Title
Mutual connectedness

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Publication Date
1989

Peer reviewed|Thesis/dissertation

MUTUAL CONNECTEDNESS: HOLISTIC NURSING

PRACTICE UNDER VARYING CONDITIONS OF INTIMACY

by

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DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF NURSING SCIENCE

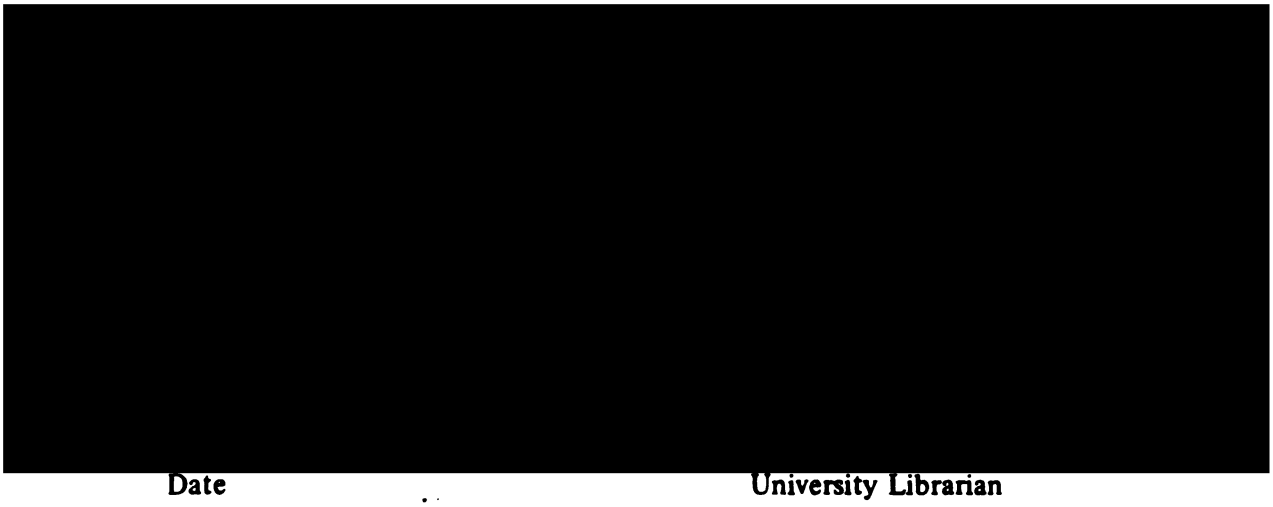
in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA

San Francisco



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MUTUAL CONNECTEDNESS: HOLISTIC NURSING PRACTICE UNDER VARYING CONDITIONS OF INTIMACY

Abstract

MUTUAL CONNECTEDNESS: HOLISTIC NURSING PRACTICE UNDER VARYING CONDITIONS OF INTIMACY

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University of California, San Francisco, 1989

The purpose of this study was to: a) define and describe holistic nursing practice in private settings, and b) to generate theory of client-nurse interaction in holistic nursing practice.

Nurses in private holistic practice (N=12) and their clients (N=18) participated in the study. Data were obtained through one face-to-face, taped, nurse interview and three client interviews with each subject over a three month period. Information was elicited from the nurses: a) to determine if they met the predetermined criteria for holistic nursing practice, i.e., integrated counseling, teaching and energy releasing touch therapies in an environment structured for safety, respect, nurturance, and beauty; and b) to obtain data about their beliefs, practices, and experiences. Clients provided data about their decisions to obtain holistic nurse services, their thoughts and feelings about their relationship with the nurse, and perceived changes in health status. Grounded theory strategies were employed.

Findings revealed a profile of holistic practice--the nurses, their practices and clients. Analysis of the client-nurse interaction from the interactional stance of

the nurse and the experiential perspective of the client provided the Theory of Mutual Connectedness. The major categories were intimacy, mutual connectedness, nursing therapy and healing. Mutual connectedness served as context for nursing therapy, and occurred under conditions of intimacy. Nursing therapies served as strategies for facilitation of healing processes. The theory provides explanation of interactional processes that facilitate and deter healing in that setting.

Large scale societal support for holistic nursing practice is lacking because the use of energy releasing touch therapies can not be explained by traditional Western scientific theory. Holistic nurses depend on the emerging science of holism for foundational support and explanation.

Holistic nursing in private settings provided opportunity to study caring in the client-nurse relationship. This study, descriptive and explorative in nature, is confirmable only as clients and nurses read it and recognize the experience as their own. It is not generalizable to other populations.

Dorothy S. Oda, DNSc
Chair, Dissertation Committee

8-28-89
Date

Dedication

This dissertation is dedicated to Jocelyn Nielsen, my friend, nurse, mentor and colleague, whose commitment to health and healing inspired this study.

Acknowledgements

I would like to express my sincere gratitude to Dr. Dorothy Oda for her guidance and direction in her role as advisor to me at the University of California San Francisco. She always took things in stride and acted as if no problem were insurmountable.

I also thank Dr. Leonard Schatzman for his challenges and perspective in an area foreign to him and second nature to me. His persistence required that I be ever aware of my biases. Dr. Mary Duffy also lent her assistance and support and I am ever grateful for her efforts.

My respect and deep appreciation goes to Dr. Julie Corbin, who led the grounded theory analysis group and provided direction and assistance in the theory building process. My dream is that someday I can guide another student through the grounded theory process with equal skill and understanding. She was always available and appeared to enjoy working with me on the project. It never seemed to be a burden for her.

Dr. Harriet Lionberger lent both her knowledge of holistic nursing and her editing skill as she read the drafts chapter by chapter and made suggestions. I am deeply indebted for her insights, her support of the project, and her writing suggestions.

Belinda Young transcribed all the interviews and prepared all of them for Ethnograph computer software. Her

organizational skill and patience with me were greatly appreciated as I learned to work with the data and computer program.

I also want to thank the nurses and clients who participated. Their support and cooperation never waivered and their belief in the project motivated me to do my best and to live up to their trust that I would represent them accurately.

Thanks also go to my friends who never failed to believe I could do it, and to my daughter, Renae, who believed in what I was doing simply because she loves me.

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CHAPTER ONE

THE STUDY PROBLEM

The Holistic Health Movement: Background for Holistic Nursing

Holistic nursing emerged during the 1970's as a part of the social phenomenon called the holistic health movement. This social movement was characterized by conferences and seminars for health workers and lay persons who were dissatisfied with established health care services and who were interested in exploring alternatives as a more effective way or as a supplementation to current practice.

Assumptions of the Holistic Health Movement

Pelletier (1977) compared basic assumptions held by proponents of the holistic health movement with those held by mainstream modern medicine. Mainstream medical practice was based on the belief that persons could be separated into parts for understanding and for treatment. Persons were conceptualized as having bodies, minds and spirits separate from each other. Each part was cared for by its own specialist, the physician for the particular body part, the psychiatrist or psychologist for the mind, and the clergy for the spirit. The physician-patient relationship placed authority and responsibility for health and healing with the physician; the client followed orders. It was assumed that if one is not sick, one is well; and that good medical care would produce good health if the patient followed the

physician's orders. The aim of medicine was to eliminate disease and its symptoms--the negative or destructive element in the life of the person.

The holistic health paradigm, in contrast, held that a) promotion of wellness, disease prevention, and treatment must involve the whole person--body, mind, emotions and spirit; b) the relationship between health care worker and client must be in partnership, with the client taking an active part in the process; c) health care is not exclusively the responsibility of medicine since diagnosis and treatment of pathology do not in themselves lead to health and fulfillment; and, d) illness can be viewed in a positive way since it may provide the individual creative opportunity to learn about the self within the context of the lifespan (Pelletier, 1977).

Definitions and perceptions of health and healing emerged in the holistic health movement which were more consistent with that of the World Health Organization (WHO, 1980). "Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity." One definition expressing the holistic health perspective (Miller, 1977) is used here to represent new views on health, illness, and the role of the health worker. "Every person achieves a unique interdependent relationship of body, emotions, mind and spirit, inseparable from other individuals and society. Illness can best be understood as

disturbance within the dynamic balance of these relationships. Health may be defined as the harmony of the whole, and the work of the health professional as aiding in reestablishment of a more fully conscious equilibrium within the whole" (pp. 143-144).

The definition of healing used in this study was given in a definition of health by Greifinger and Grossman (1977) as the "process of becoming; a dynamic movement toward full realization of latent possibilities, not only in the human body, but in human feelings, minds, and spirits" (p. 207). The notion of holistic healing here addresses the whole person and is seen as involving increasingly complex organizational and integrational patterns of wholeness. Healing is considered a lifelong process and encompasses one's spiritual, emotional, mental, and physical aspects. Based on the foregoing, health is perceived in this study as a state of total being, and healing as the process of becoming through emergence of one's potential.

These assumptions and definitions of health and healing required different approaches to health care. Pelletier's work, among others (Kreiger, 1987; LeShan, 1982; Ornstein & Sobel, 1987; Siegel, 1986) has provided support for alternative and/or supplemental approaches to health care derived from ancient cultural healing techniques. These techniques were perceived to treat human deviations from health as disturbances in human energy patterns.

Therapeutic modalities thought to release and balance these human energy patterns to promote health and facilitate healing processes were taught in workshops. These approaches were conceived to promote the relaxation response (Benson, 1976) thought to release a person's inherent healing potential.

Conflicts in Scientific Thought

The emerging science of holism provided theoretical support for new perspectives and therapeutic modalities. Evolving theories and research indicated that persons and their environments or worlds are made up of energy patterns that in turn are part of larger energy patterns. Since foundational science was important to those interested in holistic health, they sought understanding of theories of holism being proposed. Some of the major holistic theories used to support holistic thought were: Einstein's theories of Quantum Mechanics and Relativity, Bohm's theory or the Implicate Explicate order, and Pribram's Holographic Hypothesis of the Brain. The perspective presented in the science of holism was in sharp contradiction to the beliefs held by Western science and medicine as it had evolved over the past 2000 years. This new approach focused on organizational patterns related to wholeness, and cleared the way for holistic approach to health and healing.

The scientific method as the only legitimate process of inquiry in the study of health and healing was challenged.

Some professionals advocated a pragmatic approach--doing what works rather than what has been scientifically proven. Others insisted on traditional methods of science but believed that more openness to possibility would advance knowledge about the nature of reality. These persons encouraged the exploration of new ideas or creative pursuits in the study of healing. LeShan (1982) argued for the use of qualitative research in the domain of health. Quantitative research was viewed by him as appropriate for the study of disease but not for health. He believed that since health and healing address the realm of consciousness which is not measurable, qualitative study is essential. "Everything is naturally and organically connected to everything else; there are no `things' at all, only an ongoing process." He stated, "My joy can be stronger than it was yesterday, but not three times stronger" (p. 79).

Language

A new language emerged with the new paradigm since common language is based upon the traditional ways of thinking about the nature of reality. The new language dealt with concepts and language of energy fields, energy patterns, and energy release. Even the language of health and of healing seemed strange and unfamiliar. It was argued that the term "holistic health" was redundant since, of course, health is holistic. Building a language appropriate for these concepts has been difficult within the holistic

movement. The language itself has provided a barrier to understanding of the movement by much of the educated general public. Even those scientists involved with research related to holism complain about the "fuzziness" of the language and cry for precision (Pribram, personal communication, February, 1987). The language used in this study will sound strange and foreign to many educated readers. The writer has attempted to use sufficient explanation or clarification of terms related to the language of holism. Language presents a formidable challenge in this study and the reader is asked to bear with the writer's attempts to explain the different points of view.

Impact of Nursing Theory on the Nurse Perspective

Nurses, educated in both the arts and sciences, were intuitively comfortable with these ideas about health and healing. The holistic health movement attracted many nurses, who seemed particularly interested in the development of skills related to energy releasing touch therapies and imagery. Through continuing education programs, nurses learned to apply Therapeutic Touch, massage, Jin Shin Jyutsu, acupressure, deep relaxation and visualization, to name a few of the therapies used by holistic nurses. Ultimately, they participated in multidisciplinary exploration of basic assumptions of the old and new paradigms through courses and application in

practice.

Examination of the theoretical underpinnings and history of the nursing profession makes nurses' interest in holism understandable. Nursing theory with holistic assumptions dates back to Florence Nightingale (1860), who identified the promotion of health as the aim of nursing. She believed disease to be a reparative process, and that to only treat symptoms with medications and poultices was to go against natural healing processes. Nursing could provide an environment that supplied the patient with the elements needed for healing. She ridiculed the "deep-rooted and universal conviction that to give medicine is to be doing something, or rather everything; (and) to give air, warmth, cleanliness, etc., is to do nothing." She argued that "the exact value of particular remedies and modes of treatment is by no means ascertained, while there is universal experience as to the extreme importance of careful nursing in determining the issue of the disease" (p. 9). She believed that suffering was not symptomatic of disease but of the lack of what is needed by the person from the environment, i.e., fresh air, light, warmth, quiet, cleanliness, punctuality and care in the administration of the diet. Focus on administration of medicines and treatments as the sole functions of nurses was problematic to Nightingale even as it is to many nurses today. She believed the laws of health and of nursing were one and the same, and were needed

for both the sick and the well. The only difference she saw was that the breaking of these laws sometimes produced less violent consequences with the well than with the sick. These notions were similar to and compatible with those of the holistic health movement.

Nursing theories developed during the past ten years by Martha Rogers (1970; 1980), Margaret Newman (1979; 1986), and Rosemarie Parse (1981) hold perspectives similar to and compatible with the science of holism and the basic assumptions of the holistic health movement. Even the language of these recent theorists is similar to that used in the holistic health movement. The writings of nurse theorists address the inseparability of person and environment, the promotion of health and the healing of persons through evolution of consciousness.

Holistic Nursing--A New Role

Nurses who participated in and were influenced by the holistic health movement began to think of themselves as "holistic nurses." Organizations were formed to provide networks of support for the nurses. Most continued to work in hospital and institutional settings, a few established full private practices, and many were able to combine work in health care institutions with a small private practice. It is unknown how many holistic nurses there are in private practice although there are roughly 1700 members in the American Holistic Nurse Association (AHNA) and 600 in the

Nurse Healers Professional Associates, Incorporated. Both groups are predominantly nurses but do include other health professionals. W. Wetzel, leader in the AHNA estimated that 25% of the membership have private practices (personal communication, May 20, 1989). The AHNA conference scheduled for June, 1989 had a half-day session scheduled on "Starting your own nursing business." It would seem that interest in private holistic nursing practice is increasing and the role is being considered an option for nurses.

Nurses in private holistic practices provide a unique opportunity to study a role that is free from non-nursing restraints. Nurses working independently and autonomously are free to practice nursing as they define it, provided they practice within the limits of state regulations and professional standards for care. In the California Nurse Practice Act, regulations governing these nurses covers their activities as autonomous nursing functions, as opposed to those of nurse practitioners whose work involves collaborative functions requiring linkage to a physician.

The distinction between nurses who have a private nursing practice in certain areas, e.g., psychiatric-mental health nursing or consulting, and those who have a private holistic nursing practice may be made by contrasting the ideas of "holism" with "wholism." Many nurses maintain that these two words can be used interchangeably, but distinction is made by this writer to contrast differing philosophies of

"(w)holism." Nursing is often presented as having a "wholistic" approach since the person is viewed as a bio-psycho-social being with many dimensions. This view is based on von Bertalanffy's (1968) System Theory that the whole is greater and different than the sum of the parts. There is emphasis on the dynamic interaction of parts within the whole. "Holism," in contrast, reflects the view that "all is one," that the whole is manifested in each part and the parts throughout the whole. There is emphasis on interpenetrating processes of integration and organization within the whole, the whole encompassing the entire universe (Pribram, personal communication, February, 1987).

Both camps believe knowledge and understanding of health and healing is achieved through the study of integration and organizational process of the person. Mainstream nursing within this framework might be considered "wholistic," while the perspective of the nurses in this study would be "holistic." "Holistic" nurses are more likely to work with touch therapies to "release blocked energy" since they perceive reality as being made up of energy patterns rather than parts that make up the whole. Nursing in general, therefore, is considered to be "wholistic" with some differences in philosophy about the nature of reality.

Therapies thought to release blocked energy patterns were labelled and identified by Doris Sutterly (1987). She

named the therapies "energy releasing practices" and divided them into 1) those taught for self-care, i.e., yoga, aerobic exercise, meditation; and, 2) those applied by another, i.e., Therapeutic Touch, Jin Shin Jyutsu, acupressure, massage or Reiki. These latter therapies are referred to in this study as touch therapies. These therapies emerged from ancient healing traditions and are based on Eastern medicine beliefs that persons are made up of energy patterns that can be blocked in a variety of ways, often by attitudes and emotions.

Holistic nursing practice has been defined for this study as the provision of teaching for self-care, counseling, and touch therapies in a caring environment that is safe, nurturing, respectful, and aesthetically pleasing or has order. Caring (Benner & Wrubel, 1989) is considered the motivational force for the nurse. This investigator assumes that the intent to facilitate healing provides direction through the use of nursing therapies.

Purpose of the Study

The first purpose of the study was to describe holistic nursing practice. Descriptive data regarding holistic nurses in private practice, their practices, their movement from wholistic to holistic practice, their clients, and the experiences of clients in holistic nursing setting were collected and examined. The second purpose was the generation of theory related to nurse-client interaction in

private holistic nursing practice. Interactional theory of the relationship process was developed from data collected from both client and nurse perspectives. Definitions and theory of holistic nursing practice had been developed in previous unpublished studies; a summary is presented in Chapter Two (Schubert, 1985a; 1985b; 1986; 1987). This study was conducted to test and further develop the previous work.

Significance of the Study

Examination of this new role for nursing practice was to gain knowledge of how nurses seek to promote health and facilitate healing. Research related to health promotion and healing is needed to help determine ways to improve heath care practices in a way that is cost efficient and effective for the consumer. Little attention has been paid to natural healing processes in funding of research and implementation of health promotion programs. Health promotion has received minimal recognition of its value, and healing has received essentially none. Because technologically oriented disease care is enormously expensive and is a drain on public resources, plans were made during the Carter administration (U.S. Department HEW, 1979; U.S. Department HHS, 1980; U.S. Department HHS, 1984) to implement experimental health promotion programs. These plans were abandoned during the early Reagan era (Nelson & Simmons, 1983). The bulk of funding continues to go to

disease care, with a little going to disease prevention, and almost none to health promotion. Research is needed to determine cost effective services that will improve consumer health.

Experimentation with new roles for nursing is needed for health promotion by nurses. Exploration and study of the effectiveness of new approaches is important for nursing and for society. Nursing in institutional settings has been viewed by many nurses as restrictive, especially those oriented to health promotion. Holistic nursing in private practice has no restrictions imposed by other disciplines. A careful examination of nursing in these settings may help clarify what nursing has to offer the client in institutional settings and/or in the outside community.

This study also provides outcome data related to holistic nursing practices. Energy releasing practices have been taught in schools of nursing and continuing education programs over the past ten to fifteen years. Although there have been studies of Therapeutic Touch related to specific outcomes, there have been no studies to document client experiences of healing or life change over time within a holistic nursing practice.

The nurse-client relationship in the private practice setting investigated in this study provided an opportunity to gain knowledge of client-nurse interaction. Client experience with intimacy in this relationship provided rich

data for interactional and caring process theory. It was believed that private practice was the setting where the caring relationship could best be developed and studied because with increased time together the nurse's attention could be focused entirely on the client.

The Study Questions

The major questions addressed in the study were 1) what is holistic nursing practice, and 2) what is the nature of the relationship between the nurse and the client in holistic nursing practice? More specific questions asked within the broader framework were:

1. What are the issues which prompted the nurses to move from traditional to holistic nursing practice?
2. What is the educational background of nurses in private holistic nursing practice?
3. What therapies or services are provided in holistic nursing practice?
4. What are the issues which prompted clients to seek holistic nursing care?
5. What problems do clients bring to the nurse in holistic nursing practice?
6. What is the nature of the nurse-client relationship?
7. What is the nature of client outcomes as perceived by the client?

In summary, this study examines an area of nursing that

has received little attention but is growing in importance. The descriptive nature of the investigation is a beginning in the analysis of holistic nursing as a clinical practice.

CHAPTER TWO

LITERATURE REVIEW AND PREVIOUS WORK

Section I: Review of Literature

Literature reviewed for this project provides a background for understanding the development of holistic nursing practice. Readings in this section address the following issues: a) holism in the history of science, b) the contemporary science of holism in the natural sciences, c) holism in nursing theory, and d) nursing research related to health promotion, and e) holistic healing theory and research. Section II contains a review of pilot studies and theory developed previously by the investigator.

Holism in the History of Science

Historically, civilizations have considered health and healing to be matters of the soul and spirit (Wertheimer, 1979). Only during the past two to three hundred years has disease been considered a mechanical process devoid of spiritual meaning even though Western scientific tradition has its roots in ancient history. This science has required the separation of mind and body to gain knowledge related to humans. Democritus (465-365 B.C.) first described the mind and body as separate entities. This dualism has been a major theme, albeit controversial, in the development of Western thought. Descartes (1596-1650) later defined dualism for Western science, stating that mind and body belong to different realms, each known and understood

separately from the other. He believed they interacted through the pineal gland. Kant (1724-1804) continued the development of dualistic ideas about the nature of humans. He relegated the study of the body which could be separated into parts and studied as complex machinery to science, and the parts that could not be separated, i.e., the mind, spirit, ethics, and religion, to philosophy.

Hegel (1907) argued in favor of alternatives to the separation of mind and body in classical science as he sought to merge religion and science in the search for knowledge. His philosophy provided an organizational view of nature in which nature was perceived as having a spiritual goal of eventual self-realization. He differentiated between simple behavior observed in mechanical events of non-living things, and that of more complex living organisms. He maintained that knowledge of things could not be obtained by reducing them to parts for study.

The work of the gestaltists developed during the mid-nineteenth to early twentieth century. They maintained that "properties of parts depend upon the relation of the parts to the whole; part qualities depend upon the place, role and function of the part in the whole" (Wertheimer, 1979, p. 136). They held that the whole does not equal the sum of its parts, nor is the whole just more than its parts. It is a dynamic system fundamentally different from its parts.

Wertheimer (1979) credited Kantian philosophy for opening the door for psychology to take the early lead in the development of holistic science, yet Hegelian philosophy seems more consistent with current holistic thought.

Science of Holism

The perspective of holism, even though it persisted throughout the past two thousand years of Western thought, has emerged as a more powerful influence since the theories of Einstein were introduced in 1905. His work challenged many existing scientific laws held since the time of Newton's work.

Quantum Mechanics and Relativity Theory

Einstein's theories reflected a picture of the universe which merged space and time, matter and energy, gravity and acceleration. His work implied that separation of these dimensions could be from illusions built from long held societal beliefs about the natural world (Zukav, 1979). He introduced room for the notion that consciousness has a role in experience of order and organization in the universe.

While Einstein's theories were being challenged and tested in the natural sciences, other scientists, philosophers, and theologians were considering the new paradigm for understanding of life processes. Alfred North Whitehead (1969) and Ludwig von Bertalanffy (1968) were two of many colleagues influenced by Albert Einstein and his work. While von Bertalanffy's beliefs were similar to

Whitehead's he emphasized interaction among parts. In contrast, Whitehead's theory of relations, permanence and change emphasized interpenetrating processes within an interconnected universe. Parts were seen to merge with the whole being manifested in each part. Whitehead's work reflected more accurately the position of holistic thought.

Bohm's Theory of the Implicate Order

David Bohm (1980), physical scientist, friend and colleague of Einstein is one who has continued to develop and expand the theories of Einstein and Whitehead. Bohm's Theory of the Implicate Order encompasses both Special Relativity theory, pertaining to the cosmic level of the universe, and Quantum Mechanics, to the exceedingly small. All existence was described by Bohm as "a great sea of cosmic energy" (p. 93), interconnectedness or unbroken wholeness being the common denominator of Relativity and Quantum theories.

Bohm further differentiated between the implicate order which is enfolded energy, intangible, holding all potentiality; the explicate order is energy unfolded and manifested as things. The explicate order presents to our senses and there is language for that domain, but there is no physical sensation or language for the implicate. Consciousness and matter merge in the experience of the explicate. Bohm described the "holomovement," a dynamic flow within the universe, which he presented as being a huge

hologram with the whole existing throughout the parts and the parts throughout the whole universe.

Pribram's Theory of Holonomic Brain Function

Karl Pribram (1971; 1987), neuroscientist at Stanford has extended Bohm's thinking to his Holonomic Theory of Brain Function. The hologram has served as a model in his theoretical interpretation of laboratory animal experiments and clinical data from humans with brain lesions. His data has provided strong evidence that the brain works as an organized whole in a complex web of reciprocal processes organizing the whole and reflecting order and regularity. These processes involve a dynamic relationship of spacetime images and the spectrum of the energy domain in patterns of processing images, memory storage and retrieval as well as other brain functions. Spacetime and spectrum merge to provide information defined as decreasing uncertainty.

Since the brain, through the nervous system, coordinates all the body processes and directs the relationship of person-environment through consciousness, the brain and its function are the focus of many holistic therapies. Unravelling the mysteries of brain function may lead to a change in health care and healing therapies (Ornstein & Sobel, 1987). Computer science has opened up new technology for advances in this endeavor (Pribram, 1987).

Prigogine's Theory of Dissipative Structures

Prigogine's (1984) Theory of Dissipative Structures described a process of becoming wherein entropy is dissipated in the emerging process. A state of near equilibrium results in little growth or change, but in a far-from-equilibrium state there is a point of chaos in which the organism (person) can organize its forces and move to a higher level of complexity, organization or functioning, or it can give up, fall back, regress. Prigogine refuted the Second Law of Thermodynamics which indicates the universe is running down because of built up entropy. He provided arguments that open systems dissipate entropy, establish increasing order and complexity. This theory provides support for theory that stress can be either destructive or helpful in the evolution of a person. Consciousness may determine the direction of change, emergence of order or chaos.

Nursing Theories of Holism

Nurse theorists discussed here have presented holistic perspectives of person-environment compatible with those theories of holism described earlier. They have applied conceptually defined nursing within the framework of the science of holism. Holistic nursing practice is the implementation of those conceptual models related to health and healing and to the nurse-client relationship. Clients may be individual persons, families, groups, populations,

countries, or worlds; but, for the sake of simplicity only the words client and person are used here.

Rogerian Theory of Unitary Man

The science of holism applied to person is reflected in Martha Rogers' (1970; 1980) Theory of Unitary Man, which she described as a theory of becoming. She addressed emergence, growth, and fulfilling one's potential as she used "wholistic" type thinking in her 1970 writings and "holistic" in the more recent work. Her assumptions are related to theories of Relativity, Quantum Mechanics, and General System, and her ideas reflect those presented by the science of holism. Rogers did not define health but presented the life process as developmental or evolutionary within the person-environment perspective.

Newman Theory of Health as Expanding Consciousness

Newman's (1979) theory of health, framed by Rogerian views, emphasized the expansion of consciousness in one's developmental process of becoming. Consciousness was defined as the "capacity of the system to interact with its environment" (1986, p. 33), and is observed as quantity and quality of response to the environment. The total pattern of person-environment interaction, therefore, is seen by Newman as a network of consciousness determining and determined by space, time and movement.

She addressed disease and illness as manifestations of the person's unique life pattern. She argued that

elimination of disease alone does not change the person's pattern, and that disease may represent health for the person if it results in expansion of consciousness (Newman, 1979; 1986).

Parse's Theory of Man-Living-Health.

Parse (1981) extended Rogers' and Newman's assumptions when she addressed the role of personal freedom and responsibility in the choice of meanings applied to life events. She also emphasized priorities as reflections of consciousness, one aspect being that of personal choice. Consciousness, then, was viewed as significant in the development of rhythmic patterns within the person-environmental context. Parse emphasized the aspect of becoming in the unfolding of potential for the person-environment.

Pattern Processing in Nursing Practice

Nurse scientists Rogers, Newman and Parse have provided a theoretical pathway for holistic nursing practice consistent with the emerging science of holism in the natural sciences. Newman (1986) argued for a non-intervention model of nursing practice since an intervention is perceived by her as something done to the client with the expectation of a predetermined outcome--an attempt for the nurse to change the client in some way. Together, these theorists have provided support for the theory of holistic nursing practice proposed by this writer. Nursing, in this

model is focused on relational elements; the intent being not to change a person's pattern but to recognize it and to relate to the person in an authentic way. Clients are free, then, to release limiting patterns if they choose to do so, and to experience an unfolding of potential, whatever that may be for the person.

