Healing Ourselves, Healing Others

First in a Series

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The healing role of nurses has been undervalued and undeveloped for a long time. A literature review of nurses and healing reveals the fears and frustration generations of women healers and nurses experienced as they strived to practice their art. The current nursing shortage reflects the toxicity of the nursing work environment. The satisfaction and liberation of nurses who have found ways to practice their calling also emerges, giving hope to those in the field as well as their patients. The first in a series, this literature review served as the foundation for a qualitative study entitled, "Medical-Surgical Nurses' Self-Perceptions as Healers," which will appear in the next issue of Holistic Nursing Practice. KEY WORDS: CAM, ERAs of medicine healing environments, healing paradigms, holism, nurse healer, relationship and caring connection, spirituality and healing, wounded healer


There are approximately 2.5 million registered nurses in the United States, yet there is a shortage in the workforce that is projected to worsen over the next decade. Recent scrutiny of the nursing workforce yields a multifaceted explanation for this shortage, including nurses feeling undervalued, dissatisfaction with salary, frustration with working conditions, and treatment by senior-level healthcare leaders. Quinn views nurses as an endangered species who reflect the toxicity of the healthcare environment, which affects those who work in the environment as well as those in need of care.

Historically, nurses have often been a primary target for manipulation, and even elimination, when the economic stability of the healthcare market is threatened. Only a few years ago, nursing staff numbers were cut drastically in most hospital settings, and unlicensed assistant personnel were slated to take over many aspects of patient care. Nurses tried to warn those in charge that this patient care delivery model would not work, but nursing’s collective voice was not heard. These events left nurses feeling undervalued, frustrated, and concerned with what they view as the erosion of care.

Watson poignantly shared her perspective in Postmodern Nursing and Beyond:

My pain is witnessing mainstream, institutional nursing trying so hard and yet being so defeated by institutional oppression . . . . Nursing struggles both within its inner self and within the outer world; it does not know or is not able to grasp, experience, witness, or create its own power . . . . It continues to struggle in its attempts . . . to be heard, seen, and valued for its strength and its worldview of possibilities.

This experience is not new. It is well documented that the roles of nurses within the healthcare team have never been fully understood or valued. The often confused and conflicted image of the nursing profession is closely linked with dichotomous roots as disreputable women and saintly figures. With the work of Kalisch and Kalisch, it became clear that media portrayals of nurses have been misleading, and not necessarily reflective of the intelligence required for nursing. Aspects of nursing pertaining to autonomy, sophistication, and complexity of roles have not been evident, perpetuating stereotypical images and contributing to the devaluing of the profession.

The fact that an overwhelming majority of nurses are female has also affected the struggle for an accurate and clear identity. Nursing care is often perceived as "intellectually undemanding and soft . . . a second-class kind of career." In fact, although there are men in nursing, the key issues that concern nurses are still women’s issues. Nursing is
“still viewed as traditional women’s work, but it is done in a traditional man’s world.”\textsuperscript{4(p33)} There are many parallels between the history of women as healers, the feminist movement, and the story of nursing. Throughout these journeys, women have struggled to secure a place at the healthcare table, hold on to it, or evolve further from that place.

Ehrenreich and English\textsuperscript{6} trace the threads of nursing and medicine back to the “wise women” of western history, asserting that women have always been healers. In their daily experiences as midwives, counselors, and cultivators and dispensers of healing herbs, these “wise women” as they were called, were accused of being witches and charlatans by authorities. “For centuries, women were doctors without degrees, barred from books and lectures, learning from each other, and passing on experience from neighbor to neighbor and mother to daughter. . . . Medicine is part of our heritage as women, our history, our birthright.”\textsuperscript{6(p3)}

Nurses do healing work, yet most nurses have not been formally socialized to view themselves as healers. The title, “healer” is loaded with associations, meanings, and implications. By delving into the literature about nurses and healing, we begin to see the larger context in which nurses have struggled for identity. We see the roots of fear and frustration that so many in our profession experienced. Exploring further, we realize a path that may lead nurses out of this confusion toward greater role clarity and purpose. As we transform ourselves, we can begin to transform the environments in which we work, so they may become truly supportive of healing.

REVIEW OF THE LITERATURE

The word “heal” is based on the Anglo-Saxon root “haelen,” which means “to be, make, or become whole.” Keegan\textsuperscript{7} describes a healer as one who is capable of producing or catalyzing the integration of body, mind, and spirit in the direction of wholeness, or healing. Dossey et al\textsuperscript{8} describe healing as a blending of technology with care, love, and compassion; as learning to open that which has been closed in order to expand inner potentials; and as a lifelong journey where we seek healing for ourselves or help others to recover from illness or transition to a peaceful death. The notion of nurses as healers has emerged relatively recently (over the past 25 years) in nursing literature. Criteria and guidelines attempting to define nurse healers are still under development; therefore, nurse healers often go unrecognized.

According to Keegan and Dossey\textsuperscript{9} nurse healers can be found within all areas of nursing practice, education, administration, and research. Nurse healers understand the importance of creating healing environments, relationship-centered care, the mind-body dilemma, intention, healing versus curing, the human spirit in healing, exploring personal meanings in lived experiences, and the opportunities for integrating complementary/alternative (integrative) healing modalities into their practice. “A nurse healer is one who facilitates another person’s growth toward wholeness—body, mind, spirit—or who assists one with recovery from illness or with transition to peaceful death.”\textsuperscript{9(p3)} Nurse healers are further described as dynamic individuals who recognize and use personal, clinical, educational, and research strategies needed to transform a biotechnologically driven healthcare system into a personal, relationship-centered system in which patient’s perceptions are changed and coping abilities increase.\textsuperscript{10}

There are distinctions between “healing” and “curing,” and the nursing literature is clear that curing is a “small and incomplete subset of healing, limiting ‘curing’ to the disease while ‘healing’ is applied to the person.”\textsuperscript{11(p199)} According to Keegan and Dossey,\textsuperscript{9} “Curing has been associated with power, analysis of data, and technology, whereas healing has had little status and few financial rewards. Current information necessitates that we mesh curing and healing for the most effective results.”\textsuperscript{9(p29)}

According to Wardell and Engebretson,\textsuperscript{12} the term healer is “classically used to identify those individuals affirming a life commitment to healing work that defines who and what one is. The service provides a spiritual connection, and the classic healer moves between two worlds: that of the spirit and that of daily life.”\textsuperscript{12(p62)} This is a lofty and challenging definition of the term “healer,” and brings to mind the sacred and all-encompassing nature of healing work. Whether one believes that God heals, or that faith is necessary for healing, or that science and technology heals, or that the mind controls the healing response, it is clear that the healing process contains much mystery.

