CHARACTERISTICS OF A HEALING ENVIRONMENT AS DESCRIBED BY EXPERT NURSES WHO PRACTICE WITHIN THE CONCEPTUAL FRAMEWORK OF ROGERS' SCIENCE OF UNITARY HUMAN BEINGS: A QUALITATIVE STUDY

by

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This work is dedicated to the memory of Cale Moore, my soul mate, and my parents – Eunice and Edward Waters. The pandimensional presence of these beautiful and powerful beings is a continuing source of comfort, strength, and inspiration to me.

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Studying nursing's role in creating healing environments has been a professionally and personally transforming experience. Interviews and dialogue with the extraordinary nurses who participated in this study have increased my passion for and commitment to my profession. My immersion in the data about the processes of healing has prompted an examination of my own life patterns and stimulated changes. What is clear is that these healing transitions occurred because a group of knowledgeable and caring nurses became a major influence in *my* environment and healing occurred. Though prohibited from identifying my subjects by name, I want to acknowledge them as a group of nurses who gave me a tremendous professional gift: *meaningful messages from their collective wisdom.*

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The purpose of this study was to identify and describe characteristics of a healing environment from a nursing perspective. This qualitative study was conducted using an interpretive descriptive method consistent with a naturalistic inquiry model. A purposeful sample of 9 expert nurses who practice within the conceptual framework of Rogers' Science of Unitary Human Beings was selected. Data were collected in phone interviews. Fourteen themes were inferred from the subject interviews, and were organized into three categories correspondent to three of the research questions; manifestations of healing, relationships and conditions characteristic of a healing environment, and nursing practices and processes identified as facilitative of healing. The investigator integrated the thematic findings from subject responses with conceptions inferred from the interviews as a whole to formulate an interpretive narrative description of seven characteristics of a healing environment: 1) the client defines focus and nature of his/her healing experience; 2) relational experiences are recognized and treated as central energetic influence in creating a healing environment; 3) nurses and nursing's unique professional role are understood, valued, and supported as a dimension of the health care organization's culture; 4) the nurse is recognized within the health care setting as the professional with the potential for the greatest impact in creating a healing environment; 5) nursing practice is theory based with a professional focus on designing client centered care that facilitates healing; 6) the organizational culture supports balancing individualization of healing experiences with standardization of best curative practices; 7) a healing philosophy is embedded in the professional culture and organizational core values. Conclusions were: a) confirmed congruence between themes and SUHB core concepts; b) relationship is the most powerful influence on healing process; c) nursing's role is central to creating a healing environment; d) theory based practice is essential to professional level care; and e) individualizing and partnering are as critical to healing as best practices and clinical standardization are to curing. The investigator recommended specific questions to research, education and practice leaders to address nursing's capacity to create healing environment and existing deterrents to reaching this potential.

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INTRODUCTION

Background and Significance

Though creating a healing environment is an oft quoted goal of nursing, there is no formal professional consensus on what constitutes a healing environment. In general, the professional literature on the subject is ambiguous and provides little direction for practice. This study is designed to determine the characteristics of a healing environment as described by expert nurses who practice within the nursing conceptual framework of Rogers' Science of Unitary Human Beings (SUHB). The purpose is to discover the elements required to create a healing environment from a nursing practice perspective.

The essential nature of environment to the healing process is firmly rooted in nursing's history, reflected in contemporary theories, and projected as a priority for future scholarship. Florence Nightingale's writings are replete with references to the importance of environment to healing. She differentiated the role of medicine and nursing on this basis, describing the physician's role as diagnosis and treatment of disease and the nurse's role as providing the external environment and fostering the internal environment necessary for healing (Nightingale [1860] 1969; Tschirch 1997). The industrialization of health care over the last 35 years has and continues to present challenges to nurses who seek to maintain their traditional professional role of creating environments that foster healing (Cowling and Taliaferro 2004; Gunther and Alligood 2002).

The importance of environment to the profession is reflected by its recognition as a defining concept in Nursing's metaparadigm, which is the underpinning of contemporary nursing theories. The four metaparadigm concepts (person, health, environment, and nursing) and the propositions that describe the relationships among these concepts define the domain of nursing and distinguish it from other disciplines. Nursing's metaparadigm is recognized as a key framework that "…represents a unique

perspective for inquiry and practice" (Fawcett 2000, p. 4). The relationship between patients/clients and their environments are recognized as a focus for inquiry. In reflecting on the future of nursing scholarship, Meleis (1997) states that knowledge development will be driven by clinical practice using methodologies "to reflect the holistic nature of patients' responses and their embeddedness in their environments" (p. 225). Despite these indicators that nursing considers environment central to healing, the literature reflects a diverse and ambiguous interpretation of these concepts. In addition, there is a dearth of research on the subject.

Kritek (1997) points out that healing is a term that evokes a sense of familiarity even though the range of meanings for the term is highly diverse. From a review of the literature, this investigator confirmed Kritek's observation. The terms healing and healing environment were rarely defined; however, the terms were commonly used as though their meanings were well understood. Of the 825 references identified in general nursing and health care literature as addressing "healing", 690 used the term in various ways to describe interventions for a particular problem (e.g. wound healing, infection management). The remaining 135 references used the term healing to describe broader applications or experiences but there was little trending information of use.

The literature specifically referencing the concept of healing environment was even more limited, providing less than two dozen research publications on the subject. One useful trend was identified in the literature: the Samueli Institute's commitment to developing protocols and conducting research into the integrative medicine concept of creating *Optimal Healing Environments*. A review of publications on this initiative, beginning in 2002, is included in the review of the literature. Though this *Optimal Healing Environment* trend shows promise for addressing a neglected area of research, the publications to date reflect a medical model orientation to the subject. The medical model approaches, which focus on diagnosis and treatment, used in structuring *Optimal Healing Environment* protocols have been of limited use in achieving the aims of this nursing study.

Literature reporting nursing applications of Rogers' SUHB provided information relevant to the focus of this study. Like Nightingale, Rogers envisioned the human-environment dynamic as central to nursing practice. According to Rogers (1994), "…The uniqueness of nursing lies in its focus on unitary, irreducible human beings and their environments" (p. 3). Rogers' model is grounded in the concept that human energy fields are irreducible wholes that are integral with their environmental energy fields, which also are irreducible wholes. Human-environment energy fields are in mutual process. Research based on Rogers' SUHB has been conducted on various aspects of the mutual process of the human-environmental field, nursing modalities to facilitate changes in human-environmental fields, and pattern manifestations indicative of healing. SUHB research was found to be both useful and germane in achieving the aims of this study and was used in designing study questions, interview tools, and interpreting results.

This study is expected to contribute to nursing's body of knowledge through a disciplined analysis of descriptions of how a healing environment is created provided by a specific sample of expert nurses who practice within the context of a common nursing model, Rogers' SUHB. Though there are numerous publications referencing varied aspects of healing and healing environments, this investigator could find no studies that provide nursing practice-based research on the characteristics of a healing environment. This study can thus provide insight into and an initial perspective on the meaning and characteristics of a healing environment from a practice point of view.

Purpose

The purpose of this study is to identify and describe characteristics of a healing environment from a nursing perspective. The intent is to provide a coherent description of relationships, conditions, and practices that foster a healing environment. To achieve this purpose, a qualitative inquiry was conducted to answer the following questions.

Main Question:

What are the characteristics of a healing environment as described by expert nurses who practice within the conceptual framework of Rogers' SUHB?

Related Questions:

What changes in clients did the subjects describe as manifestations of healing?

What conditions and relationships did subjects report as characteristic of healing environments?

What nursing practices and processes did subjects report as facilitative of client healing?

For purposes of this study, the following conceptual definitions will be used.

Healing is an endogenous, natural process that facilitates a person, family or community experiencing innate wholeness. The expansion of consciousness is key to the healing process and this consciousness is the process through which healing is extended from the individual to the web of energy field connections.

A healing environment provides the conditions and relationships to support individual, family, and community healing. Conditions refer to the attendant circumstances within which healing is expected to take place. Relationships refer to the nature of the connections between the patient/family and individual professionals, caregivers, groups, and the organization as a whole.

Theoretical Framework

Rogers' SUHB was selected as the theoretical framework for this study because Human-Environmental field dynamics are central to its practice applications and thus show congruence with the proposed inquiry. Practice relevant research has been conducted on homeodynamics, mutual process, appraisal and patterning, and voluntary mutual patterning of human and environmental fields. These terms refer to the principal components of Rogers' SUHB, and will be described in this introduction, below. A

review of theories derived from Rogers' SUHB, as well as relevant research based on this theoretical framework is included in the review of the literature.

The first step in understanding Rogers' Science of Unitary Human Beings is to comprehend the paradigm from which her theoretical model emerged. In 1970, when Rogers' first published her conceptual model, her ideas were considered revolutionary. Rogers' conceptual system was developed within the context of evolving knowledge in relativity theory and quantum physics as well as innovative philosophical perspectives regarding the implicate order of life and evolutionary nature of consciousness. Consistent with this new knowledge, Rogers described humans as energy fields that manifest a unique pattern. The environment was also described as an energy field that is integral to the human field.

Sarter (1988) conducted philosophical research on Rogers' conceptual model. She concluded that Rogers' view of reality, centered on energy fields characterized by unique and ever-changing patterns, was consistent with emerging physics and philosophical points of view. Rogers identified a number of scientists who influenced her during the development of her model. Among them were: Einstein (1961), Bohm (1980), and Capra (1982), as well as several others in the forefront of Relativity and Quantum Theory development. Sarter identified numerous similarities between Rogers' world view and philosopher Pierre Teilhard de Chardin and some Eastern philosophies. Rogers' view of reality emerged from a synchrony of physics and philosophy. Bohm's (1980) conception of an implicate order within the universe and Teilhard de Chardin's (1970) contention that the fundamental stuff of life possesses consciousness were both influences in Rogers' world view.

These views are consistent with Rogers' pandimensional view of the world as a unitary whole consisting of integral energy fields with a dimension of awareness. According to Sarter's (1988) analysis, Rogers' concept of pandimensionality appears to have been influenced by the concepts of relativity and quantum theories. Sarter also identified the concept of evolutionary idealism as being very similar to Rogers' world view. She defines evolutionary idealism as "the view that the fundamental substance of

the universe is consciousness or conscious energy, which is evolving in the direction of higher, more complex levels of knowledge, feeling and will" (p. 96.). In sum, Rogers' conceptual model is deeply rooted in a complex and sophisticated paradigm that is consistent with leading edge discoveries in science, physics and provocative philosophical perspectives. Rogers' SUHB reflects her vision for nursing in this emerging paradigm.

The SUHB conceptual framework reflects the four central concepts in the nursing metaparadigm. Table 1 provides conceptual descriptions for the SUHB theoretical framework; the concepts are listed along with their definitions .Within this framework, reality is viewed as a non-linear domain without spatial or temporal boundaries; it is a pandimensional unitary whole. Within this unitary whole, an energy field represents the fundamental unit of existence. The term energy reflects the dynamic nature and the term field reflects the unified nature of an energy field. All energy fields are dynamic, continuously moving, evolving, and infinite in nature. There are two field dimensions, the human field and the environmental field. Each of these fields is an irreducible, indivisible whole that is identified by pattern. Energy fields are open with free flow between the human and environmental fields.

The concept of homeodynamics refers to the change dynamics inherent in energy field processes. Rogers posited that human and environmental field processes are shaped by three principles of homeodynmaics: resonancy, helicy, and integrality. The principle of resonancy delineates the direction and flow of change in the energy field: a continuous flow from lower to higher frequency patterns. The principle of helicy reflects the nature of change: continuous, unpredictable, innovative and increasingly diverse field motion. The principle of integrality reflects the mutual process between the environmental and human energy fields. When caring for a client, the nurse is part of the client's environmental field. The nurse and the client relate through mutual process. As a highly influential part of the client's environmental field, the nurse is able to partner with the client in patterning his or her energy field to promote well-being.

Table 1: Rogers' Science of Unitary Human Beings (SUHB): Annotated Conceptual Definitions

Energy Field	**Energy Field** is the fundamental unit of existence-living and non-living. The term energy reflects the dynamic nature and the term field reflects the unified nature of an energy field, which is in continuous motion and infinitely connected to all other energy fields. **Human Field**: is identified by a unique pattern that manifests characteristic specific to the whole but which can not be predicted from knowledge of the parts. The human field is irreducible, indivisible, and pandimensional (Rogers 1990). **Environmental Field:** is identified by pattern and is integral with the human field. It is irreducible, indivisible, and pandimensional (Rogers 1990).
Pattern	The distinguishing characteristic of an energy field perceived as a single wave… each human field pattern is unique and is integral with its own unique environmental field pattern. Manifestations of field patterns are observable events in the real world. They are postulated to emerge out of the human – environmental field mutual process (Rogers 1992).
Openness	Energy fields are open, without boundaries to impede energy flow between human and environmental fields (Rogers 1970).
Pandimensionality	A view of reality that is a nonlinear domain without spatial or temporal attributions that best expresses the idea of a unitary whole (Rogers 1992).
Homeodynamics	Refers to change dynamics reflected in human and environmental field patterns. The three dimensions, also referred to as principles, reflect the direction (resonancy), nature (helicy) and the process (integrality) of human-environmental field change dynamics. These dimensions/principles are applicable to group as well as individual human-environmental fields. **Resonancy** delineates the direction of evolutionary change in energy field pattern. (It) is the continuous change from lower to higher frequency wave patterns in human and environmental field patterns (Rogers 1990). **Helicy** reflects the changes characteristic of the human- environmental fields: continuous, innovative, unpredictable and increasing diversity in patterns (Rogers 1990; Fawcett 2005a). **Integrality** reflects the nature of the relationship between the human and environmental fields which is a continuous mutual process (Rogers 1990; Fawcett 2005a).
Well Being	A term used to reflect the SUHB view of the nursing metaparadigm concept of health. Rogers did not consider health and illness dichotomous conditions (Fawcett 2005a). Rogers specified: the multiple events taking place along life's continuum denote the extent to which a person is achieving his [or her]…(Rogers 1970).
Nursing	A learned profession that encompasses two dimensions: Independent Science of Nursing and the Art of Nursing Practice (Fawcett 2005a). **Independent Science of Nursing**: an organized body of abstract knowledge specific to nursing based on scientific research and logical analysis (Rogers 1992 and 1994). **Art of Nursing Practice**: The creative application of nursing science for human betterment.(Rogers 1992).

Rogers emphasized nursing as a learned profession that encompasses a science and an art (1992). She posited that nurses use their science through creative applications to bring about the well-being of their clients. Pattern recognition and appreciation, mutual process, and voluntary mutual patterning are key processes (Cowling 1990; Barrett 1998). From a Rogerian perspective, individualization of care is essential to healing. Technical interventions associated with specific health problems are incorporated into the client's care, but do not define the nurse's practice. The client's care is based on pattern appraisal, mutually defined goals, and mutual patterning of the client's human-environmental field. Manifestations of pattern changes are observable events that can be appraised from information, observation, and intuition. In SUHB practice applications, the healing significance of these pattern manifestations are validated by clients. The centrality of human-environmental field dynamics in the application of SUHB makes this conceptual framework compatible with the intent and purpose of this study.

Following Chapters

Chapter 2 provides a review of nursing/health professions SUHB literature relative to healing environments. Chapter 3 describes the study design and methodology. Chapter 4 reports the study findings in answer to the research questions: themes inferred from interviews and characteristics of a healing environment described in an integrative interpretive narrative form. Chapter 5 provides this investigator conclusions and recommendations.

CHAPTER 2:

LITERATURE REVIEW

This review of literature includes two components: 1) research and selected publications identified through an examination of health professional literature specifically related to healing environments and 2) theoretical and research publications identified through a search of Science of Unitary Human Beings (SUHB) literature and selected for relevance to this study. The purpose of the review was to determine the general state of knowledge relative to healing environments and to identify salient findings from research on SUHB nursing applications in creating healing environments.

Healing Environment

The health professions literature reflects little consensus regarding what constitutes a healing environment. There is the dearth of credible research on the topic. A search of CINAHL and MEDLINE literature from 1982 through 2007 identified 137 publications related to the topic of healing environment. Of the 137 publications, 53 were focused on physiological healing topics such as wound healing. Of the 84 publications relevant to this study, only nine were reports of research studies. Through special search assistance, additional publications on studies related to specific aspects of a healing environment were identified. This investigator also included reports regarding a national dialogue and program of study on *Optimal Healing Environments* (OHE) that began in 2002. Leaders from the Samueli Institute, a non-profit organization committed to facilitating and studying healing, fostered this new program development. These reports include an overview of the concepts, literature reviews, evidence based protocols, and proposed research recommendations. Reviews of published research reports on healing environments as well as selected articles providing descriptions or exemplars of healing environments are included also.

Optimal Healing Environment

The *OHE* initiatives facilitated by the Samueli Institute have generated a notable number of publications in the alternative and complementary medicine literature during the past 5 years. The Institute's stated goal is to facilitate basic and clinical research in the science of healing. The following three symposia were sponsored and the presentations published: in 2003, Definitions and Standards in Healing Research; in 2004, Toward Optimal Healing Environments in Health Care; and, in 2005, Developing Healing Relationships. Published papers from these symposia have initiated the development of an organized body of information on the concept of OHE (Chez and Jonas, 2005).

In a 2007 presentation (August 9), Wayne B. Jonas, the President and CEO of the Samueli Institute, provided an overview of the OHE program. During his presentation, he reviewed the institute's definition of healing and OHE. He also described models used by the institute for developing an OHE. The definitions were as follows:

> Healing: The physical, mental and spiritual processes of recovery, repair and reintegration that increase order, coherence and holism in the individual group and environment. Healing may or may not result in cure.
>
> Optimal Healing Environment: A system and place comprised of people, behaviors, treatments and their psychological and physical parameters. Its purpose is to provide conditions that stimulate and support the inherent healing capacities of the participants, the relationships and their surroundings.

The Samueli model delineates three dimensions of OHE: the inner environment, interpersonal environment, and outer environment. There are seven goals related to these dimensions. The personal goals relative to the inner environment are developing healing intention and experiencing personal wholeness. The social goals of the interpersonal environment are cultivating healing relationships and creating healing organizations. The behavioral goals of the outer environment are practicing healthy lifestyles and applying cooperative medicine. The final goal of building healing spaces appears to bridge all

three dimensions and incorporates nature, color, light, art, architecture, aroma, and music. It is interesting to note that the dimensions of healing identified in the OHE model parallel subjects found in the general health care literature associated with healing environments: physical design, organizational conditions, interventions/supports to facilitate client healing experiences, and relational factors that influence healing.

A series of presentations from the 2004 symposium published in *The Journal of Alternative and Complementary Medicine* proposed OHE protocols or integrative medicine protocols for patients with specific problems and for particular patient populations, such as the elderly or patients facing end of life health care experiences. These OHE proposals have broad scope because they integrate curative as well as complementary health care practices. The proposed guidelines are structured as tools to facilitate OHE. Most of these OHE guidelines make recommendations for practice as well as providing direction for outcome evaluation and research on a particular patient population. OHE guidelines have been developed and published for the following health care problems: chronic cardiovascular disease (Marshall et al. 2004), trauma spectrum responses (Osuch and Engel 2004), substance abuse (Wesa and Culliton 2004), chronic low back pain (Cherkin and Sherman 2004), diabetes mellitus type II (Kligler 2004), and hypertension (Wesa and Grimm 2004). Though structured in a conventional medical format, these protocols provide a comprehensive and integrated approach to patient care that incorporates the creation of a healing environment.

Healing Spaces

Schweitzer et al. (2004) provide an evidence-based, broad scope view of the OHE concept of healing spaces. The authors address the impact of environment on behaviors, actions, and interactions. They contend that the design and functionality of space and organizational behavior have an impact on the client's intention and awareness, wholeness and energy, and healing relationships. In their view, personal space is an important variable in creating a healing environment. Single rooms are considered

preferable to facilitate better operations among staff, safe management of medication administration, and infection control. In addition, Press Ganey patient satisfaction scores indicate that family and clients are more comfortable in private rooms and report a higher degree of satisfaction (Kaldenberg 2004).

A recent evidence-based review identifies the sensory environment as another important factor in creating a healing space (Schweitzer et al. 2004). There is some evidence that pleasant aromas lower patient anxiety in specific settings and negative smells or odors have been observed to stimulate anxiety, fear, and stress (Redd 1994). Noise has been identified as a highly negative environmental characteristic. It increases patients' perception of pain and increases the use of pain medication, contributes to sleep deprivation, and causes confusion and disorientation among some patients. There is some evidence that noise may contribute to increased lengths of hospital stay (Grumet 1993). In particular, some research shows noise levels can influence patient outcomes (Yinnon et al. 1992). The EPA took a position more than 30 years ago that hospital noise levels should not exceed 45 decibels (dB) during the day and 35 dB at night. The International Noise Counsel has suggested a maximum of 45 dB for acute care facilities in the daytime, 40 dB in the evening and 20 dB at night. Studies have shown, however, that hospitals routinely exceed these parameters. Reports indicate that noise levels from 60 to 84 dB have been measured in intensive care units, and an average nighttime noise level of 67 dB has been reported in acute care and general medical units (Grumet 1993). A controlled study of healthy women in a sleep laboratory showed significant disruptions in sleep with noise levels similar to that in a CCU. There is less evidence on the effect of positive sounds (Topf et al. 1993).

Light is another important environmental variable, having both a physiological and psychological effect on patients. Schweitzer et al. (2004) reported extensive evidence on light's effect on human chronobiology. The two physiological phenomena reported most often relative to light variances are circadian rhythm disruption and seasonal affective disorders. Light naturally affects the circadian rhythm of the body's biofunctions by regulating melatonin production and influencing biochemical and

hormonal rhythms. Disruptions in these circadian rhythms can negatively affect sleep, mental focus, and work. Seasonal affective disorders are usually noted when there is a shorter span of daylight during the year. Seasonal affective disorders cause symptoms of irritability, fatigue, and depression. Evidence was sufficient to confirm that inadequate light exposure can have an impact on performance as measured by student test scores (Heschong 2003). Poorly designed or maintained indoor lighting systems have been documented to create vision problems, eye fatigue, headaches, and loss of concentration (Zilber 1993).

In an evidence-based review, Schweitzer et al. (2004) indicated that art and music also had a positive effect on patients' healing experiences. Research on art selection (Ulrich 1993, 1995, 1999) suggests that ambiguous, emotionally negative, or provocative art should be avoided and that art selected to promote healing should create a sense of calm and coherence. A considerable body of knowledge exists to support the healing effect of music. Music has been found to mitigate nausea and emesis in chemotherapy patients, decrease pre-operative anxiety in infants, improve physiological and behavior measures in premature infants in the intensive care unit, and reduce the stress of visitors to hospitals. Music used to facilitate patients' recovery from surgery decreased the need for analgesics (Aldridge 2004; Caine 1991; Dubois et al. 1997; Knight and Rickard 2001; Menegazzi et al. 1991; Moss 1988; Nilsson et al. 2001; Robertson 2000; Wang et al. 2002; Yilmaz et al. 2003).

Lorenz (2007) conducted an integrative review on research relative to patient rooms in acute care hospitals. The focal point of the integrative review was the extent to which these rooms had an influence on the promotion, maintenance, and restoration of healing and well-being for patients. Using a rigorous integrative review strategy, Lorenz selected 18 studies for review. She defined the concept of healing environment as follows. "Healing environment is a term that describes the physical and cultural surroundings that are designed to support patients and families through hospitalization, medical visits, healing, and bereavement." (p. 263). Nine studies related specific clinical outcomes to design characteristics in the environment. The most marked changes noted

were in length of stay, utilization of narcotics, and physiological and behavioral responses (Lorenz 2007).

Two studies of brightness in patients' rooms found that the patients with the brighter rooms had a decrease in length of stay (Beauchemin and Hays 1996). Studies evaluating patient response to noise in the critical care environment found a negative impact correlation between noise and heart rate response, an increase in heart rate in response to conversation in the room as compared with background noise, and that patients sleep better in private rooms in the ICU area (Baker 1993; Baker et al. 1993). Lorenz (2007) reported results of a study that evaluated the impact of the view from the patient's room on postoperative recovery. The findings indicated that patients who had a window view of trees had better recovery results on the following indicators than those patients with a view of the brick wall: decreased length of stay, fewer negative chart entry notes, and reduced need for pain medication.

Altimier (2004) describes the way light, color, noise management, and privacy were incorporated into the design of a new Neonatal Intensive Care Unit at Good Samaritan Hospital in Cincinnati. In addition to the physical design, nursing staff members were engaged in developing a family-centered culture of service. The physical design and cultural development created a healing environment that resulted in positive patient care outcomes and staff satisfaction. While all other factors remained constant, the change in environment was correlated with improved medical outcomes, decreased length of stay, decreased hospital costs, and increased family satisfaction. Measurable improvements were achieved in outcomes associated with two premature birth complications: intraventricular hemorrhage (bleeding into the brain due to immature blood vessels) and retinopathy (eye disorder that could lead to blindness). Over a two-year period, data reflected a 6% decrease in cases of stage 3 and 4 retinopathy and an 8% decrease in rates of grades 3 and 4 intraventricular hemorrhage. Cost saving estimates associated with the documented decreased length of stay was $13,114,000 per year. Anecdotal reports indicated improved family care-taking skills prior to the neonate's discharge that resulted in greater satisfaction for both family and staff. This case

description provides an excellent illustration of how empirical information can be applied effectively to make the changes that create a healing environment. These studies provide compelling evidence that environmental factors affect patient outcomes. The outcome measures used ranged from physiological parameters (heartbeat) to the cost savings correlated with reducing incidents of complications. Based on these findings, this example of a healing environment increased family and staff satisfaction and, at the same time, improved health outcomes.

A study conducted by Mroczek et al. (2005) confirms the idea that the physical environment is a key element in the improvement of the healing environment for staff, as well as patients. The authors examined the effects of the health care environment on staff satisfaction after a new facility was specifically built to enhance the healing environment. The study involved a survey of 700 employees. Respondents were most positive about the increased natural light in the new building, the music provided, and air flow. Homelike patient rooms were also rated as positive or very positive. The circular design of the building and the art work were rated less positively, but there were no ratings in the negative range. The study findings confirmed that health care staff valued the design features that enhanced healing experiences.

In summary, the evidence provided supports the contention that sensory factors as well as structural design influence the healing potential of patient care environments. The use of healing spaces, which incorporate nature, color, light, music, art, aroma, and design, is a core construct in creating healing environments.

Complementary Healing Modalities

The general nursing literature reported several studies of healing modalities as part of the creation of a healing environment. These modalities include relaxation techniques, comfort touch, music, movement, aromatherapy, and massage. Relaxation techniques studied were qigong, self-hypnosis or johrei, and mantra repetition. Hui et al. (2006) conducted a study that compared the physiological and psychosocial impact of

qigong and progressive relaxation techniques. Sixty-five subjects were assigned to one of two groups. One group was trained in qigong, and the other in progressive relaxation. The results indicated that the qigong group showed greater improvement in psychological factors and systolic blood pressure. Both groups improved on quality of life assessment. Laidlaw et al. (2005) compared relaxation responses among three groups, one assigned self-hypnosis, one johrei, and one served as a control group. Outcomes were evaluated using mood and quality of life tests prior to the training and again, three months or more afterward. The findings indicated that both relaxation methods enhanced the healing environment, raised energy levels, and decreased anxiety. Bormann et al. (2005) evaluated the efficacy of frequent mantra repetition on stress, quality of life, and spiritual well-being of 65 veterans over a five-week period. The subjects were given a pre- and post-test using a self-report questionnaire that measured stress, anxiety, anger, quality of life, and spiritual well-being. Mantra repetition as a relaxation exercise resulted in significant improvement in all variables measured.

Two studies conducted on comfort touch were reported: one on the institutionalized elderly and another on clients with cancer. Butts (2001) conducted a study on forty-five elderly female nursing home residents who were divided into three groups. The treatment group had five minutes of comfort touch (handshake, hand holding/touching, and shoulder touch) and conversation twice a week for four weeks. One control group had no treatment or intervention and the other control group had only verbal interactions. Data were collected at the beginning of the study, two weeks later, and two weeks after that, at the end of the study. Comfort touch improved perceptions of self-esteem, well- being, social processes, health status, life satisfaction, self-actualization, faith/belief, and self-responsibility. Weze et al. (2004) evaluated the healing experience of a gentle touch reported by 35 clients with cancer. The subjects had four 40-minute sessions of non-invasive touch on the head, chest, arms, legs, and feet within a six-week period. They were given a questionnaire before the first treatment and at the end of the study period. The most significant improvement showed reduced stress and increased relaxation. It also showed measurable increases in pain reduction.

