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HOLISTIC NURSING

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The Journal of Holistic Nursing, a quarterly publication of the American Holistic Nurses' Association, publishes original articles of merit related to holistic nursing. The emphasis of the journal is on original work, including education, practice, and research.

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Editorial

Putting Ideas Into Practice

The worst thing for me about starting college was knowing that I would have to take a required history course before I could matriculate into the nursing major. All through high school, history was the one subject I liked the least. I had trouble with American History and World History and couldn’t see how memorizing a bunch of facts about either of these subjects would make me a better health care provider! So, although I was wildly ecstatic about going off to the big city to begin my academic career, a part of me truly dreaded signing up for that freshman history course.

To my great delight, when I met with my prenursing faculty advisor, I learned that there was a menu of courses that would fulfill the prerequisite in history. Of course, there were the usual offerings of U.S. History Prior to the Civil War, History of the World, 1800-1900 A.D., and History of the World’s Great Religions. But the one that caught my eye and that turned out to be one of my favorite courses during that freshman year was The History of Ideas. Oh, I was exposed to history all right (and I probably even memorized some general dates), but instead of struggling with the names and dates of famous battles and warriors, I was caught up in the development of philosophical ideas of great thinkers. Instead of reading a survey of world history, I read The Question of Socrates (Levin, 1961) and The Origin of Species (Darwin, 1859/1960).

That course taught me a great deal about how ideas can shape the behavior of human beings for better or for worse. Historical characters such as Stalin, Hitler, and Mussolini became not merely the names of dictators who lived and died in European countries on specific dates in time. Rather, they were men whose ideas had a profound and deadly influence on the actions of millions of people. By the same token, Aristotle, Plato, and William James became persons whose...
ideas had the power to change the way I think and act today. For readers who have not had the benefit of a whole semester’s course in the History of Ideas, I strongly recommend reading Sophie’s World (Gaarder, 1991). Not only does it contain the essential ideas of many of the world’s greatest philosophers, it is presented as a whimsical mystery that addresses a young woman’s spiritual quest for self-understanding.

To this day I am intrigued by new ideas that can influence the way we live our lives. The idea that people could leave the surface of the earth and walk on the surface of the moon paved the way for a whole new series of technological developments. That single idea, borne of someone’s dreams or fantasies, has shaped the careers and daily lives of thousands of people around the world.

The idea that holistic nursing is the best possible way to deliver patient care services is currently transforming the lives of hundreds and thousands of professional nurses throughout the world. Moreover, by putting their collective and creative ideas together, holistic nurses are beginning to transform the health of the people we serve. To date, we know very little about how the idea of holistic nursing affects both the nurse and the client. We have many anecdotal accounts but very little rigorous research to support our beliefs and claims. This presents a serious challenge to us as a profession whose mission is to enhance “healing the whole person from birth to death” (Dossey, Keegan, & Guzzetta, 2000, p. 28). This journal is a significant contribution to meeting this challenge. Whereas many have complained that the journal is “too stuffy with all that research,” others have recognized that these published reports are essential to putting our ideas into practice. In this issue of the journal, we not only present the results of some fine research but are introducing a new, more practical department: Applied Concepts of Holistic Nursing. Editorial Board Member Vicki Slater, Ph.D., has graciously agreed to assist in editing this section of the journal. We hope that these anecdotal accounts of the way holistic nurses apply the ideas and concepts of holistic nursing in their practice will inspire others to be as thoughtful about their practice. We also hope that it might spark in some the idea that conducting rigorous research of nursing practice can provide evidence that holistic nursing is the best possible way to deliver care in the 21st century!

Lynn Rew, Ed.D., R.N.C., H.N.C., F.A.A.N.
Editor
REFERENCES


Ethical Principles Applied to Complementary Healing

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With the public and professional shift to an interest in alternative/complementary therapies and holistic health, existing assumptions about the relationship between providers and clients are being challenged. This study explores the ethical approaches and underlying principles in the expectations of three organizations espousing holistic health and touch therapies. An analytic technique using a qualitative approach was applied to the documents of written ethical codes and standards from these organizations and was augmented by field exposure from previous work with each of the groups of healers. The emphasis on and approach to the principles of paternalism and autonomy from the groups provided contrasts with general biomedical approaches. All groups gave attention to the constructs of nonmaleficence, beneficence, and autonomy, with a strong emphasis on virtue ethics. The shift in the expression of the principles of paternalism and client agency allowed the healers to employ the therapeutic effects of placebo, suggestion, optimism, hope, and surrender with the avoidance of noicebo effects.

The introduction of alternative healers into the existing health care culture challenges not only the implicit and explicit understandings in which patient-provider relationships are transacted but also expressions of the ethical foundations on which those assumptions are based. Use of alternative or complementary healing practices has increased to 46.3% in 1997, an increase of 10% since 1990, according to Eisenberg et al. (1998). Complementary therapies are provided by lay healers as well as nurses who have reconceptualized nursing activities as being in the domain of healing (Snyder & Lindquist, 1998). Public exposure to healers, who often express the ethical approaches
of autonomy and paternalism in a way that differs from biomedicine, raises new questions with regard to the patient-provider relationship in all therapeutic arenas. The purpose of this study was to understand the ethical perspectives of lay and nurse healers.

The focus in health care delivery now includes concern for quality of life in long-term management of chronic illness and the importance of lifestyle issues in prevention. This shift from acute care management challenges the traditional patient-provider relationship and requires that the locus of responsibility for action move toward the patient and out of the exclusive control of the provider. These changes affect the provider-client relationship and often are not overtly discussed, with the net outcome that both patients and providers may be unsure of their respective roles.

The explicit aspects of provider-client relationship are established through formal contracts including legal forms, standards of practice, and specific codes. Implicit aspects of the relationship are evident in the assumptions and expectations about the respective patient/provider roles and their attendant responsibilities and behavior. A form of implicit paternalism in contemporary medical care delivery is the assumption that the provider makes decisions in the best interest of the patient (Brody, 1997). Healers often practice according to ethical frameworks that draw on historical and cross-cultural models of healing that emphasize different aspects of paternalism and autonomy from general biomedicine. The reemergence of some of these implicit aspects of paternalism in a culture that values individualism and autonomy raises new issues in contemporary health care delivery. Exploration of these issues can assist in opening the dialogue for the development of a synthesized ethical approach for contemporary integrated health care.

**Biomedical Ethical Framework**

Biomedical ethics focuses on attaining an appropriate balance between two philosophical approaches: paternalism and autonomy. Paternalism refers to the long-standing idea of the provider holding special knowledge and skills and using these to help the patient, as a father would care for a child. The principle of benefiting and not harming the patient is the dominant ethical consideration (Brody, 1997). This is consistent with the principles of nonmaleficence, beneficence, and a concept of personal virtue. Nonmaleficence is characterized by the following statement: “One ought not to inflict evil or
harm” (Beauchamp & Childress, 1994, p. 190). This reflects the Hippocratic maximum, first, do no harm. Beneficence has three obligations: One ought to prevent evil or harm, remove evil or harm, and do or promote good. These obligations generally assume a positive action to benefit others. These principles largely depend on the virtue or personal morality of the provider.

In contrast, autonomy has been an important approach that underlies decision-making in medical care and has been championed by nursing. Autonomy is the duty to decide responsibly for oneself about one’s own interests (Ashley & O’Rourke, 1994). Two conditions, liberty and agency, are essential to this principle. Liberty refers to independence from controlling influences or constraints, and agency refers to the capacity for intentional action. Much discussion in medical ethics has centered on the issues of competence and capacity for intentional action. Autonomy generally plays an explicit role in the patient/clinician contract through the establishment of legal documentation and standards for practice and decision making.

Ethical principles are illuminated and articulated in a cultural context. It is therefore important to understand the historical context of current ethical approaches. The ethical approaches of paternalism and autonomy have been the focus of debate in Western culture. However, since the 1960s, autonomy has become the predominant focus in medical and nursing ethics (Brody, 1993).

**Paternalism**

Since the time of Hippocrates, the foundation for Western medical ethics has been based on the perspective that choice making was left to the one with specialized knowledge who was committed to benefiting the sick (Veatch, 1989). This position recognized the centrality of competence, judgment, and compassion of the healer, which was consistent with the prevailing principles of beneficence and nonmaleficence. The paternalistic view is predicated on the provider’s commitment to the patients’ best interests and may exclude patients from meaningful participation in decision making (Wear, 1993).

The paternalistic model developed out of the historic merger of medicine and religion. Jonsen (1990) described a type of knightly nobility stemming from the 11th-century Knight Hospitallers that has pervaded the practice of medicine. These knights were to be healers and servers of the sick and poor. The impetus to become a practitioner in the healing arts was, true to the religious-theological roots, a calling
of service to humanity. This view has been reemphasized at different points throughout history and is evident in nursing through religious orders such as the Sisters of Charity. It is also reflected in cultures in which the role of healer is combined with that of spiritual leader. Shamans, mediums, curanderos, spiritualists, and many indigenous healers are cross-cultural examples of the integration of these roles (Csordas, 1995; Eliade, 1974; Kinsley, 1996). The dual role reflected the belief that the esoteric knowledge and skills of the healer allowed the healer to serve as a broker with the god(s) and spirits to accomplish healing.

In biomedicine, the patient-provider relationship has historically been informed by paternalism in which decisions and responsibility rested with the provider. This presumed a paternal relationship of the provider to the patient and obligated the provider to act beneficently and to make all or at least some of the decisions (Beauchamp & Childress, 1994). This position views the primary agenda as patient healing. The patient comes to the clinician for treatment or healing, and both parties agree (often implicitly) that anything that undermines this is to be avoided (Brody, 1993). Patients enter the relationship with trust and thus comply and cooperate with the clinician’s recommendations. The clinician’s knowledge (competence) and an assumed ethic of commitment to patient healing and welfare direct the decision making. This allows the clinician to inform the patient selectively and to use whatever means necessary to promote healing, including the therapeutic use of placebo, surrender, hope, optimism, and suggestion (Brody, 1993).

Although the paternalistic model is often cast in a negative light, in actuality, biomedicine has not replaced paternalism with autonomy but incorporated aspects of both. Paternalism implicitly influences the assumptions from which both the patient and provider establish their relationship. This shared understanding determines patient/provider roles, the locus of responsibility, and expectations. These concepts will be explored further in the context of the healers’ ethical codes.

**Autonomy**

Documentation of Nazi “medical experimentation” in the Nuremberg trials and medical research in Tuskegee provided evidence that medical research had breached the public trust (Ashley & O’Rourke, 1994). These abuses and others violated the historic
medical ethic of beneficence or the traditional principle of primary allegiance to the protection and promotion of the best interest of the patient. These events also were in sharp contrast to the Western sociocultural values that promoted individualism and fostered the right to self-determination (Jonsen, 1990). Thus, a new ethos of patient autonomy based on the doctrines of informed consent and the right to refuse treatment was advanced. The purpose of focusing on autonomy was to empower patients to retain control of their lives in decisions about health care. This principle afforded a major check and balance on paternalism and the abuses of medical maleficence. The result was an emphasis on autonomy that has been institutionalized in biomedicine by legal imperatives of patient rights and informed consent. Nursing has developed the role of patient advocate largely based on this principle.

**Design of the Study**

A top-down analysis described by LeCompte and Schensul (1999) refers to qualitative data analysis where a theoretical framework is applied to a data set. The theoretical framework generates the coding system. The framework for this study was derived from the aforementioned bioethical principles. The biomedical ethical approaches of autonomy and paternalism were used as a framework for the analysis and provided an ethical construct for comparison. These principles were used to code the data from documents and the field. The document analysis examined written codes and standards from three organizations espousing the use of holistic health and touch therapies, alternative/complementary therapies that are often associated with nursing. To understand the application of the ethical principles, data were drawn from previous fieldwork with healers. The data were analyzed, and exemplars were extracted that illustrated the healers’ constructions of the ethical principles inherent in autonomy and paternalism, which is the focus of this report. In ethnography, the addition of fieldwork to document analysis allows for a deeper understanding by adding multiple data sources (Janesick, 1994).

**Procedure**

Published codes/standards from three organizations—Healing Touch International (HTI), Reiki Touch™ Institute of Holistic Health,
Inc. (RT), and the American Holistic Nurses Association (AHNA)—were examined. Each organization represented a different constituency of lay and nurse healers: HTI is a mixed group with primarily nurses, RT is primarily lay healers with some nurses, and AHNA is exclusively nurses. The documents included The Code of Ethics from Healing Touch International, Lakewood, Colorado; Ethical Standards presented to the Texas State Legislature in 1997 by Reiki Touch Institute of Holistic Health, Inc.; and the AHNA Code of Ethics for Holistic Nurses published in Holistic Nursing (Dossey, Keegan, Guzzetta, & Kolkmeier, 1995). These groups were chosen because they represented modalities most frequently used by nurses. No attempt was made to represent the ethical views of all alternative healers or modalities. Much diversity in training, explanatory models, and personal interpretations exists within the complementary-healing community.

Field data on the lay healers were drawn from an ethnographic study of alternative healers, many who were practicing Reiki and forms of laying on of hands (Engebretson, 1992), and from fieldwork with HTI seminars (Wardell, 1998). The authors used participant observation, long discussion, and interactions involving more than 500 hours with lay healers and with more than 400 participants in HTI seminars. Institutional Review Board approval had been obtained, and permission from the healers was granted. The fieldwork focused on many aspects of healing and, in both settings, primarily involved master healers instructing and mentoring more novice healers.

Data Analysis

The published codes and standards were coded into statements reflecting the ethical principles of paternalism and autonomy and justice, with emphasis on paternalism and autonomy. These categories were further coded into the components of these principles that were identified in the documents. Coding was initially done independently by the two investigators and then compared and discussed until consensus was reached. The categories were then used to code the field data. Field data afforded an exploration of the actual practice of these principles and standards. Additional categories emerged from the field data but were within the original ethical framework. Data from documents and field observations of behavior and interviews formed a triangulation or multiple perspectives on the ethical
principles. This independent analysis, followed by discourse, was repeated in the analysis of the field data and strengthened the rigor of the process. Findings were then compared with the literature on medical ethics and contrasts were described.