Nursing Research Related to Health Promotion

Health promotion in nursing theory (Newman, 1979; 1986) and related literature (Duffy & Pender, 1987) reveals a concern with pattern recognition. Patterns revealed in the life of clients have been viewed as observational data for holistic nursing practice of health promotion.

Nursing research in health promotion is in it infancy. A review of this literature (Schubert, 1987) revealed three research programs based on the following conceptual themes.

Studies Related to Smith's Model of Health

The first program was one based on Smith's (1981) four models of health: clinical, role performance, adaptive, and eudaimonistic. Fontes (1982) and Laffrey (1985a) used self-actualization as measured on the Personality Orientation Inventory (POI) (Maslow, 1962) as a construct of eudaimonistic health and attempted to show a relationship between health conception and health status. Investigators later questioned the use of the POI since Maslow's (1962) definition of self-actualization implied separation from or an overcoming of environment, a notion distinctly in

opposition to nursing theory that person-environment emerge in a pattern of interrelationship (Rogers, 1970). Since health is perceived and experienced in a variety of ways, Laffrey was able to show with a large randomly selected sample that health conception is related to behavior choice (Laffery, 1985). These studies provided beginning knowledge of how health perception influences health behavior choice.

Fontes (1982) used measures of moderation and balance as parameters of health. She used, in addition to the POI, two measures designed to determine degrees of personal need and cognitive style to provide evidence of moderation and balance as determined by mid-range scores. She concluded that moderation and balance, described as harmony with the universe were probably not represented appropriately by mid-range scores. This study was an attempt to determine measurable health constructs for health promotion research.

Pender Studies

A second group of studies was lead by Nola Pender. Pender (1985) and Pender and Pender (1986) addressed theories of psychophysiology and health psychology. These studies were more limited in scope and measured prior determined behavioral responses to specific stimuli or intervention. Pender used these studies to test and modify Rosenstock's (1966) Health Belief Model (Pender, 1982), the Theory of Reasoned Action (Ajzen & Fishbein, 1980), and locus of control theory (Wallston, Wallston & DeVellis,

1978). Progressive muscle relaxation (PMR) training was used in these studies as the independent variable with blood pressure being the dependent variable. These studies were considered pilot in nature as they used small groups of convenience samples in pilot community health programs.

Newman Studies

The third group of nurses participated in a research group to test Newman's (1979) theory of health as expansion of consciousness with correlates of consciousness being time, space, and motion; movement being a function of space and time (Engle, 1984; Engle & Graney, 1986; Mentzer & Schorr, 1986). In these studies, the actual clock time was equated with a consciousness index, an indicator of health. Inconsistent results were evident, but over several studies, the findings were consistent with theory and the program of basic research continued to progress over several years. Engle (1984) provided a chart of results over four studies of persons involving subjects of different age groups. The findings, indeed supported the hypothesis that perception of time duration increases with age. The program focused on ways to study patterns of time and movement in the person-environment interrelationship. Mentzer and Schorr (1986) tested their hypothesis that low levels of perceived situational control were related to decreased time perception, operationalized as low levels of consciousness. The researchers in this case questioned their use of

clocktime as a measure to determine consciousness. They realized that the concepts of space and motion had to be incorporated into the research strategy as required by the theory, not just time and consciousness. This group of studies reflects an effort to determine appropriate constructs for research related to health promotion. Although they used small samples under less than perfect condition, these nurse researchers demonstrated creativity and ingenuity in their search for constructs.

These studies reflected tremendous difficulties with construct validity in health related research within the empirical analytic paradigm. Qualitative research was not used in any of the health promotion studies reviewed.

Holistic Healing Theory and Research

The literature on healing is predominately from anthropological studies of other cultures and faith healing related to religious practices in this culture. A choice was made to include only nursing research, evidence of natural healing processes in the body which Cannon referred to as the "wisdom of the body," and some assumptions from Meek's (1977) theory of healing.

Nursing Theory and Research

Nursing literature is practically devoid of research or theory of healing, except for that of Therapeutic Touch. There have been several studies of Therapeutic Touch published over the past 15 years by Kreiger (1974; 1975;

1979; 1987), Heidt (1980), Quinn (1982), Macrae (1987), Randolph (1980; 1984), Fedoruk (1984), Meehan (1985) and Lionberger (1985), to name a few. Dependent variables have included hemoglobin levels, anxiety as measured by muscle tension and skin temperature, behavioral stress in premature infants and acute pain. Two descriptive studies have been made of Therapeutic Touch practitioners (Randolph, 1980b; Lionberger, 1985). Lionberger reported that nurses most often used Therapeutic Touch to relieve pain, tension or anxiety. It is also used to accelerate and facilitate healing, as well as to relieve symptoms. These studies have made a significant contribution to nursing knowledge of healing, yet very little is known at this time. Studies do show that clients respond favorably to Therapeutic Touch, and nurses experience a sense of healing in themselves as they employ the technique. There have been no studies to examine the client experience with Therapeutic Touch in relation to holistic healing.

Touch therapies used to release energy, currently perceived as metaphysical in nature seem strange to most people of this culture. A more familiar perspective of healing, involving the body's capacity for self-protection and regeneration, is well recognized and accepted.

The wisdom of the body. Kreiger (1987) reminded the reader to acknowledge the intrinsic self-healing power of the body and cited the following processes. The

immunosystem immediately recognizes foreign agents entering the body; the autonomic nervous system reacts protectively to threat or trauma; the endocrine glands governs fundamental body functions, and the thalamus sorts physiological stimuli sent to the brain. Certain organs, including the skin, bones, nerves and liver all have regenerative ability. Protective psychological defenses also provide protection by reacting to overloads of emotional stress.

Hans Selye (1956) first conceptualized the effects of stress on the body as the General Adaptation Syndrome. This work has since inspired a large body of knowledge of the effects of stress, positive or negative; the type of stress; and coping strategies as modifiers (Ornstein & Sobel, 1987). Modifiers include practices of mental attitude adjustment (McKay, Davis & Fanning, 1981) and deep relaxation (Benson, 1976). Mental attitude adjustment includes such things as changing the way one thinks about oneself or about events, making the difference between hope and despair in one's life. Deep relaxation has been practiced in a variety of ways; e.g., autogenic training, hypnosis and progressive relaxation all induce a deep state of muscle and mental relaxation. Such relaxation is known to induce states of healing in the body and mind. Relaxation is also used as precursor to meditative states for healing of the spirit. The question then arises as to what happens in the body to

initiate healing.

Ornstein and Sobel's (1987) overview of brain research as it relates to health and healing provided documented evidence of how the brain controls the immune system, regulates pain and uses our emotions for health and healing. Chemical neurotransmitters in the brain known as acetylcholine, norepinephrine, serotonin, dopamine and endorphins are now thought to determine temperament, mood and the function of intrinsic healing systems. Endorphins also appear to affect appetite and immunity. Neurotransmitters carry messages between cells, and neurohormones produced and secreted by the brain carry messages through the blood stream to target organs. These powerful drugs of the brain influence and control moods, thoughts and bodily functions.

Production of these chemicals has been linked to belief or expectation through experimentation involving placebos. Experiments done at the University of California San Francisco (Levine & Gordon, 1984) with placebos found that clients responded to "hidden" placebo administration (known to the investigator but not to the client) as well as that given openly to clients. They did not respond to preprogrammed placebo administration (known to neither investigator or client), indicating presence of subtle communication of which the client and investigator were not aware. Placebo effects, then, are of great interest in

healing research since belief and expectation produce accompanying changes. Ornstein and Sobel (1987) state, "psychological factors such as emotional state, mood, `will to live,' and the doctor-patient relationship may turn out to be as important as drugs in that they promote the synthesis and release of endorphins and other compounds in the brain" (p. 97). The healing rituals of "primative" societies and folk medicine may have biological effects by helping to stimulate the brain's own healing system. These physiological links may stimulate a renewed inquiry into the role of emotional and mental factors in health and healing. The healing ritual of "primitive" societies and folk medicine may have biological effects by helping to stimulate the brain's own healing system. These ideas support the need to coordinate medical therapies with the brain's own efforts to heal itself. This investigator believes that support of those intrinsic healing processes is the work of nursing.

Herbert Benson (1976) addressed deep relaxation as one way to stimulate intrinsic self-healing processes. He provided evidence that when tension is released from the mind and body for just a few minutes each day, there is a healing response. He suggested one method of using the Relaxation Response, and other ways of reaching this deeply relaxed state were developed by others. Some of these techniques were: autogenic training (Luthe, 1969),

meditation (LeShan, 1975), progressive relaxation (Jacobson, 1938), hypnosis with suggested deep relaxation (Benson, 1976).

Positive affirmations and imagery have been increasingly recommended as other ways for the client to stimulate healing in specific ways. The client is taught to stop negative thoughts and replace them with affirmations of self-worth and confidence, and to visualize an image of themselves as they want to be. This work has been encouraged in holistic nursing practice (Dossey, et. al, 1988) "to awaken the inner healer" (p. 223). Howard Hall and colleagues (1983) used hypnosis and imagery to determine the response of lymphocytes in cancer patients. They found that the younger people in the group had increased numbers of lymphocytes after just one hypnotic session followed by self-hypnosis for one week. This was a group of only 20 persons, ages 20 to 80, but indicated the need for further research. Indications that imagery and positive affirmations stimulate healing processes. They found that changes in self-perception stimulated release of neurotransmitters and neurohormones important for healing.

Pribram's (1971; 1987) theory of Holonomic Brain Functioning based on laboratory animal experimentation and clinical data of humans with brain lesions gives cellular level information regarding perception. His data indicates reciprocal and cooperative efforts between neuron-neuron

activity and patterns or contours of slow potential pattern processes occurring at the dendritic junctions. The slow potential patterns create the perception or context for interpretation of the neuron-neuron message. The slow potential patterns provide the means for pattern perception as well as the pattern for perceiving incoming information. The use of deep relaxation and imagery may be examples of tools for effective change of these slow potential dendritic microprocesses. Such changes could affect perception of incoming data related to one's health and healing.

A general theory of healing. Assumptions of Meek's (1977) General Theory of Healing are as follows: a) a healer does not do the healing; it is accomplished by reinforcing or supplementing the client's own extraordinary capability of self-healing; b) the trillions of cells in the body are linked by highly perfected communications system with the generating energy to power the communications system; c) the cells of the body are dying and generating so that every cell is new within six months, indicating that if the client can help new cells be born in a healthy state, the body can move back to health; d) the body is composed largely of water, and since water is extremely sensitive to radiations from a wide spectrum of energies which are measurable, it is believed there will eventually be a knowledge of healing; e) the watery body which atomically speaking is 99% empty and therefore is not solid as perceived; f) electro-magnetic

energy fields as described by Burr and Northrup (1935), determine the form new cells and organs take as they replace the old ones; g) healing will seldom start and will not be permanent unless there is a desire on the part of the patient to return to health. Meek also stated that mind and brain are separate. Pribram would argue that his theory of brain function allows for mind functions from brain processes.

Conclusions

Holistic nursing practice presents the scientific investigator with several problems for consideration. Although the results of these energy releasing touch therapies cannot be explained by Western scientific knowledge of human energy, the emerging science of holism and nursing theory provides explanation and foundational support for such practices. Traditional scientific investigative approaches are hampered in the study of holistic nursing because there are few concrete and consistent factors obtainable. Each client's experience is considered unique and outcomes may be manifested in a myriad of ways. There is a dearth of literature related to health promotion and healing as defined for this study.

Section II: Pilot Studies and Previous Work

The purpose of this section is to provide the theoretical framework derived from previous pilot work and theory building related to holistic nursing practice. This theory was used in the selection of nurse participants for the current study.

Theory of Healing Environments

In 1984-85, the investigator conducted an observational study of nursing practice in a children's acute psychiatric hospital unit. Observations of nursing activities were documented over a period of 60 hours within a two week period. Fifteen nurses from three shifts were involved, although most observations took place during the days and evenings.

Characteristics of a Healing Environment

Nurse activities were categorized and conceptualized to provide the basis for a theory of healing environments (Schubert, 1985). Those activities provided safety, nurturance, respect and aesthetic beauty. These concepts were defined as follows:

Safety. Safety, protection from harm and from fear of harm, for the whole person--mind, body, emotions and spirit. For example, the nurse provided physical safety, and took steps to prevent fear of isolation and of being judged incompetent or inadequate.

Nurturance. Nurturance included attention to those

aspects of environment identified by Nightingale (1860) necessary for healing: noise, air, temperature, hygiene, food and protection from emotional upset. In the pilot study, nurturance included provision of nutrition, rest, sleep, exercise, fresh air, medical treatment and touch. The latter two were added to Nightingale's list of nurturing activities. Medications and medical treatments were seen to provide elements to the internal environment of the child by establishing or re-establishing biochemical balance. Touch, observed frequently in the study, was considered a nurturant activity based on the work of Montagu (1978), in which touch was determined essential for health and healing, and indeed for life itself.

Respect. Respect was defined as consideration and concern for the person, and belief in the client's capability and competence. The client was not protected from situations where there was opportunity for learning and growth, but was encouraged and supported while being challenged. Unsolicited advice and help was considered discouraging and detrimental since such help implied inability to learn.

Beauty. Beauty was defined as those materials, forms and expressions that bring pleasure to the senses, i.e., tactile impressions, flavors, sounds, colors, textures, forms (Santayana, 1896). The provision of structure and order in the environment was also considered an aesthetic

consideration. The worlds of nature, music and color bring many of these pleasures which are intuitively known to stimulate healing, yet usually ignored in health and healing practice.

Additional concepts in the theory of healing

In the study described above, caring appeared to motivate creation of the healing environment. Intent to promote health and facilitate healing directed decisions about care; and being centered allowed the nurse to be focused, to attend to the moment at hand and to do what was most helpful for the client.

Caring. According to Leininger (1978), caring refers to nurturant and skillful activities that reflect empathy, support, compassion, protection, and other qualities dependent upon the needs, values, and goals of the client. Several nurse theorists have examined caring as the essence of nursing (Benner, 1984; Gaut, 1981; Leininger, 1984; Watson, 1979). The resulting theory of caring for nursing has its roots in the work of Mayeroff (1971), who detailed elements of caring: a) knowing, or rationally and intuitively acknowledging strengths and weaknesses while recognizing the person's needs, goals and wishes; b) perceiving a person or problem from different perspectives with understanding and acceptance; c) allowing others, as well as the self, to make decisions and to set their own goals; d) honestly accepting one's own thoughts, weaknesses,

and motivations before approaching those of the other person; e) humbly recognizing that the other's learning is not under the caregiver's power to control; f) trusting and allowing the other to be a self-determining person, not an extension of the caregiver's will; g) seeing the present moment as having great possibility; and h) using courage to help the self or others to accomplish uncomfortable or difficult tasks. Caring, of course, begins with self-care, and only the nurse who cares for herself is in a position to care for her clients.

Watson (1979), while pioneering a caring philosophy for nursing, listed the following assumptions: a) effective caring promotes health; b) caring responses require acceptance of a person not only as he or she is now but as what he or she may become; c) a caring environment is one that offers the development of potential while allowing the person to choose the best action for himself or herself; d) caring, which is central to nursing, is more "healthogenic" than is curing, but is complementary to the science of curing, which is central to medicine.

Benner (1984) stated that a "caring, involved stance is prerequisite for expert, creative problem solving." Difficult problems require both conceptual and perceptual ability, and caring provides the necessary engagement and attentiveness to make the best decision for the interest of the client (p. 214). Watson (1984) and Gaut (1981) both

discussed caring as action, but this investigator includes intention to help or heal as underlying that action.

Intent to heal. Because healing and health promotion are the goals of nursing activities, Kreiger (1979) addressed attitudinal conditions necessary for facilitation of healing. They were: a) intention to help or heal; b) motivation to serve in the interest of the client; c) willingness to confront oneself in relation to the first two conditions. These conditions are concomitant with Mayeroff's (1971) contention that caring requires self-actualization. Meeting one's personal needs is inadequate motivation for helping others.

Intention to heal does not imply that healing is accomplished by the nurse. Instead, the nurse reinforces and supplements the client's capability of self-healing (Meek, 1977). That is, the integration, order and balance evolve as the person moves toward his or her potential for being.

Centering. Lionberger (1985) identified four characteristics of what nurses in her study referred to as centering: a) disciplining attention, b) achieving a calm relaxed state, c) establishing receptivity, and d) becoming a channel for the energy of healing (p. 48). Providing a mental set for focusing on client needs and excluding preconceived notions regarding those needs (Lionberger, 1985), centering marshals consciousness in the interest of

the nurse-client relationship. Nurses in the Lionberger study described centering as the collection of thoughts and energy in the present moment, clearing the mind of extraneous thoughts, and directing attention to the person at hand.

Patterson and Zderad (1976) addressed the concept of centering from a different perspective. They focused attention on the "being" aspect of nursing in contrast to "doing," although they stated that these aspects are never separated in reality. They maintain that "being there" or "being with" is associated with doing since doing involves the caring nurse's active presence. Under these conditions full attention is turned to the client with full awareness of the present. These writers are addressing the concept of being centered used by holistic nurses.

Assumptions of the Healing Environment Theory

This theory, then, provided the assumption that nursing practice, at least in this particular setting, was based on caring and the intention to heal. Nursing activities were directed to the provision of an environment conducive to healing, i.e., safety, nurturance, respect, beauty and/or order. Such an environment would provide those elements thought necessary for healing from within. This process was considered in contradistinction to, yet consistent with the acts of curing--the acts of an external source to remove disease or symptoms.

It was recognized that the provision of environments conducive to health and healing may be a central aim of nursing in other nursing settings. Since the caring process was perceived as central to nursing, and distinct from the curing process, it was assumed that nursing in autonomous private practice could provide knowledge of the caring process at work. The next step in the process then was to test the theory in relation to that situation.

A Pilot Study of Holistic Nursing Practice

In 1985, the investigator interviewed a nurse in holistic nursing practice and eight of her clients. The nurse answered questions about her educational background, work experience prior to the private practice, the reasons she made the change, the establishment of her practice, business aspects, her clientele, services provided, and her beliefs about health and healing. The nurse recruited client interviewees who had been seeing her over a period of months or years and were willing to share their experiences. The investigator contacted the clients by telephone to gain their consent to be interviewed and to set up appointments. All were eager to tell the investigator about their experiences. They answered questions about their relationships with the nurse and about changes in their lives which they attributed to that relationship.

These interviews received only a cursory analysis and were scanned for elements of holistic nursing practice and

for beliefs about health and healing. The clients as well as the nurse were all strong promoters of holistic nursing and believed they had experienced significant life changes as a result of the nurse's care. One client stated that initially she was very frightened when the nurse knew things about her she had not knowingly revealed. For this reason, the client had only seen the nurse once, and had then sought another therapist who treated her for two years. Subsequently, she returned to the nurse and had been working with her for one year at the time of the interview. She reported great changes in her physical, emotional and spiritual health.

The experience of this client was especially intriguing and stimulated interest in the study of the client-nurse relationship. Observations suggested that private holistic nursing practice would be an ideal place to study this phenomenon. Data from this study were used in conjunction with review of the literature, personal knowledge of holistic practice, and dialogue with colleagues to build a) a model of health, and b) a theory of holistic practice.

A Model of Health

The investigator developed a model of health to represent the perspective found in holistic nursing practice. It defines health as integration of mind, body, emotions and spirit through expansion of consciousness, as put forth by Margaret Newman (1979; 1986). She maintained

that consciousness directs the person-environment interrelationship.

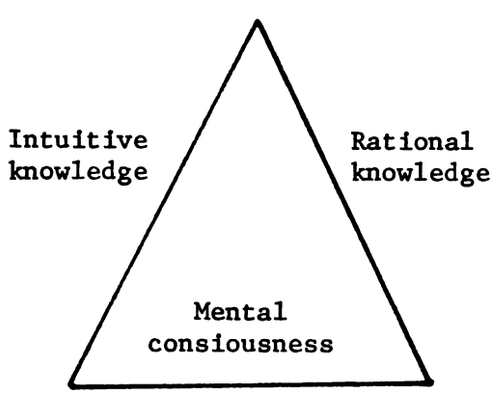
In the model, the individual's mental, physical, emotional and spiritual dimensions are represented by triangles. Sides of these triangles represent areas for growth within each dimension. A model of integration of these dimensions through consciousness follows discussion of each triangle.

The Mental Dimension

The three areas of development for mental health are presented in Figure 2.1. Consciousness of the mental aspect directs growth.

Figure 2.1

The Mental Dimension of Health



The mental aspect meets the person's need to know and to express knowledge about the person-environment. Creative expression of rational and intuitive knowledge is necessary

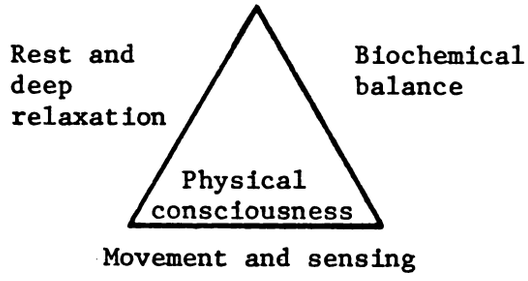
for growth and development of the mind. (See Figure 2.1) Expression releases energy necessary for the flow of thought.

The Physical Dimension

The physical dimension also has three aspects of concern to be defined (See Figure 2.2).

Figure 2.2

The Physical Dimension of Health



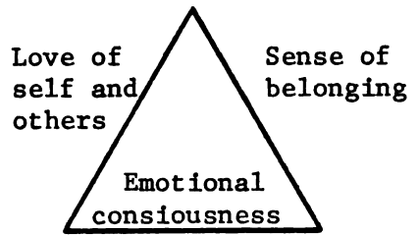
Physical health allows the person to respond with the body in interaction with the environment. Cellular nutrition depends upon the intake of nutrients through air, food, food supplements, medications, and avoidance of toxic substances. Aerobic exercise and deep breathing provides oxygen for biochemical balance. Movement and sensory stimuli of taste, sight, sound, smell, and touch provide the experience of person-environment interrelatedness. Deep relaxation facilitates a sense of well-being through letting go of tension and allowing the body to heal itself, preventing illness, and promoting general health (Benson, 1975).

The Emotional Dimension

The emotional aspect develops as feelings about the self in relation to the environment. There is a need to love and be loved, to belong, and to express love through action (See Figure 2.3).

Figure 2.3

The Emotional Dimension of Health



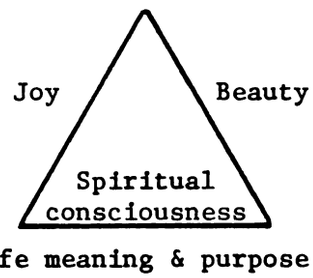
Much health promotion work is done at the point of "feeling cared for" as it seems this feeling is necessary before one can "care for others or for the self." Health behavior depends primarily on one's ability to care for the self and to believe that one is worthy of being "cared for." Adler (1927) maintained that the basic human need is to belong. Recent work in the area of social support further emphasizes the importance of meeting this need. As caring, love and a sense of being connected to the universe takes on depth and breadth, expression through service to one's community, humanity, world and supreme being (in whatever form that may be) takes on a spiritual quality.

The Spiritual Dimension

Spiritual health needs are for beauty, joy and laughter, life meaning, and purpose (See Figure 2.4).

Figure 2.4

The Spiritual Dimension of Health



A sense of connectedness, of lightness and joy that transcends life experience, however painful that may be, are indicators of spiritual health. Beauty occurs through color, light, sound, fragrance, taste, and rhythm to nurture the spirit. Joy and laughter are aided by humor and play bringing lightness to the spirit. Meaning and purpose provides direction and motivation for the spiritually healthy person. Frankl (1959) documented the necessity of meaning and purpose in one's life.

Through this model, it was proposed that health behavior, including psychophysiological events and actions experienced as lifestyle changes occur in response to changing patterns of consciousness. Needs change as the person-environment relationship evolves. Thus, changes in

health behavior patterns occur with expansion of consciousness, a pattern of health behaviors emerges to facilitate healing. Specific behaviors differ according to individual uniqueness. Behaviors implemented in a particular lifestyle must be congruent with the needs of the total person-environment context.

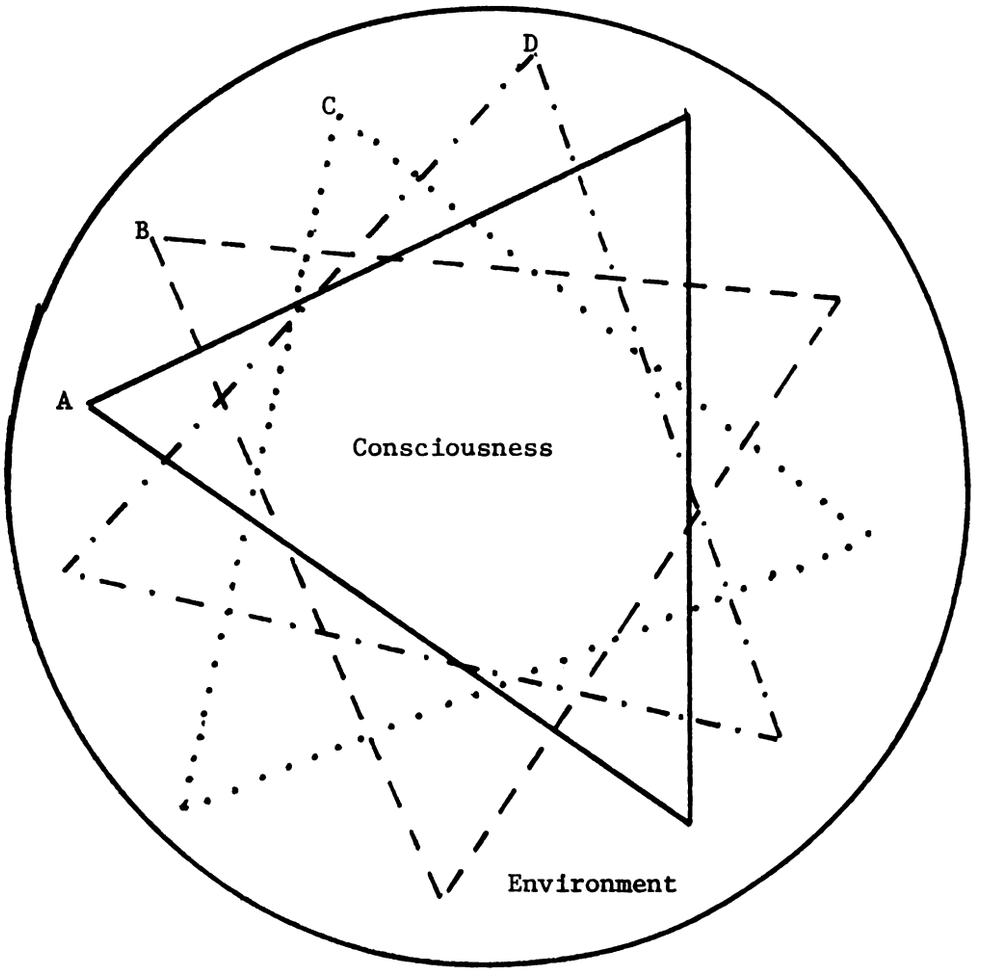
Integration of Dimensions

In the following model, the triangles represent interpenetrating processes as the four dimensions form a pattern of wholeness. All is in a dynamic process, moving, constantly changing within an evolutionary process of being and becoming. The healing environment described earlier is represented by the circle. Caring and the intent to heal offer opportunity and support for healing and for healthy patterns to emerge through expansion of consciousness.

In reality, no lines demarcate person and environment. Persons establish their reality through integration of self within this environmental context. Their worlds are continuously being reshaped by new meanings and relationships.

Figure 2.5

Health--The Integration of Physical, Mental, Emotional and Spiritual Dimensions through Consciousness.



A = Physical

B = Mental

C = Emotional

D = Spiritual

Theory of Holistic Nursing Practice

Analysis of the pilot data also stimulated the development of theory related to nursing activities. Analysis revealed that holistic nursing therapies include: a) teaching for self-care related to health promotion and healing; b) counseling to ease interpersonal and intrapersonal conflict; and c) touch therapies, i.e., massage, acupressure, Jin Shin Jyutsu. Investigator theory holds that these therapies are integrated within an environment created to promote health and facilitate healing.

Teaching for Health Promotion and Healing.

Teaching was defined as guiding someone by sharing knowledge and skills through instruction, and demonstrating or role-modeling. The relationship offered opportunity for teaching and learning, for both the nurse and the client, in relation to the proposed health model.

Assumptions related to teaching. In holistic nursing practice, it is assumed that persons foster their own healing processes in their choice of health behaviors directed to meet the needs of their total person. It is further assumed that nurses teach both by providing a perspective of holism for health and healing that addresses needs of the body, mind, emotions, and spirit, and by being a living example in the nurse-client relationship.