However, the results did not indicate an improvement in feelings of panic, anger, disability, or immobility.

Sandel et al. (2005) conducted a dance and movement program designed to measure improvement in quality of life in breast cancer survivors. Thirty-five women completed the trial that included a 12-week intervention. The study design was a randomized controlled trial with a wait list control group allowed to cross over to active treatment in weeks 13 to 25 of the study. The Lebed method that focuses on healing through movement and dance was used as the dance program intervention. Three outcome measures were evaluated: breast cancer quality of life, shoulder range of motion, and body-image scale. All three measures showed improvement while the subjects were dancing and immediately after treatment. The same degree of improvement was seen in healthy women who completed the same dance program.

Hays (2006) studied the impact of music on the well-being of people 60 years old and older. The author used two focus groups to develop an in-depth interview. One group included five subjects from varied backgrounds who listened to music, but who did not play any musical instrument. The second group was composed of eight amateur musicians. Based on the information gleaned from the focus groups, interviews were conducted with 30 subjects, age 60 to 98. Fourteen had no music skills, 12 were amateur musicians, and 12 were professional musicians. According to the interviews, the subjects used music as therapy to relieve stress, endure pain, release their emotions, and as part of specific activities. The social aspects of music were important to all three groups. Hays found that music contributes to a sense of well being and helps people cope with illness and disability whether they are listeners or musicians.

Fellowes et al. (2007) conducted a meta analysis on the use of aromatherapy and massage for symptom relief in patients with cancer. The authors retrieved 1,322 references in an exhaustive and extensive literature search, but only ten articles both met the inclusion criteria and were randomized controlled trials. These 10 articles covered eight separate research studies and included 357 patients. The studies all showed the consistent benefit of reduced anxiety after massage. The authors reported that one study

indicated a reduction in depression, three indicated a reduction in pain, and two indicated a reduction in nausea. The benefits of the addition of aromatherapy were inconclusive.

In summary, all of these studies indicated that the use of complementary modalities contributes to the healing environment and facilitates healing experiences for patients. In clinical settings, nurses are frequent providers of the modalities described above. Nursing research on healing modalities applied by nurses specifically practicing within Science of Unitary Human Beings theoretical framework will be included in the second section of the literature review.

Spirituality as Environmental Influence

Six spirituality studies and one concept analysis were reviewed from the healing environment literature. Four studies and the concept analysis reported findings relative to spirituality in managing oncology patients, one study focused on prayer after stroke, and one study was about spirituality in the lives of domestic violence survivors.

Villagomeza (2005) conducted a concept analysis on spiritual distress in adult cancer patients. She noted that although generally unacknowledged, spiritual distress in cancer patients is widespread, and that only 28.9% of the nurses interviewed in another study indicated that they made a nursing diagnosis of spiritual distress .She also reports that nurses do not generally discuss spiritual matters with patients. The author provides cues for recognizing spiritual distress and provides case studies that illustrate varying degrees of distress. The author proposes that nurses enhance the healing environment by recognizing spiritual distress and taking action to address the problem.

Schneider and Mannell (2006) studied spirituality and faith as coping mechanisms for parents of children with cancer. This research examined the role of spirituality, both secular and religious. Subjects completed a background questionnaire and kept a time diary, as well as participated in an in-depth interview. Most felt that spirituality provided support and that faith and prayer were important. These researchers concluded that the

availability of faith resources could enhance the healing environment for some patients and their families.

Laubmeier et al. (2004) conducted a study on the role of spirituality in the psychological adjustment to cancer. The subjects appraised the level of life threat they were experiencing. These life threat appraisals, rather than cancer stagings, were used to categorize study responses. The findings indicated that the higher the degree of spirituality the client reported the less distress and better quality of life he/she reported– regardless of perceived life threat. Existential well being (meaning in life) was reported to be more important than religious well–being for this group.

Sherman et al. (2005) conducted a 2-year longitudinal study on patients diagnosed with advanced cancer or AIDS. These patients and their family care givers were assessed to measure their spiritual well being as a dimension of quality of life. Subjects were referred to the study by a primary care physician, oncologist, AIDS specialist, or advanced practiced nurse. Each patient in the study was followed monthly from diagnosis and referral until death. Each month the subjects completed a questionnaire that took about one hour. Based on study findings, the authors posited that the hospice philosophy of providing spiritual support as part of palliative care was validated. They also concluded that a healing environment for these terminally ill patients required a spiritual component structured to be responsive to the individual within the context of his/her disease process.

Kristeller et al. (2005) studied the impact of oncologists who assisted with spiritual interventions for their patients. In this study, patients were assessed prior to the visit, immediately after the visit, and three weeks later. Using measures of quality of life, spiritual well-being, communication skills, religiosity, and depression, 76% of the patients in the spiritual group found the talk with their oncologist somewhat useful or very useful. The physicians were comfortable having the spiritual conversation with 85% of the patients. The assessment at three weeks showed a decrease in depression and an increase in quality of life. Overall, the intervention was positive and patients felt a sense of caring on the part of the physicians. The majority of patients found the spiritual

intervention somewhat or very useful. The intervention also seemed to enhance patient/physician relations with this particular group of patients.

Gillum et al. (2006) conducted a study of 151 female domestic violence survivors to determine the importance of spirituality in their lives. The authors measured the degree of physical and psychological abuse, depression, quality of life, social support, self esteem, and spirituality. The study provided further evidence that spirituality has an effect on well being and enhances the healing environment. The research supports the notion that spirituality is a significant factor in client resilience and the ability to recover from traumatic life events.

Robinson-Smith (2002) studied the impact of prayer on subjects who had experienced a stroke. The qualitative study included eight subjects from varied religious orientations. Seven of these eight subjects reported prayer was a significant factor in their recovery.

The studies described above indicate that spiritual support can be an important component of a healing environment. Although one study indicated that nurses do not routinely discuss spiritual matters with patients, findings from other studies indicate that many patients are open and responsive to communications about spiritual matters. In fact, Gauthier (2002) found that a "return to spiritual roots" was identified by a sample of terminally ill clients as a facilitative pattern in creating a healing experience (p. 225).

Organizational and Relational Influences

Health care delivery in the United States is characteristically specialized, high tech, standardized and impersonal. Health costs are equivalent to14% of the nation's GNP and approximately 50% of worldwide health expenditures are in the United States. Yet, the United States ranks 26th worldwide on health care indicators and 54% of the United States population surveyed are dissatisfied (Lafferty 2004). The Institute of Medicine (IOM) has called for a major redesign of health care to achieve six aims: safe,

effective, patient centered, timely, efficient, and equitable health care. To achieve these aims, the IOM (2001) committee recommended implementation of 10 principles:

1. Care is based on continuous healing relationships
2. Care is customized according to patient needs and values
3. The patient is the source of control
4. Knowledge is shared and information flows freely.
5. Decision making is evidence-based
6. Safety is a system property.
7. Transparency is necessary.
8. Needs are anticipated.
9. Waste is continuously decreased.
10. Cooperation among clinicians is a priority.

These principles reflect a focus on developing organizational norms consistent with relationship based, patient centered care.

Other factors driving change in health care delivery are the shift in population demographics, health care needs, and growing recognition that patient engagement is essential to positive outcomes. The prevalence of chronic diseases is increasing due to extended life expectancy and an aging population base. Chez and Jonas (2005) point out that these changes in health care needs require a shift from acute care focus to an emphasis on "maintenance functions and relief of suffering" (p. S-3). Positive outcomes for the chronically ill require that the patient and family develop self-management skills in making day to day decisions (Wagner et al. 2005). This means the "healing landscape" is expanded to include a variety of places, people, experiences, and influences in the patient's life. "The concept of a healing landscape shifts the focus from healing in the encounter and/or practice to healing within each patient's life space."…"The healing landscape focuses our attention on the multiple relationships that participate in the emergence of healing" (Miller and Crabtree 2005, p. S-45). Within this landscape, the health care provider's effectiveness in communicating determines his/her influence on health outcomes. In a study of 500 patient-physician encounters, patients who indicated they received adequate communications about their symptoms and prognoses reported increased satisfaction with their experience, less worry, fewer unmet expectations, and

reported better outcomes relative to their symptoms two weeks after the encounter (Jackson et al. 2005)

Relationship Centered Care (RCC) is a concept consistent with the notion of a healing landscape. Beach et al. (2006) provides a clear summary of the concept:

> Relationship-centered care is health enhancing. It is founded upon, proceeds within, and is significantly influenced by the web of relationships that promote the well-being, and full functioning of patients. In RCC, the patient is often our central concern, but is not considered in isolation from all others. Instead, while the clinicians' first responsibility is to prevent and alleviate illness, we do this work mindful of the contributions of the family, our team, our organizations, and our community to what can be accomplished. Similarly, we must be mindful of the impact of what we do with patients on the well being of all others involved, including their integrity, functional capacity, resilience, and financial stability. Finally, we do this work in full knowledge that our own well-being and function need to be sustained if we are to continue to serve others vigorously (p. 57).

The RCC concept emerged from the work of the Pew-Fetzer Task Force on Advancing Psychosocial Health Education (1994) and since that time, RCC initiatives have been implemented in education, research, and clinical practice.

Four RCC models were selected for review. Two of the models provide matrices that describe patterns illustrative of various relationship states. Beach et al. (2006) describes characteristics associated with clinician-patient, clinician-clinician, and clinician-community relationships in the following realms: knowledge; approach, philosophy, and attitudes; behaviors; and outcomes. These descriptions clarify the nature of these various relationship dimensions. Malloch and Moore (2000) structured a matrix delineating the 5 stages for developing expertise in becoming a health care relationist. This matrix was based on Benner's novice to expert framework (1984). Manning-Walsh et al. (2004) developed a model that reflects 5 ascending levels of RCC focus and engagement: self focus – commitment to personal growth, respect and care for self; self-other focus- reflects commitment to shared relationship; reciprocal learning focus-engagement in equitable, alternating learning from each other; mutuality focus-developing synergy and co-creating within relationship; and transformed relational capacity-an enhanced ability to connect with others. This model reflects the expansion of

focus and engagement in relationships as it moves from one level to the next. Safran et al. (2006) describes the organizational dimensions of RCC and reports evidence linking the following outcomes with positive organizational culture and relationship patterns: improved patient outcomes, decreased length of stay, improved workforce morale and decreased turnover, and reduced mortality in settings with effective collaboration.

Caring characteristics can be identified by assessing individual and organizational patterns. Duffy. (2007) conducted a descriptive study of 557 adults from five acute care institutions to determine the independent factors relative to the concept of caring and how these factors explained variance in caring. This information was then used to evaluate the psychometric properties of the caring assessment tool. Eight independent factors were identified: mutual problem solving, attentive reassurance, human respect, encouraging manner, appreciation of unique meanings, healing environment, affiliation needs, and basic human needs. Healing environments defined in accordance with Watson's (source) theoretical framework of caring include "the mental, physical, socio-cultural, and spiritual elements in a setting" (p. 10). It is interesting to note that of all the variables, mutual problem solving explains the largest percentage of variance relative to caring behaviors. The authors described the mutual problem solving category as hospitalized adults appreciating nurses who helped them understand their health and illness. "Implicit in this factor is providing information, teaching and learning, as well as using best evidence." (p. 8)

Fenton (1987) developed and tested the Scale of Humanistic Behaviors based on Howard's Model (1975), to provide a framework for assessing environmental conditions within health care organizations. The model proposes three categories of conditions reflective of humanistic behaviors: ideological, structural, and emotional. Ideological conditions are the cognitive behaviors of recognizing inherent worth, irreplaceability, and the holistic nature of persons. Structural conditions reflect the interaction patterns of freedom of action, status equality, and shared decision making and responsibility. Emotional conditions are patterns of empathy and positive affect. Fenton (1997) reported, "Humanistic behaviors by nurses are most highly correlated with area of practice, type of

unit and collegial environments." (p. 34) Humanistic behaviors exhibited by staff and organization patterns provide the context for a healing environment.

Leadership is also cited as an important factor in creating the conditions for a healing environment (Belanger 1996; Kerfoot and Neumann 1992). Malloch (1997) studied the relationship between staff perceptions of a healing model application in the clinical setting and their job satisfaction. She found that nurses practicing within the context of a healing model were more satisfied and had a positive effect on organizational outcomes. Exemplars of two organizational models are described below: the Plain Tree Model and the Relationship Centered Care Model.

Komarek (2004) provides an exemplar of a Plain Tree Model that has been operational since 1989. This particular example is located in a long-term care facility and the author identifies the nine components that make up their Plain Tree environment: a supportive environment, physical involvement of family and friends, physical environment, respect for the individual, access to information, participation, choice, human environment, and autonomous decision-making. The Plain Tree Model is characterized by openness, especially open access to information so that patients and families can be participants in their care. Patients and their families also have access to library and Internet resources to become informed about health issues and options. Dr. Komarek credits the Plain Tree Model with the high level of patient satisfaction and employee satisfaction at this facility.

Taylor and Keighron (2004) describe how implementation of the relationship centered care model helped in their hospital's transition from a negative to a positive environment over a 15-year period. The culture and image now is one that is characterized as a healing environment. This organization case narrative discusses how they moved from a contentious organization that made negative headlines in the late 1980s and early 1990s to an organization with a focus on relationship-centered care and a healing environment. In the course of the transition, they developed a process for change and developed a healing environment model that addressed internal and external issues

requiring change. The authors describe the transition as moving from a fear-based culture to a nurturing culture.

.Relationships and organizational philosophy, norms and culture are major factors in creating a healing environment. The Fetzer-Pew Task Force on Relationship Centered Care and the Institute of Medicine recommendations to focus on healing relationships and patient centered care have ignited a national movement toward a greater degree of client sensitivity and engagement. Since Nightingale, nursing has defined its central role in creating a therapeutic relationship with the client/patient. A major nursing function is to integrate objective information into the context of the client's subjective experience to facilitate healing (Swanson et al. 2004). Research supports the positive effects of a healing environment on health outcomes. Relationships are recognized as central in creating a healing environment, and yet there are limited studies on healing relationships per se (Quinn et al. 2003).

Summary

This review of literature encompassed scholarly and research publications on healing environment from the general health professions literature. Though there are pockets of valuable information, the current conceptions and approaches to creating a healing environment reflect ambiguity and fragmentation of efforts. The limited studies published are focused on aspects of the environment rather than the whole of the environment. Therefore, there is not a substantive body of research on the healing environment. O'Malley (2005) points out that "the climate is harsh for studying healing environments. The current background and context of health care delivery is largely chaotic and dysfunctional" (p. S-19). He identified key barriers to research on healing environments: no established career paths for investigators, lack of funding sources, and insufficient data to quantify research need. The new (OHE) publications emerging in the integrative medicine literature offer a more coherent framework for facilitating research on what constitutes a healing environment. However, the OHE studies and protocols are

shaped by medical model assumptions (focuses on diagnosing and treating diseases/problems) and publications center on physician roles. The medical model orientation of the OHE initiative limits its relevance to other disciplines.

Healing Environment in the SUHB Literature

This section of the review of literature includes theories derived from and research conducted using the Science of Unitary Human Beings (SUHB) conceptual model that relate to creating a healing environment. From a search of CINAHL and MEDLINE databases, this investigator found 626 references published in the nursing literature between 1982 through 2007. Of those, 201 were research publications. Theories and research findings specific to elements of this study were selected for inclusion in this review. This section of the review is organized into a component on theories derived from SUHB and a component on relevant research studies. The research component is further divided into three parts: studies focused on the principles of homeodynamics, studies focused on mutual process, and studies focused on pattern and patterning.

Theories Derived from the Science of Unitary Human Beings Framework

Rogers' Science of Unitary Human Beings (SUHB) Conceptual Model has generated six grand theories, twelve middle-range theories, and numerous research studies and practice applications. Fawcett (2005a) describes and organizes the components of nursing knowledge into a hierarchy according to level of abstraction. A conceptual model is identified as the most abstract theoretical component of the nursing knowledge hierarchy and is defined as “a network of concepts that accounts for broad nursing phenomena” (King and Fawcett 1997, p. 93). Rogers Science of Unitary Human Beings (SUHB) is a conceptual model. Theories consist of concepts and propositions that

reveal relationships among the concepts; "…"theories vary in levels of abstraction…grand theories are more abstract than middle-range theories but less abstract than conceptual models" (Fawcett 2005a, p.1 31). Young et al. (2001) explain that a theory "describes the nature and workings of a model"…and provides guidelines for analyzing phenomena and interpreting research findings relevant to study phenomena (p. 11). Grand or general theories present a broad scope view of nursing and its phenomena; mid-range theories present a limited scope view relative to an aspect of nursing that focuses on selected phenomena. In her criteria for evaluating nursing theories, Fawcett (2005a) differentiates the methodologies for testing grand and middle range theories. Fawcett posits that qualitative, inductive methodology is an appropriate method for testing the philosophical claims and concepts expressed in grand theories. She also suggests that an important indicator of grand theory relevance is the extent to which it generates mid-range theories that can be applied to practice. Fawcett proposes that mid-range theories be tested through the use of instruments designed to measure empirical indicators of the concepts being studied. The following provides an overview of grand theories and mid-range theories derived from the Rogers Science of Unitary Human Beings Conceptual Model; research on both grand and mid-range SUHB theories has been conducted and reported in the literature.

Three of the six grand theories derived from the SUHB were developed by Rogers and the other three were developed by nurses who studied with Rogers. Fawcett (2005a) characterizes Rogers' grand theories as rudimentary derivatives of her conceptual model. Two of these theories relate to specific dynamics of change. The Theory of Accelerating Evolution proposes that evolutionary change is speeding up, increasing in diversity and proceeding towards higher wave frequency patterns that tend to create new norms (Rogers 1980, 1992). The Theory of Rhythmical Correlates of Change focuses on the integral rhythms of the human and environmental fields. This theory posits that "humans and their environmental fields evolve and change together" (Rogers 1992, p. 32). Rogers' Theory of Paranormal Phenomena explains extra-sensory and trans-personal experiences within the context of pandimensionality, which is characterized by absence of temporal

and spatial boundaries. Pandimensionality also is proposed as one of the operant concepts supporting the use of alternative modalities of healing, such as: Therapeutic Touch and imagery. These Rogerian theories are usually referenced and applied in association with the conceptual model of SUHB

The grand theories developed by Parse, Fitzpatrick, and Newman are all consistent with the unitary paradigm and assume or adopt several SUHB concepts (Fawcett 2005a). Parse's (1992) Theory of Human Becoming was derived from the SUHB model but also was heavily influenced by existential phenomenology. Her theory focuses on persons' lived experiences, their views on health, and proposes that people co-create their health experiences. Parse's theory has three central principles and nine assumptions. The principles' themes reflect the focus of the theory: 1) structuring meaning, 2) co-creating rhythmical patterns, and 3) transcendence. Parse and her students have developed research and practice tools to facilitate use of her theory. Fitzpatrick's (1988) Life Perspective Rhythm theory, derived from SUHB, posits that human development occurs within human-environmental fields and rhythms indicative of this development include consciousness, perceptual motion, and temporal patterns. Newman's Theory of Health as Expanding Consciousness is a grand theory derivative of SUHB. According to Newman (1994), the nurse client relationship is a partnership in the mutual process of expanding consciousness. In her theory Newman describes this relationship as a three-step process: 1) the meeting which typically occurs because the client needs help and is at a "choice point", 2) the nurse and client connecting through a shared state of consciousness, and 3) the nurse and client "moving apart" (p. 112). Frequently the nurse meets the client because the client is ill and needs nursing care. Newman (1990) views disease as a"… reflection of the pattern of energy exchange between man and environment "…and is an integrating factor that provides the tension necessary for developing consciousness (p. 168). From Newman's theoretical perspective, health challenges serve to move persons towards expanded levels of consciousness."

Fawcett (2005a) identifies twelve middle-range theories derived from SUHB. As indicated above, mid-range theories are derived from conceptual models or grand theories, focus on specific phenomena, and are empirically tested. Mid-range theories bridge the gap between grand theories and practice. The following lists SUHB mid-range theories that have been studied and published:

- Power as Knowing Participation in Change (Barrett 1986)
- Theory of Human Field Motion (Ference 1986)
- Theory of Sentience Evolution (Parker 1989)
- Theory of Creativity, Actualization, and Empathy (Alligood 1991)
- Theory of Self-Transcendence (Reed 1991, 1997)
- Theory of Kaleidoscoping and Life's Turbulence (Butcher 1993)
- Theory of Enfolding Health as Wholeness & Harmony (Carboni 1995)
- Theory of Healthiness (Leddy and Fawcett 1997)
- Theory of Perceived Dissonance (Bultemeier 1997)
- Theory of Aging (Alligood and McGuire 2000)
- Theory of Enlightenment (Hill and Hatchet 2001)
- Theory of the Art of Professional Nursing (Alligood 2002)

Empirical studies of SUHB middle-range theories relevant to creating a healing environment will be described in the following component.

Research Relevant to Principles of Homeodynamics

Homeodynamics, a core SUHB concept, refers to change dynamics exhibited within and by energy fields. The concept of homeodynamics has three associated principles: helicy refers to the nature of change which characteristically is continuous, innovative; unpredictable and increasing in diversity; integrality refers to the process of change which is continuous and mutual between human and environmental fields; and resonancy refers to the direction of change which is evolving with the frequency moving from lower to higher frequency wave patterns. In the SUHB conceptual model, these

principles are central to creating healing changes within the human-environmental fields. A substantive amount of research has been conducted to test and further delineate human-environmental field dynamics. A number of researchers developed mid-range theories on human-environmental fields based on the principles of homeodynamics. They developed instruments and empirical indicators to test their theories. Several of these studies provided useful information about the nature and dynamics of changes within the human-environmental fields. Research instruments have also been developed to measure changes and pattern manifestations associated with specific SUHB practice applications.

Fawcett and Alligood (2006) reviewed research instruments and clinical tools developed specifically to investigate and facilitate SUHB practices. They found that 13 SUHB research instruments were available. The instruments fall into the following design categories: 4 semantic differential scales, 2 visual analog scales, 5 Likert scales, and 1 structured interview tool. Five of the instruments are designed to elicit client perceptions and /or experiences of human environmental field dynamics: the Human Field Motion Test, the Perceived Field Motion Scale, the Index of Field Energy, the Person Environmental Participation Scale, and the Human Field Rhythm Scale. The Power as Knowing Participation in Change Tool (PKPCT) assesses a person's capacity to change through the use of semantic differential ratings of awareness, choice, freedom to act intentionally, and involvement in creating changes. This tool has been applied in a wide range of situations. Leddy's (1996) Healthiness Scale is a Likert Scale that measures the person's perceived purpose and power to achieve goals. The ratings include meaningfulness, ends, choice, challenge, confidence, control, capacity, capability to function, and connections. The Temporal Experiences Scale, which is also a Likert Scale, measures subjective experience of time awareness as an indicator of human-environmental process influences. McCanse's (1995) Readiness for Death Instrument is a visual analog scale that measures the physiological, psycho-social and spiritual aspect of healthy field patterns as death is developmentally approaching. The Human Field Image Metaphor Scale measures the individual's awareness of the infinite wholeness; in the clinical setting, this is usually observed as expanded awareness and a sense of connection

with self, others and a greater whole. The Diversity of Human Field Pattern Scale, which is a Likert rating, measures diversity of human field patterns or the degree of change in the evolution of human potential throughout the life process. Assessment of Dream Experience, through a Likert rating, measures dreaming as a beyond waking experience. The reviewers located one clinical tool which is relevant to this study. Carboni (1992) developed this interview tool to conduct a nurse-client mutual exploration of the healing human environmental field relationship. It measures the nurse and the client's experiences and expressions of changing configurations of energy field patterns of the healing human environmental field relationship. This investigator found the interview tool used in Carboni's study helpful in developing interview guide questions for this study.

In addition to the research tools, Fawcett and Alligood (2006) compiled and evaluated information on clinical tools designed to facilitate application of nursing practice and processes consistent with concepts in the SUHB. These tools are designed to guide nurses through the application of SUHB processes to assure that assessment, practice modalities and evaluation are conducted and documented in an appropriate manner. These clinical tools are categorized based on their client focus: individuals, families, or groups/communities. Two individual assessment tools are generic and three are designed for specific populations, i.e. post-partum mothers, older adults, clients with chronic pain. Two tools are designed for families and two for groups or communities. These clinical tools provide guidance for assessing selected individuals, families, and groups and can be used as a source of aggregate data in assessing trends.

Dykeman and Loukissa (1993) conducted an integrated review on early studies testing SUHB theory. Of the 20 studies reviewed, 12 focused on one of the principles of homeodynamics (resonancy-direction of change, integrality-process of change, or helicy-nature of change), 2 of the studies addressed a combination of 2 of these principles. Six of the studies were designed to test concepts from various SUHB theories. Only 3 of the 40 instruments used in these studies were specifically designed to measure SUHB concepts. The other 37 instruments had been designed to measure generic concepts

related to change or environmental processes. The outcomes revealed that hypotheses were completely supported for 5 studies, hypotheses partially supported for another 10, and hypotheses not supported for the remaining 5. Dykeman and Loukissa concluded that use of instruments not sensitive to or designed to measure SUHB constructs had been a factor in the study outcomes. Of the 3 studies conducted using tools designed specifically for SUHB research applications, hypotheses were fully supported in 2 of the studies and partially supported in the third. The authors raised questions about the impact of instrument design on study outcomes. The following briefly describes the 5 studies in which the hypotheses were fully supported and specifies the SUHB concepts used as theoretical base:

- Alligood based her study of the relationship of creativity, actualization, and empathy on the principle of helicy (1986);
- Cowling based his study of the relationship of mystical experience differentiation and creativity on the principle of helicy (1986);
- Ference based his study of the relationship of time experience, creativity traits, differentiation and human motion on the principle of resonancy (1986);
- Smith based her study on the relationship of perceived restfulness and varied auditory input on the principle of integrality (1986); and
- Barrett's study on the relationship between human field motion and power was supported and reflected the principle of helicy (1986).

The authors of this integrated review made the observation that their work reflects the importance of having research instruments designed to measure specific concepts being studied (Dykeman and Loukissa 1993). In describing criteria for evaluating mid-range theories, Fawcett (2005b) also points out the importance of having empirical indicators that are appropriate measures for the concepts being evaluated.

Barrett's (1986) mid-range Theory of Power as Knowing Participation in Change has been applied in a wide range of situations. As indicated earlier, this theory is based on the homeodynamic principle of helicy, which reflects the nature of change in human environmental fields. According to Barrett (1998), power is defined as "being aware of

what one is choosing to do, feeling free to do it, and doing it intentionally" (p. 9). Barrett developed a highly reliable tool that measures a person's capacity to knowingly participate in change. The tool is a semantic differential scale designed to rate the four "Power as Knowing Participation in Change" theory concepts: awareness, choices, freedom to act intentionally, and involvement in creating changes. The scale provides options for rating each concept within three contexts: myself, family, and occupation. The Power as Knowing Participation as Change Tool (PKPCT) is used both as a practice tool and a research instrument.

Barrett (1998) conducted an integrative review on studies using the PKPCT and reports that these studies show a positive correlation between power measured by the PKPCT and the following variables: "Human field motion"-reflective of changes in the energy field-" life satisfaction, purpose in life, well-being, self-transcendence, spirituality, perspective-taking, imagination, perceived health, and socio-economic status." Studies showed an inverse correlation between power as knowing participation in change and the following variables: "Personal distress, chronic pain, environmental factors, anxiety, previous crisis, injury severity, and hopelessness" (p. 14). Qualitative studies using the tool tended to focus on patient role and decision-making patterns. Studies conducted on nurse subjects showed a correlation between power and leadership effectiveness, imagination, and empathy.

