



# THE JOURNAL

of the New York State Nurses Association

SPRING/SUMMER 2003

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Complementary and Alternative Therapies in Nursing

- Holistic Nursing Management of Pain and Suffering: A Historical View with Contemporary Applications
- Reiki: A Supportive Therapy in Nursing Practice and Self-care for Nurses
- A Pilot Feasibility Study of the Effects of Touch Therapy on Nurses
- Therapeutic Play: Developing Humor in the Nurse-Patient Relationship
- The Spirit of Healing: How to Develop a Spiritually Based Personal and Professional Practice



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## ■ EDITORIAL

In 1998, the National Institutes of Health established the National Center for Complementary and Alternative Medicine (NCCAM) to provide support for research in this rapidly expanding public health field.

Complementary medicine is defined as that which works *with* conventional medical care, and alternative therapies are those that *replace* conventional approaches to health problems. Many of these therapies have been practiced for centuries and comprise “a group of diverse medical and healthcare systems, practices, and products that are not presently considered to be part of conventional medicine” (NCCAM, 2000). This issue of *Journal* focuses on the nursing perspective regarding Complementary and Alternative Medicine (CAM) and contains several articles from research and practice.

The healing practices embraced by CAM focus on mind-body connections that move beyond the traditional western biomedical model of care. The therapeutic value of CAM, is based upon ancient traditions. Today, patients have a wide range of options for improving health and preventing chronic illness, such as herbals, nutrition, manual healing methods, mind-body techniques, and spiritual approaches (Fontaine, 2000).

One study estimated that 42% of adults use some form of CAM, with more than 629 million visits for these therapies exceeding the number of visits for conventional health care (Eisenberg, 1998). In addition, many people obtain therapies on their own through health food stores or over the Internet. In order to provide optimal and comprehensive care, nurses need to be aware of their patients' use of CAM. These therapies can be helpful, or conversely they may on occasion be extremely harmful. For example, more than half of the population of the United States uses some form of dietary supplements. Ephedra, which has been implicated in the recent death of a professional athlete, is an ingredient in many products that are classified as dietary supplements (FDA, 2003).

The articles in this issue provide excellent examples of how nursing practice can evaluate and integrate complementary and alternative therapies:

Deborah McElligot and her co-researchers report on a pilot study of the effectiveness of AMMA touch therapy in a sample of staff nurses that shows remarkable promise for future research.

Martha Greenberg's grounded theory study describes nurses using humor as an alternative healing-caring strategy with a core process of therapeutic play involving caring for self or another.

Robin Gallob's overview of Reiki, a healing energy applied through touch, gives comprehensive background and describes how this modality can be integrated into nursing practice.

Martha Fortune and Marjorie Baker-Price combine their vast experience with healing through the use of alternative interventions to describe their philosophy of “the spirit of healing,” and illustrate how these concepts can be put into practice.

Deborah Metalliano challenges nurses to provide holistic pain management for patients by including complementary practices that reflect a mind-body connection.

In all of these examples, nurses are examining the effectiveness of various modalities and embracing the therapeutic effects of the CAM.

Suzanne S. Dickerson, DNS, RN  
Jane Tuttle, PhD, RN  
Guest Editors

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## Holistic Nursing Management of Pain and Suffering: A Historical View with Contemporary Applications

Deborah Matteliano, MS, RN, ANP, FNP-BC

### Abstract

Nursing is rooted in caring for those who suffer and experience pain. As nursing has grown through the ages, technological advances and socioeconomic changes have required nurses to adapt as they continue to provide holistic, patient-centered care. Over the past century, nursing practice has been dominated by Western medical culture, resulting in a relegation of the caring-healing practices of nurses to the margins of healthcare delivery. Recent changes in the ontology of caring-healing practices are rooted in a new knowledge of complimentary practices. Advancements in behavioral sciences and the neurobiology of pain and suffering, together with an acceptance of Eastern and other healing practices, have enriched and enlightened our understanding of pain management. The recent growth of self-help and support programs has enlightened the healthcare consumer in choosing treatments. Contemporary clinical practice may now include methods that reflect the interconnectedness between the mind and body, such as biofeedback, healing touch, aromatherapy, progressive relaxation, meditation, and behavioral therapy. This article examines the historical concepts of pain and suffering that have influenced the approach to pain management and describes significant holistic methods that may be utilized by the nurse in managing pain.

Pain and suffering have been variously defined within the context of culture and history. Since man's earliest beginnings, the growth of poppies for analgesia and the use of massage, acupuncture, and analgesic incense have been documented (Greystone & James, 1975). While the Chinese began very early to alleviate pain as a method to treat disease, the Greek culture viewed an enjoyable life as one that took pain in its stride. Pain was "the soul's experience of evolution" (Ilich, 1976, p. 147). Thirteen distinct terms for pain were translated from Hebrew to Greek in the second century, B.C. Pain was equally applicable to the suffering of the soul, and the body and soul were inextricable (Ilich, 1976).

In the fourth century B.C., Aristotle and Hippocrates initiated a materialistic view of the body that was the prelude to a separation of

mind, body, and spirit. Donovan (1989) described Aristotle's view of pain as an emotion rather than a sensation, experienced by the heart and not the brain, thus separating the attributes of the living human body.

The metaphysical attributes of pain and suffering also were influenced by Catholicism and Protestantism during the Reformation and Counter-Reformation. Pain was considered to be synonymous with sin, something to be endured as punishment. Pain control was equivalent to interference with the divine plan (Donovan, 1989).

During the European post-classical period, suffering was viewed as part of a greater force of nature. Only an outsider, such as a priest, politician, or physician, could interpret or destroy it. This belief, which persisted until the 17th century, considered pain to be the "manifestation

of nature's weakness, of a diabolical will, or a well-deserved divine curse ... the meaning of pain was cosmic and mythic, not individual and technical" (Ilich, 1976, p. 149).

A shift to the perception of pain as a personal matter became more apparent during the 17th century, when Descartes attempted to develop a scientific anthropology that addressed the issue. In many ways, Descartes' work was a culmination of the previous efforts by scientists and philosophers, such as Aristotle and Hippocrates, who had laid the groundwork for the view that there are distinct functions of the mind, body and spirit. Descartes's *A Treatise of Man*, published in 1664, was well received during the Age of Enlightenment. This philosophy, known as Cartesian thought, has since permeated the science and application of pain management.

**Deborah Matteliano** practices in a spine rehabilitation clinic where she specializes in pain management and spirituality.

## Pain as a symptom

For Descartes, pain became the body's defense, a signal designed to protect its mechanical integrity. According to Regis, a pupil of Descartes, "... the great engineer of the universe has made man so perfectly, and he could not have invented a better device for his maintenance than to provide him with a sense of pain" (Ilich, 1976, p. 50). The metaphysical aspect of pain and suffering thus lost favor to the enlightened view that the mind and body are separate, and pain is thus reduced to a mere symptom.

The belief that pain was a symptom, subject to the influences of nature and devoid of any metaphysical explanation, was inculcated by the beginning of the 19th century. "Progress in civilization became synonymous with the reduction of the sum total of suffering ... pain is viewed as a passive happening inflicted on helpless victims" (Ilich, 1976, p. 50). Healthcare practitioners responded by seeking to stamp out pain and suffering through physical interventions.

The Cartesian perspective has lasted through the centuries and imbues the assessments of healthcare providers in subtle ways. Do the pain symptoms presenting in a patient point to real disease? The legitimacy of the patient is reduced to the perception of the assessor, leading to the current lexicon of observable symptoms and "pain behavior." Consistent with Cartesian thought, pain is regarded as a vital alarm that signifies physiologic disorder. Nurses are still taught that to treat pain may preclude an accurate diagnosis in acute care situations such as fractures, even though modern radiologic testing can provide evidence for the diagnosis.

Applied nursing has always been rooted in caring, yet the full expression of caring has been impeded. The image of Florence Nightingale with the lamp represents the tireless effort of nurses to relieve pain and provide comfort. Despite this, according to McIlveen and Morse (1995), during the past century nurses have been cautioned to divert attention away from a patient's illness. The fear is that one increases pain by drawing attention to it. It is also likely that caregivers protect *themselves* from facing an inability to remove pain.

This defensive posture separates the caregiver from the essential caring that is inherent to the role of the nurse, and serves to perpetuate the experience of pain for the patient. To deny the existence of pain may deny individuals' rights to be who they are (McCaffery & Pasero, 1999).

As Florence Nightingale (1859) wrote,

The symptoms or sufferings generally considered to be inevitable and incident to disease are not always symptoms of the disease at all, but . . . of want of care or knowledge or attention in care of fresh air, of light, or warmth, or of quiet . . . the reparative process which Nature has instituted and which we call disease, has been hindered by some want of knowledge or attention in one or all of these things, and pain, suffering, or interruption of the whole person sets in. (p. 5)

Nightingale's commentary on the wholeness of human health is a response to the loss of the sense of health as it was formerly known to be: as soundness of body, mind, and spirit. The reduction of personal descriptors to mere symptoms is far from the lived experience of the whole person. Sensation and response cannot really be separated (Benner & Wrubel, 1989).

## A new attitude toward pain

Nurses have learned the science of objectivity and its importance when there is a quick biomedical treatment for a disease. Yet, this approach fails to deal with the more nebulous aspects of pain and suffering when patients are cut off from the meaning of suffering in the context of their lives. It is in this area that nursing has developed powerful paradigms to address the challenges presented by rationalistic, biomedical, and technological models applied to pain and suffering.

According to Watson (1999), nursing has developed as a science and discipline since the late 19th century, whereas the natural sciences are much older. Early nurse researchers drew heavily from the biomedical model in formulating precepts and theories. Advances in nursing research and theory during the late twentieth century, however, have been applied to the understanding and management of pain and suffering. Drawing from the works of scholars in philosophy, anthropology, and psychology, nurse theorists have posited unique paradigms applicable to the science of pain management.

Stress and coping (Benner & Wrubel, 1989), the phenomenon of caring and healing (Leninger, 1981; Watson, 1999; Hover-Kramer, 2002), and

the unique attributes of the nurse-patient relationship are well-researched experiences. Watson (1999) calls "the Human Science Nurse Paradigm" a valid perspective of nursing that integrates the human-to-human care process. It is based on an epistemology that can include metaphysics as well as esthetics, the humanities, art, and empirics. With regard to pain management, the human science view opens new vistas for the application of techniques that address the person as a whole and unique being.

## Nursing management of pain

Nurses view pain as a multidimensional experience. McGuire (1997) provides a model for nursing care entitled "Multiple Dimensions of the Experience of Pain" that encompasses the inter-relatedness of the body, mind, and spirit. This framework includes physical, sensory, affective, cognitive, behavioral, sociocultural, and spiritual elements. The utility of this for nurses is that conceptualizing pain in this way leads the nurse to approach assessment in a broader manner. The nurse approaches the patient from multiple dimensions, focusing on the entire experience, allowing for individualized and comprehensive pain management.

The fear is that one causes pain by drawing attention to it. It is also likely that caregivers protect *themselves* from facing an inability to remove pain.

*Because stress, anxiety, fear, and fatigue decrease the threshold for pain, imagery can be used alone or with progressive muscle relaxation to make pain more manageable.*

To examine contemporary nursing pain management, it is useful to widen the field of view to the larger context of suffering. Spross (as cited in Barsky et al., 1998) refers to suffering as an overarching phenomenon under which pain is a category, and which nurses need to recognize in everyday practice. Stark and McGovern (1992) analyze suffering and present guidelines to measure it. Characteristics of those who suffer yet remain resilient are examined. Humans have the ability to transcend self-centered suffering and find lessons that enrich and enlarge life. Suffering is a subjective phenomenon, a perception of “underserved adversity” that involves physical, sociological, psychological and spiritual attributes.

For nurses, the ultimate goal in pain management is to relieve suffering, yet they are taught little about it. They confront it with tools of technology that often miss the mark. They may not even be aware of how they shape painful experiences during the course of care, and promote suffering.

Smythe (cited in Diekelmann, 2002) describes such an adverse experience during a patient-nurse encounter. As the patient received a backrub:

It hurt. It definitely hurt. She was coming from one patient to another . . . I was one of five or six . . . I felt quite tense when she left . . . it's had an effect on how badly I've tolerated pain. It's made me more tense, more uptight, and therefore made it more difficult to cope. (p. 190)

## Pain management techniques

The following selections of contemporary pain management techniques address physical, emotional, psychological and spiritual dimensions. Pain management techniques may be divided into two general categories: those that require a patient's active participation, and those that are more passive.

The following overview is a sampling of some of the more widely applied techniques by nurses who manage pain and suffering.

### Active Participation

#### Meditation

Meditation is a useful pain therapy. Many types of meditation have demonstrated clinical usefulness. Mindfulness Meditation, a process that increases insight and concentration, is one technique used for chronic pain. Mindfulness Meditation and Mindfulness-Based Stress Reduction (MBSR) have been examined empirically and have demonstrated clinical usefulness (Snyder & Lindquist, 2002).

These forms of meditation generally involve eliciting the relaxation response, centering the breath, and then focusing attention freely from one thought to the next. With MBSR, three formal meditation techniques are involved: body-scan meditation, a sitting meditation, and mindful *hatha* yoga, which include simple stretches and postures. These techniques are currently used in many settings in the U.S. and abroad (Snyder & Lindquist, 2002).

#### Relaxation Techniques

Relaxation techniques such as Progressive Muscle Relaxation (PMR), guided imagery, and distraction have been widely accepted methods with broad application to pain management. These techniques rely to some degree on classical conditioning. With distraction imagery, the relaxation technique is more effective where it is changing and novel, whereas relaxation techniques tend to be more useful if the same one is used each time (McCaffery & Pasero, 1999).

With PMR, the goal is to increase body awareness and decrease perception of stress. Muscles are alternatively tensed and then relaxed in a progressive manner. It is believed that PMR may provide the patient with a sense of control, which patients' in pain often feel they lack. This method has been found to be efficacious for postoperative pain, tension headache, back pain, and cancer pain. It also

reduces stress, a known contributor to pain (McCaffery & Pasero, 1999).

Bandura's (1975) cognitive theory of self-efficacy is helpful in understanding how people cope with the chronic pain experience pain. The theory holds that a person's expectation of self-efficacy determines how much effort a person will put into facing a difficult situation such as suffering and pain. To enhance self-efficacy, a practitioner must demonstrate pain control methods during group education and also teach pain control methods patients can use on their own.

Lazarus & Folkman (1986) describe the process of “cognitive appraisal” for handling stress. Cognitive appraisal determines how a person interprets then reacts to a situation and is a useful method for shaping the way a person interprets a painful situation and guiding the emotional reaction to a positive outcome. This occurs through an exercise that identifies negative coping strategies associated with a lack of control.

A sense of control is associated with positive coping and results in positive pain management outcomes. The purpose is to replace coping strategies that are maladaptive, such as negative thoughts, and replace them with positive ones such as: “I can handle this.” Ellis & Harper (1978) have the patient list negative, catastrophizing thoughts and then list the activation event, describing the consequences for these thoughts and disputing the negative thinking with new positive thoughts.

#### Imagery

Imagery is a mind-body intervention that utilizes the imaginative powers to affect change in physical emotional and spiritual dimensions. Because stress, anxiety, fear, and fatigue decrease the threshold for pain, imagery can be used alone or with progressive muscle relaxation to make pain more manageable. Vivid detailed images work best for pain control, and the cognitive reappraisal used with imagery can increase a sense of control and power to reframe the meaning of pain (Snyder & Lindquist, 2002).

### Biofeedback

Biofeedback (BF) is a modality that requires the patient to learn to apply relaxation to a measurable end point, which reinforces the relaxation technique. According to McCaffery & Pasero (1999), BF is a form of psychophysiological feedback that gives patients insight into responses they normally would not see. Motivating or coaching the patient is key to the success of this therapy, as the patient must continue to practice and apply the techniques at home to achieve the goals that are mutually set between the nurse and patient.

Nurses, with their specialized knowledge in physiology, psychology, and health and illness states, are ideal professionals to provide BF as part of their practice. The American Association for Applied Psychobiology and Biofeedback is working to include biofeedback practice in basic nursing education programs (Snyder & Lindquist, 2002). It is helpful for nurses to have experience in relaxation and imagery during the initial sessions of biofeedback. Certification in biofeedback is available and may be required for insurance reimbursement.

There are various types of biofeedback applications, all of which involve measurable outcomes. Autogenic training utilizing electromyography feedback is generally the most effective method to create a reading that is used as feedback to reinforce relaxation. Temperature measurements may also be used. Autogenic phrases or systemic relaxation may be combined with music, guided imagery, or hypnosis.

### Passive Participation

#### Aromatherapy

Aromatherapy can alter pain perception and produces measurable outcomes. Essential oils such as Roman chamomile, peppermint and lavender may be used for this general purpose.

Documented mind, body, and spiritual effects have been noted with topical application or inhalation therapy. The effects of the oil are based on its chemistry, and are to be inhaled or applied topically. Essential oils are adaptogens. They may react individually, depending on the needs of the person and the pharmacologically active components that work at cellular, psychological, and physical levels (Snyder & Lindquist, 2002).

According to Jager (1979), inhaled scents trigger powerful and rapid responses and massaged oils can be measured in the blood within twenty minutes. Tisserand (1988) found that lavender had a sedating effect similar to Diazepam. According to Ingham (1989), Therapeutic Touch with essential oils may be an effective method of treating chronically ill patients who suffer from “skin hunger” — a longing to be touched.

#### Therapeutic Massage

Therapeutic massage involves the manipulation of soft tissues. Nurses have the ability to apply these basic techniques, due to their advanced understanding of tissue and muscle structure and function. Massage is a holistic approach that promotes the mind-body-spirit connection and has been an intrinsic part of nursing care for centuries.

