Healing Ourselves, Healing Others
Third in a Series

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A review of the literature (Part 1 in this series) revealed the power and pitfalls of being female and being a healer. A qualitative study of medical-surgical nurses (Part 2) gave a glimpse of the satisfaction, frustration, and confusion nurses experience as healers. In particular, participants did not engage in regular self-care behaviors and did not articulate ways to create healing environments that would support nurses as well as patients. In this third and final article, implications and recommendations beyond the study will be shared. Education, clinical practice, leadership, and research are aspects of professional nursing that may benefit from these interpretations.

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While teaching a group of RN to BSN students recently, the subject of being “wounded healers” came up (see Parts 1 and 2 of this series in March/April and May/June issue). One nurse shared that she had experienced ongoing depression, but had never felt comfortable sharing this with her colleagues at the hospital where she works. Immediately, 2 classmates shared that they, too, had suffered with depression for years and did not share this aspect of self with colleagues. Indeed, a survey of 229 nurses experiencing depression revealed that 30% did not reveal their condition to colleagues. In this same survey, 69% perceived work to be the cause of their depression. A majority of these nurses cited social support as the most useful coping strategy. It is sadly ironic that the seeds of healing may be denied in environments that are supposed to be dedicated to the healing of others.

At a recent social gathering, a nurse explained to me that she and her colleagues who work in a local community hospital feel exploited by the nursing leaders and administrators. The wound of powerlessness was evident as she shared stories of unrealistic expectations and a nonsupportive work environment. The fact that her nursing administrator talks about the value of holistic practice and encourages the use of complementary healing modalities is even more discouraging and confusing, as this same administrator frequently uses hierarchical ways of relating and an insensitive interpersonal style. This nurse described how her “heart sinks” at times as she loses hope of things ever changing for the better at work. She also shared her frustration, as she does not know where to look for greener pastures. Recent research supports the fact that nurses feel unsupported and abused in their work environments; this reality is sadly compounded by the fact that nurses too frequently do not practice the self-care that would buffer them from the damage incurred in these environments. While the impact cannot be fully measured, recent research underscores the negative outcomes for both nurses and patients in the current healthcare environment.

In observing friends and colleagues as they complete doctoral degrees in nursing, tales of mistreatment they receive at the hands of nursing faculty who sit on their doctoral committees have become a familiar refrain. The incidents range from feeling “jerked around,” dismissed and ignored, and used (eg, as access to a certain clinical setting for the faculty person’s own research pursuits), to tolerating issues of ego and hierarchy and insensitive time scheduling (eg, faculty postponing a meeting for months, which costs the student dearly in time and money). In fact, these occurrences are not uncommon, and doctoral students too often feel they have been damaged by their educational experiences.
The common denominator in the 3 situations described above is that in each, nurses are not free to be fully authentic, to feel fully valued, or to be fully empowered to care for themselves or others. Although ours is a healing profession, we do not always experience healing interactions within our ranks. We as individual nurses and as a collection of professionals must intentionally focus on healing ourselves from within. As we begin healing ourselves, we will have the potential to make a greater impact on the healing of others.6,7

This article will use the review of literature and the qualitative study detailed in Parts 1 and 2 of this series as a foundation for proposing changes in academic and clinical nursing environments. As we examine the identity of nurses as healers, the need for self-care for caregivers, and the creation of healing environments, it becomes clear that we must look at the preparation of nurses as the beginning of the process toward healing ourselves from within so that we can better facilitate healing in others.

NURSING EDUCATION

In a recent editorial in the Journal of Nursing Education, Tanner8 reminded us that nursing is not only a profession but also a calling that requires constant renewal of body, mind, and spirit. While most nursing faculty feel compelled to cover content as prescribed by such organizations as the American Association of Colleges of Nursing (AACN) (Essentials of Baccalaureate Education for Professional Nursing Practice [Essentials])9 and the Institute of Medicine (IOM),10 what might it be like if the compulsions to teach about holistic healing were equally strong? What if a priority for nurse educators was to help students to make sense of what life means and to look for ways in which these existential issues are revealed in everyday nursing practice? What if “Who is the self that nurses?” became an essential question to ask of nurses, those who prepare them for practice, and those who lead them?9,8

As both an art and a science, nursing requires that its practitioners develop as both artists and scientists. Various types of teaching/learning processes are required to facilitate this; yet a common denominator should always be to emphasize thinking and learning rather than cognitive gains.11 Thinking and learning are holistic processes that can address issues of body, mind, and spirit, rather than just mental processes.

One of the wounds nurses incur is feeling inadequate, or that they might not know enough. Many nursing students and practicing nurses carry the fear of not being knowledgeable enough, not making the grade, not performing well enough in clinical settings. Many carry the memories of feeling intimidated or put down in past learning environments, even prior to their basic nursing education. Many students need help to overcome earlier programming that tells them they are not “good students.”

