Healing Ourselves, Healing Others
Second in a 3-Part Series

Christina Jackson, PhD, APRN, BC, HNC

Although not used in most nursing texts and journals, the term “nurse healer” is common in holistic nursing literature. Nurses who identify themselves as healers have tapped into a source of strength and confidence that adds creativity and vitality to their nursing work. In this qualitative study, the researcher asks 11 relatively "holistically naive" medical-surgical nurses if they would label themselves as healers. Their responses reveal an inherent understanding of the multidimensionality of the healing process and the importance of relationships and therapeutic presence to the healing role. KEY WORDS: complementary modalities, holistic practice, nurse healer, personal wounding and empathy, spirituality Holist Nurs Pract 2004;18(3):127–141

In a very broad definition, the “healing professions” include all nurses, physicians, and allied health professionals. However, it is not a label one frequently hears in relation to individuals within these professions. Nursing work that is performed thoughtfully and with care can be viewed as intrinsically healing in nature. Do nurses realize this and claim this healing role in the course of their daily work?

Although the concept of the nurse as healer has been more visible in the nursing literature within the last 25 years, it is not common practice to socialize nursing students/nurses into the “healer” identity. However, it is possible that most nurses actually know themselves in this way and just need acceptance and encouragement to claim this identity.

PURPOSE OF THE STUDY

This study seeks to uncover whether or not medical-surgical nurses not involved in holistic circles such as the American Holistic Nurses’ Association (AHNA) identify themselves as healers. The study also aims to determine what factors might contribute to this self-image in terms of educational background, professional experience, and personal experience. It also aims to discover what shapes the experiences and perspectives of those who do not call themselves healers. The literature review for this inquiry appeared in the last issue of Holistic Nursing Practice; examine that piece to establish the foundation for this report.

METHOD OF INQUIRY

In this qualitative investigation, participants had the opportunity to describe their experiences of seeing themselves as healers, or not. Since there was no way to know ahead of time whether or not nurses would identify themselves as healers, this study could not be carried out using requests such as “Tell me about your experience of being a nurse healer.” Instead, depth interviews using a semistructured approach were used to gather data, and the process of immersion/crystallization (I/C) was used to analyze and interpret this data. In addition, this study was an exploration of individual perceptions and narrative understanding about nurses’ self-perceptions as healers.

A combination of homogenous, criterion, and network (snowball) sampling strategies were used. Homogenous sampling is recommended when using depth interviews because it can help to account for cultural and contextual influences that may emerge in the data. For that reason, an all-female sample was selected to remove factors related to gender. Nurses from the same specialty area were interviewed to reduce variables related to different types of practice settings. In particular, medical-surgical nurses were chosen because this is the practice setting in which
most nurses form their initial identity as nurses during the educational process.

The researcher made initial contact with several nurses who were professional acquaintances and who worked as managers on medical-surgical floors of 3, university-affiliated, community hospitals located in a large metropolitan area. These managers recommended nurse interview subjects. Those interviewed then gave names of others who might be interested, and these nurses then became the final interviewees. Saturation of themes was reached after 11 interviews.

Each interview, which lasted from 40 to 60 minutes, was audiotaped in the participants' homes and was transcribed verbatim by an undergraduate student at the university where the researcher worked. As qualitative designs are "flexible, iterative, and continuous," interpretation and analysis occurred during the interviews themselves, and sampling strategies, interview questions, and even analytic styles changed slightly as the study evolved. For example, as more nurses were interviewed, the researcher asked more questions about how nursing students could/should be socialized into healing roles.

Depth interviews are organized around a guide that includes several rapport-building biographical questions related to the topic being investigated, as well as 1 to 6 open-ended or "grand-tour" questions with associated prompts, probes, and follow-up questions designed to elicit narratives "detailing the informant's conception of the identified domains" and categories (see Table 1).

The researcher developed the interview guide from the literature review, her personal interviews of nurse healers, and her experiences as a faculty member working with nurses returning for bachelor of science in nursing degrees. She developed and refined interview questions by using a focus group and conducting 2 pilot interviews. Two founding members of the AHNA considered experts in holistic nursing determined the face-validity of the interview guide. In addition, the researcher continually assessed validity throughout the study, making adjustments as she interpreted data and the quality of the questions at eliciting responses. She shared transcribed interviews and data interpretations (themes and understandings) with several participants for validation.

To move from research questions and gathered data to interpretations and write-up, the researcher used I/C—a cyclic process whereby she immersed herself in the text of narrative data, reflected, and arrived at intuitive crystallization in the form of themes, categories, and relationships, followed by re-immersion in the data, until reaching reportable interpretations. I/C is a process-oriented approach based on the earlier work of Moustakis. It takes time and the ability to listen deeply and reflexively, enlisting both right- and left-brain skills, to identify patterns and connections among themes.

**ETHICAL CONSIDERATIONS**

The proposal for this study was approved through an institutional review process; written informed consent

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**Table 1. Interview guide**

<table>
<thead>
<tr>
<th>Pertinent biographical questions (rapport-building phase of the interview):</th>
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<tbody>
<tr>
<td>• What year were you born?</td>
</tr>
<tr>
<td>• How many years have you been a registered nurse?</td>
</tr>
<tr>
<td>• What type of basic nursing degree did you receive?</td>
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<tr>
<td>• What is your highest educational degree at this time?</td>
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**At this time the first "grand tour" question was asked (the depth phase of the interview):**

1. What drew you into the field of nursing? (Nurses were also asked if they felt called to be a nurse. If participant responded "yes," they were asked to describe the nature of this calling.)
   - Do you have any specialty nursing certificates or certificates in other healing modalities?
   - Are there any other therapeutic modalities you practice or have learned, such as Reiki, massage, etc?
   - Have you ever sought healing (traditional or nontraditional) for any physical, emotional, or spiritual trauma or wounds?

2. What role do religion and/or spirituality play in your life?

3. Would you call yourself a "healer"? (If participant responded "yes," they were asked to say more about this. They were also asked how long they have viewed themselves as a healer, if there was a particular event that changed their perspective, and if they had ever thought about being a healer prior to this interview.)