Counseling in Holistic Nursing Practice

Corey (1977) defined counseling as the process in which opportunity is provided to explore personal concerns; this exploration leads to increased awareness of choices among possibilities. Counseling in nursing, as perceived by the investigator, is used to ease intrapersonal and interpersonal distress and conflict in the person-environment context. Travelbee (1971) maintained that persons are offered opportunity to learn and grow through the resolution of conflict and in the discovery of meaning in suffering. Benner & Wrubel (1989) defined stress as "the disruption of meanings, understandings, and smooth functioning, so that harm, loss, or challenge are experienced; and sorrow, interpretation, or new skill acquisition is required" (p. 59). They argued that coping strategies taught for stress management promote distancing from the situation and from one's emotions, and that although the person may feel better, such distancing separates the person from life history and meanings. In situations of tragedy and suffering, Benner considers it inappropriate and harmful to distance from feelings of grief and loss. Travelbee (1971), on the other hand, believed that persons have a capacity for coping by finding meaning in their grief and loss. While suffering is certainly not the only avenue to meaning, meaning provides a way of coping that promotes integration and growth.

Qualities of the helper that promote healing. Truax and Carkuff (1967) identified a) empathy, b) respect, c) concreteness, d) genuineness, e) immediacy, f) confrontation, g) self-disclosure, and h) personal power as those qualities of the helper/counselor that accompany positive change in clients regardless of the counseling approach used. They defined empathy as the ability to "tune in" to the other person's feelings, thus helping to overcome feelings of alienation and isolation. The feeling of being understood leads to trust, a necessary element for a healing relationship. Genuineness implies honesty, spontaneity, good will, and integrity. Genuine persons do not hide behind their roles, but show consistency of thought, feeling and behavior. They make themselves known. Respect reveals attitudes and behaviors of attending to others, being "for" others, recognizing each person as unique, seeing others as self-determining, and suspending critical judgment. Concreteness means speaking of thoughts, feelings, and behaviors in specific terms rather than in generalities. Meaningful communication occurs when specific events and feelings are explored. Self-disclosure is the revealing of self to others by sharing persistent reactions, willingness to reveal current struggles, unresolved personal issues, goals and aspirations, pain, joy, strengths and weaknesses, and the meaning of certain experiences. It is not revealing innermost secrets or expressing every reaction, or even

telling stories about oneself that focus attention on oneself. When confrontation is used, discrepancies in words, feelings, and behavior are highlighted. A direct, honest, sensitive and timely counselor can help people take an honest look at themselves. Confrontation for healing does not entail being hurtful or critical, but is an act of caring and respect. Immediacy brings what the client says to an immediate situation. Personal power is an attitude of confidence with the power that comes from within when one knows and likes oneself. Such a helper helps the client to have confidence, to trust, and to enter into their relationship without fear of hurting the helper.

Personal development of the nurse is perceived to be critical in holistic nursing practice. The ability to work with clients in this way requires great understanding of the self and others, maturity, and skill in interpersonal relationships.

Assumptions related to counseling in holistic nursing. It is assumed that when persons are provided opportunity to address their concerns in a healing environment, they will experience healing through release of blocked emotional energy and the discovery of meaning in their lives. This release will lead to integration, balance, and harmony. Characteristics of the nurse as healer determines to a great extent the quality of the healing process.

Energy Releasing Touch Therapies

Therapeutic Touch was introduced to nursing by Dora Kunz when she taught Delores Kreiger how to use her hands to work with a human energy field to restore balance and harmony. It is probably the most common energy releasing touch therapy used by nurses. Kreiger (1979) described four steps in the act of Therapeutic Touch: a) centering oneself; b) using the tactile sensitivity of the hands to detect differences in the energy field around the body; c) mobilizing the client's energy field; and d) consciously influencing this energy through the use of the hands to balance and repattern energy. This therapy is being taught in schools of nursing and there is a growing body of knowledge of research and practice (Kreiger, 1974, 1975, 1979, 1981, 1987; Beck and Peper, 1981; Clark & Clark, 1984; Fedoruk, 1984; Lionberger, 1985; Macrae, 1979).

Jin Shin Jyutsu had its origins in ancient cultures and was rediscovered in the early 1900's by Master Jiro Murai of Japan. He taught Mary Burmeister who introduced the healing art to the United States. It's practice involves a light to heavy touch along flow patterns bearing 26 pairs of "safety energy locks." The hands are said to be used as "jumper cables" for release of blocked energy. One listens for the synchrony of pulses in the finger tips. The basic philosophy involves getting to know oneself (Burmeister, 1988).

Acupressure and acupuncture have been practiced for about 6000 years in China and other Eastern countries. Acupressure is similar to the Eastern practice of acupuncture except the practitioner uses the thumb or finger pressure instead of needles to release congestion and allow energy to flow (Dossey, et. al, 1988). Both use twelve pairs plus two coordinating meridians that bisect the body and 657 points along those meridians as the basic concern of these healing arts.

Partial massage has long been practiced by nurses in hospitals while doing backrubs. It is known to stimulate circulation and is a means of relaxation and comfort. Massage usually is the only touch therapy used in the hospital because of perceived lack of time for nurturant activity. Basic massage techniques taught in schools of nursing can be augmented by learning full body massage through continuing education classes (Dossey, et. al, 1988).

The use of imagery did not emerge as a technique to introduce new patterns at that time. Instead, hypnosis through deep relaxation and suggestion was perceived as a tool to aid release of tension.

Since the results of these therapies cannot be explained by traditional Western science, practitioners of holistic therapies have turned to the science of holism and other cultures for techniques and explanation of how they work. The ancient cultures of China, Japan, India, and

Egypt as well as many primitive cultures which use Shamanism have cultural beliefs that include these practices (Kreiger, 1981).

Burr and Northrup's (1935) theory of electro-magnetic human energy fields influenced Martha Rogers' theory of nursing as well as Meek's (1935) theory of healing. The theory of electro-magnetic human energy is not compatible with current medical science but with the science of holism and Chinese medical practices. In Chinese medicine, energy patterns of the body are thought to exist as meridians (energy vortices of the body), and other Eastern cultures recognize the Chakra system as the primary unit of attention for healing. These approaches are now being used in this country by holistic nurses and other practitioners as they use the various touch therapies to release blocked energy patterns.

Assumptions related to the practice of touch therapies in holistic nursing. Holistic nurse practitioners assume that persons are made up of energy patterns that can be sensed and manipulated to facilitate healing.

Conclusions

This practice theory is proposed as a guideline for holistic nursing practice. Impressions stated here have accumulated over many years of investigator observation, clinical experience, and dialogue. Further development depends, at least partially, on a) validation or refutation

by other nurses engaged in holistic nursing practice, and b) examination of client experiences related to holistic nursing practice. The present study examines the emerging theory and continues its development in relation to practice.

CHAPTER THREE

METHODOLOGY

Since the purpose of this study was to explore and describe holistic nursing practice in its many dimensions, a qualitative method was used. Grounded theory was the method of choice since the major focus of the study was the client-nurse interaction. This method generates theory based on assumptions about social interaction from the symbolic interactionist perspective. This view is especially suited to the study of relationships, or interactions, between the client and the nurse. This section discusses symbolic interaction theory, grounded theory methods, standards of rigor, the design used for this study, the process of inquiry as the design was implemented, and limitations of the study.

Symbolic Interactionism

Grounded theory techniques apply the assumptions of symbolic interactionism. These assumptions are based on a definition of "things" as anything that can be referred to such as physical objects, persons, oneself, institutions, activities, situations, and ideas or principles. According to Blumer (1969), the basic assumptions are that a) humans act toward things on the basis of their meanings for themselves; 2) meanings of things are derived from social interaction; and 3) meanings are handled or modified in an interpretative process used by the person dealing with the

thing. Social interaction is seen as the process that determines action since individuals and groups work to align their actions with those of others. Actions are interpreted by others who then act according to the meanings derived. There is not just a response to an environment, but a world established on the meaning of things derived through social interaction.

Conditions for Actions

Schatzman and Strauss (1973) identified concepts, based on the above assumption, that were considered central to practical application. One of these assumptions is that humans present themselves with perspectives and definitions derived through social interaction that become conditions for actions; therefore, one's actions are substantially self-determined. There is a decided emphasis on process in this perspective since the field under study is in process with itself and with other fields, and the researcher is in process with the field itself, with data gathering, the data, and the emerging theory.

Alignment of Actions

Alignment of actions is a social process addressed by symbolic interaction theory. This concept was especially significant for this study because alignment of action is seen to take place by participants indicating to one another what to do and interpreting indications made by others. The process of fitting one's acts with those of others

establishes alignment. It is done by identifying a social act in which one is about to engage and by interpreting each other's acts. The separate lines of action fit and merge as persons align their acts together by interpreting and indicating. This was especially significant in the study of interactions between clients and their nurses.

Grounded Theory

Data used in generating grounded theory are obtained by qualitative data obtained through and grounded empirically in observation, interview, or review of records. Thus, the method generates theory of the everyday world as it exists for study participants: that is, theory grounded in that data. The analytical techniques include both deductive and inductive methods of analysis. The data are studied sometimes word-by-word or phrase-by-phrase, and coded, i.e., placed in categories with dimensions and properties. Categories identified through open coding are then raised to higher levels of abstraction through an inductive process as meanings and understanding evolve from the data. Theoretical memos are written as categories and linkages emerge until there is a point of saturation, that is, no new categories emerge from the data. Further sorting of the data determines the fit between the data and the theory. Verification is obtained through sharing the theory with others who are involved with the field studied.

Grounded theory meets Blumer's (1969) criteria for

exploration and inspection of the empirical world of social processes. Worlds are explored by developing and sharpening inquiry so that problems, direction of inquiry, data, and analytical relations and interpretations arise from and remain grounded in the empirical world. The method is flexible and adapts its position to different vantage points with the focus beginning broad but sharpening as the work progresses. The inspection process is intensive and focuses on examination of the empirical content by identifying analytical elements and forming theoretical propositions. It is flexible, imaginative, creative, and free to take new directions regarding things, processes, and relationships. Grounded theory also fits Blumer's criteria that a method must respect the nature of the empirical world in its problem identification, conceptions, procedures of inquiry, techniques, concepts, and theories.

Standards of Rigor

Qualitative studies are held to a similar standard of excellence as those using quantitative and statistical data. Sandelowski (1986) addressed standards of rigor for qualitative studies according to truth value, applicability, consistency, and neutrality, identified by Guba & Lincoln (1981) as evaluation criteria for excellence in research. Sandelowski (1986) used credibility as a determinor of truth value, fittingness as applicability, auditability as consistency and confirmability as neutrality. The same

criteria are met in quantitative methods by internal validity, generalizability, reliability, and objectivity.

She maintained that a qualitative study is credible when people having had the experience recognize the description as their own. The closeness of the investigator-subject relationship both facilitates and threatens truth value. The investigator must be aware of her or his own personal issues to keep them separate from those of the client in the data gathering and in the analysis. Fittingness requires that the findings fit into contexts outside the study situation, and that readers find meaning in terms of their own experiences. Auditability requires that another researcher can clearly follow the "decision trail" used by the investigator. Confirmability refers to the findings themselves rather than the subjective or objective stance of the investigator, and is determined when auditability, truth value, and applicability are established. These criteria for rigor are used as standards for this study.

Investigator bias. Sandelowski (1986) stated that there is no way to study something without changing it; any study is as much a reflection of the investigator as the phenomenon. This perception is consistent with holistic thought. Schatzman and Strauss (1973) discussed the relationship between the researcher and his field of study by saying: The researcher:

> "claims no antiseptic distance and noninterference from outside influence. When he enters the field, he does so with his skills,...processes, and perspectives--indeed, his methodological biases--that link him with models of work and thought long since established in former training institutions and modified by experience" (p. 2).

Potential for personal bias must be considered in this study since the investigator has been deeply entrenched in holistic nursing practice as a client, educator, and practitioner. The ideology of holism related to health, healing and nursing held by the nurses was shared with the investigator. In some situations, familiar meanings were most likely taken for granted but efforts were made to avoid this by questioning. When the nurses resisted answering the questions because of investigator familiarity with the perspective, they were told that their answers could help with explanation and language about these concepts, unfamiliar to many. When assumed meanings were identified later, they were followed up with telephone calls to establish clarity.

Since this investigator could not be considered unbiased, analysis required constant awareness of personal bias. The investigator attempted to use her increased clarity and understanding rather than to promote untruths based on prejudice. Four professional nurse colleagues, unfamiliar with holistic nursing were involved in the analysis to lessen investigator bias in that area. Two holistic nurses confirmed the results from the nurse

perspective. Investigator skepticism is essential to the research process in general, not only for the researcher of holistic practice.

Benefits of familiarity with the field. Access to nurses and clients was one benefit of the researcher being part of the holistic nursing world. Also, the interviewing process was enhanced by the investigator's comfort due to familiarity with the thoughts and feelings expressed. On the other hand the same familiarity may have prevented recognition of issues relevant to the study.

Study Design

A pool of twelve nurses in private holistic nursing practice known to the investigator or referred by colleagues were selected from the greater San Francisco Bay area to serve as a resource for obtaining client participants and descriptions of holistic nursing practice.

Contacting Nurse Participants

Telephone contact was made with the nurses to invite participation in the study and to schedule an interview. The telephone call was followed with a mailing of the form, "Consent of the Holistic Nurse Practitioner" (Appendix A) and "Questions for the Holistic Nurse Practitioner" (Appendix B). The nurses were asked to review the materials and complete the "Questions for the Holistic Nurse Practitioner" prior to the interview, if possible.

Nurse characteristics. The questionnaire requested demographic data and general questions about the practice, education and training, work experience, and personal history related to the nursing practice. Eligibility of the nurses was determined by the theoretical framework for holistic nursing practice developed by the investigator and described in the previous chapter. They were interviewed to determine whether they did indeed use counseling, teaching and touch therapies within an interpersonal and physical environment intended to promote health and facilitate healing (see Appendix C).

Contacting Client Participants

Eligible clients had to be a new client of the nurse, at least 18 years of age, and English fluent. Each nurse was requested to ask the new clients for permission to give their names and telephone numbers to the investigator. They were asked to refer to the investigator only as a nurse interested in studying holistic nursing practice and not to include information that might influence the client in what they might say, e.g., that the investigator practices holistic nursing. The nurses were also asked to give each consenting client a copy of the "Consent of Client" (Appendix D) and "Questions for the Client" form (Appendix E) to review prior to being contacted so they could be fully informed. Upon receiving word from the nurse of the client's permission to be contacted, clients were contacted

by telephone to answer any questions they might have, to invite participation in the study, and to schedule an interview. If they had not received the materials, they were mailed if time allowed prior to the interview. If not, the questionnaire was completed during the interview session.

Client characteristics. The questionnaire included queries about the client's health history, family, cultural and social background, education, vocation, interests, and demographic data. The number of clients per participating nurse was not to exceed four. The investigator chose to study first time clients including those who chose not to return and those who dropped out of the relationship during the first three months so that data would include those who had negative as well as positive experiences.

Interview Schedule

The nurses were interviewed one time prior to meeting the clients. The clients had three separate interviews over a period of three months. The first was within two weeks of the first nurse-client visit, the second six weeks after the initial visit, and the third three months from the first meeting with the nurse. The clients were interviewed over this period to gather data regarding the formation of the client-nurse relationship. The first three months of the relationship were considered significant in the formation of the relationship.

Interview Content

The nurses were questioned about their transition from traditional nursing to private holistic nursing practice, and how they conducted their practices, i.e., how they used counseling, teaching, energy releasing therapies, and how they worked to create an environment conducive to healing. They were asked to describe and explain their views of health and healing. The theory of holistic nursing practice was briefly discussed with them and they gave their responses to those ideas. The "Consent of the Client" was reviewed at the beginning of the first interview and signature obtained. The answers to "Questions for the Client" were completed and discussed during the first part of the initial interview. Both the nurse and client consent forms included permission for the interviews to be taped. All participants received a copy of the consent form for their reference.

During the first client interview demographic and health related information were sought as well as experiential data based on the first client-nurse meeting. The second and third meetings focused on the client experience of the client-nurse relationship and on any health changes as perceived by the client (See Appendix F).

Interview questions were designed to guide the investigator in data gathering. Questions addressed the broader study questions presented in Chapter One but were

more specific. They were designed to approach the study problem from different perspectives to insure security of significant data. For example, clients were asked for both details of the client-nurse interaction and a description of the relationship.

Confidentiality

Confidentiality was assured as far as possible by adherence to the plan approved by the University of California San Francisco Committee on Human Research. Interview content was identified only by a coded identification number with all names and places eliminated. The content was shared only with a transcriber charged with the responsibility of confidentiality and a small group of professional colleagues engaged in the process of analysis. Tapes were erased following transcription; transcriptions were kept in a locked file.

Process of Inquiry

This section contains description of events related to carrying out the design. Processes related to gaining entry, organizing of events and data, interviewing, recording the data, and analysis are described.

Gaining Entry

Twelve nurses who fit the criteria for eligibility were obtained easily and quickly. If the nurses described how they used the four dimensions determined by the investigator to constitute holistic nursing practice, and considered

themselves in private practice, they were found eligible. Nurses known to the investigator were interviewed first and they made referrals to others. Additional nurses who had heard of the study volunteered to participate but were not included since twelve was considered an adequate number from which to obtain the desired 15-20 clients.

Eighteen clients were obtained through referrals from eight of the nurses. Two nurses provided four clients each, two had three and four had one. Client recruitment took much longer than expected and was more difficult due to fewer new clients beginning therapy during the summer. Some nurses seemed hesitant to refer clients they thought might not return, and needed encouragement from the investigator to refer new first time clients. Other hesitated to broach the subject on the first visit and expressed surprise when clients were willing to be contacted. There was also strong desire by the nurses to have clients participate who had experienced positive results and were eager to talk about it. They were at times reluctant to make the request until a client returned, but with frequent telephone calls from the investigator, the protocols were met insuring an unbiased sample. Most of the nurses and clients seemed extremely busy and three clients chose not to participate when they realized the amount of time involved. Yet, all who started completed the study.

Interviewing

The participants were all interviewed in settings convenient to their locations and scheduled activities, i.e., their homes, offices, offices of nurses, parks, or in restaurants. Most of the interviews were limited to one hour but a few went longer.

Interview items were developed to serve as a guide for questioning but the questions were weighted differently over time as the data gathering progressed. During initial nurse interviews, efforts were made to avoid direct use of questions and to obtain answers in an indirect way. The interviewer soon determined that more direct questions provided clarity to both participant and investigator. Questions were supplemented during the interviews by the use of active listening skills to obtain the needed data. The client interviews went through several changes although weighting was changed more than content. The wording of questions related to beliefs about health and healing did change since requests for definitions of health and of healing were usually met with looks of uncertainty and confusion. The question became more like "How would you describe yourself if you were completely healthy?" and "Tell me what healing is like and how it happens for you."

The client-nurse relationship became the major emphasis as the categories began to emerge during analysis. Those clients who did not continue seeing their nurse throughout

the study period continued to have some thoughts and reactions about the relationship which they shared with the investigator, but were questioned predominantly about perceived changes in their health status over the three months. The data received from these clients were considered to a limited extent as baseline data for the study to determine if those who continued with the nurse experienced more perceived changes than those who did not.

The last two or three client interviews included some discussion of the evolving analytical story. Those clients responded by discussing their personal experience of holistic nursing practice and the client-nurse relationship. These clients were more concerned, though, with their own personal experience and it did not seem helpful at that point to discuss theoretical interpretations of the data with them. Discussion of the results might be more appropriate with those who had history as a client.

Most of the clients seemed to enjoy the interviews very much and expressed appreciation for including them in the study. They seemed eager for the opportunity to talk about their health and healing and some of those who had not experienced a bond with their nurse asked if they could continue to see the investigator. All nurses and clients expressed the desire to read the completed study, even those who did not continue in the relationship with their nurse.

Recording and Data Management

All interviews were tape recorded and transcribed. The Displaywrite 4 word processing program was used to prepare transcripts for Ethnograph computer software. This software provides an interactive menu driven set of programs designed to assist the researcher with the mechanical aspects of data management. Codes were entered into the computer so that a sort could be made of any combination of categories in a variety of ways suited to the needs of the researcher.

Management of approximately 80 hours of interview data in this fashion required careful organization. The typed transcripts were proofed while listening to the taped interviews. Memos containing the investigator's observations and thoughts about the interviews were made at that time. The transcripts were then prepared for use with the Ethnograph and entered into the computer and a printout was made with numbered lines ready for coding. One Ethnograph file was made for nurse data and one for clients.

Analysis

The grounded theory analysis group under the tutelage of Julie Corbin, Ph.D., R.N., and Anselm Strauss, Ph.D., provided guidance and assistance as the theory emerged. The investigator met regularly with the group of three colleagues involved in grounded theory studies. The researcher provided the empirical data and codes, and the group assisted with the inductive analysis process. Some

open coding was done in the group but usually it was done individually, taken to the group, and discussed intensively until categories and linkages emerged from the data. Theoretical memos were written after these sessions and open coding continued.

Analysis began with the memo writing during the proofing of the transcripts and was followed by open coding, the abstracting of categories, dimensions, and properties from words, phrases, and sentences of the interviews. Categories continued to emerge but the theory began to take shape when the focus of the analysis narrowed to that of interaction between the nurse and client. At that point the researcher wrote memos tracking the course of interaction between the nurse and the client over the three months. This was done for eight nurse-client pairs. These memos were also coded and discussed intensively in the group. The remainder were coded and categories were found to match those of the eight memos.

The "interaction" category of the entire set of interviews was then coded using the categories of the theory of interaction to determine the actual fit between theory and data. When the fit was evident for the interaction aspect of the interviews, the rest was organized as supportive and descriptive data for the holistic nursing practice context.

Limitations of the Study

Primary limitations of a study such as this using qualitative data and inductive methods rest with the researcher. The quality of the data depends on interviewing skill and the ability to establish good working relationships with the participants. Second, the researcher comes to the study with preconceived notions and perceptions. Such perceptions are helpful as they guide the research process but limit one's ability to see different perspectives. This limitation is an important factor to be considered when the investigator is also a practitioner of the area under study. While virtually no one can undertake qualitative work without some internal biases, being of the same clinical field produces certain unavoidable presets that may unconsciously color the inductive process.

The results of this study may be confirmed only as clients and nurses apply the findings to their own experiences of holistic nursing practice. Further research is needed to confirm or refute the theory for other holistic nursing populations.

Summary and Conclusions

Grounded theory methods were applied to obtain and analyze interview data of nurse and client experience related to holistic practice. Collegial involvement of non-holistic nurses during analysis was used to decrease the effects of investigator bias. Results can only be applied

to the study population after being confirmed by those of that population and cannot be considered generalizable.

CHAPTER FOUR

ANALYSIS AND RESULTS

Section I: Profile of Holistic Nursing Practice

This section contains the profile of holistic nursing in private practice--the nurses, clients and settings. The nurse profile covers the nurse participants' educational, professional and cultural backgrounds; transition from traditional to holistic practice; beliefs held about key concepts of health, disease, healing and nursing; health status; and professional and political involvement. The practice setting profile includes development, location, clientele, services provided, record keeping and business aspects. The client profile covers cultural influences, education and occupation, interests and hobbies, health and health care history, reasons for using holistic services, attraction to holistic practices, sources of referral, presenting problems, lifestyle and stress, response of support persons, the course of and response to use of holistic care, the course of and response to therapy, and money matters.

Profile of Nurse Participants

The twelve nurses were female and ranged in age from 31 to 65 years. Their cultural backgrounds included Canadian and Jamaican, but were predominantly rural American. Three had been educated in Canada and one in the Dominican Republic. As a group, their special interests were similar

and included healing and helping others, meditation, spiritual practice, metaphysics, love of nature, and peace projects. Hobbies reported included creative expression through dance, music, and working with the hands by gardening, sewing and crafting.

Educational Background

There was wide variation in educational backgrounds. Six held Master's degrees in nursing, two had completed post-Master's work in psychiatric-mental health nursing, and one was certified by the State of California as a Psychiatric-Mental Health Nurse. Five held baccalaureate degrees, four in nursing and one in education. One was a diploma graduate with intensive yoga training and massage, who presented herself as a masseuse rather than a nurse. Five had completed academic programs at the University of California San Francisco.

The nurses had all spent several years in workshops and specialized programs studying metaphysics and energy releasing therapies in addition to their academic degrees. Ten had additional education and experience in counseling and interpersonal communication. Training in holistic therapies included the energy releasing therapies used in their practices, which were massage, Jin Shin Jyutsu, acupressure, therapeutic touch, hypnosis and meditation.

Professional Background

The nurses had broad work experience in institutional

nursing prior to private practice. Table 4.1 shows the amount of time they had practiced nursing; ranging from 10 to 43 years. Most had worked in a variety of hospital and community health settings. Specialty areas included areas of acute care, i.e., operating room, intensive care, pediatrics, obstetrics, community health, and psychiatric nursing. They had been or presently were administrators, or instructors in universities, colleges, or continuing education programs. Only two currently worked in hospitals as staff nurses, one who was committed to changing nursing within the hospital and one who intended to work in her job until her private practice grew larger.

Table 4.1:

Years in Nursing

YEARS	10	15	20	25	30	35	43
NUMBER OF NURSES	3	1	0	1	2	4	1

Table 4.2 shows the length of time the nurses had been in private practice. This time varied widely and ranged from less than one year to twenty years. All worked as private holistic nurses, but four were not charging for services. Only two nurses were in full-time private practice with no other source of financial support. Seven were currently employed as nurses by institutions full or part-time.

Table 4.2:

Years in Private Practice

YEARS	< 1	3-5	6-10	11-15	16-20
NURSES	2	4	4	0	0

Nurse History of Transition to Holistic Practice

The nurses described the transition from traditional nursing to private holistic practice. They described their efforts to integrate learning from nursing theory, work experience, the women's movement, holistic health classes and workshops, metaphysical teachings, and personal growth. Common themes in their transition were the need or desire to improve nursing practice, to implement their changing values in practice and, for some, to accomplish those two goals by using knowledge accumulated in the process of improving their own health.

Desire to improve practice. Commitment to improve on traditional health care systems was common among all the nurses. Several mentioned "needless suffering" of people who receive traditional care and one stated that "the medical people would be sick if they realized what they are doing to people."

Dealing with conflict had played a large part in working out their transitions. They mentioned conflicts between Cartesian science and holistic thought, religious teachings and holism, education and metaphysical teachings,

the health care system and holistic practice, nursing theory and traditional practice. Private holistic practice was perceived as a way to resolve many of these conflicts and to integrate their beliefs about themselves as nurses. At the time of the study, the nurses felt some resolution of conflict they had felt earlier, since holistic practices are currently being taught in many schools of nursing and there are textbooks that contain related instruction.

One nurse described the events that led to her decision to establish a holistic practice:

> I started teaching at the University and hoped to teach my values to Master's students about the therapeutic relationship, their own self development, care--the healing process. This was early `70s' when California was interested in holistic health. There was a lot going on then in the holistic health movement. I was involved with all this--holistic health conferences, Esalen Institute--doing sensory development, awareness development...I developed a nursing model for private practice as a computer simulation model. The more I looked at the simulation, the more I said `I'm going to do this.'

Changing values. Another described her experience in relation to a desire to find a life purpose:

> I'd done two years of nursing in Michigan and had taken a yoga class. I was basically on my spiritual search and I was looking at different aspects of religion. Then taking a yoga class, I got in touch with certain different ways of being in my body--started to fit together, and then I worked on my nutrition for a long time. I wish I really knew when the light bulb went on. It was a combination of things. It was the late sixties and early seventies.

Many saw their changing practices as aspects of personal evolution within a spiritual development

perspective. While they admitted having religious backgrounds, their spiritual practices were eclectic and included meditation and spiritual readings from a variety of sources. Only one was a devout follower of a specific religion and sought guidance from the church in relation to her practice. Spiritual practices of the others were exemplified in the following comments:

> I was raised Catholic and was very devout until I was about nineteen and then officially announced that I was an agnostic. I did some searching through Eastern practices but never really adopted a guru or attended one practice. I studied Vipassana meditation and did a retreat to learn that technique...If I sit down to meditate, that's the technique I use...And then I have another teacher who is from a spiritualist tradition in England and she has helped me to understand my spiritual nature more from a nondenominational standpoint.