The current trend toward the “additive curriculum,” whereby new biomedical, nursing, and healthcare information is added on without taking any away, can feed into the fears surrounding not knowing enough, and leave faculty and students frustrated and stressed. And yet, with all of the new information to be learned, how much time is devoted to developing the role of the nurse as thinker and healer? With rapid changes in biomedical and healthcare information, we may be misled in believing that coverage of as much of this content as possible will truly and fully prepare nurses of the future. Rather, teaching students to think, use resources to find current answers, and respond to patients authentically as individuals in the here-and-now moment may be the best way to prepare safe and effective caregivers.

The socialization of nurses as healers should begin in basic nursing preparatory programs, and be continued throughout the career spectrum as a part of orientation and continuing education programming. The process of nursing practice is as important as the content of nursing practice, and should be given equal time. Educators must decide which aspects of prescribed content can be imparted or taken in by students independently, and which need to be done within the supportive classroom environment. For example, a new recommendation is that content related to genetics be included in nursing curricula because of the recent advances in understanding the human genome. This needs to be carefully analyzed to determine what aspects of this topic are critical for nurses to understand. The ethical issues, and the ways nurses may need to respond to questions and dilemmas patients face—in essence the human response to situations this new technology may trigger—are fertile areas to pursue. Precise information about more of the biomedical aspects of this new technology may not be as important to cover as making sure nurses know where to find information should they need it. Nurses who enter a field in which this knowledge would be necessary will learn what
they need to know when the time comes—and will be able to get current information.

Nurses need to be comfortable with their role as healer, which is a constant over time and will apply to any environment in which they might work. Reading and reflecting on literature pertaining to nurses as healers (see Part 1 of this series) as well as increasing their own self-awareness are good places to begin this process. Hall\textsuperscript{6} identified 3 main areas that nurses can explore to develop themselves as healers. The first is that nurses must enter into a process of self-reflection because the more aware of their own personal wounding they become, the more they can begin to heal, and thus be able to respond more therapeutically to their patients. For the past 15 years, my students are assigned Scott Peck’s book \textit{The Road Less Traveled} to increase self-awareness. Feedback from hundreds of nurses over time has confirmed the benefits of using this book. By using reflection questions and maintaining a journal as they read, students begin to touch on aspects of their own lives that will come into play as they do nursing work. There are, no doubt, other books that can facilitate this process of self-understanding.

The second area identified by Hall is that nurses must explore and develop the healing relationship and healing arts such as complementary healing modalities. Books such as Snyder and Lindquist’s \textit{Complementary/Alternative Therapies in Nursing}\textsuperscript{12} or Keegan’s \textit{Healing with Complementary & Alternative Therapies}\textsuperscript{13} are wonderful resources to accompany nurses’ personal exploration of these therapeutic modalities. I use \textit{Holistic Nursing: A Handbook for Practice}\textsuperscript{14} as required reading to help nurses explore various healing modalities and develop an understanding of the complexity and diversity of healing. This understanding is the third area Hall recommends for nurses to explore as they develop as healers. Carlson and Shields’ \textit{Healers on Healing}\textsuperscript{15} and \textit{The Healing Path: A Soul Approach to Illness} by Barasch\textsuperscript{16} are both books that may enhance nurses’ understanding of the complex and personal nature of healing, and lay fertile ground for discussion in classrooms or staff development settings. Just reading one chapter of any of these books at a time and discussing over a brown bag lunch could lead to an enjoyable literature/journal club in any setting. Inviting an interdisciplinary group of participants could add unexpected twists to discussions and build therapeutic community in academic or clinical settings.

Over time, nursing education has focused more on technologic and pharmacologic interventions and less on the more holistic strategies that formed the earliest foundations of nursing practice. At times, in an effort to match the prevailing climate, nurses have allowed nursing education (and practice) to be dominated by the biomedical paradigm, often at the expense of using more natural, holistic kinds of interventions. While the idea of “PM care” (evening care that included a backrub) almost seems a thing of the past given the current patterns of admission, length of stay, and staffing, nurses inherently know that patients are being shortchanged if they do not receive this comforting kind of care. Nurses, too, are shortchanged as they lose another means for connecting with patients. Touch, along with the other senses, can provide a mutual flow of healing communication. Florence Nightingale knew this, and we instinctively know this.

Nursing educators are positioned to play a critical role in reclaiming, honoring, and expanding the holistic roots of nursing for the betterment of society. It has not been proven empirically that recipients of nursing care, as well as those providing care, can thrive in an environment that values body-mind-spirit–based interventions, mutuality, caring intention, personal meaning and growth, and clear communication among all persons. However, through other, equally valid ways of knowing, we can safely assume that this type of environment would likely enhance and not reduce the potential for caring and healing. If one accepts the potential for these foundational concepts to improve healthcare, a more systematic process of socializing nursing students into these values and philosophical foundations is in order. Nursing faculty must acquire knowledge, skills, and theoretical foundations to effectively teach holistic, integrative healthcare content. Content on caring, healing, and integrative therapies must be integrated into undergraduate, graduate, and continuing education curricula as quickly as possible, and educational materials pertaining to philosophy and use of these therapies need to be generated and expanded.\textsuperscript{17(p6A)} The recommendations from the IOM encourage care that is based on continuous healing relationships and customized according to patient needs and values.\textsuperscript{10} Thus, nurses must know how to develop relationships within healthcare environments as they are, as well as how to identify patient needs and values.

