in the concept of relationship-centered care will lead to successful quality initiatives that will result in the transformation to a healing health care environment through not only the process but the experience of being in the process.

DIRECTIONS FOR FUTURE RESEARCH

1. Evaluate the effectiveness of integrative health care as a catalyst in the transformation of hospitals as healing environments.
2. Determine the impact of the role of holistic nursing in the hospital setting.
3. Evaluate the effect of interdepartmental partnerships based on relationship-centered care in the healing of patients and staff.
4. Determine the financial impact of a healing environment on the hospital system.

NURSE HEALER REFLECTIONS

After reading this chapter, the nurse healer will be able to answer or will begin

Exhibit 33–5 Music Therapy Intervention

Music Therapy Intervention

Date ____/____/_____
Time CD Started: _____
Total time required of nurse (for set up and assessment):_____ (minutes)

____ **MUSIC THERAPY CD: (check one)** ____ **MUSIC THERAPIST**

☐ Relaxation	☐ Contemporary	☐ Easy Listening
☐ Classical	☐ Country Western	☐ Rock 'n' Roll
☐ R & B	☐ Big Band	☐ Oldies Rock 'n' Roll

Listened to entire CD or approx. length of intervention:_____ (minutes)

VITAL SIGNS:

Pre-intervention
Anxiety Level _____ (0-10, 0 = no anxiety, 10 = worst possible anxiety)
Pain Level _____(0-10, 0 = no pain, 10 = worst possible pain)
Heart Rate _____ Respiratory Rate _____

IF PATIENT FELL ASLEEP, DO NOT WAKE UP TO ASSESS
Fell asleep (circle one) Yes / No

Post-intervention
Anxiety Level _____ (0-10, 0 = no anxiety, 10 = worst possible anxiety)
Pain Level _____(0-10, 0 = no pain, 10 = worst possible pain)
Heart Rate _____ Respiratory Rate _____

MEDICATION:
Please record each dose or *total dosages* of pain and anxiety medications during the *past 12 hours.*

Pain Medications:	**DOSAGE**	**TIME GIVEN**
Anxiety medications:	**DOSAGE**	**TIME GIVEN**

© 2003. Used with permission by Lori Knutson, RN, BSN, HNC, Abbot Northwestern Hospital, Director of Integrative Medicine, Minneapolis, Minnesota.

a process of answering the following questions:

- How do I contribute to the healing environment of a hospital?
- How can I cultivate the knowledge, skills, and intuition in the manifestation of professional healing relationships?
- Do I feel confident to champion the evolution of integrative health care in the hospital environment?
- Is my spiritual practice one that supports my ability to initiate change in the hospital setting?

NOTES

1. B. Dossey, L. Keegan, and C.E. Guzzetta, *Holistic Nursing: A Handbook for Practice*, 3rd Edition (Gaithersburg, MD: Aspen Publishers), 747.
2. K. Malloch, D. Sluyter, and N. Moore, Relationship-Centered Care, Achieving True Value in Healthcare, *Journal of Nursing Administration* 30, no. 7–8 (2000):379–385.
3. I.R. Bell et al., Integrative Medicine and Systemic Outcomes Research, Issues in the Emergence of a New Model for Primary Health Care, *Archives of Internal Medicine* 162 (2002):133–140.
4. R. Snyderman and A. Weil, Integrative Medicine: Bringing Medicine Back to Its Roots, *Archives of Internal Medicine* 162 (2002):395–397.
5. R. Greenleaf, Center for Servant Leadership, *What is Servant-Leadership?* Available at: *www.greenleaf.org*, Accessed June 15, 2003.
6. American Holistic Nurses' Certification Corporation (2003).

RESOURCE

American Holistic Nurses' Certification Corporation
811 Linden Loop
Cedar Park, TX 78613
Phone: 877-284-0998
email: ahncc@flash.net

Index

Note: page numbers followed by *t*, *e*, or *f* denote tables, exhibits, or figures respectively

A

Abbott Northwestern Hospital. See Integrative medicine and the healing environment
Abilities Assessment Instrument for elderly women, 381
Absence of disease, 218
Acceptance, as coping strategy, 417
Acculturation, defined, 307
ACE Factor, 116
Achterberg, J., 571
Acidophilus, effect on health, 461
Acquired immunodeficiency syndrome (AIDS), beneficial effects of exercise, 481
ACTH, 125
Active listening, 77
"Actual caring occasion," 84
Actual nursing diagnoses, 354
Actualization, 44
AcuCancer, massage therapy, measurements of outcomes variables, 647
Acupressure, 181, 367
  defined, 643
  technique, 661
Acupuncture, 181, 213, 324
  massage, 648
  in reducing withdrawal symptoms, 793
  for smoking cessation, 770
Acute pain, 127
Adaptation potential, 84
Adaptive Child, 674
Adaptive Learning Systems, 860
Addiction and recovery counseling, 783–808
  addiction defined, 784–785
  are you a problem drinker?, 800e
  cycle of addiction
    early stage, 785
    late stage, 786
    middle stage, 785–786
  definitions, 783–784
  directions for future research, 807–808
  holistic caring process
    assessment, 799, 800e
    case study, 806–807
    evaluation, 807, 807e
    outcomes, 800, 801e
    patterns/challenges/needs, 799–800

specific intervention
imagery script, 804–806
learning to tell a personal story, 803
relaxation and imagery, 804
resistance to spirituality, 803–804
support from family and friends, 802
support groups and professional help, 802–803
therapeutic care plan and implementation, 800–802
models of addiction
character defect model of AA, 787–788
cultural model, 787
dysfunctional family system model, 786–787
ego psychology model, 787
genetic disease model, 786
medical model, 786
psychosocial psychoanalytic model, 787
self-medication model, 787
trance model, 788
transpersonal intoxication model, 788
transpersonal-existential model, 789
NCCAM research centers for CAM evaluations, 20t
nurse healer objectives, 783
nurse healer reflections, 808
statistics, 784
vulnerability model of recovery from addiction, 788–799
Al-Anon, 791–792
Alcoholics Anonymous, 791, 792e
basic points, 789e
body work and energy work, 793
Bodymind responses, 797–799
deepening the recovery process, 795
denial of the problem, 789, 789e
detoxification, 791
early recovery, 792–793
emotional education of children, 788–789
enabling, 791–792
nutritional factors, 793
recognition of addiction, 789–791
relapse, 793–795
warning signs, 794
spectrum of willfulness, 795, 796*f*
spectrum of will-lessness, 795, 797*f*
spiritual development and transformation, 795–796
Addictive behavior patterns, and stages of change, 764–766, 765*t*
action stage, 69
contemplation, 69
integration between processes, 71–72, 72e
maintenance stage, 70
precontemplation, 69
processes and interventions, 71e
spiral model, 70f
stage preparation, 69
Additive empathy, 265–267
Adipocyte hypertrophy theory, 723
Adjuvant analgesics, 128
Adolescents
discovering self-identity, 431–432
foreclosure group, 432
identity diffusion group, 432
identity achievement group, 432
moratorium group, 432
Adult ego state, 673–674
Adults, care of, and use of massage therapy, 646–648
Advair, 846–847
Advance medical directives, 102
Adverse events, methods of coping with, 114
Aerobic exercise, defined, 480
Aesculapian healer centers, 644
Aesculapius, 618
Aesthetic knowing, 58–59
predisposition to, 59
Aetheism, sensitivity to persons professing, 162
Affective factors, and pain, 128
Affirmations, 391
as coping strategy, 413–414
African-Americans, 319
aging, NCCAM research centers for CAM evaluations, 22*t*
cultural variation in human-environmental responses, 330–331*t*
health risks, 310
tobacco use by, 760
Afterburn, 745
Age, 354
and values systems of cultural groups, 312
Agency for Health Care Policy and Research (AHCPR), 213
Agency for Healthcare Research and Quality (AHRQ), 213
Aging
beneficial effects of exercise for aging adults, 483–484
NCCAM research centers for CAM evaluations, 20*t*
and nutrition, 466

AHNA Standards of Holistic Nursing Practice, 9–12, 31–37
  Core value 1
    holistic ethics, 33
    holistic philosophy, 32–33
    holistic theories, 33
  Core value 2
    holistic education and research, 33–34
    holistic nursing and related research, 34
  Core value 3, holistic nurse self-care, 34–35
  Core value 4
    cultural diversity, 35–36
    holistic communication, 35
    therapeutic environment, 35
  Core value 5, holistic caring process
    assessment, 36
    evaluation, 37
    implementation, 37
    outcomes, 36–37
    patterns/challenges/needs, 36
    therapeutic care plan, 36
  guidelines, 32
AIDS, beneficial effects of exercise, 481
Air pollution, 289*f*
Al-Anon, 791–792
Alaska Natives, tobacco use by, 760
Alcoholic Anonymous (AA), 784, 791
  character defect model, 787–789
  "dry drunks," 793
  H.A.L.T. acronym, 794
  "self-will run riot" behavior, 790
  the twelve steps, 792e
Alexander, Marline, 871–872
Alexander technique, 484, 655
Allopathic/traditional therapies
  defined, 5
  model, and holistic models compared, 9t
All-or-nothing thinking, 407
Alpha lipoic acid, 459
Alternative Link, ABC coding, 367, 369
Alternative medical systems, 18e
  and integrative medicine and complementary therapies, distinctions between, 892
Ambience, defined, 275
America Speaks, 285
American Association of Health Plans, 214
American College of Sports Medicine (ACSM)
  guidelines, 480, 481
  Position Stand on Weight Loss, 480
American Dietetic Association (ADA), 293
  achieving long-term weight loss, 727–728
  diabetic diet, 743
  guidelines, daily caloric intake, 724
American Holistic Nurses' Association (AHNA)
  decryption of holistic nursing, 81
  position statement
    on holistic nursing ethics, 99e
    in support of a healthful environment, 273
  on self-responsibility, 669
  Standards of Advanced Holistic Nursing Practice for Graduate-Prepared Nurses, 11
  views of holism, 86
American Holistic Nurses' Certification Corporation, 894
American Medical Association (AMA), 214
American Nurses' Association (ANA)
  Code for Nurses, 103
  Standards of Practice, 10–11
American Samueli Symposium on Healing Research, 215, 222
AMMA therapy, 655
Amnesia, role of in survivors of child sexual abuse, 816
Amygdala, 118, 120
Anagogic-metamorphic thinking, 59
Analgesics, 127–128
Anatomy of an Illness, 505–506
Anderson, Ray, 287
Andrews, M.M., 320
Anger management, survivors of sexual abuse, 822–823
Angier, Natalie, 508
Anima mundi, 278
Anthropocentrism, defined, 275
Anthropologists, use of humor, 498–499
Antibiotics, resistance to, 115
Antioxidants, 459–460
  defined, 451
Antrobus, J., 570
Anxiety
  massage therapy and, 646–648
  music therapy and, 624
  reducing with imagery, 573
  using coping humor, 501
APACHE II score, 858
Apollo, 617
Appleton, C., 60
Archetypes, 670, 672–673

case study: use of different archetypes, 683–684
Healer, 677
Teacher, 677, 678
Visionary, 677, 678
Warrior, 676–677
Aristotelian theory, 95–96
Aristotle, and laughter, 498
Aromatherapy, 193, 367, 827–848
administration
credentialing, 835
infection, 837–840
MRSA, 838
slow healing wounds, 839
inhaling and touch, 835
for insomnia, 835–836
oral intake, 835
for pain, 836–837
self-help, 835
typical topical application, 834–835
adverse reactions, 834, 834e
application methods
the 'm' technique, 832, 847–848
olfaction, 832
topical, 833
touch in aromatherapy, 832
clinical approach to, 830
definitions, 829
directions for future research, 848
essential oils
blue gum (Eucalyptus globulus), properties of, 840e, 846
Boswellia carteri, 846
Chamaemelum nobile, 836, 837, 838*t*, 847
distributors of, 842*t*
extraction method, 830–831
frankincense, properties of, 841e
identification by botanical name, 831–832, 831*t*
lavender, 831–832, 835–837, 838*t*, 839, 847
Matricaria recutita, 839
Organum majorana, 836
peppermint (Mentha piperita), properties of, 840e
Rosa damascena, 847
Salvia sclarea, 847
teatree, 838
properties of, 840e
Zingiber officinalis, 847
history, 830
holistic caring process
assessment, 841
case study
woman with mild asthma, 845–847
woman with unresolved chronic pain, 847–848
outcomes, 843, 844e
patterns/challenges/needs, 841–843
setting goals, 843
specific interventions, 845
therapeutic care plan and implementation, 843–845
how it works, 833
negative reactions, 833
nurse healer objectives, 829
nurse healer reflections, 848
nursing theory, 833
power of natural smells, 827
who uses it, 833–834
Aromatherapy Registration Board (ARB), 835
Arrien, Angeles, 676–677
Art. See also Creativity
in the hospital, 871–872
and spirituality, 166–167
Art of nursing, defined, 57
Arthritis
effects of aromatherapy and masssage, 837
NCCAM research centers for CAM evaluations, 20*t*
Asana, 552
Asbestos fibers, 288
Asian-Americans, 319–320
cultural variation in human-environmental responses, 330–331*t*
Aspirin, 127–128
Assagioli, Roberto
psychological laws, 574
uses of imagery, 574–575
Assagioli's Dimensions of the Psyche, 184*f*, 198–199
Assertive communication, as coping strategy, 414–416
Assessment of spirituality, 153–158
Care and Nuture of the Spiritual Self—Personal Reflective Assessment (PRA), 157, 158
exercises to facilitate awareness of, 153e
Howden's Spirituality Assessment Scale, 155, 156e, 157
Personal Spiritual Well-Being Assessment (PSWBA), 157

Spiritual assessment tool, 153, 154–155e, 155
Spiritual Well-Being Assessment (SWBA), 157
Assimilation, defined, 307
Association for Applied Psychophysiology and Biofeedback Institute of America, 544
Association of Healing Health Care Projects, 857, 858
Association of Humanistic Psychology, 673
Association of Transpersonal Psychology, 673
Asthma
beneficial effects of exercise, 483
identifying potential triggers, 118
Aston-patterning, 484
Attend, Connect, Express (ACE) Factor, 116
"Attention thermostat" effect, 761–762
Attitudes
defined, 57
and values, 65
Audiocassette/videocassette library, 630–631
Auras, 120, 190–193
chakra functions and aura interpretations, 191*t*
damage to, 193
defined, 175
the electromagnetic human source, 192*f*
intuitive explanations, 192–193
physical explanation, 192
Autogenic training, 538–539
defined, 523
hypothesized effects of, 539*t*
research-based outcomes of relaxation, 537*t*
Automatic thoughts, and cognitive therapy, 406–407
Autonomic nervous system (ANS), 123
Autopoiesis
defined, 111
network response, 117
Avis, Angela, 835
Awareness
and cognitive therapy, 403–406
defined, 429
developing, 164–165
Ayurvedic medicine, 21*t*, 321
exercises, 481

B

Balacs, T., 834
Balance paradigm of healing, 323e, 324
Barbara Brennan School of Healing Science, 655
Barker, E.R., 157
Barrett, E.A.M., 363, 550, 833
Barrett's Theory of Power, 524
"Battered Child Syndrome," 815
B-cells, 599, 602, 603
Beck, A.T., 398, 399, 725
Beck, C.T., 350
Becker, E., 788
Becker, R., 179–180
Beecher, H., 858
Behavior and lifestyle changes, strategies for smoking cessation, 763–766, 765*t*
Behavioral theories of weight loss, 723–724
healthy eating for hunger, 724
modifying behavior, 724
nutritional continuum, 723–724
reward system, 724
stimulus-response theory, 723
Behaviors. See also Addictive behavior patterns
and the human health experience, 67
Being
the art of, 143
defined, 93
"Being present," 239
"Being there," 237
Beliefs, 65
changing beliefs and values, 317–318
cultural, 315–316
defined, 57
myths and beliefs, 695–696
Bell, Mary, 655
Bell's theorem, 115–116
Bengston, W.F., 202
Benner, P., 178, 349, 350
Benor, D.J., 191–192, 201, 202
Benson, Herbert, 528, 529, 797
Bentham, Jeremy, 96
Berk, Lee, 507–508
Bernal, H., 309
Berne, Eric, 673–674
Bertalanffy, L. von, 7, 217
Beta–blockers, 121
Beta-carotene, 459
Beta-endorphin, 761
Bifurcation, defined, 111
Binary thinking, 57
Biodance, 379, 380