4. How do you know when healing has taken place?

5. How would you describe your feelings about your current work as a nurse?

6. What do you do to take care of yourself?
Table 2. Demographic characteristics of participants

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Educational preparation</th>
<th>Years in nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denise</td>
<td>56</td>
<td>LPN, AD grad</td>
<td>LPN 24, RN 11</td>
</tr>
<tr>
<td>Alice</td>
<td>26</td>
<td>BSN</td>
<td>1.5</td>
</tr>
<tr>
<td>Marie</td>
<td>44</td>
<td>Diploma</td>
<td>22</td>
</tr>
<tr>
<td>Anna</td>
<td>50</td>
<td>AD</td>
<td>19</td>
</tr>
<tr>
<td>Liz</td>
<td>63</td>
<td>Diploma</td>
<td>37</td>
</tr>
<tr>
<td>Kim</td>
<td>46</td>
<td>BSN</td>
<td>21</td>
</tr>
<tr>
<td>Dede</td>
<td>24</td>
<td>Diploma</td>
<td>2</td>
</tr>
<tr>
<td>GT</td>
<td>54</td>
<td>LPN, AD</td>
<td>LPN 22, RN 7</td>
</tr>
<tr>
<td>Bunny</td>
<td>52</td>
<td>Diploma</td>
<td>31</td>
</tr>
<tr>
<td>Lucy</td>
<td>35</td>
<td>Diploma, BSN</td>
<td>4.5</td>
</tr>
<tr>
<td>Ann</td>
<td>52</td>
<td>AD</td>
<td>15</td>
</tr>
</tbody>
</table>

was obtained from each participant. The researcher assured participants that the contents of the interview would be held in confidence and that their identity would remain anonymous. As each interview was audiotaped, the participant had the right to ask that the tape recorder be turned off at any time during the interview, as well as that the interview tape be turned over to her at any time. Each participant chose a pseudonym, which the researcher used when referring to the participant during the taped interview and during transcript identification and quote reference.

The researcher interviewed 11 female medical-surgical nurses between the ages of 24 and 64. No other delimitations were placed on the sample population. Demographic characteristics of the 11 participants can be used to determine whether the study results have meaning and applicability to other situations (see Table 2).

LIMITATIONS

The themes that emerged in this study are relevant only to the 11 nurses who participated in this study. The researcher’s interpretations were made through a subjective immersion in the data collected. For this study, as with the majority of related studies, the postmodern lens has been applied. While these observations may be extremely valuable and deeply valid, it is problematic that they have not been more fully supported by other types of research that can actually measure outcomes and verify claims. It is difficult to know to what extent this will ever be possible. Many of the key concepts are inherently difficult to measure, such as to what extent nurses feel like they are healers and how this identity may manifest itself in actual behaviors, thinking processes, or feelings on their part. The ways in which patients respond to nurses who clearly self-identify as healers would be a good direction to pursue, because outcomes such as patient satisfaction with nursing care can be more easily measured with existing tools. Still, in order to teach other nurses how to be better healers, it must first be defined and described by those who already experience themselves in that way. This study may provide another ray of light to illuminate these phenomena.

It is possible that another researcher would interpret the data gleaned from the nurses in this study differently. In addition, the actual data would have been different in some ways had another person conducted the interviews.

SELF-IDENTIFICATION AS A “HEALER”

All of the participants self-identified as healers, with varying degrees of self-reflexivity. About half of the participants reactively rather than proactively claimed the healer identity, meaning that while 5 of the participants immediately responded “yes” and elaborated readily when asked if they were a healer, the other 6 needed time to think, sharing that they had never really thought about whether they were a healer or not.

While all of the participants seemed to claim the healing role, many did so with qualifications, and it became apparent that for most, this is not something they have reflected on.

GT: No, I wouldn’t call myself a healer; but I think my patients get better—well, I guess it is sort of healing, but I never thought about it . . .

Liz: I really haven’t thought about it in that way. I guess now that you put it that way . . . but I really haven’t [thought about it in this way before]

Several nurses seemed uncomfortable with claiming the healer identity because of the power inherent in the term.

Dede: Would I say I was a healer? Sometimes, I guess so, yeah . . . cause I can help them feel better, but I wouldn’t say I have all the power. I think the patient has the power . . . to feel better or heal . . .
Some participants seemed uncomfortable with taking credit for positive outcomes and wanted to be identified as part of a larger team working together for the patient’s good.

Marie: I would say to a certain extent... I guess we’re not like a total healer, but we’re part of the team that helps with the healing of patients...

Anna: I think so... I contribute towards it. I think I’m part of the whole team that’s working toward the goal of the patient, hopefully. So yes, [I am].

ADDITIONAL THEMES

Four overriding themes specifically related to nurses’ healing role were revealed in the data: healing is multidimensional and beyond curing; healing is about caring connections and relationships; healing involves nurse presence (listening, being with); and teaching is an important part of the healing role. Additional themes that emerged included affirming the importance of spirituality to the healing process; a deep love for and loyalty to nursing as a profession; extreme frustration with the work environment; significant self-sacrifice at the expense of self-care; the nurse as wounded healer; and the rudimentary use of complementary and alternative healing modalities (CAM). Most of these themes correlate with the themes identified in the literature pertaining to nurses’ journeys toward holism and development of the healer identity.2,5-9

Several themes emerged in participants’ responses in this study that correlate with other research findings. These included the notion of healing as being multidimensional and involving the body-mind-spirit totality of persons; the importance of nurse presence and caring connections and relationships; nurturing growth and development through teaching; affirming the importance of spirituality in healing work; experiences of personal wounding and healing; and some familiarity with and limited use of CAM therapies.

Themes that have appeared in related studies but did not emerge significantly in this sample include a strong emphasis on self-care; the use of self as the most important instrument of healing; the importance of exploring meaning in the illness experience; the need to create healing environments; the view of persons as energy fields; greater involvement with CAM therapies; and a well-developed connection with the spiritual nature of healing work.