In the study featured in Part 2 of this series, it was evident that the nurses who were interviewed did not
regularly practice self-care. Most nurses are not taught the importance of nurse self-care to the delivery of quality patient care as a part of their basic nursing education.

The whole issue of self-care [nurturing and honoring self] was not something I learned in my nursing preparation. Nurses were told to comply, to be oriented to caring for the patient and caring for the physician, and to be secondary to everyone else. So we were not taught that unless we are together and unless we are caring for our own body, mind, and spirit, and are at a point of optimal health, well being, peace, and harmony, then we’re not giving [our patient] everything we can.18

Building self-care into curricula as an expectation throughout the educational experience can emphasize the importance of self-care behaviors. Role-modeling and experiential learning are likely the most effective way to accomplish this. Choosing texts that emphasize holistic, creative approaches to learning content can make a significant difference in the ways students take in and use new information. For example, a new text19 uses the art techniques of “pointillism,” mandala, origami, and space photography to help students engage with content about nursing theorists and their work while at the same time connecting to new sources of inspiration and stress release.

A culture of self-care can be built into any teaching/learning setting simply by adding regular group stretching and breathing breaks, music, healthful nutrition resources, and adequate bathroom resources with appealing soaps and creams. Teaching basic massage and foot reflexology techniques and making regular time for students to “practice” these techniques on each other helps them become accustomed to touching others in therapeutic and purposeful ways beyond the touch used for hand-holding, assessment, or treatments.

Faculty can be expected to model this core value as they engage in their own program of self-care, and students can be encouraged as they do the same. Movement, hobbies, artistic expression, meditation, animal companions, and massage are but a few of the myriad ways people care for themselves. Journaling about their experiences is a way to encourage self-reflection in nursing students, as well as monitor and evaluate progress in this expectation. Giving course credit for self-care activities is a way to emphasize the importance of these activities. In my course, Psychosocial and Spiritual Care, students are expected to engage in some form of self-care throughout the course and maintain a reflective journal about this experience. Ten percent of their course grade is derived from this activity. Since many self-care strategies are complementary healing modalities, this is an additional way to build an experiential learning component for these therapies into the curriculum.

Despite a high level of public interest in and growing evidence to support efficacy of integrative healthcare, nursing programs are still very uneven in their approach to teaching holistic philosophy and complementary and alternative healing modalities (CAM). In a recent study of complementary health and healing content in baccalaureate nursing curricula across the United States,20 it was evident that although a majority of programs (77%) reported including such content, there was great variance as to specific content, underlying philosophy, texts, and resources used. While this is not necessarily negative, it was also clear that this content was, for the most part, presented didactically, which is less than ideal. A didactic approach in combination with experiential learning is a more sound way to fully convey the totality of these modalities. In addition, this content should not be simply “added on,” but embedded throughout the curriculum.

To ensure an adequate foundation for understanding CAM therapies, many of which make use of the body-mind connection, nursing curricula can include content related to psychoneuroimmunology and psychophysiological self-regulation.21 An understanding of the science underlying many CAM therapies can facilitate and inform personal and professional decision making regarding the use of these modalities. This increased understanding would also strengthen the ability of students to educate others regarding appropriate use of these modalities.

Breda and Shulze22 introduced content related to CAM to nursing students by discussing the physiology of stress and how to elicit the relaxation response. Many of the CAM therapies are ideal for anxiety and stress-related disorders, and are also very available, making this a perfect experiential introduction. Although initially skeptical, by the middle of the course, students move toward greater acceptance of these modalities, and many disclose their own prior experiences with these strategies. That these interventions have yet to be embraced within most allopathic healthcare settings is further discouragement for nurses who may, nevertheless, be curious about them. Certainly, many CAM therapies
are holistic in nature, though the potential for them to be removed from a holistic context is always present. Attention to holistic context should be a priority in teaching CAM to nurses. Nightingale espoused interventions that were holistic, and so there is a strong precedent for the nurses of today to use them, as well.

Schools of nursing need to be structured as healthy environments that foster learning and well-being of faculty and students. This opportunity for informal learning can speak louder than words and facilitate a socialization process that will empower new nurses to create healing cultures in their workplaces after graduation. In the study presented in Part 2 of this series, every participant identified her teaching role as part of her healing role. The root words for both doctor and nurse relate to this teaching role. If teaching and healing are linked, then nurse educators must be fully aware of our healing role with each student we encounter. The belief that an educational process can be an inherently healing process makes sense, and it can lead people to become more whole and create shifts within aspects of self. Educators can affirm, give hope and inspiration, and help to mend past wounds. Conversely, educators can tear down, discourage, frustrate, and inflict wounds.