Biofeedback, 14, 124, 194, 221, 544
clinical indicators for, 545e
defined, 523
holistic nurse learning experiment II, 545–547
holistic nurse learning experiment II (variations), 547–549
impact and usefulness of, 544
monitors, 544
and relaxation, 526
research-based outcomes of relaxation, 537*t*
specialized training, 544
temperature unit, 546*f*
Biofield, NCCAM research centers for CAM evaluations, 20*t*
Biologic variations, and cultural competency, 328, 331*t*
Biological theories of weight loss
adipocyte hypertrophy theory, 723
energy balance theory, 723
genetic disposition to accumulation of fat, 722–723
metabolic stimulants for weight loss, 723
set point theory, 723
Biologically based therapies, 18e
Biophotons
defined, 175
research, 199–200
Bio-psycho-social-spiritual model, 8, 10f
Blending breaths and co-meditation, 709
Blood pressure readings, and spirituality, 114
Bloom, Sandra, 552
Blunters, 116
Body mass index (BMI), 721
Body therapy, defined, 643
Bodymind, 4. See also Psychophysiology of Bodymind healing
communication, and touch therapy, 650–651
defined, 111
Body-mind imagery, defined, 567
Body-mind-spirit
affects of true healing environment, 48
integration, 565
Bohm, David, 43
Bohr, Niels, 112
Bone healing imagery, 592–594
Bones, broken, healing of, 180
Books, on cultural diversity, 334
Borysenko, J., 442, 704
Boswellia, NCCAM research centers for CAM evaluations, 21*t*
Botanicals, NCCAM research centers for CAM evaluations, 21*t*
Bowden, J.W., 796
Bowen technique, 201
Bowers, Edwin, 654
Boyle, J.S., 320
Bradshaw, R., 835
Brain centers
effect of odors on, 832
location of, 120
Brain development, and play, 508
Brain Electrical Activity Maps (BEAM), effect of odors on the brain, 832
Brain wave biofeedback, for people in recovery from addictions, 799
Braud, W., 573
Breathing
and energy healing practice, 530
and relaxation, 529–530
Brennan, B.A., 190–191, 192
Briggs Institute for Evidence-based Nursing, 214
Brownell, K.D., 724, 728, 732–733
Brownfield, A., 837
Bruyere, R., 188
Buddha's Four Foundations of Mindfulness, 528
Buddhist Tibetan prediction of the 12th century, 279
Building a healthy environment, 273–301. See also Holistic caring process; Irradiation of food; Noise pollution; Smoking
building learning communities, 286–287
choosing a sustainable future, 283–286
definitions, 275–276
directions for future research, 301
environmental conditions and health, 288–290
evolvement of environmentalism, 279–280
factors contributing to an unhealthy environment, 273–274
hazardous environmental elements, 288
coping with, 298*t*
living in a toxic world, 279–283
life-affirming trends, 282–283
questions to evaluate products, companies, and initiatives, 283e
three key principles
precautionary principle, 282

principle of reverse onus, 282
principle of the least toxic alternative, 282
nurse healer objectives, 275
nurse healer reflections, 301
nurses' working environment, 295
telling one's story
core elements driving the multidimensional crisis, 278
transformative unfolding to a more integral world, 278–279
two stories of the evolution, 277–278
working from the inside out, 287–288
Bulimia, 724–725
Burkhardt, M.A., 157, 158, 681
Burn graft healing imagery, 594–597
Burn patients, music therapy and, 624
Burns, D.D., 398, 399
Business, and future sustainability, 285
Business communities, striving toward sustainability, 286–287

C

Caesar, Julius, 644
Caesarean section, complications, benefits of social support, 402
Callanan, M., 696
CAM, web-based research system, 213
Campbell, D., 858
Campion, Jeanne, 552
Canadian Association Physical Fitness Physicians for the Environment (CAPE), 293–294
Canadian Cattlemen's Association, 294
Cancer
environmental risk factors for, 462–463
foods with anticancer properties, 463
high-fat, low fiber diet, 463
massage therapy, 646–647
NCCAM research centers for CAM evaluations, 21–22t
recommendations, 463–464
treatment, pain reduction during and guided imagery, 571–572
Carbohydrates, 454
Carcinogens in drinking water, 281
Cardiopulmonary resuscitation (CPR), family presence at, 214
Cardiorespiratory endurance, 487–488
Cardiovascular disease
in aging African Americans, NCCAM research centers for CAM evaluations, 22t
application of imagery, 572–573
beneficial effects of exercise, 481–482
homocysteine levels and, 453
protective effects of dietary nutrients, 462
Cardon, Kerrie, 868
C.A.R.E., 873
Caregiver Assistance Program (CAP), 860
CareWise, 866
Carey, Peggy, 875
Caring, 64. See also Transpersonal healing and caring
perspectives on, 42
Caring Model, 861e
Caring touch, defined, 643
Caring-healing interventions, defined, 5–6
Caring-healing paradigm, 19, 24
Carkhuff, R.R., 261
Carotenoids, 458*t*
Carper, B., 47, 58
Carson, Rachel, 279–280, 281
Cascade Healthcare Community, 859
Catharsis, as coping strategy, 414
Cell growth factor, 125
Cell-to-cell communication, 200
Center for Health and Learning (CHL), 864–865, 876
Centeredness, defined, 233
Centering
defined, 175, 643
developing, 164–165
Central nervous system (CNS)
effects of sympathetic and parasympathetic stimulation, 123*t*
interconnectedness, 122–124
Central Oregon Council on Aging, 874–875
Central Oregon Health Council (COHC), 874
Certification
advanced practice, 11
Holistic Nurse Certified (HNC), 10
Holistic Nurse Clinician, 894–895
Chah, Achaan, 527
"Chakra Suite," 622–623
Chakras
Assagioli's Dimensions of the Psyche, 184*f*
chakra functions and aura interpretations, 191*t*
defined, 175
five perspectives of, 182*t*
intuitive explanations, 185–190
chakra development, 188–189, 189*t*
chakras as transformers, 185–186
data processing, 185, 186
established responses, 186

exercise to become aware of your own chakra energy, 186–187
Homo erectus, 187–188
Homo sapiens, 188, 189
the need for chakras, 187
scientific explanation, 185
traditional explanations, 181–185
oral tradition format, 184
Change. See also Stages of change
being open to, 55
Changing outcomes, 395
Chaos, defined, 111, 233
Chaos theory, defined, 275–276
Chaplin, Charlie, 499, 500
Cheeks, David, 542–543
Chemical exposure, 289*f*
Chemotherapy, massage therapy for patients receiving, 647
Chemotype, defined, 829
Chi, 179, 320, 324
Chi Kung, 176
research-based outcomes of, 531*t*
Child sexual abuse. See Incest and child sexual abuse
Children
benefit of massage therapy, 648–649
discovering self-identity, 431
in pain, massage and aromatherapy, 837, 838*t*
Chinese, use of touch, 644
Chinese ancient practices, 530
Chinn, P., 59, 60
Chiropractic, 655
NCCAM research centers for CAM evaluations, 22t
Choice (acronym), 552
Choices
potential, development of, 389, 390
self-assessment of, 385*f*
Choosing the value, 65–66
Chronic pain, 127
Circadian rhythms, 121, 124
Civil Rights Act (1964), 309
Client of holistic nursing, defined, 6
Clinical aromatherapy, defined, 829
Clinical Education Specialist (CES), 896
Clinical imagery, defined, 567
Clinical intuition, 349
Clinical Nurse Manager/Assistant Clinical Nurse Manager (CNM/ACNM), 896
Clinical Nurse Specialist (CNS), 896
Clinical objectives, 5
Closed vs. open system, 235
Clustering, 440–441, 441*f*
Cochrane Back Review Group, 647
Cochrane Collaboration, 213
Cochrane Collaboration Field in Complementary Medicine, 649
Cochrane Review of physical training cystic fibrosis, 483
Cocreative Aesthetic Process, 61–63
defined, 57
engagement, 62
movement within and movement through, 62
mutuality, 62
new forms, 62
Code of Ethics for Holistic Nurses, 99e
Coenzyme Q10, 459
Cognition, 115
"cognitive domain," 118
defined, 397
Cognitive, defined, 397
Cognitive awareness, 432
Cognitive distortions, 407–411
defined, 397
Cognitive factors, affecting pain interpretation, 128
Cognitive inference, 350
Cognitive theories of weight loss, based on reversal theory, 725
Cognitive therapy, 120, 397–423
basic principles, 402–403
application, 417–418
challenging stress and winning, 405e
cognitive restructuring, 121*t*, 401, 410
defined, 397
definitions, 397–398
directions for future research, 423
effects of cognition on health and illness
physiologic effects of stress, 399–400
psychologic effects of stress, 400–401
social-behavioral effects of stress, 401–402
spiritual effects of stress, 402
stress response, 399, 400*f*
goals of, 403
holistic caring process
assessment, 418
case study, 421–423
evaluation, 423
outcomes, 418–419
patterns/challenges/needs, 418

setting goals, 419–421
therapeutic care plan and interventions, 421
nurse healer objectives, 397
nurse healer reflections, 423
origins and history of, 398–399
process of cognitive therapy
automatic thoughts, 406–407
awareness, 403–406
choosing effective coping, 411–417
cognitive distortions, 407–411
stress warning signals, 404*e*
for weight management
based on reversal theory, 732–733
cognitive restructuring strategies, 733, 734*e*, 735–737
Coherence, and healing, 43
Coleman-Kennedy, C., 784
Collective Unconscious, 199, 440
Co-meditation, and blending breaths, 709
Committee on Interagency Radiation Research and Policy Coordination, 292
Common sense understanding, 61
Communication. See also Therapeutic communication
assertive, as coping strategy, 414–416
and cultural competency, 326–327, 327–328, 330*t*
process, components of, 77
standards of practice, 35
Communities, criteria for mobilizing citizen engagement, 285–286
Community-practitioner relationship, knowledge-skills-values, 25*t*, 26–27
CommunityWorks, 552
Complementary and alternative medical (CAM) therapies, 16–24, 212
arguments against using, 214
caring-healing paradigm, 19, 24
in combination with multimodal interventions, 221–222
comparative outcomes studies, 214–215
defined, 16
five domains of CAM therapy, 17, 18–19*e*
inclusion in curricula, 16–17
and integrative medicine, distinctions between, 892
numbers using, 215
and the placebo response, 224
popularity of the therapies, 16
psychophysiologic outcomes, 220–221
studies to evaluate, 215
ultimate goal of, 17
visits to CAM practitioners, 16
Complementary transaction, 674, 675*f*
defined, 670
Computer-based patient record, standardized vocabulary for, 352
Concept, defined, 79
Conceptual model, defined, 79
Concrete objective information, 578–579
Concreteness, 264
Confiding in others, and healing, 116
Conflict management with an HMO, case study, 685–686
Confrontation, 268
Confucian theory of ethics, 103
Connectedness. See also Healing relationships
fostering, 161–162
with nature, 141–142
with others, 142–143
Personal Reflective Assessment (PRA), 159
with the Sacred Source, 141
with self, 143–144
Connecting with life energy imagery, 587–588
Conscious self, 185
Consciousness
defined, 93
and energetic healing, 178
holistic ethics and, 98, 100
mechanisms of, 120
shifting into a healing state, 50
Consciousness-created reality, 197–198, 203
defined, 175
Consensus Development Conference on Acupuncture, 213
Contextual issues, in analysis of ethical dilemmas, 102
Continuous Ambient Relaxation Environment (C.A.R.E.), 873
Contractarian theory, 96
Contrasts of daily experiences, 135
Co-op America, 287
Coping
choosing effective coping, 411–417
humor, 501–502
Core Curriculum for Holistic Nursing, 10
Coronary artery disease, effects of holistic intervention program, 221–222
Correct biologic imagery, 592
defined, 567

Cortical interconnections, 127
Cortisol, 125
Cosby, Bill, 509
Cost-gain analysis, 269
Cousins, Norman, 505–506, 507, 543
Cowan, S., 282, 283
Coward, D.D., 434
Craniofacial disorders, NCCAM research centers for CAM evaluations, 23*t*
Crawford, P., 140
Creation, relationship with, 244
Creative involvement, 242
Creativity, 61, 81*t*
  creating works of art, 438
  to enrich the life of the spirit, 167
  and music, 623
  opening creatively to the client, 109–110
Creator, relationship with, 243–244
Credentialing, aromatherapy, 835
Crisis, ancient Chinese hexagram for, 528
Critical Parent, 673
Cross, R., 858
Crucible Program, 655
Cryptotrauma
  cautions and contraindications, 549–550
  and PTSD, 550
Cultural blindness, 313
Cultural competency, 64, 308–310. See also Cultural diversity and care
  components of
    adaptation skills, 310
    awareness and acceptance of cultural differences, 309
    awareness of one's own biases and attitudes, 309–310
    not promoting superiority of one culture, 310
    share knowledge and skills straightforwardly, 310
  cultural destructiveness to cultural competency, 309
  culturally competent health care, 307, 309
  defined, 6
  nursing applications for developing, 325–327
    communication, 326–327
    introduction, 325–326
    studying terminology, 325
    use of translators, 327
  websites on, 334
Cultural Creatives, 318
Cultural diversity and care, 307–334
  cultural competency, 308–310
  definitions, 307–308
  developing cultural competency, 325–327
  development of cultural patterns and behaviors
    changing beliefs and values, 317–318
    cultural beliefs, 316–317
    gender roles, 314–315
    geography and migration, 313–314
    technology and culture, 317
    value orientations, 315–316
  directions for future research, 333
  and ethics of holistic nursing, 101–102
  ethnic groups in North America, 318–320
  health disparities
    common myths and errors, 312–313
    difference in prevalence of illness between groups, 310
    effects of socioeconomic status, 310–311
    factors related to culture, 311–312
    race and ethnicity, 311
  holistic caring process, 327–329
    assessment, 329, 332*e*
    evaluation, 333
    outcomes, 329, 331
    patterns/challenges/needs, 329, 331
    therapeutic care plan and implementation, 332–333
  impact of culture on health care, 320–325
  introduction, 308
  nurse healer objectives, 307
  nurse healer reflections, 334
  resource list, 334
  standards of practice, 35–36
  variation in human-environmental responses, 330–331*t*
Cultural imposition, 313
Cultural model of addiction, 787
Cultural negotiation, 344–345
Culturally and Linguistic Appropriate Services (CLAS) standards, 325–326, 327
Culturally sensitive, 64
Culture, 64–65
  cross-cultural influences
    on humor, 499
    on relaxation practices, 526
  defined, 57, 307
  perspectives on spirituality, 140
  variations
    in pain response, 129
    in touch therapy, 645

Curing. See also Healing vs. curing
defined, 45
Cutaneous pain, 126
Cycles, defined, 111
Cymatics, defined, 617
Cystic fibrosis (CF), beneficial effects of exercise, 483
Cytokines, 125