PKPCT theory and rating scale are relevant to measuring healing environment characteristics because the measurement of this concept can facilitate determining the extent to which the client is likely to participate in the healing process. An assessment attained by using the tool can provide the information base needed to facilitate increased client engagement in the healing process. As indicated by the results reported in this integrative review, Power as Knowing Participation in Change has been an influential mid-range theory among SUHB practitioners and researchers. The PKPCT has been used to examine the nature (helicy) direction (resonancy) and process (integrality) of change in a variety of applied research studies (Caroselli and Barrett 1998). These study findings

support that client engagement in human-environmental field change processes is essential to healing.

Mutual Process

Mutual process is essential to creating a healing environment. Human environmental field changes that facilitate healing occur through mutual process, the dynamic reflective of the principle of integrality in the SUHB framework. Dr. Delores Krieger (1994) described this as the SUHB's most important contribution to nursing knowledge: "Without a doubt, the greatest gift the Rogerian framework gave to nursing was to clearly define the essence of concern in professional nursing practice – unitary human beings in mutual process with their environment." (p. 45) Dr. Kreiger pointed out the nurse's responsibility for being centered and staying focused on this process. "This would mandate that the nursing practitioner, as healer, be in a constant state of mindfulness about the dynamics of the ongoing mutual process" (p. 55). Davidson (2001) used the metaphor "fingerprints on copper" to describe nursing's role in the human-environment mutual process. She posits that changes made by the environment on copper are similar in process to the environmental influence of nurses on the human field.

The nature of the nurse-client relationship is fundamental to establishing a mutual process that facilitates healing. Relationships are the key to creating connections that lead to an awareness of wholeness. According to Quinn (1992), "When true healing occurs, relationship is re-established – relationship to and within self, to others, with one's purpose" (p. 26). Quinn coined the term "right relationships" to describe this connection within oneself and with meaningful others. This section of the review includes SUHB values and relational concepts that impact the mutual process of creating a healing experience.

Art of Nursing Theory

Relational patterns and values exhibited in practice behaviors are associated with the art of nursing. Alligood (2002) derived a theory of the art of nursing using

interpretive hermeneutic research techniques in examining Rogers' publications. Through this process, Alligood identified three values inherent in Rogers' writings which are foundational to the art of nursing practice: respect inherent in the relationship between the nurse and the client, responsibility for designing and implementing individualized client care services, and empathy as a "feeling attribute of the continuous person-environment process" (p. 58). Rhodes (1990) conducted a study of nursing art using a hermeneutic research technique comparing nursing values with Sparshott's characteristics of classical and expressive lines of art. Among the attributes of classical nursing arts were caring, presence, advocacy, empathy, imagination, and healing. Interpersonal expression, intuition and intentional use of one's self have been identified as attributes of expressive nursing art (Jenner 1997; Rhodes 1990) and these attributes are explicitly or implicitly found in SUHB or unitary paradigmatic research.

Empathy

In 1992, Alligood proposed two types of empathy: basic and trained. She described basic empathy as a natural feeling reflecting a trait and trained empathy as a learned role taking form associated with developing clinical or professional roles. Evans et al. (1998) studied the difference between basic and trained empathy and the sustainability of trained empathy. The investigators assessed a sample of 106 baccalaureate nursing students at the beginning, during, and at the end of their educational program. Study findings indicated that educational efforts to teach trained empathy did not result in the nurse acquiring an enduring capacity to apply empathy in the clinical setting. Basic empathy was proposed to have greater potential for developing therapeutic empathy. The researchers recommended that nurse educators build creatively on identified basic empathy levels of entry student nurses in designing learning experiences rather than relying solely on role specific educational strategies.

Peloquin's (1996) research on empathy suggests the basis for such a strategy. From the perspective of a Professor of Occupational Therapy, Peloquin describes parallels between art appreciation and expressions of empathy. Art is seen as a way of

eliciting emotional response and sensitizing the participant. Peloquin describes “three actions that works of art elicit from those who produce or appreciate them: a) a response, b) emotion, and c) connection. It can be argued that each of these actions resembles the actions of empathy.**”** (p. 656) In addition to these actions, Peloquin further identifies “three rules that may dispose a person toward empathy: reliance on body senses, use of metaphor, and occupation by virtual worlds” (p. 658). The actions and rules suggested by Peloquin offer a framework for a creative educational approach to developing empathy among students. This approach appears consistent with suggestions made by Evans et al. (1998) relative to building on natural feelings in developing therapeutic empathy.

Alligood and May (2000) proposed a theory of empathy specifically designed for nurses based on King’s concept of interacting systems. “this nursing theory of intrapersonal empathy proposes that empathy organizes perceptions; facilitates awareness of self and others; increases sensitivity; promotes shared respect, mutual goals, and social awareness; cultivates understanding of individuals within a historical and social context; and affects learning” (p. 245-246). Walker and Alligood (2001) compared the use of a “borrowed theory” of empathy, Kohut’s self psychology model, with this nursing theory of empathy to determine if there were significant differences in their applicability for nursing. Findings indicated that the nursing theory of empathy provided advantages to nursing practice. Within a nursing context, empathy can influence conceptualization of the nurse’s role and how she/he executes it.

Presence

Finfgeld-Connett (2006) used SUHB with other unitary theoretical models as a framework in the conduct of a meta-analysis of presence in nursing. Presence is a concept has been explicitly or implicitly incorporated into a number of nursing theories, including the SUHB. Finfgeld-Connett points out, however, that it is a concept that is not fully defined and is often confused with other concepts such as caring, empathy and therapeutic use of self. Their meta-analysis included 14 qualitative studies and 4

linguistic concept analyses. One of the outcomes of this study was a synthesized description of presence:

> Presence is an interpersonal process that is characterized by sensitivity, holism, intimacy, vulnerability and adaptation to unique circumstances. It consists of a process in which patients demonstrate a need for openness to presence. In turn, nurses must be willing to enact presence and practice within an environment that is conducive to it. Nurses must also possess personal and professional maturity and base their practice on moral principals of commitment and respect for individual differences. The process results in enhanced mental well being for nurses and patients, and improved physical well being for patients. In keeping with the nature of a process, the consequences of presence go on to influence future enactment. (p. 708)

Nursing "presence" has been broadly identified as a relational factor in creating an environment supportive of healing. Paterson and Zderad (1976) describe presence as "a mode of being available or open in a situation with the wholeness of one's unique individual being; a gift of self which can only be given freely, invoked or evoked" (p. 122). McKinnergin and Daubenmire (1994) differentiate three levels of presence: physical presence (being there), psychological presence (being with), and therapeutic presence (a whole person to whole person relationship between the nurse and patient). Quinn (1992) characterizes this type of presence as the nurse providing sacred space for the patient within the environmental field; a place where the patient can be loved (or cared for) during his/her vulnerability and through the change process.

Caring

Like presence, caring is a concept that is broadly referenced in nursing literature. Smith (1999) conducted a study to examine indicators of congruence between the literature on caring and SUHB. Through a systematic concept clarification process, Smith proposed a "synthesis of five constituent measures of caring within the SUHB: manifesting intentions, appreciating patterns, attuning to flow, experiencing the infinite, and inviting creative emergence" (p. 14). After this publication, dialogue regarding caring as a concept within the SUHB conceptual framework continued as evidenced in both published literature and dialog at meetings of SUHB scholars. In 2002, Watson and

Smith conducted a comparative analysis of Watson's Theory of Transpersonal Caring and SUHB. From this effort, they proposed an integration of intersecting concepts into four unifying statements supportive of a trans-theoretical perspective of transpersonal caring within a SUHB frame. The following trans-theoretical tenets are proposed (Watson and Smith 2002):

- The intention of transpersonal caring expands in open, resonating, concentric circles from self to other to Planet Earth to universe. It includes caring consciousness, and participating knowingly in human-environment energy field patterning;
- The nurse's authentic presence, consciousness and intention in a caring moment manifests caring field patterning;
- The nurse's presence and caring consciousness potentiate change in the field, by co-creating human-environment patterning from lower frequencies to higher frequencies (i.e. caring consciousness carries higher energy frequencies than noncaring consciousness);
- Transpersonal caring resides within a field of caring consciousness and energy that transcends time, space, physicality, and is one with the universal field of consciousness (spirit) – the infinite (p 458).

The integration of these theoretical perspectives was offered as providing significant opportunities for research and practice applications.

Intentionality

Zahourek (2005) developed a grounded theory on intentionality and healing which she posits is consistent with Rogerian theoretical concepts and is firmly rooted in the unitary world view. Her findings described the evolutionary development of healing intentionality within the nurse-client mutual process of patterning a healing modality. Zahourek's conception of intentionality differs from the causal notion of intent as a focused awareness to achieve a specific outcome. The predominant attribute of Zahourek's theory is the development of three forms of intentionality that compose the matrix of healing which reflects three phases of capacity development:1) generic intentionality which is characterized by a drive for relief, 2) healing intentionality is the "goal directed" phase focused on repair; and 3) transformative intentionality which evolves from self development and creates shifts to "experience of wholeness,

connections and meaning in the universe" (Zahourek 2005, p. 107). The assumption is that the more developed the nurse's capacity of intentionality, the more she/he is able to support the healing evolution of the client.

Nurse-Client Healing Relationship

Carboni's (1995) practice theory, Enfolding Health as Wholeness and Harmony, is relevant to this research study because it explores healing as a characteristic of the nurse client relationship and as a goal in patterning the human environmental field. Carboni's practice theory introduces several new concepts derivative of the SUHB and reflective of Bohm's (1980) conception of an implicate order. (underlying unity and wholeness) and explicate order (observable discrete objects, events, etc.). Carboni describes the nurse- client mutual process focused on the evolutionary movement of energy within the client's human environmental field. This field shift moves from a "fragmenting place" in which the client experiences field fragmentation and disharmony to a "healing place" in which the client experiences wholeness and harmony. The movement from fragmentation to wholeness is accomplished through homeodynamic principles operant in facilitating the shift in the human environmental field pattern. Carboni developed an instrument to measure unitary constructs associated with the implementation of her theory. This instrument is a semi-structured interview tool designed to explore the nurse client healing relationship. The tool has two major components:

1) An experience component in which the client and the nurse are asked to describe their experiences and
2) An expression component which is designed for the nurse and client to search together for a metaphor that represents their relationship.

There are a number of cues and variables that facilitate the description of experiences and the selection of expressions that are mutually reflective.

In addition to her practice theory and structured interview tool, Carboni developed a process of inquiry design that is consistent with the philosophy of Science of Unitary

Human Beings. As indicated earlier, this practice theory and instrument were useful sources in developing the design of this study and interpreting the findings. Carboni's study involved obtaining descriptions from a nurse and client who shared a healing experience. This study was designed to acquire descriptions from expert nurses that represented a pattern of healing experiences. Though there were clear differences in the studies, Carboni's approach assisted this investigator in developing interview questions for the nurses that elicited rich descriptions of client manifestations.

Spirituality and Healing

Walton (1996) proposed that all relationships, especially the nurse-client relationship, have the potential to include a spiritual dimension. Nurses are present when clients and their families face illness, death, suffering and the opportunity to heal; these are inherently spiritual and/or transformational experiences. From her concept analysis on spiritual relationships, Walton synthesized a definition: "a spiritual relationship may be a relationship to self, others, a higher power, or nature in which one behaves humanistically, has a sense of responsibility and personal identity, and describes the relationship as producing intimacy, wholeness, and wellness" (p. 242). Spiritual relationships, as described by Walton, facilitate healing through mutual process.

Several Rogerian scholars (Malinski 1991; Smith 1994; Hills and Hanchett 2001) have linked spirituality to the principles of hemodynamics (particularly integrality) and the concept of pandimensionality. Malinski (1994)describes the flow of these processes and manifestations: "Pandimensional awareness of the mutual human/environmental field process (integrality) is a manifestation of higher frequency patterning(resonancy) associated with innovative, increasingly creative and diverse(helicy) experiences of what is called spirituality"(p. 17). Based on her research, Smith (1994) described the manifestation of spirituality as "interconnectedness with all life including a transcendent dimension" (p. 41). As a major influence on the human-environmental mutual field process, the nurse has the opportunity to foster spiritual experiences as well as recognize spiritual manifestations of the healing process.

The SUHB research reviewed in this section reflect the key role of mutual process in influencing human-environmental field dynamics. In order to create an effective mutual process, the nurse and client must connect. These studies reflect processes involved in developing a therapeutic nurse-client relationship and the significant influence the nurse-client relationship has on creating a healing environment.

Patterns and Patterning

Pattern appraisal and deliberative mutual patterning are central to practice within a SUHB framework. Alligood and Fawcett (2004) conducted a hermeneutic interpretive study on Rogers' conception of pattern and patterning. Rogers (1990) defined pattern as the "distinguishing characteristic of an energy field perceived as a single wave". Alligood and Fawcett found that patterning was a term used to refer to visible manifestations of patterns. From their research, they defined patterning as "the dynamic or active process of the life of the human being. Manifestations of patterning are visible or otherwise accessible to the senses." (p. 11) A complete review of the SUHB literature on patterning is beyond the scope of this study. Studies selected for this review reflect the impact of pattern and patterning on creating a healing environment.

Fawcett (2005a) described the SUHB practice methodology based on the works of several Rogerian scholars: E. A. M. Barrett, M. Bogulawski, H. K. Butcher, W. R. Cowling, III. This methodology describes the Rogerian approach to assessment, selection and application of practice modalities and evaluation. Pattern manifestation knowing (assessment phase) focuses on appraising human and environmental field patterns, interpreting their meaning and significance, and setting mutual goals. Voluntary mutual patterning (intervention phase) reflects the nurse and client's response to the pattern appraisal. The nurse and client partner to determine action required. The nurse integrates individualized and creative nursing modalities to facilitate healing while incorporating technical care associated with resolving health problems. The evaluation phase of care involves re-appraisal using pattern manifestation knowing and appreciation approach. During this phase the nurse and client mutually determine progress towards goal

achievement and choices relative to additional patterning. Several Rogerian scholars have developed practice inquiry and research processes specifically designed to study patterns and patterning. Cowling's (2001, 2004) appreciative inquiry process is an example.

Nurses practicing within a Rogerian framework have pioneered practice theories and modalities that facilitate pattern changes and healing experiences. In some instances, practice modalities have been adapted to make them congruent with SUHB conceptual framework. These modalities may involve the use of one or more of the following: subtle energy techniques, motion, sound, light, color, humor, relaxation, nutrition, affirmation, art and nature, bibliotherapy or journaling. Eight studies have been included in this review to illustrate how these types of modalities can be used by the nurse and client in voluntarily patterning the human-environmental fields. Pattern manifestations indicating the nature and extent of the changes also are described.

Therapeutic Touch (TT) is an example of a well known SUHB practice modality.. Kreiger (1993) developed TT, a mutual process subtle energy modality that facilitates healing changes in field patterns. TT has been researched and demonstrated in a variety of settings throughout the world; numerous publications are available describing studies focused on various populations and problems. The following study was selected for inclusion in this review because it is a good example of the TT patterning process and documents pattern manifestations indicative of changes. Garrard (1995) conducted a study on subjects who were HIV positive to determine the effectiveness of TT in re-patterning their immune and coping responses. Garrard selected CD4 (T-helper lymphocytes) count levels to assess the subjects' immune system status. .He selected the Coping Resource Inventory for Stress (CRIS) to assess subjects' coping responses. Statistical analysis revealed a significant improvement in the subjects' CD4 counts as well as an improvement in the subjects' coping skills as a result of TT therapy.

Barrett (2003) describes imagery as "the universal language of the mind that uses the imagination to think in pictures, sounds, smells, or touch sensations."…Then describing the modality within SUHB frame of reference, she further states.

> Imagery exercises transport us from the domain of logical, causal, conceptualization to the analogical, acausal realm of pandimensional

> spacetimemotion (sic)where they facilitate the seeing and doing of possibilities. The motion is not physical; rather, it is unitary human field motion, which I define as perceptual experience of the continuously moving position and flow of the human field pattern. Light, color, sound and motion can arise spontaneously in imagery or can be introduced in exercises designed for use in healing (p. 1).

Two studies on imagery are included to illustrate the impact of nurse-client voluntary patterning using guided imagery. Lewandowski (2004) conducted a study to determine the influence of guided imagery on the patterning of pain and power in clients with chronic pain. The findings showed that guided imagery was effective in reducing chronic pain, but did not have a statistically significant impact on increasing their sense of power. Thompson and Coppens (1994) conducted a study to determine if guided imagery would alter the patterns of clients undergoing magnetic resonance imaging. The focus was on identifying pattern manifestations of anxiety levels and movement. Based on the subject reports and operator reports, the experimental group had less movement during the MRI testing activity, and they demonstrated a lower level of state anxiety than the control group.

Bray (1989) investigated the relationship among creativity, time experience, and mystical experience as pattern manifestations. The study was conducted on 193 college students. The findings did not support the hypothesized relationship between creativity and mystical experience or between creativity and timelessness for the subjects group as a whole. However, significant correlations were found between mystical experience and both timelessness and creativity for participants who practiced meditation techniques, prayer or relaxation. The differences in pattern manifestations appeared to be associated with the subjects' engagement in meditative type experiences.

Yarcheski et al. (2004) conducted a study to examine the relationship of perceived field motion and human field rhythms to perceived health status, health conception and well being in early adolescents to determine which health related variables are most compatible with the SUHB. The sample was 142 early adolescents who used the study instruments in their classrooms. The findings in this study indicated a statistically significant correlation between perceived health status and conception of well being and

human field motion. The notion that pattern manifestation can be observed, measured and used as an inference for the client's status was suggested by study findings.

Krause (1991) investigated the impact of a specifically designed nursing intervention tailored for a pulmonary rehabilitation education program on the field patterning of a group of individuals with dyspnea. Clients who were exposed to the education program did not show any increase in their power profile. However, they did show a positive pattern change in the level of dyspnea. A pattern emerged permitting identification of three progressive check stages during the course of the study: awareness, acceptance and adjustment. Additional variables identified as part of the pattern manifestation were hope, trust, courage, openness, patience, honesty as well as relevant knowledge and skills. The researcher reported findings indicating support for the SUHB principles of integrality, helicy, and resonancy.

Wall (2000) investigated the affects of a pre-operative exercise program on changes in pattern manifestations of hope and power among 104 lung cancer patients. There was a control group and an experimental group. The group that exercised demonstrated an increase in their sense of power, while the no exercise group demonstrated a decrease in their sense of power. However, there were no differences identified in the patterns of hope.

Camp et al. (2002) examined the affects of therapeutic massage on perceptions of pain, sleep quality, symptom distress and anxiety, and patients hospitalized with cancer. The study was designed as a comparison between a group of patients who received massage and a similar control group who received only interactions with the nurse. The findings indicated that pattern manifestations relative to pain, sleep quality, symptom distress and anxieties showed improvement for the subjects who received therapeutic massage, and only anxiety improved for the patients in the control group. The findings support the use of massage with patients who are receiving chemotherapy or radiation therapy.

Patterning "involves the mutual participation of client and nurse in a caring partnership" in using non-invasive healing modalities to facilitate positive change in the

client's human-environmental field. (Malinski 1997, p. 115). Healing modalities include, but are not limited to, Therapeutic Touch, imagery, meditation, affirmations, story-telling, dream interpretation, healing rituals, and movement (Madrid and Barrett 1994). As indicated by the finding above, these modalities provide observable, measurable changes in the client's conditions. Nurses frequently employ these modalities in response to client's symptoms, conditions, or interests. Using SUHB framework, Hanley and Fenton (2007) describe nursing improvisation of care employing such modalities to bring comfort and create healing experiences.

Summary

The SUHB literature reflects the centrality of nursing in creating a healing environment and the conceptual model appears to provide a coherent framework for research and practice. Research on human-environmental fields, nurse-client mutual process, and human-environmental field patterning are specific in delineating the nurse's role in creating a healing environment. The distinction between healing and curing is reflected in research and clinical application reports. Based on the literature review, it appears the SUHB conceptual model is frequently used as a theoretical framework for research. Though there are numerous reports of individual SUHB practice application projects, there is less evidence of broad based applications in clinical settings. More frequently, the investigator found that aspects of the SUHB conceptual framework were integrated into practice models or used in outcome evaluations of healing modalities.

Literature Review: Relevance to the Study

Research found in the general health professions literature was limited to studies of aspects of the environment and did not address influences reflective of the environment as a whole. The research on physical influences was discrete from research on relational influences which was discrete from specific intervention influences. However, organizational models cited in the literature incorporated several of these aspects of a healing environment (e.g. physical and relational). Evaluations demonstrated that these healing environment models improved selected client outcomes as well as client and staff satisfaction. This investigator found the research applications of environmental influences in these models useful in developing context for experiences described by study participants. The Optimal Healing Environment (OHE) publications offer a more coherent framework for studying healing environments and facilitating clinical applications. The OHE literature informed this study by providing an integrative medical model lens on the concept of a healing environment. Based on the view through this lens, this investigator considered the potential OHE influence on creating norms for healing environment models and the impact that could have on nursing roles.

The SUHB literature emphasized nursing's role in creating a healing environment and provided research supporting the theoretical constructs relative to human-environmental field processes. Research on mutual process and patterning provided baseline information for developing inferences and interpreting interview data about subjects' experiences in developing relationships (mutual process), engaging client's in patterning, and in describing manifestations of healing. Research on the principles of homeodynamics was useful in linking this study's findings with SUHB theoretical concepts. This investigator discovered notable congruence between research findings reported in the literature and findings from this study.

CHAPTER 3:

METHODOLOGY

Research Design

This study was conducted using a qualitative descriptive method (Parse 2001) with an interpretive approach as delineated by Thorne et al. 1997) and consistent with the naturalistic inquiry model (Lincoln and Guba 1985). Interpretive description was selected because it encourages the use of existing knowledge, derived from formal research or clinical experience, to guide inquiry and provide a foundation for linking study findings to the broader base of nursing knowledge (May 1989; Morse 1994b; Thorne et al. 1997). Rogers' Science of Unitary Human Beings (SUHB) was used as the theoretical foundation for the study. Consistent with an interpretive descriptive approach, the theoretical foundation of SUHB was used as a context for the inquiry rather than a structure for organizing the study. This provided the freedom necessary for inductive analysis of findings (May 1989; Thorne et al. 1997). A semi-structured interview was used to collect data. The analysis process included immersion in the data, identification of salient descriptions, extraction of natural meaning units (NMU) from salient descriptions, categorization of descriptions, identification of themes, and, finally, integrative interpretation of themes and interviews as a whole. The outcome is an interpretive description of the study phenomena (Morse 1994c; Thorne et al. 1997).

Human Subject Protection

The UTMB Institutional Review Board approved this study as a category 7 project which is defined as research on individual or group characteristics or behavior. The methodology, interview tool, specified processes for managing the data and maintaining confidentiality and structured communications were reviewed and approved

(documents provided in Appendix A). Study participants were provided detailed information about the study and participation expectations. Potential subjects were contacted initially by telephone; the investigator described the study intent, expectations of the subjects and clarified questions. Subjects were sent e-mails or letters confirming their agreement to participate and informed that consent to be a study subject was affirmed by their participation. All subjects were assigned a pseudonym prior to their interviews to ensure confidentiality. Findings are reported in a manner that protects the identity of the subjects. Interview transcripts, tapes, demographic profiles, and data worksheets have been maintained in a locked storage in the investigator's office. When all aspects of the study concludes, the data base and work materials will be shredded and disposal conducted in a manner that assures that confidentiality is not breached.

Methodology

Sample

A purposeful sample of expert nurses who practice within the framework of Rogers Science of Unitary Human Beings was selected. Consistent with naturalistic inquiry principles, the sample was selected for the purpose of maximizing rather than generalizing information. In this same vein, the sample size was determined when information redundancy occurred (Lincoln and Guba 1985). Morse (1994a, p. 182) suggests that studies designed "toward discerning the essence of experiences include about six participants…." This investigator reviewed reports on four studies focused on interpreting specific experiences. Sample sizes in those studies ranged from 6 to 15 (Rashotte et al. 1997; Takman and Severinsson 1999; Zerwekh 2000). A sample of nine subjects was included in this study, achieved, as noted above, through information redundancy.

Morse (1994a) points out that a good informant is someone with the requisite knowledge and experience desired for the study and is also someone with the ability to

reflect in an articulate manner. To increase the probability of selecting good informants, this investigator developed criteria for choosing a purposive sample. Since the study was designed to elicit observations and interpretations from expert nurses who practice within Science of Unitary Human Being conceptual framework, the criterion for selecting the sample focused on identifying nurses who would be good informants. The first criterion was that selected subjects would acknowledge she/he practiced using a SUHB orientation. Since human-environment mutual process is a core construct in SUHB, theory, this investigator posited that nurses who practice using this framework are more likely to have reflected on how their practice as a nurse relates to the client and his/her environment. The second criterion was a requirement that subjects would have published about their practices in credible professional journals or other scholarly sources. It was posited that nurses who have published about their practices have demonstrated their capacity to be knowledgeable, reflective and articulate informants about their practice applications.

The initial subjects were identified from two listings compiled by Fawcett (2000): "Published Reports of Research Guided by the Science of Unitary Human Beings" (pp. 390-395) and "Published Reports of Clinical Practices Guided by the Science of Unitary Human Beings" (pp. 398-400). Ten potential subjects were identified for the study. Seven were identified from a critical review of the publication listings specified above. Three were identified from recommendations made by subjects recruited early in the process. Recommendations were elicited in order to identify subjects that would broaden the mix of clinical backgrounds in the subject pool. Whether subjects were identified from the literature or recommended, each one was assessed to ensure she/he met the stated criteria. This investigator reviewed potential subjects' publications and presentations to determine evidence of expertise, reflective patterns, and ability to articulate. One of the subjects withdrew during the interview because the subject decided that her recent limited participation in practice made it difficult for her to answer the questions; she had been, she noted, a full-time researcher for several years.

The final sample consisted of nine doctorally prepared expert nurses who practice within the theoretical framework of SUHB. All participants were Anglo--Saxon females with over 30 years of experience in nursing. Clinical backgrounds represented in the sample include: acute care, community health, mental health, substance abuse and women's/infant care. Four of the subjects are faculty members who maintain clinical practices. One holds a clinical leadership role in an acute care setting; four are in private practice and/or consultation roles. Four are within the 51-60 year old age range and 5 are 60 or older. Four are married, three divorced, one widowed and one single. The nine subjects live in eight different states: 2 in New York, 1 in Massachusetts, 1 in North Carolina, 1 in Georgia, 1 in Florida, 1 in Texas, 1 in Colorado and 1 in Idaho. All have published on their practice. Six have developed and researched practice modalities and/or theories derived from SUHB.

Clearly, this sample is not representative of the general nursing population and is relatively homogeneous in terms of ethnicity, gender, and age. Selection criteria were structured to identify good informants. There were no criteria specified relative to demographic mix or personal characteristics. The variance in geographic distribution occurred by chance but does provide a breadth of regional perspective in the sample. This is an older, professionally mature sample of nurses with proven practice and inquiry expertise.

Data Collection Procedure

Potential subjects were contacted initially by telephone; the investigator described the study intent, expectations of the subjects and clarified questions. If a potential subject expressed interest, she was sent a letter describing the study, requesting the subject's participation, and indicating that the investigator would telephone at a mutually agreeable time. Enclosed with the letter was a form requesting professional and demographic information Approximately two weeks after the mail out, this investigator called each potential subject to discuss the study and what was desired and expected. When the potential subject agreed to participate, she was asked to complete and return the

demographic profile and was informed that her participation in the study was indicative of consent. At that time, a pseudonym was assigned to ensure that the subject's identity would remain anonymous on tape recordings, transcriptions, and other records used in data management. When a date for the telephone interview was established, the subject was emailed confirmation of the interview, a description of the recording process, and an overview of the interview plan. (See Appendix A)

This investigator used a semi-structured tool designed to elicit information necessary to answer the research questions (copy in Appendix A). These telephone interviews were audio-taped and transcribed. The transcriptions were sent via email to the subject for verification and clarification. Two subjects requested hard copy transcriptions to be sent by mail. The investigator reviewed the subject's feedback, made necessary additions and corrections, and analyzed the transcript in accord with the specified data analysis process. In five instances, a second follow up call was made to further clarify information. One subject added an exemplar to her interview.