Back massage induces a relaxation response, and when studied in the subjective realm of quality of life and perception, research results have

been positive. In a study of cancer patients by Smith, Kemp, Hemphill, and Vojir (2002), therapeutic massage was shown to improve sleep, and to reduce pain, symptom distress, and anxiety in a group of cancer patients. Deep massage and myofascial release (MFR) are techniques that require advanced skills beyond traditional nursing education.

### Spirituality and prayer

An important holistic consideration in the care for a suffering patient is spirituality and prayer. The philosophy of holism is that there is something beyond the body and mind, and that the essence of this is intrinsic to human life. This essence is called the spirit. The meaning and purpose of life, faith in something beyond oneself, hope, love, and forgiveness are expressions of spirituality. Each individual may have a unique perspective of this essence or life force. Spiritual assessment should be a part of the nursing process, and numerous assessment tools exist.

O'Brien (1999) has developed a measure for the construct Spiritual Well-Being, which contains three subscales: Personal Faith, Religious Practice, and Spiritual Contentment. This tool requires three to four minutes to complete and defined characteristics that would guide treatment, including prayer. Sample diagnoses, such as “Spiritual Distress” or “Spiritual Well-Being,” are used as a guide to implement care. Spiritual care encompasses compassion, which literally means “to suffer with.” The nurse’s role is to help give meaning to the suffering, provide compassion, and provide comfort (Donley, 1991).

Prayer is often associated with religion, yet prayer, like spirituality, transcends religion (Snyder & Lindquist, 2002). Prayer has been an integral part of nursing for centuries. During the turn of the century, many schools of nursing were Christian-based, and prayer was a part of care. A resurgence of spirituality as integral to holistic nursing care has coincided with a new awareness of the importance of prayer. Meditation is a form of private or contemplative prayer. Other forms of prayer are group prayer or prayer as part of a faith-based or religious community. Prayer is also defined as non-denomination specific, such as a communication that persons have with a higher being (Snyder & Lindquist, 2002).

Prayer may be used for healing or as an aid to alleviate suffering. Prayer is also regarded as a coping mechanism with positive health outcomes (Wilt & Smucker, 2001).

Prayer and distant healing are excellent therapies for research, as they require no physical or social contact between healers and patients (Jonas & Levin, 1999). A prospective, double-blind, randomized study by Byrd (1988) found a significant number of coronary care unit patients who were prayed for (intercessory prayer) had less need for ventilatory assistance, fewer antibiotics and diuretics, and significantly lower severity scores. These findings underscore the power and importance of spiritual care and have important implications in pain and suffering management.

A resurgence of spirituality as integral to holistic nursing care has coincided with a new awareness of the importance of prayer.

## Therapeutic touch

The “laying on of hands” is currently standardized as a treatment system known as therapeutic touch (Kreiger, 1991). The process involves focusing the intentional energy from the nurse to the patient in a focused manner. The nurse focuses thoughts on healing and well-being for the patient. Pain is responsive to therapeutic touch and spiritual healing (Jonas & Levin, 1999). Studies of therapeutic touch and healing reported immediate reductions in pain resulting from tension headaches and surgery (Keller, 1983; Meehan, 1985; Wirth, as cited in Jonas & Levin, 1999).

Therapeutic touch (TT) is administered by touching lightly with the hands, or, as in noncontact therapeutic touch, with the hands a few inches away from the body. This type of healing includes the healer’s intuition of the energy field surrounding the body. Various hand movements are performed over the patient’s body to redirect energy. The redirection and smoothing of energy allows for an equal distribution of temperature and unimpeded energy, a necessary condition for healing (Maxwell, 1996). A program of TT was studied in pain patients for two years and was found to produce a statistically significant decrease in severity of symptoms on the McGill-Melzak Pain Questionnaire (Redner, Briner, & Snellman, 1991).

## Conclusion

According to Spross (as cited in Barsky et al., 1998), nursing practice is the domain of the patient and research findings support the essential relevance of nursing practice. Nurses in the domain of practice care for those who suffer as an everyday experience. The very “everydayness” of pain and suffering management addresses issues of personhood and requires a sensitivity and attention to meaning.

Nurses, by their proximity to patients, shape patients’ experiences of pain, ameliorate suffering, and ultimately work to reduce pain. (Barsky et al., 1998). The nurse has been at the center of pain and suffering management since the inception of nursing. Nurses as pain managers are part of the Human Science Nurse paradigm defined by Watson (1999), that open vistas for holistic care techniques.

Caring is not complete without an understanding of the *personal* meaning in a patient’s suffering. While the nurse’s repertoire has always contained healing and holistic techniques, a new appreciation for the understanding of the multidimensional aspects of pain have fostered a growth in the knowledge base that supports these techniques and adds new ones. Nurses in the domain of the patient must be provided with the information they need to employ these management techniques that are the essence of nursing: healing through caring.

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## Reiki: A Supportive Therapy in Nursing Practice and Self-care for Nurses

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### Abstract

Reiki is a complementary, energy-based healing modality. It has ancient roots, but is uniquely suited to modern nursing practice. Reiki training offers a precise technique for tapping into healing energy, or *ki*, and transmitting it through touch. Reiki treatments are gently balancing and provide energy that supports the well-being of the recipient in a holistic and individualistic way. Relaxation, pain relief, physical healing, reduced emotional distress, and a deepened awareness of spiritual connection are among the benefits attributed to Reiki in anecdotes, case studies, and exploratory research, as summarized in this review of literature. Reiki is easily adaptable to nursing practice in a variety of settings, and can provide support for the practitioners of Reiki themselves, as well as benefiting those they treat with Reiki.

There is a growing interest in complementary and alternative therapies that are noninvasive, do not rely on expensive technology, and are holistic in focus. Reiki (pronounced *Ray-key*) is one such modality that has experienced tremendous growth over the past thirty years or so. Factors that have supported the rapid spread of Reiki include the simplicity of its application and its adaptability to many settings and situations.

Reiki was brought to the West by Hawayo Takata, a Hawaiian woman who herself received treatments in Japan. She taught practitioners, mostly in Hawaii and on the west coast of the United States, from 1938 until 1974. In 1974, she started to train other teachers of Reiki, known as Reiki Masters. By the time of her death in 1980, she had trained 22 Reiki Masters.

In the intervening years, these teachers and their students have trained countless practitioners and Reiki Masters, estimated to

be over a million (Rand, 1991). As Reiki has spread in popularity with the general public, it has also found its way to healthcare professionals and into medical institutions (Alandydy & Alandydy, 1999; Barnett & Chambers, 1996; Mills, 2001; Rand, 1997).

### Reiki as a treatment modality

Reiki is a Japanese concept that can be translated as “Universal Life Force Energy” and also refers to the specific technique for accessing that energy. *Ki* is the term used to describe the activating energy that carries life force — the creative and organizing energy that supports and sustains all living things, analogous to the Chinese concept of *chi* or the Yogic understanding of *prana*. All living beings are seen as partaking in *ki*, and *ki* flows throughout the body and the field surrounding it. (Barnett & Chambers, 1996; Nield-Anderson & Ameling, 2000).

The Reiki technique allows an individual to effortlessly tap into this healing energy, making it available through touch. Reiki energy is perceived as flowing from the practitioner’s hands as a passive transfer. The recipient receives or “draws in” the Reiki energy, which is believed to support the innate healing functions of the individual. According to Barnett and Chambers (1996, p. 22), “the vital energy recharges, realigns, and rebalances ... bringing harmony and wholeness to all the recipient’s systems.”

Although it happens outside of conscious intent and awareness, the “taking in” of the energy is actively directed by the client’s own system and energy needs. Unlike other energy healing modalities, Reiki is not dependent on the practitioner’s ability to sense disruptions in the energy field or to diagnose energy patterns, and there is no need to direct or manipulate the energy in any way (Nield-Anderson & Ameling, 2000).

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Similarly, practitioners do not have to be concerned with how much energy they are providing; only as much as is needed will be accepted by the recipient (Barnett & Chambers, 1996). One cannot “overdose” with Reiki. When Reiki practitioners are doing a Reiki treatment, they are not using their own personal energy to do the work of the treatment; rather, they are linked with a source of healing energy outside themselves. As a result, they do not have to guard against depletion of their personal *ki*, and do not have to take action to replenish themselves after working. Doing a Reiki session seems to benefit the practitioner as well as the client. Since the Reiki energy is flowing through practitioners during treatments, they also experience Reiki’s balancing effects (Barnett & Chambers, 1996).

Reiki is described as holistic in action. Frequently, physical symptoms bring people to explore Reiki (Barnett & Chambers, 1996). They also may sense that treatment options available through the allopathic medical model are not addressing their needs or may have an interest in self-help modalities (Mansour, Laing, Leis, Nurse, & Denilkewick, 1998).

Reiki treatments are also reported to assist people dealing with emotional distress, such as depression or anxiety (Barnett & Chambers, 1996; Engebretson & Wardell, 2002; Mansour et al., 1998) and clients may notice shifts in mental attitudes or the ability to make desired changes in behavior following treatments. Although Reiki is not “faith-based” and is not claimed by any particular religious tradition, Reiki practitioners and clients may also experience a deepening of their own sense of spiritual connection (Mansour et al., 1998).

During a typical Reiki session, the fully clothed client lies supine on a massage table. After connecting with the Reiki energy, the practitioner lightly touches the client, following a sequence of hand positions that cover the front of the body. The client then rolls to a prone position, and the back of the body is treated. Each hand position is maintained for several minutes. A full treatment lasts 1 to 1-1/2 hours.

Hand positions are static; there is no manipulation of tissues or movement other than changing to another position (Barnett & Chambers, 1996; Olson & Hanson, 1997; Rowland, 1998). Hand positions vary from practitioner to practitioner, based on their training and the specific needs of the client. For example, if a person is not comfortable in the prone position, the hand positions for the back can be adapted to a side-lying position. A client presenting with a sprained ankle would most likely receive (and expect) direct treatment to that site, even if that particular position was not part of the standard routine of the Reiki practitioner. Reiki is adaptable, and can easily be practiced with a client in a chair or hospital bed.

When a full treatment is not practical, a few hand positions may be selected for a spot treatment, e.g., to address a headache or a bruised knee. If it is inconvenient to apply the standard positions due to the presence of medical equipment, patient positioning, or transport conditions, Reiki can be done while holding a hand and sitting at the

bedside or by laying a hand anywhere that can be comfortably reached by the practitioner (Barnett & Chambers, 1996). A Reiki treatment can also be given with the practitioner’s hands a few inches from the surface of the body, as direct touch is not required for the transfer of energy to occur. Burns, abrasions, and paresthesias therefore are not contraindications to the application of Reiki. Reiki is believed to pass through clothing, dressings, or casting materials without loss of efficacy.

## Reiki as experienced by practitioner and client

During a session, many practitioners are aware of the flow of the Reiki energy, although this sensitivity is not required for effectively transmitting Reiki. They may sense a rise and fall of the energy “draw.” They may notice a difference in the energetic activity at different hand positions and adjust the duration of a given hand position accordingly.

Practitioners often report a sense of warmth, tingling, or pulsation in their hands during a treatment session. (Barnett & Chambers, 1996; Rowland, 1998).

Similarly, the person receiving a Reiki treatment may report heat or cold, waves of energy, tingling, heaviness, or floating sensations. Profound relaxation and time distortion are common experiences, as are emotional responses such as peace or bliss (Barnett & Chambers, 1996; Bullock, 1997; Engebretson & Wardell, 2002; Mansour et al., 1998). The effects of a Reiki treatment may be appreciated immediately or may only become apparent after the session, as recipients notice changes in their daily lives. This example is derived from the author’s client files:

**A Reiki treatment can be given with the practitioner’s hands a few inches from the surface of the body, as direct touch is not required for the transfer of energy to occur.**

“Betty” was a middle-aged, retired counselor who came for a Reiki session. Her main goal was stress reduction, as she was experiencing conflict with her teen-aged daughter and was in a demanding training program for a new professional career. Throughout the first session, she was especially restless, itchy and fidgety, and it seemed that her expectations had not been met (it is far more common for clients to drift off to sleep). A few weeks later, to my surprise, she called to schedule a series of sessions. In the interim, she had noticed that she was less reactive when her daughter was provocative, and that it was easier to decide upon appropriate actions when dealing with her. She had also noticed that her sessions with a psychotherapist were more productive, as she seemed to have more insight and clarity.

## Reiki training

First-level Reiki classes typically include content on the history of Reiki, applications of Reiki, ethical considerations, and instruction and practice of the hand positions used in direct treatments for one’s self and for others. Second-level classes include several advanced techniques for focusing the energy in specific ways, e.g., directing it toward emotional issues or mental attitudes. First- and second-level classes are usually 1 to 2 days in length.

*Reiki can be integrated with standard nursing care or offered as a stand-alone treatment in any situation where relaxation, pain relief, or enhanced healing would be desired.*

Level Three or Reiki Master training involves further exploration of Reiki through treatment sessions for one's self, for others, and for self-reflection. Attainment of this level is required for a teaching Reiki to others. Level Three has traditionally been an apprenticeship program, with the candidate working closely with a Reiki Master over the space of a year or more, although shorter, non-traditional programs are offered by some teachers.

Reiki is unique among energy healing and other manual therapies in that it is not "learned" or "taught" in the usual sense of the words. Information about Reiki, such as its history and a sequence of hand positions, can be taught in class or learned from a book. The actual ability to connect with the Reiki energy cannot be obtained in this way, but is rather imparted by the Reiki Master through a ritual called the attunement process (Barnett & Chambers, 1996; Rowland, 1998). This is an energetic initiation, which is believed to align and open the pathways in the body that carry healing energy.

The ability to tap into Reiki energy and transmit it through touch is thus passively acquired by the student as a direct result of the attunement ritual. Reiki energy is immediately available to the student after the attunement process is completed, and a new student is able to offer effective Reiki treatments without a lengthy learning curve. The process to establish the connection with Reiki energy and start the flow of energy may be as simple as making physical contact with intention to transfer healing energy, or as Rowland (1998, p. 35) describes, "Hands on, Reiki on." The practitioner may also use a personal routine for centering and invoking the flow of the Reiki energy. Following the completed attunement process, the new practitioner has a permanent connection to Reiki energy and is able to access it at any time.

## Benefits of Reiki for practitioners

Reiki is also unique among hands-on therapeutic modalities in its effectiveness in

providing care to the caretaker. Many in the healthcare professions struggle with balancing personal needs with the demands of the workplace and may find it difficult to schedule time for personally restorative practices. Reiki is not only a technique that a practitioner can offer to a client, but is also a way for practitioners to take care of themselves.

Hand positions for self-treatments are taught in basic Reiki training and students are encouraged to give themselves regular treatments. Practitioners experience the same benefits from a self treatment as do their clients: relaxation, a sense of being cared for, pain reduction, and an increased ability to cope with life's challenges (Barnett & Chambers, 1996; Rowland, 1998).

A complete sequence of hand positions for self-treatment may take 20 to 30 minutes to complete. Full, conscious attention to the process is not necessary, however. A practitioner can connect with the energy, put a hand somewhere on his or her body, and allow the Reiki to flow while occupied with other things such as reading, listening to morning report, or participating in a staff meeting. Practitioners often find that this practice helps them to be calm and focused in a stress-filled environment or gives them a needed energetic boost.

## Nursing applications

Reiki is adaptable to a wide variety of settings. The flow of the Reiki energy is triggered by the practitioner's intention and contact with the recipient. It does not require preparation by the practitioner (other than training) or obvious hand movements. The practitioner can allow Reiki to flow through the hands while doing other things, such as range of motion exercises or helping with activities of daily living. Reiki can therefore be integrated with standard nursing care or offered as a stand-alone treatment in any situation where relaxation, pain relief, or enhanced healing would be desired.

Following are examples of Reiki used in healthcare settings:

A woman in her late twenties, diagnosed with AIDS and AIDS-related diarrhea, was admitted to hospice with a Stage 2 decubitus ulcer of about 2.5 cm, for which she was receiving standard care. One of the nurses who worked with her is an advanced Reiki practitioner. While doing dressing changes three or four times a week, she also gave a 5- to 10-minute Reiki treatment, with the intention of providing pain relief during the procedure. Unexpectedly, given the frail physical condition of the patient, the ulcer healed completely over the course of about a month. (M. Angerame, personal communication, June 9, 2003)

Bullock (1997) presents a detailed case history of a home hospice client with an aggressive cancer with unknown primary site, deep venous thromboses, and pain, who received regular Reiki sessions as part of his visiting nurse service and palliative care. Pain relief, decreased edema, improved ambulation, and an enhanced sense of well-being followed the Reiki treatments.

Silva (2002) is a gerontologist and administrator of an Assisted Living Facility for patients with Alzheimer's disease. She describes her use of Reiki with two of the residents. She reports that Reiki was helpful in reducing agitation, pacing, wandering, and paranoia and that mealtimes and physical care became easier for the staff as a result.

At Columbia/HCA Portsmouth Regional Hospital in Portsmouth, N.H., a 15-minute Reiki treatment was offered pre-operatively to surgical patients, with over 800 patients choosing to participate in 1998. Although no formal data collection was done, there was the perception that patients benefited from the treatments, with less pain medication required, shorter length of stay, and improved patient satisfaction (Alandydy, P. & Alandydy, K., 1999).

*Improved social relationships and decreased emotional distress were experienced by all four women, two of whom had reported suicidal feelings prior to Reiki.*

## Research on Reiki

Therapeutic Touch and Healing Touch are energy-based healing modalities that were developed by nurses, taught as continuing education courses for nurses, and are the subject of many research studies. In contrast, Reiki has been embraced by practitioners from all walks of life, mostly outside of the mainstream healthcare system. As a result, systematic evaluation of Reiki from a scientific perspective is just starting to emerge.