BEYOND CURING

Participants readily offered examples of their healing influence related to giving emotional care and support. The participants clearly understood healing as more than just physical or cure-oriented, as demonstrated in the following statements:

Marie: A healer is anyone who physically, emotionally... can help someone with their problems in one way or another... you’re helping them through as far as administering meds and emotional support, you know you’re helping them through the crisis...

Dede: You’re focusing on helping them feel better; giving them relief from tension or pain... using empathy.

Several nurses described the body-mind-spirit synergy that is the focus of nursing care:

Kim: ... stress, illness, relationships all have physical effects. If you’re ill physically, you can feel depressed emotionally. If you’re depressed, you can feel physically tired. So I know this interrelationship should be addressed [by the] healer. In a broad sense, a healer is the person who holds your hand and listens to you... intervenes physically... or a counselor who intervenes emotionally, psychologically or spiritually. I see “treating” as a short-term and quick intervention. Healing takes more time. You can treat a wound, but it takes time to heal. I think nurses are the ones who spend time with the patient.

Denise: Just the fact of comfort that you give to people, you realize that’s the whole act of nursing. By assessing their needs and giving an explanation of what’s going on, you are a healer. Just helping someone through watching a loved one die is healing for them, too, because the grieving part starts then. And at that point, it’s no longer really that you’re taking care of the patient, but of the family. I guess if there’s any healing it’s more emotional and mental versus physical, because the physical part is slow.

Marie: You know healing has happened when a withdrawn patient becomes more open, more communicative, they might smile more, they might speak more, they just tell you more about the
family... They'll say "I have a good outlook... this is what I want to do when I get out.'"

Nurses in this sample consistently described their healing actions in terms of the whole person. They also demonstrated the understanding that people heal on many levels and that dramatic shifts can occur in the psyche and spirit of patients whose bodies remain wounded.

CARING CONNECTIONS AND RELATIONSHIPS

In the following quotes, nurses express the element of mutuality as it relates to care. Because they view their healing role as multidimensional, nurses described the feelings of satisfaction and the positive effects on outcomes when relationships and mutuality are experienced.

Denise: You can just feel when you’ve connected with somebody, that you’re helping them. You can see their whole body relax. If you see a hair on a [female patient’s chin], you ask, “Want me to shave it?” and you can just see their eyes water. It’s like “oh my heaven. They’ve been holding this in for how long?” To connect with someone on such a personal basis when you don’t even know him or her—that’s being a healer. You know they can face the next lab person who comes in much more at ease. If we feel better we’ll heal better. If hair is clean and they’re shaved and smell good, everyone reacts differently and more positively to them. I’ve had doctors come out and ask, “what’s different” about a patient, and all it was a shower and shave. Lab work’s not changed; physical condition’s not changed. When the doctor’s perception changes, the person’s own self-perception changes.

In addition, nurses spoke of the benefits of relationships to providing accurate care to enhance healing:

Kim: I think relationship is very important in the healing process. If you have a good rapport with your patient and get to know the patient, you may realize that a patient’s being treated for something they don’t have, but they have similar symptoms... Healing is a relationship. It’s something you do with a patient, and the patient has to be in agreement with [the plan of care] or you don’t have a plan of care.

Martin Buber (1878–1965), philosopher, scholar, and poet, reflected extensively on the nature of human interactions. In his book I and Thou, he examines the potential of relationships as mystical and spiritual in nature, where each party reflects on the other’s selfhood. This relationship is the “I-Thou” (used as 1 word), and takes on a separate identity, becoming what Buber called the “between,” an encounter that can be “beheld” by the participants. This relationship is one in which mutual healing occurs through respect for uniqueness, diversity, and a desire to know another’s essence. This relationship is a manifestation of the sacred in our everyday life, according to Buber. He saw any division between the sacred and the secular as false.

Buber envisioned that relationships should not be based on power, but on encountering another. This emphasis is important for those in the nursing profession to remember, because of the inherent power inequities so frequently encountered by patients as they navigate through the often-unfamiliar territory of healthcare environments.

Humanistic nursing is concerned with the “between” of nurses and “others,” who could be patients, families, colleagues, or communities. Through authentic presence, the nurse is aware of the uniqueness of self and other, even as a merging of understanding takes place. This awareness of distinction allows for questioning, thus facilitating the therapeutic role of the nurse even as he/she enters into a mutual relationship.11 This ability to maintain a therapeutic approach while entering into a mutual encounter requires a great deal of reflection and self-examination by nurses. Self-awareness allows for reflecting on the “I-Thou” relationship. As understanding grows, persons enlarge their conceptions of self and others.

Paterson and Zderad11 drew heavily from Buber’s writings to develop their ideas and are among the many nursing theorists who emphasize the importance and power of relationships between nurses and those for whom they care. Watson believes that human care can be effectively demonstrated and practiced only within the context of interpersonal relationships.12

Williams13 designed a study that examined the relationship between patients’ perceptions of nurse caring and satisfaction with nursing care. After controlling for patient variables of age, gender, and pain level, the researcher found a significant positive relationship between patients’ perceptions of nurse caring and their satisfaction with nursing care. The researcher concluded that current healthcare delivery focuses on the tasks of nursing rather than the interpersonal relationship between nurse and patient.
with time and resources mostly allocated for physical care needs, but rarely ever for interpersonal patient needs. Williams' study supports the notion that relational factors in the nurse-patient encounter are important to patients' satisfaction with care.

The quality of relationship between nurse and patient can affect many aspects of delivered care. In a study of intuition in nursing practice, Leners found that the quantity and quality of nurse intuitions about patients related to the depth of the relationship with patients. Depth was not dependent on length of time spent with patients, as evidenced in the reports of emergency department and intensive care nurses spending very little time with patients, yet reporting significant intuitive experiences.

Nurses who participated in this study (N = 40) consistently referred to “deep connections,” “true understanding,” and a feeling of “recognition” when describing intuitions that occurred frequently and that proved significant. One participant stated: “Intuition is my ability to connect at a soul level with another person, and in that connection there is a deeper ability to understand and to heal. It is a deep connection that I feel.” In this study, the deep connection between nurse and patient facilitated the occurrence, quality, and use of intuitive knowledge.