ANALYSIS OF THE PUBLISHED CODES AND STANDARDS

Holistic nurses appeared to build their code on the ethical standards of the nursing profession published since the early 1950s by the American Nurses Association and the International Council of Nurses (Curtain & Flaherty, 1982). HTI, composed of nurses and nonnurses, also appeared to be strongly influenced by nursing’s historic ethical codes. The lay healers, represented by RT, followed the ethical principles, but the standards did not appear derivative of any of the professional codes for nurses. Figure 1 identifies ethical concepts from the published codes/standards that will be reviewed and analyzed.
Paternalism

Nonmaleficence. Nonmaleficence, to do no harm, was specifically identified in the HTI and RT documents and implied in the AHNA statements. For example, this statement prohibited the inappropriate use of healing energy: “No energy is given beyond the capacity for the person to receive following the principle: do no harm (HTI).”

Beneficence. Beneficence, to do good, was specifically stated in all three documents and even more frequently implied as the following statements illustrate. “[The] client’s plan of holistic nursing care shall be implemented within the context of the system of the individual to progress forward and upward toward a higher potential of functioning (AHNA).” “We agree to touch others . . . with an understanding of the extraordinary power we have in our safe-keeping (RT).”

Virtue. One striking difference between the ethical statements of all three groups and those of traditional biomedical or nursing ethics was the emphasis on the personal virtues of the healer. All addressed the importance of the attitude, intent, and actions of the healer. Statements that reflect this view include the following: “strive to achieve harmony in their own lives and assist others striving to do the same (AHNA),” and “Our first duty is to heal ourselves: spiritually, mentally and physically. We realize that we are not only instruments, but also models of healing (RT).” The emphasis on development of the healer is related to the centrality of spirituality in healing.

Autonomy

Autonomy, incorporating both concepts of liberty and agency, was well-represented in all three documents. Exemplars will be used to identify how each of these was met.

Two aspects of liberty, client permission and respect for choice, were evident in the following statements: “The individual rights are upheld at all times and the person’s coping method is to be respected (HTI),” and “We will give Reiki when requested—and only when requested (RT).”

Concepts related to agency included client competency, locus of action, mutuality, holism, and personal empowerment. Competency
was implied in this statement: “The client is a fully knowledgeable participant in the health/healing process based on his/her ability (HTI).”

Locus of action related to clients’ active participation in healing and is evident in the following statement: “Healing is an individual lived experience. Therefore a healing touch practitioner is a facilitator of the health/healing, not the cause of the changes. Change is within the control of the individual at all times (HTI).”

The relationship between client and provider was described through the concept of mutuality. This statement reflects this mutual agreement: “We agree to touch others with...an ongoing awareness of their and our spiritual, mental and physical boundaries (RT).”

The perspective of holism was voiced by the following: “Holistic nurses shall focus care on the whole client...not merely the current presenting symptoms or tasks to be accomplished (AHNA).” The inclusion and centrality of the spiritual domain in healing was evident as all documents had several statements honoring the spiritual nature of the client and the healer. Spirituality not only involved the individual client but also extended beyond the individual to the nature of the work as “holistic nurses shall develop competency in practice to facilitate a sense of sacredness about their work (AHNA).”

Client empowerment was an additional consideration in the ethic of personal agency and was evident in the following statement: “We will encourage them not only to receive the Reiki that is their birthright, but also to claim their personal power to take charge of their own healing (RT).”

Justice and Distribution of Care

Justice and distribution of care was recognized in all three documents. All suggested a universal right of everyone to receive care, not unlike traditional biomedicine.

Findings From the Fieldwork With Regard to the Practice of Healers

The following discussion focuses on the manner in which autonomy and paternalism were approached by the healers. Figure 2 depicts the main areas identified.
Autonomy. An example of the respect for autonomy and client liberty was reflected in the importance placed in obtaining permission from the recipient of healing. The need for permission was strongly emphasized by most lay and nurse healers. The method of acquiring permission could be at a conscious level or at the soul or spiritual level. Thus, a healer could obtain spiritual permission at the unconscious level, which was considered as important or more important than conscious permission. When dealing on the spiritual level, the healer was directed to be very sensitive to subtle responses of nonpermission. One healer described this as noticing blocks in energy flow, resistance, or interruptions as potential subtle messages that permission was not granted. Differences existed as to the explicit nature of the permission. Some healers adamantly believed that permission must always be gained, even resorting to a psychic
permission when the patient was not physically present (for distant healing). In contrast, others believed that no permission was needed, as the benefits from the healing are there for persons whenever they choose to accept the healing. This implies that the ultimate responsibility lies with the client as “nothing is done” until the client is ready or accepting. Individual autonomy or agency of the client was paramount in the understanding that the recipient’s spirit, not the healer’s, was always in control. This placed the locus of responsibility unequivocally with the patient/client. Lay healers often warned their apprentices that to go counter to this spirit could invoke karmic responsibility. Nurse healers did not speak of karmic responsibility but stressed keeping clear of the client’s/healer’s work, by maintaining separateness while connecting at a spiritual level.

*Paternalism.* Aspects of the healer-client relationship reflected perspectives that can be associated with the paternalistic model. Healers purposefully incorporated the therapeutic effects of placebo, suggestion, optimism, hope, surrender, and avoided noicebo effects. Noicebo is the explicit identification of possible adverse effects, which leads individuals to actually experience these effects (Benson, 1996; Spiro, 1986). All these therapeutic effects relate to beneficence except noicebo, which relates to nonmaleficence.

Brody (1993) defined placebo as a form of therapy or intervention that is believed to be without specific action for the condition being treated. Healers viewed these placebo effects as a receptivity of the client for positive outcomes and not one that implied deceit on the part of the healer. Spiro (1986) included the intent of the healer as part of this use of placebo. Many healers espoused a belief that the client would receive benefit from the session whether or not they believed in the therapeutic effects of the modality. However, they would reap more benefit if they believed in the therapeutic powers. Many healers stated they encouraged clients to “expect a miracle” or to “accept a miracle.” This was one example of how healers encouraged clients to expand their world of possibilities and expectations. Others would engage in discussions about the client’s experiences. This could include “unusual” events, for example, feeling hands that were known to be somewhere else. This created an environment in which anything could happen. While making no guarantees, they always held open possibilities for their clients.
The healers intentionally used suggestion in three ways: giving positive suggestions, the use of visualizations, and affirmations. Often healers instructed clients to feel and experience themselves as healed. This approach gave people an opportunity to experience their bodies in a different way through meditation or other methods of entering an altered state of consciousness. The client was encouraged to recreate this experience. These uses of suggestion were based on a belief that the mind could physically manifest an experience. Another technique was the use of visualization. Clients were encouraged to visualize a specific healing process or to see themselves able to perform specific functions. The healers felt the power came from visualizing oneself as healed or already possessing the attributes of the desired outcome. Verbal affirmations were used as positive statements that were repeated often in a ritualistic manner.

Optimism and hope were always maintained. The focus of the healing work was to maintain the client’s general attitude of optimism and hope to counteract the overwhelming attitude of despair that many clients experience when their life view is reduced to a diagnosis and/or prognosis. The healers did not deny the reality of terminal conditions, and this was openly discussed with several clients. The discussions were determined by the readiness of the client. The focus was redirected into living and all aspects of life including relationships, spirituality, and emotional attachments.

A positive view was taken even though the healer might “know” the client was dying. For example, one healer described a healing with a young man who had a strong commitment to his two small children and a diagnosis of an inoperable liver tumor: “My hands passed right through the liver and to the heart, it was here that his work was to be done.” This indicated to the healer that healing would focus on issues of love, relationship, and attachments. Further discussion with the client validated some of the conflicts in the above areas that were overwhelming him. Clients were often asked if they wanted to live and direction taken from there. Because attachment to a “cure” was not the predominant focus for the healers, clients were encouraged to explore their own paths or meaning in healing. The healers, in general, did not consider death as a failure of healing but rather a part of life. One healer, working with a client who was dying of AIDS, stated that “his dying will be his healing.”

The element of surrender was evident in the fact that clients were cautioned not to have defined or predetermined outcomes. Healers iterated that some of the most powerful healings occurred when the
client surrendered his or her will to a “higher good,” which is a paternalistic perspective. Healers also avoided defined or predetermined outcomes and often would deliberately release the idea of an outcome of physical healing with the rationale that it would be presumptuous to assume that outcome would necessarily be in the best interest of the client. One healer stated, “We don’t know, but it may be in that person’s spiritual path to have that disease a little longer.” The lay healers frequently adhered to the biblical idea of “Thy will be done.” Nurse healers often had an individual god or religious focus, but this was not part of the students’ learning. However, both focused on acceptance of whatever was the best outcome for the client/healee.

The lay healers consciously avoided any negative suggestion (noicebo), as they felt that negative ideas or statements could manifest into physical reality. Clients were particularly vulnerable to suggestion when they presented themselves for healing. Healers extended their avoidance of negative suggestion to thoughts or emotions. They believed that personal negative thoughts or feelings of the healer could be transmitted to the client and could interfere with the healing or actually cause harm. Healers attempted to get themselves in a centered state of mind prior to working with clients. This allowed the healer to separate from his or her own concerns and conflicts and focus completely on the healing of the client. A special connection was said to exist between the client and healer, yet separateness was maintained to avoid contamination in either direction.

Some lay healers articulated a code of ethics, reflective of the paternalistic approach, whose origins they ascribed to the “Hermetic Code.” This code reportedly has foundations in ancient Egyptian and Greek philosophy and is attributed to Hermes, god of wisdom and communication. They reported this code as embodying the following obligations: (a) The healer must always offer healing whenever he or she is asked; to refuse would be a violation of the trust of having been given the gift of healing, and (b) the healer must never use the relationship (as a healer) for the exploitation of personal financial gain, personal power, or sexual favors. This code was not mentioned in the other two groups. However, nurses were encouraged to care for themselves and respect their limitations or hesitancy in healing.

Concept of virtue. Lay and nurse healers emphasized the need for the healer to operate from an ethical perspective of having a character of virtue, which was consistent with historical principles of paternalism. With the healers studied, the intent and personal character of
individual healers were identified as crucial to the work of healing. This ethical framework implores the healer to focus more on what to be than what to do (Spiro, 1986). If the healer is virtuous, actions stemming from this intent would then be beneficent. Much of the preparation of healers revolved around healing and developing the healer. For example, several healers were actively working on “getting their own ego out of the way.” Some identified this as the major challenge in becoming a healer. One lay healer stated, “To deal in the currency of spirit one must let go of self as intervener.”

**DISCUSSION**

Biomedical ethics reflects a tension between balancing the obligation to honor the patient’s autonomy while honoring the obligation to act for the patient’s medical benefit (paternalism). These issues were evident in the healer-client relationship. Healers were fairly consistent in their written ethical statements and practice. They reflected contemporary society’s high regard for client autonomy by the attention to seeking permission and by affixing the locus of healing or agency for healing within the client. Client agency was based on the spiritual level of the client. This approach allowed them to conceptualize disease and dying in the larger perspective of the client’s spiritual existence that transcended the success/failure perspective of a disease/cure focus.

From this broad position, healers were sensitive to the client’s belief system and activated and incorporated many therapeutic tools, such as the powers of belief, hope, and surrender in healing, generic to the paternalistic model. They engaged clients in the use of positive suggestion, albeit modified by the attention to the spiritual meaning of the illness and the healing process for the client. A sensitivity to the toxicity of negative suggestion, noicebo, was especially notable in the practice. Virtue ethics is historically associated with paternalism, and the emphasis on personal development is consistent with the reemergence of aspects of paternalism. As these healers generally were not in a position to inform clients of ominous diagnosis or poor prognosis, they were able to exempt themselves from many common areas of potential noicebo effects.

In comparing ethical practice between alternative healers and biomedical clinicians, it is important to understand the differences in scope of practice. Biomedical practitioners, including nurse
practitioners, are the only providers who can legally diagnose and prescribe treatments. Biomedical treatments often have fine risk/benefit ratios and are based on an esoteric and complex understanding of biological sciences and medical technology that are beyond the ability of most clients. Healers generally practice as complementary to or integrated within biomedicine. Although they possess esoteric and complex understandings of their paradigm of healing, they do not officially diagnose disease, nor are they subject to the same legal and ethical responsibilities as biomedical practitioners. Typically, they provide care to a self-selected clientele with homogeneous beliefs and expectations.

As the locus of responsibility has shifted to the patient, an additional ethical concern is raised. Instead of empowering the patient, it can promote issues of client guilt for not getting better or for having the illness or problem in the first place. This can lead to blaming the victim, which can be disabling and may escalate stress. However, most healers attributed the working of disease as a powerful learning experience for the patient, not as a failure of the patient to “cure himself.” An extreme focus on client agency could also decrease emphasis on the ethics and virtue of the provider.

Contemporary alternative medicine actively employs some therapeutic aspects of paternalism lost when autonomy became the paramount focus of modern medical ethics. These healers may be addressing a gap that emerged when modern science and technology diminished the art and spirit from healing in the practice of medicine. The current popularity of alternative healers may be, in part, interpreted as a public request for the incorporation of some healing techniques of the paternalistic model that address the integration of the body, mind, and spirit. As our understanding of healing increases, it challenges the notion of the sufficiency of any one modality, aspect, or approach. Only with thoughtful integration can health care incorporate these benefits of autonomy and paternalism. A true healing model, recognizing the complexity of healing, will require the integration of healing arts and biomedical practitioners.

**Conclusion**

Recognition of the need for client agency in areas of health promotion and living with chronic illness is shaping much of contemporary health care. The concepts of client autonomy depicted by these
healers contribute to incorporation of client agency. By appreciating the value of diverse healing modalities and sharing the decision making with clients, clinicians preserve patient autonomy and honor the principle of beneficence. Providers risk maleficence if they ridicule, trivialize, or discourage patients’ access to therapies from which they could benefit. These healers have illuminated client concerns related to noicebo effects. Careful consideration of the benefits gained from placebo, suggestion, optimism, and hope offers providers use of important age-honored tools of healing. Exposure to alternative healers has stimulated issues for reexamination. The contrasting emphasis and approach to paternalism and autonomy between healers and biomedicine warrant further study. Virtue ethics, which has been eclipsed by the recent emphasis on autonomy, calls for investigation in relation to contemporary health care.

REFERENCES


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Continuing Education Opportunity

Ethical Principles Applied to Complementary Healing

Test ID #: 608  
Credit Hours: 1.3  
Passing Score: 7 (70%)

This continuing education opportunity is administered by the American Holistic Nurses’ Association, which is accredited as a provider of Continuing Education in Nursing by the American Nurses Credentialing Center’s Commission on Accreditation.