D

Damasio, A., 117
Dance of human life, 135–136
Dance therapy, 485
"Dark night of the soul," 148
Data analysis triangulation, 220
Data source triangulation, 220
Davidhizar, R., 322
Daydreaming research, 570
De Vernejoul, M.C., 179, 180
Death
from alcoholism, 784
defined, 693
from smoking, 760
Decibels, 619
Defense patterns, defined, 670
Deliberate rationality, 61
Denial, definitions of, 783, 790*e*
Deontologic theory, 96
Depression, 401
and smoking cessation, 763
Descartes, René, 112, 215–216
Deschutes County Coalition for Quality-of-Life Care, 867–868
Description, nursing theory, 82
Descriptive expressions of health, 217–218, 218*t*
Detoxification, 792
defined, 783
Diabetes
AMA diabetic diet, 743
beneficial effects of exercise, 482
stress management, 482
type 2 (adult-onset), 727
Diagnostic concept, 354
Dialectic, defined, 57
Diaries. See Journal-keeping
DiClemente, C.C., 739, 740*e*
Diet and nutrition. See Eating to promote health; Nutrition
Dietary goals and recommendations, 457*t*
Digestion, 460–461
Direct action, as coping strategy, 413
Director of Programs and Services, 892
Disclosure, and healing, 114
Disease
defined, 57
genetic predisposition to, 311
and responses to life challenges, 235
use of imagery with, 577–578
Disqualifying the positive, 407
Dissanayake, E., 59
Dissociation, defined, 815
Distraction
combined with positioning and parental support, 221
as coping strategy, 413
Disturbances, decreasing, as goal of health care, 7–8
Divine connection, 238–239
Doing, 143
"Doing" and "being" therapies, 12–14, 14f, 15
Doona, M.E., 236
Dopamine, 761
Dossey, B.M., 148, 236, 240
Dossey, L., 130, 178
Double effect, principle of, 95
Down-regulation, 124
Draper, E., 858
Draper, John, 550
Drawing, and imagery, 604–605
Dreams, learning from, 439–440
Drug interactions, when using essential oils, 834*e*
Dry drunks, 783, 793
Dualism, 139, 316
Durable power of attorney, 102
Dying, defined, 693
Dying in peace, 693–717
definitions, 693
directions for future research, 716–717
grief and loss, 694–695
helping people to die well, 693–694
holistic caring process
assessment, 697–698
case studies, 713–716
evaluation, 716, 716*e*
outcomes, 698, 798*e*
patterns/challenges/needs, 698
specific interventions
becoming peaceful: relaxation and imagery scripts, 704–708
blending breaths and co-meditation, 709
death bed ritual, 712

learning forgiveness, 704
leavetaking rituals
celebrating holidays, 712
getting unstuck, 713
healing memories, 713
letting grief be present, 712–713
rearranging and giving away, 712
releasing anger and tears, 713
sustaining faith and hope, 713
mantras and prayers, 709–710
the pain process, 708–709
planning an ideal death, 702–704
reminiscing and life review, 710–711e, 712
therapeutic care plan and implementation
beginning of the interaction, 698, 700
during the dying process, 700–702
incorporate the senses in rituals, 701
at the moment of death, 702
nearing death awareness, 696–697
nurse healer objectives, 693
nurse healer reflections, 717
releasing attachment to the physical body, 691–692
Dysfunctional family system model of addiction, 786–787

E

Eastern view of God, 139
EAT and STOP strategies, weight management, 733, 734e, 735
EAT for Hunger strategy, 742, 743
Eating disorders, 724–725
Eating to promote health
cancer
environmental risk factors for, 462–463
foods with anticancer properties, 463
high-fat, low-fiber diet, 463
recommendations, 463–464
cardiovascular disease, protective effects of dietary nutrients, 462
healthy choices
foods to avoid, 467
high-fiber diet, 467
low-fat diet, 467
other important health factors, 467–468
menu planning, 462
nutrition and aging
glucose metabolism imbalance, 466–467
hypoglycemia and carbohydrate cravings, 467
hypoglycemic diet plan, 468e
insulin resistance syndrome, 467
medications that impair nutrient absorption, 466
psychosocial factors to consider, 466
risk of macronutrient and micronutrient deficiencies, 466
obesity
contributing factors, 465
defined, 465
guidelines for weight management, 465–466
osteoporosis
guidelines for healthy bones, 465
prevention program, 464
risk factors for, 464–465
role of calcium and other nutrients, 464
supplement recommendations, 465
stress response and a healthy diet, 462
Ecologic center building, using principles of sustainability, 284–285
Ecological approach, to nursing process, 345
Ecological Society of America, 289
Ecology, defined, 276
Ecominnea, defined, 276
Education
emotional education of children, 788–789
and future sustainability, 285
holistic education and research, 33–34
holistic ethics, 102–103
infant mortality, and educational level of mothers, 310
in-service education, 377
integrative medicine educational offerings, 893–894, 894e
standards of practice, 33–34
techniques, 249
Education and Research Coordinator, 893
Effkin, J.A., 349
Effleurage backrub, effects of, 213
Egan, G., 261
Ego psychology model of addiction, 787
Ego states
case study: use of different ego states, 684
defined, 670
Egyptians, use of touch, 644
Eidetic psychotherapy, 574
Einstein, Albert, 91, 113–114
Electorencephalogram (EEG) studies, 195
Electron Beam Tomography (EBT) studies, 865
Ellis, A., 398, 399, 411

Emergency rooms, use of humor as coping tool, 503–504
Emerson, Ralph Waldo, 91
Emmelkamp, P.M., 399
Emotional hook, 411–412
Emotional intelligence, defined, 670
Emotional reasoning, 407
Emotions
  identifying and expressing, 410–411
  and the neural tripwire, 118–120, 119*f*
    location of the brain centers, 120
    state-dependent memory and recall, 118–120
  and neuropeptides, 126
  potential, development of, 388, 390
  self-assessment of, 383*f*
Empathy, 60, 263
  additive, 265–267
  as coping strategy, 416–417
Empirics, 47
Empowerment, child sexual abuse, 820
Endocrine system
  and the meridian system, 179
  and the stress response, 124
Endorphins, 118, 128
End-state imagery, defined, 567
Endurance, defined, 480
Energetic Approaches to Emotional Healing, 654
Energetic healing
  aromatherapy, 193
  the aura, 190–193
    chakra functions and aura interpretations, 191*t*
    damage to, 193
    the electromagnetic human source, 192*f*
    intuitive explanations, 192–193
    physics explanation, 192
  chakras
    Assagioli's Dimensions of the Psyche, 184*f*
    five perspectives of, 182*t*
    intuitive explanations, 185–190
      chakra development, 188–189, 189*t*
      chakras as transformers, 185–186
      data processing, 185, 186
      established responses, 186
      exercise to become aware of your own chakra energy, 186–187
      Homo erectus, 187–188
      Homo sapiens, 188, 189
      the need for chakras, 187
    scientific explanations, 185
    traditional explanations, 181–185
      oral tradition format, 184
  and consciousness, 178
  definitions, 175–176
  energetic defined, 176
  eyes, ears, and touch, 193
  the healer, 194–196
    approaches, 194
    EEG activity, 195
    healing intention, 194–195
    heart rate variability, 194
    pulsed electromagnetic fields (PEMF), 195–196
    therapeutic touch and superconductors—SQUID, 195
  laying-on-of-hands, 176
  meridians
    effects of damaged, 179
    intuitive explanations, 180–181
    scientific explanations, 179–180
    traditional explanations, 178–179
  novice vs. experienced practitioners, 178
  nurse healer objectives, 175
  nurse healer reflections, 205
  the one being healed, 196–199
    Assagioli's seven dimensions of the psyche, 198–199
    consciousness-created reality, 197–198
    holographic theory, 196–197
  overview of, 177–178
  research
    biophotons, 199–200
    implications for, 201–203
    tensegrity and the geodesic dome human, 200–201
  sound and music therapies, 193
  subtle energies, 176, 177
  term described, 176
  traditional explantions, 190–192
Energy, philosophy of, 173
Energy balance theory, weight loss, 723
Energy center, defined, 643–644
Energy fields, 87*e*, 88*t*, 653, 671
Energy healing, and breathing, 530
Energy meridian, defined, 644
Energy-based therapies, 18*e*, 530, 587–588, 652
Engagement, 62
  defined, 58
Engagement/lack of engagement, 67
Engebretson, J., 139, 332, 344

Engel, G., 398
England Health and Safety Executive, 289
Entrainment, 244
Environment. See also Building a healthy environment
  definitions of, 6, 82, 83–84, 85, 276
  nurse as healing environment, 49–50, 244–246
    effect on the individual, 246
    focused intention, 245
    process of healing, 245–246
    ways for nurses to become an instrument of healing, 245
  sense of connection with, 161–162
Environmental adaptation, 82–83, 87*e*, 88*t*
Environmental control, and cultural competency, 328, 330–331*t*
Environmental ethics, defined, 276
Environmental justice, defined, 276
Environmental Protection Agency (EPA), 288
  noise level of hospitals, 619
Environmental tobacco smoke (ETS), exposure to, 760
Environmentalism, evolvement of, 279–280
Epictetus, 398
Epistemology, 276, 278
Eras of medicine, 12–24, 12*f*, 13*t*
  complementary and alternative therapies (CAM), 16–24
  "doing" and "being" therapies, 12–14, 14*f*
  rational vs. paradoxical healing, 14–16, 14*f*
Ergonomics, defined, 276
Erickson, E., 430–431, 432
Erickson, Helen, 83, 343, 345
Erickson, M.E., 833
Erickson's Stages of Development, 83
Essential fatty acids, 456, 462
Essential of Master's Education, 11
Essential oils. See also Aromatherapy
  blue gum (Eucalyptus globulus), properties of, 840e, 846
  Boswellia carteri, 846
  Chamaemelum nobile, 836, 837, 838*t*, 847
  defined, 829
  distributors of, 842*t*
  extraction method, 830–831
  frankincense, properties of, 840e
  identification by botanical name, 831–832, 831*t*
  lavender (Lavandula angustifolia), 831–832, 835–837, 838*t*, 839, 839e, 847
  Matricaria recutita, 839
  Organum majorana, 836
  peppermint (Mentha piperita), properties of, 840e
  Rosa damascena, 847
  Salvia sclarea, 847
  teatree, 838, 840e
  Zingiber officinalis, 847
Essential Readings in Holistic Nursing, 10
Estabrooks, C.A., 650
Estebany, Oskar, 646
Ethical code, defined, 93
Ethics of holistic nursing, 63
  advance medical directives, 102
  AHNA position statement on, 99e
  analysis of ethical dilemmas
    contextual issues, 102
    medical indications, 101
    patient preferences, 101
    quality of life, 101–102
  cultural diversity considerations, 103–104
  definitions, 93–94
  development of holistic ethics
    consciousness, 98, 100
    Eastern monad-yin-yang mode, 96
    presuppositions, 96–98
    Western concept of masculine and feminine, 96
  development of principled behavior
    legal aspects, 101
    values clarification, 100
  directions for future research, 104
  ethics defined, 93
  ethics education and research, 102–103
  morals and principles, 94–95
    law of unintended consequences, 95
    moral dilemma, 95
    moral distress, 95
    moral uncertainty, 95
    principle of double effect, 95
    rules and precedents, 94–95
    three primary principles, 94
  nature of ethical problems, 94
  nurse healer objectives, 93
  nurse healer reflections, 104
  in our changing world, 91
  traditional theories, 95–96
Ethnic groups in North America, 318–320
Ethnicity
  defined, 307
  and health care disparities, 311
  variations within ethnic groups, 312–313

Ethnocentric responses, 65
Ethnocentrism, 313
  defined, 308
Ethnography, 217
European Americans, 319
Evidence-based practice, research, 212–214
Examination periods, immunologic changes during, 125
Examine discrepancies, 268
Exercise and movement, 166, 477–491
  anaerobic vs. aerobic exercise, 744–745
  definitions, 479–480
  directions for future research, 491
  exercise, 480–484
    ACSM guidelines, 480, 481
    ACSM Position Stand on Weight Loss, 480
    needs in special situations
      aging adults, 483–484
      AIDS, 481
      asthma, 483
      cardiovascular disease, 481–482
      cystic fibrosis, 483
      diabetes, 482
      Eastern approaches, 481
      fibromyalgia, 483
      low back pain, 482
      osteoporosis, 482–483
      psychiatric conditions, 483
      rheumatoid arthritis, 483
    percent of adults engaged in, 480
  frequency, duration, and intensity, 745
  holistic caring process
    assessment, 485
    evaluation, 490–491
    outcomes, 485, 486e
    patterns/challenges/needs, 485
    specific interventions: exercise (basic), 486–489
      client evaluation, 487e
      fitness components, 487–488
      guidelines, 488
      nurse-led programs, 489
      old and new fitness paradigms, 487*t*
      reducing risks, 488–489
      rewards, 488
    specific interventions: movement (basic)
      case study, 489–490
      components of, 489
    therapeutic care plan and interventions, 485–486
  movement, 484–485
  nurse healer objectives, 479
  nurse healer reflections, 491
  as part of weight management, 726, 744–745
  post-exercise oxygen consumption (EPOC), 745
Exercise for LIFE strategy, 743–744
Expanded Consciousness Theory, 85
Expertise, 81*t*
Explanation, nursing theory, 82
Extra low frequencies (ELF), 197

F

Failure, reframed, 339
Faint or freeze, 118, 120
Fall and tragic separation, 277
False Memory Syndrome Foundation (FMSF), 816
Family presence during cardiopulmonary resuscitation, 214
Fatty acids, essential, 456, 462
Fear, acknowledging and dealing with, 757
Fear response, 118
Federal Food, Drug, and Cosmetic Act (1938), 292
Feedback, 260, 267
"Feeling the Feelings" technique, 735
Feelings, and memory, 118–120
Feinstein, D., 694, 696
Feldenkrais, Moshe, 655
Feldenkrais method, 484, 655
Fever, 113
Fiber, 454–455
Fibonacci number, 189
Fibromyalgia, beneficial effects of exercise, 483
Field of Consciousness, 198–199
Fight or flight response, 118, 120, 399, 400*f*
  vs. relaxation response, 525, 528, 529
"Fighting Fair" technique, 735, 737
Firestone, L.A., 61
Fisher, Faith, 521
Fitness. See also Exercise and movement
  defined, 480
Fitzgerald, William, 654
Flashback, defined, 813
Fleisher, S., 570
Flexibility, 480, 487
Focused smoking, 759, 769–770
Folic acid, 458*t*
Fontana, D., 439, 440
Food Additives Amendment, 292

Food and Drug Administration (FDA), 292
Food Irradiation Information Center, 292
Food Technology Services, Inc., 292
Foods. See also Eating to promote health; Weight management counseling
  to avoid, 467
  being connected to the food source, 719
  irradiation of (See Irradiation of food)
  to prevent illness, 333
Foot reflexology, defined, 644
"Foot-in-the-door" strategy, 69
Forgiveness
  defined, 670
  effects at every level of being, 45
  learning, 704
  spiritual view of, 145–146
Foster, G.D., 727
Foulkes, D., 570
Foundation for Unity Consciousness, 655
Framework, defined, 79
Frankl, V., 402, 433, 695
Frasure-Smith, N., 401
Free radicals, defined, 451
Freel, M.I., 249
Frequency, 618–619
  defined, 617
Freud, Sigmund
  Oedipal Complex, 815
  psychoanalytic view of humor, 498, 501
Friends Committee on Unity with Nature/Sustainability, 287
Frisch, L.E., 343, 363
Frisch, N.C., 343, 363
Fry, William, Jr., 506
Fuller, R. Buckminster, 200