A great deal of attention is focused on the concept of “healing” within nursing, medical, and lay literature, though in nursing literature, this area still has not been extensively investigated. Research has been qualitative, and very small groups of nurses
(n = 1–15) have been used. Personal experiences of nurses as healers are more visible within nursing journals that focus on holistic content, but these concepts have not been extensively presented to a broader nursing audience through inclusion in other journals.

Oliver searched the nursing literature from 1966 through 1989 using 3 databases and found only 14 articles that discussed “nurse as healer” or “healing” interventions used by nurses. She then conducted an informal survey of nurses who were attending a conference that was oriented toward holistic nursing and therapeutic touch. She asked a group of 55 nurses if they considered themselves healers, and 52 nurses raised their hands. Oliver concluded that, although the term “nurse healer” may be vague, many nurses self-identify as healers. Although a majority of these nurses called themselves healers, they were self-selected and were in the process of being exposed to content related to their identity as healers. This likely influenced whether or not they saw themselves as healers. The nurses were not naive to the notion of nurses as healers, and had already (to varying degrees) been part of a socialization process to that effect.

PATHS TO HEALING WORK

There are different paths to becoming a healer. Some can respond to a deep sense of calling into healing work. Or, one can be born into a lineage of healers with a sense of knowing oneself to be a healer from the start. Healing ways can be transmitted through close mentoring relationships beginning in childhood. One can have an experience or series of experiences that point in the direction of healing work. Some go through a process of education, guidance, and practice to develop specific skills and intuitive abilities for healing. Wardell and Engebreton caution that simply practicing particular modalities or becoming certified in specific techniques does not make one a healer. Rather, it is the “commitment and intensity within a complex system of knowing that creates a healer.”

A path to healing work that is considered significant by many who have written in this area is that of being wounded in body, mind, or spirit, and through one’s own healing process to emerge with a commitment to share deep empathy, insights, and loving energy with others in need of healing. This process is known as the path of the “wounded healer,” and may be an essential component of a nurse’s effectiveness with her/his patients.

THE WOUNDED HEALER

The theoretical foundations for the archetype of the wounded healer can be traced to Greek mythology. In addition, the way of Shamanic healing has been present across the ages and across cultures. It, too, represents a clear foundation for the wounded healer archetype.

According to Greek mythology, the centaur Chiron was accidentally injured in the leg with an arrow, leaving him lame and in constant pain. Knowing he was immortal and also that he would never heal, he retreated to his cave. When an opportunity arose to change his circumstances by making a sacrifice, he took it, and this attempt to limit his suffering signified transformation and transcendence. He emerged with a conscious desire to heal others even though his physical wound remained. He transformed his own wounding into a positive experience and one that led him on a path of courage, conscious choice, and transcendence. He taught others the ways of healing herbs, including the mythical Asclepius, whose actions served as a basis for modern medical training. It is interesting that the Asclepius myth “revealed the interrelatedness of healing and wounding through the symbol of the caduceus, a staff encircled by a snake. Interpreted as a renewal of life, the snake typified healing and freedom from illness because of the ability to shed its skin.” This ability to transform by shedding skin is a metaphor for apparent decline, self-renewal, innate healing ability, and therefore, the wounded healer.

Shamanism is an ancient, indigenous healing practice. By entering states of altered consciousness using prayer, trances, and/or drugs, shamans attempt to gain knowledge from the spirit world that will enable them to assist the “patient” to heal. Shamans enter into and experience a person’s pain, and help them define meanings of the experience. Cure of the illness is not as important as incorporating the lessons learned into the total fabric of the patient’s life story. By expanding their own consciousness, shamans work on spiritual, emotional, and physical levels to transform a patient’s suffering into growth. Through their willingness to enter into the patient’s experience of suffering and their view that this is an opportunity for soul growth rather than something that should be
feared, they represent wounded healers in the fullest sense of the term.

Henri Nouwen described the wounded healer as one who must deal with personal wounds even as he attends to the wounds of others. This attitude of preparedness is captured in this Talmudic depiction of the awaited Messiah: “He is sitting among the poor covered with wounds. The others unbind all their wounds at the same time and bind them up again. But he unbinds one at a time and binds them up again, saying to himself: ‘Perhaps I shall be needed; if so, I must always be ready so as not to delay for a moment.’”

In psychology and psychotherapy literature, the reality of the healer is touched upon in the concept of countertransference. From a classical psychoanalytic perspective, countertransference is something undesirable with the potential to taint the therapeutic relationship. Through unconscious emotional reactions to a patient, the unresolved conflicts of the therapist (ie, wounds) may interfere with the therapeutic process; therapists, therefore, should be as self-aware as possible. The practice of therapists seeking their own therapy is widely encouraged, in the hope that the potential for harm to clients will be diminished.

There is another way to view countertransference, however. Conti-O’Hare points out that because the mind and body are not distinct and separate entities, a purely psychological application of the concept of countertransference is probably not possible. Could it be that these reactions experienced by a healer could provide valuable insights into the needs of the patient? For example, the emotional and physical responses a healer might experience while working with a patient may well be communication of valuable information. This information may convey key direction for therapeutic (sp) interactions.

It is important to distinguish between “wounded healers” and those who have experienced trauma and wounding without self-awareness. Those who especially identify with their wounds, and do not take actions to transcend (sp) them, experience draining of their energies, and are less likely to be able to extend healing energy toward others in need of support. Conti-O’Hare illustrates this point in her description of healthcare workers who neglect to care for themselves properly. “Without awareness, they drain their healing energies, making themselves therapeutically ineffective and incapable of transcending their own wounding. Practitioners who smoke or experience weight problems, such as marked obesity, have difficulty concealing their trauma from patients. The inability to provide positive role modeling of self-care hinders the performance of the healer.”