Dealing with personal health problems. Several nurses identified having had a serious health problem that influenced their search for "a better way" to work with their own health and that of others. Here are two examples:

> I was talking to a former student and she told me about taking this Jin Shin Jyutsu class and introduced me to the senior practitioner in the area. Then someplace along the way I got arthritic symptoms in my hands where I was dropping things and my joints were aching and hot. My grandmother was crippled for the last 15 years of her life and I had no intention of having arthritis. My father had lumpy hands, too, so I had some treatments and the symptoms went away and they never came back. So I was impressed. The pain and tension in my back went away too, and I began to feel a lot more comfortable. That was only the beginning of it. I decided that if it [Jin Shin Jyutsu] can do that I better study it.

and;

> Well, I had been meditating but basically I got one

> kidney infection after another and I felt that if I took another pill I'd be dead. And then with the fear of that, all it was doing was making my kidneys reflux and they weren't keeping away infections like they were supposed to. They were one third the size of normal. That's why I started doing all these things even more in earnest.

Integration of Traditional and Holistic Practice

The nurses had sought ways to integrate holistic practices into their job positions. They had used Therapeutic Touch over periods of several years in acute pediatrics, long-term care and orthopedics.

One nurse currently taught stress management programs in hospitals for nurses and for patients, did career counseling for nurses, and incorporated holistic nursing in her clinical practice. She said:

> When I do my intakes...I just have time to get `em in there, check their vitals, and ask how they are and get an update, a quick [nursing assessment and plan]...And then in my plan, I might say "Reinforce stress release, stress management skills and family communication." And then the doctor will see that and they'll address it.

The nurses believed their credibility and relationships with the staff made it possible to incorporate holistic practices in their work. When trust was established, nurses were free to introduce new practices.

Not all the nurses believed holistic practice in the hospital was possible. For example:

> It's not accepted there, you can't practice it there, and you don't have the time, unless you really want to burn out. You can do little bits and pieces, but you really can't give a full body massage for an hour. The time isn't allowed, there's no respect for it, and the patients don't want it, either. They don't have the

> knowledge to know that it would be really good for them. They don't want to be touched sometimes, either.

Beliefs Related to Key Concepts

The nurses' beliefs about health, healing and nursing were primary influences in the move from traditional to holistic practice.

Health. They all talked of health as integration of mind, body and spirit--the whole person. It was often described as inner peace, but a more comprehensive description is given here:

> I see health as basically a sense of harmony. If everything is balanced and energy is flowing and moving, there is no illness. The only time that any disease or discomfort occurs is when energy gets stuck. So--health is feeling positive, optimistic, cheerful, not having the negative attitudes of insecurity, worry, anger, grief, or pretense. Like I can be myself and I don't have to hide anything or pretend anything. Then things work in my life, and I have no symptoms of any kind. There is a satisfaction that life is good and that I'm doing what I want to do with minimal conflict...Health is balance...I'm not experiencing extreme emotions of any kind. That doesn't mean it's neutral and boring but the kind of feeling I have is--I guess serenity. There is not extreme peaks or valleys. There are feelings of joy, being delighted with things, but not an extreme feeling--just very pleasant...

Health behavior as attitudes, thoughts, feelings, and action was discussed as it affects health:

> I think a person's thoughts have a great deal to do with how they feel, and I think that this affects the body in a very strong way. Our physical care affects this. Our nutrition affects this--our acceptance of ourselves--our belief system affects this. And it does this quite a bit, I believe, by affecting the immune system and this gives our immune system the strength to protect us in a positive way.

Disease. While the nurses believed that illness or

disorder was a sign of not thinking or living right, they also saw illness and disease as teachers and helpers in our lives. One explained, "I'd like so much for people to really understand how much disease is a friend and can teach us if we just let it." They indicated that the nurses' role in disease prevention is to prevent further disease by getting the clients back on track before new symptoms appear. They seemed to agree with Nightingale (1860) that nursing assists clients during illness to get what is needed from the environment, while the body recovers from disease.

Healing. The nurses, as a group, perceived healing as a process in which people move toward a state of peace and harmony described as health. Healing was described as a life-long process--"We're always breaking down things and building up things and gaining more strength throughout our whole lives." Their beliefs differed somewhat on how to facilitate that process, but they agreed that healing occurs inside the client and is not under the control of the nurse/healer. They all agreed they were facilitators of healing. The following descriptions of facilitating the healing process indicates variation in the degree of nurse involvement:

> I'm just the channel who helps them to relax and to be guided on some level. The healing really is within and it's really a process of relaxing, and um being open to the spirit which is within everyone.

and;

> A person's body heals itself if you allow it to and

what I can do is be a facilitator of his own healing.

Other definitions took on a more mystical quality:

> It's as though there's a wisdom that's way beyond me and it's like my contacting something. No matter what modality you use--if you have confidence, the healing field is there--and if you are participating in it, it will help the person. Before I start a treatment I make myself a hollow reed so that the energy of the "all that is" can come through me to help others to help themselves, and as I visualize myself as the hollow reed, as the energy coming through, then I'm just a participant in this. It's very spiritual.

The term "healer" was an enigma to many of the nurses.

One who was comfortable with being called a "healer" said:

> A healer is someone like a guide and a helper, helping people to open themselves up for change. So, helping, giving them safe support, insights, as well as touch, and all the other aspects in the process of developing a relationship to make them feel safe enough so they are willing to make a change. I see myself as that person that steps in between somewhere in their life to help them overcome that crisis and to grow from that crisis that they are going through.

Those who were uncomfortable with being called "healer"

perceived a healer as one who cures or "fixes" the client.

> I never wanted to be a healer because you can misuse a healer, too. Just like in relation to medicine, you can come to get fixed. And I'm not interested in fixing them. I'm much more interested in teaching people how to stay well;

and,

> Maybe that is why I object to being called a healer because I think, well--a healer is someone who uses energy and comes in and fixes and I don't think I do that;

and yet,

> A true holistic healer knows immediately when they say that word "healer" that they are not talking about themselves as being a healer. We use that word only because we don't have another word to use. It is the

> accepted word but we know as we're saying it that we are really meaning that the person is going to heal themselves.

Some nurses objected to clients coming to the nurse expecting to be cured or "fixed" as they called it. Others saw the expectation as part of the disorder presented by the client. They anticipated that such an attitude might change in the healing process.

Nursing. One participant defined nurses as "persons who have skills or resources to share with others on their paths of well-being." Nursing was considered "helping the individual develop what is within them," and "helping people--being supportive and caring." One nurse described her efforts to not become a nurse because she as a young woman had defined nursing differently:

> I had always wanted to not be a nurse, you know...And when I went into the nursing program it was with the intention of doing physical therapy, but as a nurse. I thought that nursing was servile, not very dignified. I thought of it as a sick oriented field and I wanted to help people be healthier. I wanted physical therapy because it seemed like they worked with people who were involved in getting better.

This nurse had become excited about nursing as a way to promote health and healing when she attended therapeutic touch workshops presented by Dolores Kreiger. She has continued to practice therapeutic touch in the acute pediatric unit where she works as well as Jin Shin Jyutsu in her private practice.

The nurses' definitions of health, disease, healing and nursing are consistent with the definitions provided earlier in the theory of holistic nursing practice.

Health Status of the Nurses

The nurses practiced health behaviors they deemed necessary for good health. They spoke of living lifestyles and practicing behaviors they thought to be healthy, i.e., meditation, breathing exercises, relaxation, no smoking, very little alcohol if any, getting enough sleep, regular physical exercise, and good social relationships with friends. They were concerned that they take time to heal and to be healthy.

> I think it's very important for me to meditate regularly, to be very centered, very quiet, and to take care of myself, and sometimes I'm not doing such a good job. I'm working on that. I'm doing better in terms of having enough time to be outside, for instance, because that is very important to me. Nature is very healing for me.

They felt their health was enhanced by practicing touch therapies. There were descriptions of feeling more energized and relaxed after giving a treatment. One nurse stated:

> I don't think I could be a nurse if I didn't do therapeutic touch and Jin Shin Jyutsu. I know that often in my shift...the only energizing thing I do is the Therapeutic Touch or Jin Shin on somebody. It's the only thing that makes me feel like I'm nurturing somebody and I nurture myself because I have to get into a centered state to do it.

They also received massages, Jin Shin Jyutsu treatments, and Therapeutic Touch to maintain good health

and often exchanged treatments with another holistic nurse.

There was concern that they serve as good role models for clients and for nurses. They felt that in traditional nursing, nurses are encouraged to not take care of themselves by "doing overtime, working night shifts, and other things that are not really healthy." One stated:

> I'm strongly attached to this notion that if nurses are going to be a force, a strong force for the improvement of healthcare and health, we've got to get our own [acts] together as individuals, which means living a healing lifestyle.

The nurses all appeared to be in excellent health with lots of energy and stamina. The two who were 65 years old both appeared to be much younger, were energetic and had flexible bodies. They all claimed a high degree of satisfaction and excitement in their work with clients. This excitement was expressed by one: "I think it's fascinating and it's really very exciting to see people change. It's like I learn something different with everyone."

Professional and Political Involvement

The nurses were involved in a variety of political and organizational activities. Some belonged to a women's political group that had been successful in helping several nurses be elected or appointed to public office. Others had been active in the California Nurses' Association (CNA), Holistic Health Interest Group, Nurses in Transition, American Holistic Nursing Association, Nurse Healers'

Cooperative, and several church related organizations devoted to world peace. They also were part of their respective nurse specialty organizations. One nurse, however, had withdrawn from all group and political efforts to devote the time and energy to her practice which included encouraging other nurses in their involvements.

Professional network support was considered essential. Most of the nurses belonged to a support group, a group practice, or a place where nurses are involved in health promotion and healing activities. Those not belonging to a support group expressed a need for such contact:

> I guess what I would like is more people who do what I do--connecting with each other and sharing their experience...I'm interested in hearing other nurses and their experiences, sharing with them, and that wonderful rapport that I feel nurses have amongst themselves.

Conclusions

In summary, it was apparent that the nurses in general were committed to health promotion, healing--as they defined it--and nursing. They were highly educated with long professional careers and considered themselves change agents in society.

Profile of the Practice Setting

Practice settings were in various stages of development. A pattern of practice setting development emerged from the data.

Initially, participants provided holistic nursing

services free of charge to family, friends and acquaintances in homes or wherever the nurse happened to be. After accumulating a certain amount of experience and confidence, they charged a small fee or accepted donations from clients. Some nurses created rooms in their homes in which to work with clients, some visited clients in their homes, and some opened offices either alone or with a group. They continued in their job positions until their private practices grew to the point where they could be financially independent.

Three nurses in the study shared office space that included two workrooms and a waiting area. Another office consisted of a waiting area large enough for group meetings and a workroom. Six worked in their own homes or the homes of their clients. Three of these had separate workrooms in their homes. One had established a healing center, which also served as a home for her and her family.

The center was in a very large home which had been a rectory. It had two large classrooms, a library and waiting area, a health food store, sauna, a large entry way, office room, and two workrooms in addition to the living space of four bedrooms, three bathrooms, kitchen and dining area.

The practices were in various stages of development with the healing center having been in operation since 1973. In contrast, four were thinking about charging fees for services and considering setting aside a work area for that purpose. The rest were well established in their work

settings with regular clientele who paid for services.

Environment. The nurses saw their caring as an essential part of the client environment. They indicated that a beautiful place was desireable if possible, but that one could practice holistic nursing under very poor conditions.

> It's important to have an environment in private practice that is real soothing and cozy. I wish our office were off the street and more in an environment that was I think more nurturing than this is but this is what we have right now...Jin Shin brings its own order.

Another nurse described the room she had established as a workroom for her private practice:

> I have lace curtains on the window. The table that I have beside the bodywork table has a plant on it and a candle. Sometimes fresh flowers, of right now I have some drying rose petals. The posters on the wall is-- It makes a statement about Chinese medicine, the ancient wisdom. And then there's another poster from a calendar from Findhorn that has a statement about life and love...I think simplicity is very important so that there's space for the person to experience whatever it is they want to be there...They [clients] have a connection with that room or with that experience when they go out in the world. They call it my womb.

The nurse in the healing center added another dimension of environment in that like-minded people found community with each other whether or not they needed the services of the nurse. People could come for social gatherings, meditations, classes or workshops.

Clientele

The number of clients seen per week by each nurse ranged from fewer than five to fifty or sixty in the

community center. Table 4.3 shows the number of clients per week for each nurse.

Table 4.3

Clients Seen per Week

NUMBER CLIENTS	< 5	5-10	10-15	15-20	50-60
NUMBER NURSES	5	4	0	2	1

The nurses reported seeing clients with problems of any nature across the entire lifespan from birth to death. While one treated people with the whole gamut of human problems, others saw clients with certain problems more than others. These nurses said they saw "mainly people with muscle strains and back problems," "people addicted to all kinds of things," or "lots of nurses suffering from "burnout" and depression who are wanting to make career changes." While the background skills of the nurse determined the nature of the work done, the nurses considered their services potentially beneficial with any condition.

The nurses reported that clients seek care that is both alternative and supplemental to traditional Western medicine. Clients come, according to reports, to decrease side effects of chemotherapy, and to increase the therapeutic effects of medication. They seek help with chronic pain and acute conditions, and come prior to or after surgery to facilitate healing. They seek help with

relationship issues and problems, many experiencing grief and needing help with its resolution. The nurses indicated that many believe there are deeper problems at the root of their physical problems and want a way to work with their total selves. Clients were said to come for physical symptoms, but reasons for coming changed with healing.

Nurses as clients were reported to make up a large percentage of clientele in some settings. Catholic nuns sought help from a nurse able to work with problems from a spiritual perspective and church members saw nurses of their own faiths. Artists and real estate agents were well represented in certain practices. Since word-of-mouth was the source of referral, clientele followed patterns related to satisfied clients. The nurses did not require that their clients be under care of a physician.

Services Provided

The nurses responses provided support to the investigator's definition of holistic nursing practice as the provision of counseling, teaching and energy releasing touch therapies in a caring/healing environment. They indicated that their practices did fit that theoretical model, but they described widely varied strategies used in each area.

Counseling. Counseling services ranged from a full counseling program of individual, couple, family and group counseling by one nurse to "mostly listening" by another.

Some nurses felt they lacked qualifications for counseling but did have confidence in themselves as good listeners. One nurse was hesitant to admit counseling "because I'm not trained to do counseling." When she was told by the investigator that counseling was defined here as helping people to talk about whatever was troubling them, she admitted doing lots of that:

> ...the main part of counseling for me is the listening...Having them feel free to talk about what happens and when tears come, to be able to share that with them--and to let them talk about and explore their own feelings about why they think this is happening.

Some nurses thought it was easier for people hesitant to seek psychological or spiritual counseling to go to the nurse for help with a physical problem. For instance:

> A lot of times they come see me for nutritional advice and they get the nutritional advice in about the first ten minutes of our talking and then they get counseling the rest of the time, but to them they feel they've been to see me about nutrition. It's like they're afraid to even think that they might need some kind of counseling.

Teaching. Teaching was a major part of the work of the nurses, not only with their clients, but with nurses, nursing students, and community groups. Teaching was for health promotion and disease prevention. All the nurses emphasized teaching of individuals and families in their practices. They taught aspects of touch therapies to use on themselves and family members. Homework between sessions was often given as a self-help program, and some nurses gave this instruction routinely at the end of every session. One

said: "I really feel like it's up to the person to heal themselves and that it's a part of my function to give them helpful knowledge."

A variety of classes related to health and healing of the mind, body and spirit were presented in two settings. For example, one included a series on spiritual development, and another held yoga classes. Brochures at both settings listed a wide variety of classes, the most being offered at the community center. Many of these classes were offered as continuing education for nurses.

Energy releasing therapies. Energy releasing therapies used included Therapeutic Touch, Jin Shin Jyutsu, acupressure, massage, and deep relaxation. The nurses generally agreed with the use of the term, except one who had reservations about the concept of energy conflicting with the teachings of her church. She was comfortable with the idea that her work released tension and conflict which others in the study referred to as blocked energy. Hypnosis was used for deep relaxation and often accompanied visualization excises to enhance feelings of well-being.

Four nurses primarily used Jin Shin Jyutsu therapy. This therapy was observed and explained as touching the body in different places, using the hands as "jumper cables" to balance and release blocked energy. The hands and fingertips are placed along the meridians of energy flows of the body. The nurse "listens" for synchrony of pulses in

her fingertips as she holds various points. It is used to facilitate holistic healing. Experience with the modality was described by one of the practitioners:

> The thing I like about Jin Shin is that it works on a physical, emotional and spiritual level. You don't have to go to your psychiatrist...It's not bad to do that, I think...I think that's overdone so much nowadays. I like Jin Shin...It's almost like a blender and you come out and whatever was in turmoil--it's changed. It's not even an issue any more and it's been worked out and it's taken care of and it's clean. So you never had to put it on the table...It's not always that way but many times it is and it works on that level so other things become needless.

Seven used Therapeutic Touch, a therapy requiring no touch to the skin as the hands move through the energy field around the body as it releases and balances energy. The client sits or lies in a relaxed state while the nurse moves her hands in sweeping movements from the head to the feet. The nurse senses blocked energy in her hands such as tingling, warmth or pulsing. Some of the nurse participants used Therapeutic Touch exclusively and most used it in combination with other therapies. One nurse reported using both Jin Shin Jyutsu and Therapeutic Touch in a situation where a woman with uterine fibroid tumors was having severe cramping:

> I have been recently combining Therapeutic Touch [with Jin Shin] in some particularly difficult situations...Last week I just kept perceiving it all during the treatment. It was like a thick band of grey metal or something above this woman's pelvic area. Finally, I said "Would you mind if I try a little Therapeutic Touch? It just involves moving my hands above you body" and she said "fine." And so I did Therapeutic Touch and it worked. It dissolved that thick band of stuck energy and her cramps went away

immediately and so it worked.

This nurse's comment on "perceiving" a non-physical phenomenon in relation to the client during treatment was not usual. These perceptions seemed to be symbolic representations of the concept of blocked energy.

Acupressure was used predominantly by three nurses and massage by one. One nurse used all four therapies interchangeably as requested by clients. She would ask at the beginning of each session what they needed on that day. Most of the nurses in the study know at least two therapies and interchanged or combined them.

The concept of energy pattern enhancement was introduced to the developing theory as nurses talked not only of releasing and balancing energy patterns, but also of using visualization or imagery to aid the emergence of a new pattern. One example of visualization could involve a process of deep relaxation and seeing in the mind's eye the painful moments from which the person established a self-destructive life pattern. Then they could be directed to see the way they use that pattern in their life, and to see the way they would like the situation to have been, and/or the way they would like themselves to be. This kind of exercise is believed to help release old patterns and introduce new and healthier ones. Positive affirmations are used by inducing a state of relaxation and having the client repeat statements designed to change negative attitudes about

oneself and other to positive ones. For example, one affirmation that has been used with school children is, "I am loveable and capable; people see me as loveable and capable." These words introduce new thoughts and ways of perceiving oneself. It is believed that changes in self-perception leads to changes in health behaviors.

Other services. Two nurses sold nutritional supplements in their practices and had integrated nutritional assessment services in client care.

All the nurses reported making referrals for those problems they felt inadequately prepared to handle, or if they felt uncomfortable with the situation presented:

> If people have acute care issues or things that look like they are malignant, I really want them to follow-up with a traditional physician or a nontraditional one who has a traditional background. I don't want them to just let things get worse so I encourage people to go. I had a lady today that appeared like she had phlebitis and she had had it for a week. I thought she should see a physician...

Nurses also encouraged clients to use community resources. One nurse who was working with a person who had cancer shared this experience:

> I then referred him to the Cancer Society, to a support group, to holistic counseling therapy group for people that have cancer. They have a licensed counselor and can help him make his decisions about returning for more chemotherapy. I have been searching for a doctor that I could refer him to for a second opinion because he really doesn't accept going through more treatment. So that kind of counseling is important.

Effects on Nurses from Providing Holistic Services

Nurses reported that the high satisfaction they experienced was due to seeing changes in the lives of clients. They all had many examples of both immediate symptom relief, as this nurse related:

> I've seen instant relief of headaches, for one. I mean, by the end of the treatment the headache's gone pretty much every time--and with the women, with the menstrual problems, I've had amazing things happen with the very first session...It's so good at settling children...To have a screaming baby fall asleep within ten minutes is wonderful;

and of life healing that took place over weeks, months or years as described here by a nurse who treated a woman with cancer:

> She was granted an extra five years until her kids grew up...She did a lot of work in therapy with family therapists and other kinds of consultants that she used. She and her husband got closer together and the kids matured...And she was conscious up until the last...She was doing amazing things. And she had a good quality of life up until the very last two weeks...So it was very worthwhile working with her.

The nurses believed the treatments were almost always a pleasant experience for the clients in that they relaxed and seemed more peaceful. One nurse related this feedback from a client:

> One of the clearest feedback things I had that made me feel successful in doing Jin Shin was--She said, "I feel so close to God after our treatments." That's it. She didn't say "pain." My headaches gone--my this is gone, whatever. She said "I feel close to God." And to me that means she feels integrated. She feels close to her source. She feels together.

The group as a whole felt their work was, in general, well accepted by clients, patients in the hospitals, families, and colleagues, including physicians. It seemed the nurses were more comfortable in front of physicians and colleagues if they were doing one of the therapies that used skin contact than if they were doing therapeutic touch. One explained:

> I have had some interesting experiences with doctors where they have come in when I've been working and they will say "What are you doing?" And I'll just explain. Now, Therapeutic Touch, no one has ever come in while I've been doing that and I would feel a little bit strange explaining that to a physician, I must admit. But with the Jin Shin, I've had physicians come in while I've been working on their patients. I'd say about four times--and they don't want to interrupt me, they don't want me to stop. They just want to know what I'm doing and then say "Great. If that will help," because it's usually for pain relief and they want their patients to be comfortable too.

Record Keeping

None of the nurses kept extensive records on each client, but only brief notes if they kept any. They gathered varying amounts of data from a comprehensive overview of health and lifestyle to no record at all. Most of the nurses depended to a large extent on assessment by the use of energy releasing touch practices and paid less attention to health history except as a way to learn client perception of themselves and their health. Those who used herbal remedied and nutritional supplements found records necessary. The nurse who kept the most comprehensive records collected health assessment and lifestyle data on

energy and used this as baseline data for further notes.

Business of Practice

The business aspects of money and marketing presented the greatest problems for the nurses. The high cost of liability insurance was identified as a concern for some. It was difficult for them to give sufficient time to the business aspect when they had a job in addition to private practice. They reported that they enjoyed providing nursing services, but did not enjoy setting up the business and admitted having a lack of business sense. The nurse who had the least trouble with business said her father was a banker and played games with her that taught how to solve problems related to business and money.

Fees. Many of the nurses stated that charging money for service and marketing were their greatest problems in practice. One nurse described her experience as she overcame feeling of insecurity when entering private practice:

> The first couple of years I was teaching just to pay bills. But at the beginning you have to learn if it's right for you, and you have to let go of all the fears. You have to trust the money will be there for your needs. It took me years to learn that and to have that inner confidence...I had to learn that even when I had no idea how the mortgage would be paid, that the money would come from somewhere.

She also spoke of what it takes to financially manage her business:

> People often ask us how come we can make it and other holistic health centers fold. Mostly [its] because we're very much down to earth and don't spend much

> money and try to economize. We don't try to put everything together but just let it unfold. We don't have a secretary, we do not pay the teachers. They are paid out of the class fees brought in by participants.
>
> We don't have anyone on salary. So all it costs is just what it take to run everyday things for the center.

The nurses' fees ranged for private sessions from no charge to sixty dollars. Sliding scales were often used, as bartering for goods and services. Table 4.4 give the fees per hour charged by the nurses. Some of the nurses who worked for a salary were hesitant to charge for service since they already had an income to support themselves. Those charging the highest fees were in longer term full-time private practice.

Table 4.4:

Fees per Hour

DOLLARS/HR	NO CHARGE	* 20 ***	* 35-40***	* 50-60 ***
NURSES	2	2	4	4

*Sliding scale ***Bartering available

One nurse who charged twenty dollars per session said she thought a lot of nurses would like to do holistic practice, but that "it isn't practical, because if you're going to do it right, you can hardly support yourself." Her husband supported her, but she felt the cost involved took much of what she earned even though she practiced in her own home.

They felt it was appropriate not to charge when first starting to practice, then as it felt comfortable to ask for donations or trade treatments with colleagues. Later they could set fees that would be comfortable for them to pay for the same services. They charged for giving workshops but often put that money into equipment, materials and scholarships for other nurses to attend seminars and workshops on holistic healing. They gave many lectures at no charge for community service.

One nurse had started a business of making and selling audiotapes to facilitate deep relaxation. She invested her time and money and then charged clients one dollar apiece for them to cover the cost of the blank tape. The predominant theme among the nurses was reluctance to charge for nursing for holistic nursing services. One participant said she would feel more comfortable doing home visits with a stethoscope and doing physical assessments in the more traditional nursing sense.

There was an admission that clients are "reluctant to accept treatment without some kind of payment," but even this acknowledgement did not help the nurse who had decided she could not enter private holistic nursing practice because of the discomfort around charging money for what she considered her "spiritual work." Yet, she supported those nurses who did charge for services. Since she was salaried and in the process of retiring she was not under financial

pressure.

The need for third party payment for nursing services was recognized. The certified psychiatric-mental health nurse in the study was eligible for some third party payment programs with physician referral. Another nurse had been paid through Workmen's Compensation to treat a work injury, but the others knew of no other eligibility for third party payment.

Marketing. Marketing was another major issue since most of the nurses wanted more clients. Their attempts at advertising such as buying advertising space had been generally unsuccessful. A flyer in a hospital, though, had attracted several nurse clients. Gift certificates for a Jin Shin session and participation in community raffles were being tried. All of them depended primarily on word-of-mouth for obtaining new clients. A nurse who had been part of a group to start a holistic nursing practice described her beliefs and experience with the word-of-mouth process:

> My belief was that my clients would like what I did and refer other people to me. I had two clients and believed that they would bring others and the practice would grow, and that's what happened...The other nurses who kept waiting for doctors to refer people never made it.

Liability insurance. The high cost of malpractice and business liability insurance was addressed. While some carried malpractice insurance they often did not know if it covered them in private practice. Two stated they had

malpractice coverage for private practice. The cost was over three hundred dollars per year, "too much, especially for a part-time practice." Other felt coverage in this type of practice was "irrelevant since the practice is determined by the wishes of the client and there are no invasive therapies involved." Liability insurance for the offices used was a major expense.

Legal Issues

The nurses expressed knowledge of the Nurse Practice Act and were confident that their practices were covered as independent functions of nursing. They felt it necessary to be familiar with the Nurse Practice Act and to be able to verbalize the independent functions, which include comfort measures, counseling, and teaching, in contract with clients. Energy releasing touch therapies were considered comfort measures.

Autonomy was a significant issue for holistic nursing practice. As one stated,

> A holistic nurse has to go really deep inside her own creative self to do this work. I see that as part of the evolution of a holistic practitioner--that they be autonomous and independent. They can relate and coordinate and work in a team in any way they can, but without being independent they can't do that."

The concept of autonomy for private holistic nursing was seen as significant in the discussion of what to call nurses in holistic nursing practice. The investigator had introduced the term "holistic nurse practitioner," but was

quickly told that was not appropriate because a "nurse practitioner" in California, according to the Nurse Practice Act, must work with and under the supervision of a physician. This linkage is not required of nurses who practice only independent nursing functions.

Participants were asked for suggestions of titles more appropriate than "holistic nurse practitioner." The following suggestions were made: "nurse healer," "holistic nurse specialist," "holistic nurse," "nurse in holistic practice," "Jin Shin Jyutsu Practitioner" or "Therapeutic Touch Practitioner," "Nurses practicing holism," and "Nurses practicing alternative healing modalities." Some suggested they might someday simply be called "nurses," the implication being that this type of practice might be the model for nurses of the future. One observed:

> If you ever use your information for a book, or to develop a model for a Master's program for instance, for the holistic nurse, nurse practitioner in California, it would probably be easier to do it as nurse practitioner. That model is already understood--of what a practitioner that you are training or developing. But within the Nurse Practice Act, you would be better off with the old term, Nurse Specialist, of Clinical Nurse Specialist.

One recognized the issue of such spiritually oriented work in regard to the law. She commented, "There is too much spirituality in holistic practice to make people comfortable within the legal point of view. So that should be interesting to see how that [is] defined after a while."

Conclusions

The organization and settings of the practices represented in this study held much variety, yet the similarities were consistent with the theoretical model proposed by the investigator. The data provided refinement and support for the holistic nursing model. None of the information was inconsistent with the developing theoretical model.

Profile of Client Participants

Sixteen women and two men made up the client sample. Table 4.5 shows age distribution which ranged from 21 to 68 with a mean age of 43.