G

Gallows humor, 502–504
Game, 670, 674
Gandhi, Mahatma, 129–130
Gattefosse, Maurice, 830
Gatto, J.T., 286
General healing response. See Placebo response
Genetic disease model of addiction, 786
Genetic disposition to accumulation of fat, 722–723
Genuineness, 264
Geography, and development of cultural patterns and behaviors, 313
George, William, 884
Gerber, R., 179
Gerontopsychiatric nursing, 442
Gestalt intuition, 350
Gibson, J.J., 349
Gigar, J., 322
Gillette Nursing Summit on Integrated Health and Healing, 212
Ginger, NCCAM research centers for CAM evaluations, 21*t*
Glucocorticoids, 125
Glucose metabolism imbalance, 466–467
Glutathione, 459–460
Glycemic index, defined, 451
God, 239. See also Spirituality and health
  various other names for, 141
Golden Rule, 96, 98
GOMER, 502
Gorski, T., 794
Gough, W.C., 194
Government, and future sustainability, 285
Grace
  concept of grace and presence, 238–239
  defined, 233
  spiritual view of, 147
Graceful presence, defined, 234
Grad, Bernard, 646
Graham, H., 570
Gramling, K., 60, 61
Grant, L., 284
Great Chain of Being, 39
Greeks
  nature of comedy and laughter, 498
  therapeutic touch, 644
Green, Alyce, 544
Green, Elmer, 544
Green, L.L., 796
Gregorios, 97
Grief, 694–695
  defined, 693
Grounded theory research, 217
Grounding
  defined, 644, 813
  skills, child sexual abuse, 820–821
Grudin, R., 62
Guide, defined, 234
Guided imagery, defined, 567
Guided imagery and music (GIM), 623–624

H

Habit breakers, defined, 759
"Haelan effect," 44
Hall, B.A., 149
Hall, H., 571

Halpern, Steven, 622
H.A.L.T. acronym, 794
Handler, Seymour, 455
Hands-on healer. See Touch
Happiness, and survival, 114
"Hardiness factor," 116
Hardy, M., 834
Harlow, H., 645
Harman, W.W., 203
Harmony, and healing, 43
Hatch, R.L., 149
Hazardous environmental elements, 288
  coping with, 298*t*
HDL, defined, 451
Headaches, massage therapy, 646
Healer. See also Nurse as an instrument of healing
  root word of, 231
Healer archetypes, 677
Healing, 380. See also Nurse as an instrument of healing; Transpersonal healing and caring
  approaches to, 247–248
  concepts of, 235–236
  criteria for evaluating, 231
  defined, 6, 234, 235–236, 379
  process of, 236
  root word of, 231
Healing awareness, defined, 379
Healing Coach, 893
Healing energy, and laughter, 505
Healing environment, defined, 234
Healing Health Campus, 875
Healing health care, defined, 857
Healing Health Care Philosophy, 857–858, 859, 869, 876
  examples of research studies, 858
  nursing theorists, 858
Healing HealthCare Systems, 872, 873
Healing intention, 194
Healing interventions, 246–249
  evaluation of, 249
  outcomes of, 248–249
  preparations for, 246
  protection from the dynamics of energetic interaction, 246
  research on effectiveness of, 250–251
  steps of the holistic caring process, 247–248
Healing modalities, cultural, 332–333
Healing process, defined, 6
Healing relationships, 222–223
  nature of
    example, 239
    importance of, 239–240
    relationship with Creation, 244
    relationship with Creator, 243–244
    relationship with others, 241–243
    relationship with the self, 240–241
  qualities of relatedness, 242
Healing system, defined, 41
Healing Touch, 176, 181, 194, 202, 655
Healing vs. curing. See also Transpersonal healing and caring
  curing defined, 45
  curing follows a predictable path, healing is creative and unpredictable, 46
  death not a failure, but a natural process in the healing system, 46
  healing is always possible, 46
  healing without curing, 45–46
Health
  defined, 6, 58, 429
  definitions of, 82, 83, 84, 85
  determinants of, 310–311
  and illness, as indivisible, 113
Health as Expanding Consciousness Model, 345
Health Belief Model
  behavior modification, 68
  categorization of patient characteristics, 67–68
  cognitive device, 68
  criticisms of the model, 67
  engagement categories, 68
  "foot-in-the-door" strategy, 69
  increased social support and cognitive strengthening, 68–69
  major factors determining engagement, 67
  rewards, 68
  values clarification, 69
Health Canada, 293–294
Health care: impact of culture on, 320–325
  cultural sectors
    folk, 321–322
    popular, 321
    professional or orthodox, 321
  explanatory models, 322, 322*e*
  holistic health paradigm, 321
  magicoreligious health paradigm, 320–322
  multiparadigm model of healing, 322–325, 323*e*
  scientific or biomedical paradigm, 321
Health care system, 48–50

Health maintenance, ineffective, 361e
Health promotion, defined, 6
Health status, 354
Health-seeking behaviors, 361e
HealthyStart, 876
Heart-brain electrical wave synchronization, 574–575
Heartlanders, 318
HeartMath studies, 194
Hedges, Andrea, 853
Heidt, P., 858
Heisenberg, Werner Karl, 112, 222, 223
Heisenberg's Uncertainty Principle, 211
Hellerwork, 484
Helping, helpfulness of, 260
Henry, Janet, 500, 835
Herbal supplements, 21*t*, 333
Hermeneutics, 217
High School students, tobacco use among, 766
Higher Self, 178, 185, 198
Higher Unconscious, 198
High-fiber diet, 467
Hippocrates, 644, 827
Hispanic-Americans
  cultural variation in human-environmental responses, 330–331*t*
Historical research, 217
HIV, 837
Hmong, cultural variation in human-environmental responses, 330–331*t*
Hobbes, Thomas, 96
"Holding sacred space," 49
Holism
  bio-psycho-social-spiritual model, 8
  natural systems theory, 7–8
Holistic, defined, 93
Holistic caring process, 159–166, 341–372
  assessment, 295–296, 347–351
  defined, 6
  definitions, 342
  developing centering, mindfulness, and awareness, 164–165
  directions for future research, 370, 372
  ensuring opportunities for rest and leisure, 166
  evaluation, 300–301, 301e, 369–370
  fostering connectedness, 161–162
  implementation, 369
  intuitive thinking, 348–353
  nurse healer objectives, 341
  nurse healer reflections, 372
  outcomes, 297*t*, 363–365
  patterns/challenges/needs, 296, 351–363
    a descriptive tool, 363
    diagnostic descriptors, 360e
    diagnostic statement, 353
    health-seeking behaviors, 361e
    ineffective health maintenance, 361e
    multiaxial structure of nursing diagnoses, 353–359, 354e
    proposed health promotion diagnoses, 360e
    standardizing terminology, 351–353
    Taxonomy II: Domains of Nursing Diagnosis, 352e
      domains, classes, and diagnoses, 355–359e
      structure: seven axes, 353–359, 354e
    wellness pyramid, 359, 361–363
  praying and meditating, 165–166
  specific interventions, 297–300
    case study, 299–300
    personal environment, 297–299
    planetary consciousness, 299
    ways to change negative self-talk triggers, 746–748
    workplace noise, 299
  tending to the spirit, 160
  theory and practice
    applications of holistic nursing theory, 345–347
    concept of nursing process, 343–345, 344*f*
    contemporary definition of nursing, 342–343
    reflective practice, 345, 346e
    taxonomy of nursing practice, 347
  therapeutic care plan and implementation, 296–297, 365, 367
  touching, 160–161
  using rituals to nurture the spirit, 163–164
Holistic communication, defined, 6
Holistic ethics, defined, 93
Holistic nurse, defined, 6
Holistic Nurse Clinician, 885, 893, 894–895, 896
Holistic nursing, 8–12
  AHNA standards of holistic nursing practice, 9–12
  directions for future research, 28
  major challenges, 8–9
  nurse healer reflections, 28
  standards of practice
    assessment, 36
    evaluation, 37

implementation, 37
outcomes, 36–37
patterns/challenges/needs, 36
and standards of practice, 34
Holistic philosophy, standards of practice, 32–33
Holistic theories, standards of practice, 33
Holografic model, to understand brain function, 120
Hologram
defined, 176
of the person, 348
Holographic theory, 196–197
Holons, 44
Homocysteine
defined, 451
high levels of and cardiovascular disease, 453
Hope, spiritual view of, 145
Hoping humor, 500–501
Hormones, 124
endocrine, 125
stress hormones, 571, 648
Hospital noise, 290–291
Hover-Kramer, Dorothea, 687
Huang Ti Nei Ching, 644
Hudson, R., 834
Human Becoming, Theory of, 85–86, 345
Human Care Model, 345
Human caring process, 257
defined, 6, 41
Human energy system, defined, 644
Human health experience, 57–74
art of holistic nursing
aesthetic knowing, 58–59
the art of nursing, 60–61
the cocreative aesthetic process, 61–63
engagement, 62
movement within and movement through, 62
mutuality, 62
new forms, 62
creativity, 61
as defined by Florence Nightingale, 58
ethics, 63
five abilities of the artful nurse, 60
intuition, 61
"making special," 59–60
predisposition to aesthetic knowing, 59
technology, 63
aspects of, 63–73
affective themes, 63
caring, 64
cognitive dimensions of health-disease, 63
culture, 64–65
health behaviors, 67–69
Health Belief Model, 67–69
stages of change in addictive behavior patterns, 69–72, 764, 765*t*
values clarification, 65–67
the workplace and human health experience, 72–73
definitions, 57–58
directions for future research, 74
nurse healer objectives, 57
nurse healer reflections, 74
Human immunodeficiency virus (HIV), in children, use of aromatherapy, 837
Human potentials
actualization of, 377
circle of, 379–380, 380*f*
Human-environmental responses, cultural variation in, 330*t*
Humor, laughter, and play, 495–516, 873–874
cathartic laughter, 504
connecting with the joyful child, 495
definitions, 497
directions for future research, 516
holistic caring process
assessment, 510
evaluation, 516
of client's subjective experience, 512*e*
outcomes, 510, 511*e*
patterns/challenges/needs, 510
specific interventions, 512–516
case studies, 514–516
therapeutic care plan and interventions, 510–512
and holistic health, 510
humor and locus of control, 509–510
humor and stress management, 509
humor from different perspectives, 498–499
three major theories of humor, 499
humor in the hospital, 873–874
humor program packages, 514
meanings of the word humor, 498
nurse healer objectives, 497
nurse healer reflections, 516
physiologic response to laughter, 506–508
power of playfulness, 508–509
resources, 519–520

review of humor and the health professions, 498
sounds of laughter, 504–506
supplies for humor programs, 513e
therapeutic humor
cautions about using humor in health care settings, 503e
coping humor, 501–502
forms of humor, 500
gallows humor, 502–504
hoping humor, 500–501
Humphries, Christmas, 495
Hunt, Valerie, 185
Hyperpyrexia (fever), 113
Hypertension
effects of psychoeducational approaches on, 434
malignant, as a meridian problem, 181
Hypnosis and self-hypnosis, 540, 541–544
defined, 524, 542
naturally occurring trances, 542–543
research-based outcomes of relaxation, 537*t*
therapeutic suggestions, 543–544
Hypoglycemia and carbohydrate cravings, 467
Hypoglycemic diet plan, 468e
Hypothalamus, 123
Hypothalamus-pituitary-adrenal axis, 125

I

I Ching, 279
Identity status, defined, 429
Illness
defined, 58
meanings attached to, 3
and positive perceptions and meanings, 4
use of imagery with, 577–578
Imagery, 124, 165, 166, 567–610, 568–581
"absence of stimuli" definition of imagery, 568
clinical effectiveness of, 570–573
in cardiovascular disease, 572–573
coping strategy for perioperative patients, 572
"ideo-motor" aspect of, 571
during MRI procedures, 572
pain reduction during cancer treatment, 571–572
physiologic responses, 570–571
in reducing anxiety, 573
stress reduction, 571
clinical imagery, 569
clinical theories
eidetic psychotherapy, 574
psychosynthesis, 574–575
definitions, 567–568
directions for future research, 610
effectiveness of imagery, 569
holistic caring process
assessment, 581–582
case study, 605–609
evaluation, 609–610, 610e
outcomes, 582, 583e
patterns/challenges/needs, 582
specific interventions
facilitation and interpretation of the imagery process, 585–586
guided imagery scripts
bone healing, 592–594
burn graft healing, 594–597
connecting with life energy imagery, 587–588
correct biologic imagery, 592
guidelines, 586–587
imagery and drawing, 604–605
immune system odyssey, 599–604
induction for imagery, 587
inner guide imagery, 590–591
pain assessment, 591–592
pain reduction, 591
special/safe place imagery, 588–589
worry and fear, 589–590
wound healing, 597–599
therapeutic care plan and interventions, 582–585
music and, 623–624
nurse healer objectives, 567
nurse healer reflections, 610
placebo effect, 568–569
research definition of, 569
resources, 613
and states of consciousness, 569–570
survivors of sexual abuse, 823
techniques, 575–581
concrete objective information, 578–579
descriptors by stressful health care event, 580*t*
fears in imagery work, 579, 581
in holistic health counseling, 575–576
imagery with disease/illness, 577–578
impromptu imagery, 575
symbols and metaphors of transformation, 578*t*

transpersonal use of imagery, 576–577
values and spirituality, 576
Imagery process, defined, 567
Imagery rehearsal, defined, 567
Immediacy, 268
Immune system
and cognition, 117
components, 600–601*f*
and imagery, 599–604
and the stress response, 124–125
Impromptu imagery, 575
defined, 567
Incest and child sexual abuse, 811–825
definitions, 813–814
directions for future research, 825
emotional consequences, 816–817
history of, 814–816
attempts to control behaviors in Medieval and Victorian times, 815
in Eastern cultures, 814
Freud's theories, 815
incest taboo, 814
repressed memories and accusations, 815–816
role of amnesia, 816
statistics, 815
in Western cultures, 814–815
holistic caring process
assessment, 817–818
case study, 823–824
evaluation, 824–825, 824e
outcomes, 818, 819e
patterns/challenges/needs, 818
specific interventions
anger expression and management, 822–823
empowerment, 820
grounding skills, 820–821
imagery, 823
relaxation, 821
writing, 821–822
therapeutic care plan and implementation, 818–820
impulsive behavior, 817
nurse healer objectives, 813
nurse healer reflections, 825
physical symptoms, 817
problematic relationships, 817
sexual dysfunction, 817
Inclusivity, 242
Incongruity theory of humor, 499
Incorporate the choice into behavior, 66
Independent Integrative Nursing Interventions (IINI), 894, 895–896
Induction for imagery, 587
Industrial agriculture, and food-borne illness, 294
Infant massage, 648–650
Infant mortality, and educational level of mothers, 310
Infection, use of aromatherapy, 837–840
MRSA, 838
slow healing wounds, 839
Information flow, 117
natural systems theory, 8
Information theory, 111, 117
Inner balance, 114
Inner guide imagery, 590–591
Inner strengths, spiritual assessment tool, 154e
Innocent archetype, 440–441
Inouye, S., 839
Inpatient cognitive therapy, 417–418
In-service education, 377
Insoluble fiber, 454
Insomnia, use of aromatherapy, 835–836
Insulin resistance syndrome, 467, 726–727
Integrative biophysics, 200
Integrative medicine and the healing environment, 883–888
definitions, 885
directions for future research, 896
introduction, 885–886
music therapy intervention, 897e
nurse healer objectives, 885
nurse healer reflections, 896, 898
Total Healing Environment
at Abbott Northwestern Hospital, 886–887
functions of integrative medicine at, 893–896, 894e
integrative medicine initiative at, 892–893
assessment, 887–890
analysis, 890
comprehensive interdisciplinary department interview, 888
fundamental component of, 887–888
healing environment survey, 888, 889e
Integrative Medicine CAM Admission Survey, 890, 891e
Integrative Medicine Chart Audit, 888, 890e

conclusions, 896
defined, 885
external/physical elements, 887
external/psychological elements, 887
initiating the culture change, 890, 892
integrative medicine (IM), 892
components, 893
educational offerings, 893–894, 894e
program principles, 893
team, 893
vs. complementary therapies and alternative medicine, 892
internal/physical elements, 887
internal/psychological elements, 887
Quality Improvement Practitioner roles, 896
Integrative Medicine (IM) Practitioners, 893
Intensity (loudness) of sound, 619
Intention, defined, 6, 176, 194, 234, 644
Interconnected and interdependent, 109
Interconnectedness
between individuals and their surroundings, 140–141
unifying, Howden's Spirituality Assessment Scale, 155, 156e
Interconnections in life, 114
spiritual assessment tool, 154–155e
Interdisciplinary triangulation, 220
Interleukin-2, 125
Internal coherence, 194
International Center for Nursing Ethics, 103
International Classification of Nursing Practice, 352–353
International Council of Nursing (ICN), 352
International Society for Humor Studies, 499
Interpersonal interaction, 348
Interpretation of Dreams, 815
Interventions. See also Healing interventions
aims of all nursing intervention, 84
consistent with specific nursing theories, 88*t*
and core use by specialty organizations, 371e
and cultural practices, 332–333
how to choose, 367
noninvasive, 367, 368e
nursing intervention defined, 367
Intimacy, defined, 670
Intuition, 60, 81*t*
defined, 6, 234, 342, 349
intuitive process, 349
Intuition log, 439
Intuitive awareness, 432–433
Intuitive perception, 349
Intuitive thinking, 348–349
cultivating intuitive processes, 350–351
facilitating, 349
and nursing experience, 349–350
Inventory of Professional Activities and Knowledge of a Holistic Nurse (IPAKHN), 9–10
Investigator triangulation, 220
Iowa Intervention Project, 367
Iowa Outcomes Project, 364
Irradiation of food, 291–294
controversy about, 293–294
current status of in the United States, 292–293
long-term effects on humans, 294
meat and poultry irradiation, 293
regulatory explanation, 292
technical explanation, 291–292