There are abundant anecdotal reports of benefits from Reiki treatments, and many practitioners have “Reiki stories” of major changes in health status attributed to Reiki. The interested reader is directed to Barnett and Chambers’ (1996) book, *Reiki Energy Medicine: Bringing Healing Energy to Home, Hospital, and Hospice*, which contains a collection of well-presented examples that support their presentation of the nature of Reiki and its application in a wide variety of settings. Mills (2001), a veterinarian and M.D. specializing in obstetrics and gynecology, shares the story of her discovery of Reiki and her experience with applying it in her professional practice.

Several pilot and preliminary investigations into the effects of Reiki treatments have been completed (Engebretson & Wardell, 2002; Mansour et al., 1998; Olson and Hanson, 1997; Wardell & Engebretson, 2001). Two studies were primarily descriptive, with the intention of characterizing the experience of Reiki treatments and identifying directions for further research. Another examined the effects of a Reiki treatment on chronic pain. All used a convenience sample, with no control or placebo arm.

Engbretson and Wardell (2002) interviewed healthy volunteers after they experienced a single Reiki Touch session, consisting of two hand positions held for 15 minutes each. Participants frequently reported alterations in their internal experience of time, body awareness and sensations, cognition, and emotional states. The pattern that emerged from the interviews was paradoxical, as

participants reported opposites such as weightlessness vs. heaviness and relaxation vs. high arousal, with some participants reporting both extremes simultaneously. This variability of experience supports the belief that Reiki promotes a state of balanced well-being, with individual responses reflecting the homeostatic needs of the individual at that time. The authors suggested that research designs must be complex enough to capture these paradoxical or self-regulating effects.

Mansour et al. (1998) investigated Reiki by taking a phenomenological approach. A Reiki Master, three of her clients, and a Reiki practitioner participated in lengthy in-depth interviews (totaling approximately 5 to 10 hours for each participant). Four of the interviewees had received between 15 and 50 Reiki sessions and their experiences are summarized here.

The four participants experienced major psychological or physical changes, or both, which they attributed to Reiki. One reported improved sleep patterns, and normalization of low blood pressure and hypothyroidism. Another experienced resolution of endometriosis and chronic abdominal pain. Improved social relationships and decreased emotional distress were experienced by all four women, two of whom had reported suicidal feelings prior to Reiki. Two identified major healing in the realm of their spirituality. The researchers concluded that these findings support the holistic nature of Reiki, and that benefits may be cumulative with repeated treatments.

Wardell and Engebretson (2001), in an arm of the descriptive study summarized above, measured physiological parameters relating to relaxation during a single, 30-minute Reiki Touch treatment. State anxiety was significantly reduced, as was systolic blood pressure. Other physiological measurements were in the direction of relaxation, but were not statistically significant.

Olson and Hanson (1997) did a pilot study on the effectiveness of Reiki in pain management. Twenty volunteers who had

persistent pain of at least moderate intensity received one Reiki treatment for about 1-1/4 hours. They rated their pain on a visual analog scale (0-10 points) and on a Likert scale (0-5 points) before and after the treatment. All participants reported a reduction on at least one of the pain rating instruments. The mean decrease in pain scores, 2.25 points on the visual analog scale and 1.25 points on the Likert scale, was significant ( $p < .0001$ ) for each test.

Clearly, research into the nature and practical benefits of Reiki is still in the exploratory phases. A rich body of anecdotal evidence from credible sources suggests the range of possible benefits for practitioner and recipient. There are methodological challenges inherent in the design of clinical trials to examine Reiki, including randomization and controlling for placebo effect and standardization of treatment (Nield-Anderson & Ameling, 2000), assessing the cumulative effects of repeated treatments (Mansour et al., 1998), and capturing the variability of effects that a holistic and balancing therapy may produce (Engebretson & Wardell, 2002; Mansour et al., 1998). It is hoped that further research will build upon the wealth of anecdotal reports using study designs that can address the holistic nature of Reiki’s effects.

## Summary

Reiki is an accessible, simple-to-use complementary healing modality that can easily be integrated with standard nursing care in a variety of settings, from labor and delivery to hospice. Published anecdotes and preliminary studies suggest that Reiki can assist with pain relief, enhance healing, foster relaxation, alleviate emotional distress, and promote wellness in a holistic way. Reiki also offers benefits to the practitioner in the form of a powerful method for self-care that can be integrated into daily routines. Reiki is a “low-tech, high-touch” modality that can gently bring balance and ease to our personal and professional lives and to those we touch.

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# WHAT'S NEW IN THE HEALTHCARE LITERATURE

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- Ernst, E. (2002). The risk-benefit of commonly used herbal therapies: Ginkgo, St. John's wort, ginseng, echinacea, saw palmetto, and kava. *Annals of Internal Medicine*, 136(1), 42-53.

To answer the research question regarding the benefits and risks of commonly used herbal medicines, the author searched several data sources. Systematic reviews were included if they contained randomized controlled trials, used humans as study participants, and looked at the effectiveness of any of the herbals contained in the title. Results were mixed and inconclusive. Major findings, however, indicated that St. John's wort may be useful in treating mild to moderate depression and that echinacea may play a role in preventing and treating upper respiratory tract infections. Saw palmetto may have short-term effectiveness for benign prostatic hypertrophy and kava showed possible short-term effectiveness in treating anxiety. Ginkgo may be effective for dementia and intermittent claudication, but has questionable effectiveness for cognitive function and tinnitus. Finally, ginseng was found to be ineffective for a variety of conditions. The author concludes that evidence on the effectiveness of these herbal medicines is incomplete and that further research of good quality is needed.

For a systematic review of this article, see *Evidence-Based Nursing*, 5(3), 80.

- Vallerand, A. H., Fouladbakhsh, J. M., & Templin, T. (2003). The use of complementary/alternative medicine therapies for the self-treatment of pain among urban, suburban, and rural communities. *American Journal of Public Health*, 93(6), 923-925.

This descriptive study collected and analyzed data about self-treatment patterns for pain among urban, suburban, and rural residents in various community sites in eastern Michigan. The sample of 595 participants had a mean age of 47 years and was 81% Caucasian and 60% female. Rural residents had the lowest average annual income and suburban residents had the highest. No significant differences in pain levels were found among the three resident groups. Seventy-six percent of those surveyed used some form of complementary/alternative medicine (CAM) therapy. Among the three resident sites, the highest proportion of CAM users were found in the suburban group (82%), with 77% of urban and 58% of rural participants using CAM therapies. Thirty-one percent of participants reported that their primary care provider did not know about their pain self-treatment choices. These results point to the need to carefully assess patients' use of all modalities for pain control. Nurses need to have current knowledge about CAM therapies in order to accurately assess patient use.

- Mikula, C. (2003). Balneo-phototherapy: A new holistic approach to treating psoriasis. *Journal of the American Academy of Nurse Practitioners*, 15(6), 253-259.

This article describes balneo-phototherapy treatment and presents a case study to demonstrate outcomes. Psoriasis is a chronic, noncontagious skin disease that can occur on any part of the body. Balneo- (means bath) phototherapy (means light) originated centuries ago in the region around the Dead Sea. The first scientific report of the therapeutic benefits obtained at the Dead Sea was published in 1959. The salts of the Dead Sea, which contain high levels of magnesium, are believed to cause significant skin penetration to heal several chronic skin conditions. Bathing in Dead Sea brine increases skin sensitivity to the effects of exposure to narrowband ultraviolet B. The case study is that of an 18-year-old male who presented at the center after one month of unsuccessful treatment by a dermatologist. After 12 balneo-phototherapy treatments, the patient's psoriasis was considered in remission and his quality of life had improved so that he could return to school and sports activities. This treatment is offered at centers in Germany, Switzerland, Italy, and Japan, but at only one center in the United States. The author is a nurse practitioner at the Mavena Derma Center in Des Plaines, Ill. She stated in the conflict of interest disclosure that she does not have ownership or financial stake in the center's interests.

- Kwekkeboom, K. L. (2003). Music versus distraction for procedural pain and anxiety in patients with cancer. *Oncology Nursing Forum*, 30(3), 433-440.

A randomized controlled experiment was conducted to test the effects of a music intervention versus distraction at controlling procedural pain and anxiety. The study took place at a comprehensive cancer center in the Midwest. Sixty cancer patients who had noxious medical procedures, such as tissue biopsy or port placement, were evaluated before and after their medical procedures to provide ratings of perceived control over pain and anxiety. Fifty-eight people provided usable data. Results showed outcomes achieved with music did not differ from those achieved with distraction. Additional results showed that outcomes achieved with usual treatment were not significantly different from those obtained with music or distraction interventions. The investigator suggested that patients having noxious medical procedures should be asked about their preferences before and during procedures.

This issue's literature summary, as submitted by members of the *Journal* Editorial Board, is devoted to the topic of complementary and alternative therapies.

Quinn, J.F. (2000). The self as healer: Reflections from a nurse's journey. *AACN Clinical Issues: Advanced practice in acute critical care*, 11(1), 17-26.

The author proposes that the growing popularity of complementary and alternative medicine (CAM) is a manifestation of the public's yearning for a humane and holistic healthcare system. She argues that nurses can contribute humaneness to care delivery by successfully recovering their historical identity as healers. Heal, from the Anglo-Saxon *healen*, means to become whole. Using the self as healer changes the role of the nurse from "fixer" of problems to facilitator of the patient's healing process. The context for healing is the healing relationship, in which the patient is recognized as a person and it is accepted that the locus of all healing and curing is within the patient.

To become healers, nurses must be willing to bring an authentic caring presence and an open heart into relationships with others. It is important to let go of attachments to the outcome of healing work. Finally, to be a healer, there must be a conscious and intentional decision to do so. Essential skills for healing, which can be learned through study and practice, include "holding sacred space," "intentionality," "caring touch," and "rituals of centering and releasing." This article is important for nurses interested in the introspective preparatory work required for facilitating healing in relationship with patients.

Marks, B.A., Brown, A., Hahn, J.E., & Heller, T. (2003). Nursing care resources for individuals with intellectual and developmental disabilities across the life span. *The Nursing Clinics of North America*, 38(2), 373-393.

Regardless of their work settings or roles, most nurses will at some time come into contact with persons who have developmental or intellectual disabilities. The authors of this article have amassed a rich and varied annotated list of resources related to delivering nursing care to these individuals, families, and groups. Among the categories covered are advocacy, assistive technology, communication and access to health care issues, health promotion, mental health issues, sexuality, women's health issues, and rehabilitation research training centers.

Thorne, S., Paterson, B., Russell, C., & Schultz, A. (2002). Complementary/alternative medicine in chronic illness as informed self-care decision-making. *International Journal of Nursing*, 39(7): 671-683.

This article reports on a qualitative study of the effects of CAM therapies on 21 Canadian adults with chronic illness. Specifically, three groups were studied with the following conditions: HIV/AIDS, Type II diabetes mellitus (DM), and multiple sclerosis (MS). Data were derived from a larger study of self-care decision-making.

Based on a literature review, the authors suggest that the use of CAM by people with chronic illness is better explained by complex decision-making rather than a single factor. Research methods included individual interviews, focus group data, and a technique known as "think-aloud tape recordings."

Participants reported using a range of CAM therapies, primarily for symptom management. Examples included reflexology for foot problems associated with DM, acupuncture and polarity therapy for the muscle spasms of MS, and various types of massage to improve energy levels in people with HIV/AIDS. All participants mentioned the benefits of CAM in promoting wellness and control. The perceived benefits involved disease control and symptom management rather than expectations for cure.

Most of the participants had discussed their use of CAM with their conventional healthcare practitioners and some had received information about CAM from their conventional providers. Rather than seeing these modalities as opposing the biomedical approach, most participants "revealed a pragmatic enthusiasm for anything that seemed to facilitate their well-being" (p. 675). Most participants valued scientific evidence, tempered by what they believed their bodies were telling them.

Hagerty, B.M. & Patusky, K. (2003). Reconceptualizing the nurse-patient relationship. *Journal of Nursing Scholarship*, 35(2), 145-151.

This article explores how the nature and development of the nurse-patient relationship (NPR) can be reconceptualized and made more congruent with contemporary health care. The authors review theoretical and empirical literature and analyze implicit and explicit assumptions about the NPR, including linearity, trust, time and role expectations. They offer the Theory of Human Relatedness as an alternative model for the NPR, which takes into account the current need for brief interaction between nurse and patient.



## A Pilot Feasibility Study of the Effects of Touch Therapy on Nurses

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### Abstract

The White House Commission on Complementary Alternative Medicine (CAM) has recommended that safe and effective CAM practices be evaluated to determine their role in maintaining wellness and promoting health. There is little research on individual bodywork/energy therapies and their effects on wellness. The purpose of this pilot study was to assess the effect of AMMA treatments on relaxation and anxiety in staff nurses, and to examine themes describing the nurses' experiences. It was hypothesized that nurses receiving AMMA treatments would demonstrate reduced anxiety, as measured by a Visual Analog Scale (VAS) and increased relaxation, measured by physiologic parameters. The study was designed as a prospective, randomized, blinded clinical trial, with convenience sampling of 24 nurses working 12-hour shifts. While both groups demonstrated decreased anxiety after intervention, the experimental group consistently showed greater differences between pre- and post-treatment anxiety scores. The mean change in physiologic parameters between groups was not significant. Themes derived from a final interview included: importance of touch in nursing care, stress reduction, increased self-awareness, the need for self-care and a new understanding of the mind-body connection. Outcomes suggest the need for further research with a larger population to assess this intervention's impact on anxiety, stress, self-care and caring relationships.

The growing popularity of Complementary and Alternative Medicine (CAM) (Eisenberg, Kessler, Noelock, Calkins, & Delbanco, 1993) has resulted in a need to evaluate its effect and impact on health. The White House Commission on CAM has recommended that safe and effective CAM practices be evaluated to determine their role in maintaining wellness (WHCCAM, 2002).

Healthcare systems are attempting to investigate and utilize options to enhance the wellness of staff and patients (Eisenberg, 2002). It is important to note that the use of CAM does not automatically mean one is receiving a holistic approach to care. According to Quinn (1984), it is the approach, not the tools of care, that determines holistic and healing practices.

Nursing is inherently holistic (Nightingale, 1859/1969), focusing on caring for the body, mind, and spirit. Nurses have been recognized as leaders in research and the provision of holistic CAM therapies (Mulloney & Wells-Federman, 1996). Therefore, nurses are in a position to provide and direct the public in use of appropriate complementary therapies. The emerging use of CAM and its supporting

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theories (Watson, 1979; Rogers, 1989) provide strategies to facilitate healing using holistic nursing interventions.

Anecdotally, AMMA Therapy® has been used to foster wellness by identifying and relieving symptoms of stress, creating a state of relaxation, and increasing energy. Striving for evidence-based practice, AMMA Therapy was examined as a holistic nursing intervention. Theories derived from Traditional Chinese Medicine (TCM) and holistic nursing support its use. This intervention was examined in an attempt to foster wellness as the issues of a nursing shortage arise. The goal was two-fold: to determine the effect of AMMA treatments on relaxation and anxiety in staff nurses and to examine themes describing their experiences.

## Complementary therapies

Complementary therapies are used for various reasons, including maintaining wellness, promoting relaxation and comfort, and reducing anxiety (Austin, 1998, Koehn, 2000). When various therapies have been used to initiate the state of relaxation, the physical results were similar and supported health, balance, and healing (Oz, 1998). Benson (1975) described the relaxation response as a hypo-metabolic state of decreased sympathetic nervous system arousal.

Physiologically, relaxation is evidenced by decreased blood pressure, oxygen consumption, respiration, heart rate and muscle tone, arterial blood lactate, and alpha brain activity. (Mandle, Jacobs, Arcari, & Domar, 1996; Lesserman, Stuart, Mamish, & Benson, 1989). The changes that occur with relaxation techniques are more beneficial than those that result from sitting quietly or sleeping (Wallace & Benson, 1972). Relaxation has been reported to include

decreased pain, blood pressure, heart rate, and anxiety (Wallace & Benson, 1972; Miller & Perry, 1990; Ashton, et al., 1997).

The physiologies of the relaxation and stress response can affect cognitive, emotional, social, spiritual, and behavioral well-being (Mandle et al., 1996). Anxiety and stress are often used synonymously. Stress is defined as the perception of a threat, physical or emotional, real or imagined and the perception that one is incapable of coping with that threat (Cannon, 1914). Anxiety is defined as "...a subjective sense of unease, dread, or foreboding" (Fauci et al., 1998, p. 2486). Factors contributing to anxiety may include threats to self-concept, death, health status change, socioeconomic status, role functioning, environment, or interactional pattern (Guzzetta & Dossey, 1992). Physiologic manifestations of the "fight or flight" stress response include dilation of pupils, increased blood pressure, higher respiratory rate, and increased motor excitement, resulting from the stimulation of the sympathetic nervous system (Mandle et al., 1996).

Holistic nursing practice integrates CAM models of care that guide the healing of self and others. This holistic care is concerned with the interrelationships of body, mind, and spirit in an ever-changing environment (Dossey, 2000). Critical to the clinical practice role of holistic nursing is the need to develop a process of self-awareness and engage in self-care (Dossey & Guzzetta, 1994). Nursing theories provide a conceptual framework for this self-care as nurses engage in therapeutic relationships with their patients (Rogers, 1989; Watson, 1997).