In a process called Narrative Pedagogy, teachers can link learning to personal experience by asking students to share personal stories that relate to a theme. This experiential connecting with content embeds it within a social context, and encourages thinking from multiple perspectives as stories are shared. This then enhances personal relating to content, enhancing retention, and application to other situations. This “decentered” approach not only decenters the content of the course but also decenters the teacher, making him/her no longer the “sage on the stage,” but rather a participant in the learning process. The teacher can then cover content by linking key points to the student’s stories, as well as to the teacher’s own stories. This process of

Pulling out or pointing to the knowledge students bring with them into nursing courses, or giving language to the knowing embedded in students’ narrative accounts. This provides an alternative to “covering content” without [leaving out reflection] on practice and thinking from multiple perspectives. This style of teaching is also affirming, and can facilitate healing within students.

An additional technique for creating holistic learning environments is to use literature and film. An example of this would be to show students taking psych/mental nursing the film As Good as It Gets to enhance sensory input of content and to provide an experiential perspective, thus making the content of the course more holistic.

Nursing educational settings and the opportunities they provide for collective socialization present an important context in which to highlight the imperative of transpersonal caring. As Watson emphasized, the transpersonal caring-healing model presents a hopeful solution for healing the nursing profession itself and becomes a model of possibility for medicine and healthcare in general. She sees nursing as a metaphor for the opportunity within the professional world to reclaim and recapture ancient healing practices, “while still benefiting and drawing upon the finest medical and scientific knowledge and technology acquired during this modern era . . . in medicine and nursing science.” To develop the belief within nurses that they themselves are a vital instrument of healing, even beyond drugs and surgery, is critical. To facilitate development of therapeutic communication skills and an increased repertoire of healing interventions (such as breathing, touch therapies, aromatherapy, music, cognitive restructuring, palliative care, spiritual care, nutrition, and the like) will equip nurses to facilitate healing and create healing environments even when drugs and surgery do not work. To feel prepared and empowered as healers may reduce frustration among nurses, as well as improve patient outcomes.

Basic content in nursing programs can be taught in many ways, each way reflecting specific values and each way influencing future practitioners differently. For example, one can look at bed making as a necessary but trivial task that anyone can do, and which needs very little explanation. Or, beds and bed making can be viewed in an entirely different way as preparation of a healing space. To create an environment that is inviting, comfortable, safe, private, and restful is extremely important and influential to the patient’s healing path. The bed can symbolize these almost sacred aspects of the physical space, and the nurse can hold these intentions in mind as he/she helps to create that space with the simple act of bed making. To carry this example one step further, bed making could actually be framed for nursing students as a type of healing ritual, one that is to be done with a great deal of focused intention for the benefit of the next person who will be occupying that particular space. For nurses who are so inclined, this type of activity can also be used as a time for prayer or a brief moving meditation, or for incorporating
breathing and imagery as a short interlude of self-care.

The American Holistic Nurses Association (AHNA) has formalized standards of holistic nursing practice24 for undergraduates, and advanced holistic nursing practice for graduate prepared nurses.25 These standards explicate core values related to holistic philosophy and education; holistic ethics, theories, and research; holistic nurse self-care; holistic communication, therapeutic environment, and cultural diversity; and holistic caring process. Educator Frisch26 has suggested that these standards be used in addition to the AACN Essentials to define quality for nursing education. The Standards of Holistic Nursing shares major concepts with the Essentials; however, it accentuates nurse self-care, articulated nursing theory as a foundation for practice, managing the care environment to promote healing, and the care of the environment as essential to professional practice. While both the Essentials and the IOM recommendations emphasize delivery of whole-patient centered care, the AHNA Standards give a detailed outline of all the components necessary to actually create the kind of environment where patient-centered care of whole persons can happen. The Standards of Holistic Nursing Practice can be obtained from the AHNA, and can be used in part or in totality to guide development of nursing curricula, as well as continuing education programs.

NURSING PRACTICE

Although nurses are often in positions of coordinating healthcare, their tendency is to defer to physicians as leaders of clinical care. But, there is incongruity in most healthcare environments between who is truly influential (nurses) and who seems to have the power (physicians). This misconception leads to confusion, communication difficulties, and dysfunctional relationships among members of the healthcare team. In our current healthcare environments, the burdens of insurance coverage add another layer of hierarchy in terms of decision making. This also leads to resentment and frustration on the part of caregivers, and less than optimal outcomes for patients. By developing as healers, nurses can disengage from the negative residue of feeling powerless. “It is the experience of caring and the memories of these experiences which lead to confidence, self-esteem and energy. Engagement with [patients] enriches, protects and empowers the healer.”6(p12)

This “engagement with patients” can also be thought of as the nurse patient relationship (NPR). That this relationship is at the core of healing was evident in the data from the nurses interviewed in Part 2 of this series, as well as throughout most of the nursing literature.27 Relationships take time, and the lack of time is the single most frequent complaint from practicing nurses—whether nurse practitioner, operating room nurse, or nursing faculty. We are oriented to view the nursing process as a linear one that requires time to first establish rapport and trust. How can healing take place when there is no time to listen to patients?