To receive credit, complete the test questions and the enrollment form. Mail them together with your check payable to American Holistic Nurses’ Association at the address on the enrollment form.

Goal: The goal of this continuing education opportunity is to increase awareness about ethical principles in holistic nursing and integrative care.

Learning Objectives: After reading the article, the participant will be able to:

1. Explore the basic principles of ethical constructs in relation to complementary healing and biomedicine.
2. Use research to clarify concepts within a variety of complementary healing modalities.
3. Compare traditional biomedical views of ethics with holistic healing modalities’ view of the client-provider interaction.
MULTIPLE CHOICE QUESTIONS

1. Both explicit and implicit aspects of the provider-client relationship can impact how ethical codes are understood and applied. Which of the following is an example of an implicit paternalism?
   A. Obtaining informed consent
   B. Following protocols
   C. Health care provider determines best course of action
   D. Family making a living will

2. Which of the following is found as a tenet of autonomy?
   A. Nonmaleficence
   B. Prevention of harm
   C. Personal morality of the provider
   D. Having the capacity to make a decision

3. Paternalism incorporates an agenda of healing that is based on
   A. providers competence.
   B. freedom of action.
   C. individual decision making.
   D. legal documentation.

4. Nursing has based its role of patient advocate on
   A. nonmaleficence.
   B. autonomy of the individual.
   C. personal virtue of the provider.
   D. provider responsibility.

5. Which of the ethical codes and standards used in the study was not derived from the nursing profession?
   A. Healing Touch
   B. American Holistic Nurses Association
   C. Shen Therapy
   D. Reiki Touch

6. Patient autonomy was demonstrated in which example of locus of agency?
   A. Healer causes changes to occur in the direction of healing.
   B. The client is responsible for having caused and having cured their disease.
   C. The client is a passive recipient of healing energy.
   D. Change is within the control of the individual.

7. The fieldwork with the healers identified various uses of the placebo effect. Which of the following was not an aspect of the therapeutic use of placebo?
   A. Believing that the session was going to benefit them
   B. Accepting a miracle
   C. Providing a guarantee of the session’s effectiveness
   D. Creating an environment in which anything could happen

8. Surrender was also an element of paternalism that was used. Which of the following would be attributes of surrender as identified in the study?
A. Creating a positive view
B. Recognizing that healing occurred even though there is no evidence of a physical healing
C. Verbal affirmations
D. Use of noicebo

9. Utilizing a concept of virtue ethics would require the health care provider to
   A. engage in personal development.
   B. focus more on measurable outcomes.
   C. strive to be recognized as an intervener in the healing process.
   D. exclusively define practice by a set of protocols.

10. Differences between biomedical providers and healers can be attributed to
    A. separateness of healers from biomedicine.
    B. having the same legal and ethical responsibilities.
    C. a difference in the scope of practice.
    D. avoiding guilt.

Answer Enrollment Form

Directions: Mark your answers clearly by placing an X in the box next to the correct answer for each of the questions about “Ethical Principles Applied to Complementary Healing.”

1. □ A □ B □ C □ D
2. □ A □ B □ C □ D
3. □ A □ B □ C □ D
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7. □ A □ B □ C □ D
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9. □ A □ B □ C □ D
10. □ A □ B □ C □ D

Applicant information (please print clearly):

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Address ___________________________________
City _______________________________________
State _____________ Zip _____________
Telephone ( ) _____________________________
State Licensure Numbers __________________
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1. After reading and reviewing this article, complete the posttest and evaluation.
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3. The deadline for receiving this educational program is 2 years from the date of this issue.
4. Within 8 weeks of receiving your program response, AHNA will notify you of your test results. A passing score is 70%. Upon successful completion, a certificate and an explanation of each answer will be sent to you. If you do not pass the test, AHNA will send you a new answer sheet, and you may take the test again.

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Results will be sent within 8 weeks after AHNA receives your answer form and payment. Participants who have a passing score will receive a certificate of completion.
PROGRAM EVALUATION

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
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<th>Unsure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<td>1. Objectives were related to purpose of article</td>
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<td>2. Objective #1 of the program was met</td>
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<td>3. Objective #2 of the program was met</td>
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<td>4. Objective #3 of the program was met</td>
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<td>5. The program was worth my time and effort</td>
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<td>6. Content was appropriate for my practice</td>
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<td>7. Difficulty level of test was appropriate</td>
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<td>8. Time allotted to complete activity was accurate</td>
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<td>9. Teaching/learning resources were effective</td>
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Participant’s Checklist

___ I have enclosed the answers to the test questions.

___ I have enclosed the enrollment form with my identification information.

___ I have enclosed the fee of $10 as a check or money order (payable to AHNA)(please do not send cash).

___ I have enclosed the evaluation form.

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Nurses’ Attitudes Toward Survivors and Perpetrators of Domestic Violence

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University of Arizona

Domestic violence is of special concern to nurses, as they are often the first health care professionals to interact with battered women. The purpose of this study was to explore and describe nurses’ attitudes toward the survivors and perpetrators of domestic violence. A holistic ecological health promotion framework guided this qualitative investigation. Thirteen participants expert in the care of abused women were interviewed using semistructured questions to describe nurses’ attitudes toward survivors and perpetrators. Significant statements were identified, clustered, and placed into categories of response. Findings included identification of general themes and specific categories related to attitudes nurses have about battered women and those who abuse and injure them. The significance of this research underscores the importance of nurses’ attitudes as influencing factors in their interactions with women and families involved in domestic violence. Application of a health promotion framework encourages a holistic perspective of care for this vulnerable population.

Violence in the United States is now described as both a major health problem and a criminal justice problem. The risk for violence does not escape any segment of society, regardless of race, age, gender, economic status, or lifestyle (Hotaling & Sugarman, 1990). Reduction in violence is a major goal of Healthy People 2010 (U.S. Public Health Service, 1999) and is targeted as a public health priority by the World Health Organization (1997). The role of nurses in countering violence is one that involves action at all levels of care: primary, secondary, and tertiary prevention, as well as professional education and health policy.

AUTHOR’S NOTE: The author expresses thanks to her student research assistant, Louise Fraher, M.S., R.N., for her assistance with this study.
arenas. National nursing organizations, including the American Nurses Association (1991) and the American Association of Colleges of Nursing (AACN, 1999), have issued position statements that highlight the problem from a nursing perspective, identify the profession’s commitment to address violence as a nursing issue, and provide recommendations for nursing action.

Domestic violence against women is of special concern to many nurses because it affects large numbers of women and has implications for children, elders, and partners. Domestic violence includes physical, sexual, and psychological violence, all of which can result in acute and long-term physical and emotional injury, disability, and death. The statistics are frightening—battering affects at least 2 million women each year (Poirier, 1997); the annual rate of physical attacks on women by family members in 1992-93 was 9.4 per 1,000 women but only 1.4 per 1,000 men (Bachman & Saltzman, 1995); 7.4% to 20% of women experience abuse in the 12 months prior to their pregnancy (Campbell & Parker, 1992; McFarlane, Parker, Soeken, & Bullock, 1992); one in six women is subjected to intimate partner violence during pregnancy (Datner & Ferroggiaro, 1999); and 31% of female homicide victims were killed by intimate partners (Federal Bureau of Investigation, 1993). The annual cost of partner abuse in the United States has been estimated at $67 billion (Miller, Cohen, & Wiersema, 1998). In addition, the documentation and processing of reports of abuse by intimate partners presents a significant burden on police departments and the court system (Cochran, 1998).

Because a nurse is the first health care professional to interact with a battered woman in the emergency room, physician’s office, clinic, or women’s shelter, it is important that nurses are adequately prepared to identify women who have been battered (Woodtli & Breslin, 1997). The percentage of women identified as battered increased from 5.6% to 30.0% following staff training along with institution of protocols in the emergency room (Olson et al., 1996). Nurses continue to care for survivors of domestic violence episodes in hospital rooms, rehabilitation centers, outpatient clinics, shelters, and in the home. Essential aspects of all nursing interventions with battered women include not only attitudes of respect for the woman’s personal dignity and right to make her own decisions but also recognition of the need for a holistic approach to violence within the family unit.

Attitudes are based on one’s values and beliefs, not just on one’s knowledge (Hoff & Ross, 1995). The attitudes nurses have about survivors and perpetrators of domestic violence may affect their ability
to establish positive nurse-client relationships and achieve expected nursing outcomes. The effect that nurses’ attitudes have on their therapeutic effectiveness in caring for women survivors and their families, including the perpetrators, is unknown. Although findings of many studies on violence-related issues have been reported, few have focused on nurses’ attitudes toward either the survivors or perpetrators of domestic violence. A first step in understanding the relationship between nurses’ attitudes and nursing outcomes is to explore nurses’ attitudes toward the women who are battered as well as those who batter.

The purpose of this article is to report the findings of a qualitative study focused on attitudes nurses have about survivors and perpetrators of domestic violence. These findings are one part of a larger qualitative study that explored the feelings nurses have about domestic violence and described the essential knowledge and skills nurses need to provide care to those involved in domestic violence (Woodtl, 2000).

LITERATURE REVIEW

Although findings of many studies on violence-related issues have been reported, this literature review is limited to findings with specific reference to nurses’ attitudes. As early as 1979, Gelles confirmed the importance of helpers (e.g., nurses) in determining the outcomes of violent relationships. However, Rose and Saunders (1986) were the first to compare attitudes of nurses and physicians toward woman abuse. They found that female nurses and physicians were more sympathetic toward battered women and were less likely to believe victims are responsible for the abuse than were male nurses or physicians. In one of the few reports of physician attitudes toward domestic violence, Sugg and Inue (1992) found that physicians referred to questioning women about domestic violence episodes as “opening Pandora’s Box.” They identified feeling discomfort in asking questions, fear of offending the patient, and feeling powerless over the treatment and outcome. These attitudes were perceived as barriers to intervening in situations in which they suspected domestic violence.

In an effort to refute commonly held attitudes based on the beliefs that women are helpless and that battering occurs more frequently in certain racial or cultural groups, King and Ryan (1989) were among the first to suggest that nurses in advanced practice be change agents
to correct these misconceptions. Tilden et al. (1994) explored factors that influenced 1,521 clinicians’ assessments and management of family violence. Of the 1,521 participants, 241 were nurses. The researchers were troubled to find that (a) only about a third of participants in each of the six disciplines thought mandatory reporting of suspected elder abuse was effective; (b) about 50% of physicians, psychologists, and social workers and 37% to 39% of dentists, dental hygienists, and nurses thought mandatory reporting of child abuse effective; and (c) nearly half of the dentists and dental hygienists, 15% of physicians, and 13% of nurses viewed themselves as not responsible for dealing with family violence. However, a majority (55%-76%) of the disciplines, except psychologists, thought mandatory reporting laws for spouse abuse should be enacted. The researchers also found that participants with previous education on child, elder, or spouse abuse were more likely to suspect the presence of abuse among their patients than those without education. In a subsequent study, Limandri and Tilden (1996) examined the responses of the sample of the 241 registered nurses. They reported that (a) 87% of nurses agreed that health professionals were responsible to help those experiencing family violence; (b) 93% agreed that family violence was more a health problem than a legal problem; and (c) 76% agreed that reporting spouse abuse should be mandatory. In a qualitative study described in the same article, the authors reported findings related to responses of 9 of the 241 nurses. The nurse interviewees believed violence should not be used but “could be provoked” in cases of spousal abuse, stated that “the abused person should not allow the situation to become violent and should leave when it does,” and showed “little tolerance for adults perceived as participating in their own abusive situation” (p. 251).

Sword, Carpio, Deviney, and Schreiber (1998) reported that despite limited instruction about woman abuse in their nursing curriculum, 150 Canadian nursing students were sympathetic in their attitudes about woman abuse. The authors suggested that to enhance student learning and improve their interactions with abused women, students must first be encouraged to explore their own attitudes about woman abuse and identify their misconceptions.

In summary, attitudes about abused women were found to be related to gender; women and nurses generally agreed that the abused person was not responsible for the abuse, although abusive behavior could be provoked. Nurses and other health care professionals were encouraged to confront their attitudes toward woman abuse with the intent that subsequent interactions with abused women
would be more effective. There was little empirical evidence that education changed attitudes, but findings demonstrated that identification of abused women did increase after exposure to educational programs. Little data-based evidence was found related to either nurses’ attitudes toward the survivor and the perpetrator of woman abuse or to nurses’ expectations of care outcomes. Therefore, the research findings reported here attempt to fill the need for empirically based data in the nursing and domestic violence literature on attitudes of nurses toward the survivor and perpetrator of domestic violence as perceived by nurses and others who are identified as expert practitioners in the field of domestic violence.

**Conceptual Orientation**

The importance of ecological models is “that they view behavior as being affected by and affecting the social environment” (McLeroy, Bibeau, Steckler, & Glanz, 1988, p. 354). For nurses, this view is important because it provides an opportunity to design a range of health promotion strategies targeting multiple levels within the social environment. The holistic view of behavior proposed by ecological models permits nurses to focus attention on different types of social influences for which they can develop appropriate interventions to modify health-related behaviors. The interventions may range from those directed at the individual or family to those aimed at communities or public policy. To decrease the incidence of violence and promote the health of individuals, families, communities, institutions, and the society as a whole, interventions, including those of nurses, must be directed at multiple social levels. An ecological perspective directs attention to both the behavior and its individual and environmental determinants. This view is congruent with a holistic perspective of nursing care.

The Ecological Model for Health Promotion (McLeroy et al., 1988) guided this research study and is useful for studying domestic violence. From a health promotion perspective, the model is based on the assumption that behavior is influenced by five factors: intrapersonal, interpersonal, institutional, community, and public policy. It supports the holistic dimensions of nursing interventions that have the potential to be implemented at each level. Nurses’ attitudes related to each of the factors could guide their interventions and enhance the effectiveness of health promotion techniques available within a holistic
framework. In summary, this ecological model, with its emphasis on the effects of several levels of social factors on behavior, provides a holistic grounding for research focused on the social and health problems related to domestic violence against women.

This conceptual orientation guided the design of this qualitative study. Findings related to the analysis of the participants’ responses to two of the seven questions are reported here: What are your attitudes about the survivor of domestic violence, and what are your attitudes about the perpetrator of domestic violence? Additional information related to participant attitudes is included in a section entitled “Additional Comments.”