Table 4.5:

Client Age Distribution

AGE RANGE	20-29	30-39	40-49	50-59	60-69
NUMBER CLIENTS	4	4	7	0	3

Cultural Influences

Cultural influences plays a part in the beliefs related to holism held by the clients. The predominantly caucasian sample included one participant of Japanese descent, one Chinese, and one Afro-American. About half of the clients said the practices and beliefs were new to them, and the other indicated they had been introduced to holistic ideas and practices through cultural and religious beliefs held by their families. A Japanese woman who was also a nurse

talked about how her father, who was a Zen Buddhist, taught her about health by telling stories.

> He said, "If you get angry, it's your own body that suffers. Nobody else does"...He taught us everything--philosophy, living, coping--and all in story form. We didn't know we were being educated...I had heard about acupuncture...And my parents went through some of those treatments.

A nurse educated in England said her preparation to be a nurse also included much of this thought, since she learned to "consider the patient as a whole--like they were your own mother and father."

Education and Occupation

The clients were highly educated. All had education or vocational training beyond high school. Three had Master's degrees and seven had baccalaureate degrees. The diversity of their occupations is shown in Table 4.6.

Table 4.6:

Client Occupation

Occupation	Number of Clients
Aeronautical student	1
Artist	1
Childcare specialist	1
Computer program manager	1
Counselor	1
Electronic specialist	1
Executive secretary	1
Musician	1
Psychotherapist	1
Real estate agent	2
Registered nurse (1 retired)	3
Retail sales (retired)	1
Sociologist (unemployed)	1
Tax consultant	1
Teacher	1

Interests and Hobbies

Client participants indicated a wide range of interests including the arts, outdoor activities and sports, and literature. No pattern of interest emerged except the recognition that these were bright, educated people who enjoyed intellectual stimulation and artistic endeavors.

History of Health Problems and Health Care

Health histories revealed a wide range of experience with illness and disorder. Three had experienced no major health problems in their lives, but seven had suffered many years or a lifetime of health disorders. The rest had experienced major problems of short durations or lesser problems over a long period of time. Some examples of those with severe problems were: a) a 41 year old woman who had a stroke when she was 38 and attributed her significant recovery to hard work and a combination of traditional and non-traditional interventions; b) a 38 year old who had severe facial, head and neck injuries from a car accident when she was 31, who later developed pounding in her ear that has never stopped since that time; c) a 68 year old who has had numerous hospitalizations for gastrointestinal related problems, skin disorders, joint inflammation, and reactions to an array of medications she thought had nearly killed her. Another client had been severely ill for less than a year but with unrelenting solar plexus and had pain

that was totally incapacitating to him so that he was unable to work or participate in life activities except to search for someone who could help him. Table 4.8 shows a summary of client health history, present problems, and symptom change during the study period.

All 18 participants had used traditional medical services throughout their lives. In addition, 13 had gone to either a chiropractor, acupuncturist, masseuse, or some other non-traditional professional for treatment before seeing the nurse. Five had never before consulted anyone outside traditional medicine. Prior to this time, none had ever been a client of a holistic nurse. All but five were under medical supervision during the time of the interviews. Those not under medical care described having muscle tension, fatigue, and other conditions they related to stressful lifestyles.

Reasons for Using Holistic Services

The clients, while using traditional medicine for diagnosis and treatment, were developing interest in holistic approaches. This interest stemmed from two concerns, one from dissatisfaction with traditional medicine, and the second from attraction to holistic therapies. The clients' definitions of health and healing were, in general, consistent with the premises of holistic health teachings.

Dissatisfaction with traditional medicine. Although

clients were not dissatisfied with everything about traditional medicine--and one was totally satisfied with her present physician because he took time to sit and talk--all participants told unsolicited incidents of themselves or others being treated badly in the traditional system. Their dissatisfaction included uncaring attitudes, high cost, lack of time given, ineffective treatments, and fear of harm from the medications and treatment. One woman expressed many of these concerns as she described her thoughts and feelings about her care:

> I went to the doctor just because I wasn't sleeping good, and I was having some pain and he put me on a very strong antidepressant...Then I found out that is what my sister-in-law takes and she's been diagnosed as a schizophrenic, and then I found out they give it to people who find out they have cancer and I went "Wooo. I don't want to take that." And he had given me this big huge bottle and told me to take 25 mg. a night and to gradually bring it up to 100 a night--and I was only taking 25 and feeling weird and I thought 100--I'd feel like a zombie and--I didn't need that...What he was seeing was that I was stressed out and depressed and so instead of having me deal with it he just gave me some pills.

A retired nurse had experienced pneumothorax from a medical treatment in a hospital. After leaving the hospital she retained the thoracic surgeon because she considered him an excellent doctor. Yet, she felt she had to tolerate his restriction of her time. She was hesitant to complain but told the following incident:

> I stayed with him but he's very busy so I don't go to see him unless I have something really to complain about...He doesn't have the time. I said, "I wanted to ask you something else." He just said, "How are you today?" and "I know what you've got." He said, "I'm

> gonna send you to--" I said, "I wanted to ask you something." He's rushing out the door. Guess that's what you get when you think you've got the best doctor. I think he is very good but--It bothered me a lot. But he's so busy and has so many patients.

One client summed up his perspective:

> You finally get a chance to see somebody--in a sterile waiting room--who has a particular kind of focus--a very narrow kind of diagnostic approach--And getting some sort of hard clinical reading--then going back after taking pills for a certain amount of time. That process to me is increasingly alienating;

and this concern:

> I think it's caring that matters and we don't have that--and the love that flows. We don't have that in medicine. It's terrible what some patients have to go through just to find out about your own condition. You have to demand the reports. The doctors don't take time to do that.

Attraction to holistic practices. Although dissatisfaction with traditional physicians was pervasive, exploration of holistic therapies was the primary reason that clients sought out the holistic nurses. In general, they wanted to supplement traditional therapies with a different approach. This statement expressed these ideas:

> My goal is to incorporate the best of both because I believe in the validity of traditional Western medicine--But also, it has come to my attention that you can't discount success and years of Chinese medicine or alternative approaches. These approaches for health and well-being may be antagonistic to Western medicine, but I want to be as healthy as I can be...

A client who had just heard that her suspected leukemia was not confirmed by diagnostic tests gave her reasons for pursuing holistic approaches. She said:

> For some reason I suddenly didn't feel comfortable with

> that pronouncement. I realized that within their realm and within their perspective of knowledge they might not have a complete or adequate answer...Just because certain tests say you're okay--I think there might be more to wellness or unwellness. I went--at the recommendation of a friend--to see an acupuncturist and I only had one treatment--and I realized there were alternative ways of dealing with these conditions and that you can't discount six thousand years of knowledge...I still believe in traditional medicine but I'm not gonna put all my belief in anyone.

There was also mention by clients that they like to have holistic physicians or nurses who had traditional education. The traditional backgrounds made them feel safer. One explained:

> I go to a registered physical therapist who also does [a holistic therapy]. I've always thought this blend was good--Just like I know [the nurse] is traditionally trained and is also doing, and has for years, this kind of work--I mean, there are just so many people out there doing this work. I'm relieved and reassured when someone has the traditional training and has sought something else.

Beliefs about health. Client's definitions of health were similar to those of the nurses. Some, though, emphasized one or more dimension--body, mind, emotions, spirit--over the others. The following statements exemplify the clients' varying definitions--Mental:

> Health for me is to function mentally. I'd like to keep that flowing. Other parts of me may not do as well. That's probably a part of aging, but if I can function mentally and be alert and think and write, I'd be grateful...You can be handicapped or have all these other things wrong with you, but if [I] can function mentally I can go on.

Physical:

> When you are physically active, it clears the cobwebs out. You become mentally more alert--It just gets the blood flowing so that nothing is blocked--and it helps

> your attitude. You know, the best thing, even with people in the hospital, the best thing you can do is get them up and out of bed and get `em moving.
>
> Emotional:
>
> When I take care of the emotional, everything else will follow--using my time, my brains, my resources--Well, I'm happy and when I'm happy, I'm extremely productive.
>
> I can work on ten projects and I'm very, very, very creative.
>
> Spiritual:
>
> Every woman who is interested in freedom must take the time to reflect and ask herself what is it, what is the spirit that comes from within--I think that a piece of health is knowing what the nature of that state is like--and then honoring it, too;
>
> and Integrated:
>
> Good health is holistic health--meaning your emotional, your physical, your spiritual, intellectual worlds come together. They're all integrated and I've been struggling to have all those things meet together. And that's what I think my goal is--to integrate all these realms and finding out, being knowledgeable about myself--It's a long process but it's one that I'll never give up.
>
> Health for me is to be in tune with the universe--To be happy with what I'm doing, enjoying my environment, surrounding, friends...So I'm happy to be where I am...

Beliefs about healing. Clients also had more difficulty explaining their concepts of healing than did the nurses. There were three general ideas expressed: a) Healing is spiritual in nature and arises from caring, love and peace; b) there is an aspect that can be facilitated by another person; and c) it is an internal process and one can learn to work with it to heal oneself. Clients emphasized the ideas most important to themselves in their healing

processes. The man who hoped for someone to relieve his pain stated:

> Healing is feeding the body whatever it needs to get itself out of it's slump...I need some outside help...I've become real slanted and skeptical, and I'm hard to convince...I would think that if the facilitation for healing was strong enough, it would be able to create some shift in your body where you would notice it.

This person sought a way to heal herself:

> Healing is finding the problem areas and learning how to go where they are and touch them. That to me is the process of healing, learning to go in there and feel around and see what's wrong and say "oh." Think about it and visualize it. Say "Oh, this won't do. This has to go away," and it will go away....

She later talked of her nurse and healing:

> All she can do is facilitate--or help facilitate my growth--my understanding in how and why things are happening. But ultimately, my responsibility to myself is to be able to do that.

Source of Referral

Word-of-mouth was the major source of referrals, since eleven had been referred by acquaintances or friends of acquaintances who knew the nurse. Table 4.7 reflects the sources of referrals.

Table 4.7:

Source of Referrals

Referral Source	Number of Clients
Friends/Acquaintances	11
Chiropractors	2
Self (knew the nurse)	3
Article written by nurse	1
Yellow Pages ad	1

The experience of word-of-mouth referrals was described by these clients:

> My boyfriend has known her for years. He is studying physical therapy and through his connections he heard about [the nurse]. Actually, I think he had a back problem and his physical therapist told him to go to see her;

and

> My sister knew two people who had dealt with [the nurse] and she thought that because it was near where I live--These people had received wonderful benefits and she thought it was very foolish of me not to take advantage of it...

One client responded to the nurse's letter printed in an organization's newsletter:

> I was impressed with her interest in being clear on a technical more Western oriented level--and also interested in her wide scope of considering what health is. I like that balance--and a lot of it was just a gut feeling.

They also talked of referring other people to their nurses and several were surprised how open their friends were to exploring these new ways of working with health problems. Newly acquired skills and knowledge were also shared with their friends.

Presenting Problems

Presenting problems ranged from fatigue and temporary pain of muscle tension to severe chronic conditions. See Table 4.8 for a full account of problems initially presented to the nurse. Muscle tension of the neck, back and shoulders was the most frequent problem. These symptoms were usually perceived in combination with other symptoms or

underlying stressors.

When asked what they considered their main health problem, most restated their presenting problem. A few, though, described it differently; as feeling low self-worth or holding on to feelings without expression. An underlying fear of two others was of being harmed by the medications they were taking, and the hope was that the nurse could help them decrease or eliminate them. One stated:

> I still have to take all that medicine and I don't like taking it because I think it keeps my resting heart rate much too high. No matter how much I exercise I still can't bring that heart rate down--I don't like the thought of overstimulating my heart or overworking my heart.

Lifestyle and Stress

All but one client led very full and busy lives. Six perceived their lives as extremely stressful. Troubled relationships were the major stressor for 15 clients. These relationships involved spouses or significant others, family members and fellow workers.

One client was just graduating from a baccalaureate nursing program and preparing for graduate school. She said:

> ...the stress I was under was pretty overwhelming. I was juggling the end of one job and beginning of the other--School was ending and all the hoopla around graduation--and family visiting--And it just felt like much too much to ask of anybody...

A woman who worked in the computer industry and had previously been happy with her advancement in the company

reported:

> I've been putting very long hours and the stresses have been tremendous...We're in a takeover situation. Our company's been acquired and it's total reorganization...

She wasn't certain whether she was considered a good enough employee to keep her job, and said, "I never thought I wouldn't be sure of who I am. That really bothers me."

A Japanese nurse--interned, with her family, as a teenager during World War II--remembered social prejudice, isolation and loss of personal possessions. She felt those stresses continued to affect her health.

Response of Support Systems to Holistic Care

Support systems ranged from meager to rich and strong. A client whose husband had died suddenly two years earlier was returning to Ireland where she would be with family. She said:

> I feel I don't have real close friends. Maybe there's one but she's not an easy person to communicate with. She tells me all her problems, but I can't tell her mine...

In contrast, a client who had had a stroke three years ago considered her friends her greatest asset. She organized a ceremony to celebrate her recovery and invited about 12 or 14 close friends. She described her friends thus:

> There were people I have felt very close to over this time period, including some of the healers with whom I work--Therapists, body therapists--who have known me all this time. I mean, it was my circle of friends. I have some really wonderful friends--I am really blessed that way.

When asked about talking with friends and family about going to a holistic nurse, clients generally felt they received support and acceptance. Most reported choosing who they told and who they did not. One client explained:

> I tend to talk to people who are of like mind, and they're trying to heal themselves or in some kind of healing process.

Others were supported by friends and family members with the exception of an important member. A young woman who was still largely dependent upon her father for financial support described her father's position:

> My father doesn't believe in holistic stuff but he says if it helps he's glad. He wouldn't stop me from doing it, but neither would he encourage it--or pay for it.

Some clients received unexpected responses. A client who initially expected her mother, a nurse, not to approve of holistic nursing therapy found her to be supportive. Three persons mentioned they were hesitant to talk with family members from other parts of the country about their experiences, because of regional differences in values.

Course of Therapy and Change in Symptoms During Study

Two clients made only one office visit and chose not to return. Another did not return after seeing the nurse for eleven sessions within two weeks without noticeable change. Presenting symptoms of two continuing clients did not change during the three months. Table 4.8 provides a summary of health histories, presenting problems and changes related to

the initial symptoms presented. Changes not related to presenting symptoms are discussed as part of the healing process in Section II of this chapter.

Table 4.8:

Overview of Client History, Symptoms and Symptom Changes

Client Number	Health History	Presenting Symptoms	Symptom Changes
#1	Concussion at age 8 years of age	Pain 8 months Head & solar plexus	No change
#2	Occasional dermatitis	Stress, fatigue, Pain in shoulder	No pain, Remains stressed
#3	Head and face injuries from car accident, 1982 Miscarriage 11/87	Pregnancy, persistent pounding in ear, stiff neck	Healthy No change Relieved
#4	Hepatitis, pancreatitis, gout, arthritis, skin disorders, hysterectomy, foot surgery, Severe withdrawal from Valium & Meds.	Arthritic pain right knee, hip, and leg; fatigue sore body	Less pain Increased activity & energy Less soreness
#5	Yeast infection 7 years	Chronic yeast infection, weight loss	Off medication Controlled with diet and lifestyle
#6	Stroke 3 years ago. Residual impaired use left hand. Neck, back & shoulder tension	Impaired use of hand, muscle tension	No change Tension relieved
#7	Asthma (3 meds/day) Colitis, allergies	General well-being colitis, asthma	Less medication fewer symptoms

Table 4.8: Continued

Overview of Client History, Symptoms and Symptom Changes

Client Number	Health History	Presenting Symptoms	Symptom Changes
#8	Hemorrhoidectomy, 1986	Bone spot on diagnostic test	Unknown
#9	Depression, 1981 bronchitis, pneumonia, knee surgery, 1981	Depressed immune system Prevent AIDS, Lingering cold	More energy No recent colds or infections
#10	Hysterectomy Diverticulitis	Hypertension	Maintaining stable B.P. on medication
#11	Chronic headaches for many years lessening recently	Headache Stiff neck	Headache relieved Less stiffness
#12	Healthy. Shattered kneecaps, allergies	Stress management	None
#13	Mental disorder, foot surgery, endometriosis, tubal ligation	Stress, endometriosis, shoulder blade pain	Decreased pain and symptoms
#14	Appendectomy, tonsillectomy	Sprained back muscle (reoccurrence)	Minimal & infrequent pain
#15	Skin problems	Muscle tension from emotional and mental stress	Decreased tension, happier and expressing feelings
#16	Appendectomy, dental work	Stress & tight muscles from car accident	No change recurring accidents and stress

Table 4.8: Continued

Overview of Client History, Symptoms and Symptom Changes

Client Number	Health History	Presenting Symptoms	Symptom Changes
#17	Pneumothorax, 1972 hysterectomy, endometriosis	Neck pain from arthritis, fatigue	Minimal stiffness Pain relieved Lots of energy
#18	Strep throat, tympanoplasty, chronic bladder infection and kidney infection	Genital warts, pain control and healing, fatigue, stress	Fast healing, increased energy

Money Matters

Expense was a concern for ten of the participants. They dealt with it in a variety of ways. One decided that part of her healing process was not to return until she could stabilize her finances, three spaced their sessions so that they could afford them, one shared the expense with her boyfriend who bartered for sessions, and one dropped out because of the expense. One client expected not to be charged before his symptoms were alleviated and was angry with the nurse as well as previous caregivers because they charged for ineffective services. His nurse offered to barter and he did for a short time by taking care of her house when she was away. On the other hand, a client whose nurse would not take payment was troubled because she was not allowed to pay. She said:

> She tries to do it once a week but it's been a little erratic because of her time. I hate to see her just squeeze in time...It makes me uncomfortable when I feel like it's sometimes an imposition...I wish, too, that--We talked about it and I wish, too, that she should set a certain fee. Do you know anything about how others do it?...I mentioned it to her because people will gladly pay.

Only one client was receiving third party payment for care and that was through private group insurance. She had a referral from her physician to see the certified psychiatric-mental health nurse.

Summary

The client participants in this study sought holistic health care from nurses in private practice. They were educated, middle-class workers and professionals who sought holistic health care as adjunct to traditional services. They presented a wide range of health problems for nursing care and responded in a variety of ways to the experience. Section II provides understanding of variation in response within a theory of client-nurse interaction.

Conclusions

Descriptive data related to nurses clients and practice settings provided a profile of holistic nursing practice in private setting. The profile presented indicated that such context was an appropriate place to study client-nurse interaction.

ANALYSIS AND RESULTS

Section II. Theory of Mutual Connectedness

The data based profile of holistic nursing practice presented in Section I of this chapter provided the context for theory of client-nurse interaction. This theory is presented here.

Private holistic nursing practice is an appropriate setting for study of nurse-client interaction since a) the focus of practice is the relationship, and b) the nurse practices independently and dictates practice parameters--within the law and professional standards. Autonomy allows her to practice caring as she and her client define it in their relationship. The Theory of Mutual Connectedness emerged from interactional data obtained in the nurse interview, and client data regarding the relationship, over the period of the study.

The data that yielded the theory was coded initially as "interaction." Four major categories--intimacy, mutual connectedness, nursing therapy, and healing--emerged from the interactional data. Intimacy is the process of getting to know one another by sharing one's personal and private worlds. Since health and healing involve personal and private aspects, holistic nursing practice requires intimacy in the relationship. Mutual connectedness is the joining

together of the nurse and the client in a relationship committed to the health and healing of the client. Nursing therapy constitutes work done in the client-nurse relationship, and healing is the process of self-transformation during which one fulfills latent potential. This potential emerges from within the client as tension and conflict are released. These major categories with their respective theoretical positions are presented in Table 4.9.

Table 4.9:

The Concepts of Mutual Connectedness

(Position)	Condition	Context	Strategy	Outcome
(Category)	Intimacy	Mutual connectedness	Nursing therapies	Healing

This chapter contains two sections. The first section describes the process used to develop the grounded theory; and the second presents the theory.

Developing the Theory

The process began with coding the data related to interaction in the interviews, and proceeded through five steps: generating conceptual categories, saturating the categories, identifying a core category, forming conceptual linkages and writing the theory.

Coding and Generating Categories

The investigator wrote eight nurse-client interactional stories by using the events described in the client interviews and from the interactional stances revealed in

the nurse interviews. These stories were then raised from the empirical to the conceptual level by coding and generating categories. Constant comparison facilitated emergence of conceptual categories and the delimitation of properties.

Saturation of Categories

Interaction data from the client interviews were then coded using categories identified in the interactional stories to test for fit and to determine additional categories. Processes used to accomplish saturation included open coding, theoretical sampling and professional dialogue related to identification and refinement of categories. Thirty-eight categories were identified and these eventually became the categories used to form the conceptual linkages of the theory. (See Table 4.10, p. 126).

Identification of a Core Category

Intimacy arose repeatedly as an in vivo code from the client data and was determined as a condition for holistic nursing practice. Mutual connectedness was described in both client and nurse data and required efforts on the part of each, making it a process of alignment and mutuality. Nursing therapy were introduced as the strategy for healing. Healing was addressed in the data as the outcome of consequence of therapies within the context of mutual connectedness. The emergence of mutual connectedness as the

pivotal point of the theory made it the core category.

Table 4.10

Theory of Mutual Connectedness: Categories and Conceptual Linkages

MAJOR CATEGORY	Intimacy (condition)	Mutual Connect-edness (context)	Nursing Therapy (strategy)	Healing (outcome)
PROPERTIES	Emotional Physical Mental Spiritual	Stages of trust Dynamic	Pattern identifi-cation Pattern enhancement	Inner-directed Time
CONDITIONS	Nurse readiness Client comfort	High degree of knowing self and other	Nursing knowledge and skills Work roles Intuitive knowing	Letting go Introduc-tion of new patterns
STRATEGIES	Nurse communicat-ing caring Client negotiating for comfort	Nurse attunement to Client deciding to trust	Counseling Touch therapies Imagery	Self-acceptance
OUTCOMES	High degree of knowing self and other	Work roles formed Intuitive knowing	Letting go Introduc-tion of new patterns	Self-integration Self-transform-ation

The outcomes for each major category provides conditions for

the next major category.

Formation of Conceptual Linkages

Since all major categories related centrally to the core category and to each other, the grounded theory requirement for conceptual relationship among the categories was fulfilled. Conceptual linkages of these categories may, with further testing, be used to form hypotheses related to the grounded theory.

Writing the Theory

The theory is written conceptually reflecting linkages among the various concepts. Lengthy descriptions from the data are replaced by abstractions. The theory presented here included discussion of categories, properties, conditions, strategies and consequences or outcomes. Dimensions reflect the variation under which categories of events occur and provide the basis for conceptual linkages among the various indicators. Excerpts from the interviews are included to explain more fully the concepts of the theory and to provide empirical grounding for the reader.

The Theory

The theory that emerged from this study was entitled Mutual Connectedness: Holistic Nursing Practice under Varying Conditions of Intimacy. The core category is mutual connectedness and the other major conceptual categories are intimacy, nursing therapies, and healing.

The theory explains the nature of client-nurse

interaction in a setting created to promote health and facilitate healing. It identifies potential problems and pitfalls involved in this relationship, and the skills needed for holistic nursing practice. It also describes how healing may be facilitated in this relationship, for both the client and nurse. Healing of the client, though, is the primary consideration and focus of this study, with healing of the nurse secondary and coincidental.

The categories are perceived primarily as a progression of events from the time the client enters the setting in which intimacy is expected, to establishment of a connection or bond, to the therapeutic work of the nurse, and to healing, as the client learns to let go of tension and conflict. The categories are discussed in that order even though the process is cumulative, with each aspect affecting every other.

Intimacy

Intimacy, the experience of getting to know and of being known by sharing one's most innermost self is the condition for mutual connectedness. It is the means by which the nurse comes to know the client, and the client decides whether to trust the nurse. Holistic nursing, by its very nature, requires intimacy within the client-nurse relationship. The client, then, must be willing to share in an intimate relationship and to be known to the particular nurse. To encourage this willingness to share, the nurse

must provide an environment that promotes trust.

Properties of intimacy in holistic practice. Intimacy in holistic nursing has physical, emotional, mental and spiritual properties. Nurses vary in their emphasis on the different aspects of intimacy since each individual practice is unique. Although intimacy is required in all holistic nursing practice, the nature and degree of intimacy varies with the nurse, the therapy used, and the comfort of the client.

The degree of physical intimacy varies with the amount of touching and nature of the touching. High physical intimacy includes therapies such as full body massage with all the clothing removed. A moderate degree of physical intimacy is required during the use of acupressure or Jin Shin since only certain points are touched with no removal of clothing. An example of relatively low physical intimacy would included the use of Therapeutic Touch where no clothing is removed and the nurse does actually touch the skin. Even though some therapies require less physical intimacy than others, it is expected in all holistic nursing settings since energy releasing touch therapies involve the nurse working close (within two or three inches) to the body over an extended period of time. Touching involved certain points on the body, some of which were in places usually considered private and personal. In Jin Shin Jyutsu and acupressure, some of these points mentioned by clients

included the groin, the pubic bone, and different points on the hip bones.

Emotional intimacy was reported was sharing of feelings by verbal expression, crying, laughing or other means. The nurses, in their interviews, acknowledged that they listened carefully and allowed expression of feelings and concerns as clients felt the need to talk. Yet, the degree of expectation for emotional intimacy varied from high to low. High expectation included those nurses who identified physical disorder with emotional problems and used counseling skills to identify troubled emotional patterns. Moderate expectation occurred when the nurses used active listening skills to encourage sharing and discharge of emotion. Low expectation included those who used Jin Shin Jyutsu to treat emotional distress and did not encourage emotional discharge.

Mental intimacy, or the sensing of each others thoughts and feelings, was a frequently reported experience of the nurses. They reported that they often felt their clients' bodily sensations and at times knew their thoughts. The nurses varied in the degree of mental intimacy they expected to share in the relationship. Those with high expectation communicated the experience to the client as part of their getting to know each other. Others chose not to say anything for fear of frightening the clients. Mental intimacy, while not required in holistic practice, was

expected and accepted by the nurses who experienced it as something that happens in close attunement to the client.

Spiritual intimacy--a sense of oneness--was another aspect of the experience accepted and appreciated when it occurred in the relationship. A few clients in this study acknowledged early emergence of this experience and treasured the moments. One described his feeling as he began to experience this level of intimacy:

> It feels like we're on the spiritual level. It's more of this letting down my barriers and accepting our oneness--I guess that's it--A weakening of my barriers of wanting to separate--and being closer.

There was wide variation in the intimacy expected by nurses and experienced by clients. While physical intimacy is expected by nurses in all holistic nursing interaction, and emotional intimacy is expected of clients; mental and spiritual intimacy are not necessarily expected but enjoyed and appreciated by both nurses and clients. Nurses have different expectations of intimacy according to the therapies they use. For example, they may expect high physical and low emotional intimacy; or low physical, high emotional, and high mental intimacy.

Conditions for intimacy. Intimacy occurred in the relationships with varying degrees of nurse readiness for intimacy and client comfort with intimacy. Nurses prepared for intimacy by centering themselves so they could fully attend to the client, and by preparing the room for comfort

and relaxation. Both nurse readiness and client comfort with intimacy occurred in various degrees from low to high. Clients described reactions to situations representing low nurse readiness in that the nurse was distracted from the client by extraneous events. One situation was that of a well-prepared room, but a nurse who was distracted by the telephone. The client described her experience:

> And the thing that was hard--She was waiting, I think, for a phone call from someone. And she kept listening--and she went to answer it a couple of times...She had the phone in the other room, but it was pretty loud.

She felt the nurse's attention was not with her and the experience lacked something important for her. She chose not to return.

The client's degree of comfort with intimacy was experienced as a) willingness to be known was confronted, and b) the decision whether to trust the nurse was made. Willingness to be know is critical to the experience of intimacy. Persons have a general and often unfulfilled need for intimacy. Being known increases vulnerability, however, so fear of intimacy is common (Schaef, 1989). Facilitators related to need and barriers related to fear were balanced by clients as they determined their willingness to experience intimacy. The clients entered holistic nursing practice with varying degrees of comfort about being known. They varied in degrees of comfort related to different ways of experiencing intimacy. They addressed their comfort as

it related to physical, emotional, mental and spiritual intimacy. Some were initially surprised by the intense intimacy in a client-nurse situation but became comfortable very quickly. As one stated in the six-week interview:

> I'm more comfortable with the intimacy of the treatment...It's because of the nature of the touching--um--There's just a more intimate nature of the treatment, and also even when she's not touching me it's a more intimate--I mean, it's not uncomfortable. It's a positive thing that I wasn't expecting.