The caring-healing relationship encompasses an understanding that the practitioner serves as facilitator of the healing process. The patient is supported through the process of healing by understanding the human experience and utilizing self-care strategies (Watson, 1999). This holistic

## Definitions

**AMMA Therapy®:** a comprehensive healing art encompassing eastern and western healthcare perspectives. It utilizes bodywork therapy, nutritional/lifestyle counseling, and stress management to increase self-awareness and promote healing/wellness. It is concerned with the balance and movement of life energy (Qi) in the human body. (Sohn & Sohn, 1996)

**AMMA treatment:** the bodywork portion of AMMA Therapy. AMMA utilizes all the techniques of the major forms of therapeutic massage: deep pressure and point manipulation as in *shiatsu*, foot reflex points similar to reflexology, deep facial and connective manipulation techniques similar to Rolfing, as well as muscle stretching and pushing techniques used in European or Swedish massage (Sohn & Sohn, 1996). Working on both the primary and tendino-muscle energy pathways of the body, all the systems of the mind-body complex can be affected.

**CAM (Complementary and Alternative Medicine):** "Healthcare practices outside the realm of conventional medicine, which are yet to be validated using scientific methods." (Eisenberg, 2002, p. 1)

**Healing:** "the process of bringing together aspects of one's self, body-mind-spirit, at deeper levels of inner knowing, leading toward integration and balance with each aspect having equal importance and value." (AHNA, 2000, p. 2)

**Healing process:** "a continual journey of changing and evolving of one's self through life; the awareness of patterns that support or are challenges/barriers to health; may be done alone or in a healing community." (AHNA, 2000, p. 2)

**Holistic nurse:** "a nurse who recognizes and integrates body-mind-spirit principles and modalities in daily life and clinical practice; one who creates a healing space within herself/himself that allows the nurse to be an instrument of healing for the purpose of helping another feel safe and more in harmony; one who shares authenticity of unconditional presence that helps to remove the barriers of the healing process." (AHNA, 2000, p. 3)

**Holistic care:** Care that is concerned with the interrelationships of body, mind, and spirit in an ever-changing environment (Dossey, 2000).

**Intuition:** "perceived knowing of things and events without the conscious use of rational processes; using all the senses to receive information." (AHNA, 2000, p. 3)

**Wellness:** "integrated, congruent functioning aimed toward reaching one's highest potential." (Gaydos, 1997, p. 28)

*AMMA Therapy is a comprehensive healing art utilizing  
all the techniques of the major forms of therapeutic massage.*

self-assessment is vital for both the nurse and the patient, as the holistic practitioner should be a model for the patient.

AMMA Therapy, which is based on the principles of TCM is congruent with Holistic Nursing theories. Evidence of the effectiveness of this intervention has been reported via anecdotal and case study (Young, 1993). While there have been numerous nursing studies reporting the effects of therapeutic touch, (O'Mathuna, 2000; Quinn, & Strelkauskas, 1993; Randolph, 1984) there is little documentation of the effects of bodywork/physical touch combined with energy work, such as AMMA.

AMMA Therapy has been recognized by the American Holistic Nurses' Association (AHNA) and American Organization of Bodywork Therapies of Asia (AOBTA). *Am-ma*, which means "push-pull," is concerned with the balance and movement of life energy in the body (Sohn & Sohn, 1996).

AMMA Therapy is a comprehensive healing art utilizing all the techniques of the major forms of therapeutic massage. It is a specialized form of hands-on bodywork that combines deep tissue manipulation with the application of pressure, friction and touch to specific points on the body as well as the energy channels on which they are found. These channels are identical to acupuncture channels. The practitioner relies primarily upon the sensitivity and strength of the hands to remove blockages and free the flow of energy in the body—thereby restoring, promoting, and maintaining optimal health (Sohn & Sohn, 1996).

## The use of AMMA therapy by nurses

Holistic nursing theories support the use of AMMA by nurses. The Science of Unitary Human Beings (Rogers, 1989) proposes that a human being is a complex, multidimensional energy system in constant interaction with its environment. Man is a unified being, from

which the body, mind and spirit cannot be separated (Rogers, 1989). Nursing interventions must address this complex system and recognize the constant changes occurring as we interact with patients. The Theory of Human Care (Watson, 1997) describes illness as a disharmony between body, soul, and spirit that leads to stress. Nursing's role is to help people gain a high degree of harmony within the self in order to promote self-knowledge and self-healing (Watson, 1999).

Concepts related to holistic care have origins in ancient Chinese philosophy dating back to 5,000 years ago (Sohn & Sohn, 1996). Within this philosophical view, man and universe were considered to be an integrated whole, as described in the theory of systematic correspondence, the theoretical foundation of TCM (Wong, T. & Pang, S., 2000). In this system, man is seen as a microcosm of the universe, constantly in dynamic interaction, endeavoring to maintain a state of balance. Fundamental principles such as Yin-Yang and Five Elemental Phase theories were developed to explain the interconnectedness and movements of universal life force or *Qi*.

Yin-Yang theory is based on the "simultaneous opposition and unity of two cosmic forces of the universe" (Bramlett & Chen, 1994, p. 179). The five elemental phases represent five qualities in the universe, five phases of a cycle, and five processes or inherent capabilities for change (Maciocia, 1989). AMMA treatments and recommendations are based on these fundamental principles. Illness is perceived as a disharmony of the living forces of the universe. The focus of healing is to counteract imbalances, rather than treating the symptoms of illness (Wong & Pang, 2000). Ancient healing methods included the use of massage, acupuncture, and herbal therapies.

Bramlett and Chen (1994) cite several congruencies in Rogers's Science of Unitary Human Beings and Chinese healing theories. These can easily be applied to AMMA therapy,

as it is founded in the principles of TCM. The concept of energy fields in Rogerian theory is similar to that of *Qi* in TCM. AMMA Therapy assesses and treats patterns of disharmony, related to *Qi* disturbances, while building the immune system so the body can move naturally toward healing (Sohn & Sohn, 1996).

Rogers's Principle of Integrality, which describes the continuous mutual process between human and environmental energy fields, aligns with the Chinese concept of the five elemental phases in the universe. Both accept the "integral and unitary nature of the universe" (Bramlett & Chen, 1994, p. 194). The same concept is embraced by AMMA therapy. Assessments, treatments, and recommendations are based on the whole energy field assessment, not one symptom.

The use of complementary therapies is supported by Watson's Theory of Human Care, as self-care strategies are implemented and the focus is on health promotion rather than on the cure of a disease (Talento, 1995). Both AMMA Therapy and TCM propose that to provide care, the practitioner must first be in a state of balance, health, or wellness. The practitioner must demonstrate caring and compassion, increased self-awareness, stamina, emotional development, and sensitivity (Sohn & Sohn, 1996). Watson's theory endorses a practitioner's striving for the cultivation of sensitivity to self and others to form relationships that foster healing.

During an AMMA Therapy session, assessments are made at the beginning of each treatment using tongue and pulse diagnoses; review of medical history, including posture, diet, exercise; and observation of the patient's signs, symptoms, and complaints. (Sohn & Sohn, 1996). An AMMA treatment is then designed to address the client's particular imbalance. Assessment continues throughout the treatment as the energy channels are assessed and the patient provides feedback. Recommendations are made at the end of the session and may include dietary changes, exercises, meditation, and various stress-reducing techniques.

## Hypotheses

For the purposes of this pilot study, only the bodywork aspect of AMMA Therapy was examined, using a “standard revitalizing treatment.” This was an attempt to control the assessment skills between study group practitioners and to remove the variables different treatments and recommendations would have had on the participants’ responses to anxiety and relaxation.

It was hypothesized that nurses receiving weekly AMMA treatments would demonstrate a greater reduction in anxiety when compared to the control group, as measured by the Visual Analog Scale; and that nurses receiving weekly AMMA treatments would demonstrate an increased state of relaxation when compared to the control group, as measured by physiologic parameters of blood pressure, heart rate, pulse-oximetry, and stress dot.

## Method

A prospective, randomized, blinded study design was used to determine the effects of AMMA treatments on AMMA-naïve staff nurses. A quasi-experimental design was selected, using repeated measures, pre-test, and post-test. The study was approved by the North Shore University Hospital-Long Island Jewish Health System Institutional Review Board (IRB).

### Participant Selection

Participants were selected through a convenience sampling of staff nurses working full-time, 12-hour shifts at a tertiary care center. Nurse managers distributed a request for participants, specifying the following inclusion criteria:

- Staff nurse working a full-time, 12-hour shift at North Shore University Hospital;
- Agreement to meet for 1 hour per week for four sessions during non-working hours;
- Willingness to complete the required documentation and assessments;
- Consent to receive a touch intervention; and
- Agreement to report changes in status of health or use of medicines/herbs throughout the study.

Nurses’ experiences with AMMA were determined by a questionnaire regarding their experiences and training in various complementary modalities such as yoga, Tai Chi, Reiki, therapeutic touch, reflexology, massage, hypnosis, or imagery. All participants completed demographic and informed consent forms.

Questionnaires and demographic forms were reviewed for the following exclusion criteria:

- Current use of medication affecting the cardiovascular, neurological, or psychological systems;
- Pregnancy;
- Adverse response to touch;
- Surgery or hospitalization within the past 90 days; or
- Training in holistic nursing and knowledge of or experience in receiving AMMA treatments.

It was hypothesized that nurses receiving weekly AMMA treatments would demonstrate a greater reduction in anxiety when compared to the control group.

The first 30 names of eligible participants were randomly and equally divided into control (receiving mock treatments) and experimental (receiving authentic AMMA treatment) groups. Three participants from each group withdrew from the study before receiving treatments. One control group practitioner withdrew from the study as it began and the four participants in that group were unable to reschedule with another practitioner. The final number of participants was 12 for the experimental group and 8 for the control group.

The issue of a control group must be addressed by researchers conducting studies on complementary therapies. The investigators felt strongly that it would be difficult to control for a practitioner’s intent and for the power inherent in any touch. There was concern that control group participants, who were participating on their days off, were receiving only mock treatments. These issues were resolved after discussions with the bio-statistics department, which assisted in the control group design. Previous studies of complementary therapies have used other modalities as controls. The desire in this study was to discover as much as possible about the effects of the AMMA treatment while limiting variables that other therapies might offer.

Although participants were to be unaware of which technique they received until the completion of study, one control group participant discussed the procedure with an individual not participating in the study who was familiar with AMMA Therapy. After making this discovery, this participant was not willing to continue the study. This raises a question about contamination between the groups, although the investigators had no evidence that participants communicated with each other about their experiences.

For nurses in the control group, the average age was 38 and 100% were female. Seventy percent had bachelor’s degrees, 15% held associate degrees, and 15% were diploma graduates. In the control group, 85% identified “job/work” as their major source of stress and 15% listed “family” as a source of stress.

The average age of the experimental group was 34 with 75% female and 25% male. Fifty-eight percent of the nurses had bachelor’s degrees, 25% associate degrees, and 17% were diploma graduates. In the experimental group, 73% listed “job/work” as their major source of stress and 17% listed “family.”

### Practitioner Selection

Control design included an attempt to match control group practitioners with experimental group practitioners in terms of their years of nursing experience. Control group practitioners had to be clinical nurses with at least seven years’ nursing experience and without formal training in CAM therapies. They were naïve to the AMMA therapy technique. Each completed an IRB tutorial and the approval process.

Nurses who administered AMMA treatments had received formal training in excess of 500 hours (the standard set forth by the AOBTA to define a Clinical Practitioner) and had been oriented to study treatment protocols. Prior to the study, practitioners administered treatments to each other to ensure that the treatments would be as similar as possible.

### Measurement Procedure

A Physiologic Parameter Sheet, including measurements for blood pressure, heart rate, pulse oximetry, and skin temperature, was completed for each participant upon enrollment in the study, before and after each treatment, and at completion of the study. To measure skin temperature, a stress dot was placed on the participant's left hand between the thumb and index finger. A change in color reflected changes in skin temperature corresponding to a value indicating stress level.

A Visual Analog Scale (VAS) was used to measure perceived anxiety. The VAS is a 10-cm line ranging from "no anxiety" to "extremely anxious" (Gift, 1989). Participants marked a slash on the line to describe their perception of anxiety. Olson and Sneed (1995) reported a significant correlation between the anxiety VAS and the Spielberger State/Trait Anxiety Inventory and the Profile of Mood States.

At the end of the study, participants completed final interview questionnaires, which asked them to describe their experiences with the study, how the study affected them personally, and the relationship of the experiences to their nursing practice.

In an attempt to control for intent, the nurses were instructed to hold their hands on certain areas of participants' bodies and to count to 60.

### Treatment Procedure

The control group received four weekly treatments consisting of control group practitioners placing their hands on various parts of the participants' bodies in the same sequence as the AMMA treatment, according to a Standardized Touch Therapy Protocol (STTP).

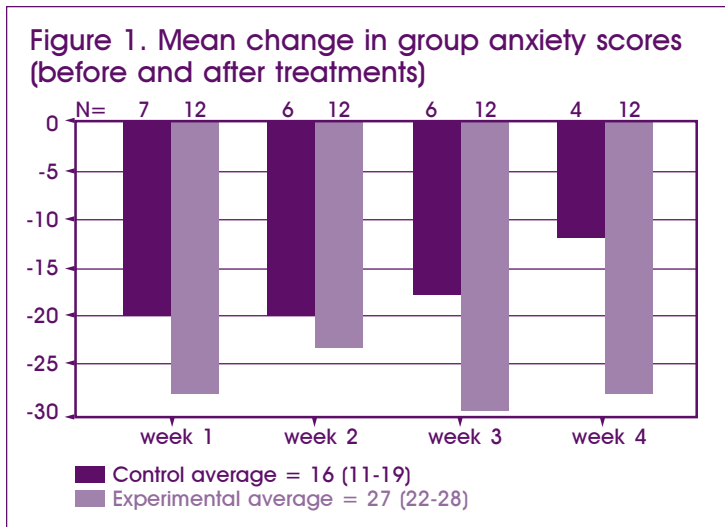
The STTP (see box, below) was designed to sequentially mimic AMMA treatment. It did not include pressure, intent, or circular digital motion used in AMMA Therapy. "Intent" is defined as the conscious awareness of being in the present moment to help facilitate the healing process

(AHNA, 2000). In an attempt to control for intent, the nurses were instructed to hold their hands on certain areas of participants' bodies and to count to 60. The control group practitioners demonstrated competence in the STTP after three training sessions.

The experimental group received four weekly AMMA treatments. The AMMA treatment session consisted of a standard revitalizing treatment (SRT). This treatment is described by Sohn & Sohn (1996) as a sequence of circular digital pressure along particular Chinese energy channels on the head, chest, arms, hands, feet, abdomen, legs, and back. It is performed while the practitioner is using intent to remove blockages from the energy channels, as well as pressure on designated "points" or areas on the body.

## Standardized Touch Therapy Protocol

1. Using palms of hands, hold the participant's head bilaterally along temples for two minutes.
2. Place one palm over forehead and the other palm on the opposite shoulder holding for one minute.
3. Cradle with both palms along the occiput and hold for one minute.
4. Lightly stroke portions of the face and hairline slowly three times.
5. Place both palms on the top of the shoulders for one minute and then the upper chest for one minute.
6. Slowly stroke the left arm from the shoulder to the fingers three times.
7. Gently touch the four quadrants of the abdomen using the palm of the hand with a pressure of 2 on a scale of 0-10 (0 = no touch and 10 = strongest pressure) Move from RLQ to RUQ to LUQ to LLQ.
8. Slowly stroke the left leg moving from upper thigh to toes. Repeat for a total of three times.
9. Hold the bottom of the foot and then stroke the top of the foot moving downward three times.
10. Move to the opposite side of the participant. Slowly stroke the right arm from the shoulder to the fingers three times.
11. With palms of hands bilaterally, gently touch the hypochondrial region along the rib cage.
12. Slowly stroke the right leg moving from upper thigh to toes. Repeat for a total of three times.
13. Hold the bottom of the foot and then stroke the top of the foot moving downward three times.
14. Have the participant turn face down on the table.
15. Using shampoo movements, touch the back of the head.
16. Place palms on shoulders for one minute and then place them on upper back for one minute.
17. Perform 3 long strokes moving from upper to lower back, using pressure of 2.
18. Stroke the back of the left leg three times moving from posterior upper thigh to heel. Hold the foot for one minute.
19. Move to the opposite leg and stroke the back of the right leg three times moving from posterior upper thigh to the heel. Hold the foot for one minute.
20. Place palms on the upper back and stroke towards the lower back three times.
21. Assist the participant into a sitting position and make sure he/she is fully alert and oriented prior to standing.



Participants in both groups were assigned to the same clinical practitioners for each session.

Treatments were limited to 45 minutes, allowing an additional 15 minutes for assessments. Dialogue was limited to necessary feedback from the participants. No findings or recommendations were discussed during the treatments. All participants received treatments in the same room in an attempt to control for temperature, sound, and light as recommended by Hartwig and colleagues (1994). The room was furnished with a chair, massage table, stool, desk, and lamp. The same pulse oximeter, blood-pressure machine, stress-dot technique, and VAS were used for every participant.

### Statistical analysis

A repeated measure design was used to compare the two groups. As this was a pilot study and exploratory in nature, a formal power calculation was not appropriate for this stage of research.