**METHOD**

**Sample**

Using a network sampling technique, the researcher identified a purposive sample of 13 health care providers who agreed to participate in individual interviews focused on their experiences, attitudes, and expectations of outcomes related to abuse against women. Members of the health professional community in a large southwestern city recommended the informants to the investigator because of their experience and expertise in caring for survivors of domestic violence. Each informant was contacted by telephone and invited to participate in the interview session after the purpose of the study had been explained. All informants agreed to participate, and individual meeting times were arranged. Each participant was assigned a code number; the list of names with the corresponding code number was known only to the research assistant and kept in a locked file. After the completion of the 13th interview, the investigator and research assistant agreed that data saturation had occurred and no additional participants were contacted.

**Procedure**

Interviews with participants took place at locations determined by the participant and lasted from 1 to nearly 3 hours. All interviews were audiotaped and conducted by a graduate student completing her master of science degree in nursing. Using the interview guide, the investigator and the graduate student, an experienced nurse, role
played simulated interviews and discussed potential interviewer responses. Field notes taken during the interview were supplemented and completed immediately following the interview. The interviews were transcribed by a third person not connected with the research study. The written transcripts were compared to the audiotaped interviews to ensure accuracy.

Four of the 13 participants were randomly selected and agreed to be interviewed a second time. Again, these interviews were individually scheduled to last 1 hour. The purpose of the second interview was to "feedback the findings" that emerged from the analysis of the 13 interviews to help assure the conformability of the findings (Guba, 1981). Miles and Huberman (1984) recommend conducting feedback sessions after the final analysis of the data rather than during data collection so that the researcher can provide feedback in a more systematic format and at a higher level of inference. The participants agreed with the findings and were verbal in their supportive comments confirming the accuracy of the report. During the second interview, the participants emphasized the need for education in domestic violence and all types of abuse as part of the formal curriculum for nursing students and continuing education for all nurses. They voiced their opinion that education (a) may help change attitudes of some nurses, (b) would enhance assessment and identification of battered women and those at risk, (c) might increase the frequency and effectiveness of nursing interventions, and (d) would hopefully improve outcomes.

**Instrument**

Although the instrument consisted of seven structured questions and one open-ended question, only responses to the two questions focused on nurses' attitudes are addressed in this article. Questions were based on research findings in two previous studies (Woodthli & Breslin, 1996, 1997). The questions were reviewed and discussed with a doctorally prepared women's health nurse practitioner, researcher, and educator whose methodological focus is primarily qualitative. Minor changes in words and in sequence of questions were suggested and implemented. The structured questions targeted responses to the stated purposes of the study; the open-ended question encouraged participants to add information or insights they believed were relevant. The research assistant conducted a pilot interview with one nurse to test the clarity of the questions. The content of this interview was not included in the analysis of findings. No revision of the
questions or format was indicated, but the hour of time allocated for the interview was exceeded. This extended length of interview time proved to be repeated for all but one of the participants.

Analysis

The transcript copies were reviewed independently by the investigator and the research assistant. The responses to each question were aggregated and significant statements identified. Together the investigator and research assistant compared the significant statements by question for similarities and differences. When differences emerged, they reviewed the transcripts and field notes together, discussed the differences in interpretation, and came to consensus. They then independently analyzed the significant statements by question and placed the statements into categories. Again, they compared categories and came to consensus. Together, they abstracted the categories of response into the general themes for each question. The data from the open-ended question are included in a separate category. No significant differences were discovered in analyzing the responses to the open-ended question. Likewise, no substantive changes occurred during the second interview to modify the response categories or themes. Participant responses to the second interview primarily confirmed, expanded on, and provided additional rationale for the results of the analysis.

Results

The study findings reported here are related to the attitudes of nurses toward survivors and perpetrators of domestic violence. Comments focusing on nurses’ attitudes related to nursing outcomes resulting from their care are included in the section “Additional Comments.”

Sample

Of the 13 participants, 11 were registered nurses, 1 was a social worker, and 1 a counselor. The 2 non-nurses had worked extensively with nurses in their respective professional roles and had many opportunities to observe, cooperate with, and collaborate with nurses in the care and referral of domestic violence survivors, their children,
and the perpetrators. The investigator used these “outsider” views and experiences of knowledgeable professionals external to nursing as comparison data to the “insider” views of the 11 nurses. Analysis of the 2 non-nurse interviews did not differ significantly in attitudes from those expressed by the nurse participants. In fact, the non-nurse participants praised the genuine concern nurses showed for battered women, the expert direct care they provided, and nurses’ commitment to refer the domestic violence dyad and children to other professionals and organizations for additional help and assistance. Both of the outsiders commented favorably on nurses’ attitudes toward those involved in and affected by the dynamic, complex, and very difficult physical and emotional aspects of domestic violence situations. In summary, the observations of the 2 non-nurse participants confirmed the findings expressed by nurses about their attitudes toward survivors and perpetrators of domestic violence.

The 11 nurse participants were all registered nurses who ranged in educational preparation from diploma to master’s degree. Ten nurses were female; 1 was male. All were currently practicing in various health care specialties and settings including pediatrics, maternity, mental health, public health, doctor’s office, adult care home, emergency room, and urgent care. Ten were working in a metropolitan area; 1 worked in a small community hospital. Several participants stated they had previously contacted Child Protective Services and Adult Protective Services. One participant was a trained sexual assault nurse on call when her services were needed, one had participated in an outreach rural domestic violence program, one was a victim witness volunteer, two volunteered at women’s shelters, and another volunteered at a shelter for perpetrators only. One nurse identified herself as an abuse survivor of 18 years, and another confided that her daughter was currently in an abusive relationship.

**FINDINGS**

**Question 1: What Are Your Attitudes About the Survivor?**

Three categories emerged from the analysis of responses to this question: attitudes about the survivor, nurses’ responses to the survivor, and nurses’ role in caring for the survivor. The general theme derived from the three categories of participants’ responses to this question is, The Survivor Is Crying for Help.
Attitudes about the survivor. Participants said that the survivor is an individual who “is crying for help.” Yet, they said, “survivors are adults who have options and choices” about their lives and how they choose to live. Participants described the survivor as a woman who is often dealing with other complex issues, such as children, finances, and multiple other family problems that limit the choices, at least in the survivor’s mind, that are open to her. They emphasized their concern that the survivor is “always in potential danger” of even more violent episodes as the violence escalates. Most stated that the survivor has “low self esteem and feels isolated from others,” including her family and friends. Participants believed that these issues and personal characteristics coupled with the survivor’s “lack of insight” into the dynamics of violence, and especially into her own unique situation, constituted barriers that resulted in her experiencing great difficulty leaving the situation and indeed often prevent her from leaving.

Nurses’ interaction with the survivor. Participants stated that nurses’ attitudes toward the survivor should be caring and empathetic “wherever the victim is in the violence cycle.” They emphasized the need for nurses’ interactions to demonstrate “respectful attitudes” toward the survivor’s person, feelings, and right to decide. They stressed the need for nurses’ interactions to reflect attitudes that are objective, without bias, and some participants even used the word “neutral.” Participants said that nurses’ attitudes and interactions with the survivor should reflect the knowledge that survivors belong to all socioeconomic groups, can be both males and females, and represent all cultures and ethnicities. One participant said nurses’ responses and interactions should reflect the attitude of “arm them with facts but touch them emotionally.”

Nurses’ role in caring for the survivor. Participants were quite emphatic about the “do and don’ts, the cans and cannots” of the professional role. They distinguished between appropriate nursing role behaviors and those clearly outside the role. Participants believed that nurses can and should make emotional contact with each survivor in ways that convey caring and respect. Nurses, one said, must treat each survivor as “a unique individual in a unique situation with a unique set of problems.” Participants stressed that “getting the victim help is the focus” of what nurses can do. They described help as first recognizing the problem and then providing information, knowledge, support, resources, and especially, safety. Several
participants said that nurses must accept the fact that, although “they can offer help, the survivor has the right to decide not to accept it.” On the other hand, participants clearly described what nurses cannot do. They cannot own the problem, make choices or decisions for the survivor, rely on stereotypes, act on their biases, or “take personally the anger that is sometimes projected onto them.”

Question 2: What Are Your Attitudes About the Perpetrator?

The participants discussed nurses’ attitudes about the perpetrator within the same three categorical types they used in their responses to the survivor question. Again, three categories of participants’ responses emerged from the data: attitudes about the perpetrator, nurses’ interactions with the perpetrator, and nurses’ role in caring for the perpetrator. The general theme taken from three categories of responses to this question is, The Criminal Justice System Judges, The Nurse Does Not.

Attitudes about the perpetrator. All participants stated that “the perpetrator is dangerous,” can repeat the violent episode, or can become even more violent. They stressed that nurses always need to be aware of the “potential for violence.” Several participants said that perpetrators may need to be jailed but may be “protected from the police by their families and the survivor herself.” Participants characterized perpetrators as usually lacking in self-esteem and often dealing with issues of power and control. One participant said she grew up in a violent home and “at times feels sorry” for the perpetrator. Others suggested that perpetrators may themselves “be victims of a violent society,” such as child abuse, gangs, or violent family dynamics, and that they need help as well. Participants viewed the perpetrator as “part of the problem but also part of the solution.” They stressed his need for help as a member of the dyad or family. Many of their comments reflected the holistic perspective of family, not just focusing on the survivor or the perpetrator. Participants also warned against assuming there is just one perpetrator. In domestic situations, they said, violence may be mutual with both partners engaging in violent behaviors toward the other. There may be “two perpetrators and two survivors.”

Nurses’ interactions with the perpetrator. Again, the participants stressed the need for nurses to be nonjudgmental and “neutral” in
their attitudes. They urged nurses to recognize their own feelings. “It’s easy to feel anger toward the perpetrator,” but nurses need to “put their anger on the back burner” and not let their biases or negative attitudes get in the way of care for the survivor or their recognition that the perpetrator needs care as well. They stated that the nurse needs to recognize that the survivor often sees the perpetrator as the one whom “she loves” and to whom she “is connected” or who is the “father of her kids.” In contrast, participants also reported that some survivors see the perpetrator as a “monster” or as a person whom she fears but is “afraid to leave.” Participants suggested that nurses’ responses to the perpetrator be guided by viewing the perpetrator within a “larger context” in which the social or cultural environment may permit or encourage violent acts toward women or view the perpetrator within the framework of the cycle of violence, family history, or childhood abuse. However, participants also stressed that nurses’ interactions with the perpetrator must ensure safety for themselves and for others in the environment. Some participants were quite explicit about nurse-perpetrator interactions (e.g., “Don’t get into an argument”; “Don’t let them get between you and the door”; “Make sure you are able to call security”). Most participants identified the need for nurses to respond to the perpetrator in ways that reflect a more holistic view of the domestic violence dyad: the survivor and the perpetrator rather than the survivor or the perpetrator. As one participant said, “It’s not that simple.”

Nurses’ role in caring for the perpetrator. The participants stressed that the immediate focus of the nurses’ role is directed toward “care of the survivor.” Nevertheless, they said, nurses need to deliver appropriate care to the perpetrator and treat the perpetrator as a “human being.” They indicated that appropriate referrals needed to be made for the perpetrator as part of the plan of care and stated that the collaboration with other health providers, such as social workers, was an essential part of treatment of the whole family: children, perpetrator, and survivor. The participants spoke about the need for nurses to know when and how to refer and who on the care team could best manage the follow-up care. They emphasized that it was unrealistic and inappropriate in the current interdisciplinary health care delivery environment to expect that the nurse can “do it all.” They stated that the nurses’ role also included ensuring protection for themselves, the survivor, and others involved in the domestic violence episode. Several of the participants emphasized that “the law’s role is to judge the
criminality of the act” and that the nurses’ role is to practice within the “legal and ethical standards of the profession.”

Question 3: Additional Comments

Participants added many comments to those they had already expressed in their responses to the two “attitude” questions. First, they talked about their attitudes related to the long-term effects of nursing care on the survivor. They said that they hoped one result of interactions with a nurse would be that the survivor would ultimately be able to “leave the violent situation and remain safe,” but if she chose to remain, she would be more aware of the increased danger to herself and family and would follow up on the referrals. Participants expressed their hope that violence-related education would change the attitudes of some nurses and result in increased identification of abuse, earlier intervention, collaboration with other health professionals, and more referrals. Participants expressed the hope that positive nurse attitudes would encourage nurses to become strong advocates for social and health services such as rape crisis teams, women’s shelters, violence prevention programs in schools, and increased funding for violence prevention programs at all levels. Participants also suggested that a positive outcome of survivors’ interactions with nurses would be an attitude of nurses as their advocates, as people who provide health care for the abused and those in danger of being abused. Finally, participants stated that they hoped an outcome of nursing care would be that survivors would use the information and insights they gained to become advocates for themselves and for other women and children involved in violent relationships.

Discussion

Attitudes about the survivor were first identified in terms of the survivor herself and then in terms of the nurses’ attitudes toward her. The dichotomy is curious from the perspective of the perceived differences, at least in these participants’ views, about the survivor as the person “who is” and the survivor as a person “for whom” the nurse provides care. In the first instance, the survivor as the person “who is,” it seemed as if the participants were discussing the characteristics of a battered woman from a fairly objective, if not impersonal,
perspective. For example, this is a woman who is an adult, has choices, has low self-esteem, and feels isolated. However, in the second instance, nurses’ attitudes about the survivor as a woman “to whom I give care,” the participants seemed to be giving themselves permission to express their own feelings about the ways nurses should view the survivor, attitudes nurses should hold. For example, nurses should be respectful, caring, empathetic, and not stereotype. It was as if the participants were describing two aspects of the survivor: an adult woman who has experienced a terrible violent assault to her personhood and a woman patient about whom nurses should have specific attitudes in order to provide professional nursing care.

It is interesting that in nearly every instance, the participants referred to the battered woman as “victim” despite consistent use of the word “survivor” by the interviewer. The use of the word survivor by the interviewer was deliberately chosen to indicate the strengths or potential strengths of a woman who (a) had endured a violent physical assault, (b) had the persistence and the will to endure and carry on, (c) was an adult with the right to make her own decisions, and (d) had the potential to use her personal strengths to achieve a safe and satisfying life. Participants did not question their own use of the word victim when they talked about this woman who survived. They did not seem to perceive the dissonance: their description of person as victim, as one who is crying for help, always in danger and isolated from family and friends, often afraid to leave the situation, and their expectation that this victimized person behave as an adult, logically consider options, and take responsibility for her choices. This is an area that needs to be investigated in more detail; that is, what is the difference, if any, between the attitudes of nurses who perceive the battered woman as a victim and those who perceive her as a survivor? Does the difference influence nursing interactions and/or interventions? Are the values on which attitudes are based different between those who view the battered woman as a victim and those who view her as a survivor?