Data Analysis

According to Thorne et al. (1997), interpretive description "…requires that nurse researchers come to know individual cases intimately, abstract relevant common themes from within these individual cases, and produce a species of knowledge that will itself be applied back to individual cases.…The inductive analysis and interpretive process is characterized by immersion in the data, synthesizing, developing conceptualizations, and addressing the…dialectic between individual cases and common pattern…" (p. 175). After reviewing Thorne (1991) and Parse's (2001) guidelines for analysis of a qualitative descriptive design, this investigator chose to augment those general data analysis guidelines with a more structured process. Kvale's (1996, pp. 193-204) approach to interview analysis was selected because it is consistent with the general processes described by Thorne and Parse. This approach also adheres to Thorne's (1991) call for using processes that pose questions about the overall meaning of the data as the means

for data reduction, display and interpretation rather than using complex coding systems and small unit data reduction.

The following summarizes the interview analysis process that was used in accordance with the sequence described by Kvale.(1996, pp.193-204):

1. Meaning condensation: Each interview was distilled into "natural meaning units". These natural meaning units (NMUs) were given labels reflecting general subject categories.
2. Meaning categorization: The NMUs were sorted into like categories. The categories were reviewed for themes; theme categories were distilled and synthesized several times.
3. Narrative structuring: The interviews were evaluated as "wholes" to determine the story inherent in each individual interview. This was used to enhance theme interpretation.
4. Meaning interpretation: Themes and patterns were interpreted within the framework of SUHB.

The investigator substantiated the trustworthiness of this study by ensuring that the four criteria conventionally associated with establishing rigor in qualitative research were met: credibility, transferability, dependability and confirmability. These criteria were synthesized from several detailed descriptive discussions about qualitative research (Beck 1993; Guba and Lincoln 1989; Koch 1993; Lincoln and Guba 1985; Slevin and Sines 1999). A study auditor provided process oversight, facilitated investigator reflection and objective engagement with the subjects, and reviewed the analysis process. Criterion specifications and the methods used to meet each criterion are described below:

Credibility: a study is deemed credible when it faithfully presents the experiences and reported reality described by the study subjects. Five processes are used to establish credibility.

- Reflexivity-accounting for the impact of the investigator's perspectives: The investigator debriefed regularly with a selected study

auditor in order to minimize the impact of investigator bias on the study process and interpretations.

- Verification by study participants: As indicated in the previously described procedure, study participants were asked to verify interview transcripts and provide clarification when needed during the analysis process.
- Well-defined description of data collection and analysis processes: The process was structured and executed in accordance with qualitative standards and Kvale's process guidelines. This process is described in detail.
- Data management structured to reflect decision trail from interview materials through interpretations: A process map was used and monitored by the study auditor.
- Coherence of interpretations: consistency in logic was demonstrated in decision steps and validated by the study auditor.

The study auditor has graduate preparation in nursing and holds a PhD in the humanities. This auditor was selected for her expertise and experience in critically appraising qualitative research. The auditor employed historical research methods in completing her dissertation and has been a Principal Investigator on several complex projects that used both qualitative and quantitative methods. As a faculty member, the auditor has had extensive experience in reviewing scholarly papers. The auditor had no previous background with the subject of healing environments or SUHB and was therefore more able to provide an objective point of view.

Transferability reflects the extent to which the study findings or propositions can be applied to another context. To assess transferability, the study participants and context must be adequately described. A detailed description of study subjects and context for the study is included.

Dependability refers to the quality and consistency of the processes used to determine findings. A study auditor was designated to determine if the database and decision trail adequately substantiated study findings and interpretations. The auditor verified each process step, reviewed findings and validated interpretation logic.

Confirmability refers to evidence that processes and decisions clearly reflect the way interpretations were determined. Confirmability is established through the concomitant achievement of credibility, transferability and dependability. Credibility, transferability and dependability have been substantiated through processes described above.

Limitations of the Study

There are several limitations of this study. The first relates to the composition of the study sample. All subjects are doctorally prepared nurses who practice within a Rogerian theoretical framework, are expert practitioners, and have documented practice scholarship in professional publications. This sample is not reflective of the general nursing population. The advantage offered by this sample is that the subjects were highly skilled at observing phenomena, interpreting and communicating its meaning. They were the appropriate subjects for generating answers to the research questions. Practicing nurses who wish to use outcomes of the study are likely to view the subjects as quite different from themselves. In addition, they may view the use of SUHB as a barrier to transferability if they are not familiar with this theoretical base or do not use any theoretical framework in their practice. Interpretative presentations and publications may be required to make the study outcomes useful to the practicing nurse.

There were several challenges associated with data collection. The investigator and study participants were not able to interact face to face due to geographic distances. All interaction between the investigator and study participants occurred via telephone, email, fax, or postal service. This restricted data collection since face to face exchanges often generate additional communication and data. Telephone calls were tape recorded

and transcribed to facilitate accurate communication. Subjects were able to review and refine transcripts to decrease potential distortion. Email and mail correspondence have been maintained in confidential subject files for reference and can be accessed to validate analysis outcomes. Due to the investigator's personal illness leave, there was a 5 year delay between the initiation and completion of this study. As a result, four subjects had to be reengaged in the process when the study was resumed. Information was updated and the subjects were willing to bridge the time gap.

CHAPTER FOUR:

FINDINGS

This chapter presents findings related to the research questions posed for this study of the characteristics of a healing environment as described by nine expert nurses who practice within the theoretical framework of Rogers' SUHB. These questions are as follows:

Main Question:

What are the characteristics of a healing environment as described by expert nurses who practice within the conceptual framework of Rogers' SUHB?

Related Questions:

What changes in clients did the subjects describe as manifestations of healing?

What conditions and relationships did subjects report as characteristic of healing environments?

What nursing practices and processes did subjects report as facilitative of client healing?

Findings are organized according to research questions. The three related research questions cited above served as the basis for developing the semi-structured interview tool used in gathering the data for this study. The subjects' responses to the interview questions were analyzed, recurring themes inferred, and themes categorized to correspond with these three related study questions. This investigator synthesized the thematic findings relevant to these three questions into an integrated interpretive narrative response to address the main question. The findings answering the research questions are reported in the same sequence as the findings were derived: related questions answered first and then the main question. Quotes from subject interviews were selected and included in answers to illustrate thematic patterns. Subject quotes are indented and single-spaced; the quotes were not edited. Brackets were used to indicate entries by the investigator intended to clarify the meaning of quotes extracted from the interview texts. Table 2 provides a listing of themes per research question. Appendix A provides

transcript excerpts illustrating the subjects' recurrent response patterns that formed the basis for inference of the defined themes.

Table 2: Themes responsive to related research questions
What changes in clients did the subjects describe as manifestations of healing?
Recognizes the need for change and demonstrates intent to change
Engages knowingly in reorienting and mutually patterning the energy field
Expresses sense of expanded awareness and sense of connectedness with self, others, and a greater whole
Exhibits observable and intuitively understood human field pattern changes
What conditions and relationships did subjects report as characteristic of healing environments?
Right relationship with self and meaningful others
Intentional mutual process
Energetic influences from collective relational experiences
Client centered design
Healthy nursing culture facilitates a healing environment
Philosophically grounded, open and in search of meaning
What nursing practices and processes did subjects report as facilitative of client healing?
Theory based practice
Nurse as environment
Appraisal and mutual patterning
Nursing art of designing care

Answers to Related Research Questions

What Changes in Clients did the Subjects Describe as Manifestations of Healing?

Four themes were identified from subjects' responses describing changes in clients that the subjects perceived to be manifestations of healing. The subjects provided a consistent perspective on context: the client's experience of healing is always defined by the client. This paradigmatic view stands in stark contrast to the conventional health service model in which the provider diagnoses the client's problem, prescribes how to fix the problem, and specifies the outcome parameters indicative of successful resolution of the problem. In the conventional model, the client is referred to as a patient, a term that often reflects his/her passive role in the health care management process. It is noteworthy that in these findings, the term client is used to reflect that the nurse is providing a professional service to a person actively engaged in the process of healing. Though the subjects' responses acknowledged the need for diagnostic and therapeutic interventions, their approaches integrated those aspects within their understanding and application of the SUHB framework and practice methodology. Each of the following four themes reflects the subjects' focus on the centrality of the client in defining the process and the experience of healing.

Recognizes the Need for Change and Demonstrates Intent to Change

The client's recognition of the need to change and his/her demonstration of intent to change were reported as an initial and essential manifestation of the healing process. Constraints or dissonance in the energy field create an awareness and impetus for change. The recognition of the need for change leads to intentional efforts to make this change occur. This intent may be reflected by the client's openness to information and willingness to seek new alternatives. The client's intent reorients his/her energy field toward the process of healing. Two excerpts from Subject W's transcript are representative of the responses from which this theme was derived:

> …recognition is the beginning of healing. You don't have real healing as I'm describing it without that recognition. So the key to movement toward the healing experience is the person recognizing that something needs to change…
>
> I think one of the most important things in healing is the sense of purpose and meaning and direction. This also comes from one's unique intentionality. Intent to change is immensely important. We tend to change our orientation. When we change our orientation, the direction of the energy flow changes because we've shifted. We've made a conscious decision to do things differently. When we do this, energy changes, the patterns change, and the manifestations of patterns change.

Engages Knowingly in Reorienting and Mutually Patterning the Energy Field

Knowing engagement in reorienting and mutually patterning his/her energy field reflects the client's perceivable movement from intent to active engagement in making changes in his/her human-environmental energy field that manifest healing. Subject responses relative to this theme were clearly rooted in the unitary paradigm, SUHB theoretical concepts/practices, and derivative SUHB theories (e.g. *Power as Knowing Participation in Change*). As this theme implies, the subjects reported client-nurse mutual patterning of the human-environmental energy field as a means of facilitating client healing. Basic to this process is the assumption that the client and environment are integral energy fields and the nurse is part of the client's environmental field. When the nurse and client share mutual intent, the mutual patterning of both their energy fields are potentiated. The nurse contributes professional knowledge and skills, information, options, support, and focused energy to the mutual patterning process. The nature of the nurse's support and participation is responsive to the individual client's human field pattern, which includes his/her illness or health concern. The client engages and focuses healing through

knowingly participating in the change process. Whatever nursing practices are used, either conventional or alternative, the client is an aware, knowing, active participant who makes choices relative to the changes to be made. Mutual patterning facilitates shifts from lower to higher energy frequencies within the client's energy field; higher frequency energy waves increase the rate of the change process. The following three excerpts are representative of the responses from which this theme was derived:

> …it all starts with the person's capacity to look at possibilities and make choices around those [possibilities]…and how much energy [the person] *has* at that moment. As a nurse, I had better be able to enter into [that person's] world so that I can understand [the person's] energy and meaning [of this experience] and help…explore that.…So the degree [to which the person] can claim the possibilities, you see [him/her] coming into a healing mode. We're engaging the energy to help them move to a new state of being. It is partly my energy and partly their energy and partly universal energy. It is moving them to a new state of being. (Subject V)

> There are four dimensions of power (awareness, choice, freedom to act intentionally, and involvement in creating changes). This power enables clients to knowingly participate in change. Information enters the patient's field and allows them to participate in creating change. First, they gather the information and look at their options and then they get necessary information that helps to shift their directionality. …So people who are moving towards healing are people who are usually shifting from lower to higher power choices and from less awareness to more awareness, from lesser freedom to act on their intentions to greater freedom to act on their intentions. And in involving themselves in ways that help them to get to where they want to go. (Subject M)

> When you are engaged and you know you are and they know you are, things move quicker – it speeds up – it's like the whole process of getting well…goes more rapidly. (Subject C)

This theme reflects the extent to which the SUHB framework defines how these subjects view the primacy of the client's power and the mutuality of the nurse-client process in bringing about energy field changes that are healing in nature.

Expresses Sense of Expanded Awareness and Sense of Connectedness with Self, Others, and a Greater Whole

Persons dealing with health challenges may exhibit a fragmented sense of self and feel dissonant with, or isolated from, meaningful relationships in their lives, including their perceived relationship with themselves. As these persons engage in the healing process, they frequently experience expanded awareness and a sense of connectedness that prompts changes in their relationships. Reconciling and reconnecting with self and significant others becomes a priority and is both a step in the healing process and a manifestation that indicates healing has occurred. As people heal, characteristically, they want to share their experience with people who are meaningful in their lives. They also exhibit an openness and willingness to create new, meaningful relationships. Subjects report nurses often facilitate reconciling, reconnecting, and changing relationships that lead to healing as manifested through expanded awareness and connectivity. According to subject responses, clients who are critically ill or terminally ill are more likely to express experiences of spiritual awakenings that manifest an expanded awareness and a sense of connection with a greater whole. In addition, clients who have made significant life changes associated with a health episode describe transformational experiences. The following excerpts are representative of the responses from which this theme was derived.

> Many times they will move from the struggle of dealing with the specific intent to abstain from substance abuse into experiencing serenity in their recovery process. [Move from specific intent to abstain from substance abuse to an intentionality to seek wholeness.] Though each person describes it differently, it seems to be this all-encompassing peace, which may reflect their transformational stage. (Subject A)

> They come into our…program feeling isolated and alone and they are not feeling connected to anything outside themselves. They are running their life on a battery, as opposed to having an alternator helping the battery along. When they see they can quietly resolve issues in their lives by reflection they feel a great relief. …[Then] there is an expanded awareness and people are connecting in ways that they haven't been connecting before…moving from an isolated, fragmented position into a connected, more coherently whole position. …I see two levels of

> manifestation. One is by taking action for themselves through their expanded awareness and the other is by sharing in very specific ways with others about this change within themselves. They tend to bring people in that they feel connected with and want to make them a part of the healing process that they are experiencing. (Subject S)
>
> After patients have gone through a series of treatments with nurses using alternative therapies, I've noticed that although they may still have the illness, they feel like they know themselves more and they are more comfortable with themselves. [They] feel more a part of the world and the universe. It *is* a real sense of being a part of a greater whole for both the nurses and the clients. So their healing is the connection with themselves and their connection with others and their expanded connection at a universal level. (Subject W)

As the healing process progresses, expanded awareness and the experience of connectedness permeates the client's relationships and life.

Exhibits Observable and Intuitively Understood Human Field Pattern Changes

Subjects' responses reflected agreement that changes indicative of healing can be both observed using the senses and can be apprehended through intuitive knowing. Subjects reported changes associated with healing as a perceived shift in the whole pattern of the client's energy field. However, they acknowledge the challenge in "seeing the whole" without breaking it down into parts when they try to describe and understand the changes. Subject C's description reflects this view:

> [The challenge] is to see the whole. I think we see it, I'm not sure we can perceive it all at once so what happens is that I think we notice the pattern has changed and I think this is a holistic thing. Intuition is big. The things that we know don't just come out of the air. There is a perceptual pattern that is enough that we become aware of it. So appearance of face and eyes, I think is reflective. I think it's in the voice and I think that even in the manner of movement. We perceive the whole and then we try to understand the whole. In that process we sometimes go to those things that seem to be making up the whole and try to express them. If you've gone into mutual process as a nurse with this client in previous meetings, then when this person sees you, there is a way in which your proximity and his/her seeing you generates an eagerness. What happens is not just in them but in both of you. The pattern changes are reflected in that interaction. It's like what

> they say and how they say it, both. Maybe more than that we don't understand, but it's noticeable.

In seeking to describe changes indicative of healing, subjects emphasized the importance of differentiating curing from healing. Curing is focused on resolving a specific health problem. A client may be cured but not healed, especially if the client has been a passive participant [patient] in the management of his/her health care problem. Conversely, a client might be healed but not cured, particularly in cases of chronic or terminal illnesses. The changes that indicate cure involve the elimination or reduction of the problem or its manifestations. The changes indicative of healing are reflected in the client's life process which includes the meaningful integration of health issues. Optimally, healing is the goal and curing is an objective to be achieved within the healing process (Cowling and Taliaferro 2004; Gunther and Alligood 2002). Subject D's description is representative of the subjects' responses:

> I think the difference between curing and healing is an important one. I think of curing as a culminating kind of an event and it is a yes or no. I think of healing as an ongoing process that is endless because it is almost one and the same with the life process. So what you have are moments of healing, moments of right relationship, moments when something comes together in a new way that gives the system more energy or more wholeness in that moment. Then the system is changed from that point on and goes on.

According to subjects, healing is reflected in observable physical, cognitive, emotional, and movement changes. These changes may be exhibited through a more relaxed demeanor, greater eye contact, freer movement, stronger voice, more coherent behavior, and increased interpersonal engagement. In addition to these observable indicators, subjects report intuitively recognizing changes in the client's energy field, such as the intent and directionality of the field. Again, Subject C describes the pattern of subjects' responses reflecting this combined reading of observable and intuitively understood changes indicative of the healing process:

> Some observable manifestations of healing, I believe, have to do with emotion and movement, facial appearance and eyes, affect, the position of the body and the voice when a person speaks. Not just what is said, but how it is said…the

> rhythm of…speech. What we are talking about is the whole collection of observables that we put some label on. I think nurses do help people articulate what they are experiencing. When something has been inside and doesn't have words, the nurse can help that person find the words to express. What happens with that expression is there is an emotional release. It's a structure that helps them understand or have some meaning.

Healing may be incremental or may appear to happen in a moment. Whatever the process trajectory, subjects agreed that changes indicative of healing are observable and intuitively known to the client, nurse, and significant others.

What Conditions and Relationships did subjects Report as Characteristic of Healing environments?

Subject responses were clear in their messages that relationships are the most important aspects of a healing environment. As such, relationships serve as barometers reflecting both indications of problems and indications of healing changes. Relationships were also identified as the primary context for creating energy frequency shifts resulting in healing changes. Recurring themes relative to relationships addressed reconciling relationships with self and others, client-nurse mutually connecting, and collective impact of relational experiences. Conditions subjects identified as characteristic of healing environments include themes related to physical design, organizational culture, and philosophical influences. Since relationships were identified by subjects as by far the dominant environmental influence, this investigator chose to report these three recurring themes first.

Right Relationship with Self and Meaningful Others

According to the subjects, clients' illnesses are frequently developed from or are complicated by internal discord and fractured relationships with others. A recurring message within the subjects' responses was that reconciling one's relationship with self

and significant others was an essential step in the healing process and was also a sign that the healing process had begun. Discordant relationships with self and others diminish the energy field. Reconciling relationships with self and others increases energy to the field and opens the possibilities for change. The following two responses illustrate the subjects' perceptions regarding the impact of relationships on the energy field.

> When people don't feel that they have options or that there are possibilities, their perception of their field diminishes. …[In these situations, people are relating to] the perception of the closeness or the openness of the field. So I think that people's perceptions of themselves are a pattern manifestation of their relationship with their energy field." [relationship with self].. (Subject D)

> When there is this notion of right relationship, when some element of the system comes into new pattern and the pattern is a healing pattern, then one of the things that goes along with that is there is more energy for the whole system. Whatever level that right relationship emerged in, more energy is available for the whole to do the work of that system…the way I think about healing is this emergence of right relationship at one or more levels of the person. [There] *is* an increase in order [and] an increase in energy. (Subject D)

Some illnesses, such as substance abuse, are enmeshed in relationship influences. Subject A provides insight regarding how relationships can be a painful aspect of the illness and how relationships can serve as the primary vehicle for healing.

> …substance abusers frequently have broken relationships or have developed very tense relationships with their families and their friends. There may have been threats on the part of family members. There may have been [marriage dissolutions]. They may have lost significant others and they may have lost their jobs and homes. They may have been threatened, cajoled, or taken to court by key people in their lives. Once these people have gotten into a program and become well established, it is the relationships with the people in the program that help change their flow of energy and create the possibility for them to heal. The energy begins to calm down; it begins to flow more smoothly…[and appears less chaotic]. The relationship with self is the most important impetus for change and relationships [with others] are the bedrock of healing. (Subject A)

Subjects' reported the importance of recognizing when relationships were creating a barrier to healing. In these instances, changing the nature of the adverse relationship is necessary for the client to reorient her/his energy field pattern and make healing possible.

These negative relationship patterns may have developed over years, may involve very significant persons in the client's life and may be challenging to negotiate. Subject W provides a representative example of this type of situation.

> A woman with scleroderma was incredibly ill and dying. She realized that her relationships with her family were not working. That she was really a servant to them and to her kids and had been just overly self-sacrificing. That she needed to change that in order to heal. She did. She told her kids that she wasn't going to see them every weekend and she began to set limits with her adult children. She then related to me and this made a big impact on her process of healing. Reconciling her relationships with herself and with her children made it possible for her to begin the healing process. (Subject W)

In sum, "right relationship" was identified by subjects as key in creating a healing environment. The client's perception of self is a reflection of his/her energy field pattern. When there is discord with one's perception of self, there is discord in the energy field pattern. Repatterning the field requires a shift to right relationship with self. This repatterning relationship with self often occurs within the context of open and accepting relationships with others.

Intentional Mutual Process

This was the most frequently recurring of all themes identified from subject responses relative to relationships. The subjects' responses reflected Rogers' principle of integrality and the SUHB practice method of voluntary mutual patterning. Intentional Mutual Process, as used by the subjects, referred to the client-nurse connecting in a meaningful way. The subjects described how through this connection, a mutual intent to repattern the energy field formed. According to the subjects, this mutuality of intent creates synchronicity in the client-nurse energy field waves that increase wave frequency and potentiates change. Subject M provided a typical response delineating this process.

> Mutual process magnifies the possibilities of what can happen when intentionalities are united and that is a lot of what happens in any kind of therapeutic relationship. We talk about relationships heal no matter what kind of

> therapy or healing in any kind of paradigm or any kind of theoretical perspective. It's always the mutual process that is so important in what happens and in change. There is a special type of synchrony that is happening in health patterning and the healing process work. The mutual process, when people are willingly committed to it, brings about healing. If someone is freely and you are freely committed to a certain intention there is a lot of healing energy attached to that." (Subject M)

Subjects report the rhythmicity of mutual process contributes to creating higher frequency wave patterns that facilitate energy field change. Subject C provides a graphic description of the mutual process rhythm within a relationship.

> Some of the dissonance in the patient's energy field gets dealt with because the patient is sharing things with the nurse and the nurse is interacting with the person in such a way that their process becomes more mutual. By that I mean they understand and know more about each other. Then I think what happens is that they are able to sort of move together. At that point, when it's mutual, the nurse is moving with the patient and the patient is moving with the nurse. I think of it like jumping rope. Remember when you were ready to go in and jump…you would stand there and sense and use your hands and often you would sense the rhythm of that rope. You go in and start jumping. When you are really and truly in that process with the patient, it's like you are actually going to jump right with the rhythm of the rope. When we really have these relationships that are mutual and we are moving that patient along, what I think happens is that we are in their rhythm and we sense their rhythm. (Subject C)

Subjects pointed out that mutual process cannot occur in situations where the nurse is trying to control the outcome. This is a particular challenge for nurses practicing in highly conventional settings where prediction and control are dominant values. However, the subjects iterated that efforts to control undermine mutual process. In particular, they warned against the nurse taking the position that he/she knows what is best for the client, and therefore assumes a controlling role. The following excerpts are representative of the responses relative to the risks of trying to control the relationship.

> So if my ego is tied to the outcome or to my solution, then I really am not participating fully in this mutual process between us. We partner in creating a relationship and my job is to bring resources into the relationship that can be useful to the person and to open up possibilities for [him/her] and expand…consciousness to those possibilities…my job is to create an environment

> and provide the resources for the person to realize or create [his/her] own solutions. You have to let go of controlling the situation. (Subject E)

> If a nurse sits there in her position of judging and knowing and thinking she knows the client and thinks the client needs to do what she thinks the client needs to do, that can kill the healing process. It's that very thinking that prevents us from having authentic relationships. (Subject D)

Subject S further emphasized the importance of the nurse consciously demonstrating that she/he values the client as an equal partner in the healing process. If the communication is such that the only "valued" information comes from the nurse, this inequity is apt to create the experience of the nurse being perceived as the more valued person in the relationship, undermining the sense of partnership. This excerpt clarifies that perspective.

> The relationship is important in terms of really truly valuing patients and making an attempt to understand them and then trying to be helpful from their perspective. All of this happens within a healing environment. ….Bonding requires that people like each other. Nurses have to be willing to learn from the patients because it is the 'taking something new' in from the patients that open up the channel for patients to take something in from us as nurses. ….It's important that we pay attention to what we can learn from our patients. Clients are impressed that I'm writing down what they have taught me and they are more open to what I'm saying. I sometimes learn simple things like how to store potatoes so they don't rot. When patients see we value what they have to offer us, they open up to us in a new way. We also create a different kind of balance in the relationship with this type of exchange. These relationships are mutual and mutually healing. (Subject S)

Based on the findings, intentional mutual process between the client and the nurse forms the basis for repatterning the energy field and making the changes necessary for healing to occur. The key focus is on creating a mutual relationship; one within which the client and nurse can facilitate change through mutual purpose and energetic synchrony.

Energetic Influences from Collective Relational Experiences

This theme reflects subjects' responses indicating the importance of "being mindful" that each partner in a client-nurse relationship carries the energetic influences of

all other relationships in her/his life into this specific healing relationship. Dissonance in the nurse's relationships (e.g. co-workers) has the potential to affect the nurse's openness and ability to connect therapeutically with the client. Dissonance among those around the client diminishes the energy available for healing. The therapeutic milieu is a powerful energetic influence; Subject E's response is a good example of the subjects' points of view:

> There is the immediate relationship that is going on [with the client]…and then there is the field that is beyond us but still encompassing us directly. Then there is another field beyond that, which is including the people that are in [each of] our lives. So even though we are in an immediate expression of one energetic relationship, we're influenced by all those other energetic relationships. In creating a healing environment, I must be conscious of…influencing energetic patterns. …Relationship Centered Care and the context of that *have* an effect on the immediate relationship. If you are in a clinical environment where the relationship among the team and the healers [physicians, nurses, etc.] is a therapeutic one, then it has a positive impact on your relationship with your patient. It is difficult to create a healing relationship with a patient when there is dissonance in those kinds of environments…it offers much bigger challenges because there is a drain in the field. (Subject E)

The client's relational status with significant persons in his/her life has an impact on the healing process. The subjects emphasized that one cannot expect healing to occur without making needed changes in the most meaningful relationships. The nurse may facilitate the client's reflections on his/her relationships and may help arrange for reconciliation or reconnecting to occur. Subject M's response illustrates of this perspective.

> Relationships with everyone in one's life play an important part in the healing process. It's really important to help people with their relationships with others. Healing does not take place in a vacuum; the whole environment needs to be a healing environment. If they are having marital issues, or issues with their children, or [issues within] any important relationships, if there are kinks in them; it really helps if the clients can smooth these out - which isn't easy for any of us. So when you are trying to create a healing environment…you have to at least try to [facilitate their reconciling] the most important relationships in that person's life. (Subject M)

As indicated earlier in this section, the subjects' responses emphasized that the most important aspect of the healing environment was meaningful relationships. In fact, the

subjects indicated that all other conditions in the environment were secondary to the healing relationship.

Client-Centered Design

The subjects' responses reflected an appreciation for the contributions aesthetics and attractive physical design can make to create a healing environment. However, they described these contributions as enhancements to the healing process as compared to the essential role meaningful relationships play in the healing process. Repeatedly, the subjects acknowledged that color, music, and flowers could facilitate a healing experience; but quickly pointed out that, even in the harshest conditions, people create healing experiences through the power of meaningful relationships. The following excerpts share these perspectives:

> The most important part of the patient's environment is *his/her* relationship with the practice nurse. Whether the walls are painted pink or chartreuse or black, in the moments when the patient is suffering, the artistry of the human connection is indeed the most profoundly important one. So I think the design of the physical environment can be important, but [it] *is* not paramount. When…offered without offering a healing relationship, they simply become trivial. When they are used with other support, they become much more powerful. Certainly all of us feel better in beautiful surroundings. (Subject D)

> I think that a physical environment can contribute to healing. I think that physical conditions can be patterned in such a way to promote healing potential. I think that healing does and can occur regardless of the physical environment. I think if there is a relationship, in which one is supporting another who is seeking to heal, that the physical environment is like a myth. It does not matter. I keep thinking about Katrina and the people who survived and thrived through that process and the incredible moments of healing that occurred in that environment. The healing actually occurred through relationships. The dominant condition is the healing relationship (Subject E)

Subjects' responses reflected that they perceived individualizing the environment to the client to be a higher priority than providing any particular design features. The focus described was threefold: order, individualization, and stimulating changes. Repeatedly,

the subjects pointed out that the time honored nursing practice of maintaining an orderly environment has an impact on the way the energy resonates in the field. Structuring the room for the client's preferences creates a sense of 'being settled" and a comfortable environmental pattern. Periodically introducing something new into the environment, like a family picture, flowers, or music can be a welcome change that stimulates positive energy flow. Subject C's response relative to the import of individualizing the setting is typical:

> If we are talking about a patient in the hospital, we're talking about somebody who we've extracted from [his/her environmental] pattern and plunked them down into a different pattern. They are trying to deal with that, so the way they deal with it is to try to form a pattern in the hospital. This frequently comes across as 'I like my bed table right over there'. That's trying to pattern their own environment and I encourage people not to get irritated with clients who do that. Something does happen after two or three days. Even if you travel and stay in a motel or hotel or something, the first day is very different than the second and third days in terms of how you feel when you come in. I think that's about becoming patterned to that environment. (Subject C)

Subjects' identified a number of conditions in the physical setting that impede the healing process: noise, bright lights, and constant interruptions. These stressors and any other factors in the environment that make the client feel uncomfortable should be removed. Another factor identified as requiring consideration was the potential for the client to become isolated, especially if he/she is in a private room and rarely calls for assistance. As indicated repeatedly in subject responses, "…human interaction is critical to healing". (Subject C).