Some clients were very comfortable with physical intimacy, but comments of others indicated discomfort and inability to accept this form of closeness. One who especially enjoyed the physical aspect stated:

> She has very warm hands that feel really good--so, wherever she places her hands on me, it's a sense of pleasure. It feels really nice to have warm hands on those points.

One client was distressed by physical intimacy and by failure of the nurse to prepare her for it. She expressed her concerns:

> There were some things that I thought were unprofessional. First, she didn't tell me what was going to happen. It's almost like she thought I knew...You're being touched all over your body and some of it borders on being personal.

Another described her experience and discomfort:

> I'm the type who is always waiting on other people...I wasn't used to that kind of thing...I mean I never had my back rubbed or my feet rubbed...That was the first time I ever had anything like that. She rubbed my feet and my legs and my arms...I didn't know what to expect of it--And I thought, "Well, I'm sure this won't do me much good." I think I thought I would sit in a chair with my clothes on and probably she would massage my shoulders...But she said "You just take off what's

> comfortable." And I said, "Well, I've got pantyhose on." So she said, "Well, you need to take those off--" So, I left my panty and bra and she undid my bra at the back to massage my back. So--I'm a very private person...So the massage didn't help. It just didn't appeal to me.

Some clients were relieved when they arrived at their appointments for Jin Shin Jyutsu, acupressure, and therapeutic touch to find they did not have to remove their clothing. One client, relieved to find he did not have to take off his clothes, experienced another series of surprises related to touch.

> The first time I was ticklish in the groin area--and last time it was, too--It was really hard for me when she touched me in certain areas. Then I got really comfortable and just not thinking at all--and then she places her hand on my abdomen. Well, I had a sense of being abused or beat up there at one time. It was like I just--Somehow it triggered a flashback.

Clients also varied in their degree of comfort with emotional intimacy. For many clients it was crucial and the reason for seeing the nurse. This client provided an example:

> I don't know how we got on it, um--She has a way of leading things right to the problems--You know, what's really bother me...Every time I have a symptom, my yeast symptoms mostly come up and feel their worst just because of intercourse. So she wants to know, she says, "You're rejecting something." That's where she's coming from...She really gets right into it. Like I said, though, none of that really shocked me.

There were no examples of clients who were uncomfortable because emotional intimacy was expected of them. There were some who wanted to share more than they

were allowed. Among the nurses those who did Jin Shin Jyutsu were at least apt to respond verbally to cues of distress. They believed that the therapy, itself, would calm emotions and did not encourage expression during periods of emotional upset.

Degree of comfort with emotional intimacy changed for one client and nurse from one of comfort to great discomfort. The client, who had gone to the nurse initially for emotional support with the goal of learning to express emotion, was especially disappointed when her nurse asked her to seek help from a professional counselor:

> The other night I was talking to her and she suddenly said, "I really think that you should talk to a counselor. I cannot do anything for you." And repeatedly, she said that and really pushed me away a little bit...I don't need people to tell me to see a counselor...I just need a friend.

The nurse in this example had told the investigator she felt unqualified to do client counseling but that she felt she was a good listener. Her lack of confidence in this area may have affected this situation. This incident broke the relationship when the client found the nurse unwilling or unable to provide counseling.

A few examples of mental intimacy were related, and one client was initially quite frightened by the experience. The client feared that her nurse might be harmed by the client's condition until she was reassured by the nurse. The nurse was experiencing the client's symptoms in her own

body, and relaying these sensations to the client. The client described her feelings:

> I thought it was very unusual that somebody could sense what was going on inside me. And that was my first hint of the intimacy that one shares in the patient/practitioner situation. And I was a little uncomfortable--A little skeptical, perhaps--I mean, we don't usually have those kinds of relationships with the people that we're going to for health care.

During the last interview, she expressed comfort:

> I'm more comfortable with the intimacy of the treatment...It wasn't shocking to me, but it was a little startling. It was a very, very personal thing--whereas, a doctor even though he may be touching you and inspecting you in very intimate places--there is a real detachment--where I feel that with the nurse--It's a very intimate kind of treatment and I'm not a real closed kind of person. At first, it felt almost like a violation of privacy...

Strategies for establishing levels of readiness and comfort for intimacy. Since the nurses expected intimacy, they prepared themselves and their settings for that experience. They believed that readiness included inner quietness, and that was accomplished by centering, or bringing all of one's attention to a focus on the breath. One nurse described a combination of centering and visualization as she focused on the client:

> Within myself, I try to center and try to think of that person and of myself as being one...a blending...And getting a sense of whatever affects them will be part of me--So this is a mutual kind of experience that we're having.

They prepared themselves by centering to achieve inner quiet and ability to focus on the client. Preparation for

intimacy ranged from a lot to a little. One nurse who seemed to do a lot of preparation said:

> [I make sure] that I'm centered when they arrive...[If not], I give myself a few minutes before I begin--to ground myself and to open myself as a channel through a brief meditation or breathing exercise...By reading inspirational literature...So it's being quiet...

Those who did not always take time to center themselves prior to seeing the client were those who relied on the energy releasing therapy to quiet and focus them. A nurse who did Jin Shin Jyutsu primarily, said:

> The process itself gets you to the place that you need to be...I do not think deliberately of being centered. It's in the process of paying attention to your fingertips and listening to pulses...I can be very volatile, but when I'm treating, it's a whole different state. It's very peaceful...

Nurses prepared the settings for quiet, peace and beauty, where the client would feel safe, be able to relax, and experience intimacy. The amount of preparation of the setting varied from a lot to little. One example of considerable preparation was this:

> [I prepare by] getting the room ready if I'm going to do a massage. And by putting meaning into everything I do, not just throwing the sheets on and doing it--but lighting the candles and connecting with the environment in that way...When I greet them at the door the healing art is begun as far as I'm concerned...I see myself preparing for each individual rather than just preparing for a day of work.

Some nurses indicated that preparation of a peaceful setting was not as important as the environment provided by the nurse herself. One nurse who placed lesser importance on the setting indicated she had done this work under very

unpleasant situations which included prisons. Most of the nurses made efforts to prepare a pleasant and peaceful setting although client reactions suggested they did not always feel the preparation was adequate.

The clients described their reactions to the settings. They were generally pleased with the settings and felt they gave a sense of peace and comfort. One was especially moved by the room prepared for her. She described it in this way:

> It's in her home setting and I like--I like the whole atmosphere of that therapy room--I really enjoy the atmosphere. It's very peaceful and very healing, and quiet...And she was playing the song `Ave 'Maria'...It's not an ordinary room--Peace, nurturance and care--very safe.

Reactions to other settings indicated client concern with the place provided. Here is one example where the client perceived disorganization in the setting and how that perception affected her willingness to trust the nurse.

> I was checking out her place to see how I could place her character with the apartment--To see what it could tell me about her...I felt she was not as organized as I am used to being, I guess, in my own life...And I think I was expecting it to be more organized...It made me wonder if maybe she didn't care that much about her work...

Those perceptions seemed to affect her over the entire period, and she eventually exited because she was troubled by a perceived lack of organization in the practice.

In another situation, a client was concerned about lack of privacy in the setting. There was no door on the treatment room and people in the waiting room could overhear

conversations between the nurse and the person with whom she was working. The client was aware of the problem because she had heard conversations in progress while she was waiting.

Strategies for intimacy. Nurse caring was critical to the clients' decision whether to trust. Clients looked for signs to determine whether the nurse cared for them as persons. They expected that the nurses would be fully attentive and responsive to their needs and subtle cues. Comments about the nurses generally indicated favorable responses to the clients--caring, acceptance, and respect. Caring portrayed in preparation of the work space facilitated comfort with intimacy in the relationship. Those who decided to trust made a common statement, "It seemed that she really cared about me," or "she is a very caring person." Communication of caring for the client was a critical element for the nurse in the relationship.

Clients attempted to increase their degree of comfort by negotiating for comfort with intimacy through self-talk and, rarely, with their nurses to establish comfort with intimacy. First, they engaged in self-talk to rationalize their discomfort. They tried to resolve conflict by telling themselves "the nurse can concentrate better and help me more if I don't talk while she is working," or "she knows best." One who experienced pain after the treatment stated she had accepted more pressure than she should have during

the treatment and said she was telling herself: "This will really be good for me...I can tolerate it...Suffering is good..." She was one, though, who was able to communicate her discomfort and concerns with her nurse as she attempted to create a level of comfort. She telephoned the nurse a few days after the treatment to discuss the situation before she decided to return. She said:

> I was critical of what [the nurse] was doing...Maybe that's the advantage of [my] being a therapist--at least by being psychologically sophisticated. I'm aware [I was] blaming her--[but it was me that did not communicate with her that it was too much pressure]. I did blame her initially. It was like "what did she do wrong?"...It was wonderful that we could work it through on the phone...And she knew what was right [for me and for her]...And she also had to be detached enough herself to not feel "oh, God, what'd I do wrong?"...To be able to bear with me. I mean, I know what it's like when people are critical of your work...

Other clients chose not to return when they were unable to establish a degree of comfort through self-negotiation. One other client did negotiate with the nurse for yoga classes instead of massage but eventually left the classes when she decided the classes were too large and the nurse would not miss her. The real reason seemed to be that the nurse thought the client should continue massage therapy and just the suggestion made her uncomfortable. A majority of the clients were able to achieve a necessary degree of comfort within the study period. The early stages of the relationship were difficult for many clients, but as the relationships progressed, intimacy became more comfortable.

Outcome of shared intimacy. Through intimacy, the nurse and the client experience both knowing of the self and of the other. Not only must the nurse get to know the client so that she can help, but the client must get to know the nurse so he or she can decide whether to trust. A client spoke of the need to know the practitioner:

> I was very pleasantly surprised also that a professional in health care would spend that amount of time to be that intimate--that open about herself as well, because I asked her questions about herself. I've had problems with doctors in the past. My experience with doctors is that they're unwilling to do that and so I've never felt comfortable with a doctor because I don't know much about them. And I have a sense that they don't really want to know very much about me.

The outcome of knowing one another provided the condition for mutual connectedness.

Mutual Connectedness

Mutual connectedness is the term selected to symbolize the client-nurse interaction when there is a union based on: a) knowing one another, b) nurse care, and c) client trust. The nurse greets the client with caring and acceptance. They, then, get to know one another through shared intimacy, and the client decides whether to trust. The decision to trust triggers acceptance of the relationship being offered. A union is formed in the relationship. The nurse may be very sensitive to the client and reach out with caring, but until the client reaches back with trust and acceptance, the connection is incomplete. Mutual connectedness is the

context for nursing therapy to promote health and healing.

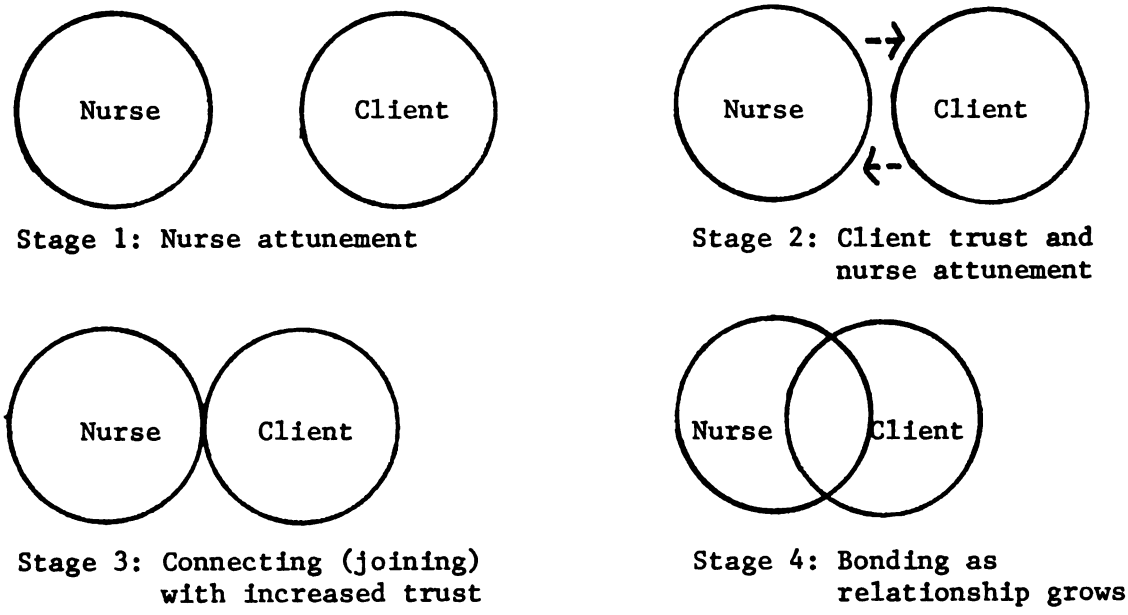
Properties of mutual connectedness. Mutual connectedness is dynamic and changes with fluctuating client trust. It often moves through stages as it grows and develops (See Figure 4.1). On the other hand, it may occur spontaneously as the client responds to the nurse, or change dramatically in response to a feeling or event. While fluctuating client trust is expected and acceptable, the nurses expect to stay constant in their caring and attunement (intense listening to and focus on the client). Clients described intense feelings in response to perceived changes in nurse caring and/or focus of attention.

Stages of mutual connectedness were obtained from the clients' descriptions of their feelings of connectedness. From these descriptions, the clients described a continuum of connectedness that ranged across a) trust, b) joining, and c) bonding. The nurses mentioned attunement and spoke of a parallel process occurring in the relationship. Moments were described in the literature and by a client who experienced a brief sense of oneness with the nurse. The beginning of the continuum is trust, the precursor for mutual connectedness. Trust moves the client closer to the nurse. Connection is the stage where the client actually participates in the relationship with the wish to be known and the wish to know the nurse. There is a feeling of making contact, of affecting another, of joining together.

There is trust with a feeling of being cared for and understood. Bonding occurs when a common purpose is identified and the connection is made stronger. See Figure 4.1 for a pictorial representation of the movement between the client and the nurse as they move through attunement by the nurse to trusting by the client, connecting or joining together, and bonding.

Figure 4.1

Stages of Connection



Stage 1: Nurse attunement

Stage 2: Client trust and nurse attunement

Stage 3: Connecting (joining) with increased trust

Stage 4: Bonding as relationship grows

Strategies for achieving mutual connectedness.

Strategies included nurse attunement to the client and client decision to trust the nurse. Attunement is the process by which the nurse focuses her caring and attention on the client and gets to know him or her.

An experience of attunement was described by a nurse who had only talked once with a client on the telephone to

make an appointment. She stated that the woman had been in psychotherapy for the past five years and had not made any changes. The nurse's attunement to this client was strong and she said:

> Before she arrived, I had worked with her for two hours. She was amazed and wondered how I could know all these things. She cried, felt better--I do not know if she will ever come back or not. I felt there was not time to waste for her and she needed the help to make her transformation.

A client provided an example where she felt the nurse was not attuned to her and did not pick up cues. The client wanted to talk and be encouraged to cry. She described her experience:

> I really went to her for emotional support--and so the minute she said, "Hi, how are you?" I practically burst into tears--quietly. I kind of said, "It's been a rough summer" and told her a little of what was happening--but either it was more than she wanted to deal with or she wasn't hearing, cause her response was to give me some sort of practical advice...And so there I was just kind of trying to stop what felt like this absolute torrent and realizing that it really wasn't appropriate for me to come in and expect that from her...She didn't really hear it and so I finally got control of my tears and we stayed on subjects that were more superficial--But it wasn't really a good experience...

More common uses of attunement which would represent mid-range on the continuum were described by these nurses:

> Basically, it's being very sensitive to what their basic need is...

and this:

> I first go by what I see when they arrive--One particular woman is sometimes not ready to just go in and take her clothes off and get ready for the acupressure or massage. She wants to talk a few minutes first...

Attunement to the client was necessary for the formation of the relationship, but there was no opportunity for a working relationship until clients responded to complete the connection. Conditions under which mutual connectedness was experienced varied with time and circumstance. Time in the relationship was relevant since connectedness formed and grew in intensity over time, although some stated they felt some bonding from the first visit. Client comfort with intimacy and ambivalence in the decision to trust influenced the amount of time needed to form the relationship. Client participants used a variety of strategies to determine if they could trust the nurse. The decision was a key issue for clients during the initial meetings. They looked for signs to determine if the nurse could and should be trusted.

For one client, trust had been extraordinarily difficult since she had suffered changes in body image due to a stroke and was hesitant to show her body to another health professional who had not watched her progress. She described her effort:

> It took me quite a while to call her. And I don't think that's to do with her as much as with me--It's difficult to put my body in someone's hands at this point. It just is--I have to go through this stuff again of developing trust and taking the risk...and being vulnerable and trusting some healer person or helper. And it's scary.

They applied their own criteria for trust and looked for signs indicating that trust was appropriate. The criteria for trust included a) trust in the person who made the referral, b) self-determined criteria for professionalism, c) results of the treatment, d) appearance of excellent health, and e) a sense of liking her.

Referral source was an important factor in deciding to trust. Those who were referred by a trusted person who, in turn trusted the nurse, found the decision an easier process.

> I know one of the things that made it easier for me to be comfortable with [the nurse] right away was--my friend that had told me how wonderful it was for him, and I have an awful lot of respect for him.

The client who found the nurse through an advertisement had the most difficulty and exited early. Professionalism was a concern for this client who did not return even though she had a good response to the treatment:

> There were some things I thought were unprofessional... She came down hard about the fact that I'd been in psychotherapy for so many years--and that by now I should be out of it...She told me that she's a proponent of unconditional love, and I should not focus on negative feelings...But my feelings are you cannot run away from your negative feelings and to suppress them is not the solution...I did go through a peace of mind the rest of that day...But my therapist would never put down another person and what they were trying to do for me...Whereas she was putting him down, you see.

Other clients used the results of the treatment as criteria for trust but it appeared that referral had also played a large part in those decisions to trust. Some said

they were especially interested to see if the nurse modeled good health. While deciding whether to trust, a client stated, "She does look healthy...I was judging that. That's very important to me." Others could not explain why they decided to trust except that they simply liked the nurse:

> She's very easy to talk to--There's just something about her. There's something about her that makes me more trusting of her motives...I think you have to like a person to be able to really talk to them...

Another client used this criteria to test the nurse:

> I didn't know what to expect...I was a little bit leery, wondering "Well, is she gonna tell me `you gotta come back from now on and, you know, just leave you money on the table.'"...[And she said] "You have to come back as many times as you make yourself have to come back. Some people only need one treatment... That's your choice"...It's like "I don't need to make the money." I [the client] need to have a successful treatment, cause she's very busy...That meant a lot to me.

Clients used a variety of criteria in their decision to trust. They looked for evidence that the nurse was motivated by caring and the intention to help, but they also looked for evidence of a successful, organized, and efficient practice operation. When a nurse failed to follow through on a commitment to send some materials, one called the nurse and was told that she did not have the address. The client shared her feelings:

> First of all, I felt this is really unprofessional. You should have a file. You should know my address...and if you don't, then you should make an effort to find it, to call me...I think if I was in her position and taking my profession seriously, then I would have had all this documented...I had feelings like maybe she just didn't care...

When the clients in the study found reason not to trust the nurse, they exited immediately from the relationship. While none of them actually distrusted the nurse's motives, there were three who exited before the second interview, and two others were planning not to return at the end of the study period. The decisions to exit involved issues related to comfort with intimacy and/or the decision to trust.

Circumstances were different for each client, and the time needed to decide to trust differed. The nature of the presenting problem and the treatment history affected the time needed to decide to trust. Some clients formed strong connections or bonds with their nurses in one or two visits. These bonds sustained them when they could not return for extended periods. One client had seen the nurse only two times, had planned to return but did not have enough money. She continued to work with the things she had been taught and kept in touch with her rarely by phone and through her friend who was also a client. She never doubted her nurse's caring and concern. Her first thought, on being told by her physician that she was doing much better, was to phone her nurse. Another client who felt she had formed a strong connection, or bond, with her nurse explained why she felt this so strongly:

> She's a warm, caring person...And I feel, with her, that boy--she's in it to help. She really gives all she'd got. And that was really my feeling about her from the very beginning--that she's doing it because she truly feels she's gonna help people.

Bonds were formed that clients thought would last long after initial symptoms and health problems subsided. A client who had only seen her nurse twice, and who planned to return as soon as she could resolve some financial problems explained her wish to return:

> --there is a trust that I have that I don't know that I had for the other people that I've worked with...There's just something about her, something about her...I think she has a powerfulness about her that reaches out...And I think she can do a whole lot more than we can talk about...I'm gonna go back cause I feel that there's just a lot more work that I want to do and that she can help me with...I think she will always be a part of my life.

The nurses all believed they communicated caring, knowing and attending at a high level and made every effort to fulfill these requirements of holistic nursing. Yet, the clients in this sample did experience times when they felt let down by the nurse. It was obvious that expectations of holistic nurses are, indeed, very high and perhaps not always attainable. Mutual connectedness, then, is created by nurse attunement, client trust and acceptance of the offered relationship. A strong connection, or bond, is the medium through which nursing work or therapy is done. A strong connection produces intuitive knowing which guides the work. The better the client is known, the more effective the nursing therapy.

Outcomes of mutual connectedness. Intuitive knowing increases with the strength of the connection. Nurses described their efforts to know their clients through

observation of pattern and by intuitive knowing of the person's essence--their inner being. Intuitive knowledge, coming from experience, deep sensitivity, and knowing of the client is considered by most holistic nurses crucial to practice. The nurses spoke of their reliance on intuition to guide their work. They said it involves both a) listening to the innermost other, and b) listening to what is happening inside the nurse as she works or is quiet. This nurse described the way she used intuition:

> It's probably my intuition that guides most of the things [I do]. Through my own reflection or meditation--being quiet inside--being able to not be into my own stuff--not my ego. Just being able to see, to watch whatever is there that needs to be balanced and needs to be brought into more harmony--to health. And I basically listen to the person and listen to what is happening inside of me...

Others were not quite so confident in its use:

> More and more my intuition--which is a feeling about things--I have only recently begun to sense that--I like it. It's very helpful. I mean, I've had it but haven't been able to trust it or use it.

Another outcome is the <u>formation of work roles</u> based on knowing of each other in the relationship. These roles, formed to promote health and facilitate healing of the client, emerge as the client and nurse experience mutual connectedness. The roles are established through knowing each other. The nurse gets to know what the client wants from her and shares ways she can help. Intuitive knowing of the client and of herself assists in the formation of these roles. The client clarifies what he or she wants and makes

those wishes known, usually in very subtle ways, to the nurse. Together through alignment of action, their roles are established. One client described this aspect of interaction with her nurse:

> It seemed like it was more or less up to me--what I wanted from her--or what I needed. And she worked around my program in what she does. I told her what I wanted from her and she went from there.

The work roles discussed here are those identified by clients as they worked with their nurses. The roles were placed on a continuum reflecting a balance of client-nurse responsibility. In order of increasing client responsibility and decreasing nurse responsibility, these roles are a) parent-child, b) teacher-student, c) partners, and d) nurse as catalyst. All the roles included the element of nurse as friend since clients describing all four roles said things like, "She's like a good friend to me." Examples are given here in this order as clients described their experiences.

The <u>parent-child</u> relationship was represented by the young man incapacitated with chronic head and abdominal pain. He wanted to be totally passive and to find someone who would make him well. He felt totally helpless and was very angry that he could find no one who could cure him.

The <u>teacher-student</u> role contained a range of responsibility for the client/student which varied over a continuum from low to high. Low client responsibility

included those situations where the nurse gave information and was direct in her approach. Situations of moderate client responsibility were those that encouraged clients to ask for or seek the information they needed. Those nurses in relationships of high client responsibility did nothing other than what was asked of them. The client was left to learn from his or her own experience with the nurse. An example of low client responsibility in the teacher-student role was this:

> She told me that there were certain things she was doing that I could do [for] myself. She said to pay attention to what was going on and I could do those things. I haven't done them...

of moderate responsibility:

> I feel like I'm learning a lot...It's like a teacher-student relationship...I mean there are all sorts of these things that I don't know so I'm real inquisitive about it...So I just try and pay attention...and I ask lots of questions...She spends extra time with me when she can...

and high responsibility:

> She taught me a lot about self-responsibility...She hasn't done much for me and I mean that in a positive way...She's pretty much left me alone...I feel like there's respect [since she thinks I'm] able to do things for myself...But I had expected that she'd be a lot more, you know, take charge...I feel like she has gained confidence in my ability to look after myself, too. I think she might be more directive with another person...I think in the beginning she was probably sizing me up, too, to figure out how clear I was about my own health direction...

Clients described their working relationships as <u>partners or alliances</u> when they perceived a strong bond and shared responsibility with the nurse. One client, at three

months, felt the bond had begun to form.

> Well, I'm more trusting, more sure after my talk with her yesterday...It seems like it's the beginning of a total working alliance--not like at first. We're beginning to work on something, I mean, [something other than] that crisis mode...There is kind of a meeting.

Identification and clarification of client goals had strengthened the bond initiated by trust.

The nurse who took little or no active part in the student-teacher relationship with high client responsibility could be perceived as a catalyst. Another client who had seen her nurse only twice but intended to return for intensive therapy spoke of anticipated work roles in their relationship:

> At this point she is--uh--the catalyst...I don't know where she will be [as I grow] and increase my self-actualization...I don't know where she will be, you know, what kind of role she'll have for me as I learn how to do these things myself...Cause I think one of the first priorities is to be able to take care of myself...

The clients and nurses assumed that the work roles were created with the intent to promote health and facilitate healing of the client. These implications are present in the examples presented. Clients expect health and healing that is physical, emotional, mental and spiritual and they seek nurses they believe can help them meet their goals. The work roles overlap and change as clients and nurses tackle various problems. The last example given was by a client who came to the nurse fearing she had leukemia. When

the diagnosis was ruled out medically, she began to plan a way to continue working with the nurse for spiritual growth and development. She felt that in certain areas of her life she would, at least temporarily, need more guidance. She perceived her spiritual growth as a major aspect of her health and healing.

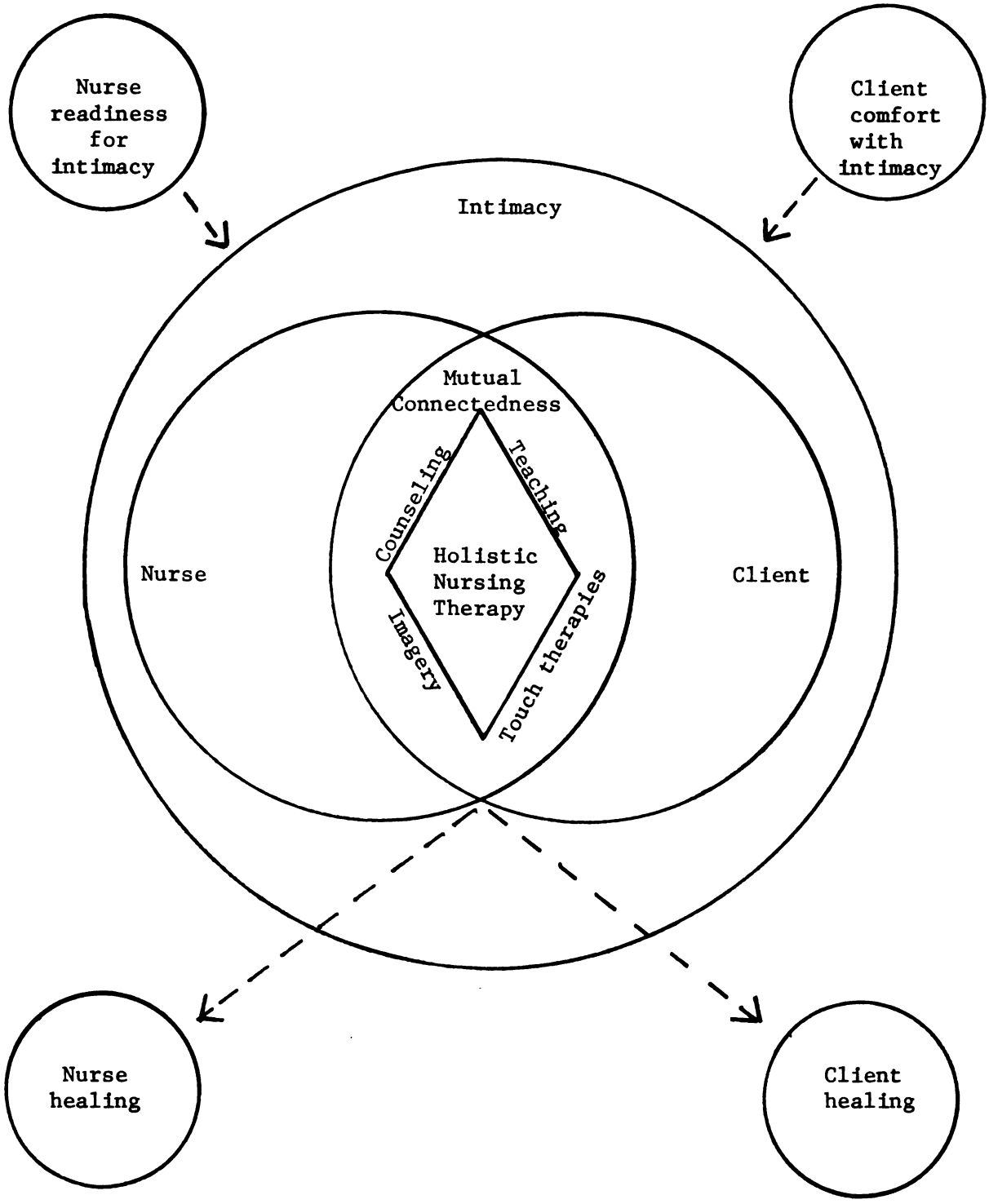
Holistic Nursing Therapy

Holistic nursing therapies are performed within a context of mutual connectedness See Figure 4.2, p. 155). The formation of work roles through intuitive knowing of each other guides the nurse as she performs her activities and are conditions of nursing therapy provided by mutual connectedness. In addition, nursing knowledge and skill is necessary for this work. Intuitive knowledge enhances nursing knowledge and skills acquired in academic and educational settings. Clients ask many questions about their medical situations, and nurses use their basic education to aid in assessment and care related to each client situation. Attention to attainment of knowledge and skill was evident in the extensive educational achievements of participating nurses, discussed in Section I. Nursing therapy includes the application of knowledge--both intuitive and cognitive--although knowledge and skills vary with education and experience.