Despite these two inconsistencies, the nursing care participants identified was congruent with their verbalized attitudes of caring, respect, and survivor autonomy. Most important, participants emphasized that nursing care be carried out within the context of psychological support and practical knowledge. The need for nurses to “touch emotionally” was mentioned repeatedly as participants identified the first priority of care as providing help and safety, followed
by providing information, resources, and support. The dual focus of emotional comfort and tangible support was reflected in their concern for the survivor, the family, and the perpetrator.

The participants’ attitudes toward the perpetrator portrayed a combination of compassion for the perpetrator and fear, not just for the survivor but for nurses and other caregivers. They seemed to deal with their fear by emphasizing the need for safety measures and other behavioral precautions. They demonstrated their compassion by their attempts to understand the perpetrator’s actions, to find a reason to explain this terrible behavior—maybe it was society’s fault, maybe it was his own history of childhood abuse, maybe it was his family or his neighborhood. The need to understand the perpetrator in the larger context of the social and cultural environment was reflected in their discussions about what the nurses’ attitudes toward the perpetrator should be. At times, this perspective of perpetrator seemed to contrast with the participants’ views of the survivor, in which participants characterized the survivor as an autonomous person, an individual adult responsible for her decisions and actions. There seemed to be little attempt to widen the context of her behavior with no discussion of the potential influences of social, family, or community factors as contributing to either her survivor status or her victim role. Again, this is an area for further research.

In their response to the question “Anything else?” participants’ answers reflected the five components of the Ecological Model of Health Promotion (i.e., intrapersonal, interpersonal, institutional, community, public policy) that framed this study (McLeroy et al., 1988). Survivor outcomes reflecting the intrapersonal perspective included an increase in self-esteem, empowerment, and a heightened awareness of the choices available to her. These suggestions support Noonan’s (1997) position that nurses can apply self-care concepts within a case management model to increase female survivor’s self-care capabilities, including self-esteem and empowerment. Interpersonal factors include outcomes such as the survivor bringing her insights and information to others in her family, friends, or neighbors and acting as advocate for other survivors and their children. Institutional factors were reflected in the participants’ desire that survivors perceive nurses as advocates, confirming the opinion expressed in the classic work of Gelles in 1979. Participants also called for educational institutions to increase their curricular content on violence-related
issues and service institutions to provide staff development and continuing education programs. Recognition for the need for curricular attention to violence has been recognized by several nurse educators and researchers (AACN, 1999; Hoff & Ross, 1995; Kerr, 1992; McBride, 1992; Sword et al., 1998; Tilden et al., 1994; Woodtli & Breslin, 1996, 1997). Community factors were represented by the overwhelming demand for more community action, support, and resources to prevent violence and meet the physical, psychological, and safety needs of those involved in violent episodes. The need to collaborate with community organizations to deal effectively with violence and abuse is recognized (Schroeder & Weber, 1998). Finally, from a public policy perspective, participants called for more funding for violence prevention and treatment programs at all levels of government and for stronger laws that ensure both treatment and punishment. Their emphasis on society’s responsibility in prevention and treatment of domestic violence echoes that of Walker (1984) who, more than 15 years ago, claimed that domestic violence survivors fall victim to two systems, the family and society.

**Limitations**

Several limitations of this study prevent generalization of findings. First, the sample is confined to one city in one part of the country. The opinions of these 13 participants may not be those of participants in other geographical areas or members of other health care disciplines. Another limitation may be the sampling of nurses who typically work with domestic violence. Nurses who do not focus on this area of practice may hold different opinions and attitudes. Additional limitations include the subjective and perhaps selective retrospective recollections of participants. Finally, although rigorous attention was given to maintaining standards for authenticity and confirmability of data, other researchers may have reached different conclusions. Therefore, these findings cannot be generalized without additional research in different settings with other participants. A quantitative study based on the opinions and attitudes expressed in these qualitative findings would provide an opportunity to examine the reliability and validity of these data and contribute additional information and insights.
CONCLUSIONS

From their analysis of their long and varied experiences with domestic violence survivors and perpetrators within several health care arenas, the 13 participants were a credible resource for examining nurses’ attitudes toward survivors and perpetrators of domestic violence. As practitioners in the field and as willing respondents to broad questions about survivors and perpetrators, they provided a rich “insider’s” and “outsider’s” view to attitudes that could not have been elicited through more structured measures.

Specifically, participants provided insights about survivor’s intrapersonal feelings and fears; nurses’ respectful, caring, and objective attitudes; and nurses’ role behaviors within boundaries of “should do and should not do.” They provided insights into their own dilemmas and conflicts by defending the survivor’s autonomy and right to decide but consistently referring to her as victim. They provided insights into perpetrators as dangerous, protected, and victimized by family history or social forces/context and defined nurses’ attitudes as “letting the criminal justice system judge them.” They provided insights into short- and long-term survivor outcomes and identified expected outcomes across a range of activities. Categories and themes that emerged from their discussions incorporated implications for nursing education, nursing practice, and nursing policy.

Analysis of participants’ attitudes supports the need to facilitate nurses’ and nursing students’ recognition of their personal attitudes, based on their beliefs and values about domestic violence, its survivors, and perpetrators. Participants clearly supported the role of nursing educators to prepare students for professional practice and of continuing education to facilitate ongoing professional development in areas related to domestic violence and abuse. They emphasized the advocacy role of nurses that motivates them individually and as a professional group to initiate, support, and promote social and health policy changes.

Finally, findings from this study support the Ecological Model for Health Promotion as a valid holistic framework that can guide the study and research of nurses as they examine their multiple roles in assisting clients in violent relationships at several levels of intervention. As nurses and the profession search for frameworks to guide their research, education, and practice, ecological models, such as the one used in this study, provide a holistic approach that has the potential to advance both the science and the practice of nursing.
REFERENCES


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A Holistic Approach to Promoting Success on NCLEX-RN

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The nursing faculty at the State University of West Georgia views individuals as an integration of body-mind-spirit. Our program’s commitment complements efforts to teach students to honor the body, mind, and spirit of patients. Within this framework, faculty recognize that factors other than nursing knowledge impact students’ ability to pass NCLEX-RN. An intervention program was designed that incorporated these factors. “Preparation for Licensure” was implemented as a holistic nursing course to intervene with students’ learning and testing needs. The purpose was to increase self-awareness, promote a positive attitude toward passing the NCLEX-RN, and provide specific strategies for test taking and stress reduction. Posttest raw scores and percent correct on the Mosby Assess Test were significantly higher (p < .05) than pre-test scores. Qualitative analysis of journal data exploring the students’ experience of participating in the course revealed three themes: Perfectionism, Self-Worth, and Consequences and Meaning of Failure.

The nursing program at the State University of West Georgia in Carrollton, Georgia, has traditionally enjoyed a high passing rate on the National Council on Licensure Examination-Registered Nurses (NCLEX-RN) examination, with scores equal to or higher than the state and national averages. The high passing rate on the NCLEX-RN was attributed by faculty to the quality of the students, a philosophical commitment to viewing students holistically, and a caring
environment supportive of student success. With the implementation of the revised passing standard (National Council of State Boards of Nursing [NCSBN], 1997), the passing rate on NCLEX-RN was 80% for the class of 1998, below the state and national average of 85% for the same year (NCSBN, 1998). The faculty became concerned about the increased failure rate and felt the need for assessment and intervention to ensure a higher rate of success in 1999.

Based on a concern for students and the belief that every student who enters the program has the potential for success, a voluntary program within a holistic theoretical framework was implemented to assist the 1999 Associate of Science class with preparation to take the NCLEX-RN. This intervention was further expanded to include test practice and was offered as a 2-credit nursing elective entitled “Preparation for Licensure” for the generic Bachelor of Science class of 2000. In designing the course, the faculty sought to incorporate interventions that recognized the body, mind, and spirits of our students. Although the ultimate purpose was to promote success on NCLEX-RN, the hope was to nurture the students toward the wholeness inherent within themselves, a goal basic to the American Holistic Nurses’ Association’s philosophy (American Holistic Nurses’ Association [AHNA], 2001). Holistic interventions including cognitive restructuring, relaxation, visualization, and positive self-affirmations were implemented. These strategies were designed to increase students’ awareness of the effect of the body-mind-spirit connection on their ability to be successful on the examination. The faculty believes that by the end of the program, students have the knowledge necessary to pass NCLEX-RN. However, it is understood that factors related to NCLEX-RN failure may also include lack of self-awareness, negative beliefs about passing, and test anxiety. The Preparation for Licensure course empowers students to move toward achieving harmony among mind, body, emotions, and spirit (AHNA, 2001), thus enabling them to be successful on the examination. In addition to the holistic interventions, test practice and content review were also incorporated.

**Literature Review**

The identification of academic factors that may predict success on the NCLEX-RN has been studied widely. Hornes, O’Sullivan, and Goodman (1991) explained 67% of the variance in NCLEX-RN scores
using the cumulative GPA for specific prenursing courses. In contrast, lower division nursing prerequisite GPA and science/liberal arts GPA were not highly predictive of NCLEX-RN success in a study by Fowles (1992). Cumulative GPA for all courses upon entrance to the nursing program was not significant in studies by Lengacher and Keller (1990) and Fowles (1992). However, Waterhouse, Carroll, and Beeman (1993) and Mills, Sampel, Pohlman, and Becker (1992) reported sophomore GPA among the strongest predictors. Cumulative GPAs at the end of the junior and senior years were significant predictors in several studies (Hornes et al., 1991; Mills et al., 1992; Waterhouse et al., 1993). Fowles (1992) found GPA at the end of the first semester of the nursing curriculum to be the best predictor of NCLEX raw scores, whereas GPA at the end of the second semester of the curriculum was not highly predictive of NCLEX-RN success. Dell and Valine (1990) found that collegiate GPA at graduation accounted for 58% of the variance in NCLEX-RN scores.

Performance on standardized tests has been found to predict NCLEX success. Waterhouse et al. (1993) found that higher scores on SAT-Math and SAT-Verbal correlated significantly with passing NCLEX-RN. Social Science subscores (Fowles, 1992; Mills et al., 1992) on the American College Test (ACT) and ACT composites scores (Fowles, 1992) significantly correlated with NCLEX-RN results, whereas ACT English, Math, and Natural Science subscores did not (Fowles, 1992; Mills et al., 1992). The percentile rank on the NLN Comprehensive Examination (Hornes et al., 1991), NLN Basics Two, and NLN Psychiatric Nursing Exam correlated significantly with NCLEX-RN scores, whereas NLN Basics One and Three did not correlate (Lengacher & Keller, 1990). Fowles (1992) found that percent correct on the Mosby Assess Test was a significant predictor of NCLEX-RN pass/fail score.

In addition to academic factors, nonacademic factors have also been examined for the effect on NCLEX-RN results. Dell and Valine (1990) found that self-esteem, as measured by the Tennessee Self-Concept Scale, Gergen-Morse Self-Consistency Scale, and the Draw-a-Person Test, did not significantly contribute to the variance in NCLEX-RN scores. Perceived role strain within the role demands of student, family, and career has not been found to predict NCLEX-RN success (Lengacher & Keller, 1990; Arathuzik & Aber, 1998). Using the Test Anxiety Inventory, Poorman and Martin (1991) found test anxiety inversely related to NCLEX scores. They also used the Cognitive
Assessment Tool to ascertain students’ thoughts related to test-taking abilities. Self-predicted NCLEX scores and self-predicted student grades were the best predictors of NCLEX scores. Poorman and Martin (1991) reported that students who passed NCLEX were more likely to consider themselves good test-takers (77%) than those students who failed (20%). They also found that students who passed NCLEX were more likely to express facilitative responses to thoughts related to the upcoming NCLEX test (36%) compared to students who failed NCLEX (less than 2%). Facilitative responses were defined as behaviors that would result in good test performance: “When I have this thought it makes me want to study more” (Poorman & Martin, 1991, p. 30). One hundred percent of students who failed NCLEX-RN reported nonfacilitative responses \((p < .05)\). Nonfacilitative responses were defined as “those in which the subjects’ meaning or belief about the thought expressed was not facilitative of good test performances, e.g., “When I think this it makes me lose my concentration” (Poorman & Martin, 1991, p. 30). In a related study that examined internal and external blocks to success, Arathuzik and Aber (1998) found that lack of emotional distress and a sense of competency in critical thinking were positively correlated with NCLEX success \((p < .05)\).

The relationship between NCLEX scores and a variety of demographic variables has been studied widely. Waterhouse et al. (1993) found no correlation between NCLEX-RN scores and the number of years taken to complete the program, participation in the American Nursing Review course, and whether the student had been on academic probation, transferred from another school, or changed majors. Hornes et al. (1991) found gender noncontributory. Mills et al. (1992) also found gender noncontributory and age inversely related to NCLEX-RN success through the end of the sophomore year. Dell and Valine (1990) found that age did not contribute significantly to the variance, a finding that is also supported by Lengacher and Keller (1990) and Hornes et al. (1991). Arathuzik and Aber (1998) noted that English as the primary language at home was the only demographic variable out of several studied that correlated significantly with NCLEX success \((p < .05)\).

Although numerous studies have focused on predictors of success, reports on interventions to enhance NCLEX-RN success are somewhat limited. Beare (1995) gives a general plan for helping students prepare, and Vance and Davidhizar (1997) relate strategies to help students after initial failure. Eason and Woolard (1991) report a
strategy in which students devise a self-directed learning plan based on a personalized report card that indicated areas of weakness.