J

Jacobson, Edmund, 536, 571
Jacobson, J.I., 196
James, William, 430, 433
Jewish morning prayer, 274
Jin Shin Jyutsu, 181, 655
Johns, C., Model of Structured Reflection, 345, 346e, 370
Johnson, Rosemary, 853, 873
Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), 8
Jonsen, A., 94
Journal-keeping, 46–47, 68, 427, 437–438
as coping strategy, 414
survivors of sexual abuse, 821–822
Judeo-Christian values and beliefs, 139, 140, 149, 162
Jumping to conclusions, 407
Jung, Carl, 389, 440, 441, 672–673

K

Kabat-Zinn, J., 116, 526, 530, 534
Kagan, J., 430
Kaiser, Leland R., 868
Kaiser Permanente, 295
Kant, Emmanuel, 96
Kelley, J., 362, 363
Kelly, P., 696
Kim Bong Han, 179, 180
Kinetic energy, defined, 480

King, I., 345
King, P., 836
Kirlian photography, of acupoints, 180
Kleinman, A., 321
Knaus, W., 858
Knowing, 143
Knowledge, 81*t*
Knutson, Lori, 897
Kobasa, S.C., 403, 509, 510
Kocka, David, 872
Koenig, H.G., 112
Kolkmeier, Leslie, 523
Kollmar, D., 146
Kolmogorov-Smirnov test, 509
Kramer, M.K., 59, 60
Kreuter, F.R., 343
Krieger, D., 176, 247, 526
Krinsley, D., 202
Kubler-Ross, E., 694
Kunz, D., 190–191, 192, 198, 247, 526

L

Labeling, 407
Lactobacillus, effect on health, 461
Lamb, S., 142
Land pollution, 289*f*
Language of Letting Go, 728
Language of spirituality, 139
Larkin, Dorothy, 542, 543
Latino Americans, 320
Lavender (Lavandula angustifolia), 831–832, 835–837, 838*t*, 839, 847
  properties of, 839e
Law of unintended consequences, 95
Lawlis, G.F., 571
Laying-on-of-hands, 176
  analysis of results, 201, 202
LDL, defined, 451
Leakey, Richard, mechanism of consciousness, 98
LEARN program, 724, 728
Learned memory, defined, 829
Learning, and music, 623
Learning communities, building, 286–287
Legal aspects, development of principled behavior, 101
Leisure. See Rest and leisure
L'Engle, M., 166
Leninger, M., 329, 345
Letter writing, 438–439
Levine, Stephen, 705, 707
Levi-Strauss, C., 814
Licensed massage therapist (LMT), 647
Life process (cognition)
  defined, 115
  living systems, 115
LifeNet, 550, 551
Lifestyle behavior change, 402
Lifestyle risks for disease, 311
Light
  behavior of, 112–113
  and darkness in our lives, 135
Lighten the Load, 289
Limbic-hypothalamic system, 118. See also Aromatherapy
  in aromatherapy, 832
  defined, 111
  neuropeptide receptors in, 126
"Lingering presence," 86
Lipids, 455–456
Lippman, Glenda, 395
Listening, 77
  in healing ways, 151e
  and intentional presence, 150–151
Littleton, L.Y., 332, 344
Liver detoxification, effects of cruciferous vegetables, 463
Living our lives
  we engage in our own grief work, 287–288
  we live in a world of vast complexity and diversity, 287
  we reside in joy of spirit and lightness of heart, 288
  we risk everything through the clarity of our values and convictions, 288
  we work with contradiction and paradox, 288
Living will, 102
Locke, John, 96
Locus of control, humor and, 509–510
Lomi, 655
Long, Susan, 854–855
Loss, 694–695
  defined, 693
Love
  spiritual view of, 144–145
  unconditional, 242
Low back pain
  exercise and, 482
  massage therapy and, 647–648
Low-fat diet, 467
Luks, A., 117
Luskin, F., 572–573
Lussier, Jim, 859, 874

Lymphocytes, 125
Lynch, J.J., 858
Lynn's Garden, 869, 870*f*

M

'M' technique, 832, 847–848
Macronutrient and micronutrient deficiencies, 466
Macrophages, 599, 602
Macy, J., 280
Magical thinking, weight loss, 727
Magicoreligious health paradigm, 320–322, 324
Magnetic resonance imaging (MRI), 192
  imagery interventions during, 572
Magnetocardiogram (MCG), 192
Magnetoencephalogram (MEG), 192
Magnification, 407
"Making special," 59–60
Mandala using for focusing, 441
Manipulative and body-based methods, 18e
Mann-Whitney U test, 509
Man's Search for Meaning, 402
Mantra, defined, 524
Marcia, J.E., 431
Marlett, G.A., 799
Marques, J.K., 799
Masculine and feminine attributes, integration of, 49
Maslow, Abraham, 673
Maslow's Hierarchy of Needs, 83, 198, 673
Maury, Marguerite, 830
Maximal heart rate, defined, 480
Mayo, P.E., 694, 696
Mazer, S., 626, 872
McDougall, G.J., 442
McGuire, Karen, 854, 874, 874*f*
Meaning of life
  choosing our meanings, 4
  how we can put meaning into our lives, 4
  Howden's Spirituality Assessment Scale, 155, 156e
  meanings attached to illness, 3
  Personal Reflective Assessment (PRA), 159
  phenomenology, 3
  spiritual assessment tool, 154e
Meat and poultry irradiation, 293
Mechanical paradigm of healing, 323, 323e
Mechanisms of healing, 215
Mechanistic view of the world, 112
Medical Director, 893
Medical Doctor, 896
Medical indications, in analysis of ethical dilemmas, 101
Medical interventions, for weight loss, 726
Medical model of addiction, 786
Medications
  cautions and contraindications, 549
  mind-body interventions for eliminating medications, 123
  self-medication model of addiction, 787
  that impair nutrient absorption, 466
Meditation, 367
  defined, 524
  and the holistic healing process, 165–166
  practices
    attitudinal foundation of mindfulness practices, 534e
    cultivating the heart of compassion meditation, 535–536
    mindful breathing during nursing practice, 532–533
    mindful breathing meditations, 533–534
    quiet heart prayer, 536
    walking meditation, 534–535
  in recovery from addictions, 797–799
  relaxation response meditation, 528
  research-based outcomes of, 531*t*
  transcendental, 528
Mediterranean Diet Pyramid, 454*f*
Meichenbaum, D., 398, 399
"Melting pot" view, 313
Memories
  brain function, 120
  and feelings, 118–120
  learned memory defined, 829
  reawakened past memories, 119
    in child sexual abuse, 815–816
    music and, 623
Mental
  potential, development of, 387–388, 390
  self-assessment, 382*f*
Mental filtering, 407
Menu planning, 462
Meridians
  defined, 176
  effects of damaged, 179
  intuitive explanations of, 180–181
  scientific explanation of, 179–180
  traditional explanations, 178–179
Mesmer, Frank, 540, 542
Message, 117
Meta motivational states, weight management, 729, 731e, 731–732, 731e

allelic state, 731
autic state, 731
mastery state, 729, 731
relic state, 729
sympathy state, 731
Meta-analysis, 211, 213
Metabolic stimulants for weight loss, 723
Metabolic syndrome. See Insulin resistance syndrome
Metaparadigm, defined, 79
Metaphors, using, 439
Methicillin-resistant staphylococcus aureas (MRSA) infection, aromatherapy using teatree, 838
Middle Unconscious, 198
Migration, and development of cultural patterns and behaviors, 313–314
Military, and future sustainability, 285
Mill, John Stuart, 96
Miller, M., 794
Miller-Watts, JoAnn, 874, 874*f*
Mind maps, 440–441, 441*f*
Mind modulation
defined, 111
pain response, 126–129
stress response, 121–126
Mind-body interventions, 18–19*e*
eliminating medications, 123
Mindful breathing, 244
Mindfulness, 324
defined, 234
developing, 164–165
practicing, and positive emotions, 114
research-based outcomes of, 531*t*
techniques, 243–244
Mindness, Harvey, 498
Minerals, 457, 459, 460*t*
defined, 452
"Miracle cures," 15–16
Model, defined, 79
Modeling and Role-Modeling theory, 83–84, 87*e*, 88*t*, 343, 345, 833
Moderns, 318
Monism, 139, 316–317
Monitors, 116
Monotheism, 139, 316
Mood, role in bodymind healing, 119–120
Morals and principles, 94–95. See also Ethics of holistic nursing
law of unintended consequences, 95
moral dilemma, 95
moral distress, 95
moral uncertainty, 95
morals defined, 93
principle of double effect, 95
rules and precedents, 94–95
three primary principles, 94
Morse, J.M., 650
Moss, R., 242
Motivation, defined, 58
Motoyama, Hiroshi, 185, 194
Mourning, defined, 693
Movement. See Exercise and movement
Movement within and movement through, 62
"Mozart effect," 620
MRSA infection, aromatherapy using teatree, 838
Multimodal interventions, 221–222
Multiparadigm model of healing, 322–325, 323*e*
Muscle strength, 487
Music therapy, 124, 166, 193, 221, 615–636
cymatics, 618
definitions, 617
directions for future research, 636
holistic caring process
assessment, 627
case study, 634–635
evaluating client's subjective experience, 630*e*
evaluation, 635–636
outcomes, 628, 628*e*
patterns/challenges/needs, 627–628
specific interventions
development of audiocassette/videocassette library, 630–631
music therapy scripts
expanding the senses, 632
merging the bodymind with music, 633–634
taking a music bath, 633
toning and groaning, 632–633
training for skillful listening, 631–632
therapeutic care plan and implementation, 629–630
individual musical preference, 626–627
intensity (loudness), 619
intervention, 897*e*
link to medicine, 617–618
music thanatology, 624
music therapy applications, 623–624

music therapy in clinical settings
selection of appropriate music, 624–626, 625*t*
usefulness in treatment of health problems, 624
nurse healer objectives, 617
nurse healer reflections, 636
psychophysiologic responses to music therapy
emotions, imagery, and the senses, 622–623
hemispheric functioning, 621
physiologic responses, 620
shifting states of consciousness, 620–621
vibrational language of, 620
purpose of music therapy, 619–620
resonance, 618–619
sound, frequency, and intensity, 618–619
at St. Charles Medical Center, 872–873
Continuous Ambient Relaxation Environment (C.A.R.E.), 873
Music: A Life-Altering Decision workshop, 872–873
Mutual self-respect, 674, 676
Mutuality, 62
Mystery, spiritual view of, 144
Myths and beliefs, 695–696
myth defined, 693

N

Nader, Ralph, 294
Nagai-Jacobson, M.G., 681
NANDA. See North American Nursing Diagnosis Association (NANDA)
NANDA/NIC/NOC (NNN), 347
defined, 342
National Association for Nurse Massage Therapists, 655
National Association of Holistic Aromatherapy (NAHA), 835
National Center for Complementary and Alternative Medicine (NCCAM), 16
CAM, web-based research system, 213
five domains of CAM therapy, 17, 18–19e
NCCAM research centers, 20–23*t*, 215
National Guidelines Clearinghouse (NGC), 213
National Health and Nutrition Examination Survey, 455
National Institutes of Health (NIH), 16
Technology Assessment Panel, 213
National Institutes of Safety and Occupational Health, 73
National Radiation Information Center, 292
National Task Force on the Prevention and Treatment of Obesity, 729
Native Americans, 318–319
cultural variation in human-environmental responses, 330–331*t*
tobacco use by, 760
tribal councils, 305
Native Hawaiian and Other Pacific Islander (NHIP) populations, 320
Natural Child, 674
Natural healing, sacredness of, 244
Natural killer (NK) cells, 125, 603–604
Natural rights theory, 96
Natural Step, The, 282
Natural systems theory, 7–8
information flow, 8
patterns of natural systems components, 7*f*
Nature, connectedness with, 141–142
NCCAM. See National Center for Complementary and Alternative Medicine (NCCAM)
Nearing death awareness, 696–697
defined, 693
Negotiation with co-workers, case study, 684–685
Nei Ching, 644
Neill, J., 434
Nelms, T.P., 245
Neonatal Collaborative Review Group, 649
Networks of relationships, 109–110
defined, 111
networks within networks, 109
Neuroanatomic pain pathways, 127–128
Neurogenerative diseases, NCCAM research centers for CAM evaluations, 23*t*
Neurological disorders, NCCAM research centers for CAM evaluations, 23*t*
Neuropeptides, 507
defined, 111
and the stress response, 125–126
Neuroplasticity, 127
Neurotic anxiety, 410
Neurotransmitters, 125
defined, 111
Neutrophils, 599, 602
New consciousness, defined, 784
New Directions program, 865
New forms, creation of, 62
Newborns, hearing loss in, 291

Newman, M.A., 64, 345, 434, 858
definition of person, 86
Theory of Expanded Consciousness, _85
Newton, Issac, 110
Nicotinamide-adenine dinucleotide (NAD), 201
Nicotine, 761. See also Smoking
Nicotine fading, defined, 759
Nicotine replacement therapy (NRT), 762–763, 769
Nightingale, Florence, 345
art of nursing and the environment, 279
definition of the art of nursing, 58
"nature alone heals," 553
prayer, 147
spiritual and psychologic dimensions of her life, 148
on supporting patients' rest and well-being, 525
theory of caring, 833
Theory of Environmental Adaptation, 82–83, 87*e*, 88*t*
Nocebo effect, 568
Nociceptors, 127
Noise pollution, 289*f*
decibel levels of various sounds, 290*t*
hearing loss in newborns, 291
low frequency noise, 290
noise levels in intensive and critical units, 290–291
workplace noise, 299
Nolan, P., 140
Nonaerobic exercise, defined, 480
Noncompliance, 67
Nonparticipant observer, 222
Nonsteroidal anti-inflammatory drugs (NSAIDs), 127–128
Norepinephrine, 761
Norman Cousin's Award, 859
North American Nursing Diagnosis Association (NANDA), 342, 347
standardizing the terminology, 351–353
Nourishing wisdom of food, 719
Nouwen, H., 692
Nowicki-Strickland Scale, 509
Nurse as an instrument of healing, 233–254
characteristics of nurse healers, 240
concepts
of grace and presence, 238–239
of healing, 235–236
of presence, 236–238
features of nursing presence, 238
four ways of "being there," 237
physical presence, 236–237
psychological presence, 237
qualities of presence, 235, 237–238
therapeutic presence, 237, 237*t*
defined, 234
definitions, 233–234
develop a sense of sacredness, 231
directions for future research, 251–252
educational considerations, 249
healing interventions, 246–249
evaluation of, 249
outcomes of, 248–249
preparations for, 246
protection from the dynamics of energetic interaction, 246
steps of the holistic caring process, 247–248
nature of healing relationships
example, 239
importance of, 239–240
relationship with Creation, 244
relationship with Creator, 243–244
relationship with others, 241–243
relationship with the self, 240–241
nurse as healing environment, 244–246
effect on the individual, 246
focused intention, 245
process of healing, 245–246
ways for nurses to become an instrument of healing, 245
nurse healer, defined, 379
nurse healer objectives, 233
nurse healer reflections, 252
practice considerations, 249–250
research considerations, 250–251
wounded healers, 240–241
Nurse self-care, standards of practice, 34–35
Nurse-person relationship, 346
Nurses, and humor, 501–502
Nurses Health Study, 461
Nursing
contemporary definition of, 342–343
definitions of, 82, 83, 84, 85
process, defined, 342
Nursing diagnosis. See also Taxonomy II: Domains of Nursing Diagnosis
defined, 342
trifocal model of, 362*f*
Nursing Intervention Classifications, Therapeutic Touch, 653