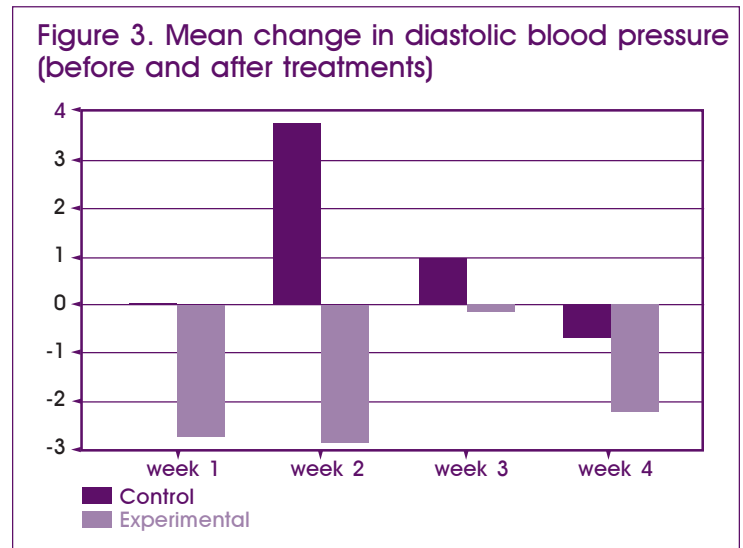
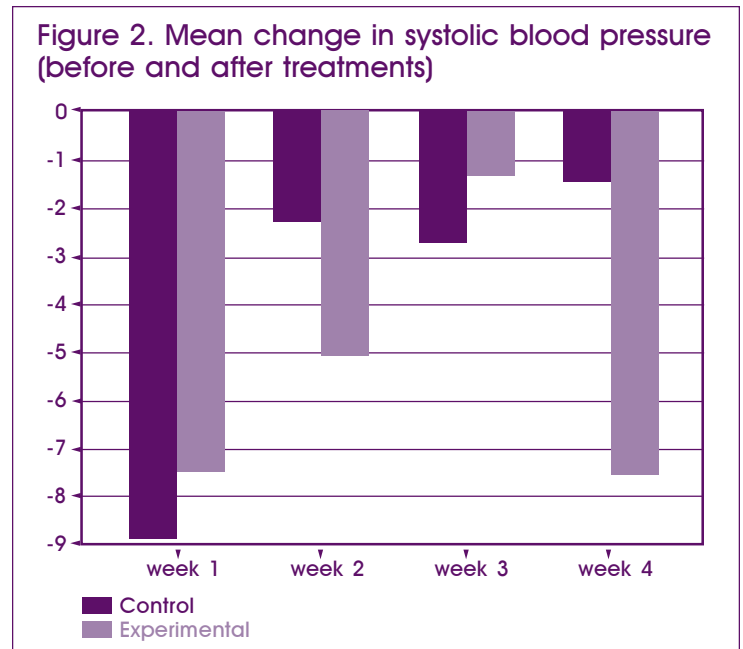
The measurements of anxiety and relaxation were treated as continuous variables. At each time point, the Wilcoxon rank-sum test was used to compare the two groups with respect to change in a given parameter from baseline.

Participants marked the anxiety VAS before and after each treatment. A 100-mm ruler measured this mark and a numerical score was attached to the point that was marked. Figure 1 represents the mean change in score before and after each treatment over the 4-week period. The mean change in physiologic data was reported for each group. A numerical score was attached to the stress dot color reading. The oximetry number indicated the percent of oxygen saturation.

### Results

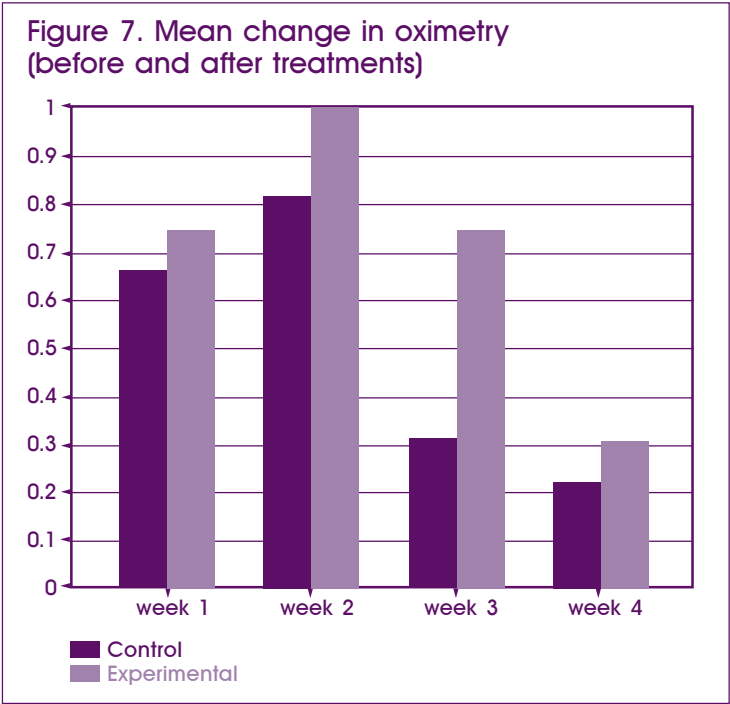
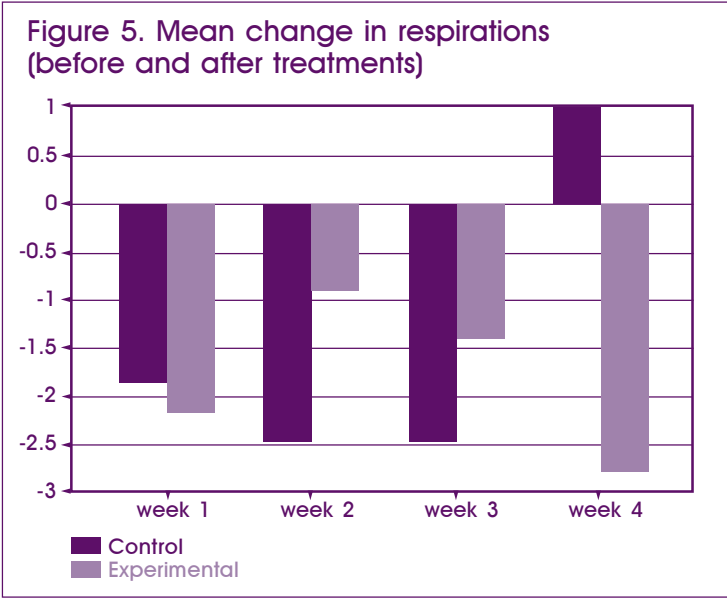
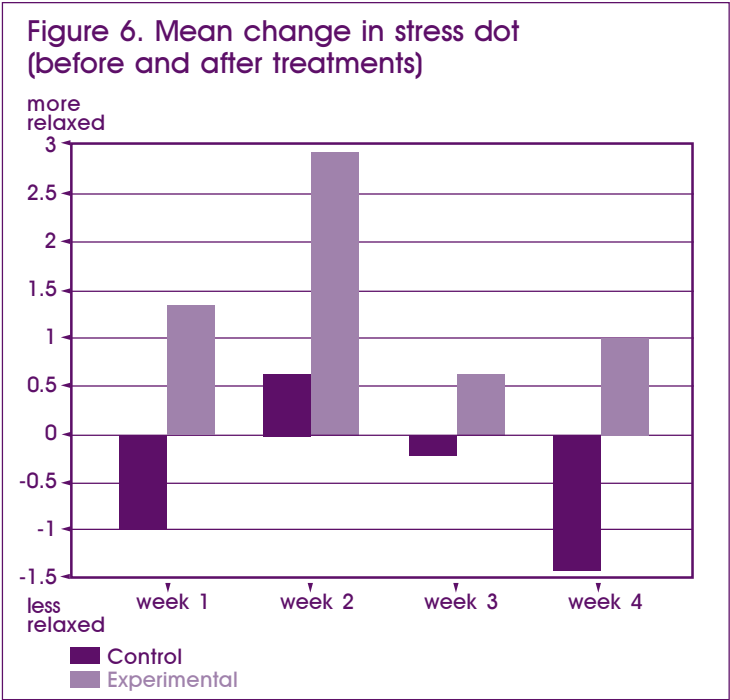
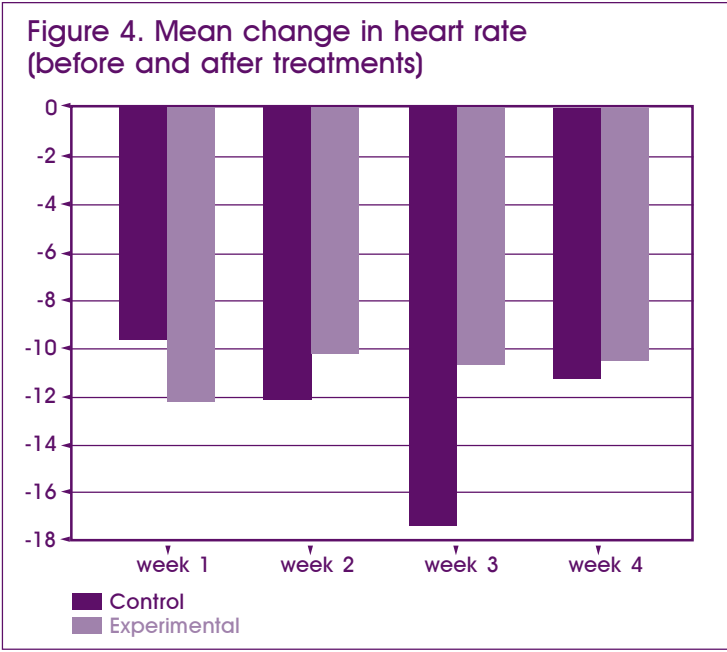
Neither hypothesis was supported in this pilot study, although several trends were noted. While both groups reported decreased anxiety after the treatments, the experimental group consistently showed greater differences between pre- and post-treatment anxiety scores (Figure 1).

After each treatment, all participants reported decreased anxiety. The average reduction in pre- and post-treatment VAS for the control



group ranged from 19 points (initial treatment) to 11 points (final treatment). The average reduction in pre- and post-treatment VAS for the experimental group ranged from 27 points (initial treatment) to 28 points (last treatment) with a report of 22 on the second treatment. The scores recorded by the experimental group represent a consistent change in anxiety level pre- to post-treatment throughout the study.

Several trends were also noted in the physiological data. The mean change in scores before and after treatments was examined for the control and experimental groups over the course of the four treatments. The measurements were taken prior to treatment (when participants were first lying on the massage table) and at the end of the treatment. The mean change in systolic blood pressure (SBP) decreased for both groups after each treatment, as shown in Figures 2 and 3. The control group had the greatest decrease in the first session. The experimental group had an equal decrease at the first and last session.



Mean change in resting heart rate decreased for both groups after treatments (Figure 4). The mean reduction in respiratory rate was consistent for the experimental group with the greatest decrease in the last treatment (Figure 5).

The mean change in the stress dot measurement, where higher numbers indicate greater relaxation, increased after each treatment for the experimental group (Figure 6). The control group showed an average loss of relaxation in all but the second treatment. The pulse oximetry reading, where a higher level indicates better oxygenation, was consistently higher in the experimental group than the control group (Figure 7).

Pre- and post-treatment measurements of participants in the experimental group indicated a decrease in systolic blood pressure, heart rate, and respirations and an increase in relaxation and blood oxygenation. However, these measurements were not significantly different from the mean changes recorded from the control group over the course of the four treatments.

*Numerous comments were made about the impact of "simple touch" and the important role it plays in patient care.*

## Limitations

This study experienced several limitations. The value of the findings was limited by the small sample size. While the decrease in mean anxiety scores for the experimental group appeared more consistent than those of the control group, the participant numbers were too small to provide statistical support for the hypotheses.

Although 30 participants, three AMMA treatment practitioners and three control group practitioners were selected for the study, only 24 participants actually scheduled their four appointments. One control group practitioner dropped out after the study began, and the participants refused to reschedule, leaving 12 experimental group participants, and 8 control group participants.

The findings were also affected by the failure of some participants to complete all four sessions. In the control group, three of the participants completed all four sessions, two completed three sessions, two completed two sessions, and one completed one session. Therefore, the final interview was completed on three of the control group participants. All 12 participants in the experimental group completed the four sessions.

Control group participants, who were being treated on their days off, cited scheduling difficulties in completing the sessions. Although participants were instructed not to discuss the study with others, one participant heard a nurse from outside the study talking about AMMA treatments, realized that she was not getting the actual treatment, and no longer wanted to attend sessions on her day off.

Limitations of room and staff availability prevented the extension of the study and replacement of the participants who dropped out. An air-conditioning vent blew cool air over the table, making it difficult for the stress dot to maintain changes in skin temperature. Anecdotally, practitioners noticed greater changes on the stress dots during treatment.

At the end of the treatment, however, when the participant turned over and parameters were measured, the numbers dropped immediately.

Treatment sessions were held on days off for both participants and practitioners, making scheduling difficult. There was no way to control for the intent of the control group practitioners, although attempts were made to do so. Both control group practitioners reported that while they tried to simply count during treatments, they enjoyed performing the treatments. This study cannot account for the effect of this intent.

## Additional data

Themes derived from the final interview included relaxation, the importance of touch, decreased stress, the desire to incorporate more touch into nursing care, increased self-awareness, recognition of the need for self care, and a new understanding of the mind-body connection.

While the purpose of the study was to determine the effects of AMMA treatments on anxiety and relaxation, additional themes developed. The touch provided during the control treatment, where attempts were made to limit intent, proved to be pleasing to the participants. Numerous comments were made about the impact of "simple touch" and the important role it plays in patient care. Some participants expressed a desire to bring touch back into nursing.

The nurses in the experimental group reported a positive experience and developed a new understanding of one holistic nursing intervention. They described feeling relaxed and less stressed. Nurses reported that the feeling of relaxation experienced during an AMMA treatment was successfully transposed to a stressful work situation and assisted them in coping. Nurses identified AMMA treatment and touch as experiences that they would like to use as they provide

nursing care. As AMMA practitioners use intent with the treatment, they are peacefully present for the patient. This provides a sharp contrast to acute care nurses' routine hospital shifts. Experiences that assist in healing both the patient and nurse while providing one-to-one care appear to be attractive.

The themes derived from this additional data form the foundation for a circle of care. As nurses perform self-assessments, discover the mind-body connection, and recognize their own need for self-care, these concepts are transposed into the nurse-client care experience.

There are implications in the concept of improved self-care in nursing that are attractive to nurses, administrators, and institutions. As patient satisfaction has nation-wide standards and comparisons, the caring relationship that consumers are seeking cannot be overlooked. Challenges of incorporating self-care and the caring relationship into the overburdened day of a staff nurse may seem unattainable. The additional data from this pilot study, however, highlights the importance of self-care and caring relationships.

## Conclusions

While the results from the experimental group suggest a positive trend, the results from the control group highlight the power of touch inherent in each of us, even without conscious intent.

It is important to note that the experimental group, in contrast to the control group, continually maintained participation throughout the study. Although there is no clear explanation for the lack of participation by the control group, this may indicate that the use of AMMA treatments promoted the nurse-client relationship and compliance with treatment.

Designing a CAM study with a reliable control group continues to be a difficulty

encountered by researchers. Consideration may be given to a crossover study with more flexible treatment times for participants. Identifying and recording non-invasive physiologic parameters that measure the relaxation response is challenging. Valid tools to measure overall wellness need to be developed. Studies with larger numbers of participants need to be supported with adequate funding.

Nurses need to ensure that the introduction of CAM interventions into health care practices assist patients with healing through holistic care. Nursing models that support self care and caring relationships

need to be identified, supported, researched and incorporated into practice. AMMA, a touch intervention that is congruent with nursing and holistic theories, warrants further investigation with larger populations. Future studies may address the effects of AMMA on anxiety, stress, wellness, nursing satisfaction and burnout.

Nurses in this study recognized feelings of stress and relaxation and planned to address their need for self-care. Holistic nursing can rekindle the spark of self-care, fueling the Nightingale lamp to burn brightly through this millennium.

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## Therapeutic Play: Developing Humor in the Nurse-Patient Relationship

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### Abstract

Although there has been considerable discussion on the therapeutic aspects of humor in the nurse-patient relationship, little is known about the experience of humor in *actual* nurse-patient relationships. This naturalistic study was conducted using grounded theory methodology with participant observation, utilizing in-depth interviews of participants in nurse-patient dyadic relationships in a suburban metropolitan New York acute care hospital. The core process was identified as Therapeutic Play, in which humor involves caring for self or another. This study offers nurses and others involved in professional relationships an explanation of the development of humor as an alternative healing-caring strategy.

Humor and its associations with health and well-being have been discussed in the literature for a century (Sully, 1902; Walsh, 1928). There is some evidence that humor is capable of enhancing health and well-being, moderating pain, and improving the function of the immune system (Bennet, Zeller, Rosenberg, & McCann, 2003; Berk, Felten, Bittman, & Westengard, 2001; Cousins, 1979; Dillon, Minchoff, & Baker, 1986; Kamei, Kumano, & Masumura, 1997; Lambert & Lambert, 1995; Lefcourt, Davidson-Katz, & Kueneman, 1990).

According to psychoneuroimmunology theory and some humor research, humor may positively influence health and well-being by moderating stress chemicals. Humor is the second most utilized complementary or alternative intervention in a survey of rural Midwestern cancer patients with 50% of the respondents using humor as an intervention, second only to prayer (Bennet & Lengacher,

1998). Humor represents an important non-pharmaceutical, noninvasive, low-risk alternative therapy.

Most studies of humor in the nurse-patient relationship have focused on selected aspects of humor, e.g., nurses' attitudes toward humor (Sumners, 1990); patients' appreciation of humor (Fox-Tennant, 1986); patients' attitudes toward nurses' humor (Schmitt, 1990); humor in the older adult (Fox-Tennant, 1990; Simon, 1988, 1990); humor and recovery rate following surgery (Fox-Tennant, 1986); humor and cultural similarity between nurses and patients (Robinson, 1977; 1991); laughter in healthy elderly subjects (Malinski, 1991; Parse, 1993; Reeder, 1991); and the nurse's perspective on humor in the relationship (Astedt-Kurki & Liukkonen, 1994; Beck, 1997). Although these studies are useful for nursing practice, they do not address the contextual dynamics

of humor in the nurse-patient relationship. This study will explore humor within the context of actual professional nurse-patient relationships from the dual perspectives of the nurse and patient.