Healthy Nursing Culture Facilitates a Healing Environment

A thread woven throughout all the interviews was the message that the health of the nursing culture within an organization directly affects the capacity to create a healing environment. Several of the subjects explicitly identified a healthy nursing culture as an antecedent to creating a healing environment. Their responses reflected the position that a

healing/healthy environment for the nurse made it possible to have a healing environment for the client. Subject V raises the issue of how nurses are viewed within the institution:

> I think a huge factor that supports nurses in actively participating with patient healing is whether that institution values nursing as nursing. There are all sorts of ways that you can look at nursing. (Subject V)

The issue of "valuing nursing" requires that nursing's role be understood in order to be valued and supported. Several subjects discussed the competing views about nursing's role, particularly in hospital settings. The following synthesizes the perspectives voiced by the subjects. Since hospitals continue to be the largest employers of nurses, these institutions have an industry-wide impact on how nurses' roles are viewed and how employment conditions are managed. In many hospital settings, nurses have limited autonomy and nursing care is structured as a series of tasks. Nurses also are assigned non-clinical functions related to meeting a variety of hospital objectives. In addition to these "making the train run on time" assignments, nurses serve as the key interface between clients and their physicians and other providers. Subjects point out that many of these providers view the nurse's sole role as making sure their plans for the client are implemented. The unintended consequences of these organizational conditions are role confusion and fragmentation. Under these conditions, the subjects assert that nurses are diverted from their professional priority of "placing the client in the best position to heal". Subject D suggested that the current organizational conditions have contributed to the nursing shortage and that an ecological approach is needed to establish a healing, supportive nursing culture:

> Alleviating the nursing shortage involves caring and healing within the health care system. It's important to create an environment for nursing. I call this 'habitats for healing'. We really need to think about nurses not as commodities that can be bought and sold, but as an endangered species. If you use an ecological model even the questions you ask are different. When you are dealing with an endangered species, you don't try to get more [of the species] into a toxic environment, you clean up the environment first. You make sure that you create a place where when you bring the endangered species, they can survive.…What will be good for healing is what will be good for nurses because the nurses in the

> institution are; in fact, [what] *is* needed for healing. You have to create environments where nurses can nurse. (Subject D)

Philosophically Grounded, Open, and in Search of Meaning

Subjects identified philosophical and ideological influences as being significant factors in facilitating healing. Three sources of influence were described: the clients' beliefs and views about themselves, the nurses' awareness of his/her ideological perspectives and the nursing framework being used. The subjects' responses reflected the perception that no matter what clients' formal belief system, clients' acceptance of their humanity- the vulnerabilities and possibilities-and their openness to change were major influences on healing potential. Subject M provides a representative perspective:

> Acceptance is a great gift that people have. You know when people have that awareness that they are human and what that means. What it means to be human. When people embrace that in its fullest, I think they are able to bring about changes, healing and otherwise. Recognizing our own humanity is a perspective that [is] empowering in terms of making changes. Power is from within. …I think one thing that is very important is people who have openness to various ideas. An acceptance of different points of view as legitimate beyond their own…people who believe that they don't have to be perfect...don't have to defend, necessarily, because they recognize that we are all imperfect – we all make mistakes.(Subject M)

Subjects' responses indicated that they thought the nurse's level of awareness regarding his/her own ideological perspectives was important. A nurse with a low level of awareness is at risk of allowing his/her beliefs to impinge on the nurse-client relationship and client freedom in making health choices. Subject D provides a response relative to this concern:

> Part of my ideology is to recognize that you don't know what is happening and your job is to just simply support whatever is happening – not to manage it. …I think we are profoundly influenced by our ideology and what we think is going on. We all have an ideology. We simply don't take the time very often to question what it is. So it's often the hidden director, the behind-the-scenes director,

> directing the show. One of our responsibilities then; if we really want to facilitate healing, is to take the unconscious, the hidden directors, and get them out front and center so that we really recognize what our philosophy is – what we believe and also what its limitations are. One question is: When are our ideologies getting between ourselves and our patients? (Subject D)

The subjects' responses indicated that they considered practicing within a defined nursing framework to be of significant value. Several of the subjects commented on the extent to which their worldview as well as their practice had been influenced by Rogers' SUHB. This philosophical grounding appeared to provide a structure for the subjects that facilitate a high level of focus and consistency in their practice no matter what the setting or circumstance. Subjects pointed out that the concurrence of these ideological influences fostered an environment in which the client could find meaning in his/her experience, finding meaning promotes healing. Subject W's response shows this perspective:

> Healing is finding meaning in your experience. I think any philosophical or religious or spiritual background – anything that helps a person make meaning of an experience is essential. People who have had patients who have been through horrible trauma, if they can figure a way to say, 'I've learned from this – I've had to change certain things in my life because of this' – then healing is possible.

What Nursing Practices and Processes did Subjects Report as Facilitative of Client Healing?

The four practice themes subjects identified as facilitative of healing are grounded in the nursing framework and practices developed from Rogers' SUHB: a theory-based practice, nurse as environment, appraisal and mutual patterning, and the nursing art of designing care. As subjects described these practices, they reported that there was a natural flow that seamlessly moved from one process into another, that re-engaged processes in the move forward. Appraisal flowed into mutual patterning while integrating the design of care, appraisal, and re-patterning would re-emerge when a new level of movement called for it. It was clear from their observations that these subjects had acquired an expertise and comfort in applying these practices in their professional roles.

The challenge for this investigator has been reporting this information coherently without too much fragmentation, since the subjects clearly described a seamlessness that is essentially nonlinear, in contrast to the need to organize and report these data. These themes are reported in four sections with a request that the reader view them as merging waves on the same tide.

Theory-Based Practice

Using a theory as the basis for practice was reported by the subjects as an indicator of professional level nursing. In their view, a conceptual framework is necessary to define the nurse-client relationship, structure the processes used in creating a healing environment, appropriately use expert knowledge, and provide professional nursing services. This process all flows from the theoretical framework. Subject C's response describes theory-based practice:

> What I would like to talk about is what I would call professional practice. I think professional practice hopefully has to do with our education. What it is is rendering a service that is focused on the patient. To me if we are focused *on* ourselves and what it is we're doing, then we really have not reached the level of professional practice. The reason I love the nursing frameworks is that they make us focus on the patient. Through the lens of the framework, you can get a view of the person and it organizes what you are seeing and gives you a way to understand that and to provide the service. You might be able to say to somebody, 'This is who I am. This is what I do and this is how I do it.' To me that is a professional person. Martha [Rogers] was pushing for a framework for research but she was also pushing for a framework for practice…a framework that focused on the person and his or her environment. That is what Rogers meant by professional practice. (Subject C)

The value subjects placed on nursing theory in general and their chosen theoretical framework specifically reflected the way they described their practice. These subjects' responses reflected Rogers' view of the unique role of the nursing profession and that perspective was consistently linked to their theoretical grounding. In the response that follows, one can identify the concepts from nursing's meta-paradigm and how the subjects used Rogerian theory to apply these concepts:

> But what makes it nursing in my view, is that I have a knowledge base about unitary human beings that is always in the context of their environment and I look at them as energy fields. There can be a single energy field in the context of their environment or [there] can be different kinds of groups with their energy field…their family of origin and their family now or their work groups. Whatever that environment is like and what is now manifesting in all of these different environments. Then my job is to try to know pattern manifestations by looking at their experiences, their perceptions, and all of this so that we can come to the next phase of the process, which is voluntary mutual patterning that we are doing together. But the basic thing of nursing to me is this knowledge base of understanding human beings in the context of their environment. (Subject X)

Subjects' responses indicated that this group of expert nurses perceived practicing within an organized nursing framework to be essential to professional level practice.

Nurse as Environment

Within the SUHB, the environmental energy field is integral with the client's energy field. Changes in the client's energy field are brought about through mutual simultaneous processes inherent in both the client's human and environmental fields. As described earlier in this document, subjects' responses indicated their conviction that in a health care setting, they consider the nurse to be the key environmental influence. Their view is that the nurse in mutual process with the client presents the best opportunity to facilitate healing changes. This theme, represented by the designation "nurse as environment", reflects the strong emphasis subjects placed on the nurses' role in the client's environment. Subject E's response is representative of the subjects' responses:

> Most of the time, we think of the environment as being a physical construct around us, and my perspective is that I am the person's environment. That human environment relationship is the thing that we are working with and I can influence myself as part of that relationship and when I make changes in myself, the relationship changes. And then the person is somehow, through some universal flow, able to change themselves. (Subject E)

Subjects describe themselves partnering with their clients to navigate a healing path. They saw the nurse's role as creating safety and trust within the environment. It is their

view that when the client feels safe, he/she is able to respond to health challenges and participate in change to bring about healing. The nurse responds to the client's pattern and circumstances to determine how to establish a trusting relationship. The client learns that he/she can rely on the nurse as a resource for information, support, and professional expertise. Subject V provides a response that illustrates how a nurse may serve as source of safety in a frightening situation:

> It's more of a special relationship in the world that matters, I think. If I determine that the patient may be getting in a panic situation, you can bring them back from that spiral by exerting more control. I need to become their world and the only thing they are aware of at the time is just me. Using the force of my energy with them, I think I can pull them back. So, it is the power of the connection with you that perhaps get them through? They can trust. They can know that I'm not leaving them. That I'm observing them. That I'm breathing with them. That I'm not going to let them get into trouble. (Subject V)

In addition to the individual nurse-client encounter, Subject V points out that it's important for the client to have a sense of what he/she can expect from nurses in general; this helps create a sense of trust and safety with the environment as a whole:

> It is interesting that, even in a short encounter, I can have an existential moment with a client. When I was working in a pre-surgical assessment setting, we were trying to convey to our clients that this is the beginning of our relationship with you. This is how we are with you here. We are available to you and we want to know your story, and we want to know what brought you here. What your stresses and worries are because we are going to be here for you and here is what is going to be happening to you next. That had a sense of trajectory to it as well, even though I probably wouldn't be seeing them again. I was helping establish [nursing] relationships in the future." (Subject V)

Subjects' responses were clear and consistent: the nurse is the primary environmental influence. The nurse partners with the client and serves as a guide on the path to healing. The nurse is a source of expert knowledge and skills who will take action for the client or coach the client depending on the situation. Once the nurse and client have established a relationship, the nurse serves as the client's advocate, interpreter, and partner in fostering healing.

Appraisal and Mutual Patterning

Within SUHB framework, knowing the client involves appraising the client's life pattern and identifying energy field manifestations relevant to health concerns. The focus is on reading the client's whole pattern and determining what is unique. Knowing the life pattern provides the nurse with a context for helping the client to identify mutually pattern emergent changes associated with healing. Subject B's response illustrates why it's important to know the client as a whole person when trying to interpret his/her specific actions and needs in a clinical situation:

> There was a woman in her 70s and the nurses were concerned about her because she was doing everything the opposite of what [they thought] should be done. Her body mechanics were so bad, and she was frail. They were concerned that she might fall. I put the bed rail down and pulled up a chair right next to the bed and I took her hand and I said, 'I'm going to be your nurse for the night and my name is Subject B, and I will help you.' I sat there for a moment and looked at the tattoo number on her arm and immediately I knew what was wrong. I touched the tattoo and I ran my fingers over it and I said, 'Is this what's bothering you?' She started to cry and said, 'Yes, yes, yes. I feel like I'm again in Auschwitz – the halls, the wires and the prison'. Still you could feel that relative past was right there with her--vulnerable, bars on the rails that were up, frightened, nobody there. I said, 'I'm gong to leave the rails down, but I'm going to show you how you can get up and get down, so you are safe here. She said, 'I can't sleep at night – would you just sit in that chair? Don't do anything but just sit in that chair until I fall asleep'.

In order for the nurse to facilitate healing, she/he has to know the client's life pattern as well as the relevant clinical information. This level of knowing is greater than having bits of data about the client's physiological status. Subject V's response illustrates this:

> Knowing the patient is critical, nurses have to know what the problems are and know what to watch for and also how to create safety. I think trust and safety are essential. It's not about machinery--it's about being known. What are the likely things that can go wrong here? Who is their family? Where do they come from? Where are they going to go next? Stuff like that makes a difference because it's all about trajectory and directionality. It is essential that the patient be known. We must have access to understanding the wholeness of the person. In today's

> hospital settings, frequently nobody knows these patients. No one even knows what the patient looks like. The patient needs to be known. We need to know who they are. We know the physiological data but we also [need] *to* know if he looks down today as compared to yesterday. If a nurse is truly paying attention to who that person is as a whole person, that little piece of data planted in the mind of the oncoming nurse will alert her to watch that patient a little differently.

The move from appraisal to mutual patterning is a seamless process. When a need for change is recognized, the client and nurse begin the process of mutual patterning. They identify choices and support the client in making and implementing those choices. This approach to addressing a health concern differs significantly from the methods used by providers and nurses who see their role as controlling the situation on behalf of the client. For example, a newly diagnosed diabetic being managed through a "prescribe and control" approach would be provided information and told what to do in highly definitive terms. Using a mutual patterning approach, the client and nurse would partner in examining the choices the newly diagnosed diabetic must consider and the nurse would support the client in making choices within the context of the client's life pattern. Subject M's response is representative of this process:

> Ok, I'm aware of this. I see the X, Y, Z manifesting and I have to look now and see what kind of choices need to be made that I would choose to make as the client and helping the client doing it together. I have to see what is getting in the way because that is where the freedom comes in. That is the major blockage, usually. How am I involving myself right at the moment in creating changes? Well, maybe I am not involving myself in a way that is getting me anywhere at all and I might be making things worse. So I try to look at all four dimensions of power: awareness, choices, freedom to act intentionally, and involvement in creating change. When you do that then you really have a good assessment of knowing the power that is operating there and what needs to be done to change it. Sometimes it just helps to point out very directly and very specifically things for the client, and then it's up to the client to choose.

Subjects reflected that appraisal and mutual patterning are highly integrated into nursing practice and can be seen in nurse-client interactions in a variety of settings and circumstances. Their comments indicated that though nurses may only have brief or circumscribed opportunities to engage a client; expert nurses can use these opportunities

effectively. Subject B provides an example of an appraisal and mutual patterning that occurred by e-mail engagement. Though this is a lengthy excerpt, it provides important insight into the appraisal and mutual patterning process and its applicability even in unusual circumstances.

> Marvin was a very challenging client who had a congenital disfigurement. At age 50, he learned of a surgical procedure that could significantly improve his appearance and physical discomfort. This surgery is available only at a few health care facilities and ours is one of them. One of the challenges was preparing Marvin for this procedure at a distance since he lived Australia. Marvin was anxious to have the surgery. A treatment plan had to be developed in collaboration with other physicians. He became very angry and frustrated with the time frame necessary to initiate treatment. I sensed that his initial perception of me was "a cog in a wheel that was not making progress".
>
> In an early e-mail, when a treatment plan had not yet been established, he told me that "I was ruining his life." Marvin's communications with the providers, via e-mail and telephone, became more and more antagonistic. When I began communicating with him several months after his initial contact with our service, I appraised Marvin's communications as expressing anger and a sense of powerlessness about his inability to access the surgery quickly and about his life in general. The following E-mail exchange demonstrates how Marvin and I were able to connect and mutually pattern change.
>
> To Subject B; From Marvin
> I am very frustrated with having to do additional tests. I have waited long enough. I've wasted enough time. I lost too many years already-my childhood, adolescence, opportunities for romance, and a career. Did you know I have never had a relationship with a woman? I am too ashamed to even talk to one. I do not have much of life left. Why is this taking so long?
>
> To Marvin; From Subject B
> Please be patient, we want to do things right rather than fast. You have a complex case and the planning stage is most important. You will be getting a letter soon with recommendations. In the meantime, I want you to realize you are the one with the power to choose and act on your decisions. Now would be a good time for you to reflect on the concept of power as knowing participation in change. There are four dimensions to consider: awareness, choice, freedom to act intentionally, and involvement in creating change. It's important for you to realize you have the power to make changes in your life. You are aware of all aspects of your situation and soon you will have choices to make based on the recommendations from our team. The team will not make the choices for you, but will support you in freely acting on those choices. Marvin, you do have the power

to create change in your life, and you will have our support. Please let go of the anger, and claim the power available to you.

To Subject B; From Marvin
Beautiful Subject B, I just wanted to let you know that I am ok and to thank you for being so kind to me. I am a bit confused at the moment and a bit worn out from this journey of searching for help. My head and my heart say that I need to change. My bitterness, rudeness, and anger are wrong and damaging to everyone including myself. I do not like it. Need to let go. Need to change; otherwise I will never be happy.

To Marvin; From Subject B
You have done some serious self-examination that must have been painful but productive. Don't "beat yourself up". You have learned much from this experience and have come a long way by recognizing how your behavior affects you and others around you. That is a major step! Change is continuous but not necessarily in big steps. Take one item at a time that you think you need to deal with and work on making changes. Concentrate on how you will accomplish your goal but don't get overwhelmed. Progress may be slow, but it is still progress.

Your self-image is also important. I have seen so many people with congenital disfigurements who do not perceive themselves as able to have a loving relationship. I have learned so much from them. They enjoy all the gifts of life. I remember one man who was very disfigured. He made his living by selling items at a large flea market on a weekly basis. His beautiful wife accompanied him because he had such a successful business. He freely spoke to his customers about his self-perception. He did not feel uncomfortable when people looked at him. He knew who he was as a person and what he had to offer the world and those around him. Listening to him was very moving. You could not go away without deep respect and admiration for him and his attitude.

I am proud of your breakthrough in being able to see your health issue and your behavior in a different light. This is the first step in making change. Examine your resonating pattern of behavior. Do some journal writing on how you feel and what you can do to feel better about yourself.

I look forward to our continuing dialogue.

To Subject B; From Marvin
Thank you for the e-mail which is so encouraging.

Everything seems to be calming down, my heart, mind, and body
I am leaving in a few hours to visit loved ones so I am excited. I will e-mail you when I return.

It is evident from this exchange that Subject B, whose physical presence was at a distance, was still able to effectively connect with Marvin. Subject B did not react to Marvin's anger but facilitated his self-examination and provided him guidance relative to his opportunities to create change. Although Subject B and Marvin never physically met, they developed an appreciation for one another. Marvin's salutation, "Beautiful Subject B" was a manifestation of his perception of "inner beauty and sincerity". Subject B acknowledged Marvin's pattern manifestations of self-reflection and inner strength that were associated with his efforts to promote change.

This is an excellent example of pattern appraisal and mutually patterning change between two people who met and connected electronically.

Nursing Art of Designing Care

Subjects emphasized the importance of nursing care being designed specifically in response to the individual client. The following is a synthesis of observations made by several subjects relative to the move toward structured standardization of nursing practices. In busy health care settings, it is common to have formula nursing care plans and educational materials that are structured around the routine medical management of the client's specific diagnosis. In some instances, these structured care plans and other tools are printed and available on the nursing units. In settings with electronic medical records, these structured materials are programmed into the electronic database.

Subjects pointed out that this "programmed" approach to managing the client's "problem" may be considered expedient for addressing health problems but it decreases the probability that the client will receive individualized care designed to engage him/her effectively in the healing process. Subject C described how nurses use their art in designing care that is responsive to the client's life pattern, current health challenge and the choices he/she have to make. Subjects emphasized the need for nurses to be versatile and artful in applying various nursing modalities. Subject D' response is representative:

> It's using the whole toolbox of nursing practices and discerning which of those tools to use at the moment out of deep presence with this patient. It's really using your whole self and your awareness of the whole self to discern what is the right action for the patient at the moment. Nursing practice is selected based on what is happening with the patient or what the patient is experiencing at that moment and the nurse takes the cues from that. Again the nurses are responding to where the patient is. So I would say that another nursing practice that is important is nursing intuition.

Subjects also indicated that the artful nurse is sensitive and responsive to healing opportunities. Subject S describes how a nurse can transform a crisis into a healing moment:

> From an individual standpoint the nurse bonds with clients, identifies a focal concern, gives her care gently, helps them try to improve their well-being, expands their awareness, and teaches them to process. You have to be able to sense what needs to be done clinically and intuitively and take the appropriate actions, which vary and are individualized and personalized to situations and people. You have to be able to take whatever action is necessary to intervene in a healing crisis. If you handle the crisis right it can become a healing moment. You have to be able to think on your feet with a pocket full of tricks that you learn over time to be able to intervene in a way that will transfer the crisis into a healing moment rather than to escalate it into a nightmare. Doing this is a lot like improvisation.

From the subjects' point of view, the artful designing of patient care is characteristic of professional level practice. The implementation of problem-oriented tasks is characteristic of technical level care. Subject C's response reflects the perspective that differentiated practice should focus on the professional role of designing care:

> I think that part of providing healing environment has to do with recognizing this person and where they are in this whole process of whatever is going on with them, and who they are, and then designing care specifically for them. The healing environment is created by the art of nursing. …I think the nurse needs to be the professional person who designs care. I think that we haven't talked enough about designing care. We haven't really talked about designing the care and the importance of who designs it and then who does what part of it."

During the interview, Subject C shared with this investigator her own experience of having been diagnosed with cancer. Subject C described a poignant conversation between herself and a nurse friend shortly after she began her treatment. Her friend said to Subject C, “Do you have a nurse taking care of you?” After reflecting, Subject C replied, “No, I have a number of nurses helping the doctors manage my disease, but no one is taking care of me.” Her friend said, “I would like to be your nurse”…and then the healing began.

Summary

In summary, fourteen themes were identified from subject responses to research questions regarding healing manifestations, conditions and relationships characteristic of healing environments, and nursing practices and processes facilitative of healing. These themes reflect the thinking and the practice of nine expert nurses who use SUHB as their conceptual framework. These thematic findings demonstrated obvious correlations between subject responses and key concepts from SUHB framework. The practice patterns reflected by the subjects’ responses also demonstrated similarities and perspectual consistencies.

Main Research Question of the Study: What are the Characteristics of a Healing Environment as Described by Expert Nurses Who Practice within the Conceptual Framework of Rogers Science of Unitary Human Beings

This investigator integrated the thematic findings from the subject interview responses with conceptions inferred from the interviews as a whole to formulate an interpretive narrative description of seven characteristics of a healing environment.

Table 3: Characteristics of a Healing Environment	
Characteristic 1:	**In a healing environment, the client defines the focus and the nature of his/her healing experience.**
Characteristic 2:	**In a healing environment, relational experiences are recognized and treated as the central energetic influence in creating such an environment.**
Characteristic 3:	**In a healing environment, nurses and their unique professional role are understood, valued, and supported as a dimension of the health care organization's culture.**
Characteristic 4:	**In a healing environment, the nurse is recognized within the health care setting as the professional with the potential for the greatest impact in creating this environment.**
Characteristic 5:	**In a healing environment, nursing practice is theory-based with a professional focus on designing client-centered care that facilitates healing.**
Characteristic 6:	**In a healing environment, the organizational culture supports balancing individualization of healing experiences with standardization of best curative practices.**
Characteristic 7:	**In a healing environment a healing philosophy is embedded in the professional culture and organizational core values.**

Characteristic 1: In a healing environment, the client defines the focus and the nature of his/her healing experience.

The client is at the center of the portrait of the healing environment painted by the subjects of this study. A healing environment is one that is specifically responsive to the client's life pattern, perceived healing needs, and choices made by the client. In sharp contrast to the passive *patient* role often found in hospital and ambulatory settings, the client's role in a healing environment is characteristically an active, knowing, and fully

participating partnership in determining the changes necessary to heal and making those changes.

Characteristic 2: In a healing environment, relational experiences are recognized and treated as the central energetic influence in creating such an environment.

Meaningful relationships were identified by all subjects as the essential factor in facilitating healing. Relationships have the potential to increase or diminish the client's energy field; this impacts capacity to change patterns and heal.

Characteristically, persons collaborating to create a healing environment are mindful of the energetic influences emergent from collective relational experiences. In healing environments, nurses and other professionals recognize the importance of maintaining healthy relationships among themselves so that their relationships with clients will not be impaired by conflict or distractions. Study subjects identified Relationship-Centered Care, a model developed by the Pew-Fetzer Commission, as an example of initiatives consistent with creating relational conditions necessary for a healing environment.

Subjects further observed that separation, isolation, and relational dissonance impede healing, noting that a major factor in facilitating the healing process was the client's intentional actions to reconcile , reconnect and change relationship with both self and meaningful others in his/her life pattern. Subjects used the term "right relationship" to describe the process of bringing discordant relationships within oneself and with others into healing alignment.

Characteristic 3: In a healing environment, nurses and their unique professional role are understood, valued, and supported as a dimension of the health care organization's culture.

In organizations committed to creating a healing environment, nursing's unique role is understood to be the facilitation of client healing. The following indicators of the value of nurses and their roles were inferred from study findings:

1) Autonomy in making and implementing nursing practice decisions
2) Support for individualizing client care
3) Time and resources to support healing practices
4) Recognition of essential relationship between nurse self-healing and client healing
5) Differentiation between technical and professional practice
6) Strong nursing presence throughout the organization

Within such organizations, nurses are responsible for integrating curative aspects of care into the nurse-client mutual patterning process to create healing changes. Healing is recognized as the primary goal as defined by the client and within the client's power to attain. Curing is recognized as an empirically defined objective that may or may not be attainable. Within this perspective, the nurse's focus is on facilitating a healing experience for the client and family.

Characteristic 4: In a healing environment, the nurse is recognized within the health care setting as the professional with the potential for the greatest impact in creating this environment.

Subjects' responses echo Nightingale's view that nursing is the profession accountable for creating an environment that facilitates client healing. First and foremost, the nurse is responsible for providing a safe, comfortable, and supportive environment in the face of the fearful experiences and challenges posed by health care problems. The nurse partners with the client to co-create the energetic capacity for making desired

changes and expanding awareness that leads to healing. Mutuality of intent between the client and nurse creates synchrony within their energy fields. The rhythmicity of this mutual process shifts wave pattern frequency from a lower to higher level within the energy field. Using this mutual process, the client and nurse partner in patterning changes in the human and environmental fields that facilitate client healing. The nurse in mutual process with the client is thus the most significant environmental influence on the healing process.

Characteristic 5: In a healing environment, nursing practice is theory-based with a professional focus on designing client-centered care that facilitates healing.

Study findings strongly supported the position that theory based practice is the foundation of professional nursing and a significant characteristic of a healing environment. A conceptual framework is considered essential to the definition of the nurse-client relationship, applying expert knowledge in clinical situations, providing professional level services, and structuring processes used in creating a healing environment. Responses to interview questions illustrated the significant and substantive extent to which the subjects had integrated theoretical concepts into their practice. Though the SUHB was the conceptual framework used by these subjects, they were not parochial in their advocacy that a theoretical framework be used to guide practice; their important concern was that practice be based on a well-defined nursing theoretical framework. Findings reflected the practical and effective application of theoretical concepts in a wide variety of clinical situations.

Characteristic 6: In a healing environment, the organizational culture supports balancing individualization of healing experiences with standardization of best curative practices.