It is likely that any healthcare professional can facilitate some degree of progress toward healing in patients depending on her relationship to her own wounds. For example, a nurse who smokes and is overweight is capable of empathy for a patient experiencing similar health concerns. The nurse’s loving presence helps a patient feel heard, accepted, and valued in a way that could facilitate healing. Although the nurse may not be modeling the process toward transformation, she could still be providing foundations for healing. It is also important to remember that an obese nurse may be self-aware, understanding and accepting of her wounds even if she has experienced transformation and transcendence. Like the centaur Chiron, she may still be physically wounded, but has healed on many significant levels and is able to direct healing energies toward others.

While experiencing the path of transformation and transcendence, wounded healers are able to move beyond their own needs and hidden drives in order to be fully present to others needing support in their healing. In doing so, healers can experience their own healing benefits. Nurse-healer Delores Krieger states, “the reality of the healing act can activate compelling life affirmative drives in those who heal.” While this statement rings true, it is difficult to measure this type of shift in persons doing healing work, and we rely on phenomenologic approaches to document this reality. Modern scientific inquiry emphasizes objectivity and measurement, and has often reduced or rejected the lived experience of human beings as “anecdotal.” Some consider this lived experience unverifiable, such as that expressed in Delores Krieger’s statement, and it could be thought of as a poor arena to discover factual information that will increase “true knowledge.” Nonetheless, the idea of examining and using one’s own experiences of wounding and healing to amplify one’s ability to be a healing presence for others is oft-repeated in the literature pertaining to being a healer. This accumulation of anecdotal data closely resembles data gathered by qualitative methods, and is crucial to fully understanding the experience of being a healer.

The path of healing can take considerable time. For most, the process involves becoming rather than arriving. Certainly all healers are at different points on
their own journeys, and are able to facilitate healing in others to greater and lesser degrees.

**Holism and healing**

The concept of holism is frequently linked to discussions of nursing and healing. Nurses featured in Keegan and Dossey’s *Profiles of Nurse Healers* shared understandings of holistic concepts as related to their journeys as healers. Slater et al. reported that nurses on a journey toward holism experienced themselves more fully as healers. These nurses shared experiences of “liminality” where they felt “apart from” or “different than” mainstream colleagues as awareness of self and others expanded and self-identity shifted.

Holism can be viewed from 2 different perspectives. One is that holism involves the interrelationships of the bio-psycho-social-spiritual dimensions of persons, recognizing that the whole is greater than the sum of the parts (synergy). The other perspective is that holism involves understanding the individual as an irreducible, unified whole in mutual process with the environment. The American Holistic Nurses’ Association responds to both views, “believing that the goals of nursing can be achieved within either framework.”

Quinn examines and unites these perspectives further by asking the question “If we believe persons to be irreducible wholes regardless of illness status, then how can healing be perceived as becoming more whole?” The answer lies, she suggests, in the pattern of relationship among the elements of the whole. By using a concept from physics called coherence, we can look at ways in which all aspects of the self are in relation to one another. The greater the coherence, the more whole the system becomes. Quinn calls this concept “right relationship,” and suggests that, although all healing is truly “self-healing,” nurses can facilitate this process of moving toward right relationship within self and with others.

Holistic philosophy takes into account the intention and the therapeutic potential inherent in *presence* of the caregiver. A holistic approach also takes into account the wholeness of persons, rather than a dualistic/materialist reduction into parts. By viewing persons as energetic integrations of body-mind-spirit and environment, and by appreciating the synergy of this totality, it is more likely that healing interventions will go beyond “a materialist, specific cause approach,” thus stimulating or supporting the healing response to greater degrees.

Quinn has suggested that this totality of persons may be best represented linguistically by the term “bodymindspirit”—3 words combined into 1 word, conveying the very real unity of this relationship. This term conveys the integral, inseparable nature of these aspects of self. If we then view this bodymindspirit as the “human system,” healing can be viewed as the emergence of right relationship among any levels or aspects of this system. It is possible, then, to experience healing of the spirit even while the body remains wounded. Said differently, healing and curing can be seen as 2 separate continuums.

In keeping with the complex nature of healing, it is likely that healing at one level of the system may stimulate curing at another level. An example of this would be an individual with chronic pain who experiences growth through psychotherapy and has a resolution of the physical pain. This healing may then extend beyond the individual bodymindspirit to family members, such as the family that experiences improved relationships at the deathbed of a loved one, wherein a “cure did not occur, but healing did.”

Human beings are a totality, with all aspects of self and environment working together in synergy, and how healing is manifested cannot be predicted or reduced to generalizations. The state of healing or being healed is subjective, and must be evaluated by each individual, for themselves. “Examining the meaning of a given experience . . . of healing expand(s) and enrich(es) the meanings nurses and others might give to patient experiences, and change(s) the way care is provided.” This very real subjectivity can make clinical evaluation and measurement of the experience of being healed difficult, and thus make investigations into efficacy of holistic principles in relation to healing very tricky. An example of this is research that looks at pain relief secondary to holistic interventions such as relaxation and imagery. Although participants’ self-reported responses on numerical scales may not decrease as a result of the intervention (e.g., they may self-report pain at a 7 out of 10 level both prior to and after the intervention), they may report that they feel better. That is to say, though they may still have the same symptom, their perception of the pain experience has changed in a positive direction as a result of the holistic intervention. This kind of change in variables may go unnoticed with conventional, quantitative modes of inquiry that may focus on the quantitative, numeric data rather than an open-ended question that
may reveal a more expanded picture of changes in the pain experience (as reflected in sense of well-being, quality of life, and/or functionality) after the intervention. Thus, research methodologies and instruments that are more holistic in scope must be constructed to more accurately capture the totality of any phenomenon. Many complementary and alternative healing modalities (CAM) are inherently holistic, and thus require different approaches to gather evidence of their effects.