Watson promotes the use of self in entering a truly mutual relationship with clients to facilitate transpersonal caring. Through this type of relating, the nurse experiences the patterns and spirit of the patient, leading to transformation of both parties, and opening the way for true healing on all levels. Intuition is one way the nurse can tune into the patterns of her patient. Nurses in this study shared their experiences of intuition as part of their relationships with patients:

Lucy: Patients will say “it’s fine” and you know it’s not, they’re not fine with doing something, you know they’re scared. Sometimes you really have to listen to patients and there are times you have to say “if you really don’t want to do it, don’t do it. I don’t care whether your family or the doctor is pressuring you, if you have reservations, don’t do it.” ... just listening to someone has a healing quality. That person can say what they want and not be judged.

**HEALING AND NURSE PRESENCE**

The theme of nurse presence is found throughout the literature on caring, healing, and holistic practice.

Presence has been defined as “a way of relating that reflects a quality of being with in collaboration rather than doing to; a way of entering into a shared experience that promotes healing potentials and an experience of well-being.” Presence has also been defined as “full physical, emotional, psychological, and spiritual engagement and mindfulness of the nurse during any encounter with another.”

Nurses in this study described the need to listen to and “be with” patients and expressed the belief that this presence is a significant aspect of the healing process:

Anna: I’m an old-fashioned nurse, I think. Even with time constraints, patient care is the most important thing to me. I just make the time to let the patients know that I’m listening to them, that I pay attention to them, and I touch them. I hold a hand, or make good eye contact, depending on the situation.

Marie: At night people want someone to talk to. So I might not be giving physical care but I might be giving a lot of emotional care and just talking with the patient, spending time with them can mean all the difference in the world and it might help them as opposed to saying “here’s a sleeping pill.”

Alice: ... they’re nauseous, in pain, and sometimes even though you’ve medicated them, just sitting there with them will help. So I’ll rub somebody’s back while waiting for the medicine to kick in.

Distinguishing features of nursing presence include giving of self in the moment at hand, genuinely listening, knowing the privilege in participating in the experience, and being with another in a way that the other person perceives as meaningful. Without identifying it as such, several nurses in this study related experiences of being present for their patients, mostly by listening, holding a hand, or staying through a time of fear, sorrow, or anxiety, despite time constraints.

Buber described the importance of being fully present to another’s words, gestures, and tone of voice. Through true or authentic dialogue, one can be absorbed by listening to another human being or to nature, remaining aware of the ever-present tendency to slip into objectification. Through this genuine presence, deep encounter can occur, and the sacred can be made manifest. Buber believed that this was the truest discovery of self—self as “within relationship” rather than separate; presence is not a technique, but rather a way of beholding relationship.
McKivergin\textsuperscript{18} described 3 levels of nurse presence: The first is \textit{physical} presence, where body-to-body contact is made with another. This level includes actions such as eye contact, touching, doing, examining, hearing, and hugging. The next level is \textit{psychological} presence, in which the engagement is on a mind-to-mind plane. The skills used at this level include communicating, active listening, reflecting, counseling, attending to, caring, empathy, and being nonjudgmental.

The highest level of nurse presence, as described by McKivergin, is \textit{therapeutic} presence, in which the contact is spirit-to-spirit, or whole being to whole being. The skills used at this level include intentionality, intuitive knowing, communion, loving, and connecting. At this level, the nurse uses all the resources of body, mind, emotion, and spirit to interact with the patient. A nurse practicing at this level intentionally creates an accepting, loving environment in which the patient is more likely to access innate healing abilities. This, in turn, could lead to greater insights into self-healing. If, as many healers believe, all healing is self-healing, and if the power of love is the most potent healing force, then nurses practicing with this level of presence can offer a significant healing influence.\textsuperscript{20}

Using a phenomenologic approach and a sample ($N = 5$) of self-identified nurse healers, Hemsley and Glass\textsuperscript{21} identified the theme of “super-presencing” that was expressed by each of their participants. These nurses described placing themselves deeply within interpersonal interactions to be present to a remarkable degree, and then going beyond this to a level of transcendence. At these moments, a healing exchange occurs between the healer and the patient, allowing for healing and mutual growth. A context of love was a common theme present in all of the participants’ descriptions of these moments.

In interviews with 18 self-identified holistic nurses, Slater and colleagues\textsuperscript{6} described these nurses’ increased awareness about the effects of their presence on themselves and their patients. This was, in fact, the only concept expressed by every nurse interviewed in that study. Presence was viewed by these nurses as using oneself as the primary therapeutic nursing tool. It was described as “being available,” “willing to be with patients without an agenda,” “willing to be in silence,” “to be nonjudgmental,” and “to allow time and space to heal.” According to Slater and colleagues, “Presence appears to be the hallmark of a holistic nurse.” Although they did not clearly articulate that they see themselves as a primary instrument of healing for their patients, nurses in this sample shared experiences where they used themselves to “be with” a patient, especially when “doing to” was not useful or appropriate.

**THE NURSE AS WOUNDED HEALER**

Almost every participant described personal health crises that had occurred and the effects this crisis had on the way they practiced nursing in terms of their ability to be empathic and relate on experiential levels with their patients. In addition, most of them described personal experiences with psychotherapy related to crisis points in their life journeys where depression, loss, and/or psychic pain motivated them to seek help. In the context of these interviews, participants did not describe a healing journey that led them to seek meaning in their illness, nor did they mention communicating with their patients about the potential for finding meaning, growth, and transformation through health crises. In this regard they did not resemble nurses who have self-identified as healers as depicted in the holistic nursing literature.

Dede: When I was a kid, in one year in my family six people died [mostly of cardiac problems]... I knew I wanted a floor that also had oncology patients because it can be rewarding to help people go through it [cancer]. I’ve met incredible patients who really let you become part of their life.

Ann: I’m a cancer survivor. As nurses, we don’t know [what patients are going through] unless we’ve been there. So once you’re there, you can tell them what to expect. I’ve had so many changes in my life I’ve had to [learn to adapt] and go with the flow.