Study findings support the notion that creating a healing environment requires providing the capability to individualize client services and access to systems that support

the appraisal and documentation of healing manifestations. These findings highlight the challenge faced by conventional health care settings to provide the capacity to individualize client care within a culture that considers standardization essential for safe clinical management. Curative practice standards are mandated by regulatory, professional oversight and payer organizations. These powerful pressures have significant influence in determining the organizational culture. Organizations must be able to both meet the requirements of external forces to standardize care while concurrently ensuring individualization of care create the opportunity and conditions for nurses to provide care that is individualized and focused on facilitating healing.

Characteristic 7: In a healing environment, a healing philosophy is embedded in the professional culture and organizational core values.

Underlying other organizational factors is a philosophical position reflected in the day-to-day practice of health care, one that embraces healing as an overriding commitment**.** This patient centered, healing philosophy is integrated into organizational policies, inter-professional role relationships, infrastructure, cultural norms, and leadership patterns. Healing practices and outcomes are evaluated as quality indicators and used as parameters of individual and organizational success. This philosophy is manifested through the acceptance of client perspectives and decisions. Nurses in this environment are mindful of their own values and beliefs and consciously avoid imposing these on their clients. The nurse views the client as a partner in a healing journey in pursuit of meaning.

Summary

Study findings reported in this chapter were organized according to research questions. Themes were inferred from subject responses to interview questions related to the following: observations of client manifestations of healing; conditions and relationships characteristic of healing environments; nursing practices and processes facilitative of client healing. The fourteen themes derived from subject responses

reflected: The client determines his/her healing trajectory; the nurse is the most important influence in creating a healing environment; and nursing practices that engage the client as partner are the most effective in facilitating healing experiences. Using these thematic findings, this investigator formulated an integrative narrative response to the main research question: What are the characteristics of a healing environment as described by expert nurses who practice within the conceptual framework of Rogers' SUHB. Seven characteristics were formulated highlighting the respect for client autonomy, power of client-nurse partnership, individualization of care, nursing's unique role in facilitating healing, the importance of relationships and organizational culture, and the value of theory based nursing practice.

Chapter 5:

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

This chapter presents the investigator's conclusions relative to study findings and offers recommendations for their application. In a qualitative study, the information source is critical to achieving the goals. This investigator acquired information for this study from nine expert nurses who practice within the framework of the Science of Unitary Human Beings. These nine nurses described a level of practice that was rooted in a theoretically-based understanding of nursing, and a clearly articulated commitment to helping patients heal. The subjects' responses to interview questions reflected a grasp of the complex knowledge base that is characteristic of expert nurses and, also demonstrated an appreciation for the power of simple acts in bringing about healing.

There were fourteen themes inferred from the subject interviews. This investigator interpreted these themes within the context of the interviews as a whole, and formulated an integrative narrative of seven characteristics of a healing environment. Based on these findings, the investigator derived five conclusions:

Conclusion 1: The findings of the study are congruent with the theoretical concepts of the Science of Unitary Human Beings.

The majority of the themes are congruent with the human-environmental field processes shaped by the three principles of homeodynamics: resonancy (reflects direction and flow of field change), helicy (reflects the nature of field change), and integrality reflects the process of field change). Pattern (the distinguishing characteristic of an energy filed) is linked to one theme and pandimensionality (a view of reality that has

infinite dimensions) is linked to two themes. The themes related to theory based practice are linked to the science of nursing (the organized knowledge base of the profession) and the art of nursing (the creative application of nursing science). Table 4 specifies the themes discovered in this study and lists the SUHB concepts linked to each theme.

The first four themes relate changes in clients that the subjects described as manifestations of healing. The theme described as “recognizes the need for change and demonstrates intent to change” is consistent with the principles of helicy and resonancy, dynamics that reflect the nature and direction of change. The theme described as “engages knowingly in reorienting and mutually patterning the energy field” reflects all three principles of homeodynamics. Being knowingly engaged is indicative of the client’s recognition of the nature of the change (helicy); reorienting is indicative that the client understands the change in direction (resonancy); and mutual patterning reflects an understanding of the process of change (integrality). The theme described as “expresses sense of expanded awareness and sense of connectedness with self, others, and a greater whole” is congruent with the concepts of integrality and pandimensionality; connectedness reflects integrality, and expanded awareness reflects pandimensionality. The theme described as “exhibits observable and intuitively understood human field pattern changes” is linked to the concepts of pattern and helicy, implying pattern appraisal and recognizing the nature of change.

The next six themes reflect the conditions and relationships subjects reported as characteristics of a healing environment. The theme described as “right relationship with self and others” reflects the dynamics of helicy, resonancy and integrality. Establishing right relationship implies the client understands the nature and the direction of change necessary, and that the process of relating is an integral dynamic. “Intentional mutual process” reflects the principle of integrality. The theme described as ”energetic influences from collective relational experiences” is congruent with the principles of integrality and helicy. Integrality indicates understanding that collective relational experiences have an impact on individual relationships. Helicy reflects a recognition that the nature of these energetic influences are carried into specific relationships, such as one

Table 4: Themes: Links to SUHB Concepts

Themes	Concepts
What changes in clients did the subjects describe as manifestations of healing?	
Recognizes the need for change and demonstrates intent to change	Helicy and Resonancy
Engages knowingly in reorienting and mutually patterning the energy field.	Helicy,Integrality,Resonancy
Expresses sense of expanded awareness and sense of connectedness with self, others, and a greater whole	Pandimensionality and Integrality
Exhibits observable and intuitively understood human field pattern changes	Helicy and Patterns
What conditions and relationships did subjects report as characteristic of healing environments?	
Right relationship with self and meaningful others	Helicy, Resonancy, Integrality
Intentional mutual process	Integrality
Energetic influences from collective relational experiences	Helicy and Integrality
Client centered design	Integrality, Helicy, Art of Nursing (implied individualization)
Healthy nursing culture facilitates a healing environment	Integrality, Helicy, Resonancy
Philosophically grounded, open and in search of meaning	Helicy, Resonancy, Integrality Pandimensionality
What nursing practices and processes did subjects report as facilitative of client healing?	
Theory based practice	SUHB Science and Art of Nursing
Nurse as environment	Integrality
Appraisal and mutual patterning	Helicy, Integrality, Resonancy, Pattern
Nursing art of designing care	Art of Nursing Values: respect, responsibility and empathy (implied individualization)

between the client and the nurse. “Client-centered design” of the patient’s surroundings reflects the principles of integrality and helicy, that is, the human field and environmental field are in constant mutual process and changing in innovative ways. “Client-centered design” also relates to the values of nursing identified in the theory of the art of nursing practice. These values include respect, responsibility, and empathy and imply individualization, which is a necessity in respecting unique needs of the client. The theme described as “a healthy nursing culture facilitates a healing environment” incorporates all three principles of homeodynamics: integrality (process), helicy (nature), and resonancy (direction). The theme described as “philosophically grounded, open and in search of meaning” reflects all three principles of homeodynamics (resonancy, helicy, and integrality) and the concept of pandimensionality. This theme implies recognition of the nature, direction and process of the change associated with a philosophically grounded search for meaning. It also implies an understanding of relationships and connections that are without spatial or temporal boundaries (pandimensionality).

The last four themes reflect the nursing practices and processes that subjects identified as facilitative of client healing. “Theory-based practice” is directly linked with the SUHB concepts of the Science of Nursing and the Art of Nursing. Rogers asserted that nursing is a science with the unique body of knowledge, and that the art of nursing is in applying that knowledge base in a creative and innovative way that meets the individual needs of clients. The theme described as “nurse as environment” reflects the concept of integrality, the nurse (as a key influence in the client’s environment) is in mutual process with the client. The theme described as “appraisal and mutual patterning” is associated with all three homeodynamic principles and the concept of pattern. The “nursing art of designing care” theme is linked to the concepts of nursing as an art, and the art of nursing incorporates specific values (respect, responsibility, and empathy) and individualization of care. Subject responses demonstrated a high level of theoretical integration of these concepts into their practice.

Results of this study can be used to assist nurses in interpreting the SUHB into concrete, practical, and powerful practices that have potential to influence the healing

experiences of individual clients and to help reorient nursing care delivery in organizations. This inductive analytical view of nursing practice supports the position that structuring nursing practice within a SUHB framework is feasible; this study provides evidence contradictory to claims that such a theory is not a practical basis for nursing care delivery. SUHB frequently has been used as a framework for research or nursing modality evaluation; therefore, the literature has been written by and directed toward nurses with graduate level preparation. The challenge appears to be finding a way to communicate SUHB concepts and practice applications in a manner that resonates with nurses who are more representative of the general nursing population. Though this sample of expert nurses is not representative of the general nursing population, their practice exemplars are reflective of client care experiences common to all nurses. In early presentations of selected findings from this study, this investigator found that nurse clinicians, who were collaborating to revise a practice model, connected both cognitively and intuitively with the messages inherent in the study themes and exemplars. This suggests that these study findings might be useful to others interested in exploring clinical applications of SUHB concepts, particularly if the language of SUHB can be "translated" into concepts more accessible to the practicing nurse.

Conclusion 2: Relationship is the most powerful influence in the healing process.

Throughout the interviews, the subjects emphasized the power of relationships in creating a healing environment. They noted that clients who are facing health challenges also are frequently dealing with complicated internal discord and fractured relationships with meaningful others. Discordant relationships, whether with self or others, diminish the energy field. Subjects emphasized that reconciling relationships, internally with self and with meaningful others, increases the energy field and significantly increases the probability of healing change. Within a trusted nurse-client relationship, the subjects observed that the client appeared safe to explore the meaning of his/or current health problem and the life pattern context within which it occurred. The subjects noted that the

nurse supports the client's defined intent to heal relative to specific problems and his/her intentionality to achieve a life pattern healing. As voiced by one subject, the nurse's role is to help the clients recognize and claim the possibilities of his/her infinite potential.

As health services have become more specialized and technology laden, the relational aspects of care have been marginalized. Additional barriers have been created with the growing nursing shortage and other resource constraints. Curative interventions are given priority over relational care. Groups such as the Institute of Medicine, the Fetzer-Pew Commission, and various nursing organizations have called for the implementation of Relationship Centered Care (RCC) which has been shown to bring about measurable improvement in client outcomes, service operations, safety, and satisfaction of both staff and clients.

Subjects in this study emphasized the importance of assuring that relationships between nurses and other professionals are healthy. They noted that discordant relationships among the work group have an impact on the nurse-client relationship, and on all other relationships. These findings mirror study findings, positions, and recommendations being made at the national level that Relationship Centered Care become a structural expectation in health care organizations and a central part of the education of health professionals. Nurse leaders should actively support the move toward implementing Relationship Centered Care. This type of environment change can facilitate reorienting health professionals and organizational decision makers to the centrality of nursing's role in healing and how relationships affect the implementation of this role.

Conclusion 3: Nursing's central role of placing the patient in the best position to heal must be understood, asserted, and supported in order to create a healing environment.

Fifty per cent of the themes inferred from subject interviews were related to nurse relationships with her/his clients. In 1992, Quinn asserted the notion that the nurse *is* the client's healing environment. his notion has roots as old as Nightingale and as visionary

as 21st century concepts derived from quantum physics. ne of the themes from this study, “nurse as environment”, echoes Quinn’s message. oicing her view within the context of SUHB, Quinn reflects on the “nurse as environment”:

> Think of the nurse as the environment of the client. [From] this perspective, turn towards her/his understanding of the nurse self as an energetic, vibrational field, integral with the client’s environment. Questions we might ask if this is the focus might be, if I am the environment for this client, how can I be a more healing environment? How can I become a safe space, a sacred healing vessel for this client in this moment? In what ways can I look at, into this person to draw out healing? How can I use my consciousness, my being, my voice, my touch, my faith, for healing? (p. 28)

Nurses confront major barriers as they attempt to “be” the healing environment for their clients in an industrialized health care setting where nursing’s role is defined by medical management priorities and clinical standardization (Cowling 2004). In a study of quality nursing care, Gunther and Alligood (2002) found that quality nursing care has been defined as a product rather than a professional service. They observed that nursing care is not evaluated based on achieving the individualized goals of the client, but based on the curative or service outcomes defined by the health care organization. The findings in this study indicate that to fulfill their healing role, nurses must be able to practice in an environment where their central function is perceived to be helping the client to heal.

Since most health service organizations operate within a medical model orientation (focus on diagnosis and curative interventions), the challenge is effectively influencing decision makers to affirm that facilitating the healing role of the nurse is in the best interest of the organization. In recent decades, nurses have been co-opted into assuming greater and greater responsibility for functions that primarily maintain operations rather serve the patient directly. As a result, nursing’s central role (putting the patient in the best position to heal) has been diminished or lost. In order to re-establish the preeminence of healing as nursing’s central role, nurse leaders will need to present an evidence-based case for allocating the necessary time and resources and for relinquishing

non-nursing service maintenance functions. In the literature review, several cited studies provide evidence that a healing environment improves health outcomes, increases satisfaction, and decreases costs. The challenge is in expanding and effectively using this evidence to produce the changes needed so that nurses can return to their central nursing role.

Conclusion 4: Theory-based practice is essential to professional level care.

Theory-based nursing is the means for advancing professional level practice as described by these nurse experts. Without a conceptual framework for guidance, nurses are at risk of having their practice defined by technical functions. Theory-based practice provides the nurse with the framework for autonomously determining how to design and implement professional level care. Based on a review of healing environment literature and an analysis of these study findings, this investigator concluded that nurses who use theory to guide their practice are more likely to consider creating a healing environment and facilitating healing as central functions of their role.

Findings from this study indicate that designing individualized care is essential to creating a healing environment and is a hallmark of professional practice. The curative aspects of care involve a myriad of standardized technical interventions. Designing care is directed specifically toward providing the information, resources, and practice modalities that will be responsive to the appraisal of the client's unique pattern. Inferences from subject interviews indicate a professional nurse, guided by nursing theory, can skillfully incorporate needed curative interventions into an artfully designed plan to facilitate healing. Subjects suggest the design may include creative and energetic modalities, such as guided imagery, therapeutic touch, journaling, music, art, and movement exercises. In addition, the design may provide a variety of options for the client to expand his/her knowledge about developing a healthy life pattern. Subjects emphasized that the design should be developed collaboratively with the client by using a conceptually grounded approach. As the subjects clearly articulated, the striking

characteristic of this partnership is that the nurse serves as a guide and expert resource, but does not attempt to control the client's choices or experiences. According to these subjects, the nurse respects and honors the client's right and responsibility to determine his/her own healing journey. Nursing theories in general, and SUHB specifically, provide the framework for designing this type of care.

This investigator was struck by the extent to which theoretical orientation defined the practice of the nurses in this study. Though all of the subjects were experts, they were educated, located, and practiced in diverse places. The one thing they had in common was use of the SUHB to guide their practices. Interviews revealed a high degree of congruence regarding how they viewed their professional role, how they structured practice, and how they related to clients. Their commitment to nursing goals took priority over all other responsibilities. This investigator inquired about how theory is addressed in basic and graduate nursing education. As has been the case in service, nursing theory has been marginalizd in deference to educational foci on curative interventions and use of technology. This investigator has concluded that a return to emphasis on nursing as a unique profession is related to a return to nursing theory as a guide to practice.

Conclusion 5: Individualizing and partnering are as critical to healing as best practices and clinical standardization are to curing.

Study subjects indicated that individualization of patient care is essential to creating a healing environment. Individualization is a significant aspect of SUHB concept of the Science and Art of Nursing Practice. As indicated in the themes, the client identifies his/her individual needs and sets the trajectory for healing. Though there are no mandates requiring organizations to provide structures with the capacity to individualize care, users of health care services are making their dissatisfaction within different health care services evident through public and political discourse. Nurses have voiced a strong preference for supportive environments as reflected in work force trends and professional publications. Client and nurse satisfaction are the priority incentives to create

organizational structures with the capacity for creating healing environments while maintaining necessary standardization of curative functions. Findings from this and other studies, for example, Malloch (1997), indicate organizations that value healing and provide the conditions necessary to create healing environments increased both nurse and client satisfaction.

This investigator has concluded clinical leaders can impact the structure of nursing care delivery through revision of Nursing Practice models. Over the past two decades, Nursing Practice Models have followed the standardization trends prevalent in most health service organizations. Rather than designing care plans for individuals, nurses frequently "pull up" a standardized, electronic care plan that addresses common problems associated with the client's diagnosis. Some think the care has been individualized if preferences regarding an intervention are noted. This investigator has concluded that to create a balance between individualizing and partnering with clients and standardizing best curative practices will require reorienting nursing philosophy and restructuring practice tools.

Recommendations

The findings in this study point to the need for professional exploration of how nurses can fully develop the capacity for creating healing environments. This investigator chose to recommend questions for consideration and formal inquiry by key professional leadership groups.

Recommend academic leaders, faculty and researchers consider:

- Do baccalaureate graduates have the preparation in theory based practice necessary to actualize a professional role?
- Do graduate level students have adequate preparation in theory based practice and inquiry to provide leadership in clinical applications of theory?
- Are educators evaluating what students use to guide their practice?

- Are nurse researchers studying healing and the healing role of the nurse in ways that will impact practice and health services policy?
- Are nurse researchers investigating the impact of decreased opportunities for nurses to create relationships with clients in current health care cultures?
- Are nurse researchers investigating the influence of healing environments on patient outcomes?

Recommend nurse leaders and advanced practice nurses employed in clinical settings consider:

- Are nurse leaders asserting nursing's healing role in ways that impact organizational philosophy, design, goal orientation, resource planning, and evaluation?
- Do nursing practice models reflect healing as a central focus? If not, what then and why? Are we satisfied with models that ignore healing? How do we introduce these into current environments?
- Are nursing quality measures sensitive to healing processes and outcomes? Can healing practices be ascertained, understood, documented, or measured through existing metrics?
- Are nurse leader organizations or professional policy groups advocating for structural supports to create healing environments in health care settings?

These considerations are directed at specific groups and made in the form of questions to stimulate inquiry among key leaders in nursing to reexamine professional commitment to nursing's unique role in facilitating client healing. This investigator plans to disseminate these questions to relevant groups through publications and presentations. In addition, this investigator will be working with a group of clinically based nurse leaders in a large academic health science center to revise the organization's Practice Model in order to create a balance between facilitating individualized client healing and implementing standardized best curative practices. The group's stated purpose is to

develop a model as a foundation for creating a healing environment. This project will be evaluated and the results published. Others may find that pursuing analogous initiatives might strengthen their nursing culture and positively impact client care.

Summary

The purpose of this study was to identify and describe characteristics of a healing environment from a nursing perspective. Using a qualitative methodology, this investigator interviewed a purposeful sample of 9 expert nurses who practice within the conceptual framework of Rogers' Science of Unitary Human Beings (SUHB). Data were collected through phone interviews. There were fourteen themes inferred from the subject interviews. These themes were organized into three categories correspondent to three of the research questions; the three categories are: manifestations of healing, relationships and conditions characteristic of a healing environment, and nursing practices and processes identified as facilitative of healing. The investigator integrated the thematic findings from the subject interview responses with conceptions inferred from the interviews as a whole to formulate an interpretive narrative description of seven characteristics of a healing environment. These characteristics emphasized respect for client autonomy, power of client-nurse partnership, individualization of care, nursing's unique role in facilitating healing, the importance of relationships and organizational culture, and the value of theory based nursing practice. From the findings, the investigator concluded that: there was congruence between themes identified from subject responses and SUHB core concepts; that relationship is the most powerful influence on the healing process; that nursing's role is central to creating a healing environment; that theory based practice is essential to professional level care; and that individualizing and partnering are as critical to healing as best practices and clinical standardization are to curing. Based on study findings and literature review, this investigator recommended specific questions to guide assessment of the status of

research, education and practice development and application of knowledge about the creation of healing environment from a nursing perspective.

APPENDIX A:

SAMPLE COMMUNICATIONS AND DATA COLLECTION TOOLS

The following generic forms and related processes were approved by the UTMB Institutional Review Board for communication with study subjects, interview conduct, information verification, and data management.

Confirmation of Subjects Participation in Study

Demographic Profile Form

Interview Guide

Request for Interview Verification

Confirmation of Subjects Participation in Study

Dear Subject,

This e-mail is a follow up to our telephone conversation and serves to confirm your verbal agreement to be interviewed for my dissertation study entitled *Characteristics of a Healing Environment as Described by Nurses who Practice Within the Theoretical Framework of Rogers Science of Unitary Human Beings*. In accord with IRB procedure, your agreement to participate in the interview affirms your consent to participate in the study Attached you will find a demographic form and the interview guide. You will note that the demographic form has space for a pseudonym. This pseudonym will be used to identify tape recordings, transcripts, and other tools that require data source tracking. Your identity will remain confidential. When the study is complete, the tape recordings of our interview and all other documents linking you with specific data sets will be destroyed. I would enjoy having you provide a pseudonym for me to use; if you prefer, however, I will assign one. I would appreciate your completing the demographic form and returning to me by e-mail. I will be using the attached interview guide for our telephone interview; I do not want a written response prior to the interview..

Please e-mail me notice of 2 or 3 times that you could be available in the near future for a telephone interview. Based on your availability, I will schedule an interview time

If you need clarification or would like to contact me for any reason, you may reach me at work 409-772-8200, at home 409-762-9059, by fax 409 747-1531, by cell 409-392-1159 or e-mail pwaters@utmb.edu. My mailing address is recorded below my signature.

I really appreciate your agreeing to be in my study. Each of the study participants was carefully selected. You truly represent an important practice and scholarship perspective. I look forward to talking with you soon.

Best regards,
Phyllis J. Waters, RN, MS
The University of Texas Medical Branch
School of Nursing
301 University Blvd.
Galveston, TX 77555-1132

Demographic Data Form

CHARACTERISTICS OF A HEALING ENVIRONMENT AS DESCRIBED BY EXPERT NURSES WHO PRACTICE WITHIN THE CONCEPTUAL FRAMEWORK OF ROGERS' SCIENCE OF UNITARY HUMAN BEINGS: A QUALITATIVE STUDY

Phyllis J. Waters, RN, MS

1. ***Pseudonym:*** _____ Date: _____

2. Indicate age category

___ 21 – 30 ___ 41 – 50 ___ 61 – 70

___ 31 – 40 ___ 51 – 60 ___ over 70

3. Indicate gender: Female _____ Male _____

4. What is your ethnicity: (√ the best response)

___ Caucasian, non-Hispanic ___ African American, non-Hispanic ___ Hispanic

___ American Indian or Alaskan Native ___ Asian or Pacific Islander ___ Other (please specify) _____

___ Unknown

5. What is your current marital status (√ one response)

___ Never married ___ Separated ___ Married

___ Widowed ___ Divorced ___ Living with significant other

6. What region of the country do you reside in? (√ one response)

___ Northeast ___ East ___ Southeast

___ Northern mid-west ___ Mid-west ___ Southern mid-west

___ Northwest ___ West ___ Southwest

7. Since initial registration, how many years have you been employed in nursing?____

8. Please attach a CV or resume. If none is available, please describe your educational background and experience in nursing (attach description or record on back of this form).

Interview Guide

CHARACTERISTICS OF A HEALING ENVIRONMENT AS DESCRIBED BY EXPERT NURSES WHO PRACTICE WITHIN THE CONCEPTUAL FRAMEWORK OF ROGERS' SCIENCE OF UNITARY HUMAN BEINGS: A QUALITATIVE STUDY

Phyllis J. Waters

Thank you for agreeing to participate in this study. My interest is in the characteristics of healing environment as described by expert nurses who use Rogers Science of unitary Human Beings as their framework for practice. You were selected because the published descriptions of your practice activities indicated you would be a good informant on this subject. In responding to my questions, I would like for you to relate to your own clinical practice as specifically as possible. It may be helpful to envision one or more patients you have cared for in framing your responses.

1. When you make the clinical judgment that a client is exhibiting manifestations of healing, one could posit that part of your judgment is based on changes you have observed. Can you tell me about those changes that you consider manifestations of healing, as you perceive them?
   Prompt Questions:
   - 1.1 Can you describe for me how you perceived these changes as reflective of healing?
   - 1.2 Is there any particular order, sequence or pattern to the changes?

2. Can you recall the conditions that were associated with these changes
   Prompt Questions
   - 2.1 In your view, were relationships important in bringing about these changes? If so, can you describe those relationships and their impact?
   - 2.2 In your view, were ideological or philosophical perspectives a factor in bringing about these changes? If so, can you describe those perspectives and how they influenced the changes you observed?
   - 2.3 From your perspective, were there physical environment or aesthetic factors that were important in bringing about these changes? If so, can you describe the nature of these factors and their significance?
   - 2.4 From your perspective, were there any institutional or structural factors that played a role in bringing about these changes? If so, could you describe them and their impact?

3. Can you describe for me the nursing practices you think are important in bringing about the changes you consider manifestations of client healing?

4. Is there anything else you think is important about creating a healing environment?

Request for Interview Verification

Dear Subject,

Attached to this e-mail is a transcript of our interview and the Interview Guide that was used. I would like to ask you to verify your responses reflected in the transcript. The purpose is not for you to try to recall the interview per se, but to verify that what is recorded accurately reflects your perspectives, interpretations and conclusions regarding the practice experiences and observations you shared.

Please make your corrections or additions on the transcript draft. You will note that each line is numbered and there is space provided to the side for you to make corrections, comments or additions. I would appreciate your making additions that you believe will clarify or enhance the information. Space is available at the end of the transcript for lengthier contributions. If it is convenient for you, make the corrections on the electronic version of the transcript and return to me by e-mail; use the "forward" function to assure I receive your changes. If it is more convenient for you to make hand written entries on a hard copy, please let me know and I will send you a hard copy of this document as well as a stamped, self addressed envelope. Either e-mail or hard copy feedback will be appreciated.

Again, I would like to thank you for your willingness to work with me.

Best regards,
Phyllis J. Waters, RN, MS
The University of Texas Medical Branch
School of Nursing
301 University Blvd.
Galveston, TX 77555-1132

APPENDIX B:

COMBINED THEMES DOCUMENTATION

Healing Manifestations Themes

I. Recognizes need and demonstrates intent to heal

A. Subject A

When there is a constraint or some dissonance in the energy field that may come from an illness or a behavioral issue, the dissatisfaction begins to grow and the tension comes to an aware level and people decide, 'I want to change'. They gather information, look at alternatives as a result of this information and decide it is what they want to do and further decide on a course of action for themselves. As they participate in this the orientation of their energy field changes and as it does, you begin to see changes in the field itself as is evidenced by manifestations. Sometimes the changes in the field are overt, subtle, deliberate, or maybe unaware, or it could be very blatant.

B. Subject E

It's like the pain brings them through the door but the things that we really work on together is how they can generate different options for themselves and really free themselves from how they saw themselves before. That is the emancipatory piece of healing. They have their self definition of their field and who and what they are and something impinges on that which creates discomfort for them and when we work together and create this new and unique field, what happens is they find that they are freed up from their prior identity. They have new ways of being in relationship with themselves and other people.

C. Subject W

A study that I did with nurses and the patients with whom they worked in a healing setting gave me some important insight. Both nurses and clients had suffered the incidents in their lives made them look different, seem different, turned them around, caused them great difficulty. Often these

were losses or major health events but they were events that made them sit back and say, 'Where and who am I? Where am I going? What's my life all about?' The emotional crisis evolved from the obvious life crisis. That was the groundwork for something to happen. That recognition is the beginning of healing. You don't have real healing as I'm describing it without that recognition. So the key to movement toward the healing experience is the person recognizing that something needs to change…. [In the self and environment].

D. Subject A

When people have things going on in their lives that they are no longer willing to tolerate, then there is some level of intention. Sometimes that level of intention may not even be in their conscious awareness but it is there. Some part of their energy field begins to express, 'We've got to change'. So that subtle movement begins. At some point it brings it to their conscious awareness and they recognize, 'I can't live like this' in the case of people who are addicted to substances. Or, 'I don't want to live like this anymore'. So what is needed to change? One of the manifestations of healing is the subtle changes that begin to almost snowball until they get to the conscious awareness of, 'I'm not happy with the way things are and I want to change'. There is a growing discontent that brings to the forefront the need for change.