IMPORTANT ASPECTS OF NURSES AND HEALING

Relationship and caring connection in healing work

By walking alongside patients who are on healing journeys, nurses can foster truly mutual relationships. Beyond establishing rapport, authentic relationship represents a true sharing of self, and a willingness to be open and genuine within limits that protect patient well-being.

In Sophocles’ classic work, the brave soldier Philoctetes was bitten by a snake. He developed an infected wound which became malodorous and offensive. He cried out in pain constantly, and was eventually banished by the commander Agamemnon to the island of Lemnos, where he lived in isolation for 8 years. He possessed the magical bows and arrows of Herakles, which enabled him to hunt easily and survive.

One day, Agamemnon dispatched Odysseus to the island to persuade the wounded soldier to relinquish his magic weapons to help him win the city of Troy. Odysseus selected a young boy named Neoptolomus to accompany him and before they arrived at the island of Lemnos, they discussed Philoctete’s possible feelings of betrayal and anger at having his bow and arrows taken from him. Neoptolomus believed it was important to be honest and forthright with Philoctete, whereas Odysseus believed it was acceptable to use deception and trickery to take the magical weapons since it was for the good of the country.

Neoptolomus tried to establish a trusting relationship with Philoctete, who ended up having a sudden seizure and relinquishing the weapons to the boy, thus rendering himself vulnerable. At this point Odysseus wanted to take the weapons and leave, but Neoptolomus, having bonded with the wounded soldier, refused to assist Odysseus. At that moment, the Gods announced that if Philoctetes returned to Troy, his wounds would be healed, which indeed they were. This story illustrates one man’s empathy for another’s suffering, and the opportunities for transformation and healing through compassion.

Tresolini and the Pew-Fetzer Task Force identified knowledge, skills, and values in 4 key areas that are critical to patient-practitioner relationships in order for relationship-centered care to happen. These include practitioner self-awareness; the patient’s experience of health and illness; developing and maintaining caring relationships with patients; and communicating effectively.

Practitioner self-awareness includes knowledge related to personal, psychological, emotional, and spiritual growth. It also includes understanding the importance of self-care in relation to the caregiving role. The ability to reflect on self and work is critical to this process. To use this knowledge of self in ways that then become a resource for others who are on a healing journey is an important direction for a nurse healer to explore.

To fully appreciate the patient’s experience of health and illness implies that the nurse explores aspects of culture, family, and communities in which the patient developed and lives, and patient beliefs pertaining to his/her current health status. Most persons experiencing a disruption in their usual health status seek some sort of reason that explains why they are in their current situation. Understanding the patient’s viewpoint, as well as facilitating the patient’s efforts to understand and interpret meanings of their illness experience can mean the difference between positive versus negative health outcomes. If, in fact, illness is viewed as an opportunity for self-understanding and growth, the nurse will want to enter into relationship with the patient to learn all he/she can about that particular patient in relation to his/her current health status. To seek out and value the patient’s life story using a holistic lens, and to help him/her explore the personal meanings of his/her current health experience as a part of that life story, is a valuable aspect of relationship-centered care.

A formidable obstacle to this process of seeking out a patient’s life story is “time.” Especially in the current healthcare environment, nurses bemoan the lack of time they have to interact with patients about even the most basic information pertaining to their health, interventions, or therapeutic processes. In fact, in my discussions with practicing nurses, time is the most frequently cited barrier to delivering quality nursing care. Certainly this must be addressed in order for
nurses to feel they can interact with a patient about the potential meanings around his/her health experiences.

In order to accomplish any of the goals recommended by the Pew-Fetzer Task Force, the nurse must be able to communicate effectively and clearly with patients, families, and healthcare colleagues. This process involves creating open and nonjudgmental environments for taking in and sharing information, and facilitating learning and decision making of others. It also involves carving out adequate time, and this is, as previously stated, an ongoing problem for nurses.

It is interesting to note that many nurses who describe themselves and/or their craft holistically will deny that time needs to be a barrier, claiming that healing and caring moments can be just that—"moments"—and that these brief encounters such as a touch, eye contact, or a few words can have profound effects, creating shifts in the direction of healing. In these brief yet profound relationships, transpersonal caring can occur. Transpersonal caring has been described as "those scientific, professional, ethical, yet aesthetic, creative and personalized giving/receiving moments between two people that allow for contact between the subjective world and consciousness of the two." View the relational exchange as an interactive blending of energy fields between persons may help to illuminate Watson’s statement. In these moments, that occur between 2 people yet become distinct energetic entities in and of themselves, inner resources are unleashed that can potentiate self-healing processes as well as awareness of forces beyond the 2 individuals. Said differently, the 2 individuals, in a synergistic moment, come together and create a new field that changes them both, and that can potentiate healing depending upon the awareness, receptivity, and intention of the individuals.

The nurse seeking effectiveness in developing and maintaining caring relationships will understand the inherent power inequities that exist in most encounters between health providers and patients. Inequities regarding the hierarchical structure of institutions, race, sex, gender, education, occupation, and socioeconomic status are monitored as the nurse seeks to collaborate with patients and families in promoting health and planning care. Hall states that a reduced power differential between a patient and a professional increases the likelihood of a partnership. She suggests that nurses are in an ideal position to maximize the potential benefits of this healing alliance as they are inherently more approachable than, say, physicians. Indeed, "the core of healing power is in the healing relationship." By seeking nonhierarchical approaches to patients and caring, nurses invite patients to gain confidence and take responsibility for their own health. By offering expertise, care, and consultation, the nurse walks with the patient along the patient’s own healing path.

Without establishing relationships, nurses cannot do their often-intimate work sensitively and accurately. The quality of nursing care is greatly affected by the quality of relationships between nurses and those for whom they care, as well as by the relationships between caregivers themselves within the professional setting. In fact, respect between healthcare professionals is a hallmark of a holistic orientation toward healing. This web of relationships creates a community complete with its own cultural norms, and this environmental context has a tremendous impact on delivery of care.