Denise: I’ve had [counseling for emotional healing] which helped me understand myself and [others] better. I had intense nerve pain [in my back] and that was hard. I was always a caring person, but I have a much better ability now to understand patients... because of my own life experiences. I never thought to say, “Go ahead and cry” to patients, and now I realize there’s a need for it [and I say] “You’re going through an awful lot, you have the right to cry, don’t apologize, don’t try to stop.”

In the aforementioned study of nurses who were aware that they had journeyed into a holistic worldview in their professional and personal lives, the researchers noted that the crux of the journey to holism was “whether nurses shifted their foci from looking outward, often working to improve others’
lives, to looking inward, toward a focus on healing themselves.\textsuperscript{66}

Participants in the Slater study realized that knowing information and applying it to others did not resolve their personal distress, and that self-healing was necessary to be an effective nurse healer. Participants described the importance of looking at the significance and meanings of their own symptoms and health issues as evidenced in this statement: "If I'm going to look at myself, at my symptoms for example...as totally physical, then I've lost the battle because I haven't thought about what I'm telling myself."\textsuperscript{(p379)} This reflects the view that illness can be a reflection of inner needs Wisdom and growth processes.

Nurses in this article's study did not describe these kinds of insights into the essential nature of self-examination, self-awareness, and self-care that is so often found in the holistic nursing literature.

**USE OF CAM**

All of the nurses related personal experiences with CAM that they had used in their own lives. These experiences included the use of herbs, aromatherapy, massage, imagery, self-hypnosis, and Reiki, yet none of the participants seemed particularly knowledgeable or passionate about these modalities. Although some said they had thought about formally learning these modalities, none of them had actually done so.

Most of them described ways they used some of these modalities in their work settings despite lack of peer support and time constraints. These modalities included massage (every participant mentioned this modality), touch, imagery, and pet therapy. More than half of the participants mentioned that they had thought about going to school for formal training in massage, and some said they would like to practice massage part time while maintaining their nursing careers.

Denise: I'd really like to look into healing massage therapy. I've increased my awareness about giving nutritional guidance and gone to seminars about this. I've directed patients to physical therapy and stretching...

Some participants were particularly interested in these modalities but either did not use or felt uncomfortable using them in their work settings:

Lucy: In my traditional work setting [these other healing modalities] are frowned on. But I use these myself and recommend them [to patients]. Chiropractic, massage, biofeedback, acupuncture, acupuncture...if it works, [use it]. With herbal therapies it's best to check with the doctor [to avoid cross-reactions]. For patients with migraines or chronic back pain I'll often suggest other things because they work.

Most of the participants described some use of CAM in their own lives and limited use of these modalities in their work settings. Limitations were mostly related to time constraints and discomfort with using modalities that seem outside of mainstream care. Several participants commented that fellow nurses might look at them askance for taking the time to give a backrub and expressed concern over using therapies that were less familiar to colleagues.

In a conversation with a nurse/massage therapist during the planning phase of this study, the researcher asked, "Are you a healer?" She replied, "As a massage therapist, yes, but as a nurse, no." As the conversation continued, it became clear that in the presence of highly technical monitoring and treatment modalities, physician orders, and time constraints, this nurse did not see the possibility for a "healing relationship." However, in her massage room with soft music, oils, autonomy, and an hour of uninterrupted time, she very much felt like a healer. As with this nurse/massage therapist, many nurses begin to claim their role as healers when they learn and begin practicing holistic and integrative modalities on themselves and other (B. Dossey, PhD, oral communication, October 30, 2000).

A study of 708 nurses who defined themselves as "holistic" revealed that they viewed themselves in this way in relation to their practice of CAM. Modalities most frequently used by these nurses included acupressure, aromatherapy, biofeedback, guided imagery, healing presence, humor, journaling, music therapy, meditation, relaxation, therapeutic touch, and healing touch. This study did not look at whether or not the nurses viewed themselves as healers. That nurses are once again getting in touch with these modalities after an extended time of emphasis on technology and the medical model may contribute to a change in the ways nurses view themselves.\textsuperscript{22}

In the Slater study of nurses' journeys to holism, participants related increasing use of CAM whether or not they used these modalities with patients. For many, CAM was an important part of their self-care practice. In addition, all of them used the language of energy to describe the nature of their clients, whether or not they engaged in any kind of energetic healing practices. All recognized the presence of human energy fields,
whether or not they worked with them to facilitate healing.

Nurses in this article’s study did not use the language of energy or fields, nor did they show evidence of extensive experience with CAM. This may be due to the tensions between the dominant ERA I paradigm and the emerging ERA II and III paradigms, as discussed in the first article in this series. It is easy to see from Lucy’s comment that nurses can feel caught in the middle of the paradigm clash. This position can lead to suspicion about what is outside the dominant paradigm, or fear in openly pursuing or publicly claiming interest in CAM. At the very least, it could inhibit the use of CAM as part of professional work.

It is possible that this insecurity is reflected in the limited use and pursuit of CAM education by the nurses in this sample. Quinn\textsuperscript{23} warns that nurses who do not practice their art and science fully and without limitations are more prone to burnout, defining this state as a spiritual condition resulting from “the inhibited flow of caring, love and healing energy.”

**AFFIRMING THE IMPORTANCE OF SPIRITUALITY**

When talking about personal life lessons, losses, pain, and healing, participants wove in the spiritual dimension of their experiences. Issues of faith, meaning and purpose, hope, love, and belonging came into prominence for them, and they all related this to the responses they saw in their own patients:

GT: ... being diagnosed with ovarian cancer made me very spiritual ... you look your own mortality in the face.

Denise: Religion plays a significant role in my life, and [not to judge] but it seems people with faith handle adversity more calmly. Perhaps some people just know how to cope better ... but it gives you something in common in relating to them. [Our patients are from many different faith backgrounds], and [although] you might think otherwise, religion is alive and well.

Many participants described personal growth regarding the spiritual needs of patients:

Kim: Actually, having become a Christian has helped me a lot, because in the beginning of my nursing career, I would often take care of ... people of other faiths and I knew there was something there but I couldn’t address that. A lot of times a [patient] would say, “Pray for me,” and I would answer, “Oh, I will,” and had no clue, really, how to pray or what it all really meant. But it helps a lot to support people spiritually when there’s nothing physically you can do.