### Method

A qualitative naturalistic approach involving participant observation and intensive interviewing was used for this study. Naturalistic inquiry was most appropriate for this study since the focus was humor from the perspectives of both nurses and patients involved in nurse-patient relationships on medical-surgical hospital units. The objective of naturalistic research is to understand and describe human experience, as expressed by those who participate in the experience. People construct meanings within a specific context in which they exist (Boyd, 1993).

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## Participants

The researcher recruited participants through intermediaries in an acute-care agency. Managers of six adult medical-surgical units in one suburban metropolitan New York medical center distributed flyers to nurses and clients fitting the study criteria. The researcher selected nurses with one or more years of experience and who reported consistent use of humor with patients. Five nurses contacted the researcher signifying interest and three baccalaureate-prepared nurses volunteered to participate.

The researcher observed each nurse in multiple nurse-patient relationships before recruiting patient participants. Patients were selected based upon their level of interest, their ability to speak and understand English, and non-psychiatric medical histories. Each patient was assigned to one of the nurses who agreed to participate in the study. The patients were part of the nurses' usual room or team assignments. To this extent, the nurse-patient relationships were matched.

Three dyadic nurse-patient relationships were the focus of intensive observation and interviewing over 3 weeks during the day shift and 3 months during the night shift. Table 1 summarizes participant characteristics.

Pseudonyms were ascribed to the participants in the field notes and findings to afford anonymity. Human Subjects Review Committees at the researcher's sponsoring university and the clinical setting were obtained before participant recruitment. Participants were informed orally of the nature of the study and their participation and signed a consent form to indicate their understanding.

### Dyad 1: Heidi (Nurse) and Salvatore (Patient)

Heidi considered herself to have a good, "maybe above average" sense of humor. She defined humor by an outcome — laughter — saying, "humor to me is what makes me or someone else laugh."

Heidi was assigned to Salvatore for a two-week period after he was transferred from Intensive Care following a colostomy closure. Salvatore defined humor as "a friendly thing, sometimes more like opposites." He credited humor with saving his life and helping him to retain perspective in adversity.

### Dyad 2: Doris (Nurse) and Florence (Patient)

Doris was deliberate in her choice of words and usually very serious when speaking. She questioned her sense of humor saying, "Most of the time I think that I am just too serious." Except on rare occasions, Doris demonstrated little spontaneous humor with patients.

Doris was assigned to Florence over a three-month period. Florence, a paraplegic, was ambulatory with braces. She had a positive outlook toward life, focusing on her capabilities rather than her functional limitations. Florence considered her sense of humor one of her greatest strengths: "I find things funny some times, when to other people they might not be funny."

### Dyad 3: Tim (Nurse) and Emma (Patient)

Tim's movements were like a boxer's quick jabs. He used his hands like exclamation points to punctuate his comments. He said he was like a chameleon, changing his manner and appearance with the situation at hand. His facile humor and frequent humorous quips left others wondering what to expect from him.

Tim was assigned to Emma on the night of her cesium insertion and he continued as her nurse throughout her three-day hospitalization. Emma was passionately holistic and wholeheartedly embraced nature and natural healing. She likened the cesium radiation to the "healing energy" of the sun. Emma found her health crisis to be growth-promoting and found healing potential in humor. She said she was not a jokester, but she appreciated others' attempts at humor, especially when she grew from the experience.

## Data collection and analysis

Prior to the current study, a pilot study was conducted at a different site to familiarize the researcher with the naturalistic method, develop a preliminary interview guide, and formulate a coherent research design. The pilot study supported the need for participant observation, observation of the nurse-patient relationship from the beginning to end, a research site with a minimum number of ancillary personnel

Dyad	Gender	Age	Years in Nursing	Diagnosis	Culture/Ethnicity	Humor Promotion
1 Nurse – Heidi Patient – Salvatore	Female Male	30 48	5	Colostomy Revision	German American Italian American	Comedy clubs Television
2 Nurse – Doris Patient – Florence	Female Female	26 38	1.5	Spina Bifida-Wound flap	"Mixed" American Polish American	Bowling Comedians
3 Nurse – Tim Patient – Emma	Male Female	32 46	2	Ca Cervix-Cesium implants	Californian American Jewish American	Writing Comics Friends

*Humor and amusement are not usually associated with illness and the hospital.*

acting as direct patient care providers, and use of the constant comparative method of analysis.

Data were collected over a 14-month period. The researcher observed the volunteer nurses in many nurse-patient interactions and then focused analysis on three nurse-patient relationships. Protracted data collection and recruitment of suitable and willing clients were the major reasons for the intensive focus on three relationships.

Observations occurred at varied times during the nurses' work shifts and throughout the relationship. Data were gathered throughout 200 hours of participant observation and 25 hours of informal and formal interviews. During interviews, all participants were initially asked a broad opening question: "What is it like to use humor with this patient (nurse)?" or "What is it like when your nurse (patient) uses humor?" Interviews were audiotaped and transcribed, and field notes, transcripts of interviews, and a personal log were kept by the researcher to chronicle the research.

The constant comparative method (Strauss, 1987) was used to analyze data. Level I codes were ascribed to data reflecting events, actions, and meaningful units. Level I codes were then grouped together to produce Level II codes. For example, Level I codes of "at ease," "loosen up," and "relief" were grouped into the Level II category code, "Relaxing."

As data collection proceeded, codes were revised and categories refined to accurately describe phenomena and events. Category codes and emerging patterns and themes were compared among participants and among the dyads, to examine variations and similarities and establish linkages. Codes, categories, and themes were confirmed by re-examination of raw data from the observations and interviews, and by verification of emerging and final themes with participants.

Trustworthiness was established by prolonged engagement with the participants, triangulation, peer debriefing, negative case

analysis, and member checks to confirm and/or revise findings. An external auditor used the substantive elements of the audit method described by Lincoln and Guba (1985). Findings represent therapeutic aspects of humor for nurses and patients engaged in relationships in the hospital setting.

## Findings Categories/Themes

Humor and amusement are not usually associated with illness and the hospital. As one patient said, "This is a hospital. It isn't funny to begin with." Anxiety, preoccupation, tension, distress, and uncertainty accompany illness and lead individuals to examine their feelings about life and death. This may lead to blocking, "shutting down," or suppressing humor.

A primary task for these nurses and patients was to solve the paradox stemming from the juxtaposition of humor with issues of life and death. Participants described these issues as "so much responsibility," "tragic," and "stressful." Nurses and patients felt "serious" and tense. Tim said:

It's a hospital with sick people and life and death. When I go to the hospital, suddenly the whole thing seems so serious and I end up kind of shutting down my humor. I kind of close down the humor valve and turn on the "get on with the serious business and we had better get moving" valve.

A core process, therapeutic play, helped nurses and patients resolve this paradox and integrate humor into the nurse-patient relationship. Therapeutic play involves the redefinition of humor as a way of caring for oneself or another. It enhances health and well-being by developing a therapeutic alliance in illness.

Nurses and patients used humor therapeutically only when they perceived humor in this way. Four interactive categories emerged from the observational and interview

data and, together, these depicted the processes of learning to play therapeutically in a context that was often serious, sometimes ambiguous, and almost always contradictory. These categories were:

- Developing humor in health and illness;
- Providing emotional support;
- Seeing a vision;
- Entertaining; and
- Transcending.

## Developing humor in health and illness

Nurse participants used humor to care for patients and to attain therapeutic goals. Humor elicited laughter and a positive response, providing compassion and kindness intermingled magnanimity with honesty. Kindly humor increased the patients' abilities to perceive incongruity as amusing. Lightheartedness and self-deprecating humor were supportive, non-threatening measures that nurses used to calm patients' anxieties.

**Heidi:** Sometimes humor and that sort of light-heartedness help people feel like maybe it's not that bad. I can imagine that if I were a patient lying in bed and someone would come in with a little laughter here and there, that would help me feel more at ease.

**Tim:** I joke about myself a lot. It is very disarming and right away converts people to you. You break down barriers very fast that way. In the hospital, where it is tougher to make jokes about people, I tend to direct humor at myself. Sometimes that really does open a lot of doors, especially if you let them think you are a knucklehead and then you give them a lot of teaching stuff so that they know that you are not as stupid as you think you are.

Patients believed in the importance of developing a sense of humor to cope with illness and enhance their well-being.

*Humor, human, humane – they're almost the same word.  
When you're taking care of people, you've got to have a lot of humanity.*



**Salvatore:** If you don't laugh, everything becomes too serious. I think it would be hard psychologically for me to function and for most people to function. I think we would be on the road to insanity, to be honest. It's a crazy world and if you're gonna take it seriously, you have to be crazy.

For the patients in this study, humor was a self-care strategy that became more important when they were hospitalized. A clear choice to maintain a humorous perspective in illness was expressed by Emma as she recalled her feelings when her physician informed her that she had cervical cancer. She said that humor was a way to take care of herself following the diagnosis:

When I got the shocking diagnosis of cervical cancer, I didn't consider it, "This can be cured, therefore it is nothing." I was traumatized and I felt it was really important to make my life lighter and not to focus in on the petty problems and strains and stresses.

Patients were convinced of the therapeutic potency of laughter and gave testimonials to laughter's healing powers, specifically the stimulation of endorphins.

**Salvatore:** The laughter causes endorphins [to be] let off from our brains. The endorphins let off from laughter are very healthy, healthy for the heart, it's good for everything. That's how endorphins come out. Laughter. The more you laugh, the better off you're going to be.

When patients preserved a sense of humor and laughed, they distanced negative emotions and felt uplifted by positive emotions. When they examined their experiences with laughter, they concluded that without the transcendence of laughter they could not cope. One said, "Laughter is the most important thing. It lifts you out of the depths."

Patients also discussed the usefulness of humor in problem solving, changing perspective, gaining objectivity, and understanding alternative choices.

**Emma:** You can either sign off now or you can change a few things. It shows two ways of doing it, tackling it in a different way. Humor makes me see things in a totally new way and a way much lighter and not so ominous and heavy. That's important to me. When I can step outside of myself and see [humor in] something that normally I would take so seriously; that change of perspective is always helpful.

Nurses developed humor gradually and learned through experience. For example, nurses learned that when a spontaneous and light-hearted approach was used, humor could reduce patients' anxiety and control situations that might otherwise be impossible.

**Tim:** I use [humor] situationally. A lot of times you come into rooms and it is so confrontational because patients and families feel they are receiving some form of mistreatment. [Humor] tends to make you less threatening.

Nurses also learned the effectiveness of humor as an "icebreaker." All of the nurses joked with the patients when they first met. Given the ambiguous and paradoxical nature of humor, however, humor will not break the ice unless those involved view the situation or relationship as relaxed.

### Providing emotional support

Without the presence of sympathy and affection, nurses and patients did not define humor as emotionally supportive and caring. Nurses were conscious that humor must be perceived as kind; they spoke in low, soothing tones when they joked.

Intimacy was achieved when nurses and patients were able to take on each other's roles. This was reflected in humor that addressed sensitive topics. Nurses strived to moderate their humor in serious situations. They avoided boisterous laughter and tried to find a balance between silliness and sternness. Nurses and patients learned to recognize the limitations of humor, including its

ineffectiveness when patients had other care priorities.

The process of providing emotional support through humor involved four subprocesses: becoming relaxed, developing trust within the relationship, using non-humorous therapeutic communication before humor, and creating distraction.

### Becoming relaxed

As nurses' professional experiences and maturity increased, they gained a greater appreciation of humor. Relaxation occurred when the nurse worked with "easy-going" patients: patients who were cooperative and who understood situational constraints such as limitations on the nurse's time. Increased monitoring also promoted relaxation. Heidi said, "Each time I'm with a patient I feel a little more comfortable. I have assessment data from the previous day, so I know if there is any change."

The nurses continuously gathered data on the patients' physical health and were attuned to their mental outlook. Nurses assessed their patients' emotional states, seeking evidence of sadness, such as weeping or a dejected expression, anxiety, or good spirits. This frequent care fostered a sense of predictability about patients' physical or emotional health. All of the nurses and patients who defined humor as a way of caring had become relaxed within the relationship.

### Developing trust

Trust developed quickly when nurses felt empathy for their patients. Nurses recognized that their patients were suffering or lonely and used humor benevolently. Emma described Tim's joking as "sharing on the level of humanity." The empathic nature of humor was voiced repeatedly by Salvatore:

Humor, human, humane – they're almost the same word. When you're taking care of people, you've got to have a lot of humanity. She doesn't separate her work from humanity, so to speak. She always has the human touch. She doesn't lose that. It's not just a job.

Disclosure of personal thoughts and feelings was important in developing trust. Nurses and patients carefully observed each other for direct and indirect indications of willingness to disclose, such as eye contact. The nurse became aware of specific details about the patient in a therapeutic alliance. One nurse said, “I guess it’s easier for me to relate to people who show their emotions more than those who don’t. They talk about their feelings more.”

### Using non-humorous communication first

Before joking, nurses used a great deal of non-humorous therapeutic communication such as listening, touch, or other verbal remarks. As Tim put it:

Sometimes I tend to feel more like Mother Theresa. I’ll rub their hand and look mournful. I’ll be real compassionate with someone and I won’t be joking with them at all. Then I’ll slip in a little humorous comment.

When nurses acknowledged that their patients’ pain, physical needs, or negative emotions were serious, they established themselves as concerned and caring. Joking could then be effective in reducing anxiety or conflict. Observed by the researcher, this principle was described in detail by Tim:

We had a situation where a patient flipped out — you could tell it was going to be one of those really horrible situations. So I got everyone separated and then I went in with the lady. At first I was very tender, and let her tell me everything. Before you knew it, I was joking with her and everybody was laughing and talking and enjoying themselves.

The use of non-humorous, “tender” communication prior to joking indicated the nurse’s therapeutic intentions. It fostered intimacy and provided opportunities for the patient to trust the nurse, reinforcing the patient’s relaxation. Without the initial use of non-humorous therapeutic communication, humor might have little or no therapeutic effect.

### Creating distraction

Nurses noticed that when they playfully distracted patients, they could more easily accomplish clinical tasks such as physical assessment, ambulation after surgery, or teaching. Situations were carefully chosen for joking, such as periods of mild stress when cognitive control of anxious behavior was higher and humor was more likely to be effective.

Before coaxing her patient out of bed following surgery, moving him about, listening to his lungs, or inserting medications through his triple lumen tube, Heidi would say, “Okay, Salvatore, let’s push the ejector button on your bed and get you out” or use nicknames. The patient commented:

You need to be nursed mentally too, not just physically. The humor is mental. It’s very important. She has a way of curing you mentally while she’s working on your physical [condition]. She’ll come into the room and call me Skinny and she’ll do her work.

### Seeing a Vision

The nurses and patients engaged in abstract mental processes that began with appreciation of a novel event and perceiving its humor. In each nurse-patient relationship, an unusual event occurred involving incongruous behavior or situations. Nurses and patients defined such novel events as something that could be used for amusement.

For example, during change of shift report, Tim heard about his patient’s holistic healing philosophy and the symbols she was using while receiving cesium radiation. He found the use of crystals, nature audiotapes, and a picture of her guru taped to the wall to be incongruous and amusing. He commented:

The day nurse was telling me, “She has got all kinds of things, and you won’t even believe them; she has got the guru up on her wall.” My first thought was that it was really funny that here she was with the guru up on the wall, yet she has uranium inside of her. She has nuclear stuff inside of her.

Being amused also resolved unflattering appearances or behavior. Salvatore, a hairdresser, said with a smirk, “Being in the hospital, you know? Tubes in my nose — this is the most ridiculous thing, isn’t it?”

Tim recounted another incongruous situation:

Well, earlier in the evening [Emma] had said that the air was dry, and she kept asking me for a humidifier. A lot of times we just roll our eyes when they ask for things like that, because they don’t realize that we don’t even have pens to write with, let alone a humidifier. I said, “Well, I can get you a basin of water and we can put it on your air blower, and maybe that will help.” She said that was a good idea. There were not any basins around, so I used a bedpan. Later she needed something to wash in and there were no wash basins. So I brought in a bedpan for her to wash in, and I said something [humorous]. It was just the whole situation of the nurse bringing a bedpan to wash in.

### Promoting the comic within

Nurses and patients learned about humor from life experiences and actively nurtured their sense of humor. Their humorous experiences were at once joyous, entertaining, exhilarating, distressing, uncomfortable, and anxiety-provoking. Four methods of promoting a sense of humor were reported: viewing television or movie comedies; participating in social discourse with friends, family, or acquaintances; attending comedy clubs; and reading or writing comic materials. These were viewed as entertaining and enjoyable; sometimes they were considered to be health-promoting.

Participants also described preferred types of humor and subject matter for humor. Hiedi particularly disliked sarcasm but liked mimicry, while Salvatore disliked the visual humor of cartoons: “I don’t find them funny at all. I like verbal humor. I don’t like physical humor, although a little slapstick is okay.” His aversion to overt or subtle violence increased during hospitalization, especially following surgery when he was in pain.

Without the initial use of non-humorous therapeutic communication, humor might have little or no therapeutic effect.

## Entertaining

During hospitalization, patients were sometimes isolated and bored. The isolation provided an opportunity for them to reflect on their solitude and desire for diversion. For example, as a result of radiation precautions, Emma occupied a private room at the end of the corridor. Her isolation meant a lack of opportunity for human interaction, her primary source of humor. She said, “When someone is lying here, there’s nothing to do. You need someone to entertain you.”

Therapeutic play required participants to take the role of either comedian or audience. The comedian externalized the vision in order to share it with the audience.