Nursing Interventions Classification (NIC), 342, 347, 367
Nursing Outcomes Classification (NOC), 342, 347
  measurable indicators for outcome of self-esteem, 368e
  nursing-sensitive patient outcome, 364
  of psychosocial health, 365e
  seven domains, 364
Nursing theory, 79–90
  defined, 79, 80–81
    basic ideas and concepts, 80
    curricula based on nursing theories, 80–81
  definitions, 79
  definitions of person, 86
  description, 82
  directions for future research, 89
  explanation, 82
  five elements of holistic nursing practice, 81*t*
  need for theory, 81
  nurse healer objectives, 79
  nurse healer reflections, 89
  prediction, 82
  prescription, 82
  selected theories
    Environmental adaptation, 82–83
    Expanded Consciousness, 85
    Human Becoming, 85–86
    Modeling and Role-Modeling, 83–84
      aims of all nursing intervention, 84
    Roy Adaptation Model, 83
    Science of Unitary Human Beings, 85
    Transpersonal Caring, 84
  theory development, 81–82
  theory into practice, 86–87
    interpretation according to selected practices, 87e
    nursing interventions and specific theories, 88*t*
Nursing-sensitive patient outcome, defined, 364
Nurturing Parent, 673
Nutrition, 451–472. See also Eating to promote health
  definitions, 451–452
  dietary goals and recommendations, 457*t*
  digestion, 460–461
  directions for future research, 472
  factors in alcoholism, 793
  holistic caring process
    assessment, 468–469
    outcomes, 469e
    patterns/challenges/needs, 469
    therapeutic care plan and interventions, 469–470
      case study, 471–472
      evaluation, 472
      evaluation of client's subjective experience with nutrition, 470e
      specific interventions: ensuring optimal nutrition, 471
  homocysteine levels, 453
  impact on health and disease, 452
  nourishing the bodymind, 449
  nurse healer objectives, 451
  nurse healer reflections, 472
  nutrient deficiencies, 453–454
  nutrient sources
    antioxidants, 459–460
    carbohydrates, 454
    essential fatty acids, 456, 462
    fiber, 454–455
    lipids, 455–456
    minerals, 457, 459, 460*t*
    protein, 455
    vitamins, 456–457, 458*t*
  optimal daily requirements, 453
  recommended daily allowances (RDAs), 452–453, 456

O

Oberst, Terry, 853, 866
Obesity
  contributing factors, 465
  defined, 465, 721
  guidelines for weight management, 465–466
Objectives, for the nurse healer, 5
Occupational Safety and Health Administration (OSHA), 288
Oedipal Complex, 815
Office of Alternative Medicine (OAM), 16
Office of Minority Health, 325, 327
Old Testament, on healing humor, 505
Opioids, 124, 128
Optimal daily requirements (ODAs), 453
Optimal nutrition, defined, 452
Optimism and health, 401
Oregon Quality Award, 859
Orem, D., 345

Orentlicher, D., 94–95
Organ transplant
  emergence of right-relationship, 45
  ethical issues, 95
Organisms, complex relationships among, 115
Organization and influence in the world, categories of, 285
Ornish, D., 221, 222, 526, 530
Orpheus, 617
Orr, D., 284
Oschman, J.L., 200
Oscillation, defined, 617
Osteopathy, 655
Osteoporosis
  beneficial effects of exercise, 482–483
  guidelines for healthy bones, 465
  prevention program, 464
  risk factors for, 464–465
  role of calcium and other nutrients, 464
  supplement recommendations, 465
Osterman, P., 237
Others, 238
  connectedness with, 142–143
  relationship with, 241–243
Outcome, healing as, 46–47
Outcomes
  criteria, 364
  holistic caring process, 363–365
  standardized outcome measures, 364
Outpatient cognitive therapy, 417
Overfat, defined, 721
Overgeneralization, 407
Overweight, defined, 721
Ozone hole, 289

P

Pacific Islanders, 320
Packaged imagery, defined, 568
Pain
  aromatherapy in pediatric palliative care, 837, 838*t*
  assessment imagery, 591–592
  guided imagery used in reduction of, 572
  medical definition, 524
  music therapy and, 624
  nursing definition, 524
  reduction, imagery, 591
  use of aromatherapy, 836–837
Pain response, 126–129. See also Stress response
  cultural differences, 129
  neuroanatomic pain pathways, 127–128
  pain management, 127–128
  pain-producing substances, 127
  psychosocial pain pathways, 128–129
Pain-producing substances, 127
Panic attacks, 124
Pantheism, 139, 316
Paradigm
  caring-healing paradigm, 19, 24
  defined, 342
  metaparadigm, 70
  paradigm shift, 257
Paradoxical vs. rational healing, 14–16, 14*f*
Paramecium, 180
Paranormal events, 120
Parasympathetic stimulation, 123
Parasympathetic response, 125
Parse, Rosemarie Rizzo, 217, 345
  definition of person, 86
  Theory of Human Becoming, 85–86
Pasternak, B., 811
Pathogens, ability to reorganize, 115
Patient Bill of Rights, 8
Patient preferences, in analysis of ethical dilemmas, 101
Patient Self-Determination Act (1991), 102
Patient-practitioner relationship, knowledge-skills-values, 24*t*, 26
Pattern, 114
  living systems, 115
Pattern identification, 348
Pattern recognition, 61
  in young infants, 344
"Patterns of knowing" for nursing, 47
Patterns of natural systems components, 7*t*
Patterns/challenges/needs, defined, 6
Patterson, J.G., 236
PCBs, 281
Peace and peacemaking, spiritual view of, 146–147
Pediatrics, NCCAM research centers for CAM evaluations, 23*t*
Pendley, A., 784
Penfield, Wilder, 570
Pennebaker, J.W., 114
Peptic ulcers
  personality configurations among patients with, 114
  treatment, 113–114

Perception
  defined, 349
  influence of, 398
Perennial philosophy
  Great Chain of Being, 39
  major elements of, 39
Performance Excellence Process, St. Charles Medical Center, 877, 879e
Periaqueductal gray (PAG) area, and pain response, 127
Peri-death, defined, 693
Perineural cells, 179–180
Perry, T., 694
Person, definitions of, 7, 82, 83, 84, 85, 86, 342
Personal ethics, defined, 93
Personal objectives, 5
Personal Reflective Assessment (PRA), 157, 158
Personal self, 198
Personal space
  and cultural competency, 328, 330t
  defined, 276
Personality, and wellness, 114–115
Personalization, 407–408
Person-centered care, defined, 7
Pert, Candace, 237, 506–507
Pert, J., 126
Pessimism and health, 401
Pew Health Professions Commission, report on relationship-centered care, 24t, 25t, 26t
Pew-Fetzer Task Force, on relationships, 239–240
Phantom limb sensations, 120
Pharmacogenonics, 311
Pharmacologic therapies
  to pain management, 125–126
  for smoking cessation, 762–763
Pharmacological agents, for weight loss, 726
Phenomenology, 3, 217
Photonutrients, protective effects of, 463
Physical
  potential, development of, 387, 390
  self-assessment, 381*f*
Physical or sexual abuse. See also Incest and child sexual abuse
  "acting out" behavior, 127
  unresolved issues, 126–127
Physical presence, 236–237
Physician-assisted suicide legislation, 866
Physiologic effects of stress, 399–400
Physiologic response to laughter, 506–508
Phytochemicals, defined, 452
Phytoestrogens, defined, 452
Piaget's Theory of Cognitive Development, 83
Piercy, Marge, 274
Placebo
  defined, 211
  effect, 568–569
Placebo response, 223–224
  presence of in these conditions and procedures, 223–224
Planck, Max, 112
Planetary consciousness, 299
Planetary ethics, defined, 93
Plato, and laughter, 498
Plutarch, 644
Polarity, 176
Polyphenols, NCCAM research centers for CAM evaluations, 21*t*
Polytheism, 139, 316
Porter, Deneen, 862, 864
Post-exercise oxygen consumption (EPOC), 745
Post-traumatic stress disorder (PTSD), 119–120
  characteristics of, 551
  and cryptotrauma, 550
  increased incidence of in the disaster region after September 11th, 550–551
Postural stability, 488
Posture, defined, 480
Power, defined, 363, 524
Power as Knowing Participation in Change, theory of, 363
Practical problem, 411, 412
"Practice of presence," 345
Practitioner-practitioner relationship, knowledge-skills-values, 26*t*, 27
Pranic healing, 176
Prayer
  and faith, effectiveness of, 15
  and healing, 147–148
  and the holistic healing process, 165–166
  research-based outcomes of, 531t
Precautionary principle, 281–282
Prediction, nursing theory, 82
Premature interpretation, 263–264
Prescription, nursing theory, 82
Presence
  concepts of, 86
    features of nursing presence, 238

four ways of "being there," 237
grace and presence, 238–239
physical presence, 236–237
presence, 236–238
psychological presence, 237
qualities of presence, 235, 237–238
therapeutic presence, 237, 237*t*
defined, 7, 234, 236
essence of, 236
transcendent, 237
President's Council on Sustainable Development, 283–284
Prince, R., 401
Principle of reverse onus, 281–282
Principle of the least toxic alternative, 282
Principles of self-organization, 114–115
Prizing the value, 66
Probiotic, defined, 452
Problem-solving, 268–269
Procedural touch, defined, 644
Process
defined, 379
living systems, 115
Prochaska, J.O., 739, 740e, 763
Professional Nursing Practice Principles, 876–877, 878e
Progress and heroic advance, 277
Progressive muscle relaxation (PMR), 536–538
defined, 524
exercise: tension awareness, 536–538
hypothesized effects of, 539*t*
Protein, 455
Prototype recognition, 59
Pseudolistening, 77
Psychedelic substances, 788
Psychiatric clients, beneficial effects of exercise, 483
Psychoanalytic views of humor, 498
Psychoeducational approaches, effects on hypertension, 434
Psychoenergetic balancing, 654
Psychologic and spiritual dimensions, 148
Psychologic effects of stress, 400–401
Psychological coping factors, and pain, 128
Psychological games, 674
"Psychological hardiness," characteristics of, 55–56
Psychological presence, 237
Psychological theories of weight loss, 724–725
Psychoneuroimmunology, 216
defined, 112
importance of relaxation, 525
potential healing value of laughter, 506–507
Psychophysiologic outcomes, 220–221
Psychophysiologic responses to music therapy
emotions, imagery, and the senses, 621–623
hemispheric functioning, 621
physiologic responses, 620
shifting states of consciousness, 620–621
vibrational language of, 621
Psychophysiology of bodymind healing
definitions, 111–112
directions for future research, 130
emotions and the neural tripwire, 118–120, 119*f*
location of the brain centers, 120
state-dependent memory and recall, 118–120
mind modulation
pain response, 126–129
stress response, 121–126
nurse healer objectives, 111
nurse healer reflections, 130
principles of self-organization, 114–115
ultradian rhythms, 120–121, 121*f*
understanding living systems
Bell's theorem, 115–116
information theory, 117
mechanistic view of the world, 112
personality and wellness, 116–117
quantum physics, 112–113
Santiago theory of cognition, 117–118
theory of relativity, 113–114
Psychosexual psychoanalytic model of addiction, 787
Psychosocial factors, in nutrition and the elderly, 466
Psychosocial health, NOC classification of, 365e
Psychosocial pain pathways, 128–129
Psychosynthesis, 574–575
defined, 176
Psychotherapy, problems requiring, 261
Public Citizen, 294
Public education, history of in the United States, 286
PubMed, 213
Pulsed electromagnetic fields (PEMF), 195–196

Purification paradigm of healing, 323–324, 323e
Puritans, and touch, 645
Purpose in life
  Howden's Spirituality Assessment Scale, 155, 156e
  Personal Reflective Assessment (PRA), 159
  spiritual assessment tool, 155e
Pyrogens, 113

Q

Qi, 179
Qigong practice, 176, 529, 530, 552
  research-based outcomes of, 531t
Qualitative research, 217–218
  defined, 211
  descriptive expressions of health, 218
  five major types of, 217
  healing research, 250
Qualities, 112
Qualities of presence, 235, 235–236
Quality Improvement Specialist (QIS), 894
Quality initiatives, defined, 885
Quality of life (QOL)
  in analysis of ethical dilemmas, 101–102
  in Chinese patients, 384–386
Quantitative research, 215–217
  defined, 211–212
  elements lacking in, 216–217
  healing research, 250–251
  randomized clinical trial (RCT), 216
  scientific method, 216
Quantum physics, 110–111, 197–198, 209
  quantum theory of consciousness-raising reality, 197–198, 199
Quiet places, 521–522
Quinn, J.F., 202

R

Race
  classification of, 312
  defined, 309
  and health care disparities, 311
Radiation exposure, 289f
Randomized clinical trial (RCT), 216
Rapid eye movement (REM), 439
  suppressed, 291
Rational Emotive Therapy, 398–399
Rational vs. paradoxical healing, 14–16, 14f
Ray, P.H., 318
Raynaud's syndrome, 124
"Readiness for enhanced power," 363
Receptors, defined, 112
Recommended daily allowances (RDAs), 452–453
  for dietary fat, 456
  magnesium and calcium, 465
Recovery, defined, 784
Reductionism, defined, 212
Reed, P.G., 434
Reflexology, 661–662, 661f
Reframing, as coping strategy, 413
Reiki, 176, 202, 367, 655
Relapse, defined, 784
Relationship imagery, defined, 568
Relationship-centered care, 24–27, 857–882
  arts in the hospital
    art, 871–872
    humor, 873–874
    music, 872–873
      Continuous Ambient Relaxation Environment (C.A.R.E.), 873
      Music: A Life-Altering Decision workshop, 872–873
  conclusion, 877, 879–880
  definitions, 857
  directions for future research, 880
  Healing Health Care Philosophy, 857–858, 859, 869, 876
    examples of research studies, 858
    nursing theorists, 858
  healing our community, 874–876
  health management model, 876, 876f
  knowledge-skills-values
    community-practitioner relationship, 25t, 26–27
    patient-practitioner relationship, 24t, 26
    practitioner-practitioner relationship, 26t, 27
  life skills
    Center for Health and Learning (CHL), 864–865
    Health Coach Services, 865–866, 865e
    New Directions program, 865
  life-death transition
    Deschutes County Coalition for Quality-of-Life Care, 867–868
    healing has many dimensions, 868–871
    physician-assisted suicide legislation, 866
    St. Charles Comfort Care Services, 866–867, 867e, 868e
  nurse healer objectives, 857
  nurse healer reflections, 880