All of the participants told stories related to the religious or spiritual dimensions of their healing relationships with patients:

Bunny: I want to see how open people are before I bring religion into things ... and I would say that 99% of people, especially when they’re really sick, are looking for any hope and I think religion is the biggest hope that you have. Prayers never hurt.

Anna: I’m not religious ... but I have a certain spirituality. I do believe in God, and in my [nursing] practice I incorporate faith and spirituality with what their needs are. I’ve said, “God bless you,” or, “I’ll pray for you,” to patients and I do. I’m not a hypocrite ... I reinforce and respect their beliefs to encourage their healing. Even in my own situations, I’ll pray. It comes down to a matter of faith, I think, for each person.

Ann: I’m quietly religious. I think it’s part of my everyday life and my nursing.

Many participants expressed ways in which they found spirituality important in their life and their work, as it met the particular needs of their patients. They acknowledged the need to include “religion” in patient care, yet none described any formal approach to assessing the spiritual needs of their patients, needs that may or may not involve formal religious affiliation. Nurses in this study did not discuss any interventions they used other than prayer.

Interestingly, nurses in this study did not discuss ways in which they nurtured their own spirituality, although they were asked what role religion and spirituality played in their own lives, as well as asked to describe ways they cared for themselves. In the Slater study, participants described a deepening sense of their own spirituality as they moved toward a more holistic worldview. This was nurtured by self-care activities that promoted body-mind-spirit balance, such as meditation, nutrition, work, play, rest, and spiritual practices.\textsuperscript{8} Nurses in this article’s study did not describe engagement in many self-nurturing behaviors (see theme entitled “Significant self-sacrifice at the expense of self-care”).

According to Burkhardt and Jacobson,\textsuperscript{24} nurses may be more comfortable addressing spiritual issues that arise in the context of formal religious affiliation, for example, a Catholic patient who requests that a
priest bring communion. When it is assumed that satisfying the rites and rituals of a particular religion means that a patient’s spiritual needs have been met, many individuals may be left without spiritual care. In addition, many patients are not affiliated with a particular formal religion, and nurses who do not feel comfortable or adept at assessing more subtle signs of distress may not address this need in their patients at all.

According to Smucker, the nurse’s role in spiritual care is to nurture aspects of spiritual well-being and attend to aspects of spiritual distress in patients. Spiritual well-being can be conceptualized as harmonious relationships with self, others, God, and the world. Signs of spiritual distress are as varied as the individuals who may express them, and could include crying, withdrawal, issues pertaining to forgiveness, questioning meaning and purpose, issues of love and belonging, anger, fear, mistrust, dark humor, and despondency. Only through careful attention and listening will nurses be aware of these indicators. A nurse who attends to her/his own spiritual needs and growth is more likely to be aware of these needs in others.

TEACHINGS’ IMPORTANCE TO THE HEALING ROLE

In this study, every participant talked about teaching as critical to her healing role. It was not surprising that most lamented the lack of time for this activity.

Marie: . . . just being there for patients, we’re healing them as far as doing teaching with them.

Alice: . . . sometimes I feel like a waitress instead [of a healer] just giving meds . . . you don’t get time to do the things people need like backrubs, explaining things, teaching . . .

Bunny: . . . [in the healing role] there’s always teaching involved, whether it’s with patients, co-workers, or volunteers . . .

Kim: I feel like a healer both in giving physical treatment [like wound therapy] and explaining things to people [like disease processes, possible outcomes] . . . So I do a lot of teaching and that’s what nursing is supposed to be.

Denise: I had to do a double shift last week and it was amazing . . . I was able to reach all my patients so well. I didn’t want to go home! It hadn’t been like that for a long time. I was asked to give treatment and give comfort and educate and talk to people and help them understand. I had a dying patient and supported the family . . . it was like WOW!

Ann: I think as a healer we teach patients how to care for themselves. I had a lady with cancer who didn’t know what to eat . . . we sat down and figured it out . . . and [I felt like a healer because] if nobody had discussed that with her she probably wouldn’t have eaten and would have gotten dehydrated and been right back here in a week or so.

It is intriguing to note that every participant in this study included her teaching role as an important part of her self-identification as a healer. The importance of teaching to the healing role is an ancient understanding.

. . . A philosophical debate about the very nature of healthcare has been ongoing throughout history. Doctors believe that health requires outside intervention of one sort or another, while proponents of natural hygiene maintain that health results from living in harmony with natural law. In ancient Greece, doctors worked under the patronage of Asklepios, the god of medicine, but healers served Asklepios’ daughter, the radiant Hygeia, goddess of health.

Medical writer and philosopher Rene Dubos wrote:

Health is the natural order of things, a positive attribute to which men are entitled if they govern their lives wisely. According to [Followers of Asklepios], the most important function of medicine is to discover and teach the natural laws that will ensure a man a healthy mind in a healthy body. More skeptical, or wiser in the ways of the world, the followers of Asklepios believe that the chief role of the physician is to treat disease, to restore health by correcting any imperfections caused by accidents of birth or life.

The word “doctor” is from the Latin root “docere,” which means, “to teach.” It is fascinating to speculate as to why early physicians chose this as their label in society, especially given the seeming lack of emphasis on the teaching role among physicians in recent times. Likewise, the word nurse is derived from the word “nurture,” which can be defined as educating, nourishing, and raising. In examining these choices of title, there is evidence that healing and teaching have been historically connected, often without conscious awareness on the part of nurses and physicians. Perhaps it is innate in the human condition that to be educated is to move toward wholeness and to experience healing.
Watson considered the interpersonal teaching-learning process as vital because it allows the patient to be informed and to take greater responsibility for health and wellness, thereby distinguishing caring from curing. By facilitating this process using techniques that enable patients to determine personal needs, priorities, and goals, care remains patient centered. The teaching-learning process as envisioned here maximizes patient involvement and personal growth. The theme of teaching and healing as it emerged within this study did not appear to be as patient centered. Most of the incidents of teaching, as related by the participants, seemed to occur in a more hierarchical context; the interactions seemed more nurse directed in nature.