E. Subject W

I was trying to get some sense of order or some sense of flow between focused intent and intentionality. Here I am defining intent as a process. Intent as a person's focus on changing something specific. Intentionality is a move into the capacity to become whole, which is a much broader one than intending to change a particular aspect of your energy field. So the process of moving from intent to intentionality or from intentionality to a focused intent really depends on the individual's situation and how they perceive this situation. There is this movement, like a circle, I guess, between intention and intentionality and intention. One informs the other and they go on together to form a whole. There is awareness that the person has that will help the flow between a focused intention to change something or one aspect of their life or a focused area to a broader understanding that this is a reflection of their whole. Then the intentionality to shift into a different way of being occurs. Then sometimes you will have people who really start with a sense of their awareness is they are becoming a whole person and then they come out of this place and focus on changes that would be highly intent in nature.

F. Subject W

I think one of the most important things in healing is the sense in purpose and meaning and direction. This also comes from one's unique intentionality. Intent to change is immensely important. We tend to change our orientation. When we change our orientation the direction of the energy flow changes because we've shifted. We've made a conscious decision to do things differently. When we do this energy flow changes, the patterns change and the manifestations of patterns change.

II. Engages knowingly in reorienting and mutually patterning energy field.

A. Subject M

When you are looking at the sequence of healing, you are basically looking at the client's definition of their start point. Where something they want is not present in their lives and they are moving toward that. The client finds where they think they are in their goals for healing and where they want to go. They tell me what is getting in their way and that's where I very often use imagery because it is a way of changing beliefs and often it is the belief systems that are blocking the person's healing.

B. Subject W

Clients go through the process of trying to figure out what to do and learning different ways of dealing with things. Changing interpersonal relationships, changing environments. They work really hard at this phase, through the healing process, and then all of a sudden there is another shift and they really feel transformed.

C. Subject B

There is a difference between curing and healing. If you are working with someone who is dying of cancer, their cancer is not going away and it's there, but they can still have a healing experience. They can be healed by recognizing the wholeness of who they are and looking at things and seeing them in a different way than they've ever seen them before. One of my patients – a young man who had HIV and was dying – began this experience because he felt compassion and concern from a human being that really loved him, which is a love for human kind. We really know that this is genuine and sincere. I think that is what we do as nurses. We provide a special kind of love. It's unconditional and is a genuine love for humanity.

D. Subject B

Sometimes healing takes place in strange ways. A patient that I worked with said, 'I remember you, I remember you for just the few minutes that I was in here and you touched me and I could feel your energy.' It tells you that the transpersonal is very powerful, doesn't it? It's present and it also tells you that we do have this as a potential and we just need to use it.

E. Subject C

I can tell you it seems like there is an emotion associated with the movement. What happens is that the meaning that is in all of that seems to feel to be like fuel. You would think that if it is an emotional experience it would be draining, but it isn't, it's energizing. When you are engaged and you know you are and they know you are, things move quicker – it speeds up – it's like the whole process of getting well with whatever is going on and it goes more rapidly. There is an emotional component of healing. If somebody had resentments and there is a sudden shift where the person that is being held in this very hard hearted and resentful way is suddenly turned to in a different way so that instead of resentment and hate there is a sudden moment of understanding the other's position, they finally see and get, 'That's why'. If forgiveness happens in that moment, I would say they come into new relationship with that other person, whether the other person is there or not, it doesn't matter. Typically when that happens, the person is higher than a kite for days in terms of energy. The person's physical limit of energy seems boundless. So, I would say energy is freed in that system and that can be used now for more growth and movement towards wholeness.

F. Subject M

When the frequency of energy is high, that's when you get lots of rapid changes. At the other end when the wavelengths are long and the frequency is low, changes are still going on but at a much slower rate. Rogers believes that change takes place through wave length frequency. It takes place at different speeds, so to speak. Although it is not a continuum, you can shift from low to high very quickly and back again or all over the place. But the idea is when you are at a very high frequency point then changes take place rapidly, in an instant. Denser energies are the lower level frequencies.

G. Subject M

One of my clients had a tremendous healing power obviously since she had gotten herself walking again after being told she could not. They told her there was no point in having any more chemotherapy as it wouldn't help her but she believed it was helping her. She kept having it so for her that was healing. She did want therapeutic touch and imagery but did not want herbs or any of those other alternative therapies for cancer. She was very engaged in how she expressed her healing needs.

H Subject V

If they can respond to humor then we may have moved down the line towards healing. So to the degree that they can claim the possibilities, you see them coming into a healing mode. We're engaging the energy to help them move to a new state of being. It is partly my energy and partly their energy and partly universal energy. It is moving them to a new state of being.

I. Subject M

So people who are moving towards healing are people who are usually shifting from lower to higher power choices and from less awareness to more awareness. From lesser freedom to act on their intentions to greater freedom to act on their intentions. And in involving themselves in ways that help them to get to where they want to go. There are four dimensions of power [awareness, choice, freedom to act intentionally, and involvement in creating changes]. When the four dimensions operate together, then its power. When you look at power, you look at all four dimensions in relation to each other. This power enables clients to knowingly participate in change. Information enters the patient's field and allows them to participate in creating change. First they gather the information and look at their options and then they get necessary information that helps to shift their directionality. Then they are open to new information.

J. Subject E

How they relate to their experience changes. It's like they open to new information and they are released to have access to universal energy. They are able to process and integrate new information that allows them to move forward and change. Where they came in perceiving themselves as defined by or described by their pain experience or their illness

experience, when they move through this process they look back and see themselves in a different way.

III. Expresses sense of expanded awareness and sense of connectedness with self, others, and a greater whole

A. Subject S

There is an expanded awareness and people are connecting in ways that they haven't been connecting before. Moving from an isolated, fragmented position into a connected, more coherently whole position. They come into our substance abuse program feeling isolated and alone and they are not feeling connected to anything outside themselves. They are running their life on a battery, as opposed to having an alternator helping the battery along. When they see they can quietly resolve issues in their lives by reflection they feel a great relief.

B. Subject W

After patients have gone through a series of treatments with nurses using alternative therapies, I've noticed that although they may still have the illness, they feel like they know themselves more and they are more comfortable with themselves. Feel more a part of the world and the universe. It was a real sense of being a part of a greater whole for both the nurses and the clients. So their healing is the connection with themselves and their connection with others and their expanded connection at a universal level. I also think that everybody has the capacity to heal. Different cultures use different mechanisms to facilitate this. I think in other cultures there is an expanded awareness that is not necessarily put down in words. It may be put down in symbols, in movement, or in art. In Brazil; for example, women have this ceremony where they are taken over by a spirit. They dance the spirit and it is very complicated. But it is healing for them when they participate in this. In Japan people looked at me so strange when I ask, 'What do you think healing is?' It is a very spiritual culture from their perspective and that is how they understand it. There is a lot of ways in terms of feeling connected to the environment and nature and in honoring ancestors, for example. This honoring of ancestors and feeling this continuity over generations creates this universal sense of connection. So as a part of responding to the recognition of the need to heal or change, one of the things that happens is that people have a sense of connection with expanding beyond themselves and to the universe. The sense of connection with themselves internally and with the rest of the universe has expanded.

C. Subject S

When I work with people my whole goal is to expand their awareness. This is really all I do. When I notice that this has happened, that their awareness has expanded, that is one of the manifestations of healing that I recognize. I see two levels of manifestation. One is by taking action for themselves through their expanded awareness and the other is by sharing in very specific ways with others about this change within themselves. They tend to bring people in that they feel connected with and want to make them a part of the healing process that they are experiencing.

D. Subject D

This seems to be a big thing with people I've worked with who are seriously ill and dying. It's exploring their spiritual side and very often there is a transformation with whatever their orientation had been and very often they've not been keeping in touch with their spiritual nature, yet it comes back. So, one of the manifestations that are fairly consistent is moving back to a sense of unity or a sense of wholeness or coherence – connection with that which is greater than oneself. So people who are moving towards healing are people who are usually shifting from lower power to higher power choices.

E. Subject D

People having what we might term as spiritual awakenings are good examples of healing. This seems to be a big thing with people I've worked with who are seriously ill and dying. It's exploring their spiritual side and very often there is a transformation with whatever their orientation had been and very often they've not been keeping in touch with their spiritual nature, yet it comes back. So one of the manifestations that is fairly consistent is moving back to a sense of unity or a sense of wholeness or coherence – connection with that which is greater than oneself. So people who are moving towards healing are people who are usually shifting from lower power to higher power choices.

F. Subject M

Happenings around death can be so transforming so quickly. I think we are receptive to healing so much more at that time. The consciousness is different somehow. Very dramatic things can happen at that point and they probably happen frequently. There is very high frequency going on then. That is when changes can occur rapidly and instantly…..when somebody

is really seriously ill, spiritual connection seems to take place. Now some people want to talk about death, others do not.

G. Subject A

In substance abuse early recovery is characterized by shifting in the energy field. 'Yes, I am – no I'm not – Yes, I'm better, no I'm not'. There is ambiguity in the field until they get to the point that they just realize, 'I can't keep shifting back and forth like this – I have to continue to fine tune my program'. This changes the direction of the flow of energy in the field and the manifestations will change. Many times they will move from the struggle of dealing with the specific intent to abstain from substance abuse into experiencing serenity in their recovery process. [move from specific intent to intentionality in seeking wholeness] Though each person describes it differently, it seems to be this all encompassing peace, which may reflect their transformational stage. They describe their serenity as peacefulness and almost assurance on some level that they would never have to deal with alcoholism or addiction any more but they would have to deal with living on a day-to-day basis. As the changes in their flow become more entrained in the direction they choose to go, they feel calm and empowered that they can make the right choices as they've been able to live through a very difficult time. Part of the healing environment is to give the information and once the directionality has changed; there is calmness about the field. There is no longer dissonance as there once was. Flow is calmer and the energy more organized.

IV. Exhibits observable and intuitively understood human field pattern changes

A. Subject D

I think the difference between curing and healing is an important one. I think of curing as a culminating kind of an event and it is a yes or no. I think of healing as an ongoing process that is endless because it is almost one and the same with the life process. So what you have are moments of healing, moments of right relationship, moments when something comes together in a new way that gives the system more energy or more wholeness in that moment. Then the system is changed from that point on and goes on.

B. Subject W

They also have to recognize that the process is happening. There are periods when it is unconscious and they are not aware that it is happening and then there is an 'Ah ha!' kind of thing – the recognition may be there but they may have difficulty articulating it. You can't just mouth the

words and make the transformation actual, it is reflected in how people live and work in their relationships. There seems to be some serenity that goes with this transition and transformation. Sometimes it's very hard for them to explain.

C. Subject B

Healing I see it in whole. It isn't something I see in parts. I just know it's there or it isn't there. I think it's a process. Sometimes you can see the process evolve. You can see the anger in people and then there is less anger and then the resolution or peace. And I think the process… is so important and they can feel that presence.

D. Subject D

We may not recognize that healing is happened until months later, for example. We recognize that we are fundamentally different than we were. I had this experience myself around a relationship with my father. Suddenly I realized I wanted to reconnect with him when I was standing in front of the greeting cards in a drugstore at Easter time. Recognizing; in fact, that there had been healing happening, completely beyond my consciousness. I didn't even realize it. At some level I had already shifted and that was the beginning of acting on that healing and I actually did send that card.

E. Subject S

You get a sense of who is really moving toward a healing path because they are taking action. How do I know that healing is happening? I can sense it. One of my clients brought his friend so I realized he must have had a significant experience. So they bring their friends, which is one way of knowing that you've made some kind of positive difference with them. Also they make changes in their lives. This is how I see the manifestations of healing. Positive behavior change from their perspective.

F. Subject D

Healing may not manifest itself at a physical level. A good example of this is with people who are dying. So often nurses that are experienced learn to recognize that when someone looks like they are dying and all of a sudden wakes up bright and cheery one morning that this is likely to be the last 'hurrah'. This is likely the moment that precedes the actual death. People sometimes rally near the end and I see this as a healing moment. They are coming into right relationship at some level that is spiritual and emotional

and has given their system so much energy and freedom that the person actually physically looks like are getting well. But, in fact, then we see the next day the person dies. There is a healing moment that doesn't necessarily correlate at all with the curing of that person.

G. Subject C

Some observable manifestations of healing, I believe, have to do with emotion and movement, facial appearance and eyes, affect the position of the body and the voice when a person speaks. Not just what is said, but how it is said. The rhythm of… speech. What we are talking about is the whole collection of observables that we put some label on. I think nurses do help people articulate what they are experiencing. When something has been inside and doesn't have words, the nurse can help that person find the words to express. What happens with that expression is there is an emotional release. It's a structure that helps them understand or have some meaning.

H. Subject C

What we haven't learned is to see the whole. I think we see it, I'm not sure we can perceive it all at once so what happens is that I think we notice the pattern has changed and I think this is a holistic thing. Intuition is big. The things that we know don't just come out of the air. There is a perceptual pattern that is enough that we become aware of it. So appearance of face and eyes, I think is reflective. I think it's in the voice and I think that even in the manner of movement. We perceive the whole and then we try to understand the whole. In that process we sometimes go to those things that seem to be making up the whole and try to express them. If you've gone into mutual process as a nurse with this client in previous meetings, then when this person sees you, there is a way in which your proximity and his/her seeing you generates an eagerness. What happens is not just in them but in both of you. The pattern changes are reflected in that interaction. It's like what they say and how they say it, both. Maybe more than that we don't understand, but it's noticeable.

I. Subject B

Some of the manifestations of healing and changes depend on the environment and in the setting. In a hospital setting you can see manifestations in situations where you notice a relaxation of the muscles of the body and a regular rhythm of breathing in people who are on bed rest or who are on a respirator or in severe pain. Expression changes. Also,

the tone of their voice, it's mostly non-verbal though sometimes they do say, 'I do feel so much better'.

J. Subject S

Bonding or setting up a healing environment is not chaotic. People need to like each other and the client needs to feel comfortable. It's important to connect the client with a caregiver who can bond with him or her. Then identify problems from the client's perspective. What they think their problems are and this is how we can help create an expanded awareness. In the moment I see relief I see a person who feels understood and a person who feels tremendous relief because what once seemed like an unsolvable problem just melted. I see the experience of hopelessness transformed into hope. They don't fall into the same hole over and over. If things come up again, they recognize they can use the same process that we use and know that it will work to bring them some relief from their hopelessness.

K. Subject S

The manifestations that I see are increased awakenings, connecting with people, taking action and trying to share the help with others.

L. Subject D

What I notice about healing happening is really in the moment and it's an awareness that something has shifted so it's not necessarily a sensory input. It's not necessarily data that's coming from our 5 senses. It may be an energetic felt sense. It's actually felt just in my own body or my own energy field. I may be sitting with someone and we might be talking and I get a sudden chill or rush of energy in my body. That is really a clue. I take that as a sign of healing and I don't necessarily even know what it is. I simply listen to what emerges, even from my own body, mind and spirit at that moment.

M. Subject D

The energy of the whole field of a person and myself, as one field, something has shifted in that entire field. I think that sometimes it seems that the most chaotic and disorderly point or shift where it feels like the system is falling apart. Then in the middle of that you may have this moment. I see these things as moments of healing.

N. Subject C

The pattern of changes that reflect healing is that the nurse begins to help the client elicit their understanding of what is happening and get some coherence to it. So it becomes a more coherent experience and it's meaningful to them and they understand it as a part of themselves. Then it becomes an energizing peace.

Relationship Themes

I. Right relationship with self and meaningful others

A. Subject M

The mutuality of somebody using their energy in an intentional way, the way that you were doing it, provides the boost that someone might need. Especially if the two people in mutual process have their intentions aligned. I think that is so important since my intentionality needs to be in touch with yours or whatever. If we have mutually united our intentions, it is much more powerful. It's very powerful and all of that is happening, but especially if the person you are doing it with is at the same time connected.

B. Subject C

We've been talking a lot about the integrality of the nurse and the patient and the environment and the integrality of the relationships among those. To me healacy is that elliptical interaction. If that's the case you are just looking at the frequency. So there is this interaction, this process of person and environment and it's constant and the changes occur constantly, usually incrementally. So if you come in and your energy level and your frequency are at a higher rate. You are my nurse and I'm feeling somewhat debilitated, but I feel totally engaged with you. Then that mutual process provides me the opportunity to increase my energy frequency and maybe speed up my experience in some way.

C. Subject M

Sometimes in creating a healing environment, it is helpful to pull back people who have been role models in the client's life**,** to bring people in to ask them to help. Not with their physical presence but with their pan-dimensional presence. The client may recall instances that were very meaningful…this can be an important contribution to healing. I think there is a generational aspect to relationships and just exploring who has been meaningful in the client's life and in the client's family life is helpful. Maybe the client hasn't even known some of these people but they are an important part of the client's roots and…being. It may be helpful…to focus on this and be aware of it in some kind of way.

D. Subject A

> … substance abusers frequently have broken relationships or have developed very tense relationships with their families and their friends. There may have been threats on the part of family members. There may have been disillusionment of marriages. They may have lost significant others and they may have lost their jobs and homes. They may have been threatened, cajoled, or taken to court by key people in their lives. Once these people have gotten into a program and become well established, it is the relationships with the people in the program that help change their flow of energy and create the possibility for them to heal. The energy begins to calm down; it begins to flow more smoothly…and appear less chaotic. The relationship with self is the most important impetus for change and relationships are the bedrock of healing.

E. Subject W

> A woman with scleroderma was incredibly ill and dying. She realized that her relationships with her family were not working. That she was really a servant to them and to her kids and had been just overly self-sacrificing. That she needed to change that in order to heal. She did. She told her kids that she wasn't going to see them every weekend and she began to set limits with her adult children. She then related to me [Subject W] and this made a big impact on her process of healing. Reconciling her relationships with herself and with her children made it possible for her to begin the healing process.

F. Subject E

> I think the authenticity of the relationship, the being with the person in ways that they can appreciate the being with is what will create a healing relationship between the 2 or 3 people or however many there may be. Healingness of the relationship is really a manifestation of the relationship. Moving into a right relationship with self enables one to move into right relationship with others.

G. Subject E

> When people don't feel that they have options or that there are possibilities, their perception of their field diminishes. It is like, 'Are you looking at a point or a wave of energy?' It's the perception of the closeness or the openness of the field that the person is relating to. So I

think that people's perceptions of themselves are a pattern manifestation of their relationship with their energy field.

H. Subject D

When there is this notion of right relationship. When some element of the system comes into new pattern and the pattern is a healing pattern, then one of the things that goes along with that is there is more energy for the whole system. Whatever level that right relationship emerged in, more energy is available for the whole to do the work of that system.…the way I think about healing is this emergence of right relationship at one or more levels of the person. There is an increase in order or an increase in energy.

II. Intentional Mutual Process

A. Subject C

Some of the dissonance in the patient's energy field gets dealt with because the patient is sharing things with the nurse and the nurse is interacting with the person in such a way that their process becomes more mutual. By that I mean they understand and know more about each other. Then I think what happens is that they are able to sort of move together. At that point, when it's mutual, the nurse is moving with the patient and the patient is moving with the nurse. I think of it like jumping rope. Remember when you were ready to go in and jump. …you would stand there and sense and use your hands and often you would sense the rhythm of that rope. You go in and start jumping. When you are really and truly in that process with the patient, it's like you are actually going to jump right with the rhythm of the rope. When we really have these relationships that are mutual and we are moving that patient along, what I think happens is that we are in their rhythm and we sense their rhythm.

B. Subject M

Mutual process magnifies the possibilities of what can happen when intentionalities are united and that is a lot of what happens in any kind of therapeutic relationship. We talk about relationships heal no matter what kind of therapy or healing in any kind of paradigm or any kind of theoretical perspective. It's always the mutual process that is so important in what happens and in change. There is a special type of synchrony that in happening in health patterning and the healing process work. The mutual process when people are willingly committed to it brings about healing. If someone is freely and you are freely committed to a certain intention there is a lot of healing energy attached to that.

C. Subject S

It is through mutual process these people are here to help us heal as much as we are here to help them heal. This is how the world works. I know I'm learning from a client when I find myself writing something down because it is really interesting and cool and I want to think about it later. Bonding is happening because the mutual process is in action.

D. Subject D

It is important in the relationship that the client defines the changes that needs to take place and the terms of the healing process.

E. Subject E

So if my ego is tied to the outcome or to my solution, then I really am not participating fully in this mutual process between us. We partner in creating a relationship and my job is to bring resources into the relationship that can be useful to the person and to open up possibilities for him/her and expand…consciousness to those possibilities.

F. Subject D

There has to be a willingness to allow the system to find it's own way and a trust that if you simply stay out of the way and keep it basically safe for people, not allow it to become disruptive, the system will do that. Groups will; in fact, come to a new place but if you pull the power back, they will never take it again. That is how I experienced the healing process in a group. When you actually allow it and the group comes through that, the healing is phenomenal. There is order, a decrease in the chaos, and there is way more energy. The group becomes activated to do something, whatever it was trying to do. More freedom in creativity comes through. People having what we might term as spiritual awakenings are good examples of healing.

G. Subject S

The relationship is important and the environment is an atmosphere and the atmosphere has to include a group of people that like the clients they are taking care of. We don't fix clients in the program I work in. They might not know who Martha Rogers is, but they have to be thinking that everything is purposeful and there is no such thing as a coincidence. Those kinds of thoughts are part of our process.

H. Subject D

If a nurse sits there in her position of judging and knowing and thinking she knows the client and thinks the client needs to do what she thinks the client needs to do, that can kill the healing process. It's that very thinking that prevents us from having authentic relationships.

I. Subject D

If I'm in a situation with two or more people and the process is flowing and chaos is integrated into the process, I can sometimes feel frightened and want to pull back control. If that occurs I kill the process.

J. Subject E

The thing that is most important is letting go of the ego….. my job is to create an environment and provide the resources for the person to realize or create his/her own solutions. You have to let go of controlling the situation.

K. Subject D

A healing relationship with somebody is so much about holding a space, a possibility, or helping create an environment where the person feels really safe not to know. The patient and provider can be comfortable in the ambiguity of the healing relationship. It's critical because it's really in our profound need to know and to be able to control that we actually barricade the free flow of energy. We block energy as soon as we think we know. The practitioner has to become so comfortable with the ambiguity that the patient can be safe in the ambiguity. Because if that practitioner is not comfortable with ambiguity, then the client will not be either. Under those circumstances practitioners tend to push the client in a direction. The practitioner will ask a question and that will bring the client up into their head more and more looking for an answer that is; in fact, not in their head but it is in the living of the process.

L. Subject S

It is a mutual process as these people are here to help us heal as much as we are here to help them heal. I know I'm learning from a client when I find myself writing something down because it is really interesting and cool and I want to think about it later. I also am aware that bonding is happening because the mutual process is in action. Clients are impressed that I'm writing down what they have taught me and they are more open to

what I'm saying. I sometimes learn simple things like how to store potatoes so they don't rot. When you are learning from clients, open the channels so if you have any wisdom to share with them, they can hear it.

M. Subject D

The nurse must trust that there is an inherent mutual process. You simply create the space and support that there is wisdom in that system that will guide the process and guide the person toward healing. In groups it's much more challenging because the group can fall apart pretty quickly. My experience is that just in the moment where a group reaches the point of chaos, which in a healing model can be the moment just before a breakthrough to healing; the nurse is tempted to take control because he/she thinks the group is falling apart. If the nurse pulls back control in an attempt to save the group, it will kill the whole process of movement toward healing.

N. Subject S

The relationship is important in terms of really truly valuing patients and making an attempt to understand them and then trying to be helpful from their perspective. All of this happens within a healing environment. …. Bonding requires that people like each other. Nurses have to be willing to learn from the patients because it is the 'taking something new' in from the patients that opens up the channel for patients to take something in from us as nurses.… It's important that we pay attention to what we can learn from our patients. When patients see we value what they have to offer us, they open up to us in a new way. We also create a different kind of balance in the relationship with this type of exchange. These relationships are mutual and mutually healing.

III. Energetic influences from collective relational experiences affect present relationships

A. Subject E

The patient and nurse each have relationships that impact the way that they relate to each other. Dissonance in nurse's circle of professional relationships makes it for the nurse difficult to develop a therapeutic relationship with the patient.

B. Subject M

Relationships with everyone in one's life play an important part in the healing process. It's really important to help people with their relationships with others. Healing does not take place in a vacuum; the whole environment needs to be a healing environment. If they are having marital issues, or issues with their children or issues within any important relationships, if there are kinks in them, it really helps if the clients can smooth these out - which isn't easy for any of us. So when you are trying to create a healing environment…you have to at least try to facilitate their reconciling the most important relationships in that person's life.

C. Subject E

There is the immediate relationship that is going on with the person that I'm in relationship with and then there is the field that is beyond us but still encompassing us directly. Then there is another field beyond that, which is including the people that are in our lives. So even though we are in an immediate expression of one energetic relationship, we're influenced by all those other energetic relationships. In creating a healing environment, I must be conscious of the immediate relationship or interaction but also aware of other influencing energetic patterns that contribute to that.

D. Subject E

Relationship Centered Care and the context of that have an effect on the immediate relationship. If you are in a clinical environment where the relationship among the team and the healers [physicians, nurses, etc.] is a therapeutic one, then it has a positive impact on your relationship with your patient. It is difficult to create a healing relationship with a patient when there is dissonance in those kinds of environments…it offers much bigger challenges because there is a drain in the field.

E. Subject V

We need to pay attention to the nurses so they have the energy to give to the patients, then the patient's energy can improve. It is essential. Nursing is a relational practice so the quality of those relationships is key. The nice thing about working as staff on a unit is that nurses have their own uniqueness, too. So some patients may respond better to one nurse than to another.

F. Subject W

A guy I'm working right now is brilliant, funny and delightful but he has no relationships and he is lonesome and suffers from depression. Our therapeutic goal is to create intimacy in his life. Intimacy is an important aspect of having a healthy, whole life. Creating a relationship may be the healing goal.

G. Subject M

You need to look at what I've said about the different groups the person is in their lives and what those environments are like and what is it in those environments that might need healing that can be concentrated on? Sometimes it requires bringing other people in for one or more sessions to work on the group pattern manifestations more directly. That is if the person agrees to that and wants to do it. Very often I find that this is the most effective way to promote healing but it is conscious awareness of what is manifesting in any particular environment and is it or is it not contributing to healing? You can't just say that something is X in that environment and you have to get rid of it because you can't take a piece out of the whole and the environment is a whole. Different environments depending on which group field or individual field we are looking at and what the environment looks like – each group manifests differently. For example, if you look at someone's nuclear family group and what that manifestation was like for the client, it might be different than the manifestation from someone's current family. What is manifesting in that environment or the work environment or the health environment or whatever is going on is highly relevant to the healing process.

Condition Themes

I. Client Centered Design, enhancement to healing---Meaningful Relationship, essential to healing

A. Subject D

The most important part of the patient's environment is his/her relationship with the practice nurse. Whether the walls are painted pink or chartreuse or black, in the moments when the patient is suffering, the artistry of the human connection is indeed the most profoundly important one. So I think the design of the physical environment can be important, but it is not paramount. When …offered without offering a healing relationship, they simply become trivial. When they are used with other support they become much more powerful. Certainly all of us feel better in beautiful surroundings.

B. Subject C

I think aesthetic factors and physical environment are important but they are not as important as the human component of the environment. So I believe we do not interact with all of our environment but the human interaction-the humans in the environment have a much greater impact.

C. Subject M

In response to the question as to whether the physical environment and aesthetic factors are important, I would have to say 'yes' and then I would have to say 'no'. They are not the major factors. I think that aesthetic factors do contribute as everything contributes. Colors have a frequency. You can walk into a room and immediately feel the energy. All these things do contribute to the healing environment. I think the main thing that comes through is the feeling that comes from me [the nurse] to them. Another factor, the attitude of the people who provide care is critical.

D. Subject W

I think an attractive, well-designed physical environment is a nice thing to have and there are certainly environments that are noisy, too brightly lit and where people are interrupting all the time. This certainly impedes the process of healing. One needs an environment where you can create an intimate relationship to facilitate the healing process but I also think that people can create their own energetic environment and that this energetic

environment can supersede what is going on around them. I think about Katrina and I think about seeing people in trailers, in the lunch room, and in crowded clinics. Now granted those were not ideal places to try to create a healing space but I think you can do it with your intention and do it with your energy. You do it through relationships.