Properties of holistic nursing therapies. All therapies used in holistic nursing are carried out to

Figure 4.2

Theory of Mutual Connectedness



The relationship of major categories are shown here.

release blocked energy and enhance energy patterns. They consist of pattern identification and pattern enhancement activities and processes. Beal (1971-72) introduced these concepts to field theory and they are applied here to holistic nursing. Pattern identification may be considered the assessment of holistic nursing and pattern enhancement the "non-intervention." Since there is no specific objective other than enhancement, the word "intervention" is an appropriate word to indicate enhancement of energy patterns (Newman, 1986).

Strategies for holistic nursing therapy. The specific skills used in holistic nursing practice include teaching, counseling, energy releasing touch therapies, and introduction of new patterns by the use of techniques such as visualization and positive affirmations as described in Chapter Two. These techniques are all categorized as "imagery" in this study since they involve the use of picturing the self in a different way.

Nursing therapies, for pattern identification and enhancement, are carried out to facilitate letting go or releasing physical, mental, emotional and spiritual energy, and to stimulate growth of healthier patterns. The skills of counseling, teaching and touch therapies are used for energy enhancement. Pattern identification is made by listening to clients talk and observing how they move and relate to others. Other means of diagnosing patterns are

determined by the touch therapy used, i.e., the area around the client in Therapeutic Touch, pulses in Jin Shin Jyutsu and acupressure, and muscle tension in massage. A nurse who used therapeutic touch stated that changes in mood were carefully observed during the treatment. Pattern identification includes diagnostic or assessment skills; and pattern enhancement involves both releasing blocked energy and introducing new images and potential patterns. Energy releasing therapies all included skills for both pattern identification and enhancement. One nurse had learned a variety of tools for pattern identification. She described how she combined intuitive and rational knowledge in the application of her skills:

> [I went to an] ayurvedic medicine class to learn to use the pulse diagnosis...And I look at their tongue. I use those type of tools just to get an idea as to what meridians are offset--So I have a structure when I first start and when I work on them [I get intuitive knowledge]--or it seems to strengthen. So I get a picture before I start [the treatment] and then...I learn more about them and it strengthens what I started with.

Another presented her view of nursing diagnosis related to pattern:

> I diagnose more on a psychological level--like their thought patterns...In a way I diagnose their thought patterns as to where their thoughts are blocking them and confusing them--or where there is an issue that seems to be repetitive. I see it in the way they speak to me...

Such diagnosis takes intense focus and attention or a keen sense of intuitive knowing. The nurses used meditation and

centering as a way to increase their sense of intuitive knowing.

A nurse who was able to see colors around and through persons used this ability to assess patterns related to the spiritual aspect:

> I work with color--And it's the color that comes off the spine...This color ray tells you specifically [about the purpose of the soul]. It gets me in touch with the soul...

Enhancement of pattern by the use of touch therapies to release blocked energy--physical, emotional, mental and spiritual--was described:

> I understand...that we're a flowing body of energy and that areas of the body where the energy isn't flowing--it's kind of stuck or blocked--and by applying the fingers to those areas--and if the person is ready--the energy will flow through that area...Those blocked areas begin to open or open up more...

An example involving nurse perception of blocked physical energy was:

> I kept perceiving a thick band of grey metal of something above this woman's pelvic area. Her presenting complaint was fibroids--uterine fibroids. I kept perceiving it, so I finally asked if I could do therapeutic touch...and she said "fine"...So I did...and it worked. It dissolved that thick band of stuck energy and her cramps went away.

Visualization and imagery were often used in addition to energy releasing therapies for pattern enhancement. One nurse stated that she did a visualization with imagery at the end of many sessions. She stated:

> I think most of the work I do now is like helping [my clients] to have a vision...a clear vision of what they want. [I] give [their vision] my personal blessing, a spiritual blessing of protection and purification...to

> release new energy and freedom...It's like "I see this for you. This is happening...It's yours." They need to feel that I see it for them as well as they see it for themselves...It's almost like a contract or tie.. They lead me to their vision and I lift it up a little bit and give it back to them--And then they can hold on to it.

Counseling, in combination with touch therapies to release and enhance energy patterns, was seen as particularly helpful and this nurse talked about her experience with counseling. She used an example from one of her clients:

> She talks, she cries, she grieves, because she has not been able to do that. She also has to let go of all the negative notions about what she is supposed to be and feel. She has to learn that God loves her and to let go of the idea that she has to be perfect to be loved...

Teaching was done to help clients learn how to identify and release harmful behavior patterns, and to introduce healthy patterns into their lives and to strengthen them. One nurse described her teaching framework as being from an evolutionary point of view--of progression to spirit:

> The teaching involves certain practical things around taking better care of their physical body--their nutrition, their emotions, their relationships--dealing with anything to do with emotion that would cause too much stress...But eventually the people will be guided towards becoming more detached [from emotions], more spiritual...

The behaviors taught by the nurses included those that would enhance by letting go of old patterns and taking on new ones.

Outcomes of nursing therapy. The aim of holistic nursing therapies is letting go of self-destructive patterns and introducing new patterns that promote health. The nurse guides the client in the process of letting go, and the client's responsibility is to do it. Letting go assumes release of a) physical tension from the body, b) emotional conflict and pain in relationships, c) mental attitudes that create negative thoughts about oneself and others, and d) spiritual frustration from attempting to control things that cannot be controlled. The accomplishment of letting go leads to deep physical relaxation, emotional detachment, mental peace, and spiritual surrender.

These changes usually occur over time although some instances were reported where clients had experienced rapid and dramatic changes. Client participants described letting go in a variety of ways as they worked with their nurses. Physical letting go was usually experienced first with relaxation of the body as the nurse proceeded with tough therapy. The experience described here was shared by most of the sample:

> I could feel parts of my body relaxing and beginning to flow from top to bottom. It was especially relaxing when she brushed from the knees down to the feet with light touches to the skin. My hyperactive feeling was gone and I was happy to sit in the old chair...I was limp and yawned several times. It was as if I'd switched into low gear suddenly...

and:

> I was so relaxed after the one hour treatment that I couldn't get up off the table for about ten minutes...I

> wasn't exhausted [in the second treatment] as I was feeling more like the pressure had been lifted off me and I felt rejuvenated.

Emotional release was the second most common experience of letting go. For some, forgiveness of self and of others resulted in some detachment from emotional pain. As one said: "It's forgiving myself and forgiving other people...I guess it's kind of an acceptance...But I'm more at peace with myself and with other people--"

A very common early experience of letting go emotionally involved crying and releasing of sadness, sometimes from many years past:

> It was like a dam had just burst because I guess I had been so uptight. And I just cried on her shoulders--And felt so much better...Then I realized that I hadn't let go--I had kept all this inside of me [most of my life].

and:

> When my husband died I cried once...And now it seems like I can't stop.

They also experienced letting go of beliefs about themselves they perceived to be limiting and self-destructive. A client who was highly educated in a very responsible position described the change in her self-concept:

> All my life I always felt insecure...and felt I had to find someone to take care of me...And now I guess I've established some self-confidence and am feeling better about myself...I just came to realize I just won't take [being putdown] any more...I never felt that I was equal--maybe I know more than [others] do in some areas...I mean this is a breakthrough! It's like getting a law degree on yourself.

The clients described the experience of letting go of all thoughts and consciousness of time--of feeling totally present in the moment--as spiritual in nature. One client described a state of physical, mental, and spiritual relaxation:

> I get so relaxed to the point that I don't think I breathe for a long period of time--And there is a sense that my mind is just really calm and relaxed. And I'm not thinking about different things. It's very pleasant to be that way, too...I think the most helpful thing I've gotten out of this is on a spiritual level rather than on a body level...I was just right there and not thinking about anything else, just totally conscious of what was in the moment--And that was remarkable.

Physical letting go manifests as deep relaxation, emotional as forgiveness and detachment, mental as changing beliefs and attitudes, and spiritual as surrender and giving up the attempt to control things that cannot be controlled. Health behavior patterns change as clients experience letting go in these various ways. For many of those in the study, physical relaxation was accompanied by lifestyle changes--notably be slowing down. Those who had practiced almost frenetic activity in their lives found ways to decrease their pace:

> I think the more treatments I have and the more calm, the more centered [I become]--there seems to be a stronger pole running through me that grounds me--that keeps me from going off and doing, you know, a thousand things...

Emotional letting go of old hurts was accompanied by changes in behavior toward family members, friends, and

fellow workers. Here is an example of behavior changes toward family members as a result of letting go:

> I'm not as judgmental...I was placing importance on things that just weren't necessary...I feel more accepting of my family and their frailties--just their human characteristics. It just wasn't necessary...Not worth being unhappy about...

Letting go of mental attitudes and beliefs about oneself also resulted in behavior change. This client drastically changed her behavior in relation to her co-workers when she realized her own self-worth:

> Before, I was very modest and humble, but now I really assert myself at work--And they look at me, "What happened to this woman?"...I just said to myself, "I'm not going to stay in my shell anymore. I'm gonna put myself out there." And I'm not shy anymore. I mean, there are times when I feel uncomfortable--but [I do it anyway].

Clients reported behavior change as they experienced letting go of old destructive patterns and created new ones conducive to health and healing. Modifications in health behavior reported by clients included changes in patterns of action, thinking, and feeling toward oneself and others. They reported changing many behaviors related to lifestyle. Positive health behavior change included diet, rest, exercise, fun time, change of pace, expression of feelings, ways of relating to friends and family and vocational choices. One client, after two years of indecision and loneliness, decided to return to her native homeland. They also reported frustration in their attempts to initiate health behavior change but, in general, their attitudes

regarding changes in their behavior indicated hope and encouragement. Only two clients who stopped seeing their nurse early in the study said they made no positive health behavior changes as a result of their experience with the nurse.

Healing

Healing was defined by the nurses as "self-transformation, a continuous life process moving one toward integration, harmony, and fulfillment of potential." It was seen as "a natural process guided by wisdom greater that one's own," and therefore spiritual in nature. It was considered "an evolutionary process that comes from within and manifests in an endless variety of ways."

Healing occurs through two basic processes, one by letting go of life patterns that limit growth and change, and the other by introducing new patterns to emerge over time. The healing process occurs in holistic nursing practice as the client experiences letting go and introducing new patterns. Healing is thought to occur naturally through inner processes.

Properties of healing. Time and unpredictability were addressed in the data in regard to healing. Clients varied in their acceptance of time related to healing processes. Acceptance ranged from a demand to be healed immediately to statements indicating willingness to work over an extended time--years if necessary. The client with chronic pain left

after two weeks because he could detect no change in the level of his pain. Three clients expressed concern to the investigator that they might not experience noticeable changes in their symptoms during the three month period. They expected the work to take longer and asked to be contacted again in a year to see if they had made changes.

Healing in holistic nursing is unpredictable in that it is inner-directed and not amenable to external control. Signs of healing were manifested in any number of ways. Although changes in symptoms were apparent in many situations presented by the participants, more changes were evident in other aspects of their lives. Both expected and unexpected changes did occur. Changes occurred quickly, slowly, and not at all. There were patterns of change, though, that emerged from the data, and these patterns form the theory presented here.

Outcome of the healing process. Holistic nurses proposed that healing outcomes are self-integration and self-transformation. Nurses look for signs of healing as their clients manifest the emergence of latent potential, creative expression os self, and the desire to serve society by helping others. The healing center provided opportunities for clients to help others as they heal and experience the need to help or serve others. Participating clients manifested healing in a wide variety of ways. They reported changes in a) presenting symptoms, b) energy levels

for daily activities, c) balance of emotions, d) attitudes in relationships with the self and others, and e) goals for personal growth. Symptoms did change in some way for most clients as described in Section I. Changes over the period included disappearance or decrease in intensity, duration and/or effect of symptoms on one's life. Some clients experienced a temporary increase in symptoms before a decrease. This phenomenon was frightening and upsetting to some while others regarded any change as positive since it represented movement of some kind. The persistent pounding sensation in the ear of one client became worse after the first treatment and then lessened somewhat although it did not disappear.

Clients who continued the work, either with the nurse or alone with her teaching, reported having increased energy for daily activities. One stated:

> [When I first saw her] it was hard to get out of bed--I just wanted to lay in bed until eleven or so if I didn't have to go somewhere. Now, at nine o'clock I just can't stand it. I gotta get up and get going... I have more energy and less fatigue.

Balancing of emotion is a sign of healing expected by holistic nurses and clients. A state of balance is one where the client's emotions vary with sadness and joy but there is a consistency that eliminates emotional swings which interfere with one's sense of well-being and productivity. The clients in this study who experienced emotional changes reported being "more in touch" with their

emotions and of releasing through crying. This experience was consistent with the assumption that release is necessary before a sense of emotional balance can occur. These clients had held back tears and grief for many years and needed time for this process.

Improved relationships were described by many clients and those changes were often considered more helpful than changes in their symptoms. A client who experienced many positive relationship changes--with her husband and her mother--was one of those who reported the greatest change in this area. She carefully applied the teachings of her nurse in her relationships, and as her family watched her make changes, they asked her to teach them. At the time of entry, she and her husband were considering divorce and she dreaded answering the phone--afraid it might be her mother. During the last interview, she reported that she and her husband were communicating, the divorce was off, and the relationship had made great improvement. She explained:

> I gave up my self feelings and tried to understand more what he was trying to tell me, then I started interacting a little bit better...And I think that's good--I have to pat myself on the back for that--because I think it's good growth...To be able to sit back and say "Well, I have to step out of myself here for a minute and see him and his needs and what he's actually trying to tell me is that he loves me..."

She also said there had been considerable changes in her relationship with her mother. She relayed this experience:

> My mother came down to see me. She hasn't visited me in years...She said, "I want to change...and I want your help to do it. I want your support." And I was

> just amazed...And when she left she asked me, "Why are you so different?"...Because I've been more loving with her and more responsive...

Another felt the experience of self-transformation in a powerful way:

> It certainly has helped me to feel much better about myself as a person...[Who I really am] is coming out--the child in me and all the spontaneity, femininity--everything that's me...I never believed in God before...I can take a deep breath--and just be. It's alright to be just me...I've never had that feeling...There is inner relaxation--peace--trusting--and liking myself.

Several clients fulfilled the nurses' statements that clients change their goals as they progress in the healing process. They had observed that whether symptoms continued or not, they become less problematic to the clients. Then, they begin to address other areas of concern in their lives. One who fulfilled this expectation as she moved from concern with her body and relationships to things of a more spiritual nature. She said, "It's like another layer, another level of well-being--rather than treating illness and dysfunction." Several spoke of their desire to pursue spiritual goals as they continued with the nurse. This client who had initially gone to the nurse because she wanted her body to be more flexible said:

> She introduced me to a sacred place in myself...I don't know what else to call it--Centered, calm, trusting--things are okay--I can talk about all these bothersome kinds of things, but I'm detached. I'm not nervous and anxious...I know how to be in the world now...and I know how to be in that sacred place...but not at the same time...I want to be more peaceful more of the time...both in my work and in my personal life.

The Hawthorne effect, the role that belief and expectation plays in perceived changes during research, must be considered in all these outcomes. Holistic thought, though provides no argument against the role of belief and expectation in health and healing. The role of consciousness, including belief, is considered important in any event. There is less concern in holistic scientific thought than in traditional science, then, for ruling out such influences. In fact, this effect known also as the placebo effect is considered support for the holistic paradigm. A client, though, expressed his concern that belief could be playing a role in his experience. He said:

> I feel like I've got more energy than I had before, but--[But when I] first get started on a regimen that I feel is going to benefit me--there is another period...when the change seems dramatic...That really makes me feel good for a while. And then it doesn't seem to be as dramatic a feeling of improvement--And I think part of that is belief--and part of it might just be getting used to a new state. It's hard to tell...

The role of belief or expectation most likely contributed to these results, although clients and nurses had many surprises as they experienced and observed the changes.

Summary

The Theory of Mutual Connectedness presents the conditions, context, strategies, and outcomes of holistic nursing as practiced in private settings. Intimacy, mutual connectedness, nursing therapy, and healing were identified as major categories. Each major category was analyzed in

relation to properties, conditions, strategies, and outcomes as they emerged from the data (See Table 4.9). In this theory, the nurse and the client hold parallel responsibilities throughout the interaction process, and both experience healing as an outcome of holistic practice (Figure 4.2).

Intimacy, a requirement for holistic nursing, occurs as a condition for mutual connectedness and encompasses the nature of the entire interaction. Mutual connectedness provides the context for holistic nursing therapy, and is dependent upon nurse attunement and the client decision to trust. Nursing therapy includes counseling, teaching, touch therapies, and imagery all for the purpose of enhancing energy patterns within the context of mutual connectedness. Patterns are enhanced as clients experience letting go and introduced new patterns in the form of images. Healing does not occur in direct response to outside intervention. It is an inner process that results in a sense of self-integration or self-transformation, and may or may not include physical changes.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

This dissertation was a study of private holistic nursing practice, and of the client-nurse interaction in that setting. Since the research was carried out to expand and refine theory previously formulated by the investigator (described in Chapter Two, Section II), discussion here includes the entire theory building process. Investigator conclusions related to holistic nursing in private practice are presented for consideration and discussion. Conclusions addressed involve a) social implications of holistic nursing practice, b) the process of inquiry, and c) implications for nursing practice, education and research.

Social Implications

Problems exist in the health care delivery system for both nurses and clients. Recent emphasis on caring as the motivator for nursing care places emphasis on the needs of both the caregiver and receiver. This section addresses the unmet needs of nurses, clients and of society by the traditional healthcare system, and the solutions offered by holistic nursing practice.

Nurses. Nurse participants indicated they looked to holistic nursing for opportunity to practice in health promotion and healing, and for their own personal health and healing. It seemed to them that nurses committed to the practice of caring often find themselves working in

situations where caring is difficult to practice. It is not that those outside nursing are uncaring, but that a complex set of forces operating in the health care delivery system emphasizes diagnosis and treatment of specific symptoms. Nurses function by responding to the demands of the institutions even though they may wonder what nursing theories taught in educational programs have to do with the "real world." Institutional jobs for the nurses seem far removed from nursing theories of caring, health promotion, and holistic healing. Nurses operate under time pressure, policies and protocols that leave caring as something to do after the real work--carrying out the physicians' orders--is done. Caring activities such as listening to someone in emotional or spiritual distress, giving a massage, or taking a moment to quiet oneself are not priority activities in hospital settings.

Nurses who are pressure, overwhelmed and exhausted, who are functioning in the midst of a nursing shortage, can scarcely be expected to be caring of others. They become intolerant of the patients in their care and of co-workers. The emotional environment, then, becomes more strained and the stress can be extreme. Nurses in this situation have resorted to chemical dependency, and have suffered chronic symptoms of disease and disorder.

Private holistic practice provides an opportunity to institute caring activities in a setting created by the

nurse. Nurses in such practices are autonomous and free to practice caring as they envision it. There are no institutional restrictions or demands other than the laws of the state and standards of the profession, which do support nursing practice as caring. These holistic nurses were found to hold the ideals of caring in high esteem for both themselves and their clients. Those in the study felt that being in holistic practice was the most caring thing they could do for themselves. They stated that watching clients make positive changes in their lives helped to give meaning and purpose to their own lives.

Clients. The client participants reflected on their feelings that in traditional health care systems, they felt discounted and disrespected. This feeling may have arisen because the focus of care is on the diseased part or disorder and not on the person as a whole. The health care delivery system was seen by both clients and nurses as responding in an uncaring way. While few would argue with the notion that medical care, the curing aspect, is a necessary component of the health care delivery system, they felt it lacked what nursing has to offer--the provision of a caring environment. Much of their suffering had resulted from lack of safety, nurturing, respect and beauty or order in institutional settings. They felt that lack in these areas interfered with healing. Many if the clients had suffered severe physical, emotional, and spiritual trauma in

"health care" institutions. The lack of caring had also impacted on family support systems to create further stress and disorder.

The clients in the study with symptoms had been diagnosed and were being treated medically. They had chosen to supplement their medical care with holistic nursing services. Their intention was to facilitate their healing processes since they believed that mental, emotional, and spiritual health determined, to a large degree, their physical health. Holistic treatment was to improve their health and prevent further illness.

Society. Lack of caring has not only affected individual persons and families, but has had an enormous impact on society as a whole. Examples include the burden of cost in treatment of disease and the prevalence of chronic disease and mental disorders. Traditional health care has often proven inadequate where chronic health problems and addictions are concerned.

Disillusionment with health care was responsible for the holistic health movement of the 1970's. Its impact has continued to influence many professionals and educational institutions throughout the 1980's. Client participants in the study were only able to obtain nursing services as they were able to pay or barter. Persons of other cultures turn to their cultural and ethnic healers for this kind of help. On the other hand, it seems that many persons have limited

knowledge of and access to holistic services since they are not usually included in mainstream healthcare.

Autonomous nursing functions--those that do not require a physician--are primarily related to health promotion, and are seldom funded by third party payment. Because of funding limitations and lack of health education opportunities, the clientele of private nursing practice is generally limited to the relatively privileged in society. Since neither holistic nursing services nor health promotion are currently valued in our society, individuals seeking this care must financially support it. Clients believe that efforts to maintain their health in safe and unintrustive ways would save the insurance company money; yet they can only get help if they became ill. Insurance pays for the most catastrophic and expensive interventions but no disease prevention, health or healing.

Since autonomous nursing services are not recognized presently for their social value, nurses in private holistic practice must strongly believe in what they are doing and be persistent. They have not undertaken an easy route to nursing practice. Despite limitations imposed by lack of financial support, holistic nurses have set up their own practices during the past 15 to 20 years. A "guesstimate" of the number of nurses in private holistic practice would be at least a thousand in the United States. A colleague has approximately one hundred names of nurses in such

practices--full and part-time. The two major holistic nurse organizations have a total membership of about twenty-five hundred members and it was estimated by a leader in the larger one that twenty-five percent of their membership is in private practice.

This beginning movement toward private practice by holistic nurses represents what one nurse referred to as either evolution or the beginning of a revolution. Success of holistic nursing practice will depend upon receptivity by members of society. If clients find these services helpful, they will influence others around them. Educational programs for potential clients to learn about health promotion and healing, as well as health promotion education for nurses will strengthen the potential of holistic nursing. It is, at least, a social movement involving nurses, and deserves close examination.

Process of Inquiry

Theory building related to this study has developed over a five year period. It began with an observational study of nursing practice in an acute psychiatric setting for children, and continued with pilot interviews with a holistic nurse and a sample of her clients. Further holistic nursing theory emerged from literature review and dialogue with colleagues. Pilot study interviews sparked interest when clients expressed intense emotion about their experiences. The experience of the client was perceived as

quite different in holistic practice than in traditional health care settings. Client perceptions of their own health and healing were considered the most valid indicators of outcome.

Choice of method. A quantitative study to determine cause and effect seemed to be inappropriate for a study of client outcomes in holistic practice, since specific outcomes could not be predicted, let alone measured. As Blumer (1959) noted, the study of human life calls for an infinite array of study variables. Health and healing is no exception. Further problems are presented in the study of human experience because there is no way to precisely measure many of these variables.

Data collection and analysis. The research questions asked in this study were designed to accumulate data of the nurses' and clients' experiences as they participated in holistic practice. Questions focused on description of the nurse's transition from traditional to private holistic practice, the ways holistic nursing is practiced in these settings, and the client's personal participatory experience and outcomes.

While the nurses were interviewed primarily to determine if their work met the criteria for holistic nursing practice established for the study, they were also questioned about their own related experiences. Clients were questioned about their direct experiences with the

nurse, and also about areas of their lives related to their health and health status. Data analysis was ongoing during this time and the client-nurse relationship emerged as the critical element in the client's experience. The investigator continued to gather data addressed by all the questions, but the emphasis on the relationship increased over the study period. The longitudinal element gave information regarding changes in thoughts and feelings about the relationship as well as changes related to health and healing. Perceptions of relationship changes were reflected from interview to interview.

The study design did not allow for theoretical sampling. Coding and analysis of the data determined changes in the questioning process but not in the selection of clients. The clients remained constant throughout the entire three month period. The clients, though, did present a wide range of experiences in their various situations. Although the nurses had reported that they saw people who were terminally ill or dying, there were none in the sample. It would have been interesting to have included such a client. Clients for this study, however, were recruited on their initial visit to the nurse to avoid potential bias by sampling those favorably responsive to holistic nursing by previous visits. The clients who dropped out of the relationship with the nurse continued to be interviewed.

Data analysis was ongoing during the interviewing

process. When the analysis moved to an emphasis on the client-nurse relationship, "interactional stories" were developed to study alignment of action. These stories reflected the clients perspective of the relationship over the three month period, and the nurse's description of her interactional stance. The interviews were further analyzed in the process of theoretical saturation. The "interactional stories" thus played an important part in theory development. Since the nurses were not interviewed about their relationships with the participating clients, the theory represents client perceptions and the interactional stance taken by the nurse as she described her practice prior to meeting the clients.

Results

Findings addressed the profile of nurses, clients and settings in holistic practice. Most of the profile issues related to aspects of social change and the theory of interaction more specifically to holistic nursing practice.

Holistic nursing profile. The profile supported the perspective that holistic nursing practice emerged as an aspect of the holistic health movement. The nurses who took part in those conferences and workshops considered nursing and holistic health ideologies to be similar in nature. In fact, it appeared to them that nursing was being addressed as holistic health. For those who believed nursing to be the promotion of health and facilitation of healing, the

conferences and seminars were addressing society's need for nursing. Health professionals of many disciplines provided leadership and participation in the meetings and nursing is only one of several professions that has continued to develop the ideas introduced at that time. Holistic medicine has developed branches known as behavioral medicine and psychoneuroimmunology. Nursing has begun to develop a knowledge base in health promotion; and the role of the holistic nurse has emerged. Private nursing practice has given holistic nurses a setting, and autonomous functions identified in some State Practice Acts including California, have led to emergence of this new role--the holistic nurse in private practice.

The business aspects of practice were difficult for most of the nurses. Nothing in their backgrounds prepared them to charge fees for services or to find new clients. Questions about these issues repeatedly revealed discomfort and conflict as the nurses discussed their concerns.

The clients in the study were also breaking new ground for themselves and for their families and friends. For all of them, holistic nursing was a new experience. They could be described as skeptical since many had reservations about holistic health practices. Yet, they felt something lacking in their traditional health care services. They wanted someone to care, to spend time with them, to answer their questions, and to see them as persons. Clients sought out

nurses who were known by themselves, their friends, or acquaintances, to be caring. When friends or acquaintances suggested a nurse in holistic practice who was caring, they went to see what it was like and they told others about their experiences.

Theory of interaction. The theory of Mutual Connectedness emerged from the experiences of the clients. It was consistent with therapeutic communication theory, yet was specific to the events that occur in the high intimacy client-nurse relationship of holistic nursing practice. Mutual connectedness, the core category, represents the formation of the therapeutic relationship. Mutual connectedness occurred as the nurse and client experience intimacy, or getting to know each other. The outcome was letting go and healing. There was alignment of action representing client and nurse responsibility at each phase of the interaction.