## Make believe

A key feature of entertainment was keeping humor “make believe” and playful. As nurses and patients used humor therapeutically, they engaged in clear, unambiguous, playful representations, gestures, and meanings. Voice inflections were jovial, happy, or fantastic. For example, Tim’s voice was charged with merriment when he described to his patient the items in the hospital personal care package. Facial features and hand motions were animated as he withdrew soap and toothpaste from the hospital patient pack, like a magician pulling a rabbit from a hat. His eyes twinkled and he grinned mischievously as he made his presentation. He and Emma described this fantasy:

**Tim:** I was telling [her] about this great kit, because finally we did have a kit with a basin. I kept telling her that I was going to get her one, and it’s real great. I was bringing out Colgate and I said, “Oh no! You’re not going to be impressed by this, are you?” She laughed because I had seen her fennel toothpaste and knew that Colgate wouldn’t mean a lot to her.

**Emma:** He just made a big deal and it was really funny. He said, “You have to see what’s in this thing,” and he started tearing all these different things out and holding them up in the air and making them seem like it was Christmas time and these were great treasures.

Participants used their intuition to “get a feel” for people with whom they could joke. Florence remarked, “Some people you can joke around

with and you know you can joke around with them.” Without recognition of an invitation, such as “friendliness,” “affability,” or “a nice smile,” few people attempted humor. With such recognition, playful remarks simply slipped out of their mouths. “I was examining his abdomen after he had a barium enema,” reported Heidi, “and I just said, ‘Ooh, this stuff is like cement.’”

It is common for humorous people to prefer spontaneous, simple comments to formal jokes. Formal jokes were rare among these nurses and patients. Once, the wife of a dying patient related a rather lewd joke to Tim. Although he smiled at the joke, he later commented that he thought her behavior was quite unusual.

## Transcending

Transcending was the process of enjoying humor as a way of caring, and it was reflected in shared laughter between the nurse and patient. This laughter was intense, continuous (“unstoppable,” “we were laughing,” “we were rolling,” “on a roll”), cyclical (“even later, we were still laughing about it”), and repetitive (“that would make him laugh too”). In contrast, when “laughing-at” occurred, the experience was disturbing to either the nurse or patient and no emotional connection occurred.

Mutual laughter is an especially powerful form of nurse-patient communication because it functions as testimony to a therapeutic relationship. Patients noticed that laughter lifted them out of depression. Positive emotions were transferred and their sadness lifted. Emma said:

Certainly, if you are around someone who is depressed all the time, it is going to affect you too. So I’d much rather be affected by someone who is up. People have infectious laughs and we really respond to surroundings. The happiness makes you chuckle or whatever. It sort of radiates out – you just can’t help laughing too. By being in the same room with them, they seem to transfer those positive feelings to you. Tim was like that.

When positive emotions occurred, patients and nurses experienced a sense of well-being. Their perspectives on their relationships changed. Relationships evolved to a special bond of friendship. Patients and nurses seemed

to experience a meshing of their personalities, much like close friends, and considered their relationships to be unique and special.

**Salvatore:** [Heidi was] treating me like I would be her friend on the outside. It’s like we’re friends. Maybe I’m deceiving myself, but I really believe it’s more than just a nurse-patient relationship, or maybe that’s what a nurse-patient relationship should be.

When patients were discharged, feelings of losing connection and loss were reported by both patients and nurses. For the nurses, however, these feelings were balanced by their sense of achievement, professional pride, and the knowledge that through humor they had been as therapeutic as they could be.

## Discussion

This study documents the processes that make humor possible within the nurse-patient relationship. The nurses and patients in this study recognized the paradox of levity within the larger context of illness and its “life and death” seriousness. Therapeutic playing allowed nurses and patients to care through humor despite this gravity.

The findings indicate that humor in this relationship is a complex process that requires creative energy and cognitive skill. Participants who valued a sense of humor spoke of the need to cultivate it. Humor develops through observation and experience and is strengthened by practice, surrounding oneself with optimistic people, and thinking about ways to access humor in one’s life.

Beliefs about the importance of preserving a sense of humor in coping with illness, enhancing well-being, or attaining therapeutic goals were important for therapeutic play. Based on these beliefs, participants actively constructed the nurse-patient relationship to achieve caring through humor.

Patients struggling to accept their health problems used humor because they believed having a positive outlook was paramount for survival. Both nurses and patients described humor in the nurse-patient relationship in terms of magnanimity. Their mutually shared beliefs in the value of humor for health and

well-being made it possible for nurses to be humorously empathic.

Nurses and patients engaged in therapeutic play by becoming relaxed, developing trust, and communicating openly. Through these processes, they were able to create relationships in which humorous communication was a therapeutic vehicle and patients were supported emotionally and physically. This was not difficult for nurses who were expert in both nursing and humor skills.

Because patients felt supported, enlivened, and motivated through humor in a caring relationship, they felt empowered in relation to health and healing. Positive psychological changes were noted by the patients. The reduction of anxiety that resulted from their nurses' humorous distraction helped them to reframe concerns and anxieties that were threatening to them.

Humorous communication was accompanied by smiling, twinkling eyes, and exaggerated hand motions or voice inflection. Cues to play and joking were found in these meta-communicative gestures. This suggests that the play framework must be established around each humorous instance so there will be no difficulty in understanding the playful communication.

Mutual laughter was not only uplifting. It made it possible for nurses to regard the relationship as a professional achievement and for patients to feel genuinely cared for and about. Those nurses and patients who laughed together used joking to establish or maintain rapport and thus increase intimacy. Conversely, when "laughing at" occurred, humor was used to distance or create aloofness.

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## Future research

This study provides initial support for the use of humor as a therapeutic strategy in nurse-patient relationships. It had several limitations, some of which were inherent in the investigation of the spontaneous and situational process of humor. The unpredictability and intermittent nature of naturally occurring humor represents a general problem in humor research and a specific limitation of this study. Future studies should focus on care situations that have a greater potential for humor, such as non-life-threatening contexts, and on participants who are prone to initiating or responding to humor.

Future research should also examine therapeutic play in other settings, such as long-term rehabilitative settings, and with other age groups. Research needs to be conducted on the outcomes of humor, for example, its effects on pain management or patient/nurse satisfaction.

Because patients tend to view humor as healing, humor could be integrated into courses that teach health promotion or courses in alternative healing methods. In this study, humor relieved patients' anxiety, reduced the discomfort of being in a fearful environment, and helped to establish and sustain nurse-patient relationships. Therapeutic humor may be a behavior of an expert nurse, and may in fact delineate nursing expertise.

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## The Spirit of Healing: How to Develop a Spiritually Based Personal and Professional Practice

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### ■ Abstract

The idea of healing must be considered within the context of a holistic approach to nursing practice. The authors put forth the premise that a Spirit of Healing enters into the nurse-client relationship or into any care-giving situation. This spirit is defined as a universal energy source that is accessed through imagery, therapeutic touch, Reiki, and other related interventions. Case studies are provided as illustrations, and the authors include self-help exercises and related definitions to enhance understanding and practice. The authors explore energetic techniques to treat and prevent burnout for nurses, identify specific ways to practice nursing from a holistic perspective, and consider the possibility of transforming nursing into a change agent that will redefine the healthcare system.

In 1997 and 1998, we conducted a series of workshops for nurses called “The Spirit of Healing.” Workshop participants were invited to experience the Spirit of Healing as a bridge between the world in which healing is currently practiced and the “world of vision,” in which healing is transformed by ideas such as:

- All persons have the capacity to form their unique visions of the Spirit of Healing. This comes from a spiritually driven center composed of unconditional love, trust, courage, openness, faith, and commitment.

- Healing is a sacred challenge designed to integrate “mind-heart-gut.” Metaphorically, the mind holds the consciousness, the heart holds the soul, and the gut holds the emotions and the body.

- Nurses have a sacred trust to bring the Spirit of Healing to all they serve.

### A force for the future

Consider what the future could be like if society embraced its fears and learned to act responsibly from a place of love. There is a healing crisis in the world, but our culture does

not attempt to solve it. Rather, the problem is avoided, even hated. Healing has never been more important for growth and planetary evolution than now, in light of the events of September 11, 2001, and current world crises.

The Spirit of Healing offers one solution. It is a force that creates greater unity and wholeness. It promotes healing of all “dis-ease” at all levels — physical, emotional, psychological, and spiritual.

Through awareness of the Spirit of Healing, individuals begin to understand inner resources that are available to them at any time, in any

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## Caregiving requires an intense commitment.

place. These resources are as close as breath — indeed, the breath is a way to access the Spirit of Healing. It is interesting to note that the Latin root of the word “spirit” is “spiritus,” or “breath.”

Nurses struggle with their commitment and vision to help others heal, as well as the challenge of caring for themselves. Both are necessary to keep and enhance the essential balance of healing. To form and sustain that balance, nurses must:

- Revalue nursing practice to include the Spirit of Healing;
- Appreciate the nurse as healer;
- Transform and give rebirth to nursing as a new science of holism;
- Develop compassion as nursing’s most powerful healing tool;
- Accept pain and suffering, not as disabilities, but as elements that heal and evolve at the highest levels;
- Insist that nurses become more visible caretakers as partners in healing;
- Recognize that healing is short-circuited by burnout;
- Consider the steps of wound healing as a metaphor of the Spirit of Healing; and
- Understand how these components produce and enhance all inherent healing responses.

## Defining the Spirit of Healing

The Spirit of Healing is difficult to define. Individuals do not become aware of it until they need it, and even then it sometimes can evade them. Without formal education about this energy source, people in need can grasp and understand its power immediately. The Spirit of Healing is present in any situation in which healing is needed. It can be invoked in any language. The Spirit of Healing is a source of higher intelligence that helps restore a person to wholeness.

The Spirit of Healing has its own rhythms and patterns. Nurses augment the pattern when they assist with the healing process. In our clinical practices, we have heard physicians admit that, while they may diagnose and treat the illness, there is another energy source that works with the patient for healing. As Florence Nightingale so aptly noted, it is the duty of the nurse to place the person in the best possible situation for healing to occur, with good nutrition, positioning, attitude, and fresh air. Then healing will occur naturally.

Nurses have learned to honor, invoke, and witness the work of this energy source in countless ways and situations. It is present the first time a nurse enters a patient’s room and experiences the special feeling that is generated between the patient and the nurse.

How does one recognize the Spirit of Healing? It is a feeling that is difficult to convey in words, and yet is very real to the one experiencing it. When one feels and experiences heartfelt caring as unconditional love, innate healing responses are catalyzed. It opens one’s capacity to receive the universal flow of energy, the essence of which is love.

Caregiving requires an intense commitment. The challenge of caregiving is to determine areas where love is absent, because that is where healing needs to occur. Meditating, doing energy work, listening intently and unconditionally, creatively expressing, and being willing to share and offer — all involve aspects of love and are ways to “give care” in the Spirit of Healing to oneself and to others.

Spiritually based pathways of practice that offer this integrative healing can include the transmittal of universal life force energy (Reiki and therapeutic touch), writing (journal-keeping and poetry), and meditative practice (mindfulness, relaxation, and imagery). Many of these practices involve multidimensional healing responses on physical, emotional, mental, and spiritual levels.

## Spiritually Based Practice Techniques

### Deep relaxation

Deep relaxation is achieved by positioning the body so it does not hold tension, regulating the breath, and letting the mind “float.” Counting five to ten deep, full breaths can be a quick, easy technique to induce deep relaxation. A wonderful self-help resource to practice deep relaxation for wellness, heightened awareness and stress relief is *The Relaxation Response* (Benson, 1975).

### Imagery

Einstein said, “Imagination is more important than knowledge. Knowledge is limited. Imagination encircles the world” (Viereck, 1929). When individuals daydream, or imagine, what they desire in a deeply relaxed state, they dramatically increase motivation and ability to think creatively and also “direct energetically” the potential to manifest this desire. Body-mind research conducted over the past 30 years supports the power to imagine or visualize innate healing responses, with many studies discussing a potential relationship between imagery and improved immunological response (Rider, Achterberg, Lawlis, Goven, Toledo, & Butler, 1990).

### Reiki

Reiki is a Japanese form of energetic healing that works with *ki*, the Japanese word for universal life-force energy. Reiki teaches specific hand placements that involve a light touch on the body; working with the energetic, or aural field; and telepathic transmittal of the Reiki healing energy. Reiki is an increasingly popular form of energetic healing that is covered by some comprehensive health insurance plans. It is used to facilitate deep relaxation and overall balancing, to stimulate healing responses, and to increase insight and clarity. (Miles & True, 2003; Rand, 2000).

[Ed. Note: For more information on Reiki, see the article on pg. 9.]

## Wound healing as metaphor

In wound healing, an initial trauma disrupts the integration and protected holism of the body. There is a shock response followed by bleeding — cleansing — at a core level. The body's cells provide a multilevel protection to allow core healing to occur. A scab forms, which is glaringly different from the healthy, unwounded areas of the body, and is sensitive to external stimuli. The scab "pulls" and is painful with even minor impact. If left alone, the scab falls off. The newly created tissue initially looks different from the tissue that surrounds it. This difference will eventually fade. With complete wound healing, the wound disappears — it is as if the trauma never happened.

Wound healing is a metaphor of how individuals are meant to heal emotionally, mentally, and spiritually. Mind-body healing is an integrative approach to wellness that is achieved as a serendipitous response to tracking the energetic roots of discomfort, or "dis-ease." This exploration supports the person's divine right to create, release, and empower innate healing through integrative, loving responses.

The primary commitment of nursing is to support this healing process. As an art and a science, nursing must invoke the Spirit of

Healing to fulfill its original vision and to meet the complex, accelerated, and fractured demands of a transforming world.

It is time to name the spiritual source of love and consider it to be a critical factor in healing and teaching. It is time to understand its force in nurses' lives and in the lives of others. It is time to determine where it is absent in the world today. Nurses must be able to offer integrative healing responses to themselves and others, with the realization that they can no longer afford to separate any of the dimensions in which they live and practice.

Florence Nightingale's *Notes on Nursing* (1859) described the work of nursing as putting patients in the best condition for nature to act upon them, emphasizing touch and kindness along with the healing properties of the physical environment. She called nursing an art, and explained that nurses care for "the living body, the temple of God's spirit" (Tooley, 1910, p. 298). In contrast, the predominant values of modern society are to cure rather than to heal, to remain young rather than growing old gracefully, pampering rather than nurturing, and so on.

Today's nurses are managing patient care in the context of a sick care system that challenges their ability to care for a patient's

spirit. It is no wonder that nurses leave nursing. In many employment settings, nurses are struggling under the weight of caring for patients with multiple illnesses who require many medications and close monitoring. Nurses attempt to deliver service in a stressful and sometimes unhealthy environment. They meet educated patients and families who demand attention and further health teaching. Some nurses thrive in this type of situation. The problem comes when they are not paid, appreciated, or rewarded appropriately for this high level of expertise and demand.

A deeper problem is that nurses are not expected, nor do they have time, to care for the whole person. They are so busy doing the tasks required that they are not available to care for their clients' total needs. They end up sacrificing their ideals and giving away their power base, which is their innate ability to comfort and nurture.

Nurses want to be present, to listen, and to educate. It is not surprising that they lose their center. The result is burnout, an apt term for an energy drain. The energy of life, the spiritual core of every living thing, is greatly depleted under the stress and pressure of caring in this sick-care system. This is when the Spirit of Healing is needed most.

## A Centering Exercise

Settle back, adjust your body's position so your body feels very comfortable and relaxed, close your eyes, and imagine how easily you can direct your breath to deepen.

As you begin to sense the flowing rhythm of your deepening breath, count to yourself ten full, deep breaths, feeling more and more relaxed with every breath you take.

Observe your sensations after you have finished counting. Check in with your sense of your body and your mind.

Now imagine your breath is like a cascading waterfall flowing down and down, deep and deeper still, from the top of your head to the tips of your toes, filling up your body and your mind with life-giving air and oxygen more and more, with every breath you take.

Now focus on the endless, flowing rhythm of your exhaled breath, imagining how easily your exhaled breath sweeps up and removes any tension, stress and blockage that exists anywhere inside your being. Imagine how your body and mind seem lighter and lighter, clearer and clearer, until it seems you are just an endless part of the cascading waterfall of flowing energy that is your easy breath.

Now count five full, deep breaths. With every breath you take, say to yourself these words, "Let go . . . let go."

Observe your sensations throughout your body and mind as you let yourself just be with the endless, flowing, even rhythm of your light, cascading breath.

Now imagine you can ask your flowing breath to take you deeper still inside your being to your center. Imagine your breath knows exactly where your center is and will now effortlessly take you there. When this occurs, you are completely, wholly in your center.

Experience whatever happens now, letting yourself just be in your center, continuing to observe your sensations.

When you feel complete with this experience, imagine how easily you can direct your flowing breath to bring you so lightly and freely back and back, up and up, feeling very balanced, very clear, until at last you gradually return to full, waking consciousness.

When you are ready, open your eyes and reflect on your overall sensations for a few moments.

Feel free to spend some additional moments writing in a journal or drawing a picture of your experience, using whatever colors you wish.

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## Reclaim the power of nursing

It is time for nurses to reclaim their power as caregivers to heal themselves and support others. This view respects individual differences while offering a larger perspective. It is more than compromise or mediation. It is about solving the problem at the root level. The Spirit of Healing enters into the essence of the “wound” to resolve it with exquisite grace, using the concepts of balance and wholeness. True healing involves going to the source of the problem and addressing all pertinent aspects of the situation that caused the wound to happen in the first place.

### “I need the strength to leave my husband.”

#### *A case study from Marjorie Baker Price*

Suzanne\* was 55 years old when she was referred to me. She wanted help in finding her inner sources of clarity and “the strength to leave my husband.” She was slender and attractive, neatly and casually dressed, exhibiting mild anxiety but alert and oriented. She made good eye contact but her responses were brief, hesitant, and at times evasive. My initial diagnostic impression was Adjustment Disorder with Mixed Emotional Features (anxiety and depression).