Watson23 referred to the importance of “caring moments” between nurses and others. These moments of eye contact or touch can be transforming, even though they only take seconds. Amplified by the intention of the nurse, powerful healing can be facilitated even while doing other, seemingly task-oriented nursing activities. Hagerty and Patusky27 explicated a different way of viewing the brief but essential relationships nurses often encounter in the course of patient care. When viewed as a dynamic, iterative interaction, each encounter between a nurse and patient can be a valuable relational moment where mutual goals can be attained—even within a very brief time period. Ideally, nurses should have as much time as possible to be with patients. When this is not possible, however, nurses need not feel all is lost. Often there is no time to establish trust, yet trust on specific levels occurs all of the time, for example, trusting a nurse one has only just met at a physician’s office to give a safe injection of a correct substance at an appropriate dose. (Imagine if nurses were socialized to view the giving of an injection as an opportunity for deep connecting through using their healing intention for that whole person!) Hagerty and Patusky27 postulated the expectations in the traditional view of NPRs as being that the nurse does most of the giving, and exerts most of the control. This limits nurses’ satisfaction, as this paradigm blocks true relating on an interpersonal level. The traditional, linear view of NPRs requires trust and time to be maximally effective.

THEORY OF HUMAN RELATEDNESS

An alternative approach to the NPR is based on the theory of human relatedness (THR) and highlights patient autonomy, choice, and participation as crucial factors. Through reciprocity (the idea that the patient
has something to give to the nurse as well), patients can feel empowered. The importance of here-and-now interactions is emphasized, and so “instead of feeling discouraged because of time constraints, nurses can view their interactions as positive and potentially effective.”²³(p149) “Small talk” can be reframed as a way to facilitate connection by discovering commonalities and mutuality.

According to THR, a nurse who matches her breathing pattern to that of her patient or who paces with a patient who is manic to engage him is using synchrony to facilitate the NPR and maximize the potential for healing. By matching/modeling the patient’s pattern, the nurse can then role-model a different way of being, should the patient desire. This modeling/role modeling behavior is an example of theory of care by Erickson et al.²⁸ Progressive relaxation, imagery, guided imagery, breathing, and hypnosis are techniques that can be used to carry out the concepts of this nursing theory. These modalities are all within the scope of nursing practice. A nurse who has learned how to use his/her whole self as an instrument of healing will be more sensitive to cues from others, and can make a profound healing difference in someone’s life in a very short time using his/her expanded repertoire of healing interventions. The following poem²⁹ illustrates this:

**Sunshine Acres Living Center**

The first thing you see up ahead is Mr. Polanski, wedged in the arched doorway, like he means absolutely to stay there, he who shouldn’t be here in the first place, put in here by mistake, courtesy of that grandson who thinks himself a hotshot, and too busy raking in the dough to find time for an old man. If Polanski had anyplace to go, he’d be out instantly, if he had any money. Which he doesn’t, but he does have a sharp eye, and intends to stay in that doorway, not missing a thing, and waiting for trouble. Which of course will come. And could be you—you’re handy, you look likely, you have

the authority. And you’re new here, another young whippersnapper, doesn’t know ass from elbow, but has been given the keys. Well he’s ready, Polanski. *Mr. Polanski, good morning—you say it in Polish, which you learned a little of when you were little, and your grandmother taught you a little song about lambs, frisking in a pen, and you danced a silly little dance with your grandmother, while the two of you sang. So you sing it for him, here in the dim, institutional light of the hallway, light which even you find insupportable, because even those who just work here, and can leave when their shift ends, deserve light to see by, and because it reminds you of the light in the hallway outside the room where, when your grandmother died, you were three thousand miles away. So that you’re singing the little song and remembering the silly little dance to console yourself, and to pay your grandmother tribute, and to try to charm Polanski, which you do: you sing, and Mr. Polanski, he who had set himself against the doorjamb to resist you, he who had made of himself a fist, Mr. Polanski, contentious, often combative and always and finally inconstant-

hears that you know the song. And he steps out from the battlement of the doorway, and begins to shuffle

and sing along.

**NURSING ENVIRONMENT**

When nurses are enabled to care for themselves and to care for the whole selves of their patients, they can thrive in their work settings. As the largest group of

*Reprinted with permission from the National League for Nursing.
employees in most healthcare settings, the robust well-being of the nursing staff will have tangible benefits for the whole of the organization and the goals of that organization. Most healthcare organizations use lofty language to describe visions and values to which they aspire. If, indeed, they want to achieve their goals, the health of the caregivers they employ must be a priority.