Teaching is one of the priorities for relationship-centered care put forth by the Pew-Fetzer Task Force as part of effective communication. Imparting information and facilitating the learning of others are deemed necessary skills for nurses. Most schools of nursing emphasize the teaching role, as it is important for nurses to empower patients and their loved ones with knowledge to facilitate care and decision making.

Certainly Florence Nightingale believed in the power of the teaching role within nursing. The following quote from a private note Nightingale wrote expresses this mandate to teach:

Oh teach health, teach health, teach health, to rich and poor, to educated and, if there be any uneducated, oh teach it all the more: to men—to women, especially to mothers, to young mothers especially ... for the health of their children comes before Greek and grammar.

Perhaps even more importantly, in an era when there is often precious little time to interact with patients, the ongoing mandate and expectation that nurses will teach is a way to carve out and protect that iota of time to be with patients. As there is so little time left for relationships with patients, perhaps nurses strongly identify with their teaching role, not only because of the benefits patients may derive, but because it justifies time spent with patients and they feel good about themselves when they teach. Thus, they value the opportunity to receive direct, positive feedback from patients.

By helping people see things in new ways, healing shifts can occur. Nurses in this study appreciated the opportunities to impart understanding. They expressed gratification at easing someone’s anxiety or assisting with the decision-making process as a result of teaching activities. The strength of this theme demonstrates participants’ commitment to Nightingale’s mandate to teach health to all. That teaching is a gift to be given makes it a potent healing activity for the giver, as well as the receiver.

WORK ENVIRONMENT FRUSTRATIONS

Participants gave numerous accounts of the limitations in their work environments regarding time constraints, staffing shortages, cost-cutting measures with supplies, and sometimes, lack of support from coworkers:

Denise: Patients are so ill, and of course they keep cutting staffing down and there is a real need for nursing which the business folks [ought to be able to see on paper]. You can only be in so many places at once. I get frustrated and the patient’s safety is compromised.

Marie: I don’t think nurses get as much respect as they did 10 or 20 years ago. I know it’s a business now, but sometimes I feel like nurses and patients are just numbers. They take away staff, but give us more jobs to do. When it just gets so crazy you can’t even hear yourself think, and they expect you to, and if you do it once well it’s “you did it the other night, why can’t you do it tonight.”

According to Fagin, “Many nurses today find the activities involved in caring, to which they have devoted their education and their lives, no longer offer satisfaction.” A prime source of frustration is the lack of time to develop relationship with patients. With the average length of stay at 24 hours, little time is available to adequately establish trust, assess, and plan care with patients and their loved ones. Fagin cites the common refrain of nurses as “I love nursing but I hate my job.” The nurses in this study echoed this observation.

Quinn likens the current nursing shortage to the image of an endangered species. Certain species, such as frogs, show evidence of disease first, and act as a warning that the ecosystem is out of balance. Nurses are the endangered species in the diseased healthcare ecosystem. The work settings in which nurses spend much time and energy are the toxic environments that no longer support their abilities to be creative and caring in their work. The ongoing frustration of
working in this type of environment leads to a form of spiritual death, and nurses who are healthy enough to do so often leave in search of habitats that will sustain them.

Eventually, the nurse... will simply leave the system and perhaps open... a flower shop... Promises of more money or more flexible scheduling will not even tempt her... In the wake of her departure her colleagues will work one more nurse short, perpetuating the vicious cycle. 2,3(p9)

It was not surprising that almost all of the nurses in this sample expressed extreme frustration with their work environments. Although most of the nurses in this study expressed loyalty to nursing and a desire to continue working in healthcare, one wonders how long they will be able to endure the toxic aspects of their habitats.

SIGNIFICANT SELF-SACRIFICE AT THE EXPENSE OF SELF-CARE

It is evident that the nurses in this sample worked hard. Although the mean age of participants was 50, it was clear that their work environments were more physically, mentally, and emotionally taxing than ever before. Not only did these nurses ignore many of their own natural needs, but the environments in which they worked were not conducive to healing. Many participants described supervisory staff that seems to push them and place unrealistic expectations upon them. None of the nurses described their work environments as places of trust, support, or balance:

Marie: I’m a hard worker, but when it gets to the point that you... don’t have time to go to the bathroom or you have to eat while doing other things... when you tell your supervisor you didn’t get a break or that you’ll need to put in for overtime they’ll say “well, what do you mean?” or “why didn’t you call me” or make you feel like you should have gotten all of this done... a lot of times they’ll give you overtime but there’s a song and dance that goes along with that, too.

Dede: There’ll be hours when I forget to eat or be too busy to eat or go to the bathroom. Sometimes at work if you haven’t eaten and haven’t drunk you can get really testy but the night doesn’t always allow [the time] so you do the best you can.

Kim: Often times I don’t have dinner because I want to make sure I’m caught up by the end of the shift. I don’t exercise, I don’t sleep well, and I don’t eat well. You could say that I’m a bad nurse!

Healthcare’s cost-cutting atmosphere 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. 32 The comments of nurses in this study demonstrate the need for self-care. Yet it is clear that self-care is not a value that has been socialized into these nurses’ psyches or work environments. Indeed, emerging research demonstrates the increasing burdens of care on nurses and the relationship between negative nursing outcomes, such as exhaustion and needle sticks, and adverse patient outcomes. 33 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?

The other finding that is critical, especially in light of the nursing shortage, is the degree of self-sacrifice exhibited in these nurses at the expense of self-care. In Slater’s study of nurses’ journeys to holism, 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 two 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. 6(p372)

The data in this current study do not include descriptions of “liminal stage” behaviors. The participants described continuing efforts to work in suboptimal conditions, and did not describe efforts to step up self-care practices commensurately. Without intentional measures to ameliorate the ravages of toxic working environments, one wonders how these women can continue to nurse.

LOVE AND LOYALTY

Despite their frustrations, participants described their love of nursing. At the end of the interviews, several participants almost apologized for sounding negative toward the profession:
Bunny: I guess I sound like the health profession is going down the tubes right now, but I don’t think it’s quite that drastic. Changes are needed. When I became a nurse, did it matter what the patient needed—they got it. Now it’s a profit-making system and I don’t think the patient is getting what they deserve and it affects them and they take it out on the nurses. Then nurses are less likely to give them the care they need and it’s a vicious cycle going the wrong direction.