Self-care

Nurse healers view themselves as instruments of healing, and strive to keep themselves “in tune.” According to McKevirgin, “The process of healing is one in which the nurse exchanges energy, truth, and communication with clients to help those clients attune to their own healing capacities and implement the healthiest response possible for any given situation.” For a nurse to effectively offer physical, psychological, and therapeutic presence requires tremendous attention to personal growth and self-care. Physical presence is body to body contact and includes sensory input such as eye contact and scent. Psychological presence is mind to mind contact and provides understanding, interpretation, and meaning to life’s events. Therapeutic presence can be viewed as spirit to spirit contact and includes nonjudgment, intuition, and love. This level of nurse presence can stimulate innate healing capacities within self and others.

The cost-cutting atmosphere of healthcare settings and the stressful, professionally unsatisfying and often risky nature of these environments have diminished the caring aspects of the work, and pushed nurses to the breaking point. Yet it is clear that self-care is not a value that has been socialized into these nurses’ psyches or work environments. As Fagin states, “...when the demand for herculean effort continues on a prolonged basis, nurses begin to resent the demands placed on them.” Indeed, emerging research is demonstrating the increasing burdens of care on nurses and the relationship between negative
nursing outcomes, such as exhaustion and needle sticks, and adverse patient outcomes. How can environments where employees are not able to attend to their own health and well-being be conducive to optimal healing in the populations they serve?

In Oliver’s study, nurses were asked to share specific healing behaviors they used. The first 10 cited were related to healing others and included touching, listening, praying, caring, laughing, crying, using music, dancing, using colors, and holding/hugging. As they named these behaviors, they began to shift toward self-oriented healing behaviors, including meditating, sleeping, exercising, relaxing, eating, playing, massaging, using herbs, and faith. The researcher concluded that perhaps some of the behaviors nurses used for self-healing may also be appropriate nursing interventions. Dossey has stressed that by experiencing the benefits of these modalities for themselves, nurses are more likely to incorporate them into patient care and teaching.

In a study of nurses’ journeys to holism by Slater et al., participants described a process that resembled cultural anthropologist Van Gennep’s description of rites of passage. Stages of this process include separation from the group, marginality or liminality, and reintegration as a changeling. A limen is a space between 2 spaces and is a place where magical changes can take place. According to Slater’s findings, for nurses on a journey toward holism, this liminal stage involves a marked increase in self-care behaviors including changing jobs; returning to school; changing exercise routines; altering diets and using herbs and supplements; studying, practicing, and receiving CAM; and meditating.

Nurses who nurture their own bodies, minds, and spirits will have more to share with patients. Nurses who understand the connection between their own balance and well-being and how this impacts their ability to focus their attention and intention when working with patients tap into great healing resources. By caring for themselves, nurses may be better able to provide a safe and loving environment that will stimulate and support the innate healing potential in those for whom they care.

**Complementary/alternative modalities and healing**

Throughout the literature on nurse healers, the use of CAM is a recurring theme. CAM are those therapeutic practices that do not derive from allopathic medicine. The language used to refer to various approaches to healing can be confusing. For example, allopathic modalities are also referred to as Western, orthodox, conventional, biomedical, mainstream, standard, and scientific. The term “traditional” is problematic as it is sometimes used to indicate allopathic medicine, but can also refer to Traditional Chinese Medicine or to health practices of indigenous peoples.

Even the abbreviation CAM can be misleading, as it could indicate complementary and alternative modalities, or complementary and alternative medicine. These modalities are primarily practiced by nonphysicians and often by nurses. There is concern that physicians may take a default lead in using these modalities within an allopathic philosophical approach. Therefore, it has been suggested that the initials CAT be used instead of CAM, replacing the last word “medicine” with “therapies.” This would be a more accurate and inclusive term.

The term “integrative” suggests a holistic approach to facilitating healing that incorporates the best and most appropriate modalities from various paradigms. The National Center for Complementary and Alternative Medicine has defined the Integrated Health Model as “a multi-disciplinary system of care that incorporates both biomedical and complementary therapies. These two types of therapies are both considered when planning the care of patients.” The descriptor “expanded healthcare” has also been suggested as an appropriate term.

CAM are frequently cited in the holistic nursing literature as important healing tools. Indeed, the use of CAM is a recurring theme throughout the literature on nurse healers. Many of these CAM are already accepted nursing interventions, such as progressive relaxation, guided imagery, yoga, therapeutic touch, aromatherapy, music therapy, reflexology, active listening, advocacy, and centered presence. These are natural therapies that nurses can use independently to facilitate healing. Florence Nightingale and the early American nursing pioneers practiced many of these modalities.

An added benefit of these types of modalities is that they produce positive results in the practitioner as well as the recipient. Yeldham asserts that complementary therapies benefit both the caregiver as well as the care receiver, and have “much to offer nursing in terms of stress relief, prevention of ill-health, and the care of the sick.”
According to Quinn,23 national surveys indicate that the public is interested not only in alternative therapies, but also in a more holistic form of healthcare.23(p17) Though patient and nurse acceptance of these modalities may be increasing, the trend toward use of these healing strategies resembles an evolutionary pattern more than a revolutionary one.36 For those educated in a paradigm that does not emphasize or actually criticizes holistic healing and non-Western, nonallopathic modalities, it can take time to be persuaded as to their potential benefits.

According to physician and healing researcher Daniel Benor "(nurses) know from their intimate dealings with patients that such things as massage and an atmosphere of positive, loving care often have better results than do drugs. It's easier for them to move from that to a more active, healing role through learning about therapeutic touch techniques."39(p120) It would seem that nurses may also know this because the roots of nursing practice are grounded in these types of modalities.

Not all nurses advocate the use of these therapies, however. While the holistic nursing literature is predominantly open to and supportive of judicious use of CAM modalities, there are many nurses (perhaps who stand "outside" the holistic paradigm) who are concerned about these modalities. Moylan40 wrote about the lack of solid evidence as to the efficacy of CAM strategies, and cautioned nurses to refrain from using treatments that lack credibility: "Nursing has fought long and hard to establish its reputation as a legitimate health profession having credibility within the healthcare community and among the population at large. . . . Unfortunately, more and more frequently we are hearing of nurses who are using techniques in practice that are untested, unproven, and whose use may actually prove to be detrimental."40(p259) This statement reflects a desire to conform to safe practice standards and the research that supports them. At the same time, it expresses a strong need to be accepted and respected by those who are viewed as being in power. This speaks volumes to nurses' struggle for identity and credibility, and illustrates one of the primary means (conforming) by which nursing has tried to achieve these over the last several decades.