In a truly client-centered model, personal responsibility for health and self-care is encouraged and the goal of healthcare is not only the treatment of disease, but also the promotion of vibrant health, wellness, and the highest potential for human beings.17(p6a)

Nurses need ongoing support as they attempt to lessen the suffering they encounter each day. Most nurses are taught to empathize with and assist those who are suffering, yet they are not taught ways to understand and deal with their own responses to the suffering they encounter and absorb as a result of their work. “Understanding responses to suffering is one way to ensure that graduates remain in the profession.”30(p16) Threats that lead to the suffering of the healer can include the following: uncomfortable reminders of past personal events; unrealistic expectations of self and others; guilt; feelings of vulnerability; the high cost of empathy; the distress of inflicting pain; an obligation to not show one’s feelings; and threats to the healer’s spiritual or philosophical beliefs.30(p18)

Wise educators and nurse leaders will build systems into the routine that decrease the isolation of the healer, enabling nurses to regularly share feelings and responses to the difficult physical, emotional, and intellectual work that is nursing. An example of this would be to have a brief gathering of appropriate staff to process any and every loss or complex situation that occurs on a unit.

Debriefing, support groups should not be considered a luxury, but rather an essential tool to maintain efficiency of the staff. Providing support for the emotional as well as the intellectual responses to a profession should be considered an inherent part of the role of mentor.30(p20)

While this may sound unrealistic, having this in place as an expectation can go a long way in building community among stressed and frustrated nurses, such as those described in Part 2 of this series. Individuals who are not as affected by the situation can cover for those who are affected, and this can also enhance the experience of social support among staff. These gatherings can be interdisciplinary. Perceptions of social support in nurses’ work environment is of critical importance and may lead to enhanced quality of care and retention of nursing staff.31

Drafters of the Gillette Summit recommendations emphasized the responsibility of nurses in leading the integration of healthcare. One way of doing this is to design integrated care systems that are patient-centered and maximize the contribution that nurses can make as providers and coordinators of care. A model for such a system has been proposed by Quinn.32 She suggested combining the magnet hospital model (first proposed in the 1980s as a result of a study by the American Academy of Nursing) with holistic principles such as relationship-oriented care, mind-body-spirit orientation, and truly integrative approaches to healing. The magnet model conceptualizes nurse autonomy, nurse control, and better relationships with physicians as evidence of magnet status. “Nurses and patients in magnet hospitals are both happier and healthier from all accounts.”32(p12)

Building on the magnet concept, Quinn proposed that selected units of existing hospitals be re-created as “Nightingale units.” These units would be designed to “pay careful attention to autonomy for professional practice and full utilization of nurses’ preparation, knowledge and skill. They would also make adequate staff available, as well as the resource of clinical nurse specialists and nurse practitioners to serve as primary care clinicians.”32(p17)

The standard of care in the Nightingale unit would include all standard nursing interventions used within allopathic settings, with the addition of CAM strategies. In this context, Quinn has relabeled CAM to “caring-healing modalities,” many of which have been used in nursing practice for decades. Patients could select from imagery, healing touch, massage, meditation, acupressure, music therapy, aromatherapy, and other therapies. Nurse acupuncturists and nurse homeopaths could also be part of the team on a Nightingale unit.

The economic benefits of this proposal are clear. Patients are already paying (often out of pocket) billions of dollars for these therapies outside of the hospital. Many hospitals are already directing large amounts of money to pay for external CAM centers.

“What has been marginalized in a specialty integrative health center simply becomes the standard of care in
the hospital.”32(p20) The cost benefits grow if decreased nurse turnover rate and decreased iatrogenic effects of poor quality care are factored in.

A truly integrative care model for both inpatient and outpatient care can be established. Nurses are perfectly positioned to learn and practice these modalities, and are already licensed, insured, and employed by the hospital. “Nightingale unit nurses would be encouraged to attend to self-care along with patient care, and in-service and staff development programs with this emphasis would be as routine as programs focused on new clinical patient care skills.”32(p21)

Clear communication and an atmosphere of respect would prevail on a Nightingale unit. The goal would be to maintain a healthy habitat for the healing of all who enter the unit.

To evaluate the effectiveness of a Nightingale inpatient unit, data could be collected on the numbers, demographic characteristics, and diagnoses of patients who choose this unit over a standard unit, morbidity and mortality statistics, patient and family satisfaction, nurse retention and satisfaction, physician satisfaction, and costs. If the analyses of these data were positive, the hospital could apply for magnet status, use the Nightingale unit as a marketing tool, and open more such units.32

Again, nurse administrators and nurses in all types of work settings must create environments that are healing and nurturing for all who enter the environment. “Work environments that are healing and nurturing for staff as well as patients will enable institutions to both attract and retain nurses.”17(p7A) Malkin33 outlined priorities for designing healing spaces. Specifically, these spaces would boost immune system functioning and shorten length of stay. Suggestions include noise control, air quality, thermal comfort, privacy, light, communication resources, views of nature, color, texture, and accommodations for families/significant others. While the avoidance of noxious odors is recommended, the use of healing fragrances is not mentioned in Malkin’s book. This is also an area for attention as the art and science of aromatherapy and energetic healing potentials of essential oils are better understood. In England, the scent of lavender and citrus can be detected in the halls of hospitals as these are considered important aspects of creating the healing environment (B. Dossey, private communication, October 31, 2001).