Performance Excellence Process, 877, 879*e*
Principle-based care model, 876–877
Professional Nursing Practice Principles, 876–877, 878*e*
St. Charles Medical Center (SCMC)
awards, 859
Cascade Healthcare Community, 859
Healing Health Care Philosophy adopted, 859
healing ourselves and our relationships, 859–861
Caregiver Assistance Program (CAP), 860
People-Centered Teams: Healing Our Workplace I workshop, 860
Resiliency and Renewal workshop, 860
nursing voices of, 853–855
patient-focused and family-focused care, 861–864
The Caring Model, 861*e*
core competencies, 861–862, 862*e*
healing design, 862, 864
nursing care delivery skills—pain/anxiety/management, 863*e*
scope of services, 858–859
Relationships, 667–688. See also Healing relationships
characteristics that build, maintain, and enhance relationships, 671–672
definitions, 234, 670
directions for future research, 687–688
holistic caring process
assessment, 677–678
case studies
conflict management with an HMO, 685–686
negotiation with co-workers, 684–685
use of different archetypes, 683–684
use of different ego states, 684
evaluation, 686–687
nurse's subjective experience, 686*e*
outcomes, 678, 679*e*
patterns/challenges/needs, 678
specific interventions
counseling, 680
development of spiritual understanding, 681–682
improved communication, 682
storytelling, 680–681
therapeutic care plan and implementation, 678, 680
interactions
with clients, 670–671
with co-workers, 671
with persons in authority, 671
relationships as interactive human energy fields, 671
nurse healer objectives, 669
nurse healer reflections, 688
potential, development of, 388–389, 390
reflective questions, 667–668
self-assessment of, 384*f*
and spiritual connectedness, 142–143
well-know theorists
Abraham Maslow, 673
Angeles Arrien, 676–677
Carl Gustav Jung, 672–673
Eric Berne, 673–676
Relaxation, 521–560
ancient arts of, 524–525
benefits for the nurse and holistic caring practice, 527*e*
breathing and energy healing practice, 530
breathing in and breathing out, 529–530
caring for ourselves, caring for others, 526–527
clinical benefits of, 525, 525*e*
cross-cultural context, 526
definitions, 523–524
directions for future research, 560
effects of relaxation therapies, 539, 539*t*
survivors of sexual abuse, 821
exercise: imagine a relaxed person, 528
"faith factor," 529
holistic caring process
assessment, 553
case studies, 557–559
evaluation, 559–560, 559*e*
outcomes, 554, 554*e*
patterns/challenges/needs, 553–554
therapeutic care plan and interventions, 554–557
important factors in relaxation practice, 547*e*
meditation practices
attitudinal foundation of mindfulness practices, 534*e*
cultivating the heart of compassion meditation, 535–536
mindful breathing during nursing practice, 532–533
mindful breathing meditations, 533–534

quiet heart prayer, 536
walking meditation, 534–535
modern methods
autogenic training, 538–539
biofeedback, 544, 545e
holistic nurse learning experiment II, 545–547
holistic nurse learning experiment II (variations), 547–549
cautions and contraindications
education and information, 549
medications, 549
mental health history, 549
holistic nurse learning experiment, 539–540
holistic nursing perspectives for living in a time of uncertainty, 551–552
hypnosis and self-hypnosis, 540, 541–544
inner laboratory journal, 541–542e
PTSD, increased incidence of in the disaster region after September 11th, 550–551
research-based outcomes of relaxation, 537*t*
restorative practices, 552–553
selecting interventions, 540
nurse healer objectives, 523
nurse healer reflections, 560
the oneness of being, 524
other forms of meditation, 531–532
relaxation response meditation, 528–529
words to focus on, 528
research-based outcomes of meditation, 531*t*
resources, 564
restorative practices, 552–553, 564
self-help tapes, 623
the stress response, 527–528
suggested reading, 563
techniques, as coping strategy, 413
whole self benefits of, 525–526, 526e
Relaxation and imagery, 804
Relaxation response, 123*t*, 165, 221
defined, 524
meditation, 528–529
research-based outcomes of, 531*t*
Relaxation-affirmations exercise, 735, 736e
Release theory of humor, 499
Religion. See also Prayer; Spirituality and health
and cultural values and beliefs, 311
defined, 137–138
and future sustainability, 285
Religious activites, effects on health, 114, 324–325
Reminiscing and embarking on a life review, 442
Renewing the spirit, 521–522. See also Relaxation
Research, 211–225
definitions, 211–212
directions for future research, 225
effectiveness of healing interventions, 250–251
enhancing
multimodal interventions, 221–222
objectivity in scientific investigation, 222–223
the placebo response, 223–224
psychophysiologic outcomes, 220–221
triangulation, 218, 220
evidence-based practice, 212–214
holistic research methods, 215–218
descriptive expressions of health, 217–218, 218*t*
qualitative, 217–218
quantitative, 215–217
quantitative and qualitative approach, 219e
quantitative and qualitative research characteristics, 219e
meta-analysis, 213
need to conduct holistic research, 214–215
nurse healer objectives, 211
nurse healer reflections, 225
standards and guidelines, 215
utilization, 212
wellness model, 212
Research centers (NCCAM), 20–23*t*
Resistance training, defined, 480
Resonance, 618–619
defined, 617
Resource list
cultural diversity, 334
humor and laughter, 519–520
relaxation/biofeedback/mindfulness meditation/Yoga/Qi Gong/hypnosis/biofeedback/PTSD, 564
Resources, imagery, 613
Respect, 264
Response patterns, healthier, 339
Rest and leisure, ensuring opportunities for, 166
Rest and recreation, balance of, Personal Reflective Assessment (PRA), 159

Resting heart rate, defined, 480
Restorative gardens, 553
Restorative justice, defined, 276
Reverence, concept of, 141
Reversal theory, weight management, 729–733
  cognitive therapy based on, 732–733
  metamotivational states, 729, 730e, 731–732, 731e
    alloic state, 731
    autic state, 731
    mastery state, 729, 731
    sympathy state, 731
    telic state, 729
  unpleasant feelings and tension stress, 732
  used in smoking cessation studies, 731–732
Rheumatoid arthritis
  beneficial effects of exercise, 483
  T'ai Chi movement therapy, 484
Richardson, Teddy, 854
Right relationship
  defined, 41
  and healing, 43–45
Riley, Patty, 874
Risk nursing diagnoses, 354
Risk taking, and change, 55, 56
Rituals, 138
  and cultural healing practices, 332
  to nurture the spirit, 163–164
    first ritual guide to getting well, 163–164e
Ritz, Sandy, 500
Robert, Karl-Hendrik, 282
Robert Jaffe Advanced Energy Healing, 655
Robinson, Vera, 498
Rogers, C., 416
Rogers, Martha, 85, 245, 345, 687, 858, 869
  definition of person, 86
Role Responsibility Questionnaire (RRQ), 103–104
Rolf, Ida, 655
Rolfing, 655
Romans, use of touch, 644
Roy, Sr. Callista, 83, 345
  Roy Adaptation Model, 83, 87e, 88*t*, 345
Ruland, C.M., 694
"Runner's high," 122
Rush, M.M., 791

S

Sacred space, 143–143
Sacredness of natural healing, 243
Santa Clara Valley, 280
Santiago theory of cognition, 115–116
Sara Fisher Breast Health Project, 875
Scandrett-Hibdon, S., 249
Schaedle, Richard, 550
Schools of healing, 247
Schuster, E., 299
Schwann cells, 180
Schwartz, B., 742
Schwartz-Barcott, D., 237
Science, questioning the rules of, 209
Science of Unitary Human Beings, 85
Scientific investigation, objectivity in, 222–223
Scientific method, 216
Scudder, 181
Seattle, Chief, 142
Selden, G., 179–180
Selenium, 459
Self
  connectedness with, 143–144
  defined, 429
  relationship with, 240–241
  as Sacred, 243
Self-actualization, 45
Self-assessments, 379–392
  affirmations, 391–392
  circle of human potential, 379–380, 380*f*
  definitions, 379
  development of human potentials
    choices potential, 389, 390
    emotions potential, 388, 390
    mental potential, 387–388, 390
    physical potential, 387, 390
    relationship potential, 388–389, 390
    spirit potential, 390, 391
  directions for future research, 392
  nurse healer objectives, 379
  nurse healer reflections, 392
  practice of self-assessment, 380–387
    choices, 385*f*
    emotions, 383*f*
    meaning of the tallied scores, 387e
    mental, 382*f*
    physical, 381*f*
    relationships, 384*f*
    spirit, 386*f*
Self-care Model, 345
Self-consciousness, 40
Self-discipline, 565
Self-disclosure, 267
Self-dissolution, 44

Self-esteem
measurable indicators for outcome of self-esteem, 366e
weight loss and, 728
Self-forgiveness, 146
Self-help group meetings, 68, 69
Self-hypnosis, defined, 524
Self-identity, defined, 429
Self-image, developing positive view of oneself, 565
Self-involvement, elements of, 249
Self-medication model of addiction, 787
Self-organization, principles of, 112–113
Self-referencing Biofeedback, defined, 176
Self-reflection, 429–445
body-mind-spirit connections, 434–435
definitions, 429
directions for future research, 444–445
holistic caring process
assessment, 435
case studies, 442–444
evaluation, 444, 444e
outcomes, 435, 436e
patterns/challenges/needs, 435
specific interventions
beginning an intuition log, 439
creating works of art, 438
keeping diaries or journals, 437–438
learning from dreams, 439–440
mind maps and clustering, 440–441, 441f
reminiscing and embarking on a life review, 442
sharing stories, 441–442
using metaphors, 439
using the mandala and focusing, 441
writing letters, 438–439
therapeutic care plan and interventions, 435–437
nurse healer objectives, 429
nurse healer reflections, 445
process of self-reflection, 429–430
self, 430
self-awareness, 432–434
cognitive awareness, 432
dimensions of, 433f
intuitive awareness, 432–433
transcendent awareness, 433–434
self-identity, 430–432
Self-regulation theory, defined, 112
Self-responsibility, 58, 669
Self-talk
defined, 721
replacing negative self-talk with positive self-talk, 733, 734e
worksheets, 730e, 735–737
Self-transcendence, 40, 44, 695
defined, 693
Seligman, Martin, 860
Selye, Hans, 509
Senior Actualization and Growth Exploration (SAGE), 696
Sense of Humor Questionnaire (Svebak), 509
Sense of peace, 140
Sense of sacredness, 231
Sense of salience, 61
Sense of trust, 140
Sensory deprivation research, 569–570
September 11th, increased incidence of PTSD in the disaster region, 550–551
Seshachar, levels of consciousness, 98, 100
Set point theory, of weight loss, 723
Sexual abuse. See Incest and child sexual abuse
Sexual addiction, 784
Shacklett, R.L., 194
Shamanic practices, 529, 540
use of touch, 645
Sheikh, Anees, 705
Sheikh, Katrina, 705
Sherry, E., 838
Shiatzu
defined, 644
technique, 661
"Should" statements, 407
Sickness-care system, Western, 49
Signal, 117
Silicon Valley, toxic manufacturing processes, 280–281
Similarity recognition, 61
Simonton, C., 572
Singer, J., 570
Single-celled organisms, 180–181
Siskin, B.F., 195, 196
Sister Catherine, SCMC, 872
"Skill power," 55
Skilled know-how, 61
Skillman-Hull, 60
Skinner, B.F., 723
Slater, V.E., 178
Smell. See also Aromatherapy
power of natural smells, 827

Smith, 201–202
Smith, D., 626, 872, 873
Smith, Michael O., 791
Smith, R., 214
Smoking, 759–777
  "attention thermostat" effect, 761–762
  cessation studies, reversal theory, 731–732
  definitions, 759
  directions for future research, 776–777
  health effects on women smokers, 294–295
  holistic caring process
    assessment, 766
    evaluation, 776, 776e
    identification of habit breakers, 770–771
    outcomes, 767, 767e
    patterns/challenges/needs, 766–767
    specific interventions
      assertion of Bill of Rights, 771
      case study, 774–776
      imagery scripts, 772–774
      integration of exercise, 771
      integration of rewards, 771–772
      preparation for nicotine withdrawal, 769–770
      preparation for quit date, 769
      recording habits, 769
      reinforcement of positive self-talk,_ 772
      smoke-free body and environment, 770
      weight gain can be avoided, 771
    therapeutic care plan and implementation, 767–769
  as a "mood thermostat," 761
  nicotine, 761
  nurse healer objectives, 759
  nurse healer reflections, 777
  percent of women who smoke, 294
  physiologic responses to, 760–762
  prevalence of, and its health consequences, 759–760
    environmental tobacco smoke (ETS), exposure to, 760
    statistics, 759–760, 763
  strategies for smoking cessation
    behavior and lifestyle changes, 763–766, 765*t*
    measuring successful cessation, 762
    nicotine replacement therapy (NRT), 762–763, 769
    pharmacologic therapies, 762–763
    prevention as the best protection from smoking, 766
    self-quitters, physician counseling, and nurse follow-up advice, 762
Social organization, and cultural competency, 328, 330*t*
Social support, as coping strategy, 414
Social-behavioral effects of stress, 401–402
Socioeconomic status
  and health care, 310–311
  and morbidity and mortality of specific groups, 311–312
Soluble fiber, 454
Somatic and musculoskeletal therapies, 651–652
Somatic pain, 126
Sondrex System, 626
Sonic, defined, 617
Soul Journey, reflection on, Personal Reflective Assessment (PRA), 159
Soul of All Living Things, The, 274
Sound, 618–619
Sound therapies, 193
  defined, 617
Soy products, protective effects of, 463
Spatial thinking, 59
Special/safe place imagery, 588–589
Spirit
  potential, development of, 390, 391
  self-assessment of, 386*f*
Spirit of the Healer, 242
Spiritual awakening, defined, 784
Spiritual effects of stress, 402
Spiritual healing, 435
Spirituality
  as coping strategy, 413–414
  and recovery from addictions, 803–804
Spirituality and health. See also Holistic caring process
  arts and spirituality, 166–167
  directions for future research, 168
  effects on blood pressure, 114
  elements of spirituality, 140–144
    connectedness with nature, 141–142
    connectedness with others, 142–143
    connectedness with self, 143–144
    connectedness with the Sacred Source, 141
    cultural perspective, 140

interconnectedness between individuals and their surroundings, 140–141
sense of peace, 140
sense of trust, 140
the healing process, spiritual view of life issues
forgiveness, 145–146
grace, 147
hope, 145
love, 144–145
mystery, 144
peace and peacemaking, 146–147
prayer, 147–148
spiritual and psychologic dimensions, 148
suffering, 145
in holistic nursing
assessing and investigating spirituality in practice and research, 149–150
listening and intentional presence, 150–151
nurturing the spirit, 148–149
using guides and instruments to facilitate spirituality assessment, 153–159
using story and metaphor, 151–153
nurse healer objectives, 137
nurse healer reflections, 168
religion defined, 137
spirituality and religion, relationship between, 138–139
spirituality defined, 7, 137
term spirituality, 138
understanding spirituality, 139–140
blending of various traditions, 139–140
language of spirituality, 139
Spontaneous imagery, defined, 568
SQUID, 195
St. Charles Comfort Care Services, 866–867, 867*e*, 868*e*
St. Charles Medical Center. See Relationship-centered care
Staff nurse, 896
Stages of change, in addictive behavior patterns, 764–766, 765*t*
action stage, 69
contemplation, 69
integration between processes, 71–72, 72*e*
maintenance stage, 70
precontemplation, 69
processes and interventions, 71*e*
spiral model, 70*f*
stage preparation, 69
Standards of Advanced Holistic Nursing Practice for Graduate-Prepared Nurses, 11
Standards of Holistic Nursing Practice. See AHNA Standards of Holistic Nursing Practice
Standards of Practice, 7, 342
Staphylococcus aureus, methods for controlling, 293
State-dependent memory and recall, 118–120
State-trait anxiety tools, 251
Steingraber, S., 281
Steinke, Pam, 854
Stepnick, A., 694
Stepping Stones Project, 875, 876
Stereotypic responses, 65
Stereotyping
common myths and errors, 312–313
defined, 308
Stimulus-response theory, 723
STOP emotional eating strategy, 735, 746
Story
and metaphor in spiritual care, 151–153
sharing, 441–442
"Stream of consciousness," 569
Strelkauskas, A.J., 202
Strength, defined, 480
Stress
challenging stress and winning, 405*e*
defined, 399
-disinhibition effect, 401
management
in diabetics, 482
use of laughter and humor, 508
music therapy and, 624
outcomes of healing interventions and, 248–249
physiologic effects of, 399–400
psychologic effects of, 400–401
psychophysiologic definition, 524
social-behavioral effects of, 401–402
spiritual effects of, 402
stress-hardiness, 401
warning signals, 404*e*
Stress hormones
and massage therapy, 648
reducing release of, using guided imagery meditations, 571
Stress response, 399, 400*f*. See also Pain response
central nervous system (CNS), 122–124
endocrine system, 124