In a recent, lengthy editorial, McCaffery,41 a nurse leader in the pain management field, expresses concern regarding nurses who use nondrug treatments for pain instead of appropriate doses of analgesics. She explains that, for nurses who are truly expert in pain management, nondrug modalities (music, relaxation tapes, massage, healing touch, aromatic oils) may be helpful adjunctive therapies if they help to relax the patient. McCaffery attributes the positive effects of CAM strategies for those in pain as "simply the effect of a therapeutic relationship, not the specific technique."41(p77) She suggests that nurses spend 5 minutes of time with a patient, discussing any concerns or questions they may have. She notes the lack of randomized, blinded studies, and cites patients’ testimonials of effectiveness as "anecdotal," and "not research."41(p78) In her editorial she uses the New York State Nurses Association’s position statement concerning CAM as a model: "the policy requires full disclosure regarding the lack of valid information, the need for further research, and the need to continue conventional therapy."41(p79) The editorial makes it clear that nondrug strategies have been shown to be very safe, yet warns that nurses should avoid using techniques that lack a solid, biomedical research base in order to protect the safety of patients.

It is clear that we are in the midst of a paradigm clash within healthcare. Physician Larry Dossey42 has labeled the paradigms ERAs. ERA I developed during the mid-1800s, and describes local, mechanical/physical approaches to healing. Cause and effect relationships are sought, and quantitative data is essential as evidence of effectiveness. The mind is not considered a factor in illness, and is, in fact, a result of brain mechanisms. ERA I therapies focus on the effects of things on the body, such as drugs, radiation, surgery, herbs, and acupuncture. ERA II developed in the mid-1900s and emphasizes mind/body modalities where the mind is a major factor in disease and healing within the person. Still a local approach to healing, these therapies emphasize the effects of consciousness within the individual and include hypnosis, biofeedback, counseling, relaxation, and imagery. ERA III therapies are developing in the new millennium and emphasize the energetic nature of persons and the nonlocal nature of healing. Transpersonal modalities where the mind is a factor both within and between persons are used, and include intention, intercessory prayer, intuition, dreams, and distance healing.

Nurses frequently get caught in the middle of these conflicting paradigms, as they often lack the power and position within the system to assert knowledge that is not derived from purely empiric inquiry. Interestingly, it seems that even nurses’ intuitive
knowledge is more respected and acceptable than a large collection of anecdotal evidence such as patient testimonials. This anecdotal evidence is qualitative data, and can be interpreted and used to influence practice within a postmodern/ERA II-III paradigm. It is more likely to be dismissed within a modern, ERA I-II paradigm, as seen in the McCaffery editorial.

Nurses are in a difficult position for other reasons, as well. Educated in schools of nursing that embrace the holistic principles in which the profession is rooted, yet that also embrace the scientific method upon which nursing process is based, nurses are often able to accept multiple ways of knowing and ERA II and III types of therapeutic strategies. When they graduate, they usually work in ERA I oriented environments that do not support holistic practice and ERA II and III therapies. As a result, some measure of confidence and sense of self are undermined as the nurse experiences incongruence between his/her more natural clinical inclinations and the values and demands of the work environment. In reality, some nurses are truly more task oriented, truly less holistic in philosophy, or were educated in a heavily ERA I paradigm, and may not feel a sense of dissonance. But for many nurses, over time, the desire to cope and “fit in” can become overwhelming, and many nurses respond by fully embracing the dominant ERA I paradigm—often to the exclusion of holistic roots that were tentatively nurtured in nursing school.

Just as *relationship* seems to be a critical part of the healing process, so, too, is the *intention* of the practitioner. Krieger stated that the 2 most consistent characteristics of committed healers are compassion and intentionality. Many CAM practitioners would agree that *intention* is more important than the particular *technique* when accounting for the effects of an intervention. Indeed, one can administer drugs or perform mechanical care (ERA I techniques) using ERA III intentionality to encourage healing shifts. An example of this would be “mindful medication administration.” To practice this, the nurse would transmit loving, positive energy to a medication as well as to the person receiving the medication. Hopes and wishes for the best outcome would represent the intentions of the nurse for that particular therapeutic interaction.

Controversy surrounding the energetic modality called *Therapeutic Touch* (TT) is a good way to illustrate the tensions surrounding research of CAM. This technique involves using the hands in the energy field of the recipient to remove blockages, smooth out, and improve balance in the field. There is ongoing controversy about the effectiveness of this technique, with advocates passionately sharing patient testimonials and the positive results of countless studies. Opponents have pointed to methodological flaws in the research and cite studies that claim TT has no significant effects. Others have countered these attacks on TT with methodological concerns of their own. As this type of controversy rages and threatens the work of nurse healers, it is important to remember that *empirics* are part of the nursing whole, and not the whole of nursing. This balanced approach to the controversy of evidence validates the empiric way of knowing without invalidating the many other ways of knowing, such as intuition, feeling, caring, relationship, values, cultural symbols, and meanings.

The dominant paradigm within nursing education and practice is still that of rationality, linear problem solving, and standardization. According to Watson, “The extreme objectification of particular forms of knowing . . . perpetuates unethical caring practices and the status quo.” Nurses practicing within this paradigm are often limited by its inherently value-free, less than caring, objectified way of relating to the world. Judging from conversations with many nurses, expanding beyond this ERA I paradigm would prove liberating to their practice of nursing.

Since numerous reviews of TT research have revealed that it is harmless and safe, and since patients can access this modality on their own, it would appear logical to allow consumers and nurses the last word on the use of this modality. There is no loud, public controversy over the use of most pharmaceutical agents. In spite of reports of dangerous adverse effects and the lack of efficacy of many medications, they are an accepted part of our culture. In fact, conservative estimates gleaned from peer reviewed data suggest that iatrogenesis as a result of accepted, ERA I modalities is the leading cause of mortality and morbidity in the United States. Where is the powerful, passionate opposition to misuse of ERA I modalities? And yet, the controversy over TT remains strong. There is a deeper issue at hand, and it relates to the differing perspectives, philosophies and traditions underlying each paradigm, and the perceived threat of challenging the status quo. Buying into doubt and fear has limited the freedom of nurses to fully explore and embrace their role as healers.