A relatively easy and inexpensive way to influence the environment is through the use of music. Research data is mounting in support of the therapeutic potential of sound and harmonics.34 Carefully selected music can be an important part of the healing environment. Because music is nonverbal in nature, it is natural and subtle in its action.34 By acting as a vibrational balancer rather than as distraction, music can actually help patients relax by physiologically calming the body-mind-spirit.35 To overcome variations in taste and possible negative associations, music has evolved that has no recognizable melody or harmonic progressions to elicit a conditioned response. It has a vibrational language and flow that promotes mind-body attunement, relaxation, and contemplation.34 This music is sometimes called “New Age” or “relaxation/meditation music.”

Entrainment music is created specifically to bring brainwaves into a 7 to 8 cycle per second pattern. This alpha-theta pattern is characteristic of a relaxed, aware, or meditative state.36 Consider the normally stressful emergency room environment. Simply adding soothing music as a backdrop can transform the environment, improving the patients’ as well as the caregivers’ experiences within that setting. Certainly, all music to be used in clinical settings should be screened to make sure it is appropriate for that setting. Often, it will be the patient who chooses the music that will best suit his/her needs at any given time.

In many instances, it is appropriate for the patient to cocreate his/her environment, making the space one that is both personal and conducive to healing. Even when people will not be staying long, the idea of “transitional objects,” or objects with significance and the ability to evoke positive responses, can be most beneficial. When helping nurses to appreciate the importance of this strategy, it is helpful to illustrate additional benefits that may be derived from inviting patients to personalize the environment.

Before I began bringing my living room to the hospital with me, I was just another disease. Nurses would often come into the room and never even make eye contact with me. After I brought in the artwork and music, they began to notice the paintings, and ask me questions about the music. I became a person to them instead of just another illness.33(p18)

It is helpful for nurses to think intentionally about their ethic of caring and ways in which it may or may not be made manifest in the environments in which they work. All of us should ask ourselves if we see congruency between our values and the realities of our work settings. In reality, all those who enter our environments are affected by them one way or another.
If we work in places where healing should be taking place, or where we are preparing individuals for healing work, we need to be especially aware of ways in which this goal is supported or subverted. We can pay attention to creating places where individuals will be supported in their learning, their healing, and their work. A key component in this process is to be aware of hierarchical relationships and the ways imbalances of power can create situations where people experience stress, doubt, insecurity, even fear, and are not raised to their highest level of being. This dynamic can be seen in teacher-student relationships, healthcare provider-patient relationships, and administrator-employee relationships. At the Hospital Distrital de Evona and adjoining nursing school Escola de Enfermagem de Sao Joaode Deus in Lisbon, Portugal, nurses have instituted a clinical orientation that is explicitly shared with those they serve. The following reflects the nurses’ mission:

People who come to us come in a free and spontaneous way, and are with us as long as they wish. We offer: An unconditional response, free from criticism and judgment; a space of freedom, solidarity and human authenticity; an empathic understanding; and a positive listening.

(Marques and Lopes, personal communication, 1994, as cited in Watson) These powerful words convey a message of respect and hope for patients as well as caregivers within this environment.

NURSE LEADERSHIP

It is unrealistic to believe that simply educating nurses about holistic concepts will have a significant impact on the healthcare industry. No matter how much preparation a nurse has, if he/she enters a work setting that is not a healing environment, it will be difficult for that individual to change the status quo. While grassroots efforts on the part of nurses are essential to facilitate a shift, a more top-down approach within practice settings would no doubt hasten the transformation of healthcare environments.

Nurse leaders of today are in difficult positions as competing demands press in on them from all sides. Books that describe new ways of looking at leadership can be helpful. Quantum Leadership by Porter O’Grady and Kathleen Malloch offers leaders the opportunity to envision nonhierarchical structures that recruit the vision and abilities of all members of the team. In this way, all are empowered to set and reach goals beyond what could have been envisioned by just one person. The Center for Nursing Leadership’s Dimensions of Leadership include language that speaks to the valuing of holistic principles such as wholeness, relationship, self-awareness and self-knowledge, self-regulation, self-care, mentoring, nonjudgment, interdependence, and diversity.

It is the leader’s responsibility to role-model the priorities and behaviors he/she expects from others. An acknowledgement that workers (and indeed the leadership) need time for family, hobbies, exercise, and even support for education, is critical. The more that nonwork aspects of life are accounted for, the healthier and, therefore, more productive the workforce will become.

Certainly, leaders need to protect nurses as the valuable natural resource they are. Nurse leaders must garner support to clean up the toxic environments in which many nurses work and in which patients seek healing. To support efforts of nurses to create appealing, healing environments that speak to the body-mind-spirits of all who enter them must be a priority if healing is to occur within these environments. To empower nurses to expand their repertoire of healing interventions beyond drugs and surgery is necessary to enhance therapeutic benefits to patients. To care for nurses so that they can continue to care for patients should be the priority of all nurse leaders. To use nursing knowledge to argue for the means to facilitate the health and well-being of nurses and patients in any environment is likely the most fruitful avenue to pursue when faced with economic and outside pressure. Nurses know what is necessary. Quality healthcare is not a business as much as it is an authentic process of relating and moving toward wholeness.