Test-taking practice and instruction are common interventions used to increase NCLEX-RN passage (Ashley & O’Neil, 1991, 1994; Frierson, Malone, & Shelton, 1993; Kaufman, Baradell, Calhoon, & Durham, 1987). A 5-day course described by Kaufman et al. (1987) focused on test-taking practice and in-depth analysis of questions using a complex decision-making model. Positive outcomes as reported by the students in this program included increased test-taking skills, decreased anxiety, and identification of areas for further study. Baradell, Durham, Angel, Kaufman, and Lowdermilk (1990) updated the decision-making model used by Kaufman et al. (1987) for subsequent courses using the revised NCLEX-RN blueprint with similar positive outcomes. The course is combined with an academic advisement and development program for at-risk students. Ashley and O’Neil (1991) had at-risk students prepare for NCLEX-RN by taking a series of focused nursing examinations outside of the classroom. Intervention sessions were then conducted in which nursing concepts were clarified and principles of test-wiseness as outlined by Millman, Bishop, and Ebel (cited in Ashley & O’Neil, 1991) were demonstrated. Students identified areas of content in need of further study and effective versus ineffective test-taking practices. At-risk students who participated in the program offered by Ashley and O’Neil (1991) passed NCLEX at a rate of 92.9% compared to 50% for those who declined due to scheduling conflicts and 93.2% for not-at-risk students. The two at-risk groups in this study were equivalent for 12 academic variables, although no comparison was made for nonacademic variables such as motivation. Ashley and O’Neil (1994) conducted a similar intervention with a subsequent senior nursing class, using faculty-led study groups offered to the entire class. The comparison group for the study was the entire class used in the previous study, minus the students in the intervention group. The at-risk intervention group had a significantly higher pass rate on NCLEX-RN (86%) than the comparison at-risk group (50%). Frierson et al. (1993) sought to enhance NCLEX scores by content review, practicing specific test-taking strategies, and using learning teams with eight African-American nursing students at a historically Black state-supported university. One hundred percent of these students passed the NCLEX-RN exam compared to a range of 50.0% to 87.5% for the previous four spring semester graduates.
In summary, the review of the literature indicates that academic factors such as GPA, grades in nursing and science courses, and performance on standardized tests can clearly predict NCLEX-RN success. Test anxiety and attitudes toward testing emerged as predictive nonacademic factors. Test practice and instruction were the most common interventions. It is important to note that the NCLEX is a changing exam and some of the studies were conducted when conditions for testing and the test plan were different from the current exam. Therefore, success on the previous exam and testing environment may not predict success today.

DESCRIPTION OF PARTICIPANTS AND INSTRUMENTS

The review of the literature provides data related to factors placing students at risk for NCLEX-RN failure, including scores on standardized nursing tests such as The Mosby Assess Test and the NLN Achievement Test. The unsecured version of the Mosby Assess Test was administered to the generic Bachelor of Science class of 2000 late in the fall semester with results reported before the end of the semester. The Mosby Assess Test consists of four tests of 75 multiple-choice questions each. Four content areas are integrated throughout the tests including medicine/surgery, childbearing/women’s health, pediatrics, and mental health. The questions are also based on four broad categories including client needs, nursing process, clinical area, and focus of care. The average percentage of questions answered correctly by the students was 57%, placing them 21 points lower than the bachelor norm group.

Although all senior students were encouraged to take the Preparation for Licensure nursing elective, those students who scored less than the 20th percentile rank (9 out of 21) on the Mosby Assess Test were personally advised to participate in the course. Nineteen out of 21 students chose to participate in the course, including the 9 students who scored less than the 20th percentile rank. According to Learning and Study Strategies Inventory (LASSI), these students had a problem with test anxiety and motivation (Weinstein, Palmer, & Schulte, 1987). LASSI (Weinstein et al., 1987) is an assessment tool focusing on learning-related thoughts and behaviors and is designed to measure students’ learning and study strategies that predict academic performance. Murray (1998) described the use of LASSI as an effective tool.
in identifying behavioral barriers to learning “that can be modified through educational interventions” (p. 1). The 10 scales included in LASSI are attitude, motivation, time management, anxiety, concentration, information processing, selecting main ideas, study aids, self-testing, and test strategies.

The mean GPA before admission to the nursing program was 3.08, with a range of 2.57-3.52. The group was 74% Caucasian, with four African-American students and one international student whose primary language was English. Eighty percent were traditional students who pursued their college degree directly out of high school. All but one were female.

DESCRIPTION OF COURSE

Topics were selected for the initial intervention and the Preparation for Licensure course according to strategies designed to enhance NCLEX-RN success rates and based on holistic strategies incorporating bio-psycho-social-spiritual dimensions (Ashley & O’Neil, 1991; Dossey, Keegan, Guzzetta, & Kolkmeier, 1995; Frierson et al., 1993; Poorman & Martin, 1991). The first class began with an explanation of the program. Students were asked to write down their present thoughts about taking NCLEX-RN. Students also completed the LASSI during class.

Students’ results obtained from LASSI were explained during a later class. The problem areas identified for this class were test anxiety and motivation. Strengths for the class included attitude, selecting main ideas, self-testing, and use of study aids. Whereas half of the class had a problem with time management, the other half found time management to be a strength. Students were asked to review their LASSI results and form a learning skills and study strategies plan based on the results. For example, if a student had a problem with time management, they might plan to make a calendar for study sessions.

An important assignment for the class was to complete a minimum of 1,200 multiple-choice nursing test questions and to check the answers. A review of rationales for questions missed was included as an intervention based on recommendations in the literature (Saxton, Nugent, & Pelikan, 1999; Poorman, Webb, Mastorovich, & Molcan, 1999). The first hour of class was generally spent on course content, and the second hour provided time for students to work independently on
practice questions in a nursing review textbook. Students independently evaluated their answers on practice tests by completing worksheets designed to categorize questions missed based on lack of knowledge of content or difficulty in interpreting test questions (Poorman et al., 1999). These worksheets provided data related to content areas for review and/or test-taking problems. In addition to these test questions, the secured version of the Mosby Assess Test given at the end of the semester provided an additional 300 test questions for practice.

The second and third classes were taught by a therapist in the university’s counseling center and focused on Rational Emotive Behavior Therapy (REBT), a type of cognitive restructuring. Cognitive restructuring focuses on assisting students to understand that cognition, emotion, and behavior are integrated (Ellis & MacLaren, 1998). An activating event triggers a belief or irrational thought resulting in consequences or feelings affecting behavior. Emotional results of irrational thoughts may include anxiety, depression, rage, guilt, and feelings of worthlessness (Davis, Eshelman, & McKay, 1997). By disputing the irrational belief or nonfacilitative response (Poorman & Martin, 1991), the emotional result or effect of the event may be changed. For example, if a student is taking an exam and is unfamiliar with the content on one question, feelings of inadequacy may arise from the irrational belief that it is necessary to always be familiar with all content. Likewise, a student might have a nonfacilitative response such as “I probably won’t know the rest of the answers.” The feelings of inadequacy may cause further anxiety and adversely affect the student’s performance on subsequent test items during the same exam. With the use of cognitive restructuring, the student could learn to intervene at the moment the irrational thoughts begin and alter the progression of negative thoughts, replacing them with positive ones. The result of this process could be to improve the student’s performance on subsequent test items.

Students were given a Beliefs Inventory (Davis et al., 1997) to determine which irrational ideas are sources of stress for them. The relationship between an event, the irrational beliefs and thoughts about the event, and the subsequent emotional consequences and feelings was discussed. Ways to dispute and challenge irrational ideas were clarified. For example, when students verbalized misgivings about passing NCLEX, they were encouraged to review evidence, such as their success in the nursing program so far, to refute those thoughts. Thought stopping and the use of affirmations were explained as
methods to identify and change negative thinking. Students were informed that practicing thought-stopping techniques 20 minutes each day was necessary to change a prominent irrational belief (Davis et al., 1997). Students were asked to journal about their irrational beliefs with regard to NCLEX-RN and their practice of refuting irrational beliefs. At this time, students were informed that journals would be used with their consent as data for a qualitative study. Consent forms and journals were not to be turned in until after grades were submitted for the course to prevent feelings of coercion and to protect confidentiality.

One class provided an opportunity for students to learn strategies useful in dealing with test anxiety. A professor certified in holistic nursing taught deep breathing, stretching, and visualization techniques. Students performed the relaxation exercise in class with the instructor. They were informed that for optimal effect, 30 repetitions of 4-second inhalations followed by exhalations lasting 8 seconds should be performed on a regular basis. Students were encouraged to monitor their level of tension and practice specific relaxation strategies, such as the deep breathing exercise, prior to taking NCLEX-RN and during the exam. Two simple shoulder-stretching exercises were also demonstrated by the instructor and practiced by the students in class. Visualization of the testing experience was encouraged as a way to decrease anxiety through desensitization. Students were asked to journal about their practice of relaxation techniques.

Another class was taught by a nursing educational consultant specializing in motivation, test-taking skills, and study preparation for NCLEX. Students answered review questions individually and discussed strategies to develop skills in test taking. Guidelines were provided to assist students in determining whether questions missed were due to lack of knowledge or misinterpretation of the question. Ways to develop study plans for NCLEX-RN were discussed. Reading assignments for the class reinforced information presented (Rollant, 1999). All of the information was presented within a motivational framework in an enthusiastic atmosphere of success. Students were so positive about the class that the consultant was asked to continue the presentation at the next class.

Midway through the course, students expressed a need for specific nursing content review. Although the effectiveness of content review has not been established in the literature (Waterhouse et al., 1993), the faculty felt that responding to the students’ perceived needs might increase their confidence in ability to pass NCLEX-RN. Faculty
planned content review based on areas of need identified by the students.

Results

Paired comparison $t$ tests were performed between pretest and posttest Mosby Assess Test scores for students who participated in the Preparation for Licensure class. Posttest raw scores and percent correct were significantly higher ($p < .05$) than pretest scores. The group scored 12 points lower than the bachelor norm group compared to 21 points lower for the pretest. There was no significant difference in percentile rank and percent to pass estimate. Twelve of 19 students (63%) who took the course passed on the first try, and 5 failed. Two students in this group have not taken the exam to date. Three of the students who failed scored lower on the Mosby Assess Test posttest. Of the 9 students who scored less than the 20th percentile rank on the pretest, 4 have passed the NCLEX-RN and 4 have failed.

Qualitative analysis, from a phenomenological perspective, was conducted on the students’ journals (Guba & Lincoln, 1989). Nineteen journals were submitted by students, along with signed consent forms, for inclusion in the study. Three themes emerged from the data: Perfectionism, Self-Worth, and Consequences and Meaning of Failure.

The first theme, Perfectionism, describes students’ desires for perfection related to passing NCLEX-RN on the first try and the feelings they believe will be associated with failure. For some students, this was described as, “failure is not an option,” “It’s the end of my world to fail,” and “I must pass the first time.”

The second theme, Self-Worth, reveals students’ stories of the connection between passing NCLEX-RN on the first try and perceptions of self-worth. Participants related the NCLEX-RN to feelings of personal self-worth and sometimes viewed themselves as failures if they didn’t pass, as exemplified in one student’s statement: “I will feel like I am a failure.” A lack of confidence in the ability to pass was verbalized in statements such as, “I feel like I will do poorly,” and “I am pretty sure I won’t pass the first time.” There were also stories of positive self-worth from students who felt confident with regard to their ability to be successful on NCLEX-RN. Comments related to the belief that “I will pass on the first try” and “I feel prepared” illustrate this paradox.
Consequences and Meaning of Failure, the third theme, describes the students’ stories of devastating effects as a result of failing the examination on the first try. Comments that illuminate the meaning of this theme include the following: “I will be letting my family down,” “I have to pass the first time to be able to get a good job,” and “If I don’t pass the first time I won’t be a good nurse.”

At the end of the course, students were asked to write journal entries describing their feelings with regard to preparation for NCLEX as well as a discussion of the use of strategies learned during the course that they had incorporated into their preparation. All students reported using one or more of the strategies taught in the class, including cognitive restructuring, relaxation and guided imagery techniques, time management, identification and refutation of irrational beliefs, test practice and content review, and self-care activities. Student journal entries highlighted the positive benefits of the relaxation exercises. Students rated their stress level on a scale of 0 to 10 and reported an average of 7.03 before performing the relaxation exercises and a score of 2.2 afterward. All students reported practicing slow, deep breathing, whereas some reported adding other techniques such as progressive muscle relaxation, visualization, and music therapy. Visualizations included special places such as the beach. One student visualized herself as a successful nurse, and another visualized “relaxation waves” flowing over her. Many described setting the tone for relaxation with additional practices such as use of candles, taking a warm bath, darkness, and a quiet atmosphere. Some students reported relief from physical symptoms such as menstrual cramps, headaches, and muscle tension. Many stated that they would continue to use the relaxation exercises in their daily lives.

Course evaluations were generally positive. Several students expressed a desire for a greater emphasis on review of nursing content. Many indicated they planned to take a review course before the examination. Students felt that test practice was very helpful.

**Nursing Implications**

The Preparation for Licensure course reinforces holistic concepts and enhances the possibility that students will incorporate holism into nursing practice. By teaching students to use holistic interventions to achieve their goal of passing NCLEX-RN, this course
reinforces the AHNA’s philosophy of the importance of the integration of body, mind, emotion, and spirit on the achievement of harmony in one’s own life. Students have learned valuable tools to assist them in self-care and can apply these to the care of clients. For example, students who have successfully used techniques to decrease anxiety, such as breathing, stretching, and visualization, may be more willing to share those techniques with clients.

This course also has implications for nurses currently in practice. Although many nurses are familiar with relaxation and visualization techniques and may even recommend them to their patients, they often neglect to include these practices in their own lives. REBT may not be as familiar to nurses, yet it could be used successfully to refute their irrational thoughts and help them to reach personal goals. By replacing irrational thoughts with realistic self-talk, individuals can decrease the feelings of anxiety, anger, and depression (Davis et al., 1997). Nurses can learn to use REBT in their personal lives and can teach their patients to do the same.

**SUMMARY AND CONCLUSIONS**

Nonacademic factors unrelated to nursing knowledge have been identified by research studies that place nursing graduates at risk for failure of the NCLEX-RN. These factors include test anxiety, test-taking skill, and personal perception of ability to pass NCLEX-RN. Failure of the NCLEX-RN then prohibits state licensure and the opportunity to begin a career in nursing. The nonacademic factors affecting success on NCLEX-RN provide support for holistic intervention programs designed to identify and assist students at risk for failure. The Preparation for Licensure course was designed as an elective that incorporated cognitive restructuring techniques, strategies for studying and test taking, and methods for decreasing test anxiety. Holistic interventions such as deep breathing, stretching, and visualization techniques were used to address test anxiety. REBT, a type of cognitive restructuring, was used to improve students’ perceptions of their ability to pass NCLEX-RN. Classes on test-taking tips for multiple-choice questions addressed the issue of test-taking skill. In addition to addressing nonacademic variables, review of nursing content and test practice with review of answers and rationales were included in the course.
The influence of the Preparation for Licensure course on the students’ ability to pass the NCLEX-RN is unknown. Although the research is limited, there is some support in the literature for the use of specific interventions to enhance success rates on the NCLEX-RN. Based on this information as well as the positive results from the students, it is felt that the programs were a success and should be continued.