Dossey has suggested that the acrimony around TT can be avoided if the issue of mechanism is
avoided, and the issue of clinical outcomes is highlighted. "Saying 'we don't know how it works' is not a sign of weakness in medical research, but an indicator of scientific integrity." Others suggest that it is important to conform to dominant standards that dictate what is valid inquiry. "Definitive research is needed on TT, similar to the numerous studies of CAM presently being conducted through the National Institutes of Health... Researchers must reach consensus on the methodologies and technology required to study the mechanism of TT." It is not likely that the challenges surrounding the researching of CAM will be resolved in the near future. Paradigm shifts take time, and when data does not fit in with a prevailing paradigm, it can be ignored, no matter how compelling it may be. People are using CAM, and in large numbers. Quinna and others have suggested that what they are truly seeking is more relational, holistic care.

CAM therapies are usually considered more holistic in nature because they often aim to stimulate innate healing potential and involve more touch, intention, and time spent with the client than typical allopathic care. However, it is important to make the distinction between CAM and holistic care. Holism is defined more by the context of the care, than by the actual treatment techniques used. It should be remembered that these modalities, though inherently holistic, could easily be adopted within the dominant allopathic paradigm and viewed as a set of techniques to add to the repertoire of "treatments" already in use. Nurses who use these modalities should strive to keep them within a holistic care context. Simply adding CAM to the existing healthcare system will not change that system into a holistic one. Only by changing the underlying philosophy of care, will the system become more holistic.

Daniels and McCabed describe a time centuries ago, before theological dogma and scientific reductionism separated them, when the arts of nursing, medicine, and healing with natural therapies were integrated: "The one who washed away the sweat of fever, changed the soiled bedding, and fed special gruels of bark and root also set bones, went into the field and forest in search of medicines, and applied the soothing poultice along with words of hope, prayers, and healing rituals. The sick were nourished in body, mind, and spirit as best the caregiver was able." This is a perfect description of CAM embedded in a holistic approach to care of the total person. It is important to remember this integrative approach in order to avoid the illusion of holistic care when CAM is separated from its holistic base.

Restraining factors in claiming the role of healer

Nursing is a profession that is oriented toward healing work—it belongs within the scope of "healing arts." Yet, we see very little explicit talk about "healing" within the general nursing literature, especially as it relates to identifying nurses as healers. Why is this? It might be that there is risk in identifying oneself as a healer. Just as most aspects of the human condition have a shadow side, so, too, the healer identity has a history fraught with complexity and danger. From the 1400s through the 1700s, an estimated 9 million people, mostly women healers and wise women and the men who supported them, were killed. Some scientists speculate that through the maternal line of our mitochondrial DNA we carry collective memory of all that has gone before us. Somewhere in our collective memory we as women know that to claim the role of healer could cost us our lives, and this fear blocks our freedom to fully embrace and use this role with all of its' inherent power.

Johnson, a holistic nurse, traces the ongoing effect of this fear on practitioners of the healing arts, and the efforts of nurses to throw off the constraints which prevent them from tapping into their true birthrights as healers:

During and after these more than three hundred years of horror, the holistic way of the ancients, the Greeks, and the early Christians, submerged and hid. However, nurses in religious, poor, distant and war-torn communities kept the traditions alive. In the 19th century Florence Nightingale... wove together science and intuition creating her holistic nursing approach in modern dress. She advocated... that nurses have a distinctive role and calling... to help put the person in the best state for nature to heal. Nightingale called forth the full use of self, connecting the divine within and without as a source of inspiration as well as the foundation for a professional nursing code. She made explicit connections between and among all aspects of self, other, humanity, the environment, nature, and the cosmos. These linkages were the means of learning, understanding, and connecting health, caring and healing.

Today, women are again active as healers. The disillusionment with a healing system that is dysfunctional and lacking in effectiveness has catalyzed a desire to reclaim the roles that at one time posed a threat to survival. What is struggling for survival now is "western medicine, with its increasing
Depersonalization and alienation, as well as run-away costs."\(^{52(p)}\) A system such as this can only have limited viability.

**Creating healing environments**

The current shortage of nurses in clinical as well as educational roles reflects the ongoing frustration and sense of failure voiced by so many members of the profession over the last several decades. Indeed, a revolution in how healthcare professionals think and act may be the only thing that will bring about a change, and the "moral framework of the healer-patient relationship" is an important place to begin this change.\(^{32(p188)}\) The recently introduced term "nurse healer" describes an approach to nursing work that could be affirming and liberating to those within the profession.

The word "nurse" is derived from the Latin words *nutrire* and *nuttrix* which mean "to nourish" and "nursing mother" respectively.\(^{53}\) The word "healer" implies an active/evocative role that connotes movement and change. By combining the concepts of *nurturing care* and *evoking a response* in others, the term "nurse healer" could help induce a shift in consciousness among nurses that would require an expanded set of attitudes, behaviors, and priorities.\(^{4}\) This could also lead nurses to a strengthened sense of confidence, purpose, and satisfaction in their work. With this renewed and redefined belief in the importance of nursing work and a collective boost in self-esteem, how we present ourselves to others outside of nursing and within the healthcare industry could change in ways that may engender new levels of attention and respect for our role.