and a healthy diet, 462
immune system, 124–125
intervention, 125
mediating with a healthy diet, 462
neuropeptides, 125–126
and relaxation, 527–528
Stressors
acknowledging our own, 135–136
decreasing, as goal of health care, 7–8
repressing the meaning of these events, 135
Structure, 114
living systems, 115
Styles, J., 837
Subliminal technique, combined with music, 623
Subtle energies, 176, 177
defined, 176
Suffering
intensifying pain, 127
spiritual view of, 145
Sultanoff, Barry, 505
Superconducting quantum interferometric device (SQUID), 195
Superconscious, 198
Superfund sites, defined, 276
Superiority theory of humor, 499
Support groups and professional help, for recovery from addictions, 802–803
Supranormal paradigm of healing, 323*e*, 324
Sustainable Biosphere Initiative (SBI), 289
Sustainable future
building an ecologic center building, 284–285
concept of, 283–286
defined, 276
population growth, 284
redefinition of consumption goals, 284
a sense of the whole, 287
sustainable development, 284
sustainable growth, 284
Svebak, S., Sense of Humor Questionnaire, 509
Swartz, M.S., 116
Swedish massage, 648
Symbolic imagery, defined, 568
Symbols and metaphors of transformation, 578*t*
Sympathetic nervous system (SNS), stimulation, 123, 124
Sympathetic resonance, defined, 617
Synchronous, defined, 60
Syndrome X, 467, 726–727
Synergy, 55–56
Systems
living, 115
ordered relationships, 114–115
Systems model, 345
Systems theories and principles, 43–44

T

T'ai Chi exercises, 482, 484, 484
Taking Charge of Your Health TV Show, 864
Talking stick, 304
Tan, Stanley, 507–508
Taoist tradition, 239
Target heart rate, defined, 480
Tarnas, R., 278
Taxonomy I, defined, 342
Taxonomy II, defined, 342
Taxonomy II: Domains of Nursing Diagnosis, 352*e*
domains, classes, and diagnoses, 355–359*e*
integration of domains to the state of harmony and wellness, 362*f*
structure: seven axes, 353–359, 354*e*
Taxonomy of Nursing Practice—NANDA/NIC/NOC (NNN), 342
T-cells, 599, 602, 603
Teach Yourself to Dream, 439
Teacher archetypes, 677, 678
Teaching, from experience, 339
Technology, 63
and culture, 317
ethical issues, 94
Teleologic theory, 96
10 Secrets for Success and Inner Peace, 728
Tensegrity
defined, 176
and the geodesic dome human, 200–201
Terminology, and developing cultural competency, 325
Thanatology, music, 624
Caring Model, 861*e*
The Divine, 139
The Sacred Source, 137, 140, 141. See also Spirituality and health
connectedness with, 141
Personal Reflective Assessment (PRA), 159
one's relationship with, 162
various other names for, 141
The Spirit, 239
Theoretical objectives, 5
Theory, 81*t*
Theory of Cultural Care, 345

Theory of Environmental Adaptation, 345
Theory of Perception, defined, 349
Theory of relativity, 113–114
Theory triangulation, 220
Therapeutic communication, 258–272, 259–260
  definitions, 259
  described, 260–261
  directions for future research, 271
  elements of helping, 260–261
  feedback loop, 260
  helping skills used in psychotherapy, 261
  nurse healer objectives, 259
  nurse healer reflections, 271–272
  personal skills needed for, 260
  process of communication, 260
  "taking into account," 259–260
  therapeutic communication helping model, 259, 261–271, 262*e*
    building a relationship, 261–262, 263–265
      concreteness, 264–265
      empathy, 263
      genuineness, 264
      premature interpretation, 263–264
      respect, 264
    case study, 269–271
    deeper exploration, 262, 265–268
      additive empathy, 265–267
      confrontation, 268
      examine discrepancies, 268
      feedback, 267
      immediacy, 268
      self-disclosure, 267
    implementation of the plan, 262–263, 268–269
      cost-gain analysis, 269
      problem-solving, 268–269
      select three alternatives, 269
      specific action plan, 269
      trouble shooting, 269
Therapeutic environment, standards of practice, 35
Therapeutic massage, defined, 644
Therapeutic presence, 237
Therapeutic Touch, 176, 202, 247, 652–653, 659–660
  defined, 644
  NCCAM research centers for CAM evaluations, 23*t*
  research-based outcomes of, 531t
Thich Nhat Hanh, 521
Tiller, W.A., 202
Time, 354
  and cultural competency, 328, 330*t*
Tiserand, R., 834
Touch, 641–665
  in aromatherapy, 832
  bodymind communication, 650–651
  cultural variations, 645
  definitions, 643–644
  directions for future research, 664–665
  fostering connections, 160–161
  holistic caring process
    assessment, 656
    case studies, 662, 664
    evaluation, 664
      of client's subjective experience, 659e
    outcomes, 656, 657*e*
    patterns/challenges/needs, 656
    specific interventions: touch
      acupressure and Shiatzu (basic to advanced), 661
      additional therapies, 663*t*
      general touch (basic), 659
      healer touch (advanced), 660–661
      reflexology (basic to advanced), 661–662, 661*f*
      therapeutic massage (basic to advanced), 659
      Therapeutic Touch (advanced), 659–660
    therapeutic care plan and implementation, 656–658
  interventions and techniques
    acupressure and Shiatzu, 653–654
    Eastern, meridian-based, and point therapies, 652
    emotional bodywork, 654
    energy field disturbance, 653
    energy-based therapies, 652
    manipulative therapies, 654–654
    Nursing Intervention Classifications, 653
    other holistic therapies, 655–656
    reflexology, 654
    somatic and musculoskeletal therapies, 651–652
    Therapeutic Touch, 652–653
  labels for, 641
  modern concepts, 645–646
    touch deprivation, 646
  nurse healer objectives, 643
  nurse healer reflections, 665
  nursing studies
    care of adults, 646–648
    care of children, 648–649
    care of infants, 649–650

touching styles, 650
objectives of the therapies, 641
touch in ancient times, 644–645
Touch for Health, 655
Toxic stress response, 728
Toxic substances
causing disease years after exposure to, 288
defined, 276
living in a toxic world, 280–281
Traditionalists, 318
Trager approach, 484, 655
Training, defined, 480
Trance model of addiction, 788
Transactional analysis, 676
Transcendence, 139, 389
defined, 234
Howden's Spirituality Assessment Scale, 155, 156e
Transcendent awareness, 433–434
Transcendent presence, 237
Transcendental meditation (TM), research-based outcomes of, 531*t*
Transformation, symbols and metaphors of, 578*t*
Translators, use of, and cultural competency, 327
Transpersonal Caring Theory, 84, 87*e*, 88*t*
Transpersonal healing and caring, 42
"caring occasions," 42
definitions, 41–42
directions for future research, 51
goal of holistic nursing
healing as an outcome, 46–47
healing as the emergence of right relationship, 43–45
healing vs. curing
curing defined, 45
curing follows a predictable path, healing is creative and unpredictable, 46
death not a failure, but a natural process in the healing system, 46
healing is always possible, 46
healing without curing, 45–46
the healer, 47–48
nurse healer reflections, 51
nurse healer objectives, 41
transpersonal defined, 41–42
transpersonal perspective, 42
a true healing health care system, 48–50
effects the whole body-mind-spirit, 48
integration of the masculine and feminine, 49
nurse as healing environment, 49–50
ways of being with people seeking help, 49*t*
the wounded healer, 50–51
Transpersonal imagery, defined, 568
Transpersonal intoxication model of addiction, 788
Transpersonal Self, 39–40, 178, 198, 199
defined, 379
Transpersonal view, defined, 379
Transpersonal-existential model of addiction, 788
Transtheoretical therapy model, 739–740, 740e
Traumatic experiences, stress response, 125
Triangulation, 218, 220
data analysis, 220
data source, 220
defined, 212
interdisciplinary, 220
investigator, 220
theory, 220
Trichloroethylene (TCE), 280
Trigger, defined, 813
Tripp-Reimer, T., 329
Truax, K.B., 261
Truer Self, 185
Truth in daily living, 427
Trypsin, 201
Turmeric, NCCAM research centers for CAM evaluations, 21*t*

U

Ulrich, R., 858
Ultradian rhythms, 112, 120–121, 121*f*
Uncomplementary transaction, 674, 676*f*
defined, 670
Unit of care, 354
Unit Practice Committees (UPCs), 876
Unitary Field Pattern Portrait Research Method, 85
Unitary Human Being Theory, 345
Up-regulation, 124
U.S. Department of Agriculture (USDA), irradiation of food, 292
U.S. Food and Nutrition Board, 452
Utilitarianism theory, 96
Utilization research, 212

V

Validating your work, 377

Valnet, Jean, 830
Value orientations
  innate human nature, 315
  purpose of being, 316
  relationship to nature, 315–316
  relationship to other persons, 316
  relationship to time, 315–316
Value systems, of cultural groups, 312
Values
  changing beliefs and values, 317–318
  defined, 58, 94
Values clarification
  defined, 58
  and the human health experience, 65–67, 69
  and principled behavior, 100
Van Derbur, Marilyn, 815
Van Oppen, P., 399
Van Wijk, R., 200
Varcoe, C., 343
Vertical arrow exercise, 409
Very low calorie diets (VLCDs), 726
Violence, defined, 814
Visceral pain, 126
Visionary archetypes, 677, 678
Visualization, 577
  defined, 568
  and music, 623
Vitamins, 456–457, 458*t*
  deficiency, 453
  defined, 452
  fat-soluble, 458*t*
  water-soluble, 458*t*

W

Wagner, D., 858
Waldoks, Moshe, 498
Walker, J., 195, 196
Wallace, K., 797
Warnke, P., 838
Warrior archetypes, 440, 676–677
Water pollution, 289*f*
Watson, Jean, 42, 58, 60, 345, 833, 858
  Theory of Transpersonal Caring, 84, 87*e*, 88*t*
Web of life, and networks of relationships, 109–110
Websites, on cultural competency, 334
Weight cycling/yo-yo dieting, defined, 721
Weight lifting, 745
Weight management counseling
  approaches to weight management
    behavioral theories, 723–724
      healthy eating for hunger, 724
      modifying behavior, 724
      nutritional continuum, 723–724
      reward system, 724
      stimulus-response theory, 723
    biological theories
      adipocyte hypertrophy theory, 723
      energy balance theory, 723
      genetic disposition to accumulation of fat, 722–723
      metabolic stimulants for weight loss, 723
      set point theory, 723
    cognitive theories, 725
    psychological theories, 724–725
  case study, 749–752
  comorbid conditions associated with overweight, 722
  definitions, 721–722
  directions for future research, 752
  failure of traditional interventions
    failure rates, 725
    inability to focus on intern motivation, 728
    inability to tailor program to the individual, 727–728
    magical thinking, 727
    restrictions on calories, choices, and times, 725–726
    type 2 (adult-onset diabetes), 727
    unidimensional treatments, 726–727
      exercise as part of weight management, 726
      insulin-resistance syndrome, 726–727
      medical interventions, 726
      pharmacological agents, 726
      very low calorie diets (VLCDs), 726
  healthy percentage of body fat, 744
  holistic caring process
    assessment, 738
    evaluation, 752, 752*e*
    outcomes, 739–741, 740*e*
    patterns/challenges/needs, 738–739
    specific interventions
      action, 745–748
        STOP emotional eating strategy, 746
        ways to change negative self-talk triggers, 746–748
      contemplation, 742–743
      EAT for Hunger strategy, 742, 743
      maintenance, 748–549
      precontemplation, 741–742

preparation, 743–745
Exercise for LIFE strategy, 743–744
ways to get regular, challenging exercise, 744–745
ways to stop overeating, 742–743
therapeutic care plan and implementation, 741
holistic self-care model, 737–738
new interventions
being physically hungry vs. emotionally hungry, 735
cognitive restructuring based on reversal theory, 728–729, 730*e*
"Feeling the Feelings" technique, 735
"Fighting Fair" technique, 735, 737
relaxation-affirmations exercise, 735, 736*e*
effects of negative beliefs, 728
LEARN program, 728
reversal theory, 729–733
cognitive therapy based on, 732–733
metamotivational states, 729, 730*e*, 731–732, 731*e*
alloic state, 731
autic state, 731
mastery state, 729, 731
sympathy state, 731
telic state, 729
unpleasant feelings and tension stress, 732
used in smoking cessation studies, 731–732
self-talk and cognitive restructuring, 728
nurse healer objectives, 721
nurse healer reflections, 752
principles for long-term weight management, 737, 741–742
statistics, 722, 725–726
stimulus-response nature of being overweight, 722
weekly calendar, 739*e*
weight gain epidemic in the United States, 722
Weight Watchers, 724
Weihbrecht, L., 834
Weil, A., 179
Wellness
defined, 58
and meaning, 4
modeling a wellness lifestyle, 565–566
and personality, 116–117
Wellness model, 212
Wellness nursing diagnoses, 359
Wellness pyramid, 359, 361–363
Western view of God, 139, 148
Wheatley, Margaret, 884
White, J., 178
White House Commission on Complementary and Alternative Medicine Policy, 16
Whitfield, C., 816
Whole person assessment
defined, 234
practice considerations, 249–250
Whole person outcomes
healing interventions, 248
Wholeness
and healing, 43
journey to, 173
Wilcoxon Matched Pairs Signed-Ranks Test, 509
Willett, Walter C., 463
Williams, 288
Williams, R.B., 401
Women's health
NCCAM research centers for CAM evaluations, 20*t*
and smoking, 294–295
Women's roles in healing, 314–315
Woodruff, P., 141
"Work spirit," 55–56
Working environment of nurses, 295
Workplace and human health experience, 72–73
Workplace noise, 299
World Commission Environment and Development, 283
World Health Organization (WHO), 352
World soul, 278
World Trade Center, toxic materials in the rubble pile, 289
World view
changing, 781
defined, 79
World Watch Institute, 287
Worry and fear imagery, 589–590
Wound healing, 125
Wound healing imagery, 597–599
Wounded healer, 50–51, 109, 240–241, 279
denying woundedness, 135

X

Xenoestrogens
and breast cancer, 463
defined, 452
Xenophobia, defined, 308

Xenotoxins, exposure to and breast cancer, 462–463

Y

Yeast-fermented rice, for cholesterol reduction, 21*t*
Yes! A Journal of Positive Future, 287
Yin and yang, 324
Yoga, 530
  research-based outcomes of, 531*t*
  restorative, 552
Yoke of Compassion, 872, 872*f*
Yomata, H., 190
Yo-yo dieting, defined, 721

Z

Zderad, L.T., 236
Zen monastery, laughter in, 495
Zero-waste enterprise, 287
Zimmerman, J., 195, 858