One anecdotal incident provided encouragement that the course was successful in at least one case. Upon hearing that one of her students had passed, a faculty member went to congratulate her. This student had admitted to terrible test anxiety and difficulty taking multiple-choice tests. She stated that she was very nervous when she sat down to take NCLEX-RN. Instead of immediately starting the test, she sat there for 15 minutes, meditating, using relaxation techniques, and reassuring herself with positive affirmations. This student had increased her percentile rank on the Mosby Assess Test significantly on the posttest after taking the class. She passed the NCLEX-RN after taking the minimum of 75 questions. Stories such as this encourage faculty to continue efforts to create a holistic atmosphere addressing all areas of student need related to preparation for NCLEX-RN.

REFERENCES


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The Holism in Critical Thinking

A Concept Analysis

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In nursing, critical thinking is particularly important because of its potential impact on patient care. With the rapid changes in healthcare and the influx of new technology, nurses must be able to use critical thinking to make decisions that provide optimal patient care. The rapid, dynamic changes occurring in the healthcare setting have dictated a stronger, more comprehensive, holistic way of arriving at decisions than the traditional nursing process. This more comprehensive, holistic approach is called critical thinking. Nurses must be able to engage in critical thinking to handle the onslaught of continuous procedural and technological changes. Critical thinking has become such a key component in learning that the National League for Nursing requires that graduates be able to demonstrate critical thinking. This article is a concept analysis of critical thinking using the Walker and Avant model.

The rapid, dynamic changes occurring in the healthcare setting have dictated a stronger, more comprehensive, holistic way of arriving at decisions than the traditional nursing process (Koch & Speers, 1997). The traditional nursing process may have encouraged a more linear approach to decision making or problem solving. This more comprehensive, holistic approach is called critical thinking. Nurses must be able to engage in critical thinking to handle the onslaught of continuous procedural and technological changes in the current health care...
environment. Critical thinking has become such a key component in learning that the National League for Nursing (NLN) requires that graduates be able to demonstrate critical thinking (NLN, 1996). This ability to engage in critical thinking when providing patient care is often the key element in positive or deleterious outcomes.

For critical thinking to occur, a holistic perspective of the self and the situation must be employed. The author defines critical thinking as a process that encompasses a holistic perspective of the entire person—composed of skills, abilities, beliefs, attitudes, goals, emotions, and experiences. In addition, critical thinking involves being able to view a situation from a holistic perspective.

The purpose of this article is to report an analysis of the concept of critical thinking and understand its importance to nursing in making clinically sound decisions in the patient care environment. Concept analysis is a “formal, linguistic exercise” (Walker & Avant, 1995, p. 37) to help clarify a concept by examining the characteristics and defining attributes that make up the concept. In addition, examples are written and analyzed to point out the specific components of the concept that have been included or eliminated in the example. Although critical thinking as an intellectual, philosophical exercise can occur without the need to arrive at a solution, this article focuses on those instances where some action must be implemented in the context of patient care. Critical thinking as addressed in this article is not thinking merely for the sake of reflection or pondering of issues; instead it is purposeful with the goal of decision making. Table 1 provides a summary of concept analysis of critical thinking. The table highlights the definition, initiating factors, quintessential elements, and consequences of critical thinking.

THE ESSENCE OF CRITICAL THINKING

Importance of Critical Thinking

Part of comprehending the concept of critical thinking lies in understanding what it is not. Critical thinking is not one single entity or defining concept. It is not merely problem-solving, scientific methodology, the nursing process, reflective thinking, creative thinking, diagnostic reasoning, reflective judgment, intuition, or clinical decision making (Kataoka-Yahiro & Saylor, 1994; Lenburg, 1997; Wallace, 1996). Also, it should not be confused with traditional thinking;
traditional thinking relies on traditional past practices to answer questions, whereas critical thinking asks the important question, ‘Why?’ (Stark, 1995). Although critical thinking is not simply any one of these items, all of the aforementioned concepts make up critical thinking.

Critical-thinking literature has been covered by a wide array of disciplines. These various disciplines cited specific reasons as to the significance of critical thinking within their field. Paul (1995) wrote that critical thinking is the “essential foundation for education” (p. xi), underscoring its importance in being able to live in current society. He goes on to say that, unfortunately, students and teachers do not understand critical thinking. Brookfield (1987) stated that without

<table>
<thead>
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<th>TABLE 1</th>
<th>Summary of Concept Analysis of Critical Thinking</th>
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<td><strong>Definition: critical thinking</strong></td>
<td>A process that encompasses a holistic perspective of the entire person—composed of skills, abilities, beliefs, attitudes, goals, emotions, and experiences. In addition, critical thinking involves the ability to view the situation from a holistic perspective.</td>
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<td><strong>Initiating factors (antecedents)</strong></td>
<td>Identification of a situation requiring critical thinking.</td>
</tr>
<tr>
<td><strong>Quintessential elements</strong> (defining attributes)</td>
<td>1. recognition of a unique situation needing further evaluation 2. reasoned judgment and evaluation of the situation, recognizing personal assumptions and biases 3. remaining open-minded and flexible 4. purposefully viewing the situation from all possible angles 5. selection of the best solution based on knowledge and level of experience, with the patient’s welfare a prime focus 6. willingness to take a risk and implement a decision 7. self-confidence in implementation of selected solution 8. willingness to alter opinions when new facts are presented 9. committed to excelling for better outcomes</td>
</tr>
<tr>
<td><strong>Consequences</strong></td>
<td>A decision is made to benefit the overall well-being of the individual.</td>
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critical thinking, relationships would weaken and society would become stagnant, leading to the possible destruction of political systems. The literature is not clear whether critical thinking is an ability, attitude, or skill (Edwards, 1998). Brookfield (1987) described it as a process, never ending because of the nature of continued growth and uncertainty. Facione and Facione (1996) defined critical thinking “as that higher order reasoning used in reaching professionally informed judgments in high-stakes, time constrained, and, many times, novel problem situations” (p. 41).

In their book, Critical Thinking in Nursing, Bandman and Bandman (1988) stated, “Critical thinking is defined in this text as the rational examination of ideas, inferences, assumptions, principles, arguments, conclusions, issues, statements, beliefs, and actions” (p. 5). Paul (1995) defined critical thinking as “a systematic way to form and shape one’s thinking. . . . It is thought that is disciplined, comprehensive, based on intellectual standards, and as a result, well-reasoned” (p. 20); he viewed critical thinking from a systems perspective, emphasizing its application to daily learning. It is of paramount importance to understand that critical thinking is more than “good problem solving” (Alfaro-LeFevre, 1999, p. 59). It extends beyond problem-solving to encompass the desire to increase efficiency and efficacy in practice—integrating research, the nursing process, and clinically based findings to determine the best solution (Alfaro-LeFevre, 1999; Brock & Butts, 1998; Kataoka-Yahiro & Saylor, 1994). Critical thinking encourages skepticism and tolerance for ambiguity while using facts, abstractions, theories, deductions, and interpretations (Koch & Speers, 1997). Brock and Butts (1998) stressed that uniqueness of the situation—not well memorized, rote solutions—should be considered when engaging in solving patient problems. Schank (1990) distinguished the essential element of knowing “that” to knowing “how” (p. 87); the knowing “how” is key in development of intellectual skills and extends beyond simply the knowing “that” of factual information. Knowing how implies a thinking process that effectively applies, analyzes, and synthesizes knowledge and information. It is more than simply learning facts.

This knowing how is particularly important in nursing because of its potential impact on patient care. Alfaro-LeFevre (1999) explained that critical thinking is necessary not only to exist but also to grow and develop; without the ability to think critically, nurses cannot solve problems and therefore become absorbed by the problems. And finally, accrediting bodies look for evidence of critical thinking in the
practices setting as well as in academia. Critical thinking enhances the nursing process (Oermann, 1998) and helps in determining what is truly important (Bandman & Bandman, 1988). Thinking critically is especially beneficial in situations where nurses encounter atypical patients (Oermann, 1999). Others argued that the nursing process can no longer meet nursing’s current needs, citing that it is a linear approach from questions to answers; critical thinking is more appropriate because it fosters the exploration of alternative solutions (Koch & Speers, 1997).

Definition and Use of Critical Thinking

Critical thinking in the literature has been described as a concept, or ability, that should be fostered in everyone. Unfortunately, owing largely to the multitude of writings on this topic, there is no one consensual definition to describe critical thinking. This nebulous understanding is further clouded by the plethora of varying terminology used for critical thinking; misuse of these terms has added to the confusion and uncertainty (Lenburg, 1997). For example, Lindeman (1996) believed labels such as clinical decision making or critical judgment can be used in lieu of critical thinking. In contrast, Lenburg (1997) advocated clarifying critical thinking, clearly delineating it from other interchangeable terms that indicated some intellectual venture.

The American Heritage Dictionary (2000) defined critical as “adj 1. Inclined to judge severely and find fault. 2. Characterized by careful, exact evaluation and judgment... 3. Of, relating to, or characteristic of critics or criticism... 4. Forming or having the nature of a turning point; crucial or decisive.” Thinking is defined as “1. The act or practice of one that thinks; thought. 2. A way of reasoning; judgment.”

The essence of the words careful evaluation, judgment of reasoning, is composed of key components of critical thinking (Oermann, 1998). Authors who have written about critical thinking stressed the necessity of this intellectual process; unfortunately, there are no agreements as to the actual definition. Despite several recurrent themes on critical thinking, there is not one central, clear definition for this concept of thinking (Daly, 1998; Kataoka-Yahiro & Saylor, 1994; Ruminiski & Hanks, 1995). Critical thinking as described in the literature emphasized the components of careful evaluation and consideration, although different terminologies have been used. Critical thinking has sometimes been labeled clinical decision making or clinical judgment
(Lindeman, 1996). Kyzer (1996) indicated that it is “active, focused, persistent, and purposeful” thinking (p. 66).

For the purpose of this article, critical thinking is defined as a process of arriving at a decision that must originate from a holistic stance while viewing the situation from a holistic perspective. In other words, those engaging in critical thinking must be able to effectively marshal their entire being, to include all their feelings, attitudes, values, past experiences, beliefs, and knowledge and apply it to a situation. The term *all* is used to emphasize that the situation is not limited by emotions, feelings, knowledge, beliefs, or experiences that only apply to the current situation. Critical thinkers must understand that they have accumulated feelings, knowledge, and experiences from a variety of activities that influence the way they think.

**THE EMBODIMENT OF CRITICAL THINKERS**

Authors writing about critical thinking often cited important characteristics of those considered as critical thinkers (Alfaro-LeFevre, 1999; Bandman & Bandman, 1988; Nicoteri, 1998; Paul & Heaslip, 1995). A few of these characteristics included active communicators, open-minded, flexible, creative, proactive troubleshooters, realistic, and questioning (Nicoteri, 1998). In addition, Nicoteri believed critical thinking was not naturally inherent but must be developed and refined through practice. Other attributes of critical thinkers included being inquisitive, persistent, organized and systematic, team players, creative, honest with self/others, and committed to excellence (Alfaro-LeFevre, 1999).

Brookfield (1987) described critical thinkers as actively involved in life, creative, innovative, self-confident, and questioning. Spitzer (1997) identified four specific critical thinking skills: identifying critical issues, problem solving, timely selecting the best choice, and identifying and responding to threats and opportunities. These specific skills were identified as especially crucial to the leadership management arena; in addition, he highlighted that empowerment, stemming from authority to make decisions and solve problems, is ineffective if a person does not have the necessary critical thinking skills to make good decisions.

Facione and colleagues identified critical thinking skills as interpretation, systematicity, analysis, evaluation, self-correction, judi-
ciousness, analyticity, and courageousness (Facione & Facione, 1996; Facione, Facione, & Sanchez, 1994). Lenburg (1997) discussed risk taking as something that must be embarked on to arrive at a solution; inherent in this risk taking is the possibility of correctly calling the situation or totally misinterpreting and selecting a wrong solution.

The aim and intent of participating in critical thinking is for an optimal outcome. Therefore, critical thinking is not one single item; instead, it encompasses a holistic perspective of the entire person, composed of skills, abilities, beliefs, attitudes and goals, emotions, and experiences. In addition, the situation must also be viewed from a holistic outlook if critical thinking is to occur. In summary, after a review of the literature, the author believes critical thinking is a holistic endeavor.

**Combining the Use of the Holistic Self With a Holistic Perspective**

The author contends that critical thinking is a process of arriving at a decision that must originate from a holistic stance while viewing the situation from a holistic perspective. Critical thinkers can effectively draw upon their entire selves—to include all past experiences, beliefs, and knowledge—and apply it to a situation. The emphasis on “all” is intended to highlight the fact that critical thinkers should not rely only on pertinent information and experiences that impact the current situation; rather, they should understand that they can draw upon their accumulated knowledge and experiences from a variety of past activities and use these to view the situation. As such, there are times when knowledge and skills from one activity can effectively be used to critically think through an unrelated situation.

The second key component to critical thinking is the ability to view the situation from a holistic perspective, thus exploring the multiple alternatives and points of view. This is a much different approach than when nurses are taught to rely on what they have learned and experienced only in the realm of nursing, oftentimes looking only linearly at the situation to arrive at a solution. The holistic perspective in critical thinking mandates that nurses must use a 360-degree lens to look at the situation before arriving at a decision. As a result, this may require nurses to use some knowledge or experiences gained from areas outside of nursing.
INITIATING FACTORS

Initiating factors, or antecedents, are occurrences or precursors that trigger a critical thinking episode (Walker & Avant, 1995). A positive or negative event can evoke a moment of critical thinking. The event must be something that questions individuals’ current knowledge base, assumptions and/or deep-rooted ideas, and beliefs (Brookfield, 1987). A situation for decision making must present itself where individuals must assemble their cognitive abilities, level of expertise and knowledge, and oftentimes deep-rooted beliefs. They must recognize the situation as necessitating critical thinking intervention. In summary, the antecedent conditions that must occur create a situation that requires a solution using a holistic perspective, as well as engaging the holistic self.