Lucy: I love being a nurse. I love what I do. I wouldn’t want to change what I do; I just don’t like a lot of the politics. I don’t like the fact that a lot of healthcare talk is done with mirrors and you go to upper management and say you have 34 patients on a floor that holds 30 cause you’ve doubled private rooms and the staff is stretched as thin as you can and everyone is stressed and cranky from the physicians to the volunteers.

Despite cited stressors such as staffing problems, heavy patient acuity levels, taxing nurse-patient ratios, unsupportive administrators, and severe cost-cutting measures, none of the nurses interviewed in this study shared a plan to leave nursing, and, in fact, they intentionally tried to communicate their love of nursing despite these frustrations. This is consistent with Fagin’s observations, that nurses tend to love nursing, though they may hate their jobs, and that nurses have tended to be extremely loyal to the profession as well as to their places of employment.

Evidence that this loyalty is eroding exists, however, as revealed in a 1997 survey of the American Nurses Association (ANA) membership. Forty percent of the nurses surveyed said they would not recommend their own hospital to relatives needing care. The most frequent concerns cited were numbers of medication errors, pressure ulcers, and postsurgical complications. In addition, more than half of the nurses in hospitals that they rated as “poor” or “very poor” said they would probably not remain in nursing. These responses were in marked contrast to surveys conducted by Fagin a decade ago, in which nurses ranked their hospitals as “good” to “very good,” despite anecdotal evidence to the contrary from patients, doctors, and even from the nurses, themselves.

CONCLUSIONS

The interviews with medical-surgical nurses presented in this qualitative study provide evidence that nurses, in general, think holistically, and see the importance of relationships, presence, teaching-learning process, spirituality, and (although only marginally involved themselves) the inclusion of CAM in caring for patients. Views on healing expressed throughout interview data reveal an almost universal understanding of healing as being beyond absence of symptoms and as involving the synergy of the body-mind-spirit totality of persons.

Holistic themes that appear in the literature on healers but that were not revealed in the data from participants in this study included self-reflexivity pertaining to finding meaning in the illness experience for self and helping patients to explore this for themselves, the importance of creating healing environments, use of self as instrument of healing, and the importance of self-care. In addition, nurses in this study did not seem to have formal, consistent ways of assessing and responding to patients’ spiritual needs beyond offering to pray for or with them.

This study identified higher levels of frustration and self-imposed limitations in the nurses interviewed than do the literature pertaining to holistic nurses. Nurses who view themselves as practicing holistically seem to communicate higher levels of professional self-actualization than those who do not.

Nurses who do not view themselves as the primary instrument of healing do not view self-care as a critical aspect of providing good nursing care. Conversely, if a nurse views himself/herself as the single most important instrument for facilitating healing, even beyond any drugs or procedures he/she may use (necessarily and appropriately), he/she may be more likely to keep the instrument “tuned up.”

Nurses in this study seemed to lack awareness of the importance of finding meaning in the illness experience for self and others. All of the participants shared instances of personal physical and/or emotional wounding and healing, but most did not elaborate in terms of the meaning of these experiences or the growth that occurred as a result of the experience. To search for meaning is to attend to the existential questions of life, a process that is inherently spiritual. It is possible that nurses in this study actually engage in this activity more often than was revealed in the data. For those who did share an experience of personal wounding and healing, most mentioned the positive effect this had on her ability to more fully empathize with patients in her care.

Most nurses are socialized, to some degree, in their basic educational processes to view nursing work and
patient care as a holistic process. Caring, therapeutic communication, and respect for the whole person are often mentioned in nursing texts, yet the reality is that these basic values are too seldom modeled for student nurses in their classroom and clinical environments.

In nursing textbooks, as in the nursing literature, the nursing identity of healer is rarely mentioned. As a result, most nursing students are not socialized into viewing themselves as healers. They graduate with a rudimentary understanding of holistic process that has not been clearly articulated or modeled for them. From the start they lack a language with which to describe their experiences of holistic caring process and what this caring process means. This lack of a clear language was evident in the nurses interviewed for this study as they described their approaches to meeting spiritual needs of patients. This inarticulateness was also clearly evident as they shared their frustrations with the work environment and could not describe, outline, or perhaps even envision ways to make it better.

Almost every nurse in this sample described her work environment as a nonsupportive one. A holistic model of care is not reinforced intentionally enough in most practice settings. Also, most nurses do not experience these holistic values in their work settings. Because nursing students have not been intentionally taught the importance of self-care to quality patient care, it is often difficult for them to create healing environments as they move into work settings that are less than supportive of these values. The frustration and exhaustion that they experience can be transferred onto patients in both conscious and unconscious ways.

Although they may not be able to clearly or extensively articulate their values pertaining to holistic care and healing, or lobby effectively to create environments that are healing for themselves and their patients, the nurses in this study hesitantly self-identified as healers. Since they lack the specific language to describe exactly what this healing role means and what it entails, they can’t always tap into the power of being a healer. This was most evident in the area of “use of self.” In the holistic nursing literature, the “self” is considered the single most important instrument of healing. Thus, nurse self-care, exploration of personal wounding, presence, and intention become key tools of practice that must be nurtured as fully as possible. For the nurses in this study, self-care was limited, and awareness of the potential importance of their own woundedness and healing processes on their effectiveness as healers seemed largely unexamined, or at least was not articulated through the interview processes in this investigation.

This lack of a clear vocabulary and defined values pertaining to the healer identity holds significance for nurses as individuals and as a group. When nurses can name the values and describe the roles related to their identities as healers, they give these values and roles greater clarity and power, and are able to more easily communicate them to others outside nursing. If nurses better articulated their unique place and contributions, regardless of work setting, the process of resolving the crisis in healthcare—as manifested in the nursing shortage—could be accelerated.

A discussion of the implications of the findings from this study will appear in Part III of this series, appearing in the next issue of Holistic Nursing Practice. These implications will be developed in terms of nursing education, nursing practice, nursing administration, and recommendations for further research.

REFERENCES