E. Subject E

I think that a physical environment can contribute to healing. I think that physical conditions can be patterned in such a way to promote healing potential. I think that healing does and can occur regardless of the physical environment. I think if there is a relationship in which one is supporting another who is seeking to heal that the physical environment is like a myth. It does not matter. I keep thinking about Katrina and the people who survived and thrived through that process and the incredible moments of healing that occurred in that environment. The healing actually occurred through relationships. The dominant condition is the healing relationship

F. Subject C

All the rooms are private now, or at least most of them are. So in a way it can seem wonderful, but on the other hand, we've isolated everybody. So if human interaction is critical to healing, then we may have put something there that isn't always useful. In a lot of cases if a person's door is closed and they don't call on the light very much, they are really in their room a long time by themselves – only with their television.

G. Subject B

You can't say: Ok, this is the kind of prescribed environment we will have because different things in the environment mean different things to different patients. One time there was a picture on the wall and it happened to be a picture that the patient asked me to take away as she said it frightened her half to death. Some things make people feel good. Other things make them feel uncomfortable. People have highly individualized perspectives. As nurses we must recognize that everything has to be evaluated in terms of the individual. You can't do it in any other way.

H. Subject C

If we are talking about a patient in the hospital, we're talking about somebody who we've extracted from their pattern and plucked them down into a different pattern. They are trying to deal with that so the way they deal with it is to try to form a pattern in the hospital. This frequently

comes across as ‘I like my bed table right over there’. That’s trying to pattern their own environment and I encourage people not to get irritated with clients who do that. Something does happen after 2 or 3 days. Even if you travel and stay in a motel or hotel or something, the first day is very different than the 2nd and 3rd days in terms of how you feel when you come in. I think that’s about becoming patterned to that environment.

I. Subject C

I believe in change in the environment. Changing pictures or doing different things within the room. It’s important to let people have pictures of their families when they are in the hospital. I also think those bulletin boards that allow you to put up useful information help to pattern the environment in a positive way.

J. Subject W

There are all types of things that we can do to make an environment more pleasant for patients. Provide softer colors, provide music, provide views through windows, and some hospitals even have healing gardens.

K. Subject V

It’s important that we keep the surroundings orderly and we create calm. It’s about the way the energy resonates. Nurses since Nightingale have been committed to creating order. Creating order and also creating some kind of attractive environment helps to create a positive energy.

L. Subject S

We try to keep our residential area nice because most of the clients are not used to nice. Many of our clients are homeless and to be able to stay in a residential environment while they are recovering from substance abuse is a very unusual and positive experience. It’s very important to have clean and new things. I go around picking up clutter. Clutter and junk gather bad energy.

II. Healthy Nursing Culture Facilitates a Healing Environment

A. Subject D

Alleviating the nursing shortage involves caring and healing within the health care system. It’s important to create an environment for nursing. I call this ‘habitats for healing’. We really need to think about nurses not as

commodities that can be bought and sold but as an endangered species. If you use an ecological model even the questions you ask are different. When you are dealing with an endangered species, you don't try to get more [of the species] into a toxic environment, you clean up the environment first. You make sure that you create a place where when you bring the endangered species, they can survive.….What will be good for healing is what will be good for nurses because the nurses in the institution are; in fact, what is needed for healing. You have to create environments where nurses can nurse. One way to do this is to look at the criteria for Magnet Hospitals. My bias is that you cannot have healing unless the healing relationship is mutual and healing moments are mutual. You cannot have an environment that supports healing for patients if it doesn't support the healing …for the nurse.

B. Subject B

If you have a place that is really focused on creating a healing environment, they will [foster] not only the healing for the patient but also healing for the staff. I think that philosophy of a facility is important and I think that nurses can support each other much more than they do. If the facility fosters innovative healing modalities and focuses on compassionate care that filters down through the process with all employees.

C. Subject V

I think a huge factor that supports nurses in actively participating with patient healing is whether that institution values nursing as nursing. There are all sorts of ways that you can look at nursing. When we finally don't need 'Nurses' Week' anymore, then I will know that we are actually a profession that is valued by society.…Treat nurses horribly for a whole year and then have a week for nurse celebrations.

III. Philosophically grounded, open and in search of meaning

A. Subject B

Having a view of Rogers Science is probably what opened the world to me in terms of the infinite potential, and the processing of human and environmental energy fields. The mutual process between human and environmental energy fields may be the fertile field for healing to take place. Patterning the environment to promote healing is a therapeutic modality that I often use.

B. Subject V

Ideological or philosophical perspectives – I do think that if the atmosphere is constructed to open possibilities, if the philosophy is one of openness and not one of 'Oh, you are my problem today', how do I increase the likelihood that the best possible outcome can happen? That is a philosophical framework. What is the underlying way in which healing works? If we think about it in terms of unitary energy and possibilities, then exciting things can happen and we transcend the problem focus.

C. Subject S

Philosophical model that I use in my residential program is one that I talk to the clients about. I tell them about it because I want them to know where I'm coming from and I tell them they don't have to buy into it f they don't want to. I tell them about our philosophy because they need to know where I'm coming from if they want to understand me. For example: If they have a problem, I might say, 'This is a great opportunity for healing' as opposed to trying to solve the problem for them. This philosophy is a way of thinking, living and breathing. It's the philosophy that creates the atmosphere.

D. Subject C

I think Rogers has probably affected my art – the art of nursing the most. It has to do with the relationship…the nurse patient relationship. With Rogers; of course, if you are talking about the nurse, patients and environment, it is an environment interaction. Art is the best way to describe that.

E. Subject C

Yes, I do think that ideological and philosophical perspectives play a role in bringing about healing and mostly it will be the perspective of that nurse. I guess it would be both in the patient and in the nurse. Yes, I believe that it is important that patients trust nurses. They do, by the way.

F. Subject D

Part of my ideology is to recognize that you don't know what is happening and your job is to just simply support whatever is happening – not to manage it.….I think we are profoundly influenced by our ideology and what we think is going on. We all have an ideology. We simply don't take the time very often to question what it is. So it's often the hidden director,

the behind-the-scenes director, directing the show. One of our responsibilities then; if we really want to facilitate healing, is to take the unconscious, the hidden directors, and get them out front and center so that we really recognize what our philosophy is – what we believe and also what its limitations are. One question is: When are our ideologies getting between ourselves and our patients?

G. Subject M

Acceptance is a great gift that people have. You know when people have that awareness that they are human and what that means. What it means to be human. When people embrace that in its fullest, I think they are able to bring about changes, healing and otherwise. Recognizing our own humanity is a perspective that was empowering in terms of making changes. Power is from within.…..I think one thing that is very important is people who have openness to various ideas. I think an acceptance of different points of view as legitimate beyond their own. …people who believe that they don't have to be perfect...don't have to defend; necessarily, because they recognize that we are all imperfect – we all make mistakes.

H. Subject W

Healing is finding meaning in your experience. I think any philosophical or religious or spiritual background – anything that helps a person make meaning of an experience is essential. People who have had patients who have been through horrible trauma, if they can figure a way to say, 'I've learned from this – I've had to change certain things in my life because of this' – then healing is possible.

I. Subject W

A woman who had many problems with her sister was able to come closer to her and reconcile her relationship when the sister had breast cancer. Both of them found meaning in that. It just came out spontaneously and to me that is really healing. When people need to change and they find a philosophy that can help them change, they make a conscious decision to change within that philosophical perspective. Sometimes energy will not resonate with them around a certain ideology and at other times they will find something that really resonates with them. If it resonates for them from a personal standpoint, they begin to set up relationships with the philosophy and with other people who ascribe to this same philosophy. This is an important step towards healing.

J. Subject S

I have noticed that clients, who get heavily into religion and don't work on their own shadow, don't stay clean long. My long-term successful clients who stay clean have really bought into or are compatible with our program's philosophy: God is in charge.

K. Subject A

I think that in any instance when people have made a change or are looking for information on what to do to change….they have to pick something that will resonate with them…if it resonates with them from a personal standpoint, they begin to set up relationships with the philosophy and with other people who ascribe to that same philosophy.

Practice Themes

I. Theory Based Practice

A. Subject C

> But what makes it nursing in my view, is that I have a knowledge base about unitary human beings that is always in the context of their environment and I look at them as energy fields. There can be a single energy field in the context of their environment or they can be different kinds of group with their energy field of their family of origin and their family now or their work groups. Whatever that environment is like and what is now manifesting in all of these different environments. Then my job is to try to know pattern manifestations by looking at their experiences, their perceptions, and all of this so that we can come to the next phase of the process, which is voluntary mutual patterning that we are doing together. But the basic thing of nursing to me is this knowledge base of understanding human beings in the context of their environment.

B. Subject M

> I am continuously using my Rogerian practice methodology, which is the pattern manifestations knowing and that incorporates Richard Cowling's work pattern appreciation. And then the second part is voluntary mutual patterning that we do together and to me that is what nursing is. It's like really understanding the person, the whole person in the context of his/her environment. The knowledge that we have in nursing, about the whole person and their mutual process in their environment is what I'm always basically trying to get at.

II. Nurse as healing environment

A. Subject E

> Most of the times we think of the environment as being a physical construct around us and my perspective is that I am the person's environment. That human environment relationship is the thing that we are working with and I can influence myself as part of that relationship and when I make changes in myself, the relationship changes. And then the person is somehow, through some universal flow, able to change themselves.

B. Subject B

The fact is that when I do my nursing, it's quiet and with focus and that client is the only person in the world who is there at that moment for me to focus on. That mutual process is taking place then and now. I don't think about the hospital setting, I only think about the client and the families. If you are looking at the client from a family point of view - as a unit. I think that is most important and they know that I'm there for them because I AM there for them.

C. Subject D

An important healing practice for nursing is mindfulness and a willingness of the nurse to see himself or herself as the healer. It's first and foremost the 'self' as healer – the bringing the whole self into this relationship so it's really the caring – being fully present in the caring.

D. Subject V

I believe knowing and presence are important in bringing about changes that are manifestations of healing. In a nursing situation there is usually physicality involved. It's getting close enough to the patient so that you are giving them your undivided attention. Attention is part of this – you are actually focusing your attention on the patient's situation. Now that may appear simple but I guarantee you it doesn't happen all the time.

E. Subject V

It is interesting that even in a short encounter I can have an existential moment with a client. When I was working in a pre-surgical assessment setting, we were trying to convey to our clients that this is the beginning of our relationship with you. This is how we are with you here. We are available to you and we want to know your story, and we want to know what brought you here. What your stresses and worries are because we are going to be here for you and here is what is going to be happening to you next. That had had a sense of trajectory to it as well, even though I probably wouldn't be seeing them again. I was helping establish nursing relationships in the future.

F Subject B

I recall working with a little boy and his family. On one encounter when I saw him he was nine years old but he was two when he first presented with a brain hemorrhage. His family, of course, was very concerned but he

did well. He did develop a residual deficit of right-sided weakness. But you know his mom called me the other day and said, 'I want to just tell you how much I appreciate what you've done through the years'. I remember when you said to me, 'Enjoy him every day and live each day – think about what you can do that day and pattern the environment so that you are going to have him to be able to do the things that he CAN do – focus on the things he can'.

G. Subject E

I see Therapeutic Touch as extremely intimate in working with people because I'm intentionally and they are intentionally allowing me to share with them our energy field. To know them in a way that other people have not consciously known them.

H. Subject D

I would say the most important nursing practice is the awareness of the self as an energy field and then centering oneself – that is bringing in the quality of high energy into a centered and calm place. Then really being willing to engage with the patient at that level. So that is a key nursing practice to use the self, then in the moment what needs to happen emerges. Proximity is not the same as presence. We can get into intentionality here because let's say there is a nurse who is interacting with a patient and another person could enter the room and go over and check the IV and leave the room. All that has occurred is we might have observed the other person coming into the room and do some task and leave. Our process is different from that. What I'm saying is proximity is not the same as presence.

I. Subject W

To be a healing presence for another one must recognize their own need for healing. I would add here that they need to accept their own need for healing and then recognize they have an individualistic, unique experience of that.

J. Subject A

People frequently respond to wounded healers and that is a part of their healing process. Our perception of our field is there are boundaries and some people's boundaries are more tightly knit than others.

K. Subject W

Nurses need a lot of help to accept who they are. If nurses are healthy enough themselves, they will be able to be in human relationship with other people. So many nurses are totally drained. Many come from alcoholic families or families where they were care givers from the time they were little kids and they don't know how to ask for help. They don't know how to look at themselves and admit they have limitations. I think the single most important thing is that nurses learn about themselves and are open to help.

L. Subject D

We have to have environments that are sustaining nurses in a healing and healthy way so that nurses who are engaging patients in a manner intended to heal are aware that they are people who are, in fact, also healing. That in the moment of healing and caring this is happening for both and it's always that way. When healing happens, it is always mutual and simultaneous. It may be at different levels for each of these people. What is happening with the patient is not what is happening with me, precisely but in the moment we are both healed. Something shifts for both of us. Those are the times that we leave work deeply satisfied. There is always mutuality when this happens. We walk lighter, and we sleep better in the course of our work when we've experienced healing with someone.

III. Appraisal and intentional mutual patterning

A. Subject M

When someone comes to me, I ask them what they want. I want to know what they want and then my job, as I see it, it is to help them make those changes, if possible. I don't usually question whether the changes are or aren't possible because I believe in miracles. We figure out approaches we can use. Your approach is to work with a person in defining their own goals or their own steps because health patterning is helping people make the changes they want to make.

B. Subject C

Actually it's the art of recognizing what this person needs and bringing to that process what we have to offer as a nurse. It facilitates their healing but the healing belongs to them. It means recognizing and getting to know this person enough that you have an idea of what will facilitate their healing.

C. Subject B

You have to also look at them in terms of how do they perceive what is happening to them. They are all frightened. So I think it's very interesting that on the telephone since I've done this for so many years, I've acquired the ability to do a pattern appraisal, even though I can't see the person. By the tone of voice and just by the things being said, I can usually phase into another question or another process that is going to explore more about who the person is and what is going on with him/her.

D. Subject B

When I first go into a room I must say I look at pattern manifestations of the environment. They do tell a great deal. Are there flowers? Are there bright colors in the room? Look at the things that are personal and reflect the personality of the individual. What does the client look like? What are his/her facial expressions – body language? How do they move? What is their speech pattern like? Who is with them? What is the nature of the mutual process between the client and the people who are there? Are they having a happy conversation or are they having an argumentative conversation or are they worried? I do not view the human and environmental field in particular but can identify the dominant resonating pattern of their mutual process. There are lot things you can see in just a moment when you walk in and observe the whole picture and you act upon it.

E. Subject B

There was a woman in her 70's who was in the early stage of post operative recovery from back surgery. She had specific orders related to position and activity. Only lying and standing were permitted. She was frail and her body mechanics were severely compromised. The nurses were concerned that she was at a high risk for falling and had put the side rails up. When I entered the room, I saw the frightened look on her face as she was attempting to climb over the bed rail. I put the rail down and pulled up a chair right next to the bed. I took her hand and said, I'm going to be your nurse for the night. My name is Subject B and I am here to help you. I sat there for a moment and looked at the tattoo number on her arm and immediately I knew what was wrong. I touched the tattoo and I ran my fingers over it and I said, 'Is this what's bothering you?' She started to cry and said, 'Yes, yes, yes. I feel like I'm again in Auzwitch. I remember when I arrived there. I saw Eichman send my mother, father and sister to the left. That was their death sentence. He sent me to the right and I went to a concentration camp. I could sense that the relative past was right there

with her in the relative present. To her, the constraints and the raised bed rails represented the wire fence at Auzwitch. I felt that in her mind she could see that concentration camp and she could feel the loneliness, the pain and the suffering associated with her experience there. Her resonating pattern manifested feeling of helplessness and vulnerability. I said, 'I'm gong to leave the rails down, but I'm going to show you how you can get up and get down, so you are safe here. She said, 'I can't sleep at night – would you just sit in that chair? Don't do anything but just sit in that chair where I can see you until I fall asleep. When my evening shift was over, I sat in the chair so she could see me. I could see the benefit of my therapeutic presence as she fell asleep with a contented look on her face.

F. Subject V

It's more of a special relationship in the world that matters, I think. If I determine that the patient may be getting in a panic situation, you can bring them back from that spiral by exerting more control. I need to become their world and the only thing they are aware of at the time is just me. Using the force of my energy with them, I think I can pull them back. So, it is the power of the connection with you that perhaps get them through? They can trust. They can know that I'm not leaving them. That I'm observing them. That I'm breathing with them. That I'm not going to let them get into trouble.

G. Subject V

There are times when a patient is in a panic situation. I'm thinking about a situation like weaning a patient from mechanical ventilation. I find that what I will do in responding to their sense of panic is to get my face really close to their face so that I become the only world they see. That I can look at them and say, 'We're here, I'm here and all you have to do is breathe'. Really get their attention by being really close to them and by making sure they understand that I'm really there. You can't send them that message by standing across the room.

H. Subject E

When I see people who are lacking information or they have a knowledge deficit, or they have been seeing themselves in a particular way that begins to interfere with their satisfaction with life, primarily when I'm working with somebody like that, I'm either focusing on working with them through a counseling process of becoming more aware of themselves and options and alternatives to problem solving. From an educational

perspective of what resources are available to them and how they can access those resources.

I. Subject C

We practice within the context of three variables and those variables are respect, responsibility and empathy. So that the concept of responsibility is something I believe we kind of monitor as we interact so that is part of our art. The other thing is that respect for the patient's right so that we have to find a balance between how much they do for themselves and how much responsibility they can have and their right to make choices and do the things they would do. I think empathy is how we do that in relationship. So those three variables are related. The way we practice this continuously knowing through empathy and; to me, that then is an artistic process.

J. Subject M

Ok, I'm aware of this. I see the X, Y, Z manifesting and I have to look now and see what kind of choices need to be made that I would choose to make as the client and helping the client doing it together. I have to see what is getting in the way because that is where the freedom comes in. That is the major blockage, usually. How am I involving myself right at the moment in creating changes? Well, maybe I am not involving myself in a way that is getting me any where at all and might be making things worse. So I try to look at all four dimensions of power: awareness, choices, freedom to act intentionally and involvement in creating change. When you do that then you really have a good assessment of knowing the power that is operating there and what needs to be done to change it. Sometimes it just helps to point out very directly and very specifically things for the client and then it's up to the client to choose.

K. Subject E

If I think there is a single thing that is going to make a difference to this person and put all my energy into that one tool, I close myself off from information coming from that person about what is really going on with them.

L. Subject V

The nurses' role is to be present with the patient so there is a 'tune in' with the patient and there is a connection that is meaningful to the patient so the patient feels safe and the patient feels that they have someone caring for them and I mean that in the full sense of the word. Then the nurse is going

to be using his or her expertise in pointing out the possibilities for healing within this situation. That it's the patient's role to claim those possibilities with the support of the nurse.

M. Subject V

So it's focused attention and it's receiving the impressions of the patient and getting a sense of what are the possibilities, what are the barriers, where do we need to go in this situation? I know things about getting through surgery that this patient doesn't know so I bring fully my knowledge about pattern, trajectory, and directionality to this moment and I see how this patient lines up in that realm of possibilities and then decide where we should go.

N. Subject V

Knowing the patient is critical, nurses have to know what the problems are and know what to watch for and also how to create safety. I think trust and safety are essential. It's not about machinery-it's about being known. What are the likely things that can go wrong here? Who is their family? Where do they come from? Where are they going to go next? Stuff like that makes a difference because it's all about trajectory and directionality. It is essential that the patient be known. We must have access to understanding the wholeness of the person. In today's hospital settings, frequently nobody knows these patients. No one even knows what the patient looks like. The patient needs to be known. We need to know who they are. We know the physiological data but we also need to know if he looks down today as compared to yesterday. If a nurse is truly paying attention to who that person is as a whole person, that little piece of data planted in the mind of the oncoming nurse will alert her to watch that patient a little differently.

O. Subject V

I also think as a nurse I had damn well better know my stuff! Evidential or there may be the need for somebody to really recognize the change in pattern, which indicates they are going septic or they are going into cardiac shock. We have to be able to assess and pick up the changes early and taking action at an appropriate time. I'm all for nurses knowing that stuff as life depends on it.

P. Subject S

We must be able to identify problems from the patient's perspective. Not what I think their problem is but what they think their problems are. Then we have to be helpful with that problem. Then we can do exercises to help them realize through expanded awareness some of the things they can accomplish in a broader sense.

Q. Subject V

Directionality, size of the world, knowing the person, entering the person's world, finding the touch points, finding those points where I can make a connection. Sometimes it may be simply by my being in that role. I'm here to be your nurse and you don't need to know anything else. I'm real interested but I won't force myself upon you.

R. Subject V

I think that clients are assessing us as much as we are assessing them. When they assess a nurse who is competent and capable, they are much more likely to open their life to them. If they see a nurse who is fumbling around, who is distracted and not really interested in what they are doing, talking more to the staff than to them, why should they open their life to that person? They won't open their life and they will protect themselves from that person.

S. Subject V

It all starts with the person and where they are in that moment. Their capacity to look at possibilities and make choices around those possibilities, which relates to their sense of meaning. How much energy do they have at that moment? As a nurse I had better be able to enter their world so that I can understand their energy and their meaning and I can help them explore that. Once their meaning is clear, the other stuff is going to sort itself out. It's understanding their situation in the 'NOW', which makes a difference.

T. Subject B

You do a health patterning…you focus entirely on the patient – those are the things that you intuitively connect with the patient. You've got to deal with the technical issues, sure you do. But the healing comes from your presence and your commitment to what you are doing and your intentionality. Intentionality is the whole thing right there. It's the intent

and I think it's one of the most important things. The intentionality or participating in the healing process and that has always been my intentionality. Commitment, intentionality, and healing, and caring.

U. Subject E

I'm aware that I have flexible frequencies so depending on who I'm with, and what the needs are at the time, I can adjust my wave frequencies to be synchronized with their's.

V. Subject V

Sometimes you have a one episode encounter with a patient. That encounter with this patient has no before or middle or end to it. What we did is get our whole story so their story itself had a beginning. What we did is get the patient's whole story. So their story itself had a beginning, middle, and end, or at least up to the middle. That was my job of trying to understand what was the pattern of their life. Where are they going in terms of their safety and capacity because they are facing big surgery in the future?

W. Subject V

Let's start with critical care. What I look for is how big is the world that this person can attend to? If they are totally sedated or under medication then their world is very small. They really are functioning more on a physiological level. Let's pretend the patient is not overly sedated, and then I can pay attention to how much of the world the patient is paying attention to. Are they able to get outside themselves and give me good eye contact? The quality of eye contact makes a big difference to me. Do they see me as another person or just as something out there that might help them out of their sense of desperation? I find as people heal or move through their human process, their awareness of their world expands.

X. Subject B

When I 'm working with a patient and assessing him/her, I visualize the things the patient tells me. When they tell me something, I'm there with them. There is no one else but them. Whatever they are describing to me, it's like I'm looking at a movie and can actually see it all. This is something that I do all the time.

IV. The nursing art of designing care

A. Subject C

I think it all has to do with being sensitive. A sensitivity to other human beings. I think the nurse needs to be the professional person who designs care. I think that we haven't talked enough about designing care. We haven't really talked about designing the care and the importance in who designs it and then who does what part of it. We want differentiated practice, but we've made that just centered around skills.

B. Subject C

I think that part of providing healing environment has to do with recognizing this person and where they are in this whole process of whatever is going on with them, and who they are, and then designing care specifically for them. The healing environment is created by the art of nursing. One of the things that nurses do is try to facilitate that being a harmonious kind of thing so that they can heal. I believe that we do that with our art. For me, it has to do with the person's interactive capacity and empathy in the heart of it. Empathy seems to be the heart of it.

C. Subject S

If we're doing that with clients, being totally there when they need us, taking the time to try and understand what the real problem is, then moving ourselves into the middle of their space in an attempt to solve it, we are being helpful and promoting healing. Identifying whether a person needs coaching because the person really can do it, or that the person really can't do it because they don't have any skill sets, is important. If the person just needs coaching, I can coach. If the person can't do it, then I might do it for him/her. There comes a point where they really have to do things for themselves, as it is better for their healing process. Our program is designed around personalized care and what we do is provide personalized care where I'm taking care of you and modeling how you can do it yourself. Personalized action is when I coach you and help you take the steps I know you can take to take care of yourself.

D. Subject B

Sometimes I also do imagery on the phone by asking the client to do an imagery exercise which sort of helps get them through the day. All I ask is that they get through that particular day and then the next day, just get through that day instead of looking too far ahead. You know the relative

future can be very frightening to people when they can envision themselves in a coma or in a terrible situation. So I find this is very healing environment…using the telephone conversation to help pattern their day. We also use humor. When I finally do get to meet them, they feel like I'm an old friend and I feel the same way about them and their families.

E. Subject E

I think in any interaction with another person who is seeking to heal themselves, I bring a whole kit of options, skills and tools. I see those different tools as a sort of 'jumping off place' or ways to make connections.

F. Subject E

I can use a whole toolbox of modalities. I engage in guided imagery, visualization, journaling, meditation, mindfulness and continuing up would be looking at the use of energetics and bio-field therapies, like Therapeutic Touch.

G. Subject D

It's using the whole toolbox of nursing practices and discerning which of those tools to use at the moment out of deep presence with this patient. It's really using your whole self and your awareness of the whole self to discern what is the right action for the patient at the moment. Nursing practice is selected based on what is happening with the patient or what the patient is experiencing at that moment and the nurse takes the cues from that. Again the nurses are responding to where the patient is. So I would say that another nursing practice that is important is nursing intuition.

H. Subject M

With one of my patients I would every day have a five-minute solid meditation over the phone with the intention of the two of us uniting our intentions and focusing on healing to manifest in whatever way it might manifest. We didn't have any attachment to a specific outcome and we would focus our attention on healing. We did this almost every day for a year and continued until she died. It was always silent but sometimes I would say, 'Let's do healing from a distance'. We'd do Therapeutic Touch from a distance or sometimes I would give her a one sentence image exercise to visualize.

I. Subject S

From an individual standpoint the nurse bonds with clients, identifies a focal concern, gives her care gently, helps them try to improve their well-being and expands their awareness and teaches them to process. You have to be able to sense what needs to be done clinically and intuitively and take the appropriate actions, which vary and are individualized and personalized to situations in people. You have to be able to take whatever action in necessary to intervene in a healing crisis. If you handle the crisis right it can become a healing moment. You have to be able to think on your feet with a pocket full of tricks that you learn over time to be able to intervene in a way that will transfer the crisis into a healing moment rather than to escalate it into a nightmare. Doing this is a lot like improvisation.

J. Subject S

If you are willing to just drop everything an seize the moment and be with that person, thinking on your feet, and try to identify what possible intervention out of the 16 billion that are out there that you might be able to do to help them plan. Like a graveside visit for the next day, or interpret a picture as they are doodling. As you do this you'll be able to be witness to healing happening, which is absolutely awesome.

K. Subject S

I help people try to rise above their problems, to look at the concepts, to look at the metaphors. Don't take things too seriously. When you start seeing them do that and laughing about the metaphors, you start seeing that there is more peace about them.

L. Subject S

What seems to happen is that the opportunity for really good healing presents itself and the nurse must recognize the opportunity. It's usually at some major crisis point that the client is having. Some huge drama or some huge problem. I have to step back and say that the key thing for me is to recognize that moment as a potential healing event or opportunity. What I have to do then is use my intuition to intervene in a way that the client feels helped and understood. That's helping to resolve what seems to them at the moment a panic or a hopeless situation. I must involve them in the process so not only am I doing this but I'm helping them participating in it and also on some level direct it. You have to be willing to move with your intuition directing you and move into the energy field

of the person – protecting and shielding yourself in this process because you can't lose sight of the fact that it is their pain.

M. Subject B

You can suddenly see the wholeness of someone, you can look into their heart, and you can also feel them. I think you can sometimes resonate with their feelings and you can connect with what they are experiencing and understand it. Like the loneliness of the man underneath the covers all day long, shutting himself off from the world.

N. Subject B

First of all, I think intuition is important. What you say by your intuitive actions – don't be afraid as long as you know it's from the heart, don't be afraid to say something to the client that you think may be offensive because the client will know within a minute whether or not it is from your hear. If it is not from your heart, you may insult them by what you may say. If they know it's from the heart even though it may be wrong or an out of the ordinary thing to say, they will know it and accept it and will thank you for it probably.

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