Currently, about one third of the nursing workforce is older than 50 years, and this percentage is increasing.\(^{54}\) The settings in which nurses work need to be modified to retain an aging workforce in comfortable, reasonable, and supportive environments. Just as important is the need to create and maintain healing environments where all nurses can adequately care for themselves and their patients. Cox\(^{55}\) articulates the powerlessness nurses often experience when they feel that they lack the energy or the ability to "influence the creation of healing environments for people and for themselves."\(^{55(p5)}\) It would seem that many nurses might not even know where to begin to create this type of healing environment, because this is not explicitly taught in most schools of nursing.\(^{23}\)

Nurses desiring to enhance healing in themselves and others by making changes in their work environments need not look far for a role model. Florence Nightingale\(^{56}\) developed her ideas about nursing at a time in history when technological and pharmacologic strategies were essentially unavailable, and the nature of her interventions were inherently more holistic. This holistic approach was reflected in her priorities for caregiving as outlined in the classic volume *Notes on Nursing*.\(^{56}\) She believed that creating healing environments was a key responsibility of the nurse or caregiver. This function was the single most valuable thing a nurse could do, because by removing obstructions to healing, the patient was in a better position for healing (innate healing abilities) to work: "nature alone cures."\(^{56(p133)}\)

According to Nightingale,\(^{56}\) light, fresh air, scent, low noise levels, warmth, appropriate foods, beauty, and touch are crucial aspects of the healing environment. She also believed in the value of positive diversions and recommended "small pet animals" for the chronically ill as being a potential source of pleasure. She recommended that, if able, the invalid should "feed and clean the animal himself."\(^{56(p102)}\) She believed in the healing power of positive diversions. Although she rejected germ theory for the first several decades of her career, she had a sense that cleanliness was important, and that overcrowding led to worsening mortality and morbidity rates.\(^{42}\) In *Notes on Nursing*, she also stressed the importance of psychosocial and spiritual factors in the healing of persons. In particular, she focused on interpersonal skills of the caregiver that enhance patient well-being, cautioning against "chattering hopes and advice" that can drain the patient’s already limited energy.\(^{56(p95)}\)

Nurses who attend to creating healing environments will, no doubt, make a significant, positive impact on outcomes for patients as well as for themselves. Unfortunately, there has been little actual research done to measure this. Again, we could all learn a lesson from Florence Nightingale, who meticulously documented specific outcomes in patients, and was able to show that environmental changes she initiated did, indeed, make a positive difference in morbidity and mortality outcomes. More studies are needed that measure specific outcomes both before and after environmental initiatives are undertaken within a specific setting. In this way, we could begin to support our commonsense observations that light, sound, beauty, and scent make a significant difference in the degrees of healing experienced by persons. These
types of studies could also support the use of CAM and spiritual interventions that are being investigated more widely, by placing these interventions within a larger environmental context.

**Spirituality and healing**

Although there are many different definitions of spirituality, there are common themes across definitions. These speak of “harmony, balance, connectedness, wholeness, meaning and purpose, our identity, and our search for the transcendent or something beyond the physical realm.”

In addition, love and belonging, faith, hope, compassion, connection, and forgiveness are common spiritual themes. The North American Nursing Diagnosis Association has defined spiritual well-being as the process of an individual’s developing/unfolding of mystery through harmonious interconnectedness that springs from inner strengths.

Although they are related, spirituality is different from religion. While religion is formal, communal, more visible, and often communicated through a process of socialization, spirituality is individual, subjective, less visible, and informal. Religious practices often involve rituals that can facilitate transcendence and bring about feelings of peace and well-being.

In a meta-analysis of the literature related to spirituality, Goldberg found that spiritual care is inseparable from physical, social, and psychological care because they are all necessary aspects of the whole. She depicts spirituality in nursing care as “connection” because of the interwoven spiritual nature of the body-mind. Within a holistic framework, this connection could also be viewed as communication between human energy fields. Slater et al. reported nurses experiencing themselves and others as energetic fields in constant communication. Nurses become aware of being instruments for energetic healing on emotional, mental, spiritual, and physical levels. This experience of energetic awareness is viewed as a critical aspect of full development as a nurse healer because, ultimately, all healing is spiritual.

In his investigation of healers, Benor found that holism and spiritual healing are common denominators amongst many of the complementary therapies and those who practice them. In her exploration of the nature of healing, Quinn concludes that there is probably no such thing as an intervention that is not holistic in its impact, because there is “nothing that happens to a person that does not affect the entire (bodymindspirit) system.” If one accepts this assumption, something as routine and ERA I as the pulling out of an intravenous line becomes a body-mind-spirit intervention with ERA III implications, and should be treated as such—with care, sensitivity, and loving intention. By cultivating mindful practice, nurses can develop as healers. Moments can become opportunities to convey loving, positive energy that will facilitate healing shifts on all levels in those receiving nurses’ care.

Nurses who seek to be healing influences in the lives of their patients must take into account the spiritual nature of persons in order to be effective. It is evident that Florence Nightingale recognized this: “for Nightingale, spirituality is intrinsic to human nature and is our deepest and most potent resource for healing.” Bradshaw asserts that holistic nurses must attend to the spiritual needs and concerns of patients and families as envisioned by Nightingale in order to provide complete care.

Nurses can ask reflective questions to assist patients in achieving spiritual wellness. Eight key areas should be assessed, including meaning to life, relationship with higher power, hope, encouragement, caring, meditation, striving for growth, and forgiveness. Examples of reflective questions are “what do you do to show forgiveness for yourself?” and “what gives you strength to go on?”

Spiritual self-care is of critical importance, and nurses who nurture their own spiritual well-being are better able to recognize and respond to the spiritual needs of their patients. Spiritual practices that enhance well-being include music, being in nature, meditation, journaling, movement, and relationships, to name a few.

**SUMMARY**

The history of women, nursing and healing is an ancient and complex story. The antecedents to many of the difficulties nurses experience today in their efforts to do healing work are ancient. The concept of modern nurses as healers has been emerging in the nursing literature over the past 25 years. Dominant themes in this literature include the notion of nurses as wounded healers, holism, relationships and caring connections in healing work, the use of CAM by nurse healers for self and others, the creation of healing environments,
and the role of spirituality in healing work. This review of the literature on nurses and healing served as the basis for the authors’ research on medical-surgical nurses’ self-perceptions as healers that will appear in the next issue of Holistic Nursing Practice. This report of research will further explicate many of the concepts presented in this initial review of nurses and healing. In 2 articles that will follow, recommendations and concrete strategies for developing nurses as healers in academic, clinical, and administrative environments will be shared. In particular, brief healing relationships (healing moments), self-care, cocreative socialization of nursing students, and the creation of healing environments will be addressed.

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