QUINTESSENTIAL ELEMENTS

Defining attributes, or the quintessential elements, are characteristics of the concepts that appear repeatedly within the literature. These characteristics should be grouped to paint a clear picture of what comprises the concept of critical thinking (Walker & Avant, 1995). A key attribute is the ability to recognize that a unique situation exists that requires the implementation of critical thinking to arrive at the best solution. Using reasoned judgment is a defining element in selecting the better or worst answers. Reasoned judgment requires rational evaluation of possible solutions based on previous knowledge and experiences (Paul, 1995). Beside experience and ability to reason, one needs to be flexible, skilled, and open-minded, with the ability to view a situation from a variety of angles (Kyzer, 1996). A significant component to critical thinking is understanding one’s frame of reference (Hansten & Washburn, 2000), assumptions, and bias. The level and depth of knowledge and experience greatly enhance the ability to engage in critical thinking (Alfaro-LeFevre, 1999) and the willingness to implement a solution. Critical thinking also requires taking risks in making decisions (Lenburg, 1997) and to defend this position (Hansten & Washburn, 2000). Along with the decision, critical thinkers must be able to implement the course of action and be willing to take the risk of their actions. When supporting evidence proves a decision to be incorrect, critical thinking involves a willingness to alter opinions based on the information obtained (Hansten &
Washburn, 2000). And finally, critical thinking must have at its core the desire to excel, looking for new ways to make things more efficient and effective (Alfaro-LeFevre, 1999).

In summary, the attributes of the concept of critical thinking are as follows:

1. Recognition of a unique situation needing further evaluation.
2. Reasoned judgment and evaluation of the situation, recognizing personal assumptions and biases.
3. Remaining open-minded and flexible.
4. Purposeful viewing of the situation from all possible angles.
5. Selection of the best solution based on knowledge and level of experience, with the patient’s welfare a prime focus.
6. Willingness to take a risk and implement a decision.
7. Self-confidence in implementation of selected solution.
8. Willingness to alter opinions when new facts are presented.
9. Commitment to excelling for better outcomes.

**CONSEQUENCE**

There is the assumption that engaging in critical thinking will yield some result; these results are the consequences of the concept of critical thinking (Walker & Avant, 1995). The consequence of critical thinking is that, after considering the situation and all factors associated with it, a decision is made that benefits the overall well-being of the individual.

**Model Case**

A model case of critical thinking is one that has all the elements of the defining attributes. The model case is the exemplar representation of critical thinking (Walker & Avant, 1995).

Tammy is a 40-year-old female undergoing preoperative evaluation for a total abdominal hysterectomy. The nurse conducting the assessment interview has been a perioperative nurse for 10 years. During the interview, the nurse asks Tammy if she has had any allergic reactions to food, medications, or any type of products. Although Tammy responds with a confident “no,” the nurse notices that Tammy’s hands are reddened with some indication of a rash that extends slightly above the wrist area. Briefly, the nurse recalls that her own sister has a similar reaction because of her sensitivity to latex.
When questioned about the rash and redness, Tammy responds “Oh, sometimes my hands really itch after I’ve been wearing my cleaning gloves for a couple hours. Don’t worry, it happens all the time and it will be gone before the surgery in a couple days. It looks a little worse this time because I left the gloves on longer than usual.” After further inquiry, the nurse learns that Tammy’s mouth became reddened and edematous after blowing up balloons for her son’s birthday party last week. When questioned about food products, Tammy reveals that bananas “make my tongue and mouth swollen.” The nurse suspects Tammy may have an allergy to latex products and notifies the surgeon and anesthesia provider. The tests ordered by the surgeon indicate that Tammy definitely reacts to latex. Due to the potential for a latex allergy anaphylactic reaction and based on the advice of the perioperative nurse, the surgeon postpones Tammy’s procedure until further testing.

Discussion

This model case contains all the defining attributes of critical thinking. During the interview, as the nurse was assessing Tammy’s integumentary system, she noticed that Tammy’s hands were reddened and had the remains of a disappearing rash. Having worked in the operating room for the past 10 years, the nurse immediately recalled patients with similar reactions to latex gloves. In addition, the nurse used her knowledge from her sister’s personal reaction to latex. When she saw Tammy’s reddened hands, the nurse immediately became aware of a potential unique situation. Realizing the redness and rash could have been caused by many factors, the nurse began questioning to eliminate factors and pinpoint the possible cause. With further questioning, the nurse discovered that Tammy also had a reaction to balloons and bananas. Drawing on her knowledge from the literature and experience with latex-sensitive patients, the nurse reported her findings to both the surgeon and the anesthesia provider. Notifying both parties helped ensure that key members of the surgical team were aware of Tammy’s status. Furthermore, the nurse confidently suggested to the surgeon that Tammy’s surgery be postponed until further diagnostic testing had been concluded. The nurse’s goal was to provide the best care possible for Tammy by preventing a possible crisis situation.
Borderline Case

Borderline cases are excellent examples of those instances when some of the defining attributes of critical thinking are present. However, the absence of some of the defining attributes clearly indicates what a model case should be (Walker & Avant, 1995).

Sally, a 70-year-old female, was admitted to a neurosurgical unit for a diagnostic evaluation for unexplained vertigo. The morning after her admission, the nurse found Sally on the floor, along with her pillow and blanket. The nurse’s initial fleeting thought when she noticed the pillow and blanket beside the patient was that the patient slept on the floor because she did not like the softness of the bed. The reason for this initial, fleeting thought was because the nurse herself often slept on her floor, preferring the firmness it offered. Recognizing the unique situation and surmising the patient had fallen, the nurse activated the call button and asked for assistance. Also, because Sally’s physician was making rounds on the unit, he too was notified of the incident. Once safely back in bed, the nurse began questioning Sally about her fall and proceeded to perform a neurological assessment. Still groggy from sleep, Sally was not yet coherent enough to explain she did not fall out of bed but had chosen to sleep on the floor, something she did often at home because of “her back problems.” When the physician entered the room, the nurse explained that she found Sally on the floor, where she had fallen sometime during the night. After hearing this explanation, Sally immediately woke up and stated, “I didn’t fall out of my bed. I like sleeping on the floor.”

Discussion

The nurse quickly identified a unique situation. Because the nurse knew Sally was admitted for dizziness, she naturally concluded the patient had fallen out of bed. With this information, the nurse quickly made the decision to notify the physician as she conducted a neurological assessment. Unfortunately, the nurse did not take the time to view the situation from all possible angles, nor was she open-minded about the incident. Having worked on the neurological unit for many years, the nurse understood that patients found on the floor correlated with falls out of bed. Despite her personal experience of sleeping on the floor herself, the nurse dismissed the pillow and blanket around Sally without further considering the possibility that the
patient merely wanted to sleep on a firm surface. Although the nurse took the risk and implemented her decision to notify the physician with confidence, she did not take the time to gather the proper information and consider the other explanations. However, she did have excellent intentions in determining if the patient sustained any serious injury. Finally, after receiving all facts from the patient, the nurse willingly acknowledged that she had not properly taken the time to fully assess the matter.

Contrary Case

A contrary case of critical thinking is one in which none of the defining attributes exist. This is a clear example of “not the concept” (p. 44) and is used as a polarizing example (Walker & Avant, 1995).

Jason, a 35-year-old male, was admitted to the ambulatory surgical unit after arthroscopic surgery to his left knee. Because the procedure took longer than usual, a urinary catheter was inserted in the operating room. Unfortunately, because the anesthetic had not yet worn off, Jason remained overnight with the catheter in place. When discharge orders were written in the morning, the nurse removed the intravenous line and catheter, noting in her notes that the urine in the bag looked cloudy with a foul odor and sediments. Because the patient’s urinary output was a strong indication of possible complications, the nurse should have done more than make a note in the patient’s chart. This unusual finding is an obvious antecedent to engaging in critical thinking. At a minimum, the nurse should have contacted the physician to relay what was found in the urine bag. The patient was discharged home but was readmitted in 2 days with a severe urinary tract infection and an infection to his operative knee.

Discussion

None of the defining attributes of critical thinking are present in this case. The nurse did not recognize the cloudy, foul-smelling urine as a unique situation needing thought and intervention. Her actions were not focused on excelling for good outcomes; as a result, the patient was sent home without proper antibiotic therapy, resulting in a readmission.
CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

The vast literature on critical thinking indicates that critical thinking is essential; however, there is no consensus on the definition of critical thinking. Consequently, critical thinking is not well-defined. Critical thinking has been addressed as a key component in arriving at decisions that promote patient well-being. Lindeman (1996) believed that the most important endeavor in nursing education is the teaching of critical thinking. However, before this teaching can effectively occur, educational institutions must agree on a clear, workable definition of critical thinking; this baseline is needed so that instructors have some outline for structuring courses (Kataoka-Yahiro & Saylor, 1994).

One key to explaining critical thinking is defining it from the holistic approach. Nurses should understand that to engage effectively in critical thinking, they must be able to competently employ the appropriate parts of their abilities, knowledge, experiences, feelings, and beliefs and relate them to a specific situation. This entails being able to pull the appropriate components of their selves and apply these components to arrive at a decision. Critical thinking involves knowing what part of self must be applied and used to select a course of action. In addition, they must incorporate the holistic components of the patient—including family, environment, social, and political implications—to arrive at the optimal solution. Using the holistic self when viewing a situation allows the exploration of more alternatives than simply using one aspect of a nurse’s knowledge, feelings, beliefs, or skills. By using this definition, nurses would then be able to recognize the situation as multi-dimensional, not linear.

There must be some agreement on operational definitions of this concept, so that it can be measured to determine if students are actually learning this skill. Assessment methods should specifically focus on measuring individuals’ ability to use critical thinking, not merely on the outcomes; unfortunately, even with critical thinking, adverse outcomes do occur. Although a patient’s death may be a negative outcome, when reviewing the situation for critical thinking, emphasis should be placed on assessing the parameters of critical thinking to determine if indeed critical thinking was used to arrive at the decision. Judgment on whether or not critical thinking was used should not be based purely on negative or positive outcomes, rather the
process of critical thinking should be reviewed. However, when negative outcomes do arise, the focus should be on how to prevent such outcomes in the future, developing critical thinking even more.

In the clinical setting, this requires methods to assess the thought process to arrive at a decision (Oermann, 1998). This can be accomplished through case studies, clinical scenarios, and open-ended questions (Oermann, 1999). If nurses are to learn and be evaluated on critical thinking, they must first clearly understand its meaning. For if the definition of this concept remains fuzzy, then the ability to effectively engage in critical thinking will be just as hazy.

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The Use of Holistic Concepts in Professional Practice

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This article describes a caring interaction between a nurse and a client in emotional distress in the emergency department. The author demonstrates the use of holistic concepts such as self-care, self-awareness, intention, presence, imagery, and rituals in her relationship with the client.

As a psychiatric clinical nurse specialist, I provide psychiatric consultation to patients in the emergency department (ED). A few months ago, I had an unusually busy day. I was leaving the ED after completing four evaluations, and one of the physicians asked me to evaluate another patient (I will call her Jane Jones). The patient’s name sounded familiar to me; she had been in the hospital a year earlier for suicidal ideation.

I was exhausted physically and emotionally and could not provide the care that Jane deserved unless I cared for myself first. I needed to re-energize. On my way to the cafeteria, I stopped in the hospital chapel for some quiet time. Soft music with nature sounds played. I could hear the sound of ocean waves. I imagined I was at a beach, sitting on a comfortable chair and watching the ocean. I imagined that the waves were washing away my exhaustion, and the sun was giving me the energy I needed.

As I finished my lunch, I was paged and informed that Jane was medically clear. Jane came to the ED because she was contemplating suicide. She also had a long history of substance abuse. I reviewed Jane’s charts briefly; it was her third admission within the past 2 years. She had the tendency to come to the hospital, stay clean for a
few months after discharge, and then go back to drinking and using cocaine. I was aware that I might be biased toward this patient. Before seeing her, I stopped to wash my hands and to imagine that I was cleansing myself of any bias I might have toward her. I wanted to evaluate her without any preconceived opinion. As I walked toward her, I also imagined that she was cooperative and the interview went well. My intention was to be fully present and to care for her to the best of my ability.

When I entered the room, Jane was lying on a stretcher with her back turned toward the door. She stated that she did not feel like talking. I told her I was there to help her, but I needed her cooperation. I sat on a chair and reminded myself that there is an energy that flows through both of us and everything else. I also imagined that the two of us were surrounded by a beautiful white light that was comforting.

I told her that I had spoken to the physician and read her charts from the previous admissions, but I would like to know why she came to the hospital and how we could help her. She stated that she was tired of her lifestyle. She could not take it anymore. I said, “Why don’t you turn around and look at me so that we can have a face to face conversation.” I gently touched her shoulder. She answered she was embarrassed. She added, “I am such a mess. I feel out of control, I cannot stop drinking and drugging.”

Then, she turned around and said she should not be talking to me with her back turned. It was disrespectful. She added, “I know who you are. You have always been nice to me.” Jane really needed help and did not want to die. She said, “I have a beautiful 10-year-old daughter. This morning when I went to see her and kiss her for the last time she told me, Mom, please come back tonight, I need you.” By this time, the patient was sobbing. Jane was concerned about her daughter. Our previous positive interactions and the concern for her daughter was pivotal in switching Jane’s level of cooperation. With some encouragement, she talked to her mother who agreed to take care of her daughter while Jane was in the hospital.

In the past, Jane had refused to take medication for her depression. We talked about the importance of taking medication to treat her depression instead of self-medicating with drugs and alcohol. I encouraged her to be an active participant in her treatment. She seemed more motivated about wanting to get better. My feeling was telling me that she was now in a different place in her journey toward healing. Jane did quite well on the unit. She has not been back since the last admission, which was about 5 months ago.
The following holistic concepts and principles, which are based on Watson's theory of Human care (Watson, 1979, 1988), were applied to the therapeutic interaction described above. Caring is the foundation for healing and therapeutic presence. Self-awareness, self-care, and self-growth are fundamental in caring for others. Health can be promoted by a caring relationship as well as nursing knowledge and interventions. A person is valued and deserves the best possible care the nurse can offer to another person. Every person must be approached with unconditional love and acceptance. The nurse and the person are coparticipants in the process of healing. Individuals have energy fields that are connected to the energy of the environment (universe).

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