Implications for Nursing Practice

The findings of this study have implications for nursing practice, education and research. This section addresses each of these facets of nursing.

Nursing Practice

The development of a nursing-based grounded theory is created to explain certain phenomena related to holistic nursing practice. Holistic nurses who practice from this perspective will find theoretical guidance from this

emerging theory. This study addresses caring in clinical practice as care for a) oneself, b) the client, and c) the environmental context, for the purpose of health promotion and healing.

Caring for oneself in nursing. The health of the nurse--in all its dimensions--is paramount in holistic practice. Nurses in the study recognized the importance of their own health behaviors not only to their own well-being, but as role models for their clients. Personal growth through self-awareness guided the nurses in their health and healing processes.

Nurses in the study placed much emphasis on their own spiritual development as a basis for the client-nurse relationship in holistic practice. This emphasis on personal growth is consistent with Mayeroff's (1971) observation that only persons who are able to care for themselves can care for others.

The nurses considered their work to be very spiritual in nature and maintained their own spiritual practices to facilitate spiritual health and healing in their lives. Spiritual health is seen to be related to one's sense of purpose and life meaning. The nurse may find it difficult to address spiritual issues with a client if she has not conducted her own spiritual search and found her own peace.

Caring for the client. Mutual connectedness, the coming together through attunement and trust, emerged in

this study as the primary tool for nursing practice. This perspective is supported by other nursing theories of interaction (Peplau, 1952).

Caring in holistic nursing involves knowing on a very deep and personal basis. Since intimacy is a requirement in the holistic nursing relationship, it is a major issue in clinical practice. Health and healing involve the most intimate aspects of being and, in holistic nursing, occur at several levels--physical, emotional, mental and spiritual. When the clients first meet their nurses, they have not decided whether to trust them and may be skeptical about the unfamiliar methods used. The initial visits were described as especially difficult. Some clients did not return because they were unable to resolve their discomfort. Those who did return had to decide on an ongoing basis whether to trust and allow themselves to be known on a deep and intimate level.

The nurses seemed to take intimacy for granted and did not mention it in their interviews, except to acknowledge the privilege of sharing such an intimate relationship with someone. The preparatory behaviors described, though, indicated that they prepared carefully for intimacy. They realized that the client had to feel safe and comfortable so they could relax and let go of their tensions and fears. Yet, they did not seem to realize how the experience of intimacy affected their clients.

Interviews of clients revealed situations they perceived as caring or non-caring. They had perceptions of non-caring when the nurse was not attending fully, when she was distracted, when her needs for ego-fulfillment interfered, and when her fears of incompetence took over. Clients, even when they said they understood why the nurse was distracted by what was happening, perceived the nurse as not caring at these times. Perceived vulnerability may increase with intimacy in the client-nurse relationship. In that case, nurse sensitivity to the client had to also increase with intimacy.

Mutual connectedness in holistic nursing relationship is one of intimacy and shared closeness. It is spiritual in nature and is based on deep caring for the self and other. In his book, The I and Thou, Martin Buber (1937) discussed the spiritual nature of such relationships. He said that spiritual relationships have no concern with time practicalities, differences of status or role, or concern with consequences. He described the mutual experience of speaking to one another without holding back or pretending.

Carl Rogers (1955) also described this relationship as he addressed the spiritual union of therapist and client:

> I let myself go into the immediacy of the relationship where it is my total organism which takes over and is sensitive to the relationship, not simply my consciousness...The essence of some of the deepest parts of therapy seems to be unity of experiencing. The client is freely able to experience his feeling in its complete intensity...and I am able with equal freedom to

> experience my understanding of this feeling, without any type of diagnostic or analytic understanding. When there is this complete unity, singleness, fullness of experiencing in the relationship, then it acquires the 'out-of-this-world' quality...from which the client and I emerge at the end of the hour, as if from a deep well or tunnel. In these moments, there is...a timeless living in the experience which is between the client and me. It is at the opposite pole from seeing the client, or myself, as an object. It is the height of personal subjectivity (pp. 268-69).

Sensitivity and intuition acquired in this closest of relationships guides the formation of work roles, application of nursing knowledge, and skill in holistic practice.

The work of holistic nursing, while highly spiritual in nature, is not religious and does not follow any doctrine. This poses difficulty since people tend to confuse spirituality with religion. In the attempt to protect religious freedom in this society, there is hesitance to address spiritual issues. Nurses in traditional practice tend to ignore spiritual matters except to determine religious beliefs and refer patients to their particular clergy. Yet, support of the client's efforts to explore his or her own spiritual path is an important aspect of holistic nursing. Nurses, then, must be comfortable with their own spiritual development and to be able to provide their clients with spiritual guidance. It seems to this writer that it would be highly disrespectful to direct the client to a specific religion or spiritual path, yet encouragement

in the search for meaning and purpose is often necessary. The works of theologian-philosophers from Western cultures offer a breadth of spiritual perspectives (Buber, 1937; Teillard de Chardin, 1955). Eastern philosophers also provide such knowledge. Nurse participants recommended books consistent with client beliefs as basic tools for spiritual development. Many recommended meditation and prayer for health and healing.

Implications for Nursing Education

Nursing education has a tremendous challenge since all nurses deal with clients around basic life processes. These processes are not only very complex, but very intimate and private in nature.

Education provided for holistic practice. Contemporary schools of nursing interested in promoting holistic nursing practice do prepare students with skills related to communication, teaching and learning, the therapeutic use of self, and touch therapies (at least some massage). Since the nurses in the study were lacking in areas they needed in private holistic practice, they had obtained the additional education necessary outside of academic degree programs. Continuing education had been helpful as they learned touch therapy skills and other holistically oriented techniques for health and healing.

Education lacking for holistic practice. Nurse participants stated that they needed counseling education

beyond that of their basic academic education. Several of the nurses in the study had sought extensive education for counseling beyond that required for entry to practice. Those who had not done this additional work felt a deficit in their backgrounds. The experiences of the clients supported the need for nurse comfort with basic counseling skills. Even when the nurses had extensive preparation for counseling, the clients felt at times that their problems were handled insensitively. The close and intimate nature of the relationship seemed to emphasize sensitivity of the client and magnifies the need for the nurses to have good counseling skills.

At present, education for counseling skills receive inadequate attention in nursing schools for holistic practice. Most nurses do not receive much training in counseling other than basic communication required in psychiatric nursing. They are ill-prepared to deal with issues related to trust and the fear of intimacy.

One approach to preparation for counseling comes from psychosynthesis (Assagioli, 1977), an approach used by some psychotherapists, to integrate body, mind emotions and spirit. Cramptom (1974) in an exploration of the use of imagery in psychotherapy, described what is called mutual connectedness in this study and discussed the creation of a `psychic field' between two people. This field serves as a medium for evolution of consciousness in both person (p.

35). He stated that meaningful growth is taking place for both--that growth is not a one-sided process in such relationships. The perspective of psychosynthesis fits well within the holistic nursing perspective and is suggested as one educational approach for counseling in holistic nursing.

Personal development and role modeling of good health behaviors are also lacking in many educational programs. Education for helping with spiritual issues related to life meaning and purpose, and the nature of life is also missing in many school programs. Education in psychosynthesis would satisfy these needs for knowledge of the spiritual nature of persons as well as counseling, since the student would be working with integration of his or her own body, mind, emotions and spirit.

Other private holistic nursing issues missing from nursing education are related to business management skills. Lack of understanding about business--entrepreneurship, money issues, and marketing--presented serious problems to the nurses. They, in general, had neither academic or continuing education regarding business issues. It was obvious that nurses in private holistic practice need education for business management.

Suggestions for a holistic practice curriculum. An undergraduate curriculum in holistic nursing would assure that graduates have skills in basic counseling and in at least one touch therapy. Nursing concepts such as caring,

health and healing, leadership and management, research and theory, personal and professional development, and philosophy are also needed. The course in philosophy should specifically provide a broad spiritual perspective to encourage students in their own spiritual growth and promote understanding of spiritual health. These concepts could provide a basic foundation for holistic nursing and prepare them to use holistic therapies in a variety of settings.

Master's level education could add advanced level skills in all the above areas, creating a holistic nurse specialist. A counseling laboratory where students would be observed and provided feedback by instructors and colleagues would be very helpful. Caring through entrepreneurship and business management could be explored as a part of the leadership and management concept.

A nursing clinic on campus could provide an opportunity to the students, to the campus and the local community while educating students and the public about the potential of nursing. Through the use of autonomous nursing functions, they could provide counseling, teaching and touch therapies in an environment conducive to health promotion and healing.

Doctoral level preparation would provide preparation for leadership in research, theory development for accumulation of knowledge and education.

Certification. At present there are no educational standards for holistic nurses. Through the certification

process, standards could be created and maintained. A recommendation for the future is that a certified holistic health nurse be one with a Master's degree in holistic nursing (or at least a closely related field), and a required number of supervised hours by a nurse certified as a holistic nurse or as a mental health-psychiatric nurse. Carefully selected nurses with similar qualifications currently in holistic practice could, initially, serve as clinical preceptors.

Conclusions. Certification of qualified holistic nurses could serve as recognition within the profession. Reimbursement through third party payment programs of private insurance, Medicaid, and Medicare could serve the nurses and the public. Certified holistic nurses could refer clients to other holistic nurses for specific therapies needed by the client. These nurses would monitor the system and, therefore, nurses would be in charge of nursing. Actually, third party payment could require that clients be referred to a physician by a qualified holistic nurse. Nurse-run community centers to help people be healthy and to heal themselves could move this society toward an orientation of health rather than disease.

Social rewards could, then, include a) trust by society of the nursing profession to control its own practice, b) recognition of the value of nursing by giving status, and c) reimbursement for services commensurate with worth.

Implications for Nursing Research

The study presented fits well within nursing theory and research related to caring, but some aspects of practice do not fit well with traditional science and medicine. Caring, teaching and counseling within an environment that is safe, respectful, nurturing, orderly and aesthetically pleasing fits easily within accepted paradigms for nursing. Touch therapies can also be accepted as conducive to health and healing since experimental research has substantiated the physical and emotional need for touch in all animals, including humans (Mantagu, 1978). The need for relaxation, for release, and letting go has also been substantiated in biofeedback and psychophysiological research (Ornstein & Sobel, 1987).

Caring research. Caring, considered by many nurse theorists to be the essence of nursing, is difficult to study in institutional settings ill-equipped for caring. Decisions imposed by structures outside the control of nursing limit the nurse's freedom to practice caring behaviors in such settings. Holistic nursing practice in private settings, however, allows opportunity to examine caring behaviors and processes. Since there is little opportunity to practice such a philosophy of caring in nursing practice within institutional settings, private practice may, in fact, be the only way. Research to determine how much caring can be practiced by nurses in

institutions would be helpful.

This study indicates that caring research must seek knowledge related to fear of intimacy and other related issues. Emotional intimacy has been addressed in the psychological and counseling literature. Physical intimacy has only been studied as it relates to sexual intimacy (revealed by a library search) and to touching (Montagu, 1978). Since holistic nursing practice involves intimacy under varying conditions in all four domains--physical, emotional, mental and spiritual--it is a context where intimacy can be explored in caring relationships.

Holistic nursing practice research. Private holistic practice has not been studied prior to this time, although there have been many studies to determine the effects of touch therapies on various conditions. There have also been studies of nurses who practice holistic therapies (Lionberger, 1985).

Investigator bias was a concern throughout this study of holistic practice since the researcher is a holistic nurse and identifies with the nurse participants. She, too, was a part of the holistic health movement, has taught holistic concepts for years, and participated in holistic practice. Deep interest in these practices and a strong belief in the need for research in the area stimulated the selection of questions for study. It is very difficult, however, to distance oneself from one's own area of

practice. Scientific objectivity is threatened because of preset ideas of the investigator. The use of qualitative method further threatens objectivity because the investigator brings her own background experience and knowledge to the analysis of the data and theory building process. The nurses knew the investigator, either directly or indirectly. They knew she was a holistic nurse and often stated in response to the questions, that the investigator knew these things without asking. The clients were not told the investigator was a holistic nurse, but several seemed to make that assumption.

The standards of rigor held by Sandelowski (1986) for qualitative research were relevant to this study. Credibility, fittingness, auditability and confirmability may be applied to this study. According to these standards, the validity of this study can be tested as clients and nurses verify the experiences described. Three holistic nurse readers have verified the theory at this time. No clients have been given opportunity. An auditable decision trail is in place. Sandelowski (1986) stated that the investigator-subject relationship both facilitates and threatens credibility. This was especially true in this situation because participants apparently felt free to share their feelings but may have been influenced in some situations by what they perceived was investigator bias. The results of this study are not considered generalizable

to any other population and are only confirmable as clients and nurses recognize their own experience.

Every effort was made to maintain a neutral stance in the interviews, to follow procedure as planned, and to treat the data according to the precepts of grounded theory. Nurse colleagues not associated with holistic thought or practice participated in the analysis and derivation of theory from the interviews.

Healing. Healing--as the outcome of holistic nursing practice for both the client and the nurse--is a concept which has been missing from the literature of the "healing professions until recently" (Carlson & Shield, 1989). Holistic nursing proposes that the aim of nursing practice is not only the promotion of health, but the facilitation of healing. Traditional nursing has worked long and hard with physicians to cure--the aim of medicine. A knowledge base related to creating environments conducive to health and healing could also be developed. Healing has not been addressed in the nursing literature except as it applies to wounds or restoration of a specific body part. Although health has been defined by the World Health Organization to address the whole person, healing has not been addressed as a life process in the health profession literature.

Perhaps the theory and research literature related to stress is basic to an understanding of healing. The relationship of stress to disorder and disease, and

modification of stress by coping mechanisms has been studied (Selye, 1956; Lazarus, 1977; Cohen, 1987). A body of knowledge related to release of stress through coping strategies is being developed in behavioral medicine research. A related body of knowledge is also emerging from medicine and psychology as psychoneuroimmunology. Nursing theory might benefit by such research to strengthen knowledge of health promotion and healing. It appears to this writer that nursing has waited again for medicine to take the lead in the search of knowledge of health and healing. Nursing holds the responsibility to society for promotion of health and facilitation of healing just as medicine has the responsibility for diagnosis and treatment of disease. Nursing, as caring, has the tools--the knowledge and skills--to form a partnership with medicine to balance the medically oriented system with ways to promote health and facilitate healing.

Health. For now, there are no measurable constructs for total health or holistic healing except for client perception. Perception is being used in health promotion research and was used in this study to determine client outcomes. Healing outcomes for such an approach to nursing practice are limitless and very complex. Outcomes were discussed by the clients in terms of feeling response to practice, changes in symptoms, attitudes, behaviors, effect on others and many other aspects of life. The responses

were as varied as the clients within the dynamic flow of their lives. The practices of the nurses were just as varied and unique to each person and situation. Swanson & Chenitz (1982) may have considered such a setting and outcomes when they stated that "the more reduced, measurable and clear cut the variable, the less we are able to generalize the findings to the empirical world" (p. 241).

Energy patterns. Basic research related to concepts of energy patterns is also needed. The notion of blocked energy patterns of meridians and chakras is a foreign one to the scientific world. Yet, there are those working with these ideas of reality.

The perspective of Peper & Kunz (1987) is that humans are local concentrations of energy within a universal field. Kunz's knowledge comes from metaphysics and the ability to see energy patterns as color. (This view is also consistent with the science of holism discussed in CHapter One). They described four dimensions of the energy field in addition to the body--the vital field close to the body, the emotional field extending 18-48 inches, the mental field which interpenetrates all the others, and the intuitional field which permeates the entire universe. Hiroshi Motoyama (1975, 1976), in Tokyo during the 1970's, developed technology to measure the activity of energy centers. He created a computerized electronic sensor which sent a small D.C. pulse through a meridian on a person, and then with a

high speed computer printed out an analysis of the level of function of the corresponding organs in the body (Meek, 1977). He traced the meridians with the use of liquid crystal on the body. The meridians reflected a greenish color and were almost identical in placement to what had been known in Eastern medicine for thousands of years.

The work of brain scientist, Karl Pribram (1971, 1987), involved an empirical base and logical positivist thinking to build theory of neuronal activity in overall brain functioning. He saw the brain not only as the seat of consciousness, but the structural link between the energy patterns of the person and that of the entire universe. His work has provided a strong empirical base in laboratory data with holistic theoretical interpretation of measurable events. His work, while interesting and exciting, can only lend ideas of how caring affects brain functioning. Brain functioning is known, though to govern healing processes (Orstein & Sobel, 1987). Eventually, the work of scientists such as Motoyama and Pribram may serve as foundational science for nursing. Perhaps there will be measurable evidence of caring and its impact on the client's pattern of energy.

Future Research

Future research could be done replicating this study with nurses who have advanced academic work in counseling, and who actively combine counseling and touch therapies.

This study could help to determine if more education in counseling would make a difference in the nature of client experience around issues of intimacy.

Participating clients who have continued to work with their nurses over the past year could also be interviewed again to see what changes have been perceived over this longer period. This data might further understanding of the nature of healing.

The comparison of two groups of clients with a similar disorders and treatment regimens, one with just counseling and teaching, and the other with touch therapy added to counseling and teaching, could perhaps determine if the touch therapies do make a significant difference.

Further qualitative research would continue to explore the experience of healing in holistic practice. It would be most desireable for a neutral investigator to do such a study. Lacking such a person, those interested in such exploration should build safeguards into their studies to avoid investigator bias as much as possible, and to use collegial involvement. It would be most helpful to use a neutral interviewer, if possible.

A qualitative study of the social conflict underlying holistic nursing practice could aid understanding of the nurse and client experience. This conflict seemed to be a major theme for all those involved throughout the study. Exploration of issues related to the social phenomenon of

holistic nursing could provide knowledge and understanding.

Quantitative studies might also be done to address certain questions related to specific changes in symptoms or disease. Multiple regression statistics could be applied to determine the degree of change in a dependent variable as a variety of energy releasing techniques are applied. Perhaps a very large sample could determine patterns of change in symptoms. The patterns of healing, unique to the individual, though, seem to indicate that quantitative experimental design studies can not be used appropriately unless one is looking for a specific outcome that is measurable in some way. Research related to the experience of holistic healing must allow for a limitless number of outcomes, most of which cannot be measured.

Summary and Conclusions

A perceived lack of caring in mainstream healthcare has placed emphasis on the need for caring in nursing promotion of health and facilitation of healing. Holistic nursing in private practice affords opportunity to study many aspects of caring in the therapeutic relationship. Research related to many dimensions of health and healing necessary for nursing knowledge may be gained in these setting. This study, descriptive and exploratory in nature, provides only a glance at many issues needing further exploration and examination.

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Appendix A

University of California San Francisco
Consent of Holistic Nurse
to Participate in Study

Purpose and Background

Phyllis Schubert, a doctoral student in the Department of Mental Health, Community and Administrative Nursing at UCSF is doing a study of holistic nursing practice and the experience of clients in that setting over a three month period. I am being asked to participate in that study.

Procedure

If I agree to be in the study, the following will occur:

1. I will be asked to complete a questionnaire about myself in connection with my nursing practice. This questionnaire is attached to this consent form.

2. I will be asked to be interviewed by Ms. Schubert to answer questions about my professional academic and work background, and personal interests that led me to private practice in holistic nursing. Questions will also be asked about the practice to determine if it meets the criteria for this particular study, i.e., "Is there emphasis on health teaching? Counseling? Energy releasing therapies? Environment?

3. If I agree, audiotapes will be made of this interview.

4. I will be asked to tell my new clients, on their first visit with me, of the invitation to participate in this research, to give the "Consent of Client" to them (but not to obtain consent), and to ask their permission for me to give their name and phone number to Ms. Schubert who will contact them. I will be asked to present Ms. Schubert only as a nurse researcher interested in client experience with holistic nursing practice.

Risk/Discomforts

I may feel uncomfortable or upset answering some of the questions, but I am free to decline to answer any questions I don't wish to, or to stop the interview or participate at any time.

Confidentiality: Study records will be kept as confidential as is possible. No individual identities will be used in any reports or publications resulting from the study. Interview content will be identified only by a number code with all names and places eliminated. It will be shared only with a transcriber, the faculty committee and a small group of professional colleagues involved in analysis. Tapes will be erased following transcription, and the latter kept in a locked file.

Benefits

There will be no direct benefit to me from participating in this study. The anticipated benefit of the study is to gain knowledge of what helps persons to heal and become healthier. It is anticipated that theory development for the practice of health promotion will emerge through analysis of this data.

Alternatives

I understand that I am free to choose not to participate in this study.

Costs

There will be no costs to me as a result of taking part in this study.

Reimbursement

There will be no reimbursement of money for my participation in this study.

Questions

I have talked to Ms. Schubert about this study, and have had my questions answered. If I have any further questions, I may call her at (415) 334-4726, or write her at 151 Marietta Drive, San Francisco, CA 94127.

If I have any questions or comments about participation in this study, I should first talk with the investigator. If for some reason, I do not wish to do this, I may contact the Committee on Human Research, which is concerned with protection of volunteers in research projects. I may reach the Committee office between 8:00 AM and 5:00 pm, Monday to Friday, by calling (415) 476-1814, or by writing to the Committee on Human Research, Suite 11, Laurel Heights Campus, Box 0616, University of California San Francisco, CA 94143.

Consent

I have been given a copy of this consent form to keep. PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study, or to withdraw from it at any point. My decision as to whether or not to participate in this study will have no influence on my present or future status as a patient, student or employee at UCSF or anywhere.

_____ _____

Date Participant's Signature

Appendix B

Questions for the Holistic Nurse

Here are some specific questions for you to answer prior to the interview with Ms. Schubert, if possible. You may use very brief answers as you will have opportunity to discuss them fully at that time. These questions will help to provide a demographic picture of the nurses involved in this study. If any of the questions feel uncomfortable to you, simply do not answer them.

About your practice

1. How long have you been a holistic nurse in private practice?
2. What services do you provide?
3. How many clients do you usually see per week?
4. What is your fee?
5. Any special concerns or problems with having a private practice?

About your education and training

1. What academic degrees do you hold? From where? When?
2. Certifications and special training?
3. Other educational programs and projects?

About your work experience

1. How long have you been a nurse?
2. In what areas of nursing have you worked and for how long?

About your personal history as it contributes to your practice

1. How old are you or what decade of life?
2. Male or female?
3. Where did you grow up and go to school?
4. What have been your special interests?

Appendix C

Interview Guide for Holistic Nurse Practitioners

1. You have answered specific questions about yourself as a holistic nurse and about your practice on the form I gave you. Could you now tell me what interests and experiences led you into private holistic nursing practice?

2. My next questions concern the emphasis of your practice. Please tell me about any health teaching that you incorporate.

   Do you include counseling? In what way?

   What therapies or treatments do you incorporate?

   What, if any, emphasis do you place on environment, on providing a place that promotes health and healing, and on your relationship with the client as a part of the environment?

3. Would you describe and explain your view of health?

4. Your responses indicate that your practice does (or does not) meet the criteria needed for this particular study. (If the nurse agrees and meets the criteria, I will provide coaching for introducing clients to the study, discuss the project and answer questions.)

Appendix D

University of California San Francisco
Consent of Client to Participate in Research Study

Purpose and Background

Phyllis Schubert, a doctoral student in the Department of Mental Health, Community and Administrative Nursing at UCSF, is doing a study of holistic nursing practice and the experiences of clients in that setting over a three month period. I am being asked to participate in that study.

Procedures

If I agree to be in the study, the following will occur:

1. I will be asked to complete a questionnaire about myself. This questionnaire is attached to this consent form.

2. I will be asked to talk with Ms. Schubert about my health background, changes in health status, and my experiences with the nurse I am seeing now. I will talk with her within two weeks of first seeing the nurse, then again in six weeks, and again in three months. These conversations will be scheduled at a time and place convenient for me and will take about one hour each.

3. If I agree, audiotapes will be made of the conversations.

Risks/Discomforts

I may feel uncomfortable or upset answering some of the questions, but I am free to decline to answer any questions I don't wish to, or stop the interview at any time. Confidentiality: Study records will be kept as confidential as possible. No individual identities will be used in any reports or publications resulting from the study. Interview content will be identified only by a number code with all names and places eliminated. Content will be shared only with a transcriber, the faculty committee and a small group of professional colleagues involved in analysis. Tapes will be erased following transcription, and the latter kept in a locked file.

Benefits

There will be no direct benefit to me from participating in this study. The anticipated benefit of the study is to gain knowledge of how nurses can promote health and healing in their clients.

Alternatives

I understand that I am free to choose not to participate in this study.

Costs

There will be no costs to me as a result of taking part in this study.

Reimbursement

There will be no reimbursement of money for my participation in this study.

Questions

I have talked to Ms. Schubert about this study, and have had my questions answered. If I have any further questions, I may call her at (707) 823-6919, or write her at 3710 Hicks Road, Sebastopol, CA 95472.

If I have any questions or comments about participation in this study, I should first talk with the investigator. If for some reason, I do not wish to do this, I may contact the Committee on Human Research, which is concerned with protection of volunteers in research projects. I may reach the Committee office between 8:00 AM and 5:00 PM, Monday to Friday, by calling (415) 476-1814, or by writing to the Committee on Human Research, Suite 11, Laurel Heights Campus, Box 0616, University of California San Francisco, CA 94143.

Consent

I have been given a copy of this consent form to keep. PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study, or to withdraw from it at any point. My decision as to whether or not to participate in this study will have no influence on my present or future status as a patient, student or employee at UCSF or anywhere.

_____ _____

Date Participant's Signature

Appendix E

Questions for the Client

Here are some specific questions for you, as client of a holistic nurse practitioner. Please give brief answers as you will have opportunity to talk more about them when we meet. These questions will help to provide a demographic picture of the clients involved in this study. Please take a moment to complete this form before the interview if you can. If any of the questions feel uncomfortable to you, simply do not answer them.

Health History

1. Are you seeing the holistic nurse practitioner (HNP) for a specific concern? What is your immediate, presenting problem?

2. Are you seeing anyone for health care in addition to the HNP?

3. What health concerns have you had in the past? Any hospitalizations?

4. What type of health care did you get for those problems?

5. How did you learn about this HNP?

6. Do you have medical insurance coverage to help with the expense of seeing the nurse? Is the expense a problem to you?

7. What would you say is your number 1 health problem?

Family, Cultural and Social Background

1. Does your family or cultural background include beliefs and practices similar to those of the HNP?

2. Do you have family members? Give sex, ages, and location. Do any of them or someone else live with you?

3. Are you a part of a family or social group?

Education, Vocation and Special Interests

1. Did you complete elementary school? High school? Attend college? Degrees completed? Vocational school? Special programs?

2. What kinds of work have you done and are you working now?

3. What are your hobbies and special interests?

Sex Male or female?

Age Decade of life?

Appendix F

Guide for Client Interview Number One

1. Let's review the things you have written on the questionnaire. (Will discuss these areas of interest and concern to the client.)

2. You have answered specific questions about yourself and about your concerns as you begin your relationship with the holistic nurse. Can you now tell me what you feel are the problems to your health and how you thing the nurse can help you? What have you been doing for the problem?

3. What made you decide to go to an holistic nurse? How did you find this person?

4. Since you have already seen the holistic nurse at least once, I'd like to hear how that went. What did she do? What did you do? How was it for you? What seemed helpful? What did not seem helpful? Have you made or felt any changes in your health or life for better or worse? Or are things still the same?

5. How would you describe your relationship with the nurse at this point?

6. Do you plan to continue seeing the holistic nurse?

7. Have you discussed your current client status with anyone other than the nurse? Have you told your family and friends? How do they feel about your seeing the the holistic nurse for your health care?

8. Since everyone's view of health and healing seems to be unique to themselves, would you please give me your view of health? and of healing?

Appendix G

Guide for Client Interviews Two & Three

1. It has now been at least one month (or two months) since I last spoke with you. Please tell me if there have been any changes in your health status or in your life since that time.

2. Please tell me if you are still seeing the holistic nurse and how that is going for you. What is she doing that seems helpful? What is she doing that does not seem helpful? Is it what you expected?

3. Have you made any changes in your lifestyle during this time? If so, what changes? If not, what do you think is the reason?

4. How would you describe your relationship with the HNP over the past month (or three months)? Any changes over time? Please describe. How would you like your relationship to be? Do you think your relationship is helpful or not helpful? In what way? How would you change it to make it more helpful to you?

5. Have you told your family and friends what you are doing with the holistic nurse? How do they feel at this time about your going to the holistic nurse for care?

6. Has your views on health and healing changed since you started with the holistic nurse?

7. What is the best part of going to the holistic nurse for health care?

8. What are the problems?