Suzanne worked as a psychiatric nurse and had a 34-year-old son from her first marriage, which had ended when her son was eight. She had married her current husband five years later.

Suzanne reported no health concerns and no prior history of psychiatric diagnoses or treatment. She described her current marriage as tumultuous, and said that she and her husband had been informally separated for one month. She reported being verbally abused by her husband since the beginning of their marriage. She repeatedly expressed fear of speaking out and said she “didn’t want to make waves.” She reported, however, that when her sister had died of cancer nine months before, “my façade began to crack.” She was afraid of leaving her husband, afraid of getting cancer like her sister, and afraid of hurting others.

Throughout the six-month round of sessions, Suzanne hid much about her personal life. She would share her feelings only after I facilitated relaxation, imagery, and writing exercises designed to release anxiety and deepen insight. After several sessions, she was able to freely admit how hard it was to express herself without self-blame and censure. She continued to keep a journal between sessions, easily incorporating the writing exercises I recommended. Each exercise began with an open-ended question that opened her up to greater emotional expression.

Through these practices, Suzanne was able to face her deepest fears and openly grieve her sister’s death. Her behavior toward her husband became increasingly assertive. She eventually sought legal advice to begin a formal separation process. As she continued these practices, she described a greater sense of ease, confidence, and clarity, saying, “since I’ve come here, I’ve found my voice.”

I always felt physically uneasy when I was with Suzanne, with much heaviness in my chest. I was empathically receiving disturbing sensations related to the “dis-ease” patterning of her energy. I finally asked her if she had seen a doctor. She immediately became very defensive, which ended further discussion. I telepathically transmitted Reiki to her, especially to her head and chest, energetically supporting her willingness to open her mind and heart to deeper listening.

As weeks went by, Suzanne reported more assertive responses to her husband and more willingness to accept support and help from others. She said she felt ready to begin a new life, and we agreed to gradually stop the sessions with the understanding she would continue relaxation, imagery, and journal-keeping on her own while “checking in” as needed.

Healing is a mysterious, spiritually driven process that can occur only when individuals are fully aware of and able to accept their existence in the unfolding present in the face of their own deaths. This is paradox in which individuals, nurses included, can intuitively find a correct inner balance, a place of ease that transcends any current “dis-ease.”

The power of “give and take,” giving service and being served, is activated by an invisible and universal healing source that does not judge, but acts in the best interest of all concerned. This balance and restoration of wholeness is accomplished effortlessly and in a manner that could not be achieved by the individual alone.

About a year later, I heard from Suzanne again. She wanted Reiki treatments once a week in very concentrated half-hour sessions as a complement to her treatment for lung and brain cancer. She had just been diagnosed and had been told she had weeks to live. She received chemotherapy and radiation treatments along with the weekly Reiki sessions.

These sessions were very different from our previous meetings. For weeks, Suzanne did not talk. She came in, lay down for her treatment, closed her eyes, and said, “I’m here to forget everything – just relax. I believe in this. I trust you.” I put on music she liked and let myself be guided to place my hands where they felt most strongly pulled to go – on her head and her chest. Those were the exact places to which I had transmitted energy telepathically during our initial six months together.

I repeatedly drew all six Reiki signs on these areas and over her entire body. I worked with her energetic field, sensing her thought patterns of grief and shock with my hands and my mind. I channeled energy, lightly touching her body, her larger energetic aura, and her *chakras*, or energy centers. I telepathically supported the “okayness” for her to let go, however her spirit wished.

After about five sessions, she began to talk. She spoke of being reunited with her husband and being able to communicate freely with him and receive his care and help. She spoke of receiving support from friends and family, and how she felt she was “just beginning to live.”

As our sessions continued, Suzanne felt better and became stronger. She reported reversals in her CT scans, indicating the cancer had not only been arrested, but was receding. Our sessions once again included deep imagery and discussion.

Then her husband was diagnosed with terminal cancer. As his health deteriorated, the old patterns of verbal abuse returned. Suzanne resumed her role as caretaker and she herself became more sick, more closed, more hopeless.

When Suzanne’s husband died, her health suddenly improved once again. Our sessions continued fairly regularly, with the same combination of treatments. One winter, she went south “to the warmth and the ocean and the sun.” She looked so happy, at ease and free.

I received word soon after that she had died. An upper respiratory infection had quickly turned into pneumonia. She was hospitalized, and in less than a week had died due to complications. Her brother later wrote me that through the work we had done, she had “not only received healing, which probably extended her life, but peace.”

In this complicated case, the experience of healing may have extended the client’s life months beyond medical predictions. It certainly enhanced her quality of life by integrating greater awareness, empowerment, and acceptance through a time of great challenge and stress.

\*Not the client’s real name

## The nurse-patient bond

Mateo's experience (see sidebar) underscores the patient's need to be treated as an individual. It also suggests the special bond that is created between the nurse and patient following a therapeutic touch treatment. This bond occurs in an overwhelming majority of nurse-patient interactions. Quinn (1992) describes this as "sacred space" where the intentional use of expanded consciousness by the nurse generates a resonance with the patient and allows for a healing process to occur.

Nursing is an intricate blend of art and science, to which the nurse brings an intent to care for a patient. The nurse uses a sound knowledge base and a willing heart to enhance the health and well-being of another. The whole nurse meets the whole person in the context of family, community, neighborhood, and socioeconomic and political environment.

There is a contract between the nurse and patient that is based on mutual trust, respect, and consideration of needs. A nurse's caring makes a difference in a person's life, from birth to death; across all diseases, handicaps and settings; from high-tech interventions to the intimate art of listening.

The scope of nursing is constantly evolving. There is evidence that nurses are learning to nurture themselves and their profession in ways that honor the past and pave the way for the future. This integrated approach to caring and delivering service makes all the difference in healing.

We invite nurses to reintroduce spiritual principles into the practice of health and healthy living. We invite them to consider the balance of art and science within the principles of holism in their own personal and professional lives. In this meditative, reflective state, nurses can ask their inner selves what choices would enhance and evolve that balance.

The current "sick-care" system often treats individuals impersonally with a lack of compassion and common sense. In order for the next generation of nurses to experience the benefits of the collective knowledge of the past, this system must undergo a self-correction. The goal of nursing must be to revitalize the sick-care system into a balanced, integrated healthcare system. Such a system would incorporate the values of holism from a core of spiritually based practice for the benefit of the individual, the family, the community, the nation, and the earth.

### "I want to be treated with dignity"

*A case study from Martha Fortune*

Mateo\* was a 46-year-old Hispanic male with elephantiasis and lymphedema of both legs. His other diagnoses included chronic obstructive pulmonary disease, osteoarthritis, hypertension, depression, non-insulin-dependent diabetes, and morbid obesity. He weighed approximately 490 pounds. He suffered from multiple drug addictions fueled by his ongoing, intractable pain.

Mateo had been hospitalized for asthma and pneumonia and had received home care for cellulitis of the left lower leg. This appeared edematous on initial assessment, with erythematous, thickened, and indented skin. He was able to ambulate with a walker and transfer with minimal assistance, but required help with most of his ADLs. A home health aide cared for him daily and a physical therapist assisted him with increasing his strength, mobility, and chest physiotherapy. His chief complaint was the pain and burden of the excessive and edematous skin on both of his thighs, which made transfer, ambulation, and urination difficult.

I first saw Mateo in late September 2002 for treatment of his cellulitis. I also offered therapeutic touch, sensing his intractable pain and isolation as well as his willingness to try new procedures. He immediately expressed a desire to have the treatment and asked for it on nearly every weekly home visit, stating how much it helped relieve his pain and put him at peace.

Each TT session lasted for 5 to 15 minutes. The patient sat on his loveseat, with his legs elevated for comfort, his eyes gently closed. I centered myself, set my intention, and proceeded to clear and balance his energy field. My intention before, during, and after the therapeutic touch treatments was pain reduction, wound healing, and peace. The patient, his family members, the home health aide, and even the cat became quiet and still. The patient often fell asleep.

During the six months I cared for him, I involved Mateo's family in various wound care approaches that healed the cellulitis and completely eliminated the need for daily wound care. I noted a slight decrease in his use of pain medication and a greater willingness to discuss his deeper concerns. He became more focused in seeking relief from his symptoms and decided to pursue surgery despite his fear of the extensive procedures involved.

On a home visit by the hospital social worker, who has known the patient for some years, she asked him how he was getting along with the nurse. He told her that his nurse was a goddess, and that in all of his 46 years, he had never met anyone who was so humble and had treated him with such dignity.

*\*Not the client's real name*

## Therapeutic Touch

Therapeutic Touch (TT) emerged in the early 1970s as a technique that anyone could perform as long as the practitioner was centered, had the clear intention to help, and adopted an attitude of compassion (Krieger, 1987; Macrae, 1994). It appeared at the height of the use of high-technology treatments and may have emerged as a way to balance the high-tech world of medical care with a more hands-on, compassionate approach.

TT has been studied more than any other energetic healing method. Its language is used to describe and clarify other energy-based healing techniques. It is difficult to measure what is occurring in the process of therapeutic touch with existing technology, yet positive results are reported in the literature throughout some thirty years of data collection (Winstead-Fry & Kijek, 1999). In general, therapeutic touch research has demonstrated acceleration of wound healing (Daley, 1997; Wirth, 1995), decrease in anxiety (Turner, Clark, Gauthier, & Williams, 1998; Gagne & Toye, 1994; Heidt, 1981) and a decrease in the perception of pain (Hagemaster, 2000; Gordon, Merenstein, D'Amico, & Hudgen, 1998; Keller & Bzdek, 1986).

## I Am the Light

The following exercise is designed to help individuals find their inner spirit of healing using a combination of meditation and journal writing.

Close your eyes, settle back and let your breath settle to its most even, deepest rhythm. Imagine it washing over you like a cleansing waterfall, or as light. Count ten full, deep breaths.

With your eyes still closed, slowly stand, center yourself, and gently stretch, lifting your arms up, fingertips pointing toward the ceiling.

Focus your attention on your feet. Imagine you can draw the core energy of the earth up in to you at your deepest levels.

Now focus your attention on your raised hands, continuing to imagine how you draw the vast energy of the universe everywhere inside your being, as if you were a lightning rod.

When you're ready, sit back down, continuing to be aware of how these light-waves of energy encompass and shift you into your own sacred circle, with you at the center.

Now focus your attention on your heart. Place one or both hands over your heart. Ask your heart to offer you its gifts, its messages to you in this moment. Open your eyes, write the word "heart," and then write what your heart is saying. Then close your eyes.

Now focus your attention on your head. Place one hand on the top of your head and place the middle finger of the other hand over the point between your brows, pressing gently. Ask your head to offer you its gifts, its messages to you in this moment. Open your eyes, write the word "head," and then write what your head is saying. Then close your eyes again.

Now focus your attention on your feet. Reach down and place both your hands lightly on top of both feet, head hanging down. Ask your feet to offer you their gifts, their messages to you in this moment. Open your eyes, write the word "feet," and then write what your feet are saying.

Now read what you have written. Above the word "heart," write "love." Above the word "head," write "guide." Above the word "feet," write "direct."

Consider what you've written as your vision of the Spirit of Healing for yourself and others.

As an experiment, make a written commitment to carry out one element of this vision in your life and practice for one week and record what happens. Then consider further choices that your vision offers you for development and expression of your healing spirit.

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## The Bridge Between Worlds

*By Marjorie Baker Price*

We are the bridge between worlds  
Seeking in the gathering darkness  
To return home again.  
Both lost and found  
Spirit's connecting link  
Enfolds All in Her accepting embrace.

Desire opens the door  
(on what frequency?)  
Selves eagerly enter  
Listening in soft silence  
Finding their Will rekindled  
Whole again.

Our force is Creation  
Silken in its unfolding infinite essence  
Beckoning us to found all that allows us to trust and heal  
With open hearts and clear minds  
Playing with magic, as a young child holding a light wand

We have the power to begin again like newborn babes  
Sitting alert, smiling,  
All Buddhas in full presence  
Awakened again.

Holding a caring sacred circle,  
The Center through which all must eagerly cross  
Opposites, truly:

Love and fear,  
Peace and discord,  
Freedom and bondage,  
Willingness and refusal,  
Strength and weakness,  
Power and powerlessness . . .

All doorways to healing  
Through keen evolution –  
Rebuilding Spirit's power  
For Love once more to enter.

The makings of a new history and an ancient world  
Joined again  
The bridge waits, open.

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## BIBLIOGRAPHY: Alternative/Complementary Health

Warren Hawkes, MLS

During recent decades there has been a significant increase in consumer and health care professional interest in the area of complementary/alternative medicine. The level of interest justified the creation of a new government entity, the National Center for Complementary and Alternative Medicine (NCCAM) in 1998. Coupled with the increased interest, came an increase in the volume of literature in the field. Noted below are a variety of publications that provide an overview of both policy and clinical information in this evolving field.

Bowman, M. & Lawlis, G. F. (2001). *Complementary and alternative medicine management: Forms and guidelines*. Gaithersburg, MD: Aspen Publishers.

This loose-leaf publication is designed to provide the basics in establishing a complementary/alternative medicine program. It contains information on topics such as: initial strategic planning, marketing, staffing issues, reimbursement, documentation, and program evaluation.

Cohen, M. H. (1999). *Complementary & alternative medicine: Legal boundaries and regulatory perspectives*. Baltimore, MD: John Hopkins University Press.

This book, geared toward health care and related professionals, provides a scholarly discussion on the nature of regulating practice in the area of non-traditional health care and the trend towards consumer empowerment.

Collinge, W. & American Holistic Health Association. (1996). *The American Holistic Health Association guide to alternative medicine*. New York, NY: Warner Books.

Oriented toward a contemporary, consumer who may be unhappy with traditional medical approaches, this text is designed to provide the user with basic straightforward information on a variety of alternative medicine approaches.

Freeman, L. W. (2001). *Best practice in complementary and alternative medicine: An evidence-based approach*. Gaithersburg, MD: Aspen Publishers.

Designed as a text to provide an overview of many complementary/alternative approaches, information is provided on the background of specific therapies, evaluation and contraindications for use. The publisher provides annual updates to the volume.

Kohatsu, W. (2002). *Complementary and alternative medicine secrets*. Philadelphia, PA: Hanlet & Belfus.

Designed for use by the health care practitioner, this volume provides background on the historical development of the use of complementary/alternative health methods. It functions as a quick reference tool in a Q&A format by broad categories, such as body system or by sex.

Krapp, K. & Longe, J. L. (Eds.). (2000). *The Gale encyclopedia of alternative medicine*. Detroit, MI: Gale Group.

A four-volume compendium featuring over 700 unique entries, each with a different treatment or disease focus. It is written in lay language and heavily illustrated.

National Center for Complementary and Alternative Medicine. (2000). *Expanding horizons of healthcare: Five-year strategic plan, 2001-2005, NCCAM*. Bethesda, MD: U. S. Department of Health and Human Services.

Created in 1998 by Congress, the NCCAM created this strategic planning document to guide their work for the noted period. Details are provided on the changing health care environment, the nature and scope of alternative medicine and the government role in the process. Web site: [www.nccam.nih.gov](http://www.nccam.nih.gov).

*The New York Times guide to alternative health: A consumer reference*. (2003). New York, NY: Times Books and Henry Holt.

Produced by Jane Brody, noted *New York Times* health reporter, and other *Times* writers, this volume attempts to provide an unbiased review of the majority of common treatments. The writers have made a diligent effort to cite appropriate studies related to the credibility of many interventions.

Novoy, D. (2000). *Clinician's complete reference to complementary & alternative medicine*. St. Louis, MO: Mosby.

Not as exhaustive in coverage as other references in this area, however, this title does provide a comprehensive discussion of the major treatment approaches in this area. Details are provided on background, process, efficacy and contraindications.

Rees, A. (2001). *The complementary and alternative medicine information source book*. Westport, CT: Oryx Press.

This text is primarily a bibliographic tool designed to direct information seekers to credible sources of information related to complementary/alternative medicine. Information is provided on a wide range of sources such as books, journals, Internet sites, DVDs, etc.

Spencer, J. W. & Jacobs, J. J. (Eds.). (2003). *Complementary and alternative medicine: An evidence-based approach*. St. Louis, MO: Mosby.

The primary emphasis of this text is to provide clinical research to validate the use of complementary/alternative treatment modalities. It is well researched and documented.

Stedman, T. L. (2000). *Stedman's alternative medicine words*. Philadelphia, PA: Lippincott, Williams and Wilkins.

A dictionary/glossary of the words most commonly used/referenced in the complementary/alternative medicine field.

White House Commission on Complementary and Alternative Medicine Policy. (2002). *White House commission on complementary and alternative medicine policy: Final report*. Washington, DC: Author.

This final reports makes a list of ten recommendations that evolved out of a series of national "town-hall meetings". The recommendations are designed to guide the work the government and its newly created National Center for Complementary and Alternative Medicine, as well as the future direction of health policy in this area.

World Health Organization. (2001). *Legal status of traditional medicine and complementary/alternative medicine: A worldwide review*. Geneva, Switzerland.

This text provides a cross-cultural comparison on the use of traditional and alternative/complementary health care for over 100 countries worldwide. Detailed information is provided relative to regulation of specific practices and practitioners from a global perspective.

Yuan, C. & Bieber, E. J. (Eds.). (2003). *Textbook of complementary and alternative medicine*. Boca Raton, FL: Parthenon Publishing.

A thorough, well-referenced text providing in-depth information on the use of complementary/alternative modalities for use with a variety of disorders/diseases.

Warren Hawkes is director of the NYSNA library.

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