RECOMMENDATIONS FOR FURTHER RESEARCH

Further research is needed to determine if intentional socialization (to claim the healing aspects of the nurse role) within nursing education and practice settings would be beneficial to nurses and patients. Whether or not self-identification as healers can make a difference in the collective self-esteem of nurses remains to be determined. Other research methods should be employed to further enhance our understanding of the phenomena under investigation. Measuring outcomes of care given by nurses who self-identify as healers versus those who don’t and comparing the nursing
care given by nurses who engage in self-care practices with that of nurses who do not, are 2 examples of studies that would yield data that could strongly influence nursing education and practice. A study designed to compare patients’ satisfaction with care given by nurses who are able to clearly articulate holistic values and philosophy versus those who are not could also yield interesting results, ones that may or may not support the socialization of nurses into these values and philosophies.

Another avenue of related research that could illuminate the effects of creating healing environments would be to measure aspects of patients’ experiences in environments that are intentionally holistic as well as in those that are not. Ideally, it would be intriguing to measure specific variables before and after a process of holistic socialization has been used to transform an environment. For example, to administer brief depression and anxiety inventories to patients upon entering and leaving an outpatient pain management clinic during a 2-week period of time before as well as after the staff undergo a process of socialization to holistic practice could yield interesting data.

Research related to the role of CAM therapy practice and nurse self-efficacy needs to be continued. According to the recommendations from the Gillette Summit,17 more research related to integrative health strategies needs funding and nurses need to be rigorously prepared to carry out this agenda. Findings from this research need to be disseminated more widely and aggressively to healthcare professionals and the public. Nurses must avail themselves of all good research pertaining to healing, whether or not it fits in with the prevailing paradigm. Although the shift has begun, the allopathic paradigm still dominates the holistic approach, and there is danger that CAM may be coopted from inherently holistic roots and become a set of techniques for use within an allopathic philosophy of care. Nurses, in particular, are in positions to prevent this from happening.

As patients use these modalities with increasing frequency, nurses have professional, legal, and ethical reasons for becoming well informed about their use. While nurses must respect the values and choices of patients, they have an obligation to provide accurate information about the benefits and potential risks of any and all therapeutic modalities.40 The fact that CAM modalities often have lower risk profiles makes them even more attractive as potential therapies. As was mentioned in Part 1 of this series, the literature addressing CAM use by holistic nurses strongly suggests that these nurses typically first try CAM for themselves, and then become strong advocates for usage in their own clinical practice.41

A VISION FOR NURSING

There is power in the term “healer” and a feeling of pride in calling oneself a “wise woman” is evident in the stories told by the nurses in Profiles of Nurse Healers.42 This sense of power may be manifested in different ways, including sharing credit for positive outcomes, feeling oneself to be an important conduit for healing energy, and feeling eager to be even more available for healing encounters with self and others. That the nurses in my study did not radiate the same level of clarity, professional intention, and personal satisfaction as those profiled in Keegan and Dossey’s book was evident. If more nurses were as clear and focused in their professional and personal missions as those featured in Profiles of Nurse Healers, they might have the determination to take their places at the healthcare table where important decisions about economics and policy are made. In addition, they might advocate for themselves differently, interacting with their colleagues within and outside of nursing in more constructively powerful ways. To have the full voice of the nursing perspective in these discussions and planning venues could help to transform healthcare.

With the current and ongoing shortage of nurses in clinical practice, it is becoming increasingly essential for healthcare administrators to explore ways to recruit and retain nursing staff. Socializing nurses to develop and practice holistically through basic nursing educational programs is a good place to begin. Fostering this in the workplace is essential, and can be encouraged through continuing education and with intentional planning of healing environments.

While it is certainly possible for all nurses to facilitate healing in those for whom they care, it makes sense that some nurses do this to a more significant degree than do others. The personal attributes and attitudes of healers—as depicted in the growing body of literature—can be developed and refined. Nurses represent the largest professional group within the healthcare field. As nurses, nurse educators, and nurse leaders are intentionally exposed to educational content and role models who facilitate the development of self-awareness and self-healing, they will claim and develop their roles as healers. With
greater attention given to all of the relationships nurses experience that impact the web of healing process (eg, with self, with other nurses, with students, patients, and interdisciplinary colleagues), the quality of these relationships can be addressed to potentiate healing. In this way, individual nurses will gain clarity, toxic environments can improve, and the profession, as a whole, will shift toward a more effective approach to care and healing. By promoting the identity of nurses as healers, nurses may begin to heal themselves as individuals. This, in turn, may foster healing within the nursing profession itself, contributing greatly to the healing of our dysfunctional healthcare system.

REFERENCES


SUGGESTED READING